Peer support for breastfeeding: Guidance for Scotland

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Acknowledgements

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Foreword from the Scottish Government

The Scottish Government is committed to improving the health and wellbeing of the Scottish population and ensuring that each child gets the best possible start in life. We recognise that breastfeeding has many major health benefits, in the short and longer term, for both mother and baby, and that is why we are committed to its promotion throughout Scotland.

This means it is vital to provide excellent support to women to help them to breastfeed for as long as they wish to do so, since we know the best health benefits come when breastfeeding is maintained for a baby’s first six months and beyond. New families need the encouragement of their communities, including those who have experience of breastfeeding, as they care for their babies in the earliest days and weeks of life.

In recognition of the importance of this support, establishing breastfeeding peer support projects was a key part of *Improving Maternal and Infant Nutrition: A Framework for Action*, published by the Scottish Government in 2011. I therefore greatly welcome NHS Health Scotland’s publication of this important guidance document on breastfeeding peer support. The guidance published here will help to give Health Boards and other organisations the tools to help them to set up or maintain effective breastfeeding peer support schemes across Scotland.

Michael Matheson
Minister for Public Health
Scottish Government

Foreword from NHS Health Scotland

Breastfeeding is an achievement of the greatest importance to public health because it protects the health of mothers, their infants and children. But Scotland struggles to view breastfeeding as the normal expectation of mothers and children, families and communities. NHS Health Scotland intends that the guidance will contribute to improving the overall health of families and to strengthening communities as they build towards truly welcoming mothers and babies who breastfeed as participants in normal everyday activity. This could be at home, in a café, on a bus, in a shop or at the park.
While we have strong and indisputable evidence about benefits, what we know about effective interventions to start and sustain breastfeeding is less clear-cut. This guidance outlines the contribution of peer support for breastfeeding mothers to this area for those commissioning and delivering services, with a succinct and accessible account of the best available evidence, how it supports current policy and influences existing practice.

At the same time, the guidance highlights where gaps remain in our knowledge, for instance about the wider benefits to the mother that go beyond breastfeeding; the tangible benefits to the peer supporter; the impact on the family, particularly fathers; and the benefits of breastfeeding peer support to the wider community. These are all areas for further exploration as part of the ongoing Early Years programme at NHS Health Scotland.

Offering breastfeeding peer support is a popular activity for staff in Health Boards and voluntary sector agencies, who show real commitment to and enthusiasm for it. Yet we need to increase our understanding of mothers’ lived experiences of, and subsequent decisions around, early infant feeding in order to improve the delivery of peer support. This is particularly the case for mothers who experience the effects of social deprivation and/or who come from families for whom formula feeding is the norm. Such understanding and support can be offered by a peer, someone who is ‘just like you’; someone who has had a similar experience of breastfeeding, will know its high points and difficulties, who has had first-hand experience about how to overcome breastfeeding challenges and can share in the sense of achievement.

It is our aspiration that mothers should have equal access to breastfeeding peer support, irrespective of their personal circumstances and location. Having a health inequalities focus, the impact assessment that accompanies this guidance includes evidence from research and practice to inform how NHS Health Scotland, in collaboration with Health Boards and voluntary sector agencies, will work to ensure that we do not unintentionally widen the gap in unequal outcomes through the way that we provide breastfeeding peer support.

Being aware that knowledge and attitudes are ever-changing, we have produced this guidance as an online resource so that it can be updated to take account of new evidence about breastfeeding peer support and ways that it can help to address the inequalities that exist around infant feeding. In so doing, we hope that this guidance contributes to supporting mothers to give their infants the best start in life.

**Dr Andrew Fraser**
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1. Introduction

‘Experience shouldn’t be out of a book, should be life experience, somebody that's been through it.’ (Hoddinott et al., 2010)

This guidance about peer support for breastfeeding mothers is intended to inform professionals in Health Boards and voluntary sector agencies with responsibility for local breastfeeding support about the most up-to-date policies and evidence related to breastfeeding peer support. The guidance includes reference to training, but only as part of the consideration of ethical principles. It does not cover issues related to breast milk feeding in neonatal units as this will be the focus of a separate publication in 2014/15.

Acknowledging that professionals will need to use their judgement and take account of community populations and their specific needs, this document is not intended to be prescriptive, but rather to guide local activity as Health Boards and voluntary sector agencies continue to provide peer support to breastfeeding mothers.
2. Key messages

1. Providing breastfeeding peer support was a key recommendation in NICE public health guidance 11: *Improving the nutrition of pregnant and breastfeeding mothers and children in low-income households* (NICE, 2008).


3. Providing peer support aligns with community development endeavours and asset-based approaches.


5. Breastfeeding peer support is popular among health practitioners and voluntary sector agencies in Scotland.

6. Current thinking, beyond the evidence, suggests that breastfeeding peer support activity needs to take full account of the context in which it is delivered and the needs of the local population.

7. The provision of breastfeeding peer support is complex. It needs to be fully integrated with local service planning and delivery regarding the recruitment, training and ongoing supervision of the peer supporter.

8. Breastfeeding peer support may be intensive, involving one-to-one and/or group-based support.

9. Overall, recent review-level evidence indicates that peer support is an effective intervention for breastfeeding.

10. Breastfeeding peer support needs to be appropriately evaluated with due reference to the accepted principles of good evaluation practice.

11. The benefits of peer support need to be evaluated more broadly than exclusively focusing on breastfeeding duration. Context is important, as is taking full account of other measurable benefits at both an individual and community level.

12. As local evidence indicates that peer support is a transactional activity, evaluation of its effectiveness needs to consider both the experiences of the peer supporter and the breastfeeding mother.

13. Future activity related to breastfeeding peer support in Scotland needs to be explicitly defined and guided by well-established ethical principles, especially equity.

It is hoped that this guidance will contribute to the development of new, and the revision of existing, breastfeeding peer support initiatives in Scotland.

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1 These activities were based on the best available evidence at the time of its publication. This evidence ‘context’ is summarised in Appendix 1.
3. The rationale behind this guidance

The health benefits of breastfeeding, to both a mother and her infant, are well documented. Public health guidance published by The National Institute for Health and Care Excellence (formerly the National Institute for Health and Clinical Excellence) (NICE) in March 2008 included a key recommendation about the provision of peer support for breastfeeding mothers. Taking account of this NICE guidance, the Maternal and Infant Nutrition (MiN) Framework’s Action Plan (Scottish Government, 2011) included two activities related to breastfeeding peer support.

Both the breastfeeding community and academics acknowledge the need for national guidance about breastfeeding peer support activity in Scotland that includes the most recent evidence of its effectiveness.

Peer support for breastfeeding mothers rightly remains a worthwhile and popular activity across Scotland. On a human level, it enables women who have had similar experiences breastfeeding, to offer both emotional and practical support, (complementing that which is offered by health service provision). This may be mutually beneficial to both the peer supporter and the supported mother. Peer support of breastfeeding mothers also contributes to meeting relevant policy requirements, specifically activities 5.2 and 5.3 of the MiN Framework (Scottish Government, 2011).

This paper considers the evidence of effective interventions in relation to the provision of breastfeeding peer support. It draws on systematic review-level evidence that considers the collective findings of several studies about peer support for breastfeeding and also reports on the evidence from other relevant studies, many of which have been conducted in Scotland. The guidance also aims to highlight ethical and evaluation issues that need to be taken into account when planning or maintaining breastfeeding peer support activity in Scotland.

As current thinking emphasises the importance of other contextual factors to the success of breastfeeding peer support, an overview of relevant policy and other key documents is included to provide the background against which breastfeeding peer support activity is being developed.

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3 Please note that in order to comply with current copyright, readers may be able to access the abstracts and full papers via the included hyperlinks. To access publications that are not freely available on the Web, readers will need an Athens password that can be obtained from relevant NHS Board staff.
4. The rationale and process for identifying and summarising the evidence of effectiveness

Evidence of effectiveness from research studies helps us to identify areas for effective action. While the outcomes of individual primary outcome studies are important, these may be atypical, and potentially biased. Such issues may only become apparent when studies are repeated or interventions rolled out on a wider scale. Evidence and evidence-informed recommendations from systematic reviews and reviews of reviews seek to reduce bias by providing an overview of the findings from several studies. These form the basis of ‘highly processed evidence’, for example practice guidelines, produced by organisations such as NICE. While we acknowledge that other sources of evidence may be available, because of time constraints and in the interests of quality assurance, the evidence presented here is mostly ‘highly processed evidence’ as opposed to primary outcome studies. There may also be instances where the outcomes of a Scottish evaluation/initiative are considered important in assessing what action is required because these are highly relevant to the local context in which many findings will be directly transferrable. Where available, an indication of the evidence around cost-effectiveness is included.

When considering the included evidence, the following points should be noted:

• The evidence provides an overview of what is currently known from these selected highly processed sources. However, the evidence base identified and included within some reviews has limitations, such as a lack of robust, relevant primary outcome studies in several areas of interest; e.g. for vulnerable groups.

• Throughout the evidence summaries, issues pertinent to the interpretation of the evidence are highlighted. Attention is drawn to methodological issues relating to the evidence, such as, much of the included studies being undertaken were in the USA, and so the extent to which the findings are transferable/generalisable to Scotland is open to question. We highlight when it has not been possible to reach definitive conclusions as to what constitutes an effective intervention, because of the lack of evidence of effectiveness.

• Due to inevitable gaps in strong scientific evidence, the feasibility and desirability of adopting a purely evidence-based approach to health improvement and reducing health inequalities are limited. Activities that lack a strong evidence base may have important contributions to make to the overall impact of a package of interacting activities that together comprise a complex intervention. In judging whether to include certain activities, the NHS Health Scotland approach of considering plausible theory and ethical principles may also be used to guide decision-making (see Tannahill, A. ‘Beyond evidence – to ethics: a decision-making framework for health promotion, public health and health improvement.’ Health Promotion International 2008; 23:380–90, available from:


4 Systematic review. For definition see: www.campbellcollaboration.org/what_is_a_systematic_review/index.php
5. Searching for the evidence of effectiveness

Library searches of breastfeeding peer support interventions were conducted in November 2010 and repeated in March 2013. Details of these library searches are available on request.

The reader should note that the population groups included in the ‘highly processed evidence’ that is reviewed in this guidance were identified by the review authors and thus we are unable to comment upon the extent to which these reviews have addressed each of the protected characteristics as they are defined in the Equalities Act (2010). This will be part of NHS Health Scotland’s ongoing review of the evidence related to breastfeeding peer support during 2014/15.
6. Breastfeeding peer support context

Breastfeeding peer support guidance for Scotland has been developed with due consideration of the policy landscape. Details about documents that are relevant to the provision of peer support for breastfeeding mothers are included here.

Key documents that ‘contextualise’ breastfeeding peer support activity in Scotland include the following:

**Infant-feeding-specific**


   The Framework is intended to be used by NHS Boards, local authorities and others to assist them with making improvements to the nutrition of pregnant women, babies and young children in Scotland.

   In support of the Framework, The Public Health Observatory Division at NHS Health Scotland undertook a review to describe current maternal and infant diet and nutritional status in Scotland, (the full review is available from: [www.scotpho.org.uk](http://www.scotpho.org.uk)), and the Evidence for Action team at NHS Health Scotland provided the rationale and evidence that informed the decision-making processes for the package of activities included in the Framework. This is available from: [www.healthscotland.com/documents/4687.aspx](http://www.healthscotland.com/documents/4687.aspx)

   The Framework includes two activities related to the provision of peer support for breastfeeding mothers:

   **Activity 5.2:** Structured support, proportionate to need, will be provided for breastfeeding mothers postnatally, including:
   - support from health professionals and relevant organisations, e.g. The Breastfeeding Network, National Childbirth Trust, La Leche League, Association of Breastfeeding Mothers
   - access to breastfeeding support groups and relevant organisations
   - access to the Breastfeeding Helpline
   - access to peer/mother-to-mother breastfeeding support programmes.

   As with antenatal support, postnatal support services will need to be designed so that they are responsive and inclusive to people with additional needs. This includes those who are least likely to breastfeed or only breastfeed for a short time, such as young mothers, mothers with poorer educational attainment and those living in areas of social deprivation where breastfeeding rates are low.

   **Activity 5.3:** Accredited breastfeeding peer support programmes will be provided in all NHS Board areas. These should be modelled on a nationally agreed framework and be supervised by an appropriately trained and experienced practitioner. Peer support will be offered to women before and after birth alongside other ante- and postnatal support, and will be considered as a core part of activity to support breastfeeding.


The Framework activities 5.2 and 5.3 were developed in consultation with partners and with specific consideration of the key priority recommendation made by NICE, in response to pregnant women and new mothers, particularly those who are least likely to start and continue to breastfeed, for example, young women, those who have low educational achievement and those from disadvantaged groups. The recommendation from NICE is that commissioners and managers of maternity and children’s services (should):

- Provide local, easily accessible breastfeeding peer support programmes and ensure peer supporters are part of a multidisciplinary team.

- Ensure peer supporters:
  - attend a recognised, externally accredited training course in breastfeeding peer support
  - contact new mothers directly within 48 hours of their transfer home (or within 48 hours of a home birth)
  - offer mothers ongoing support according to their individual needs – this could be delivered face-to-face, via telephone or through local groups
  - can consult a health professional and are provided with ongoing support
  - gain appropriate child protection clearance.

- Consider training peer supporters and link workers to help mothers, parents and carers follow professional advice on feeding infants aged six months and over. The advice should promote an increasingly varied diet using food of different textures in appropriate amounts (in addition to milk), in response to the baby’s needs.

3. The Scottish Government has adopted as policy World Health Organization guidance recommending exclusive breastfeeding for the first six months of an infant’s life. It is recommended that breastfeeding should continue beyond six months, alongside the introduction of appropriate solid foods, for up to 2 years of age or as long as the mother chooses, (see [www.who.int/nutrition/topics/infantfeeding_recommendation/en/](http://www.who.int/nutrition/topics/infantfeeding_recommendation/en/)).

4. The Breastfeeding etc. (Scotland) Act (2005) made provision in relation to the promotion and support of breastfeeding, and made it an offence to prevent or stop a person in charge of a child (under 2 years of age) who is otherwise permitted to be in a public place or licensed premises from feeding milk to him/her there, (see [www.opsi.gov.uk/legislation/scotland/acts2005/20050001.htm](http://www.opsi.gov.uk/legislation/scotland/acts2005/20050001.htm)).

5. *Guide to the Baby Friendly Initiative Standards* (UNICEF, 2012). These new standards incorporate the previous standards as specified in the Ten Steps to Successful Breastfeeding and Seven Point Plan for Sustaining Breastfeeding in the Community,
but update and expand them to fully reflect the evidence base on delivering the best outcomes for mothers and babies in the UK. This is available from: www.unicef.org.uk/BabyFriendly/Health-Professionals/New-Baby-Friendly-Standards/

Relevant key policy documents


This sets out in detail what it sees as the scale of the challenge facing public services in Scotland. This document emphasises the following:

- A decisive shift towards prevention.
- Greater integration of services, better partnership, collaboration and effective local delivery.
- Greater investment in the people who deliver services.
- A focus on improving performance through greater transparency, innovation and digital technology.
- Asset-based approaches.

As such, breastfeeding peer support could potentially make a four-fold contribution:

(i) To a decisive shift towards prevention
(ii) To an increase in service integration
(iii) To greater investment in the people who deliver services and
(iv) To the development of asset-based approaches.


This makes explicit connections between these patient priorities and the values of the people working for and with NHSScotland. It includes six (three key**), Quality Ambitions that are outlined below, that will remain central to the approach to systems-based healthcare quality improvement:

1. ** Person-centred: providing care that is responsive to individual personal preferences, needs and values and assuring that patient values guide all clinical decisions.
2. ** Safe: avoiding injuries to patients from health care that is intended to help them.
3. ** Effective: providing services based on scientific knowledge.
4. Efficient: avoiding waste, including waste of equipment, supplies, ideas, and energy.
5. Equitable: providing care that does not vary in quality because of personal characteristics such as gender, ethnicity, geographic location or socio-economic status.
6. Timely: reducing waits and sometimes harmful delays for both those who receive care and those who give care.
Scrutiny of the evidence will enable consideration of whether breastfeeding peer support interventions are **responsive** (in a person-centred way) to the needs of families, infants and practitioners; will enable consideration of the **safety** of interventions from the perspective of family members, peers and practitioners alike, and will enable the identification of the most **effective** ways to promote breastfeeding in the wider community, including peer support.

The inclusion of the most up-to-date high-level evidence also contributes to being able to satisfy the remaining three Quality Ambitions. It highlights the importance of the **timeliness** of recent publications that emphasises the importance of considering whether peer support is an **efficient** use of scarce resources. It also takes account of the issue of **equality** that is central to the MiN framework activity 5.2 and is specifically addressed in the accompanying health inequalities impact assessment (HIIA) of this guidance, (see **Appendix 7**).

**Scottish Government policies/key documents: early years**

8. The Early Years Collaborative (Scottish Government, 2013) is a coalition of community planning partners, including social services, health, education, police and third sector professionals who are working towards three ‘stretch’ aims related to children’s early years:

   (i) By end of 2015, reduce the rate of stillbirths and infant mortality by 15%.

   (ii) By end of 2016, ensure that 85% of all children in each Community Planning Partnership meet all expected developmental milestones at the child’s 27-30 month child health review.

   (iii) By end of 2017, ensure that 90% of all children in each Community Planning Partnership have reached all developmental milestones by the time the child starts primary school.

The aim of the Early Years Collaborative (EYC) is to accelerate the conversion of the high level principles set out in ‘Getting it right for every child’ (GIRFEC) and the Early Years Framework into practical action, (see: [www.scotland.gov.uk/Topics/People/Young-People/Early-Years-and-Family/early-years-collaborative](http://www.scotland.gov.uk/Topics/People/Young-People/Early-Years-and-Family/early-years-collaborative)).

Among the list of process, outcome and balancing measures which CPPs may wish to consider using when determining whether the changes being tested locally are leading to an improvement, and contributing to the ‘stretch aims’, is the ‘proportion of children being exclusively breastfed at 6–8 weeks’, (see [www.scotland.gov.uk/Resource/0041/00414050.docx](http://www.scotland.gov.uk/Resource/0041/00414050.docx)).

The driver diagram that considers the theory of what ‘drives’ infant mortality, (thereby supporting Workstream 1, pre-conception to 1 year) identifies ‘improved rate of breastfed babies’ as an action that will contribute to the reduction of infant mortality. The theory of what ‘drives’ developmental milestones (thereby supporting Workstream 2, 1 year to 30 months) identifies ‘improved child dental health’ and ‘improving child nutrition’ as actions that will contribute to ensuring that developmental milestones are reached.


12. Getting it right for every child (GIRFEC, 2008) (see [www.scotland.gov.uk/Topics/People/Young-People/childrensservices/girfec](http://www.scotland.gov.uk/Topics/People/Young-People/childrensservices/girfec)). This is the national cross-cutting programme which outlines the Scottish Government’s approach to working with children and families in Scotland. Based on individual need, the wellbeing of the child is placed at the centre of the approach, which establishes the principle of giving all children and young people the best possible start in life as a priority for all services.

GIRFEC builds upon the universal services of health and education and sets out a national programme of transformational change to ensure that each child is: safe; healthy; active; nurtured; achieving; respected; responsible and included. These principles inform or influence choices and action across a wide range of roles and contexts.

As a national approach to meeting the needs of all children and young people, GIRFEC is the vehicle to deliver the other key national action plans and frameworks in the early years.


*The Early Years Framework* (EYF) uses a broad definition of ‘early years’ (pre-birth to 8 years old) but also includes a renewed focus on ages 0–3 as a period of a child’s development that shapes future outcomes.

The EYF describes a new conceptualisation of early years, including the principle that children should be valued and provided for within communities. It also acknowledges the importance of strong, sensitive relationships with parents and carers. The EYF emphasises the need to put children at the centre of service delivery, and the principle that children should be able to achieve positive outcomes irrespective of race, disability or social background.

**National policies**

14. The UK Government’s Equality Act (2010) provides a legal framework to protect the rights of individuals and advance equality of opportunity for all, (available from [www.legislation.gov.uk/ukpga/2010/15/contents](http://www.legislation.gov.uk/ukpga/2010/15/contents)). It is in response to this legislation that the health inequalities impact assessment (HIIA) of this guidance has been conducted (see Appendix 7).

**International policies**

comprises 54 articles that cover different aspects of childhood, rights and freedoms. All children and young people up to the age of 18 years are entitled to all rights in the Convention. Some groups of children and young people, for example those living away from home, and young disabled people, have additional rights. The UNCRC was ratified by the UK government on 16 December 1991. Articles 18 and 24 are relevant to the provision of breastfeeding peer support, (see: www.ohchr.org/EN/ProfessionalInterest/Pages/CRC.aspx).

Further details about some of these ‘contextual’ documents are provided in Appendix 3.
7. Defining breastfeeding peer support/help

‘A person of the same age, status, or ability as another specified person’, (The Oxford English Dictionary, see www.oed.com).

While the dictionary definition of a ‘peer’ focuses on the similarity of peer characteristics, in relation to definitions of breastfeeding peer support/help, Hoddinott (personal correspondence, 2013) suggests that while the aspect of ‘similarity’ is often interpreted as referring to a shared demography, (e.g. regarding age, ethnicity, etc.), it may well be that breastfeeding mothers simply want to share with someone who has had a similar experience/problem in relation to breastfeeding.

Following ongoing discussions of the advisory group during meetings held during 2010–2013, the following points were agreed:

• The term ‘breastfeeding peer support’ should be adopted throughout all discussions and written documents to avoid confusion with other kinds of peer support.

• Definitions of peer support need to include consideration of the role and/or limitations/boundaries of the breastfeeding peer supporter.

• The definition agreed by Health Boards needs to part of their risk management procedures and needs to take account of several of the ethical principles, e.g. equity, respect, accountability, do not harm.

• Consideration should be given to the requirement of the breastfeeding peer supporter to have relevant personal experience of breastfeeding, especially if they occupy a volunteering role.

• In exceptional circumstances, and in line with several of the ethical principles, e.g. do not harm, accountability, respect, equity, if an individual who has no personal experience of breastfeeding has displayed ‘a passionate interest in being a breastfeeding peer supporter’, their motivation needs to be established as part of their recruitment to the role of breastfeeding peer supporter.

• Agreed definitions need to distinguish between breastfeeding peer supporters who are health professionals and those who are not. In the case of the former, the staff member may not necessarily need to have had personal experience of breastfeeding if they have been trained to BFI standards. In such circumstances and in line with the ethical principles noted above, their motivation needs to be established in the course of recruitment/redeployment to the role of breastfeeding peer supporter.

• Breastfeeding peer support should offer local support to local women. This concept aligns well with an asset-based approach and encourages the provision of empathic support that is enhanced by local/contextual knowledge.

• The breastfeeding peer supporter’s sensitivity regarding cultural norms needs to be addressed. This aspect of the definition is mindful of the ethical principle of respect.

In light of the above points, definitions of breastfeeding peer support are included in Appendix 4 to prompt discussion with staff in each Health Board and voluntary sector agencies who will need to reach agreement about what defines a breastfeeding peer supporter.
In summary, definitions suggest that breastfeeding peer supporters:

- are mothers of any age who have breastfed and are keen to support other mothers to do so
- have engaged in appropriate training and/or security checks
- work in either/both community and hospital settings
- are fully aware of, and accept the limitations of, their role.

The inclusion of the definitions of a breastfeeding peer supporter in Appendix 4 does not indicate a preference for one definition over another, but merely provides examples that might be useful for discussion and decision-making related to the role and limitations of the breastfeeding peer supporter. However, definitions may vary between Health Boards/voluntary sector agencies.
8. Volunteering in Scotland

This section provides brief information about volunteering in Scotland. The inclusion of weblinks to the organisations described below does not indicate a preference for the approach of these specific organisations over others. The inclusion of this information is simply intended to provide some useful links to organisations that support volunteering.

**Volunteering in NHSScotland**

The Scottish Health Council currently hosts the Volunteering in NHSScotland programme. The programme seeks to support Health Boards sustain and develop their volunteering programmes.

Activities include the development of a national database for managing volunteering information, the support and facilitation of the Volunteer Managers Network (that is open to all NHS staff involved in managing volunteers) and the development of a community of practice that is an online portal which allows members to interact remotely, sharing practice, signposting to resources and engaging in discussions with each other.

The programme is being delivered from October 2011 to March 2014.

Each Health Board is required to retain the Investing in Volunteers Quality Standard. This ensures that volunteers receive the appropriate support and that organisations’ policies are followed. Each Health Board has a nominated strategic lead for volunteering who can signpost to the relevant member of staff. A current list can be accessed from the Volunteering in NHSScotland Programme website.

For more information on the programme see the following links:

**Volunteering in NHSScotland Programme:**

**Volunteering Community of Practice:**
See [www.knowledge.scot.nhs.uk/volunteering.aspx](http://www.knowledge.scot.nhs.uk/volunteering.aspx)

**Volunteer Development Scotland**

This is a charity dedicated to the volunteer and their enjoyment of volunteering. Governed by a voluntary Board of Directors and an active membership, VDS lead the way in informing and modernising approaches to volunteering policy, enhancing practice and improving the quality of the volunteering experience for the people of Scotland, (see [www.volunteerdevelopmentscotland.org.uk/about-us/](http://www.volunteerdevelopmentscotland.org.uk/about-us/)).

**Volunteer Scotland**

Volunteer Scotland is the main website in Scotland for finding volunteering opportunities, (see [www.volunteerscotland.org.uk](http://www.volunteerscotland.org.uk)). Health Boards have been recommended to utilise this resource when advertising for volunteers in CEL 10, (2008).²

Volunteer Centres
Volunteer Centres form part of the functions of the third sector interfaces that exist in each local authority area. The network of Volunteer Centres can assist with the recruitment of volunteers in a local area, (see www.voluntaryactionscotland.org.uk/Find_an_interface.asp).

Specific links to voluntary sector agencies that provide breastfeeding support and with whom we work in partnership are provided below.


La Leche League (see www.laleche.org.uk/).

National Childbirth Trust Scotland (see www.nct.org.uk/branches/scotland).
9. Evidence from recent systematic reviews about breastfeeding peer support

This section presents a summary of the most recent systematic review-level evidence relating to the effectiveness of breastfeeding peer support interventions. Where appropriate, and with the permission of the lead author, evidence statements have been generated from the reviewed text. These can be found in Appendix 5.

Support for healthy breastfeeding mothers with healthy term babies (Review)
Renfrew, McCormick and Wade et al., (2012). The abstract for this publication is available from:
http://summaries.cochrane.org/CD001141/support-for-breastfeeding-mothers

Evidence summary:

The aim of this review was to examine the impact of breastfeeding support for mothers in the general healthy population from a wide range of countries who were (considering) breastfeeding. Its purpose was to assess the impact of such support on breastfeeding duration, exclusivity, health outcomes and maternal satisfaction. Specifically, the reviewers sought to describe the types of support that had been evaluated in controlled studies and the settings in which support had been offered.

Other aims were to examine the effectiveness of the different modes of offering breastfeeding support, (e.g. face-to-face or telephone) to examine whether interventions with both antenatal and postnatal components were more effective than those taking place in the postnatal period alone; and to explore the impact of support that was offered proactively to women, or in response to their request for help. In addition, the reviewers planned to examine the effectiveness of interventions offered by different care providers over and above standard care and to consider the impact of background breastfeeding rates in the countries or areas where the trials took place on the effectiveness of supportive interventions in response to breastfeeding women.

Randomised or quasi-randomised controlled trials were included of women who were breastfeeding their babies, along with studies (involving post-partum breastfeeding support) that also recruited pregnant women who were considering or intending to breastfeed. The review focused on four breastfeeding-related outcomes. These were (1) stopping breastfeeding before six months post-partum (2) stopping exclusive breastfeeding before six months post-partum (3) stopping any breastfeeding before four to six weeks post-partum and (4) stopping exclusive breastfeeding before four to six weeks post-partum.

Of the 67 studies that were assessed for inclusion, 52 randomised controlled trials (RCTs) that had been carried out in 21 countries contributed to the review’s findings about the provision of support in response to breastfeeding. The majority of studies (N=37), were conducted in high-income countries, two were conducted in low-income countries, two in low-middle income and twelve in upper-middle income countries. An evidence summary is provided here.

6 Randomised controlled trial. For definition see www.medterms.com/script/main/art.asp?articlekey=39532
Who delivered the support
When all types of extra support were analysed together, they indicated an increase in the time mothers continued to breastfeed and the length of time that mothers exclusively breastfed. Support by both lay supporters and professionals had a positive impact on breastfeeding outcomes.

While there were no differences noted in relation to the stopping of breastfeeding at four to six weeks, the evidence suggests that breastfeeding lay support (rather than support offered by professionals or a combination of professional and lay support), was associated with the continuation of any and exclusive breastfeeding up to six months.

Renfrew, McCormick and Wade et al., (2012). Evidence statement 1

Type of support
All studies were categorised according to whether support was offered as predominantly face-to-face support, by telephone or by a combination of both. Despite differences between the studies, findings indicated that mothers who received face-to-face support were 20% less likely to have stopped exclusive breastfeeding by the last study assessment or before six months compared to mothers in the control group. Face-to-face support had a positive impact on the continuation of exclusive breastfeeding at up to four to six weeks. Telephone support alone or when combined with face-to-face support did not significantly prolong (exclusive) breastfeeding.


When the support was offered
No significant difference in breastfeeding outcomes could be attributed to support that was offered in the antenatal period as opposed to in the postnatal period alone.


Proactive versus reactive support
The impact of breastfeeding support that was only offered if women actively sought it remains unclear, although the reviewers suggest that this was unlikely to be effective in improving breastfeeding outcomes.

Renfrew, McCormick and Wade et al., (2012). Evidence statement 4

Background breastfeeding initiation rates in study settings
All studies were categorised according to whether the background breastfeeding rates were high (i.e.>80%) medium (i.e. 60%–80%) or low (i.e. <60%). Analysis showed that while there was no significant difference between the three settings in relation to breastfeeding cessation up to six months, differences occurred in relation to exclusive breastfeeding. It showed that the provision of extra breastfeeding support had a more pronounced effect on encouraging exclusive breastfeeding and discouraging the cessation of any breastfeeding at four to six weeks when a country’s background rates of breastfeeding initiation were high.

Intensity of the intervention: the number of postnatal contacts

All studies were categorised according to the number of postnatal contacts; unspecified or no direct contact; less than four postnatal contacts; four to eight postnatal contacts or more than eight contacts. Despite some concerns about study bias, findings indicated that while exclusive breastfeeding at four to six weeks post-partum was not significantly influenced by the intensity of contact, eight postnatal contacts had a significant impact on the persistence of exclusive breastfeeding at the time of the final study assessment.


Renfrew, McCormick and Wade et al., (2012) conclude that all women should be offered support to breastfeed their babies in order to increase the duration and exclusivity of breastfeeding and that healthcare settings should routinely provide such trained support. As support is likely to be more effective in settings with high initiation rates, efforts to increase initial breastfeeding should be in place. Based on their findings, the reviewers advise that support may be offered either by professional or lay/peer supporters, or a combination of both. Strategies that rely mainly on face-to-face support are more likely to succeed and support that is only offered when women seek help is unlikely to be effective. Finally, the reviewers advise that women should be offered ongoing visits on a scheduled basis so that they can anticipate that support will be available and that it should be tailored to the setting and the needs of the population group.

Note to the reader: The evidence summary above refers to the most recent Cochrane review which largely constitutes an update of earlier reviews that were conducted by the lead author(s). The evidence from previously published Cochrane reviews about breastfeeding peer support is not summarised here. However, readers are directed to Appendix 5 to access details of these older publications.


The aim of this systematic review was to describe peer support interventions for breastfeeding during pregnancy and in the postnatal period. The reviewers searched CINAHL, MEDLINE and the Cochrane Library databases from 2000 until the end of February 2008. The thirty included articles and four reviews focused on breastfeeding, breastfeeding peer support and the education of healthy mothers from the perspective of mothers or family members. Studies had been conducted in Europe, North America, Australia or New Zealand and some studies combined breastfeeding peer and professional support.

The findings indicated that individual peer support was most common in the postnatal period, delivered by phone, face-to-face or in groups. Overall, breastfeeding peer support was effective in promoting the initiation, continuation and exclusivity of breastfeeding. Interestingly, the reviewers note that while breastfeeding peer support during pregnancy and in the immediate post-partum period increased breastfeeding in the maternity unit, this was not sustained after six weeks. They highlight that when hospital practices did not support breastfeeding, peer support by itself was not fully effective in promoting its continuation. Combined professional with trained, experienced peer support was effective in increasing the initiation and duration of breastfeeding.
The reviewers note the impact of midwife, partner or grandmother support upon a mother’s decision to initiate and continue breastfeeding. Professionally lead group support was highly valued by mothers and increased their breastfeeding confidence and satisfaction, although mothers did not highly rate one-to-one support by untrained breastfeeding peer supporters.

Kaunonen, Hannula and Tarkka (2012) conclude that only continuous breastfeeding support, beginning in pregnancy, continuing in hospital and throughout the postnatal period until weaning, provides effective results and that different types of interventions are needed during different phases of motherhood. The role of breastfeeding peer support is most important during the postnatal period and if professional support is not available, peer support could provide an viable alternative.

In relation to clinical practice, the reviewers advise that professionals need the support of their organisations for the provision of breastfeeding peer support along with education. They need to become knowledgeable about the role of peer support for breastfeeding and their potential as educators of fathers and grandmothers, thereby increasing their skill in offering breastfeeding support. In addition, for the effective continuation of breastfeeding, professionals and peer supporters should be working together to guarantee the continuity of support for the breastfeeding mother.

**Peer Support and Exclusive Breastfeeding Duration in Low and Middle-Income Countries: A Systematic Review and Meta-Analysis.** Sudfeld, Fawz and Lahariya. (2012). The full publication is freely available from: www.plosone.org/article/info%3Adoi%2F10.1371%2Fjournal.pone.0045143#abstract0

**Evidence summary:**

The aim of this review was to examine the effect of breastfeeding peer support on the duration of exclusive breastfeeding in low- and middle-income countries (as defined by the World Bank), the reviewers searched Medline, EMBASE, and the Cochrane Central Register for Controlled Trials from their inception until April 2012.

Two reviewers independently reviewed and assessed the quality of the randomised controlled trials that included peer support in low- and middle-income countries. Where appropriate, sophisticated statistical techniques (i.e., meta-analysis and metaregression), were used to combine study results. Eleven randomised controlled trials met the study’s inclusion criteria.

The reviewers noted significant differences in the study populations, peer counsellor training methods, peer visit schedules, and outcome ascertainment methods. They found that peer support significantly decreased the risk of stopping exclusive breastfeeding. The combined results across studies showed that the effect of peer support was significantly reduced in settings in which the prevalence of breastfeeding was low, (i.e. in communities with a >10% community prevalence of formula feeding) compared to settings with moderate to high breastfeeding, (i.e. in communities with a <10% prevalence of formula feeding). No significant difference in the effect of peer support on exclusive breastfeeding at four versus six months post-partum was found and the inclusion of low birthweight infants as part of the analysis did not impact on these findings.
In their conclusion Sudfeld, Fawz and Lahariya (2012) note that, while breastfeeding peer support increases the duration of exclusive breastfeeding in low- and middle-income countries, its effect appears to be reduced in formula feeding cultures. The reviewers therefore advise that future studies are needed to determine the optimal timing of breastfeeding peer support visits; their spacing; how to best integrate peer support into packaged intervention strategies and the effectiveness of supplementary interventions to breastfeeding peer support in formula feeding cultures.

**Systematic review of peer support for breastfeeding continuation: meta-regression analysis of the effect of setting, intensity, and timing** Jolly, Ingram and Kahn et al., (2012). The abstract for this publication is available from: [www.bmj.com/content/344/bmj.d8287](http://www.bmj.com/content/344/bmj.d8287)

**Evidence summary**

The aim of this review was to examine the effect of breastfeeding peer support setting, its intensity and timing on breastfeeding continuation. The reviewers searched the British Nursing Index, CINAHL, the Cochrane Library, Embase, Medline and the controlled trials website from their inception to June 2011. Publications were robustly assessed by two of the reviewers.

Seventeen studies were included and these were grouped according to the study setting, (high-income countries, low- or middle-income countries, and the United Kingdom); intensity of contacts, (<5 and ≥5 planned contacts); and the timing of peer support, (during the postnatal period only, or combined with antenatal care). Results from fifteen studies were analysed by combining their results (using metaregression) to establish the impact of breastfeeding peer support on any, and exclusive, breastfeeding at the last study follow-up.

Findings indicated that peer support had a significantly greater effect on any breastfeeding in low- or middle-income countries; (reducing the risk of not breastfeeding at all by 30% compared with a reduction of 7% in high-income countries). Likewise, the risk of non-exclusive breastfeeding decreased significantly in low- or middle-income countries compared to high-income countries: (37% compared with 10%). No significant effect on breastfeeding was found in UK-based studies.

Breastfeeding peer support had a greater effect on any breastfeeding rates when it was provided at a higher intensity and only delivered in the postnatal period. However, no differences were found of its effect on exclusive breastfeeding rates by intensity or timing.

Jolly, Ingram and Kahn et al., (2012) conclude that although peer support interventions increase breastfeeding continuation, especially exclusive breastfeeding, in low- or middle-income countries, this does not seem to apply in high-income countries, particularly in the United Kingdom, where breastfeeding support is part of routine postnatal health care. Breastfeeding peer support of low intensity does not seem to be effective. The reviewers advise therefore that policy relating to the provision of breastfeeding peer support should be based on more context-specific evidence and they recommend that breastfeeding peer support services in high-income countries need to be robustly evaluated.

**Evidence summary:**

The aim of this metasynthesis was to examine women’s perceptions and experiences of professional and peer breastfeeding support to help understand the components of support that they considered to be ‘supportive’. The reviewers searched MEDLINE, CINAHL, the Cochrane Library, PubMed, Meditext, Nursing Consult, MIDIRS, PsycINFO, Current Contents, WHO Library Database, Scopus, Science Citation Index, EMBASE, and BMC between January 1990 and December 2007 for peer-reviewed publications about formal or ‘created’ peer and professional support for breastfeeding women, but excluding studies about family or informal breastfeeding peer support.

Qualitative studies of primiparous and multiparous women who initiated breastfeeding along with large-scale surveys (if the survey reported on the analysis of qualitative data that had been gathered through open-ended responses) were considered. Thirty-one studies were included and meta-ethnographic methods were used to identify categories and themes.

The synthesis indicated that support for breastfeeding occurred along a four-category continuum that has been described by the reviewers as follows: (1) Authentic Presence, (i.e. care provided by professionals or peers that women found ‘supportive’ and reflects a trusting relationship or connectedness and rapport between the woman and her caregiver, supporter, or both; (2) Facilitative Style, (i.e. an approach to health promotion, or helping, that enables people to draw on a range of information and experience and learn for themselves; (3) Reductionist Approach, (i.e. contrary to a facilitative style, a reductionist approach is one during which information and advice are given in a dogmatic and/or didactic style, that may be related to a personal style and a lack of effective training about how to provide ‘education’ or support. The reviewers describe this as being more likely attributable to an environment that does not provide opportunities for professionals and supporters to work in facilitative ways. Thus, a reductionist approach tends to be found alongside (4) Disconnected Encounters. This approach is characterised by a lack of rapport/relationship and is also associated with a reductionist approach. Disconnected encounters seem to inhibit learning, leading to a lack of confidence among mothers who are less likely to sustain breastfeeding. As a result some women then feel guilty and disempowered when no sense of having or building relationships is present.

In their conclusion, Schmied, Beake and Sheehan et al. (2011) emphasise the importance of adopting person-centred communication and relationship building skills to support a woman to breastfeed. Additionally, the reviewers suggest that organisational systems and services that facilitate the continuity of caregiver, for example continuity of midwifery care or breastfeeding peer support models, are more likely to facilitate an ‘authentic presence’, that involves supportive care and a trusting relationship with peers and professionals.

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7 As defined by the authors and drawing on the work of Thorne, Jensen and Kearney et al., (2004), a metasynthesis is a rigorous and analytical process of synthesising the findings of qualitative research on a particular phenomenon.

8 According to the authors the meta-ethnographic methods of Noblit and Hare (1988), particularly reciprocal translation, were used to identify ‘key metaphors, phrases, ideas, and/or concepts’ that are similar across the studies and then to derive concepts that encompass at least two, but typically more, of the studies being synthesised.
Breastfeeding Peer Counseling: From Efficacy through Scale-up.
Chapman, Morel and Anderson et al., (2010). The abstract for this publication is available from: www.ncbi.nlm.nih.gov/pmc/articles/PMC3115698/?report=abstract

The authors systematically reviewed randomised controlled trials that assessed the effectiveness of breastfeeding peer support9 for improving rates of breastfeeding initiation, duration, exclusivity and maternal and child health outcomes. They also reviewed the scientific literature describing the scale-up of breastfeeding peer support programmes.

Internet database searches, (of Pubmed, Web of Science) and The Cochrane Library generated 26 publications for inclusion. Seven studies that considered the impact of breastfeeding peer support upon its initiation indicated its success, especially when it was offered as face-to-face home visits of high intensity, delivered in the prenatal, perinatal and post-partum period. Thirteen publications, the majority of which were RCTs conducted in developed and developing countries, demonstrated the effectiveness of breastfeeding peer support for increasing its continuation. Again, the impact was increased when breastfeeding peer support was on going and delivered face-to-face. Twelve studies, mostly RCTs, indicated the positive impact of breastfeeding peer support upon exclusive breastfeeding with the exception of studies that had not been specifically designed with the expectation of improving this outcome.

Additionally, five RCTs demonstrated that breastfeeding peer support significantly decreased the incidence of infant diarrhoea and significantly increased the duration of lactational amenorrhea among mothers.

Chapman et al., (2010) Evidence statement 1: In support of breastfeeding peer support

Importantly, the reviewers acknowledge that although research on breastfeeding peer support has focused primarily on breastfeeding peer support in response to low-income mothers, this focus is likely to be due to funding priorities, and should not be interpreted to imply that only low-income mothers benefit from breastfeeding peer support. The reviewers conclude that in settings with limited healthcare resources, peer support may represent the only feasible means to provide breastfeeding education and support. The response to breastfeeding peer support may vary, depending on local breastfeeding traditions and income levels. They emphasise that there are too few studies evaluating peer support among more affluent populations to evaluate its effectiveness by income level, however they highlight one single study evaluating a breastfeeding peer support model in response to upper-income women by Dennis et al. (2002),10 in which the intervention was effective and well-received.

Chapman, Morel and Anderson et al., (2010) conclude that breastfeeding peer support initiatives are effective and can be scaled up in both developed and developing countries, as part of well-coordinated national breastfeeding promotion or maternal and child health programmes.

9 For consistency, the published term of ‘peer counselling’ (PC) has been replaced with that of peer support.

10 The full reference for this publication can be found on page 80.
Effect of antenatal peer support on breastfeeding initiation: a systematic review
Ingram, McArthur and Kahn et al. (2010). The abstract for this publication is available from: www.cmaj.ca/content/182/16/1739.abstract

Evidence summary:
The aim of this review was to examine the effect of antenatal peer support on the rates of breastfeeding initiation.

The reviewers considered randomised controlled trials, quasi-randomised trials and cohort studies with controls. They searched the Cochrane Library, MEDLINE, the Cumulative Index to Nursing and Allied Health Literature (CINAHL), the National Research Register and the British Nursing Index from their inception or from 1980 to 2009. The reviewers carried out study selection, data abstraction and quality assessment independently and in pairs, defining high-quality studies as those that minimised the risk of at least three types of bias.

Eleven studies, focusing predominantly on low-income women, were included in the review. Seven studies evaluated universal peer support, and the remaining four targeted antenatal peer support. Six studies were conducted in the USA, four were UK-based and the remaining study was carried out in Mexico. All but one of the seven included RCTs were classified as being of high quality, with three involving targeted and three involving universal breastfeeding peer support. The additional RCT was of medium to low quality, involving universal peer support and the four remaining studies were observational of medium to low quality. One involved targeted and three involved universal peer support.

All studies included both antenatal and postnatal peer support in their interventions. The number of contacts ranged from at least one to unspecified – in response to need, and the venue for support was largely home/telephone, or clinic/hospital-based. It is noteworthy that two US-based RCTs of targeted peer support included daily in-hospital peer support that began within 24 hours post-partum, which the reviewers suggest may have had an additional positive effect on breastfeeding initiation rates.

The interventions were generally similar, although in one trial, community breastfeeding awareness events also took place, and one trial used only telephone peer support. As all study designs included additional postnatal peer support of breastfeeding women, it was not possible to determine the sole effect of antenatal peer support on the duration or exclusivity of breastfeeding.

The reviewers report that in two RCTs, the control rates of breastfeeding initiation were very high, thus allowing little scope for improvement derived from breastfeeding peer support. In one trial, which evaluated universal breastfeeding peer support in Mexico, almost all women initiate breastfeeding, but it is the continuation and exclusivity of breastfeeding that are identified as problematic and positively impacted upon by the provision of breastfeeding peer support. The other trial, which evaluated targeted breastfeeding peer support, was UK-based, (where the reviewers indicate that the rate of breastfeeding initiation was less than 70%). However, in the UK trial population considered, the rate was over 95%, thus suggesting that only women who had already virtually decided to breastfeed were recruited. Despite this, the study’s primary outcome of breastfeeding at six weeks showed no breastfeeding peer support effect.
The reviewers conclude that universal antenatal peer support appears to be ineffective at increasing rates of breastfeeding initiation when offered as one or two contacts between a breastfeeding peer supporter and pregnant woman; with strong evidence supporting this conclusion from the United Kingdom. They suggest however that there may be a significant increase in breastfeeding initiation rates when antenatal peer support is targeted at women who are considering breastfeeding. However, evidence of this effect was found only among low-income Hispanic women in the United States.

Ingram, McArthur and Kahn et al. (2010) advise that because of differences in community rates of breastfeeding and levels of breastfeeding support as part of routine care in the included studies, the findings of this review may have limited generalisability. They therefore recommend that breastfeeding peer support as an intervention to improve the rates of breastfeeding initiation should be accompanied by high-quality evaluation to determine its effectiveness. Additionally, they suggest that future research might do well to focus on more intensive interventions that combine antenatal peer support and support offered in the immediate post-partum period.

**Lay health workers in primary and community health care for maternal and child health and the management of infectious diseases (Review)**


The aim of this review was to assess the effectiveness of interventions in primary and community care delivered by lay health workers (who were paid or volunteers) upon various aspects of maternal and child health, including breastfeeding initiation and continuation. A lay health worker was defined as a member of the community, not a healthcare professional, who had received some training to promote health or to carry out some healthcare services.

The reviewers searched the Cochrane, MEDLINE, EMBASE, Ovid, AMED, British Nursing Index and Archive, CINAHL, Ebsco, POPLINE, WHOLIS, Science Citation Index and Social Sciences Citation Index along with the reference lists of all included papers and relevant reviews. Additionally, they contacted the study authors for more papers.

Two of the reviewers independently assessed the 82 included RCTs. The studies took place in different settings although the majority were conducted in high-income countries (N=55). In many of the studies, lay health workers worked among people on low incomes in wealthy countries, or among people living in poor countries.

Studies that compared similar types of interventions were grouped together and where feasible, the study results were combined to obtain an overall estimate of the effect of the intervention. The included studies were diverse regarding the specific health issues that were focused on and the respective aims, content, and outcomes of the interventions delivered by lay health workers. This diversity limited the extent to which the outcomes of studies could be combined. The three outcomes that are specifically related to breastfeeding support are summarised on the next page and with the permission of the lead author, evidence statements have been generated from the text of the full review, (see Appendix 5).
The impact of the lay health worker on the initiation of breastfeeding

Despite the differences across studies, findings from 12 studies indicated that breastfeeding promotion by a lay health worker had a small yet significant impact upon its initiation.

Lewin, Munabi-Babigumira and Glenton et al., (2010) Evidence statement 1

The impact of the lay health worker on any breastfeeding up to 12 months post-partum

Once more, despite the differences across 12 studies there is evidence of moderate quality that breastfeeding promotion by a lay health worker had a small impact on any breastfeeding up to six months post-partum.


The impact of the lay health worker upon exclusive breastfeeding up to six months post-partum

Again, despite the differences across ten studies there is evidence, of moderate quality, that breastfeeding promotion by lay health workers had a significant impact on exclusive breastfeeding up to six months post-partum.


Lewin, Munabi-Babigumira and Glenton et al., (2010) conclude that lay health workers provide promising benefits for promoting the initiation, continuation and exclusivity of breastfeeding. However, further research is needed to understand which components of these often multifaceted interventions are most effective and they suggest that trials of matched comparisons of lay health worker programmes may contribute to addressing this issue.

Despite the findings from these recent systematic reviews about breastfeeding peer support, it is noteworthy that the activities included in the Maternal and Infant Nutrition Framework (2011) were based on the best available evidence at the time of its publication and that of the accompanying ‘Rationales’ publication. Thus, the evidence about breastfeeding peer support that informed Public Health Guidance 11 and Improving Maternal and Infant Nutrition: A Framework for Action is included in Appendix 1 to provide useful background to the appropriateness of breastfeeding peer support in Scotland.
References


10. Evidence from breastfeeding peer support randomised controlled trials (RCTs)

In view of the findings from systematic review level evidence that indicate that the effectiveness of breastfeeding peer support may be context-specific, findings from two RCTs are included here because they are relevant to Scotland. The study findings are summarised below and links to each publication are provided.

**Effectiveness of policy to provide breastfeeding groups (BIG) for pregnant and breastfeeding mothers in primary care: cluster randomised controlled trial**

Hoddinott, Britten, and Prescott et al., (2009). The abstract for this publication is available from: [www.bmj.com/content/338/bmj.a3026.abstract](www.bmj.com/content/338/bmj.a3026.abstract)

**Evidence summary:**

To assess the clinical and cost-effectiveness of a policy to provide breastfeeding groups facilitated by a health professional for pregnant and breastfeeding women, a prospective cluster randomised controlled trial, using mixed methods, (including embedded case studies) was conducted to evaluate the implementation of group support for breastfeeding in primary care in Scotland.

Pregnant women and breastfeeding mothers and babies registered with 14 of 66 eligible clusters of general practices in Scotland that routinely collect breastfeeding outcome data were recruited. Study locations set up new breastfeeding groups to provide population-wide support for women, while ‘control’ locations did not change their group activity.

The main outcome measured was that of any breastfeeding at 6–8 weeks, derived from routinely collected data during two pre-trial years and during the two actual trial years. In addition, secondary outcomes of any breastfeeding at birth, at 5–7 days, at 8–9 months and maternal satisfaction were noted.

Between 1 February 2005 and 31 January 2007, 9747 birth records existed for the intervention locations and 9111 for the control locations. The number of breastfeeding groups increased from 10 to 27 in the intervention locations that were attended by 1310 women, while 10 groups remained in the control locations.

No significant differences in breastfeeding outcomes were found. Any breastfeeding at 6–8 weeks declined from 27% to 26% in the intervention locations and increased from 29% to 30% in control locations. Any breastfeeding at 6–8 weeks increased from 38% to 39% in the locations that were not participating in the trial. Women who attended breastfeeding groups were older than women initiating breastfeeding who did not attend and women in the intervention locations had higher incomes than women in the ‘control’ locations who attended postnatal groups. The locality cost was £13,400, €14,410; $20,144) per year.

Hoddinott, Britten, and Prescott et al. (2009) conclude that a policy of providing breastfeeding groups in relatively deprived areas of Scotland did not improve breastfeeding rates at 6–8 weeks. They suggest that resources may be better directed towards home visits by health visitors in the first two weeks post-partum when the
highest proportion of mothers stop breastfeeding and that the costs of running such groups would be similar to the costs of visiting women at home.

**Antenatal peer support workers and initiation of breastfeeding: cluster randomised controlled trial** MacArthur, Jolly and Ingram et al., (2009). The abstract for this publication is available from: [www.bmj.com/content/338/bmj.b131.abstract](http://www.bmj.com/content/338/bmj.b131.abstract)

**Evidence summary:**

To assess the effectiveness of an antenatal service using community-based breastfeeding peer support workers on the initiation of breastfeeding, a cluster randomised controlled trial was conducted in community antenatal clinics in one primary care trust in a multi-ethnic, deprived population in the UK.

Sixty-six antenatal clinics (with 2511 pregnant women) and 33 clinics (including 1140 women) were randomised to receive the peer support worker service and 33 clinics (including 1371 women) were randomised to receive standard care.

The intervention comprised an antenatal peer support worker service that planned to offer a minimum of two contacts per woman. These were to provide advice, information, and support from approximately 24 weeks' gestation, delivered in either the antenatal clinic or at home. The trained peer support workers were of a similar ethnic and socio-demographic background to the clinic population.

The main outcome was the initiation of breastfeeding, (derived from data that was obtained from the computerised maternity records where the women delivered).

The sample was multi-ethnic, with only 9.4% of women being white British and 70% being in the lowest 10th for deprivation. Most peer support worker contacts took place in the antenatal clinics. Data relating to the initiation of breastfeeding was obtained for 95.5% of women. There was no significant difference in relation to the initiation of breastfeeding, (69.0% in the intervention group and 68% in the control groups). Although ethnicity, parity, and mode of delivery independently predicted the initiation of breastfeeding, randomisation to the peer support worker service had no effect.

MacArthur, Jolly and Ingram et al. (2009) concluded that a universal service for the initiation of breastfeeding using peer support workers provided in antenatal clinics in response to multi-ethnic and deprived populations was ineffective in increasing breastfeeding initiation rates.

**References**


11. Asset-based approaches to health improvement

Context:
‘An asset-based approach is...one which seeks positively to mobilise the assets, capacities or resources available to individuals and communities which could enable them to gain more control over their lives and circumstances. It is closely linked to the theory of salutogenesis, which highlights the factors that create and support human health rather than those that cause disease’.
(Sigerson and Gruer, 2011).

In light of the above definition and the range of evidence about the effectiveness of breastfeeding peer support that demonstrates the importance of ‘context’ for positive outcomes, other factors that are relevant to the quality of breastfeeding peer support provision are considered here.

In response to the previously cited Commission on the Future Delivery of Public Services, that emphasises capacity-building and adopting an approach that builds upon assets rather than focusing on deficits, NHS Health Scotland has produced a briefing paper which explains what is meant by asset-based approaches and summarises what is already known about their potential for improving health. This approach may provide a useful platform for developing and evaluating breastfeeding peer support interventions that could contribute to improving health and reducing health inequalities.

The key messages from the publication are included below:

• Taking an asset-based approach involves mobilising the skills and knowledge of individuals and the connections and resources within communities and organisations, rather than focusing on problems and deficits. The approach aims to empower individuals, enabling them to rely less on public services.

• There is a limited evidence base linking actions to strengthen individual and community assets with improved health and wellbeing. Measuring the impact of asset-based approaches on health outcomes is complex, and evidence that the approach can improve health and wellbeing largely comes from case studies.

• A wide range of techniques are available to support an asset-based approach, including asset mapping, co-production and various community-led, community engagement and community development methods. While none are as yet of proven health benefit, some show improvements in intermediate outcomes, such as increased self-esteem and reduced social isolation.

• The challenge now is to assess the impact and cost-effectiveness of asset-based approaches in Scotland within a robust and sensitive evaluation framework.

Adopting an asset-based approach may encourage the development and timely evaluation of innovative ways of providing breastfeeding peer support, (references to the NHS Health Scotland briefing paper and a similar paper, published by the Glasgow Centre for Population Health, are provided in the reference list at the end of this section).
In addition, the recent presentation ‘What could asset-based approaches add to our strategies for improving health in Scotland?’ by Professor Carol Tannahill at the Maternal and Infant Nutrition conference, (hosted by NHS Health Scotland in February 2013) is relevant to consideration of an asset-based approach to breastfeeding peer support. The conference webcast is available from:

http://metrostreaming.mediasite.com/mediasite/Play/b08bbdca1baa48cfa6c7c181493275481d

Moreover, in a recent editorial, ‘Global evidence synthesis and UK idiosyncrasy: why have recent UK trials had no significant effects on breastfeeding rates?’ Hoddinott, Seyara and Marais, (2011) emphasise that;

‘Breastfeeding intervention trials are complex, and a highly reductionist approach to testing a relatively small, short, single intervention seems less likely to succeed than a multi-component, multi-dose intervention that spans a greater proportion of the breastfeeding journey.’

In view of this conclusion, evidence from other publications related to breastfeeding peer support (that are not systematic reviews or RCTs) are summarised in the next section of this guidance. Additionally, evidence summaries of other relevant publications about innovative breastfeeding support provision are summarised in Appendix 2.

References

Asset-based approaches to health improvement. Sigerson D and Gruer L. (NHS Health Scotland, 2011). Available from:


Asset-based approaches for health improvement: redressing the balance (Glasgow Centre for Population Health (GCPH, 2011). Available from:

www.gcphealth.co.uk/publications


12. Single studies about breastfeeding peer support in Scotland that are relevant in the context of an asset-based approach

Other Scotland-based studies are reported on here because of their local context and the relevance of findings for potentially identifying the key elements to include in future innovative breastfeeding peer support activity.

**Significant others, situations and their influences on infant feeding. Secondary analysis of data from: A prospective study exploring the early infant feeding experiences of parents and their significant others during the first 6 months of life: what would make a difference?**


**Evidence summary:**

This secondary analysis of the longitudinal study described later examined the influences of significant others on women’s feeding behaviour. Thirty-six women and 37 nominated significant others participated in 220 interviews that were conducted approximately four-weekly from late pregnancy to six months after birth. Their responses to summative structured questions at the end of each interview that asked about the significant influences on feeding decisions were compared and contrasted with formative semi-structured data within and between cases. The analysis focused on pivotal points where behaviour changed from exclusive breastfeeding to introducing formula, stopping breastfeeding or introducing solids. This enabled the identification of processes that decelerated or accelerated behaviour change and the understanding of the resolution processes afterwards.

Results indicated that the dominant goal motivating behaviour change was that of family wellbeing, rather than exclusive breastfeeding. Rather than one type of significant other emerging as the key influence, there was a complex interplay between the self–baby dyad, significant others, situations and personal or vicarious feeding history. Following behaviour change, women turned to those who were most likely to confirm or resolve their infant feeding decisions and to maintain their confidence as mothers.

Hoddinott, Britten and McInnes et al., (2013) conclude that applying ecological models of behaviour change would enable health service organisation, practice, policy and research to focus on enhancing family efficacy and wellbeing, improving family-centred communication. This would increase opportunities for health professionals to be a constructive influence around pivotal points when feeding behaviour changes. The researchers recommend a paradigm shift away from the dominant approach of support and education of individual breastfeeding women towards a more holistic, family-centred narrative approach that acknowledges that breastfeeding is a practical skill that women and babies have to learn.
A prospective study exploring the early infant feeding experiences of parents and their significant others during the first 6 months of life: what would make a difference? Hoddinott, Craig and Britten et al. (NHS Health Scotland, 2010).

Evidence summary:

This longitudinal qualitative study with 36 families was conducted in 2009–2010 by staff at the University of Aberdeen and the University of Stirling on behalf of NHS Health Scotland. Its aim was to explore the early infant feeding experiences of mothers, including the support offered to them by others along a timeline, from the antenatal period until their infant was six months. Data was gathered to inform the development of interventions aimed at improving any breastfeeding; exclusive breastfeeding; the introduction of appropriate solids at six months and parental experiences of feeding their baby.

Identifying the ideal characteristics of a breastfeeding supporter is that they should be someone who understands and cares. The ‘experience shouldn’t be out of a book, should be life experience, somebody that’s been through it.’

Supporting breastfeeding mothers: a qualitative synthesis.

Evidence summary:

This paper synthesises mothers’ and healthcare professionals’ experiences and perceptions of breastfeeding support. Electronic databases and citation lists of published papers were searched for articles listed between 1990 and 2005 and updated in May 2007. Included studies were those that used qualitative methods, were published in English, explored an aspect of breastfeeding and had been conducted in a westernised country. Publications were reviewed and assessed independently, with key themes extracted and grouped, and secondary thematic analysis used to explore the identified key concepts.

From the original search, five themes emerged about health service support of breastfeeding: (1) the mother–health professional relationship, (2) skilled help, (3) pressures of time, (4) medicalisation of breastfeeding and (5) the ward as a public place. Social support had two themes: compatible and incompatible support. One additional theme emerged from the update in 2007, namely that of health professional relationships.

McInnes and Chambers (2008) conclude that mothers tended to rate social support as more important than health service support, which was described unfavourably, with an emphasis on time pressures; a lack of availability of healthcare professionals or guidance and the promotion of unhelpful practices and conflicting advice. Thus, the reviewers advise that changes are required within health services to address the needs of both mothers and staff.

Effectiveness of a breastfeeding peer coaching intervention in rural Scotland
Evidence summary:

The aim of this study was to assess whether group-based and one-to-one peer breastfeeding coaching improved breastfeeding initiation and duration. Action research was used to conduct an intervention in four geographical postcode areas in rural north-east Scotland. Infant feeding outcomes at birth and at hospital discharge; at one, two, and six weeks; and at four and eight months were collected for 598 of 626 women with live births during a nine-month baseline period and for 557 of 592 women with live births during a nine-month intervention period. Groups met in five locations, with 266 groups meeting in the period when intervention women were eligible to attend. Data related to the place of birth and the length of postnatal hospital stay was also collected. Control data from 10 other Health Board areas in Scotland was compared. An intention-to-participate survey about coaching participation was completed by 206 of 345 women initiating breastfeeding. Group attendance data was collected via 266 group diaries.

There was a significant increase in any breastfeeding of 6.8% (from 34.3 to 41.1%) in the study population at two weeks after birth compared with a decline in any breastfeeding in the rest of Scotland of 0.4% (from 44 to 43.6%). Breastfeeding rates increased, (compared to baseline rates), at all time points until eight months. However, the effect was not uniform across the four postcode areas and was not related to the level of deprivation. Little difference was observed in relation to the receipt of information and knowledge about the availability of breastfeeding peer coaching in the postcode areas. All breastfeeding groups were well attended, popular, and considered helpful by participants. A minority of women (only 14/206) participated in formal one-to-one coaching. Women who received antenatal, birth, and postnatal care from community midwife-led units were more likely to be breastfeeding at two weeks compared to women who received some or all care in district maternity units.

Hoddinott, Lee and Pill (2006) conclude that group-based and one-to-one breastfeeding peer coaching for pregnant women and breastfeeding mothers increased breastfeeding initiation and duration in an area with below-average breastfeeding rates.

One-to-One or Group-Based Peer Support for Breastfeeding? Women’s Perceptions of a Breastfeeding Peer Coaching Intervention.


Related to the breastfeeding peer coaching intervention study summarised above, the aim of this analysis was to investigate why group-based peer support was more popular than one-to-one peer support. This publication reports on participants’ perceptions of the coaching intervention.

Qualitative data was collected and analysed from an initial focus group; 21 semi-structured interviews; and 31 coaching group observations and respondents (n = 105/192) in response to an open question about their reasons for not choosing a personal coach in a survey of breastfeeding experiences.

Findings revealed that groups were more popular because they normalised breastfeeding in a social environment with refreshments, which improved participants’ sense of wellbeing. Groups provided flexibility; a sense of control and a diversity of visual images and experiences, which helped women to make feeding-related decisions. In a culture where breastfeeding is seldom seen in public, groups offered women a safe
place to rehearse and perform breastfeeding in front of others, despite feeling initially anxious when attending a group for the first time, and expressing doubt that one set of ‘breastfeeding rules’ would suit everyone.

Hoddinott, Chalmers and Pill (2006) concluded that pregnant women and breastfeeding mothers will voluntarily engage in an activity to support breastfeeding if there is a net interactional (verbal, visual, emotional and gustatory) gain and a minimum risk of a negative experience. One-to-one peer coaching was perceived as a greater risk to confidence and empowerment than group-based peer coaching.

**Breastfeeding peer support: Health service programmes in Scotland** Britten, Hoddinott and McInnes, (2006). The abstract for this publication is available from: [www.intermid.co.uk/cgi-bin/go.pl/library/article.cgi?uid=20255;article=BJM_14_1_12_19](www.intermid.co.uk/cgi-bin/go.pl/library/article.cgi?uid=20255;article=BJM_14_1_12_19)

**Evidence summary:**

The aim of this multiple case study was to identify and describe health service breastfeeding peer support programmes in urban and rural areas of Scotland between 1995 and 2002. The programmes aimed to increase breastfeeding rates in areas of low breastfeeding initiation.

Peer supporters all had breastfeeding experience and training was provided in the majority of programmes. Two models of peer support were identified: (1) individual support at home by trained supporters paired with pregnant or breastfeeding women and (2) group support between currently breastfeeding mothers, trained or untrained. Peer supporters’ roles were wide ranging and some became breastfeeding ‘experts’. Professionals were generally supportive of the programmes.

**References**


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11 This relates to the sense/enjoyment of food tasting.


Breastfeeding peer support: Health service programmes in Scotland, Britten J, Hoddinott P, McInnes R. *British Journal of Midwifery* 2006; Vol 14, No 1, 12–19. Available from: www.intermid.co.uk/cgi-bin/go.pl/library/article.cgi?uid=20255;article=BJM_14_1_12_19
13. Findings from peer support practice workshops (NHS Health Scotland hosted conferences, 2009 and 2011)

This section presents views about breastfeeding peer support that were expressed by professionals in practice across Scotland and captured during two conferences held in 2009 and 2011. While the practice issues clearly do not constitute evidence of effectiveness, they reflect the consistent views of professionals at two relatively recent time points.


As part of the above conference, two workshops on peer support provision reported on the following;

Creating opportunities during the antenatal period for establishing postnatal peer support
- All mothers should be given the opportunity to meet with the breastfeeding peer supporter when they attend for their booking in appointment. Related to this, is that breastfeeding peer support should be (perceived as) fully integrated into antenatal care and therefore offered as routine.
- The relationship between the breastfeeding peer supporter and the mother needs to be established during the antenatal period so that it can be built upon postnatally.

Addressing postnatal ward-based issues
- Mothers may feel under pressure to be discharged from hospital and therefore may abandon breastfeeding, only to regret doing so later. Therefore, contact with the breastfeeding peer supporter in the immediate postnatal period is vital for maximising the opportunity to establish breastfeeding.

Communication issues
- Many communication barriers exist, for example different approaches to data sharing/access to hospital record systems, so a mother may have delivered and the peer supporter may not know.
- Health professionals may not realise that a mother is receiving breastfeeding peer support.

Training issues
- The joint training of (health) professionals and breastfeeding peer supporters is essential so that they have the opportunity to develop mutual understanding/respect of each other’s role.
- Breastfeeding peer supporters need to be adequately trained and professionally supported for their own and the mother’s safety. This includes having an awareness of the limitations to their role.
Need for guidance

- Guidance is needed for the delivery of breastfeeding peer support so that there is consistency in its delivery.

‘Views about breastfeeding peer support provision’ (Maternal and Infant Nutrition Conference, NHS Health Scotland, June 2011).

As part of the above conference, two workshops about breastfeeding peer support provision were held. Links to the conference slide sets are shown below. These provide useful information, including consideration of the experience of using investing in volunteers to assist with establishing a breastfeeding peer support service. The slide sets also highlight many practical issues that were raised at the earlier breastfeeding conference but remain relevant to breastfeeding peer support guidance.

References

Breastfeeding: The place for Peer Support Guidance (Woodman, 2011). Conference slides available from:

Breastfeeding Volunteer Support, (Dalzell, 2011). Conference slides available from:

Breastfeeding Peer Support in Lanarkshire Community Mothers Programme 2011, (Brownlie, 2011). Conference slides available from:
14. Commissioning documents relevant to breastfeeding peer support provision

In addition to the evidence reviewed thus far, several commissioning documents are included here. While we acknowledge that Health Boards may not be commissioning breastfeeding peer support services, links to these documents are provided as the information contained therein may usefully inform local activity regarding the provision of breastfeeding peer support in Scotland.

In March 2012, NICE published a commissioning guide to support clinical service redesign, *Specifying a peer support programme for women who breastfeed*. This specifies three key service components:

1. Engaging communities and recruiting peer supporters
2. Training and supervision
3. Developing a high-quality peer-support programme for women who breastfeed.

This most recent commissioning guide is available from: [www.nice.org.uk/usingguidance/commissioningguides/breastfeed/specifying.jsp](http://www.nice.org.uk/usingguidance/commissioningguides/breastfeed/specifying.jsp)

Following the publication of Public Health Guidance 11 in March 2008, NICE published a commissioning guide regarding the implementation of NICE guidance, *A peer-support programme for women who breastfeed*. The guide:

1. Makes a case for commissioning a breastfeeding peer-support programme
2. Specifies service requirements
3. Offers assistance about determining local service levels
4. Encourages quality assurance.

This older commissioning guide is available from: [www.nice.org.uk/media/63D/7B/BreastfeedingCommissioningGuide.pdf](http://www.nice.org.uk/media/63D/7B/BreastfeedingCommissioningGuide.pdf)

Additionally, in September 2009, the Department of Health published *Commissioning local breastfeeding support services*. This guide considers the following:

1. Policy and performance drivers.
2. Leadership and collaboration.
3. Assessing need and strategic planning.
4. Shaping local breastfeeding services.
5. Improving performance and monitoring outcomes.

The full commissioning guide is available from: [www.medwaychildrenstrust.co.uk/documents/commissioning-local-breastfeeding-support-services-1290775672.pdf](http://www.medwaychildrenstrust.co.uk/documents/commissioning-local-breastfeeding-support-services-1290775672.pdf)
References


15. Consideration of ethical principles in response to breastfeeding peer support

Peer support for breastfeeding should be guided by the most currently available evidence of effectiveness. However, in response to issues for which we do not have robust, high-level evidence, it may be helpful to consider the use of the ethical decision-making triangle, which draws ethics, evidence and theory together, to inform future breastfeeding peer support and practice in Scotland.

Tannihill (2008) cited earlier in this guidance explains that ‘The decision-making triangle draws ethics, evidence and theory together in a practical way, placing the prime emphasis on applying an identified set of ethical principles. It embodies two shifts in focus advocated in this paper: from evidence-based to evidence-informed; and from evidence to decision-making. The latter shift is duly respectful of the range of considerations facing decision-makers, as well as recognising the limitations of a purely evidence-based approach.

‘The decision-making triangle is used as follows. Possible options for policies, programmes, services or activities are considered against the agreed set of ethical principles. Available evidence (relating to the effectiveness and risks of actions, and to health issues and their causation) is used to inform judgements as to the extent to which the ethical principles would be satisfied, and theoretical considerations are taken into account alongside evidence and/or where there are gaps in the available evidence. Decisions on how to proceed are made taking an overview across the ethical principles and weighing up trade-offs as necessary. The process is an explicit one’.

The 10 ethical principles are as follows:

1. Do good
2. Do not harm
3. Equity
4. Respect
5. Empowerment
6. Sustainability
7. Social responsibility
8. Participation
9. Openness
10. Accountability.

The application of the ethical principles to the provision of breastfeeding peer support is presented in the following section.
16. Ethical principles (after Tannahill) applied to breastfeeding peer support issues

The application of ethical principles outlined in this section need also to take account of the three Key Quality Ambitions; (1) person-centredness, (2) safety and (3) effectiveness.

If appropriate consideration of all three key Quality Ambitions is not given when establishing breastfeeding peer support there is the potential for a negative impact on breastfeeding mothers, because their individual needs may not be fully understood or addressed in a person-centred way. Thus the support offered to them may be both unsafe and ineffective.

The following pages provide some examples of how ethical principles may be applied to addressing issues related to breastfeeding peer support. While reading, please note the following abbreviations:

BF = breastfeeding
BFPS = breastfeeding peer support
BFPSer(s) = breastfeeding peer supporter(s).

It is intended that the reader will also access the accompanying HIIA of this guidance, (see Appendix 7), that provides information about the potential impact of breastfeeding peer support on health inequalities.
### Ethical principles

<table>
<thead>
<tr>
<th>Do good</th>
<th>Application of ethical principles to breastfeeding peer support</th>
</tr>
</thead>
<tbody>
<tr>
<td>Related terms include: beneficence, effectiveness, quality, utility</td>
<td>Need to consider the benefits of breastfeeding and breastfeeding peer support for all mothers and infants and the risks of not breastfeeding. Robust evidence about both these aspects is readily available.</td>
</tr>
<tr>
<td>• Relates to health improvement in populations, not just individuals.</td>
<td>Need to consider the benefits of providing breastfeeding peer support, (BFPS) to all breastfeeding mothers and infants alongside the risks of not providing it.</td>
</tr>
<tr>
<td>• In assessing the likely population health improvement benefits of given action, consideration is given to the importance (scale and degree) of the issue or issues concerned (e.g. health problems, risk factors); the causation and potential preventability/promotability of the issue or issues (e.g. mental health problems/mental wellbeing); effectiveness of the action including percentage of those exposed who are likely to benefit, degree of likely benefit, and any variations of these between population groups); transferability (of findings from evaluations in different circumstances); feasibility of delivering the action; and achievable ‘reach’ of the action. An action for which there is evidence of a high level of effectiveness in a particular location, at a particular point in time may not be as effective in other circumstances, and may not even be feasible; and the amount of benefit that can be expected from an intervention ‘on the ground’ depends on the extent to which it can reach those who stand to gain from it.</td>
<td>Need to consider the benefits of providing BFPS for specific population groups, (e.g., young mothers, mothers who do not have a family tradition of breastfeeding).</td>
</tr>
<tr>
<td>• An important consideration is whether efficacy demonstrated in controlled circumstances of research studies translates into effectiveness in ‘real life’.</td>
<td>Need to consider the good-quality evidence about breastfeeding peer support that has been generated in the UK and particularly in Scotland, about what might make a difference to improving the breastfeeding experience of mothers so that it can be used to inform local practice.</td>
</tr>
</tbody>
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14 See: A prospective study exploring the early infant feeding experiences of parents and their significant others during the first 6 months of life: what would make a difference? Hoddinott et al. (NHS Health Scotland, 2010), Available from: [www.healthscotland.com/documents/4720.aspx](http://www.healthscotland.com/documents/4720.aspx)

Do not harm
• Related terms include: non-maleficence, safety, quality.
• Application of this principle together with ‘Do good’ is a key to the discharging of responsibility for ‘health governance’ (comparable to clinical governance in health care); see also ‘Accountability’.
• Action might lead to benefits for some people and harm for others – e.g. preventive drugs may have side effects, and benefits in terms of prevention of ill health might have costs in terms of impaired wellbeing. There may be a need to judge on an acceptable balance between good and harm in populations.
• Actions to mitigate any potential harm should be identified as feasible.

Need to consider how breastfeeding peer support can be made equally accessible to all mothers, particularly groups who are less likely to consider breastfeeding, (e.g. mothers from lower socio-economic groups, young mothers and mothers from ethnic minority groups), to avoid widening the inequalities gap.

Equity
• Related terms include: fairness, equality, justice, cohesion, solidarity.
• To do with fairness. Tackling unfair health inequalities is very high on health improvement agenda, rooted in social justice and linked to distributive justice.
• Equity may involve pursuing equality of health outcomes through unequally applied actions (e.g. targeting of interventions towards disadvantaged groups).
• Fundamental to the equality and diversity dimension of health improvement efforts.

Need to consider how Health Boards and voluntary sector agencies ensure that BFPSers are aware of the limitations of the information they should provide and that these limitations are made explicit within their clearly defined role.

Need to consider how Health Boards and voluntary sector agencies ensure that breastfeeding peer supporters are aware of pathways for onward referral.

Need to consider how Health Boards and voluntary sector agencies ensure that breastfeeding peer support can be provided at times and venues that are appropriate to the life circumstances of breastfeeding mothers. BFPS needs to be easily accessed by public transport and take place in an inviting environment that offers crèche facilities for older children.

Need to consider how group BFPS sessions can be provided at times and venues that are appropriate to the life circumstances of breastfeeding mothers. BFPS needs to be easily accessed by public transport and take place in an inviting environment that offers crèche facilities for older children.

Need to consider how group BFPS sessions can be provided at times and venues that are appropriate to the life circumstances of breastfeeding mothers. BFPS needs to be easily accessed by public transport and take place in an inviting environment that offers crèche facilities for older children.

Need to consider how Health Boards and voluntary sector agencies consider equity in relation to other aspects of BFPS delivery, e.g. use of appropriate pictorial information with those whose first language is not English and/or with low literacy; interpreting services or using Skype and or telephone contact in response to remote and rural mothers.

Increasing opportunity here refers to widening both the physical and cognitive access of mothers who are able to easily avail of breastfeeding peer support and feel that their situation is understood and respected by the breastfeeding peer supporter.
Respect

- Related terms include: diversity, equity, autonomy, acceptability, consent, consensus, mutuality, self-esteem.
- Includes respect for others (individuals, families, other groups, communities and populations) in what organisations or partnerships do, and how they do it.
- Fundamental to the equality and diversity dimension of health improvement efforts.
- Also covers the protection and promotion of self-respect and self-esteem among individuals, groups and communities, as part of both promoting a sense of wellbeing and protecting against unhealthful influences and behaviours.

Empowerment

- Related terms include: autonomy, enabling, health literacy, self-efficacy, community development, solidarity, cohesion, mutuality.
- About helping individuals, families, other groups, communities and populations to have more control over their health.
- Includes promoting life circumstances, individual and collective knowledge and skills, and opportunities conducive to good health.
- An important aspect is enabling people to be free of addictions or habit-forming behaviours, rather than acting as though behaviour is simply a matter of personal freely exercised personal choice.
- May require action to limit the power of individuals and corporate entities to expose others to risk of harm.
Sustainability

- Related terms include: effectiveness (long-term), environment, citizenship, accountability.
- Three dimensions:
  - making sure that health improvement actions are sustainable for as long as they need to be
  - recognition, in all aspects of business (including administrative policies and processes as well as health improvement projects and programmes) that sustainable health improvement in populations requires safeguarding and conservation of resources and the physical environment; see also ‘Accountability’ – environmental governance
  - ensuring that healthful changes (e.g. in ‘lifestyle’ behaviours) brought about by policies and actions ‘on the ground’ are maintained.

Need to consider how Health Boards and voluntary sector agencies will pay due attention to how limited financial resources are to be used to the greatest good.

Need to consider how Health Boards and voluntary sector agencies that provide BFPS services can sustain its provision with reference to the issues of BFPSer recruitment, retention, monitoring/evaluation, supervision and support.

The opportunity costs of putting economic resources into a service that has little effect need to be balanced against what could be achieved by putting the same amount of resource into an intervention that has proven effectiveness.\(^\text{16}\)

In the current climate of staff capacity, need to consider how Health Boards and voluntary sector agencies can make a commitment to providing the appropriate peer support for a minimum of six weeks post-partum, being mindful that staff shortages may pose a risk to its provision and the continuity of the BFPSer, both lay and professional. Breastfeeding peer support should be offered by staff who are well-informed, highly motivated and who have protected time devoted to leading its provision.

Need to consider how Health Boards and voluntary sector agencies remain mindful of the need to help develop and maintain the relationship between the breastfeeding mother and the BFPSer.

Need to consider how Health Boards and voluntary sector agencies respond appropriately when the BFPSer requires support in ‘letting go’ of the established relationship with the mother, infant and family.

Need to consider how Health Boards and voluntary sector agencies protect the mother’s wellbeing and offer sensitive support to all mothers who have stopped breastfeeding by promoting the benefits of skin-to-skin contact to encourage attachment and bonding, irrespective of their method of feeding.

Need to consider how Health Boards and voluntary sector agencies remain mindful of mothers who stop breastfeeding before the first six weeks and that the BFPSer knows where to signpost them to local support beyond BFPS.

Need to consider how Health Boards and voluntary sector agencies support the BFPSer, who as part of their ‘exit strategy’, might make mothers aware of the value of play@home,\(^\text{17}\) baby massage and skin-to-skin contact as a means of continuing to enhance their parenting.

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16 See Breastfeeding peer support: Health service programmes in Scotland, (Britten et al., 2006), abstract available from: www.intermid.co.uk/cgi-bin/go.pl/library/article.cgi?uid=20255;article=BJM_14_1_12_19, and Hoddinott, P. personal communication (2013).

17 The play@home programme, which originated in New Zealand, is a physical activity programme for children from birth to 5 years which encourages interaction and loving touch to encourage bonding between parent and child. NHS Health Scotland has been tasked with the planning and delivery of the national roll-out of play@home across Scotland through the provision of training for professionals. Available from: www.maternal-and-early-years.org.uk/the-playhome-national-roll-out-programme
## Social responsibility

- Related terms include: collectivism, solidarity, citizenship, environment, community, mutuality, accountability.
- Demonstrating social responsibility through organisation’s own actions.
- Fostering social responsibility, in the interests of improving population health and tackling health inequalities, among businesses, other organisations, communities, groups and individuals.

Need to consider how Health Boards and voluntary sector agencies establish transparency/clarity about who is locally responsible for the successful provision of BFPS, accepting that this may differ between Health Boards and between voluntary sector agencies.

Need to consider how Health Boards and voluntary sector agencies provide and maintain good leadership skills among all staff who are responsible for BFPS, (including training, ongoing supervision/monitoring and PDP). Their skill set needs to be agreed upon and appropriate up-skilling provided in a timely manner as necessary, (the application of this ethical principle is linked to sustainability and the contribution of BFPS services to community asset-building).

Need to consider how Health Boards and voluntary sector agencies conduct timely and appropriate risk assessments as part of protecting the BFPSer from harm when working in mother’s homes and in the wider community.

Need to consider how Health Boards and voluntary sector agencies protect the wellbeing and safety of the BFPSer, ensuring that they are covered under all relevant workforce employment policies.

## Participation

- Related terms include: engagement, empowerment, citizenship, community, development, mutuality, ownership, solidarity.
- A cardinal principle of health promotion – doing things with people, not just for them or to them. As far as possible, people should be involved in identifying health issues and solutions, and in taking action for better health.
- Relevant even where legislative controls are being considered or implemented, as seen for example in consultation on controlling smoking in public places, and in widespread participation in making ensuing legislation work.

Need to consider how Health Boards and voluntary sector agencies ensure that the provision of BFPS includes the raising of community awareness about the benefits of breastfeeding so that mothers feel comfortable to exercise their legal right to breastfeed in public.

Need to consider how Health Boards and voluntary sector agencies encourage the active participation of breastfeeding mothers in BFPS development (the application of this ethical principle is linked to that of respect and the contribution of BFPS services to community asset-building). The link with “equity” is emphasised here as there is a need for both Health Boards and voluntary sector agencies to consider how best to encourage the participation of breastfeeding mothers from lower socio-economic groups as part of widening access to BFPS.
### Openness
- Related terms include: transparency, engagement, mutuality, consent, consensus, trust, accountability.
- Explicit application of the set of ethical principles using the decision-making triangle itself contributes to openness.
- Documenting judgments made in applying the ethical principles using the decision-making triangle is of value both in consultation and in facilitating continued constructive dialogue after decisions have been made.

### Accountability
- Related terms include: governance, effectiveness, quality, value for money (including efficiency, cost-effectiveness), openness, trust, mutuality, and environment.
- Being accountable for:
  - actions and outcomes
  - making good use of/fostering/safeguarding/conserving financial, human and other resources/the environment
  - operating in accordance with ethical principles.
- Involves five dimensions of governance:
  - health governance
  - financial governance
  - staff governance
  - environment governance
  - ethical governance.

In addition to the issues raised above, the application of ethical principles to breastfeeding peer support provision is intended to help Health Boards and voluntary sector agencies to respond to issues that may emerge from their locally conducted health inequality impact assessments (HIIs, see Appendix 7).
17. Consideration of evaluation principles in response to breastfeeding peer support

This guidance has presented a snapshot of what is currently known about peer support for breastfeeding, providing a clear overview of the available evidence about how peer support activities may plausibly contribute to positive outcomes. In addition, evidence from evaluations can be used to make more informed choices based on local need and priorities.

Where there is a lack of evidence, it is important to evaluate interventions to establish whether they are effective, or potentially harmful, or ineffective. It is also essential that evaluation is embedded within the planning and delivery of services to ensure that the local learning is captured on an ongoing basis.

This section outlines some of the key considerations and resources that will help practitioners evaluate the delivery and effectiveness of interventions related to local breastfeeding peer support that are in line with the underpinning ethical principles described in the previous section and in Appendix 6.

Planning an evaluation

Planning an evaluation should start with a clear understanding of who is going to use the evaluation, for what purposes, and with what potential consequences.

Different evaluation stakeholders may require different types of evaluation, for instance:

- Practitioners and policymakers: effectiveness; what works, for whom, in what circumstances?
- Practitioners: improvement to strengthen implementation; how can we make it better?
- Funders: accountability; should we continue investing?
- Planning and performance managers: performance monitoring/targets; developmental/formative evaluations
- Service users: service quality – access, experience, relevance to needs.

It is crucial to understand what is being evaluated and to have a clear statement of the rationale and need for the evaluation, confirming the outcomes for the programme and the process by which these will be achieved. This understanding will provide a sound basis for process and outcome evaluations.

The key principles of evaluation presented in this section have been developed by the Evaluation team at NHS Health Scotland and are provided later to guide practitioners in planning and conducting evaluations of local breastfeeding peer support services.

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18 This can only be determined by adequately powered RCTs (see footnote 6). Small studies are often biased and therefore are irrelevant at a national level. In the case of small initiatives, an assessment of the feasibility, acceptability and costs are all that can be evaluated/concluded – and even then it is difficult to avoid bias, (Hoddinott, P. personal communication, 2013).
Principles of evaluation

- Be focused on the purpose; what you really need to know (prioritise), and what will be useful and used.
- Be realistic about what you can and should evaluate; what is possible and what it is in your gift to influence, (e.g. your outputs, who you reach, your short-term outcomes).\(^{19}\)
- Be clear about how much evaluation is appropriate.
- Be clear about your evaluation design before choosing the appropriate method of data collection.
- Be appropriate about the indicators and sources of evidence you will use to measure progress towards your outcome(s).
- Be convincing to your evaluation audience: what will it take to convince a reasonable person?
- Be honest about why you are evaluating, what the evaluation will be used for, and what you can claim.
- Be clear about the learning that emerges from the evaluation and how this can be used to inform service development.

Further useful information about conducting an evaluation is included in Appendix 6.

\(^{19}\) These are changes that are likely to be achieved or achieved in the short term as the result of service delivery (or a social intervention) in the short term. A glossary of key terms used in outcomes-focused planning and evaluation can be found on the NHS Health Scotland website at [www.healthscotland.com/OFHI/Resources/Resources_glossary.html](http://www.healthscotland.com/OFHI/Resources/Resources_glossary.html)
18. A guide to conducting local health inequalities impact assessments

A health inequalities impact assessment (HIIA) is a key way to analyse and ensure the fairness and effectiveness of policy or service decisions we make. The HIIA process seeks to define the likely positive and negative health, equality and human rights impacts of a policy/service (including unintended impacts) and the population groups who will bear them.

The assessment considers impacts on potentially affected population groups. Impacts on disadvantaged groups who already suffer poorer health are particularly important. The process outlines mitigating actions, should negative impacts be identified, and presents an opportunity to enhance the positive intentions of a proposed policy or service.

A robust impact assessment using this approach is intended to achieve the following:

- Demonstration that decisions are based on a broad range of evidence and used at appropriate points in the impact assessment process.
- Involvement of key stakeholders including groups representing those with protected characteristics.
- A series of evidence-informed recommendations which will influence service development/redesign.
- Action taken as a result of the assessment that is proportionate, ensuring the best use of the available resources.
- Enhanced local knowledge and practice about impact assessment.

Information about conducting HIIAs that may be useful when Health Boards and voluntary sector agencies are conducting their own health inequalities impact assessment of breastfeeding peer support is available at: www.healthscotland.com/documents/5563.aspx

The HIIA of this peer support for breastfeeding guidance is included in Appendix 7.
# 19. Details of the Breastfeeding Peer Support Guidance Advisory Group members

<table>
<thead>
<tr>
<th>Breastfeeding Peer Support Guidance Advisory Group members</th>
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<tbody>
<tr>
<td><strong>Fiona Bayne</strong></td>
<td>Senior Health Improvement Programme Officer (Maternal and Infant Nutrition), NHS Health Scotland</td>
</tr>
<tr>
<td><strong>Dorothy Bradley</strong></td>
<td>Infant Feeding Strategist, NHS Lothian</td>
</tr>
<tr>
<td><strong>Shona Brownlie</strong></td>
<td>Programme Manager, Community Mothers and Unicef BFI, NHS Lanarkshire</td>
</tr>
<tr>
<td><strong>Ruth Campbell</strong></td>
<td>Consultant Dietitian in Public Health Nutrition, NHS Ayrshire and Arran</td>
</tr>
<tr>
<td><strong>Emma Currer</strong></td>
<td>National Officer for Scotland, Royal College of Midwives</td>
</tr>
<tr>
<td><strong>Kirsty Darwent</strong></td>
<td>Breastfeeding Network</td>
</tr>
<tr>
<td><strong>Jane Ford</strong></td>
<td>Public Health Adviser (Evaluation Team), NHS Health Scotland</td>
</tr>
<tr>
<td><strong>Gina Graham</strong></td>
<td>Breastfeeding Support Coordinator, NHS Fife</td>
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<tr>
<td><strong>Barbara Jessop</strong></td>
<td>Health Improvement Specialist, Maternal and Infant Nutrition, NHS Borders</td>
</tr>
<tr>
<td><strong>Larissa Kempenaar</strong></td>
<td>Lecturer, School of Health and Life Sciences, Glasgow Caledonian University</td>
</tr>
<tr>
<td><strong>Alison MacDonald</strong></td>
<td>Health Improvement Programme Manager, Early Years, Children and Families, NHS Health Scotland</td>
</tr>
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*Resigned from advisory group.*
Appendix 1: Evidence about breastfeeding peer support that informed Public Health Guidance 11 and *Improving Maternal and Infant Nutrition: A Framework for Action*

The evidence about breastfeeding peer support presented here is copied directly from *Improving Maternal and Infant Nutrition – Rationales for the Action Plan Activities in the Draft Framework* (NHS Health Scotland, 2010), cited previously.

This comprised the evidence that was reviewed in support of Public Health Guidance 11 *Improving the nutrition of pregnant and breastfeeding mothers and children in low-income households* that was published by NICE in March 2008.

The supporting evidence review that was commissioned by NICE, *The effectiveness of public health interventions to promote safe and healthy milk feeding practices in babies* included consideration of the then current evidence about the effectiveness of peer support interventions. The evidence about peer support that was included in review 4 is presented verbatim below with the permission of NICE.

**The effectiveness of public health interventions to promote safe and healthy milk feeding practices in babies**

Peer support programmes may vary considerably in design and delivery. Peer support programmes, volunteer counsellors and postnatal support workers have been presented separately as described by the study. Peer support programmes are also included in the evaluation of multi-faceted interventions. The peer support programmes presented have been developed by the healthcare service. It is important to consider that the effectiveness of such programmes may vary according to the ethnicity, age and culture of women recruited in the study, and acceptability to the population group.

This review identified three good quality SRs (2++) (Fairbank, 2000; Renfrew, 2005; Britton, 2007) and three additional RCTs (Anderson, 2005; Chapman, 2004a and b, Muirhead, 2006) that evaluated peer support programmes to improve the initiation or duration of breastfeeding. Fairbank et al. (2000) included four non-randomised controlled trials on peer support programmes: Caulfield et al., (1998)++; Schafer et al., (1998)++; Kistin et al., (1994) and McInnes, (1998)++. They concluded that peer support offered antenatally to women on low incomes who intended to breastfeed was effective at increasing the rate of both breastfeeding initiation and duration.

The SR by Renfrew et al., (2005) included three RCTs in their review under the category of peer supporters/counsellors (Dennis, 2002 (1++); Mongeon and Allard, 1995 (1-); Graffy, 2004 (1+++)). Two of these papers (those of at least moderate quality) are described under different section headings in this rapid review (see ‘Volunteer Counsellors’). Based on the results of their SR, Renfrew et al., (2005) concluded that effective peer support interventions were those that were given very soon after birth to women who did not have to request the support in order to receive it.
The third SR by Britton et al (2007) (not unpicked for individual grading) included nine trials of lay support (Chapman, 2004; Dennis, 2002; Graffy, 2004; Haider, 2000; Jenner, 1988; Leite, 1998; Mongeon and Allard, 1995; Morrell, 2000; Morrow, 1999) and concluded (from the six studies where exclusive breastfeeding was reported) that lay support resulted in a marked reduction in the cessation of exclusive breastfeeding (RR 0.72, 95% CI 0.57, 0.90), which on subgroup analysis appeared to be mainly within the first three months. Three of the six studies contributing to the subgroup analysis, which individually had a significant effect, were in Bangladesh (Haider, 2000), Brazil (Leite, 1998) and Mexico (Morrow, 1999). One study (Jenner, 1988) included only working-class women, while the remaining two UK studies neither of which individually contributed a significant result, were in an even mixture of all social classes (Graffy, 2004; Morrell, 2000). The overall conclusion for the seven studies on any breastfeeding was similar but less significant: lay support resulted in a reduction in the cessation of any breastfeeding (RR 0.86, 95% CI 0.76, 0.98) but subgroup analysis did not give a significant effect at any time point. There were no obvious reasons for the relative success of some studies compared to others. In fact the study with the greatest effect used intensive telephone support but was of affluent well-educated Canadian women (Dennis, 2002).

The two UK studies included in the analysis did not contribute a significant result. Overall in the review, the effect of incorporating an antenatal element of breastfeeding support into a study was not significant but those 20 studies incorporating postnatal support alone were significant (RR 0.89, 95% CI 0.84, 0.96) for reducing the cessation of any breastfeeding at last study assessment up to six months. However, the effect estimates were similar and the difference between the two effects was not significant. Six studies using lay support contributed to the analysis and their results were compatible with the conclusion. Similarly, face-to-face support appeared to be more effective than telephone support generally in the review in preventing the stopping of breastfeeding up to six months (RR 0.85, 95% CI 0.79, 0.92) and all the seven studies which used lay support contributed to the analysis.

In addition, the following three RCTs provide evidence to complement the SRs. One 1++ study (Muirhead, 2006) examined the effectiveness of peer support on the rates of ‘any’ and ‘exclusive’ breastfeeding up to eight weeks. In Ayrshire, Scotland, 225 women were randomised to receive education and support from trained peer supporters in the antenatal and postnatal periods or to the control arm with standard care including home visits from the community midwife for 10 days, visits from the health visitor after the 10th day, and breastfeeding support groups and workshops. The intervention allowed for peer support until 16 weeks after hospital discharge. No information on the socio-economic status of the women was reported. The loss to follow-up was minimal (2.2%). Thirteen women in the intervention group did not receive peer support. There were no baseline differences in those who received and did not receive support; all participants were entered into the analysis. At six weeks, ‘any breastfeeding’ occurred in 31.3% of women in the intervention group and 29.2 % in the control group (95% CI –10.0 -14.0). Exclusive breastfeeding at six weeks was 24.1% in the intervention group and 21.2% in the control group (95% CI -8.1 – 13.8). Corresponding figures for ‘any breastfeeding’ at 16 weeks were 23.2% and 17.7% (95%CI –5.0-16.0) and 1.8% and 0% for ‘exclusive breastfeeding’ (95% CI –0.7-4.2). None of the comparisons were statistically significant. Cumulative breastfeeding survival (Kaplan-Meier) was higher
in the intervention group for all participants (p=0.5), for women who intended to breastfeed (p=0.4) and for those who started to breastfeed (p=0.4). First-time mothers appeared to benefit from the intervention.

One study (Chapman et al., 2004a) evaluated the impact of an existing peer counselling programme for a low-income, predominantly Hispanic population in a large city in the USA. Two hundred and nineteen women who intended to breastfeed were randomised to receive breastfeeding education, support and counselling from peer counsellors or the control group with routine breastfeeding education, written information, hands-on assistance in hospital and postnatal access to a telephone helpline. The intervention was designed to give one prenatal visit offering breastfeeding education and assessment with optional viewing of an educational video, daily intrapartum hospital visits involving hands-on assistance and further education, and three postnatal home visits offering one-to-one counselling with optional free breast pump and further access to peer counsellor services on request. The first postnatal visit was designed to be within 24 hours after hospital discharge; however there was no information on the cut-off date for the intervention i.e. two or three months postnatally. Fifty three per cent of the women received at least one prenatal visit, which lasted a mean of 69 minutes, 94% received at least one hospital visit, and 50% received at least one postnatal home visit. The loss to follow-up at six months was 12.7%, with no significant differences between the groups. Peer counseling significantly reduced the number of women not initiating breastfeeding (RR 0.39, 95%CI 0.18-0.86). Although not significant, the authors state that fewer women in the intervention group were not breastfeeding at one and three months post-partum compared to the control group (RR 0.72, 95% CI 0.50-1.05 and RR 0.78, 95%CI 0.61-1.00, respectively). The impact of the intervention on exclusive breastfeeding was not apparent.

Chapman et al. (2004b) reports on process outcomes from Chapman et al., (2004a). In the first month, 45% percent of women received postnatal home visits and 51% received telephone contact. In the second month, the figures dropped to 8% and 12% respectively. The first quartile of breastfeeding duration among women who received prenatal visits was significantly higher than those who did not receive home visits (1.8 month vs. 0.5 month, p <0.05). Similarly, among participants who received both hospital and postnatal contact breastfeeding duration was higher than for those who did not receive this contact (1.8 month vs. 0.5 month, p <0.05).

One study by Anderson et al., (2005) evaluated the effect of peer counselling to promote exclusive breastfeeding in the same population and setting as the earlier study, but at a later date. 182 women who were intending to breastfeed, the majority of whom were Hispanic or Black, were randomised to receive breastfeeding education and counselling from trained peer counsellors during antenatal, intrapartum and postpartum visits until three months after the birth of their baby, or randomised to the control group which involved lactation education and support as per the Baby Friendly Hospital Initiative (BFHI) directives, plus lactation consultant services while in hospital, and postnatal access to a 24-hour breastfeeding helpline. The differences between this and the earlier study by Chapman et al., (2004) were an increase in the number of prenatal and postnatal visits (from one prenatal and three postnatal to three and nine respectively). In addition, breastfeeding education was extended to the woman’s family. At hospital discharge, fewer women in the intervention group did not initiate breastfeeding (RR 2.48, 95% CI 1.04-5.90). Non-exclusive breastfeeding was higher in the intervention compared to the control.
Peer support for breastfeeding in Scotland

group (RR 1.35, 95% CI 0.94-1.93) at hospital discharge, but in the postnatal period, prevalence of non-exclusive breastfeeding rates were consistently higher in the control group; at three months it was 73% in the intervention group compared to 97.2% in the control group (RR 1.33, 95% CI 1.14-1.56).

Summaries of evidence

Three ++ non-randomised control trials included in Fairbank et al. (2000) evaluated peer support programmes. The interventions included training of peer supporters, antenatal and postnatal support (telephone, home visits, group or contact at clinic) that was initiated by the peer supporter. The studies found a statistically significant increase in the initiation and duration of breastfeeding among women from low-income groups who intended to breastfeed (Caulfield, 1998; Schafer, 1998; McInnes, 1998).

Seven RCTs in Britton et al., (2007) evaluated peer support programmes. Six studies found that lay support resulted in a marked significant reduction in the cessation of exclusive breastfeeding, which appeared to be predominately during the first three months. However three of the studies were in countries not considered relevant to NICE reviews and neither of the two contributing UK studies individually gave significant results (Graffy, 2004; Morrell, 2000). (These two UK studies were of populations containing a mixture of all social classes). Seven studies showed a similar but less significant reduction in the cessation of any breastfeeding but subgroup analysis did not give a significant effect at any time point. Overall, the effect of incorporating an antenatal element of breastfeeding support into a study was not significant but those studies incorporating postnatal support alone significantly reduced the cessation of any breastfeeding up to six months. Six studies using lay support contributed to the analysis and their results were compatible with the conclusion. Similarly, face-to-face support appeared to be more effective than telephone support in preventing the stopping of breastfeeding up to six months and all seven studies which used lay support contributed to the analysis.

One 1++ RCT evaluated a peer support programme including peer support training, one antenatal visit, postnatal support (not necessarily within 72 hours) by telephone or home visit and support groups. The study found no significant difference in breastfeeding initiation and duration rates (up to 16 weeks) compared to routine care in a general population in Scotland (Muirhead, 2006).

Reference

Appendix 2: Publications about local innovative practice

The two papers that are summarised here relate to support of breastfeeding mothers offered by a professional support team in Scotland and thus technically do not relate to peer support provided in the community. However, evidence summaries are included here as they highlight the potential use of telephone support, the delivery of which may be relevant to the provision of support that is offered by a peer, particularly in remote and rural communities.

The FEeding Support Team (FEST) randomised, controlled feasibility trial of proactive and reactive telephone support for breastfeeding women living in disadvantaged areas. Hoddinott, Craig and MacLennan et al., (2012). The abstract for this publication is available from:
http://bmjopen.bmj.com/content/2/2/e000652.abstract

Evidence summary:

The aim of this study was to assess the feasibility of providing a dedicated feeding support team on a postnatal ward and to pilot the potential effectiveness and cost-effectiveness of team (i.e. proactive) and woman-initiated (i.e. reactive) telephone support after discharge. Study details are outlined in the next evidence summary.

Eligible women were recruited to a before-and-after intervention study. They were independently randomised after hospital discharge to either the intervention group, who received daily proactive and reactive telephone calls for ≤14 days, or to the control group, who could make reactive telephone calls ≤ day 14. Intention-to-treat analysis compared the randomised groups for those with complete outcomes at follow-up.

The primary outcome was that of any breastfeeding at 6–8 weeks, which was assessed by a telephone call from a researcher who was unaware of the woman’s group allocation. Secondary outcomes measured were exclusive breastfeeding, satisfaction with care, NHS costs and cost per additional woman breastfeeding.

Women who received proactive telephone calls from the feeding team were more likely to be giving their baby some breast milk at 6–8 weeks after birth than those who received no feeding team initiated calls. However, this difference was not statistically significant. 69% of women receiving proactive calls were giving their baby some breast milk at 6–8 weeks compared with 46% of women followed up in the control group. At 6–8 weeks, 53% of women receiving proactive calls were exclusively giving their baby breast milk, compared with 31% of women in the control group. The incremental cost (that were sensitive to service organisation) of providing proactive calls was £87 per additional woman breastfeeding and £91 per additional woman exclusively breastfeeding at 6–8 weeks.

The feeding team consisted of band 4 staff, one of whom was an NCT breastfeeding counsellor and another was a maternity care assistant with personal breastfeeding experience. In the main trial, paid peer supporters will be eligible to be team members, (Hoddinott, P. personal communication, 2013).
Hoddinott, Craig and MacLennan et al. (2012) conclude that proactive telephone care, delivered by a dedicated feeding team, shows promise as a cost-effective intervention for improving breastfeeding outcomes and that integrating the FEeding Support Team (FEST) intervention into routine postnatal care was feasible.

**Process evaluation for the FEeding Support Team (FEST) randomised controlled feasibility trial of proactive and reactive telephone support for breastfeeding women living in disadvantaged areas** Hoddinott, Craig and MacLennan et al., (2012). The abstract of this publication is available from: http://bmjopen.bmj.com/content/2/2/e001039.abstract?sid=01a7da83-6119-41f4-a2b7-71370641dbcf

**Evidence summary:**

The aim of this study was to assess the feasibility, acceptability and fidelity of a feeding team intervention, with an embedded RCT of team-initiated (i.e. proactive) and woman-initiated (i.e. reactive) telephone support after delivery and hospital discharge and adopting a mixed-method process evaluation.

Women who had initiated breastfeeding were recruited from a postnatal ward in Scotland. Quantitative data was gathered, comprising telephone call logs and workload diaries while qualitative data comprised 40 interviews with women, with 11 follow-up interviews with women and 17 staff. Ward observations, two weeks before and after the intervention; 16 recorded telephone calls and nine steering group meetings; 69 trial case notes and 372 responses to an open question in a telephone interview completed the qualitative data gathered. The Framework approach was applied to the analysis of this mixed-method data set.

The main quantitative outcomes measured were telephone call characteristics (i.e., their number, frequency, duration) and workload activity of staff, while the qualitative experiences and perspectives of women and staff were explored via interviews and observation.

A median of 8 proactive calls per woman (N=35), with a median duration of 5 minutes occurred in the 14 days following hospital discharge. Only one of 34 ‘control’ women initiated a call to the feeding team, as women undervalued their own needs compared to others and breastfeeding as a reason to call. Proactive calls that provided continuity of care increased women’s confidence and were highly valued by them. The findings demonstrated intervention fidelity for woman-centred care. However, the planned observation of an entire breastfeed on the ward to help with establishing rapport, and required to achieve BFI accreditation, was not well-implemented. This was because of short hospital stays, ward routines and staff–team–woman communication issues. Pragmatically, staff recognised that dedicated feeding teams help to meet women’s breastfeeding support needs when postnatal services are overstretched and variable.

Hoddinott, Craig and MacLennan et al. (2012) conclude that implementing and integrating the FEeding Support Team (FEST) trial within routine postnatal care was feasible and acceptable to women and staff from a research and practice perspective and shows promise for addressing health inequalities.
References

The FEeding Support Team (FEST) randomised, controlled feasibility trial of proactive and reactive telephone support for breastfeeding women living in disadvantaged areas. Hoddinott P, Craig L, MacLennan G, Boyers D and Vale L. (2012). Freely available from: http://bmjopen.bmj.com/content/2/2/e000652.full.pdf+html

Process evaluation for the FEeding Support Team (FEST) randomised controlled feasibility trial of proactive and reactive telephone support for breastfeeding women living in disadvantaged areas Hoddinott P, Craig L, MacLennan G, Boyers D and Vale L. BMJ Open 2012; 2: e001039 doi:10.1136/bmjopen-2012-001039. Freely available from: http://bmjopen.bmj.com/content/2/2/e001039.long
Appendix 3: Additional details of recent policy documents


The Maternal and Infant Nutrition Framework for Action is aimed at a wide variety of organisations that have a role in improving maternal and infant nutrition in Scotland. The Framework for Action stresses the importance of concentrating efforts on the early years and targeting those in need, to ensure that health outcomes for children are improved and health inequalities reduced. It describes the actions that can be taken by Health Boards, local authorities and others to improve the nutrition of pregnant women, babies and young children in Scotland.

*NICE public health guidance 11: Improving the nutrition of pregnant and breastfeeding mothers and children in low-income households* (NICE, 2008).

This guidance is for health professionals, commissioners and managers, pharmacists, those providing preschool childcare and other relevant public, community, voluntary and private sector organisations. It relates to pregnant women (and those who are planning to become pregnant), mothers and other carers of children aged under 5 and their children. It is particularly aimed at those on a low income or from a disadvantaged group.

*Scottish Perspective on NICE public health guidance 11: Improving the nutrition of pregnant and breastfeeding mothers and children in low-income households* (NHS Health Scotland, 2009).

NICE (the National Institute for Health and Clinical Excellence) produces public health guidance for England, aimed at promoting good health and preventing ill health. The guidance is informed by available evidence on the effectiveness and cost-effectiveness of programmes or interventions, using a highly developed and rigorous process. Account is also taken of stakeholders’ views and fieldwork. NHS Health Scotland produces ‘Scottish Perspectives’ on such guidance to enable the action recommendations, adapted or amended if considered appropriate, to be used to support the development and implementation of policy and practice in Scotland. Details of, and electronic links to, relevant Scottish policies, strategies and action plans are provided. The Scottish Perspectives do not constitute formal guidance.


This refreshment of Scotland’s Framework for Maternity Care is the product of the Maternity Services Action Group (MSAG). MSAG is the strategic group for maternity services in Scotland, bringing together key professional and service stakeholders with policy officers from the Scottish Government’s Child and Maternal Health Division. The aim of the refreshment is to strengthen the contribution NHS maternity care makes to improving maternal and infant health and reducing the unacceptable inequalities in maternal and infant health outcomes. In addition, in response to the specific recommendation in *Equally Well* that NHS Boards improve their capacity to reach and manage women and babies in high-risk groups, MSAG have produced practical antenatal inequalities evidence into action guidance to accompany this framework.

This guidance concentrates on the early years of life – emerging evidence shows that early intervention and support is the key to helping children reach their full potential. The guidance sets out the need for flexibility in the allocation of the Health Plan Indicator, making sure a full assessment of the child’s needs and circumstances is taken into account before making a decision on how much and the type of support required. The reintroduction of the 24–30 month assessment aims to provide support at this key stage of development and to detect any concerns as early as possible. The health improvement message, which is at the heart of the Hall 4 ethos, is further reinforced and NHS Boards are asked to ensure that key advice and messages are provided in an appropriate way.

Antenatal health inequalities: A rapid review of the evidence (NHS Health Scotland, 2010).

The aim of the rapid review was to provide an overview of the current highly processed evidence in relation to antenatal health inequalities. Additionally, the review aimed to highlight issues associated with health inequalities during pregnancy that needed to be addressed in the course of planning effective interventions or actions.
Appendix 4: Definitions of breastfeeding peer support

The definitions of breastfeeding peer support included below have been copied from websites, with permission of the organisations where they originated. While each definition is reproduced verbatim, some modification to the original layout has been made for ease of reading.

Definition from Plymouth Latch-on Breastfeeding Group
Available from: www.plymouth-latchon.org.uk/roleofapeersupporter.html

Role of the breastfeeding peer supporter

Context:

Breastfeeding peer supporters are mothers of any age who have breastfed their own baby/babies or are still breastfeeding and want to support other mothers to have a positive breastfeeding experience.

In Plymouth this role is carried out by volunteers, who have successfully completed a 10-week accredited training programme, received a satisfactory CRB check and undertaken a planned volunteer induction to the clinical/non-clinical environment.

Peer supporters aim to promote, protect and sustain breastfeeding within their local area, with the unique quality of being able to relate to mothers from a similar community, culture and values sets.

They provide factual, evidence-based information/research which enables mothers and families to make a fully informed choice about how they would like feed their baby/babies.

1. Who can be a breastfeeding peer supporter?

1.1 To be a breastfeeding peer supporter you must be:

- a mum who has breastfed (or is breastfeeding) and who has a positive attitude to breastfeeding
- willing to undertake the peer support training course
- Prepared to become a peer supporter, which is a voluntary role, for at least 6–12 months after completing the training course
- willing to have a CRB (Criminal Record Bureau) check done, in line with all staff and volunteers who work with or have access to children and babies in any setting.
- willing to undertake safeguarding training
- willing to attend regular peer support networking/update sessions.
2. Desirable qualities for a breastfeeding peer supporter

2.1 As a peer supporter you will need the following:

- To be enthusiastic about breastfeeding and breastfeeding support.
- To have a good sense of humour.
- To be caring and have a non-judgemental attitude to other people.
- To be able to work well as part of a team.
- To be a good communicator.
- To be tolerant and understanding towards people from different social, religious, ethical and cultural backgrounds.

3. Role of breastfeeding peer supporter

3.1 This is a role which is primarily to promote breastfeeding and to provide basic breastfeeding information, guidance and support, and includes the following:

- To be easily identifiable as a breastfeeding peer supporter – polo shirt/name badge provided.
- To promote the Plymouth Latch-on network.
- To promote breastfeeding in a friendly and sensitive manner, in accordance with Baby Friendly Initiative (BFI) standards and the local healthcare facility’s breastfeeding policy.
- To offer support and encouragement to breastfeeding women and their families, as requested by a health practitioner or by the woman herself, and within the boundaries of the breastfeeding peer support training.
- To be aware of the process for reporting feedback, e.g. reporting concerns to the appropriate health practitioner or designated member of staff.
- To be aware of and maintain the confidentiality of individuals.
- To be responsible to the named health practitioner for the clinical/non-clinical area.
- To maintain effective communication links with other peer supports, health practitioners and children’s centre staff.
- To be aware of infant/child safety issues and how to deal with any safety concerns arising.
- To be aware of health and safety issues including environmental risks and infection control.
- To keep up to date by attending regular network meetings, highlighting any personal training needs to the peer support mentor and participating in an annual review of practical skills.
• To participate in evaluation of training and of the peer support service, as directed by the relevant health practitioner or the breastfeeding coordinator.

• To be reliable and adaptable.

4. Breastfeeding peer supporters have a voluntary role within Latch-on Breastfeeding Groups, community settings, and on designated wards at Derriford hospital

4.1 Community environment – aspects of the role specific to this setting:

• To work alongside healthcare practitioners and children’s centre staff who have a responsibility for supporting mothers/parents with infant feeding.

• To help to create a welcoming environment, which is easily identifiable as breastfeeding friendly.

• This should be done in conjunction with the designated healthcare practitioner and children’s centre staff.

• To welcome new and existing group attendees.

• To set up and clear away for the group as needed/negotiated.

• To assist with paperwork, which relates directly to breastfeeding or data collection on behalf of the Latch-on network; e.g. registration and evaluation forms, as requested by the designated health practitioner/children’s centre worker.

• To undertake a planned induction to the Latch-on venue, under the guidance and supervision of a designated health practitioner/children’s centre staff member.

4.2 Hospital environment – aspects of the role specific to this setting:

• To wear PHNT I.D badge at all times while on the hospital premises.

• To report to a health practitioner on arrival in each ward area.

• To be aware of the security systems in the ward areas.

• To adhere to infection control measures in place in clinical areas.

• To offer verbal feedback to the healthcare practitioner regarding any concerns, matters arising, or relevant discussions pertaining to breastfeeding/lactation.

• To use peer supporters communication book as directed by the infant feeding coordinator.

• To undertake a planned induction to the clinical area, under the guidance and supervision of a designated health practitioner.
5. Role limits and boundaries

5.1 Breastfeeding peer supporters will not be expected to:

- diagnose or offer treatment advice – this should always be done by an appropriately qualified health practitioner
- take on extra responsibilities outside of the role description – as a peer supporter you are aiming to encourage and to support; you should not be tempted to lend money, to offer childcare, to change nappies or to encourage other mums to become dependent on your support
- be involved in other ward or community activities, e.g. bed-making or cleaning!
- undertake lone home visits/contacts
- give personal details to other mothers/parents, unless you choose to do so as an individual and not in your capacity as a peer supporter
- participate in any formal record-keeping, which is entered into patients’/clients’ notes, unless requested in exceptional circumstances; e.g. where a safeguarding issue has been identified or suspected
- give formal advice/instruction on parenting issues beyond the scope of a breastfeeding peer supporter
- tolerate any inappropriate language or behaviour which is deemed to be aggressive, threatening or intimidating.

6. Maintaining knowledge and skills

6.1 Support and updating for breastfeeding peer supporters

- Peer supporters who have completed the breastfeeding peer support training are encouraged to attend regular Peer Support Network sessions, which are held every three months and provide an opportunity to network, share good practice, reflect, gain practical support and regular updating of skills and knowledge.
- You will be expected to attend any mandatory training as requested by the organisation for whom you are volunteering; e.g. safeguarding, fire safety, infection control, etc.
- You may be given the opportunity to attend the breastfeeding training sessions which is mandatory for health practitioners, as spaces become available.
- You will be offered access to secure I.T. (password-protected) peer support networks, for the purpose of communicating relevant experiences, challenges, and opportunities which relate to your role as a peer supporter. Information shared must maintain confidentiality to persons and organisations.
- You will be sent an electronic newsletter on a quarterly basis, which may identify further training opportunities, such as study days, conferences, and events relevant to your role.
In the community, clinical and non-clinical settings, a health practitioner or designated children’s centre worker will have responsibility for supporting your role. You should ensure that you are aware of their contact details as a source of expert advice, guidance and support.

The peer support mentor is the first point of contact for any issues arising from the role (as described above), which does not require immediate intervention.

For any matters arising which require immediate attention, the peer supporter must seek the support of a healthcare practitioner, children's centre worker or infant feeding coordinator.

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**Definition from Best Practice for Breastfeeding Peer Support. A practical guide for those purchasing breastfeeding support services.** Available from: www.devon.gov.uk/es/microsoft_word_-_cc_guide_-_final_version_march_2012_1_.pdf

The definition of peer support from Devon County Council, (including diagram) is reproduced below.

Figure 1: Foundations of peer support

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### Peer support

**Informational support**
- Sharing experiences and information
- Modelling effectiveness skills

**Emotional support**
- Encouragement
- Reinforcement
- Decreased sense of isolation

**Mutual reciprocity**
- Shared problem-solving
- Both receiving and giving help on shared (health or farming*) issues

**Enhances**
- Confidence
- Perceived social support
- Positive mood
- Understanding of self-efficacy

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* for full description, please follow link below to original source.

3. What is peer support?

‘Peer support’ is an approach where women that have had personal and practical experience of breastfeeding offer support to other mothers. This kind of mother-to-mother support can happen informally, but most of the body of evidence is from evaluations of where peer support schemes have been hosted within a healthcare setting.

The goal of peer support is to encourage and support pregnant women and those who are breastfeeding. It should include individual support as well as mother-to-mother support groups.

3.3 Different interventions have different target groups and different breastfeeding outcomes. Women who provide peer support undergo specific training and may work voluntarily or employed in an informal group or one-to-one through telephone calls or visits in the home, clinic, or hospital. Peer support includes psycho-emotional support, encouragement, education about breastfeeding, and signposting for support with solving problems.

A peer supporter shouldn’t be offering problem-solving or counselling; their role is to give support as a ‘well-informed friend’, and will be able to signpost a mother in the right direction for more specialist help. Organisations need to be very clear that their supporters are not insured to solve problems and clearly define what is within the remit of these mums.

‘Each locality is likely to find that they need to develop their own tailored package of interventions, selecting the appropriate mix of services and outcomes’ (Dyson et al., 2005).

4. Peer support – the evidence base

4.1 Reports such as Bemerton Heath Bosom Buddies Project Report (Anderson et al., 2002) and West Howe Breastfeeding support group: Making a difference (Bournemouth University, 2004) show a higher rate than expected of women still breastfeeding six weeks after attending the groups. Interventions such as these have become commonplace in the UK as a method of supporting and encouraging a longer duration of breastfeeding.

4.2 One-to-one or group-based peer support for breastfeeding? Women’s perceptions of a breastfeeding peer coaching intervention (Hoddinott, Chalmers and Pill, 2006) compared the popularity of breastfeeding groups over one-to-one contacts. The analysis revealed that ‘groups were more popular because they normalised breastfeeding in a social environment with refreshments, which improved participants’ sense of wellbeing. Groups provided flexibility, a sense of control, and a diversity of visual images and experiences, which assisted women to make feeding-related decisions for themselves, and they offered a safe place to rehearse and perform breastfeeding in front of others, in a culture where breastfeeding is seldom seen in public’.

4.3 Supporting breastfeeding mothers: qualitative synthesis (McInnes and Chambers, 2008) found mothers tended to rate social support as more important than health service support. ‘Health service support was described unfavourably with emphasis on time pressures, lack of availability of healthcare professionals or guidance,
promotion of unhelpful practices and conflicting advice. Changes are required within the health services to address the needs of both mothers and staff’.

4.4 **Group interventions to improve health outcomes: a framework for their design and delivery** (Hoddinott et al., 2010), found ‘health improvement or behaviour change interventions delivered in a group setting are complex adaptive social processes with interactions between the group leader, participants, and the wider community and environment. Ecological models of health improvement, which embrace the complex relationship between behaviour, systems and the environment, may be more relevant than an individual approach to behaviour change’.

4.5 **NICE Promotion of breastfeeding initiation and duration: Evidence into practice briefing** (Dyson et al, 2005) concluded that informal, practical breastfeeding information delivered in the antenatal period combined with peer support programmes can be effective in increasing initiation and duration rates for breastfeeding.

4.6 **A prospective study exploring the early infant feeding experiences of parents and their significant others during the first 6 months of life: what would make a difference?** (Hoddinott et al., 2010) identified the ‘ideal characteristics for supporting breastfeeding is that information should not come from a book, but from someone who understands and cares and has life experience and has been through it’.

4.7 **NICE guidance states that a peer-support programme for women who breastfeed needs to:**

- be effective and efficient
- be responsive to the needs of women and their babies
- provide support and care, based on best practice, NICE guidance recommends one WTE (whole time equivalent or full-time) peer supporter is employed for every 250 births, refer to NICE public health guidance PH11 on maternal and child nutrition (NICE, 2008a) and NICE clinical guideline CG37 on postnatal care (NICE, 2006)
- deliver the required capacity
- be integrated with other elements of care for women requiring support for breastfeeding
- define agreed criteria for referral, local protocols and the care pathway for women requiring support for breastfeeding
- be family-centred and provide equitable access, ensuring that women are treated with dignity and respect, are fully informed about their care and are able to make decisions about their care in partnership with healthcare professionals
- demonstrate how it meets requirements under equalities legislation
- demonstrate value for money.
5. Terms and definitions

5.1 Terms and definitions are outlined below:

- **Volunteer** – a person who performs a service willingly and without pay (Dictionary.com).

- **Peer supporter** – the peer support relationship is based on a sharing of experiences, mutual respect, and empathy; in these ways, the function of peer support can be very similar to that of having a best friend (Fetsch, 2005).

- **Breastfeeding peer supporter** – these are mothers of any age who are breastfeeding or have breastfed their own baby (usually no criteria as to how long) and want to support other mothers. Peer supporters by definition aim to protect and promote breastfeeding within their local area, relating to mothers from a similar culture. They provide information which encourages mothers and families to make informed choices about how they feed their babies.

5.2 Peer supporters draw on their personal experience, combined with a training course which usually covers a wide range of topics from social and economic issues to anatomy, listening, communication skills and understanding baby’s needs from infancy to toddlerhood.

- **Volunteer breastfeeding peer supporter** – a woman who is breastfeeding her child or who has breastfed in the past that has completed training and offers the above service willingly and without pay.

- **Paid breastfeeding peer supporter** – some children’s centres, health services and social enterprises pay volunteer peer supporters to complete home visits to breastfeeding mothers or telephone contact for a fixed fee.

- **Employed breastfeeding peer supporter** – many children’s centres and health services now employ trained peer supporters to lead on breastfeeding peer support in their areas.

- **Breastfeeding practitioner** – this is an Open College Network qualification at level 3 which is offered by Healthy Babies UK CIC. This course does not require any personal breastfeeding experience as a prerequisite to the course, and can be accessed by staff and peer supporters.

- **Breastfeeding counsellor (BFC)** – a BFC is a mother who has breastfed her child for over six months who has completed a recognised training which takes between nine months to five years, depending on the organisation chosen to train with. BFC’s have a high level of breastfeeding knowledge to offer management strategies for problems as well as counselling services to women, training and education for women, peer supporters, health professionals and children’s centre staff.

- **Lactation consultant (IBCLC)** – a health professional or BFC with approximately five years’ experience of working in a specialist role with breastfeeding women who undertakes the international IBCLC six hour exam offered annually in July. These individuals are highly trained and skilled to offer diagnosis, management strategies and counselling to breastfeeding mothers and their families, as well as a training and education role for women, peer supporters, health professionals...
and children’s centre staff. Many IBCLCs work using their enhanced skills in their NHS or voluntary roles. Some work in private practice.

5.3 Accredited training courses:

- A training course that has been accredited by an organisation for its content and course tutors trained to deliver the training package. La Leche League training falls into this category. With these courses, however, although often of high quality when delivered by a trainer who has all the necessary skills and knowledge, there is no transparent measure of quality of the training delivered as it is not externally verified.

- A training course that delivers the above, but also includes an assessment of participant’s knowledge and both internal and external verification processes to assure quality and robust accountability as well as awarding a qualification. NB: organisations providing accredited peer supporter training packages have ownership of those packages and they cannot be used in their entirety or in part by individuals.

5.4 Implementation

- what follows is a section using the shared knowledge and experience of many specialist workers in this field, to assist with guidance on issues that need to be considered when planning breastfeeding peer support networks to ensure the services offered are effective, value for money, fit for purpose, based on evidence and best practice standards.

6. Recruitment of peer supporters

6.1 When developing a peer supporter recruitment process it is important to consider:

- Recruitment should be managed and undertaken by an individual with the relevant breastfeeding knowledge and experience who will have an overall understanding of the qualities which will make an effective peer supporter.

- While a professional attitude towards peer supporters should be taken, the recruitment process can be quite informal and need not involve interviews, written applications and references. An interview checklist can be used to prompt an informal chat to judge suitability of a prospective peer supporter (Appendix A).

- Supporters should be local, and where possible genuine peers of the mothers who they will be supporting.

- It should be made clear what the expectations of the children centres are in a peer supporter and what the role entails through a clear role definition, during the first meeting and reinforced throughout training, during an active role and through ongoing training.

- The process may benefit from an informal contract outlining the peer supporter's roles and the children centre's responsibilities (Appendix B).
• A positive attitude to breastfeeding is most important. Experience and duration of breastfeeding may not be the best criteria in determining a candidate’s suitability for recruitment.

• This process of recruitment should be ongoing to ensure the highest uptake of new peer supporters. Please remember women do not have to be breastfeeding when they train as peer supporters. However they must have breastfed and have a positive attitude to breastfeeding.

**Definition from Real Baby Milk.** Available from: [http://realbabymilk.org/local-support/what-is-a-peer-supporter/](http://realbabymilk.org/local-support/what-is-a-peer-supporter/)

With all the national guidance now recommending peer support as an effective method of supporting women and encouraging longer breastfeeding rates, there is also some confusion as to what a peer supporter is and what role she is to play in the provision of maternity services. This article is based on our experience of working with volunteers and groups in the South West and we hope you find it useful.

**What is peer support for breastfeeding?**

Many studies have shown that training breastfeeding mums in how to support other breastfeeding mums can have a surprising effect on both the initiation and continuation rates for breastfeeding.

Ingram J et al. (2005) studied the effect of training women on the breastfeeding figures in a socially and economically deprived part of Bristol. They concluded; ‘peer supporters combined with a breastfeeding support group are an effective way of increasing breastfeeding prevalence in areas of low continuation’.

Hoddinot P et al. (2006), studied the effect of peer support in rural Scotland. They found group-based and one-to-one coaching from peer supporters increased the initiation and duration in an area with below average breastfeeding rates.

There are many other studies showing similar results.

Traditionally peer supporters will have accessed some form of breastfeeding training – either accredited courses such as the La Leche League training or often training courses that have been developed locally.

Peer support volunteers are most usually active within a community group situation, quite often based in children’s centres or health clinics.

**What is a peer supporter?**

Normally, a peer supporter is a mum who has breastfed and/or provided breastmilk for her child, who has had a positive and successful personal breastfeeding experience and who has undertaken a peer supporters training course.

**What does a peer supporter do?**

A peer supporter is friendly and welcoming. She is always looking out for a mum with no one to talk to. She is there for mothers.

• A peer supporter listens, empathises with, supports and empowers mothers.

• A peer supporter acts as a source of good, up-to-date information about breastfeeding and related issues, and has access to resources, such as books, leaflets and DVDs, to share with mothers and helps them talk through their choices; then
supports them in whatever choice they decide to make.

• A peer supporter enables mums to have a positive breastfeeding experience, no matter how long or short.
• A peer supporter should ‘do no harm’.
• A peer supporter knows her boundaries, not giving advice, and referring on to an appropriate practitioner as necessary.
• A peer supporter gives what she feels she can to her local group, no more. She seeks support for herself as needed.

What does a peer supporter not do?
It is important that the community, and the mums attending the support groups, know that a peer supporter is not a breastfeeding expert. A peer supporter is not a ‘problem-solver.’

Peer support – mothers’ experiences
The following quotes are taken from women when talking about receiving excellent peer support.

‘Before making suggestions she always looks for the positive and makes mums feel good about what they are already doing…’

‘A friend as well as a supporter…’

‘Calm, confident and encouraging…’

‘With a quiet and calm manner she provides support in a compassionate way allowing the mother to come to their own conclusions…’

Definition from Peer support as an intervention to increase the incidence and duration of breastfeeding in Northern Ireland:

What is peer support?
The concept of peer support is that someone who has herself successfully breastfed, and has undergone some training on breastfeeding, is available from the local community to support a breastfeeding mother, usually on a voluntary basis. The peer supporter is a true peer of the breastfeeding mother and not a healthcare professional.

Peer support can be used to help address the needs of communities with very low breastfeeding rates that are seen as having ‘lost skills’ in breastfeeding, with little ‘tradition’ of breastfeeding for new mothers to draw on. In such areas, social networks that include breastfeeding are generally lacking, which results in women having little experience of breastfeeding as an ‘everyday’ activity and a learned practical skill. It can be difficult for women to ‘succeed’ in breastfeeding if they rarely see anyone breastfeed their baby, and formula feeding is normal practice among their friends and acquaintances.

21 Numerical references to the cited evidence have been removed for ease of reading. The reader is advised to access the full report to identify the cited evidence. Please note that access to this website may cease as the responsibilities of the HPA were transferred to the PHA in April 2009 and there are no plans to bring the HPA information on to the PHA corporate site.
As research has demonstrated, a predominantly bottle-feeding culture has led to a number of barriers to breastfeeding including lack of support from significant others, social embarrassment, and negative social attitudes towards breastfeeding in public places, compounded by a lack of designated facilities.

Thus, peer support has been developed as a means to overcome such obstacles by:

- forming relationships with pregnant or breastfeeding women
- sharing experiences and information
- being a role model
- giving time or being available
- normalising breastfeeding
- providing social support
- providing breastfeeding expertise.

A qualitative study provides evidence of why peer support programmes may be effective: interview data gathered from first-time mothers living in a deprived inner city in the UK suggested that exposure to breastfeeding was important. Women were more likely to decide to breastfeed if they had regularly seen a relative or friend successfully breastfeed. Women who had not had such an experience or who had only seen breastfeeding at a distance held more negative views and lacked confidence in their own ability to breastfeed. Thus, it is thought that enhancing informal support networks can encourage women to initiate and maintain breastfeeding. Peer support can also reduce social isolation, and offer women the opportunity to socialise and exchange experiences. Sharing experiences is a simple way of encouraging mothers to breastfeed in a community with few informal support networks.

**Different models of peer support and how they work**

The peer support programmes developed to date can be divided into two different categories: those that provide support to individual pregnant women/mothers and those that provide support to groups of pregnant women/mothers.

Individual support programmes may or may not adopt a proactive approach to obtaining referrals. Proactive approaches can come from health professionals who offer the service and undertake systematic antenatal recruitment. Referrals are then forwarded to a peer supporter who will arrange a face-to-face home visit or a telephone call, or meet with the mother at a support group or clinic. Proactive contacts can also be made by peer supporters on routine postnatal hospital visits. Alternative, ‘reactive’ approaches advertise contact details of peer supporters to mothers and encourage them to instigate initial contact by telephone.

Group support programmes involve health professionals or trained peer supporters facilitating breastfeeding groups. Pregnant or breastfeeding women offer mutual support and receive ‘expert’ help from group leaders.

In the UK, several voluntary organisations offer peer support including La Leche League, the National Childbirth Trust, the Association of Breastfeeding Mothers and the Breastfeeding Network. However, it has been noted that the women most

likely to participate and join these organisations are well-educated, professional and knowledgeable individuals. Therefore, lower-income women with less education may perhaps have difficulty relating to some of the women who attend voluntary breastfeeding groups and may not see them as their peers. Several breastfeeding advocacy organisations have acknowledged this challenge and are now involved in delivering training programmes to breastfeeding mothers from disadvantaged areas to enable them to provide peer support within their own communities.

The most commonly used training programmes in the UK include the well-established La Leche League peer counsellors training programme and the UNICEF Breastfeeding Management course. Some projects involve the development and delivery of their own courses, or adaptation of a related course, e.g. principles from the National Childbirth Trust training programme. Course content typically includes principles of breastfeeding and ways of supporting mothers, debriefing on personal experiences, self-awareness, listening skills, role boundaries and responsibilities, record-keeping, child protection issues, confidentiality, working safely in others’ homes and support mechanisms. Within all programmes there is a general recognition that peer supporters are there to listen to women, to validate their experiences, to facilitate and to empower. Most programmes consist of approximately 10–20 hours of learning time over the course of several weeks, and some may include mentored clinical practice. Follow-up sessions are often provided to maintain ongoing support and interest. Supporters tend to experience personal growth and a feeling of empowerment as a result of the training programmes.
Appendix 5: Evidence statements from studies that are relevant to breastfeeding peer support and details of older studies about breastfeeding peer support

This appendix includes the details of evidence statements about breastfeeding peer support that have been considered in the course of this guidance. Additionally, it includes a list of older studies about breastfeeding peer support that, while superseded by more recent evidence, is nonetheless relevant as it contributes to our understanding of the ‘historical’ place for breastfeeding peer support in a Scottish context.


**Evidence statement 1: Who delivered the support**

The reviewers examined whether the treatment effect was similar where the support was delivered by professionals as opposed to non-professionals (lay support) or both. For cessation of any breastfeeding at up to six months it appeared that support from non-professionals was associated with an increased treatment effect (RR 0.85, 95% CI 0.77 to 0.93), compared with support from professionals or both (RR 0.94, 95% CI 0.88 to 0.99 and RR 0.97, 95% CI 0.91 to 1.03 respectively), (although the test for subgroup differences was borderline for statistical significance (P = 0.05, I² = 66.4). For cessation of any breastfeeding by four to six weeks, there were no clear differences between subgroups; for this outcome there was considerable within subgroup heterogeneity and there were no significant differences between subgroups.

For cessation of exclusive breastfeeding at up to six months the treatment effect appeared to be greater where the intervention was delivered by non-professionals (lay support) (average RR 0.74, 95% CI 0.64 to 0.87) compared with professionals (average RR0.93, 95%CI 0.88 to 0.98) or both (average RR 0.76, 95%CI 0.44 to 1.32). The test for subgroup differences for this outcome was statistically significant (Chi² = 7.67, df 2, P = 0.02, I² = 73.9%). This difference was consistent with cessation of exclusive breastfeeding at four to six weeks; again, the effect size was more pronounced with lay support than with professional support.

The test for subgroup differences was significant (Chi² = 6.44, df 2, P = 0.04, I² = 68.9%). However, in view of considerable within-subgroup heterogeneity, these findings should be interpreted with caution. Further, as we discussed above, there was some evidence that more pronounced treatment effects were associated with studies at higher risk of bias; this could potentially confound any differences between subgroups.

**Evidence statement 2: Type of support**

The reviewers compared different types of intervention (support provided predominantly by face-to-face contact, predominantly by telephone, or by both face-to-face and telephone contact) for the primary outcomes. For cessation of exclusive breastfeeding there was some evidence that face-to-face support was associated with a greater positive treatment effect compared with either telephone support or mixed telephone
and face-to-face support. For cessation of exclusive breastfeeding at up to six months, women who received support face-to-face were almost 20% less likely to have given up exclusive breastfeeding by the last study assessment up to six months compared with those in the control groups (average RR 0.81, 95% CI 0.75 to 0.88). There was no significant treatment effect for support that was predominantly by telephone, or that involved both face-to-face and telephone contact (average RR respectively: 1.00, 95% CI 0.99 to 1.01; average RR 0.98, 0.94 to 1.02). The test for subgroup differences suggested that the difference between subgroups was statistically significant (Chi² = 27.52, df 2, P = 0.00001, I² = 92.7%).

This difference between subgroups persisted for cessation of exclusive breastfeeding at up to four to six weeks. Again, while there was no significant difference between control and intervention groups for predominantly phone and mixed support (RR 0.96, 95% CI 0.68 to 1.35; RR 0.94, 95%CI 0.88 to 1.01) there was a positive treatment effect for those women receiving face-to-face support although there was considerable heterogeneity within this subgroup (average RR 0.62, 95% CI 0.51 to 0.77). The test for between subgroup differences was significant (Chi² = 13.73, df = 2, P < 0.001, I² = 85.4%). These differences between subgroups did not apply to cessation of any breastfeeding at last study assessment or at up to four to six weeks; for these outcomes there was high heterogeneity within subgroups, and the tests for subgroup differences were not significant.

**Evidence statement 3: When the support was offered**

The reviewers examined whether offering support with an antenatal component rather than postnatal support alone was associated with any difference in treatment effect. The results were similar in both subgroups for all of our four primary outcomes and there were no statistically significant subgroup differences.

**Evidence statement 4: Proactive versus reactive support**

The reviewers had planned to carry out formal subgroup analysis by whether support was proactive or reactive but due to the fact that most interventions included at least one scheduled contact (proactive), they did not think that this way of categorising studies would shed light on types of interventions that were effective or ineffective.

However, in five studies the way in which support was offered differed substantively from other studies in that women were expected to access the support and it was not delivered directly to them (Graffy 2004; Hoddinott 2009; Labaree 2005; Morrell 2000; Winterburn 2003). None of these studies found a difference in outcomes between control and intervention groups.

**Evidence statement 5: Background breastfeeding initiation rates in study settings**

The reviewers were interested in whether or not background rates of breastfeeding in different settings had any impact on the success of interventions. They divided the studies into three groups: those carried out in settings where 80% or more women initiated breastfeeding (high background initiation), where between 60% to 80% initiated breastfeeding (intermediate) or where breastfeeding initiation rates were less than 60% (low). These groups showed an inverse relationship with World Bank country income groups. The studies with high background rates of breastfeeding initiation were set in countries from all the World Bank country income groups however, the four studies from low-/low-middle-income countries had the highest rates (more than 95%).
All the studies with intermediate or low background rates of breastfeeding initiation were undertaken in high-income countries.

While there were no clear differences between subgroups for cessation of any breastfeeding at up to six months, it appeared that for cessation of exclusive breastfeeding there were some differences between subgroups. Interventions were associated with a more pronounced effect on exclusive breastfeeding at up to six months in settings where there were high background rates of breastfeeding initiation (average RR 0.83, 95% CI 0.78 to 0.89) compared with areas where there was intermediate or low background initiation rates (average RR respectively 0.89, 95% CI 0.79 to 1.01; and RR 1.00, 95% CI 0.99 to 1.01). The test for subgroup differences was statistically significant despite considerable within group heterogeneity (Chi² = 27.5, df = 2, P < 0.0001, I² = 92.7%).

Results were even more pronounced for cessation of exclusive breastfeeding at up to four to six weeks with interventions seeming to be most effective for women living in areas with high background initiation rates (average RR 0.61, 95% CI 0.47 to 0.80) compared with areas with intermediate or low rates (average RR respectively 0.81, 95% CI 0.68 to 0.96; and RR 0.97, 95% CI 0.86 to 1.08), (test for subgroup differences: Chi² = 10.26, df = 2, P < 0.006, I² = 80.5%).

The same pattern persisted for cessation of any breastfeeding at up to four to six weeks with areas where background breastfeeding rates were high having a more pronounced treatment effect, although the test for subgroup differences did not reach statistical significance.

**Evidence statement 6: Intensity of the intervention: the number of postnatal contacts**

The reviewers examined whether different numbers of postnatal contacts were associated with any difference in treatment effect. They divided the studies into four subgroups: unspecified or no direct contacts (for example in studies that involved staff training rather than direct contacts with women); less than four postnatal contacts; between four and eight contacts; and more than eight contacts. For any breastfeeding there were no clear subgroup differences. For exclusive breastfeeding at the final study assessment there was evidence of subgroup differences, although there was no clear ‘dose-response’ effect; the most pronounced treatment effect was associated with between four and eight postnatal contacts (average RR 0.71, 95% CI 0.60 to 0.84) (test for subgroup differences P = 0.02, I² = 71%). However, there was some evidence that more pronounced treatment effects were associated with studies at higher risk of bias; this could potentially confound any differences between subgroups. For exclusive breastfeeding at up to four to six weeks the test for subgroup differences did not reach statistical significance, although again women receiving between four and eight postnatal contacts were the most likely to be still exclusively breastfeeding at this time-point.

As part of their summary of the review findings, the reviewers suggest that this substantively updated review provides evidence that breastfeeding support interventions increase the number of women continuing to breastfeed, and the number of women continuing to exclusively breastfeed, at up to six months and at up to four to six weeks. The size of the treatment effects varied considerably in different trials, and average treatment effects may not be applicable in different settings. The subgroup analysis suggested that face-to-face support was associated with a greater treatment effect than telephone support for exclusive breastfeeding, and that interventions had an increased effect on exclusive breastfeeding in areas where background breastfeeding initiation was high.
These findings are similar to previous versions of this review, and the findings of other reviews (e.g. Dyson, 2009; Guise, 2003; Renfrew, 1995), in that peer and professional support have been shown to be effective interventions. The reviewers concur with others (e.g. Hoddinott, 2011; Renfrew, 2007) that it is critically important to identify the characteristics of support that may make this important, but heterogeneous intervention, more or less effective in different circumstances.

**Lay health workers in primary and community health care for maternal and child health and the management of infectious diseases (Review).**

**Evidence statement 1: The impact of the lay health worker on the initiation of breastfeeding**
Twelve studies were included in this analysis (Anderson, 2005; Baqui, 2008; Caulfield, 1998; Chapman, 2004; Dennis, 2002; Graffy, 2004; Haider, 2000; Kumar, 2008; MacArthur, 2009; Morrow, 1999; Muirhead, 2006; Sloan, 2008). Breastfeeding promotion had a small impact on the initiation of breastfeeding, with studies showing an aggregate RR of 1.36 (95% CI 1.14 to 1.61). However, there was unexplained heterogeneity raising doubts about the suitability of a pooled estimate (I² = 91%, P < 0.00001) (Analysis 2.4; Figure 10). The reasons for this heterogeneity will be explored a priori in the next update and include factors such as study setting (low-, middle-, or high-income country); control group breastfeeding rates (for example < 30%; > 30%); and timing of the start of the intervention (in the first or second trimester of pregnancy, in the third trimester only).

**Evidence statement 2: The impact of the lay health worker on any breastfeeding up to 12 months post-partum**
Twelve studies were included in this analysis (Agrasada, 2005; Anderson, 2005; Caulfield, 1998; Chapman, 2004; Coutinho, 2005; Dennis, 2002; Graffy, 2004; Leite, 2005; Morrell, 2000; Morrow, 1999; Muirhead, 2006; Sloan, 2008). There was evidence, of moderate quality, that breastfeeding promotion had a small impact on any breastfeeding up to six months post-partum (RR 1.24, 95% CI 1.10 to 1.39; P = 0.0004). However, the results were heterogeneous (I² = 69%, P = 0.0002) (Analysis 2.5; Figure 11). The reasons for this heterogeneity are unclear and will be explored a priori in the next update. We will again consider factors such as study setting (low-middle- or high-income country); control group breastfeeding rates; timing of the start of the intervention (in the first or second trimester of pregnancy, in the third trimester only); and time of outcome measurement.

**Evidence statement 3: The impact of the lay health worker upon exclusive breastfeeding up to six months post-partum**
Ten studies were included in this analysis (Agrasada, 2005; Anderson, 2005; Coutinho, 2005; Dennis, 2002; Graffy, 2004; Haider, 2000; Leite, 2005; Morrell, 2000; Morrow, 1999; Muirhead, 2006). There was evidence, of moderate quality, that breastfeeding promotion by LHWs had a substantial impact on exclusive breastfeeding up to six months post-partum (RR 2.78, 95% CI 1.74 to 4.44; P < 0.0001). However, there was once again unexplained heterogeneity in these results (I² = 87%, P < 0.00001) (Analysis 2.6; Figure 12). As for the other outcomes reported above, possible explanations for this heterogeneity will be explored a priori in the next update. We will again consider factors such as study setting (low-, middle-, or high-income country); control group exclusive breastfeeding rates; timing of the start of the intervention; and time of outcome measurement.
Evidence statement 1: In support of breastfeeding peer support

The overwhelming majority of evidence from this systematic review of the breastfeeding peer counselling scientific literature indicates that peer counsellors effectively improve rates of breastfeeding initiation, duration and exclusivity. In addition to improving breastfeeding outcomes, peer counselling programmes significantly decreased rates of infant diarrhoea and lengthened the duration of maternal amenorrhoea. We conclude that breastfeeding peer counselling initiatives are effective and can be scaled up as part of well-coordinated national breastfeeding promotion or maternal–child health programmes.

Details of older studies about breastfeeding peer support

Details of older publications that have been updated by the more recent reviews that have been summarised earlier in this document are included here for the reader’s convenience.


Appendix 6: The application of evaluation principles to breastfeeding peer support

In addition to the key evaluation principles included earlier in this document, the following links provide some useful resources to plan and conduct locally relevant evaluations of peer support services.

Evaluation

Evaluation Support Scotland works with voluntary organisations and funders to enable them to measure and report on their impact and improve their services. Their website has a wealth of helpful resources, guides and tools to help organisations plan, design and carry out evaluations.

The resources section on this website includes a helpful range of evaluation tools, toolkits, and support guides on all aspects of evaluation. For those new to evaluation that are unsure where to start, there is an Evaluation Pathway in the Evaluation section of the website.

The ESS support guides lead readers through each step of the evaluation process including clarifying aims, outcomes and activities, developing a logic model, developing and using indicators, different approaches and methods to collect relevant data including qualitative evidence, analysing data, and using what is learned from the evaluation.

The Evaluation Support Scotland website can be accessed at www.evaluationsupportscotland.org.uk

NHS Health Scotland provides a series of links and documents which give advice on how to monitor and evaluate interventions with a focus on public health. This provides a starting point for those planning to undertake an evaluation.

www.healthscotland.com/resources/researchinformationguidance/monitoringevaluatinginterventions.aspx

The National Institute of General Medical Sciences provides a useful how-to guide in planning and conducting an evaluation that sets out different approaches to data collection and the benefits and challenges of each. The page can be accessed at www.nigms.nih.gov/Research/Evaluation/evaluation_steps.htm

Economic evaluation

Economic evidence helps us to understand, measure and compare the benefit we get from the allocation of resources to specific interventions and services (NHS Health Scotland, 2011). For those considering economic evaluation of peer support programmes NHS Health Scotland has produced a resource that introduces use of economic evidence to support the health improvement contribution of the third sector.

Appendix 7: Health inequalities impact assessment of this guidance

Summary report

Background

The National Guidance to Support the Peer Support of Breastfeeding Mothers in Scotland has been developed in response to one of the activities included in Improving Maternal and Infant Nutrition, a Framework for Action (Scottish Government, 2011) available from: www.scotland.gov.uk/Publications/2011/01/13095228/0

The Framework was informed by the best available evidence at the time and the report that provided the rationale and evidence to inform the decision-making processes for activities included in the Framework is available from: www.healthscotland.com/documents/4687.aspx

This guidance aims to provide Health Boards and voluntary sector agencies with information about how to provide breastfeeding peer support to breastfeeding mothers in Scotland, to meet the identified action within the Framework. The guidance has been developed in partnership with The Scottish Government and Health Boards. Representatives from the voluntary sector, although invited, could not attend.

Scope

During the health inequalities impact assessment (HIIA) process we considered how breastfeeding peer support might differentially affect specific groups, including those protected by the Equality Act (2010). In doing so, we considered the following three areas:

1. The content of three sections of the guidance (listed below) that could be modified.
2. The delivery of the guidance.
3. The design and format of the guidance to ensure that it was fit for purpose.

The three areas of the guidance that were impact-assessed to provide the opportunity for modification and for making recommendations for both national and local action in response to the HIIA findings, were:

1. Definitions of peer support.
2. Application of ethical principles to inform action in the absence of evidence about effective interventions.
3. Application of evaluation principles.

Although not part of the original remit, where relevant to this paper, we have commented on the potential health inequalities impact of delivering breastfeeding peer support at a local level.
Method

On 11 January 2013, members of the breastfeeding peer support advisory group took part in a scoping workshop to identify the potential differential impacts that the drafted guidance could have on the different population groups among mothers of babies who might choose to breastfeed their infant or not. Health inequalities impact assessment templates were used to structure the discussion, which was facilitated by Debbie Sigerson (Equality team) and Nicola Thomson (People and Performance team) from NHS Health Scotland.

The HIIA participants acknowledged that the review-level evidence about the effectiveness of breastfeeding peer support interventions that had been summarised to inform the guidance would not identify the potential differential impacts on different population groups. Therefore, the judgements and assessments made during the HIIA were based on the tacit knowledge, expert opinion and experience of the participants in the scoping workshop. This included knowledge about the specific evidence related to the profiles of some distinct populations, (e.g. lower breastfeeding rates among young mothers and mothers from families in which formula feeding was the norm).

The detailed notes of this session are available upon request from nicola.thomson2@nhs.net

Findings and conclusions

The HIIA identified the potential differential impact of breastfeeding peer support in relation to a wide range of population groups, and in response to which the recommendations included in the following section have been made. The majority of recommendations require consideration by Health Boards and voluntary sector agencies when they are implementing the published guidance and providing breastfeeding peer support. Other ‘national’ recommendations that are largely related to the evidence will be acted upon by the project lead, Kate Woodman and colleagues (unless otherwise stated on the following pages) during the financial year 2014/15. These national recommendations are shown in purple text for ease of identification. While reading, please also note the following abbreviations:

BF = breastfeeding
BFPS = breastfeeding peer support
BFPSer(s) = breastfeeding peer supporter(s).
<table>
<thead>
<tr>
<th>Population group</th>
<th>Potential impact</th>
<th>Recommendations</th>
</tr>
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</table>
| Older people, people in the middle years, young people and children | As young mothers are less likely to BF, there is potential for a negative impact on them because they may not feel empowered to BF, especially if they are without BF support from their peers or family members. Alternatively, provision of appropriate BFPS may have a positive impact by empowering/ offering ongoing support to such young mothers. | 1. Engage with Family Nurse Partnership (FNP) leads to find out how they offer breastfeeding peer support (BFPS) to young mothers and integrate lessons learned into feedback to Health Boards/voluntary sector agencies.  
2. Health Boards and voluntary sector agencies may need to provide additional support to young mothers, peers and/or other family members to support the mother’s decision to breastfeed.  
3. Source evidence to check if the age-matching of young BF mothers and the breastfeeding peer supporter (BFPSers) helps them to better engage with BFPS or if this creates a barrier.  
4. Health Boards and voluntary sector agencies should recruit widely to attract a broad age range of BFPSers, (thereby reflecting Scotland’s diverse population), so they can better respond to the request for an age-matched BFPSer. |

| Women, men and transgender people (includes issues relating to pregnancy and maternity) | As BF mothers are the focus of peer support, there is the potential for a negative impact on partners who might feel excluded from the opportunity to provide early nurturing through infant feeding. | 5. Source evidence to establish if fathers feel excluded from breastfeeding and breastfeeding peer support and integrate findings into father-specific content of the forthcoming revision of Ready Steady Baby! and Off to a good start.  
6. Health Boards and voluntary sector agencies should ensure that BFPS training includes awareness-raising of the need to engage with partners/ fathers of the BF mother and their role in supporting mothers to continue breastfeeding. |

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<tr>
<td>Disabled people (includes physical disability, learning disability, sensory impairment, long-term medical conditions, mental health problems)</td>
<td>Potential negative impact on BF mothers with a range of disabilities, (e.g. sensory, learning or physical) as assumptions might be made about their attitudes and intentions about breastfeeding. Mothers with disabilities may require tailored BFPS, including targeted information about the service, to ensure that they can access BFPS as readily as other mothers. This potentially negative impact may also apply to mothers with mental health problems, particularly mothers with postnatal depression (PND). The same need to provide tailored BFPS and targeted information as outlined above may be required. Potential negative impact on mothers with postnatal depression because they may feel unable to BF, may be less active in seeking BFPS and may feel unable to disclose their PND. In relation to each impact noted above, the adoption of a tailored and targeted approach may have a positive impact as mothers may feel appropriately and sufficiently supported to initiate and continue breastfeeding.</td>
<td>7. <strong>Source evidence of breastfeeding rates and experiences among mothers with a range of disabilities and communicate findings to Health Boards/voluntary sector agencies.</strong> 8. Health Boards and voluntary sector agencies should build upon their existing network of local organisations that represent people with disabilities to ensure their specific needs are met and that they have access to information about BFPS. 9. <strong>Source evidence of breastfeeding rates and experiences among mothers with postnatal depression and communicate findings to Health Boards/voluntary sector agencies.</strong> 10. Health Boards and voluntary sector agencies should ensure that BFPS training includes awareness-raising about PND and its impact on BF that is based on the best available evidence.</td>
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### Peer support for breastfeeding in Scotland

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| **Minority ethnic people (includes Gypsy/Travellers, non-English speakers)** | Potential negative impact on Gypsy/Traveller mothers who may be unable to easily access information about the benefits of BF and local BFPS services. Crossing Health Board boundaries may impact on continuity of care. | 11. Although aware that national support and research is ongoing, source evidence of breastfeeding rates and experiences among Gypsy/Traveller mothers and mothers whose first language is not English and communicate findings to Health Boards/voluntary sector agencies.  
12. Health Boards and voluntary sector agencies should recognise the need for cross-boundary flexibility in delivery of BFPS to promote the continuity of breastfeeding peer support.  
13. While accepting that funding to enable access to interpretation and translation services is limited, Health Boards and voluntary sector agencies should be encouraged to build upon their existing networks to ensure that mothers from minority ethnic groups can reasonably access information, including that which is culturally sensitive, about the benefits of BF and local BFPS services.  
See National recommendation 11 above. |
| **Refugees and asylum seekers** | Potential negative impact on mothers from minority ethnic groups whose first language is not English. They may not have access to information about the benefits of BF and local BFPS services. For these mothers the issue is two-fold: they may require (1) access to information and (2) the provision of information that is culturally sensitive. As mothers from cultures, (e.g., Muslim, Filipino and Vietnamese), that are sensitive about colostrum may not be aware of the benefits of it for their infant there could be a negative impact because they may not be aware of the benefits of establishing BF. | 14. Health Boards and voluntary sector agencies should provide information that is culturally sensitive about the benefits of BF in alternative formats/languages, if there is a significant population of asylum seekers in their area.  
15. Health Boards should engage with voluntary organisations and other statutory services that represent individuals with specific cultural needs. |

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<td>People with different religions or beliefs (includes people with no religion or belief)</td>
<td>Potential negative impact on BF mothers with different religious beliefs, who attend group sessions of BFPS. Their involvement may be restricted because of needing to adhere to specific prayer times and/or religious festivals.</td>
<td>16. Health Boards and voluntary sector agencies should consider prayer days/times and religious festivals when arranging BFPS visits and sessions.</td>
</tr>
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</table>
| People in different socio-economic groups (includes those living in poverty/people of low income)/people in different social classes | Mothers from lower socio-economic groups are less likely to BF and are less likely to access the BFPS service. Failure to prioritise their access needs is likely to widen the health inequalities gap. The potential for a negative impact on the access of these mothers to services may arise because:  
  • They may be less likely to have BF support from peers/family members if they do not come from a family tradition of BF.  
  • They may not be able to access BFPS due to the cost of getting to the venue or because of the cost of childcare for their other children.  
  • BFPS services may not be targeted at mothers in this group (while higher socio-economic groups tend to engage more with the service).  
  • BFPS services may not be cognitively accessible.  
 | 17. As part of their own local impact assessments, Health Boards and voluntary sector agencies should ensure that local BFPS is both physically and cognitively accessible to mothers of lower socio-economic groups. The following should be considered when trying to widen access:  
  • The location of BFPS  
  • The proximity to public transport links  
  • The cost of getting to BFPS sessions  
  • The appropriate timing of BFPS groups  
  • The cost and availability of childcare provision  
  • The appropriate use of technology, e.g. the use of mobile phones as a means of maintaining contact  
  • Address issues of cognitive access  
  18. Ensure that the above points are raised with Volunteer Development Scotland. |
| Homeless people                                                                  | It may be difficult for mothers without a permanent address to establish and maintain contact with the BFPS.                                                                                                         | 19. Health Boards and voluntary sector agencies should ensure that mothers who are without a fixed address are sensitively encouraged to provide alternative contact details to enable maintained contact, thereby increasing the opportunity for BFPS. |

## Peer support for breastfeeding in Scotland

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| **People involved in the criminal justice system** | While mothers who are imprisoned may have their babies with them until the age of 2 (subject to a risk assessment) they may not necessarily receive support to establish/maintain BF through a BFPS service. | 20. Source evidence about breastfeeding rates and experiences among mothers who are involved in the criminal justice system and/or in prison during the perinatal and postnatal period, drawing on evidence from New Zealand.  
21. Health Boards and voluntary sector agencies should liaise with the prison health services to consider opportunities for providing BFPS. |
| **People who have low literacy**              | As mothers with low literacy may find it difficult to access written information about BF, this could be a barrier to establishing BF and engaging with BFPS. | 22. Health Boards and voluntary sector agencies should provide information about BFPS in alternative formats such as Easy Read.  
23. At each contact, NHS Board staff, (midwives, health visitors and early years workers) should verbally convey information about local BFPS that might involve an ‘opt out’ referral system.  
24. Health Boards and voluntary sector agencies should encourage BFPSers to raise identified issues of poor literacy with their BFPS coordinator. |
| **People in remote, rural and/or island locations** | As mothers from remote and rural communities may not have easy access to face-to-face BFPS because there are fewer BFPSers to cover a wider geographical area, there could be a negative impact as these BF mothers may not feel adequately supported. | 25. Health Boards and voluntary sector agencies should build upon well-established practices within rural communities for providing health-related support to inform delivery of BFPS so that the barriers to accessing it are minimised.  
26. Health Boards and voluntary sector agencies should seek to provide alternative methods of BFPS, such as telephone or Skype for BF mothers and teleconferencing or videoconferencing for group BFPS sessions.  
27. Engage professionals who currently provide BFPS in remote/rural communities, e.g. the Highlands, and share lessons from their experience about how to resolve the issues encountered and how they have managed expectations about the provision of BFPS. |
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<td>Staff (includes people with different work patterns, e.g. part-/full-time, short-term, job share, seasonal)</td>
<td>As BF mothers may need to access BFPS at a time/place that suits their life circumstances, (outside normal working hours because of other family commitments), the timing of BFPS may constitute a barrier to accessing it.</td>
<td>28. Health Boards and voluntary sector agencies should ensure that BFPS activities must be reasonably accessible to all BF mothers, taking account of their lifestyles issues and those of the BFPSer.</td>
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<td>Looked after children (LAC)</td>
<td>Mothers who are looked after within children and families services may require the involvement and support of enhanced services including LAC nurses, FNP nurses and other statutory support to encourage the establishing of BF and accessing BFPS.</td>
<td>29. Health Boards and voluntary sector agencies should engage with LAC nurses, FNP nurses and other statutory support to help them provide appropriate information and support about BF/BFPS.</td>
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<td><strong>Equality</strong></td>
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<tr>
<td>Promoting positive attitudes</td>
<td>A positive impact on BF mothers because the guidance promotes positive attitudes towards BF, thereby helping BF mothers feel more confident, especially in traditionally non-BF communities.</td>
<td>30. Include in the introduction that the guidance is specifically about peer support for BF and not peer support for broader parenting, as this will help to manage expectations. Emphasise that the purpose of the guidance is to encourage BF and BFPS.</td>
</tr>
<tr>
<td>Discrimination against groups of people</td>
<td>Potential negative impact on BF mothers who stop BF. They may feel that they are losing out on an opportunity for support that was available when they were breastfeeding.</td>
<td>31. Health Boards and voluntary sector agencies should offer sensitive support to all mothers who have stopped BF and should promote the benefits of skin-to-skin contact for attachment and bonding, irrespective of their method of feeding. 32. Health Boards should be mindful of mothers who stop BF before the first six weeks and that the BFPSer knows where to signpost them to local support beyond BFPS.</td>
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<td><strong>Lifestyles</strong></td>
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<td>Diet and nutrition</td>
<td>As the BFPSer could signpost BF mothers to information about diet, nutrition and sexual health, there is likely to be a positive impact upon the BF mother. However, this will have a negative impact if the BFPSer offers advice beyond their defined role or signposts inappropriately.</td>
<td>33. Health Boards and voluntary sector agencies must ensure that BFPSers are aware of the limitations to the information they should provide and that these are made explicit within their clearly defined role.</td>
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<td>Sexual health</td>
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<td>Learning and skills</td>
<td>As the role BFPSers might provide an opportunity to enhance their learning and skills there is a likely positive impact upon the BFPSer.</td>
<td>34. As BFPS is about building and maintaining supportive relationships, Health Boards and voluntary sector agencies must provide opportunities to discuss professional development with their BFPSers.</td>
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<td>Social environment</td>
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<tr>
<td>Employment (paid or unpaid) Income</td>
<td>The BFPSer role may provide avenues through which to enhance employment opportunities, which could result in a positive impact for the BFPSer. This could also have a negative impact if the enhanced opportunities of the BFPSer undermine continuity of care for the BF mother.</td>
<td>35. Health Boards and voluntary sector agencies should clearly communicate their expectations regarding the mutual commitment of the BFPSer and the BFPS service to service delivery and professional development. This should be explicitly set out in the definition of the BFPS role.</td>
</tr>
<tr>
<td>Crime and fear of crime</td>
<td>If a risk assessment is not carried out before the BFPSer engages with a BF mother there is a risk that they might be negatively affected by crime or fear of crime.</td>
<td>36. Health Boards should develop an exit strategy from BFPS for their BFPSers that is both sensitive to and supportive of them and the mothers they support.</td>
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<td>37. Health Boards and voluntary sector agencies must carry out an appropriate induction with the BFPSer to cover any organisational policies, which may affect them. A risk assessment of the BF mother’s home environment should be carried out prior to the first BFPS visit.</td>
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<tr>
<td>Physical environment</td>
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<tr>
<td>Living conditions</td>
<td>If BFPS groups are held in public places such as cafes/community centres, there is a potential negative impact on BF mothers if they are made to feel unwelcome. There may also be a negative impact if premises used for BFPS are inaccessible, unsafe and unattractive.</td>
<td>38. Health Boards and voluntary sector agencies should promote the benefits of using BF-friendly environments, ensuring that the premises are fit for purpose.</td>
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<td></td>
<td>There may be a negative impact on BF mothers if they feel uncomfortable about having a BFPSer in their home.</td>
<td>39. Health Boards and voluntary sector agencies should keep an up-to-date list of venues that have Breastfeeding Welcome Awards.</td>
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<td>There may be a negative impact on BFPSers if the home environment of a BF mother is unsafe. While making reference to BFPS in the home it should not be assumed that home-based BFPS is the only effective model of BFPS delivery.</td>
<td>40. Health Boards and voluntary sector agencies should ensure that BFPSers are sensitive to the range of family living conditions/situations.</td>
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<td>41. Health Boards and voluntary sector agencies should ensure that both face-to-face, group and 1:1 BFPS are available beyond the home environment.</td>
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<td><strong>Access to and quality of services</strong></td>
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<td>Transport</td>
<td>As mothers from low-income families may not have easy access to BFPS that is offered in group settings, this might pose a barrier to accessing BFPS.</td>
<td>42. Health Boards and voluntary sector agencies should ensure that group-based BFPS is easily accessed by public transport and that the timing of sessions takes account of local public transport services.</td>
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<tr>
<td>Housing services</td>
<td>The BFPS may be able to signpost a BF mother to appropriate services about issues relating to her housing and/or social circumstances, which could result in a positive impact on the BF mother. There may be a positive impact on the BFPSer as the role may provide them with opportunities to access further education.</td>
<td>43. Health Boards and voluntary sector agencies should offer telephone contact[^27] and home-based BFPS if mothers are unable to access community-based support.</td>
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<tr>
<td>Social services</td>
<td></td>
<td>44. Health Boards and voluntary sector agencies should ensure that BFPSers are aware of the limitations of their defined role, are confident in signposting appropriately and that they know how to feedback to the BFPS coordinator about issues beyond the scope of their defined role.</td>
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<tr>
<td>Education provision</td>
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[^27]: See: The FEeding Support Team (FEST) randomised, controlled feasibility trial of proactive and reactive telephone support for breastfeeding women living in disadvantaged areas. (Hoddinott, Craig and MacLennan et al., 2012). The abstract for this publication is available from: [http://bmjopen.bmj.com/content/2/2/e000652.abstract](http://bmjopen.bmj.com/content/2/2/e000652.abstract)
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<td>Life (Article 2, ECHR)</td>
<td>There is positive impact on BF mothers because the guidance supports BF, which provides the best, safest and most sustainable nutrition for their infant/baby. There is a positive impact on BF mothers and their families because of robust evidence that BF protects the infant from infection/specific illnesses in early life and safeguards against others, as well as protecting the mother from a range of serious, life threatening illnesses (e.g. breast and ovarian cancer). 28</td>
<td>45. Include reference in the guidance to the health benefits of BF to both the mother and infant.</td>
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<tr>
<td>Basic necessities such as adequate nutrition, clean and safe drinking water</td>
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<td>Risk to life of/from others</td>
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<td><strong>Freedom from ill treatment (Article 3, ECHR)</strong></td>
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| Prevention of ill treatment, protection and rehabilitation of survivors of ill treatment | As BF mothers who have experienced (sexual) abuse may feel empowered because they feel that BF allows them to protect their child from harm this would be a positive impact. Alternatively, as BF mothers who have been abused may feel highly anxious that they will be unable to adequately protect their child from harm, there may be a negative impact as BF may contribute to these mothers reliving the trauma of past abuse. | 46. Health Boards and voluntary sector agencies should include awareness about sensitive disclosures as part of BFPSer training.  
47. Health Boards and voluntary sector agency BFPS training should include sessions on child protection and protection of vulnerable adults. Guidelines and training on gender-based violence (GBV) and routine enquiry should also be provided. |
| Intense physical or mental suffering or anguish | Positive impact on BF mothers because the guidance supports BF, which has a positive impact on the mother’s mental wellbeing because of the release of oxytocin. As BF may increase the sense of isolation in a culture of non-BF or give rise to feelings of guilt if a mother stops BF or cannot begin BF because of medication, this might have a negative impact on her experience of BF and on her mental health. | 48. Include references in the guidance to the UNCRC (United Nations Convention on the Rights of the Child).  
49. Include references in the guidance that highlight the mental health benefits of breastfeeding for the mother because of the release of oxytocin. |

**Liberty (Article 5, ECHR)**  
Impact on those who are detained under Mental Health law  
Impact on those who are detained while BF.  
There may be a potentially negative impact on some mothers who may not be able to continue BF because of hospitalisation or because of medication for a (mental) health issue that might be a contraindication to BF.  
50. Health Boards should develop an exit strategy for their BFPSers that is both sensitive and supportive of both the BFPSer and the BF mother.  
51. Health Boards and voluntary sector agencies should ensure that the BFPSer responds within the limitations of their defined role, referring back to the BFPSer coordinator and following established pathways if they suspect that the mother is suffering from mental health issues or has experienced/is experiencing abuse.  
52. Health Boards and voluntary sector agencies should work with the appropriate mental health services and pharmacy services to maximise the opportunity for continued BF, (including support for expressing breast milk) and access to BFPS.
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| **Fair hearing (Article 6, ECHR)**                | Because of the stipulation that the BFPSer needs to have breastfed themselves, this may not give a fair hearing to those who have not breastfed, but who are keen nonetheless to offer support, e.g. women from strong BF traditions. Potential negative impact on the right of the BFPSer to a fair hearing if they are not protected by their employer’s policies because of working in a voluntary capacity. | 53. Ensure that this stipulation is included within the definition section of the guidance.  
54. Engage with the advisory group and wider consultation group to decide whether this stipulation is adequately justified.  
55. Health Boards and voluntary sector agencies should ensure that volunteer BFPSers are protected under the same workforce policies as paid Health Board/voluntary sector agency staff. |
| **Private and family life (Article 8, ECHR)**     | If a BF mother feels that her private/family life is compromised because of the provision of BFPS, this could have a negative impact on their BF and BFPS experience. There is a potential negative impact on the BFPSer if they are not provided with a safe environment (in the mother’s home) in which to offer BFPS. There is a likely negative impact on BF mothers if adherence to data protection, privacy and confidentiality protocols is not maintained by the individual BFPSer and the coordinating service. Potential negative impact on the BFPSer if they are not made aware of the boundaries of their role as this might impact upon their work/life balance. | 56. Health Boards and voluntary sector agencies should ensure that the BFPSer respects the private/family life and home of the BF mother they are supporting.  
57. Health Boards and voluntary sector agencies should ensure that the BFPSer should not be at risk in any way when carrying out home visits.  
58. Health Boards and voluntary sector agencies should ensure that the BFPSer is provided with training on data protection (collection, storage and confidentiality), ensuring they are only given information that is necessary to their role.  
59. Health Boards and voluntary sector agencies should clearly communicate their expectations about the commitment of the BFPSer to their role that is aligned with the agreed definition of their role. |

**Private life, family life and home**

- If a BF mother feels that her private/family life is compromised because of the provision of BFPS, this could have a negative impact on their BF and BFPS experience.
- There is a potential negative impact on the BFPSer if they are not provided with a safe environment (in the mother’s home) in which to offer BFPS.

**Personal data, privacy and confidentiality**

- There is a likely negative impact on BF mothers if adherence to data protection, privacy and confidentiality protocols is not maintained by the individual BFPSer and the coordinating service.

**Participation in leisure and cultural life.**

- Potential negative impact on the BFPSer if they are not made aware of the boundaries of their role as this might impact upon their work/life balance.
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<td><strong>Freedom of expression (Article 10, ECHR)</strong></td>
<td>Positive impact on the BF mother as she has the right to express her opinions and to choose whether or not to BF. However, in some instances mothers may feel under pressure from others about their choice.</td>
<td>60. Health Boards and voluntary sector agencies should ensure that the BFPSer should be trained to be mindful of such situations and that they do not force their own opinions on the BF mother, but instead remain supportive of them.</td>
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<tr>
<td><strong>Marriage and founding a family (Article 12, ECHR)</strong></td>
<td>Potential negative impact on BF mothers if assumptions are made that an older BF mother is less in need of BFPS or if assumptions are made that a younger mother won’t want to (continue) BF for long or at all.</td>
<td>61. Health Boards and voluntary sector agencies should ensure that the BFPSer does not make assumptions about a mother’s commitment/desire to BF based on her age.</td>
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Next steps

The advisory group members involved in the workshop agreed that they would continue to review the evidence about the different population groups (outlined in the national recommendation grid below) throughout 2014/15. A report of this evidence update will be prepared for publication on www.healthscotland.com once available.

National recommendations

National bodies, including NHS Health Scotland and the Scottish Government, will take responsibility for the following recommendations that require action:

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<td><strong>Older people, people in the middle years, young people and children</strong></td>
<td><strong>Recommendation 1</strong>: Engage with Family Nurse Partnership (FNP) leads to find out how they offer breastfeeding peer support (BFPS) to young mothers and integrate lessons learned into feedback to Health Boards/voluntary sector agencies.</td>
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<td><strong>Recommendation 3</strong>: Source evidence to check if the age-matching of young BF mothers and the breastfeeding peer supporter (BFPSers) helps them to better engage with BFPS or if this creates a barrier.</td>
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<td><strong>Recommendation 5</strong>: Source evidence to establish if fathers feel excluded from breastfeeding and breastfeeding peer support and integrate findings into father-specific content of the forthcoming revision of <em>Ready Steady Baby! and Off to a good start</em>.</td>
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<td><strong>Disabled people (includes physical disability, learning disability, sensory impairment, long-term medical conditions, mental health problems)</strong></td>
<td><strong>Recommendation 7</strong>: Source evidence of breastfeeding rates and experiences among mothers with a range of disabilities and communicate findings to Health Boards/voluntary sector agencies.</td>
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<td><strong>Recommendation 9</strong>: Source evidence of breastfeeding rates and experiences among mothers with postnatal depression and communicate findings to Health Boards/voluntary sector agencies.</td>
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<td><strong>Minority ethnic people (includes gypsy/travellers, non-English speakers)</strong></td>
<td><strong>Recommendation 11</strong>: Although aware that national support and research is ongoing, source evidence of breastfeeding rates and experiences among Gypsy/Traveller mothers and mothers whose first language is not English and communicate findings to Health Boards/voluntary sector agencies.</td>
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<td><strong>People in different socio-economic groups (includes those living in poverty/people of low income)/people in different social classes</strong></td>
<td><strong>Recommendation 18</strong>: Ensure that the above points are raised with Volunteer Development Scotland, (related to recommendation 17).</td>
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<td><strong>People involved in the criminal justice system</strong></td>
<td><strong>Recommendation 20</strong>: Source evidence about breastfeeding rates and experiences among mothers who are involved in the criminal justice system and/or in prison during the perinatal and postnatal period, drawing on evidence from New Zealand.</td>
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<td><strong>Recommendation 30:</strong> Include in the introduction that the guidance is specifically about peer support for BF and not peer support for broader parenting, as this will help to manage expectations. Emphasise that the purpose of the guidance is to encourage BF and BFPS.</td>
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</tr>
<tr>
<td>Basic necessities such as adequate nutrition, clean and safe drinking water</td>
</tr>
<tr>
<td><strong>Recommendation 45:</strong> Include reference in the guidance to the benefits of BF to both the mother and infant.</td>
</tr>
<tr>
<td><strong>Freedom from ill treatment (Article 3, ECHR)</strong></td>
</tr>
<tr>
<td>Prevention of ill treatment, protection and rehabilitation of survivors of ill treatment</td>
</tr>
<tr>
<td>Intense physical or mental suffering or anguish</td>
</tr>
<tr>
<td><strong>Recommendation 48:</strong> Include references in the guidance to the UNCRC (United Nations Convention on the Rights of the Child).</td>
</tr>
<tr>
<td><strong>Recommendation 49:</strong> Include references in the guidance that highlight the mental health benefits of breastfeeding for the mother because of the release of oxytocin.</td>
</tr>
<tr>
<td><strong>Fair hearing (Article 6, ECHR)</strong></td>
</tr>
<tr>
<td><strong>Recommendation 53:</strong> Ensure that this stipulation is included within the definition section of the guidance.</td>
</tr>
<tr>
<td><strong>Recommendation 54:</strong> Engage with the advisory group and wider consultation group to decide whether this stipulation is adequately justified.</td>
</tr>
</tbody>
</table>

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29 This refers to the stipulation that the BFPSer needs to have BF themselves.
Local recommendations

Local impact assessments
The nature of the action taken by Health Boards should be determined by conducting their own local impact assessments, which should be based on their assessment of local data profiles, (e.g. number of socially disadvantaged mothers, number of teenage mothers, etc.).

Local impact assessments, conducted by Health Boards and/or voluntary sector agencies, should specifically consider each of the ‘local’ recommendations presented in this section when delivering their BFPS service to make sure that it meets the needs of the different population groups within their Health Board area.
Appendix 8: Details of the Breastfeeding Peer Support Guidance HIIA attendees

<table>
<thead>
<tr>
<th>Name</th>
<th>Position</th>
<th>Organisation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kate Woodman</td>
<td>Public Health Adviser (Early Years)</td>
<td>NHS Health Scotland</td>
</tr>
<tr>
<td>Debbie Sigerson</td>
<td>Project Manager (Equality Resources)</td>
<td>NHS Health Scotland</td>
</tr>
<tr>
<td>Nicola Thomson</td>
<td>Policy Officer (People and Performance)</td>
<td>NHS Health Scotland</td>
</tr>
<tr>
<td>Helena Barrett</td>
<td>Project Administrator, Public Health Science Directorate</td>
<td>NHS Health Scotland</td>
</tr>
<tr>
<td>Barbara Jessop</td>
<td>Health Improvement Specialist – Maternal and Infant Nutrition</td>
<td>NHS Borders</td>
</tr>
<tr>
<td>Elaine Ronald</td>
<td>Infant Feeding Advisor/Nutrition Coordinator</td>
<td>NHS Forth Valley</td>
</tr>
<tr>
<td>Shona Brownlie</td>
<td>Programme Manager, Community Mothers and Unicef BFI</td>
<td>NHS Lanarkshire</td>
</tr>
<tr>
<td>Gina Graham</td>
<td>Breastfeeding Support Co-ordinator</td>
<td>NHS Fife</td>
</tr>
<tr>
<td>Helen Yewdall</td>
<td>Maternal and Infant Nutrition Coordinator</td>
<td>Scottish Government</td>
</tr>
<tr>
<td>Dorothy Bradley</td>
<td>Infant Feeding Strategist</td>
<td>NHS Lothian</td>
</tr>
<tr>
<td>Emma Currer</td>
<td>National Officer for Scotland</td>
<td>Royal College of Midwives</td>
</tr>
<tr>
<td>Kat Hasler</td>
<td>Senior Health Improvement Programme Officer (Maternal and Child Health)</td>
<td>NHS Health Scotland</td>
</tr>
<tr>
<td>Fiona Bayne</td>
<td>Senior Health Improvement Programme Officer (Maternal and Infant Nutrition)</td>
<td>NHS Health Scotland</td>
</tr>
</tbody>
</table>