



The Breastfeeding Network and Cardiff
University

An exploration of trends and experiences of
delivery of breastfeeding peer support in
England and Wales, since 2015

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Views expressed in this report are those of the researcher and not necessarily those of the Breastfeeding Network.

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The Breastfeeding Network provides independent, evidence-based information and support on infant feeding to women, parents and families. We offer support through a peer model and have over 600 trained peers across England, Scotland and Wales. A key aim is to share the evidence in infant feeding with the families we support. Our support services reach women both antenatally and after birth and many of the women we support go on and train with the charity to support others in their community. We provide the National Breastfeeding Helpline in partnership with the Association of Breastfeeding Mothers, which is funded by Public Health England and Scottish Government. Since 2008 the charity has also provided a Drugs in Breastmilk information service which provides online support and factsheet information to thousands of families and health professionals every year on the effects of medications or treatments on breastmilk and breastfeeding. The service was founded by Dr Wendy Jones MBE and is now run by trained volunteer pharmacists who are supported by BfN and clinical supervision. Together they offer breastfeeding support alongside evidence based information to anyone who is concerned about the effects of medication or treatments while breastfeeding. We also work very closely with national partners including UNICEF, Baby Friendly and other charitable organisations and universities. The Breastfeeding Network is a Registered Charity No SC027007. For more details visit www.breastfeedingnetwork.org.uk

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Introduction

Background

Breastfeeding rates in the UK have historically been measured through the NHS Infant Feeding Survey, which ran every five years from 1975 to 2010. This survey was discontinued in England and Wales in 2015 and reinstated in 2020, meaning a significant gap in available data on long-term trends in breastfeeding during this period. Available data suggests that there was a slight increase in initiation of breastfeeding in England and Wales between 1990 and 2010 (McAndrew et al. 2010).

However, maintenance of breastfeeding beyond the first few weeks in the UK remains a challenge. By international standards, breastfeeding rates in the UK are low (Victora et al. 2016), with average rates of around 48% at 6-8 weeks post-birth reported in England in 2019/20 (Public Health England, 2020). This contrasts with rates of 74% in Switzerland, 68% in Denmark and 73% in Norway at age 2 months (Theurich et al., 2019).

Evidence suggests substantial variation between parts of England, with data showing rates of over 80% breastfeeding at 6-8 weeks of age in some regions in the South East, contrasting with 32% in some North Eastern areas (Office for Health Improvement and Disparities, 2021). There is observable social and geographical polarisation in feeding decisions, with highest breastfeeding rates observed in older, more affluent women with higher levels of educational qualifications (McAndrew et al., 2012). Evidence suggests that breastfeeding has multiple health benefits for children and mothers, including lower rates of infections in babies, as well as being protective of breast cancer in new mothers (Victora et al., 2016), with estimates that increasing breastfeeding rates could save the lives of over 800,000 infants per year globally (WHO, 2018). Economically, analysis suggests that absence of breastfeeding is associated with economic losses of about \$302 billion annually or 0.49% of world gross national income (Rollins et al., 2016). The polarisation of breastfeeding in relation to socio-economic status therefore has – not only direct health impacts – but also the potential to increase health inequalities for already disadvantaged populations.

Barriers to breastfeeding

While acknowledging the challenges in the data available, it is still notable that successive infant feeding surveys did indicate that overwhelmingly UK mothers stop breastfeeding before they planned to (McAndrew et al., 2012). Stopping breastfeeding in the early weeks is strongly associated with breastfeeding problems, with around a third of mothers reporting having experienced feeding problems leading them to cease breastfeeding earlier than they had intended (Trickey & Newburn, 2014). The most common reasons given by mothers in the first week were problems with the baby rejecting the breast or not latching on properly (27%), having painful breasts or nipples (22%) and

insufficient milk (22%) (McAndrew et al., 2012). These reasons are particularly pertinent in the early period during which breastfeeding is established.

Evidence suggests that, when extra organised breastfeeding support is offered to women, the duration and exclusivity of breastfeeding is increased (McFadden et al., 2017). However, repeated surveys have indicated that many UK mothers do not experience a supportive postnatal care context for help with infant feeding, particularly breastfeeding (Bhavnani & Newburn, 2010; Plotkin, 2017). In 2019, the First 1000 days inquiry incorporated evidence from an online forum hosted by Mumsnet (Health and Social Care Committee, 2019). Here, breastfeeding, including breastfeeding support, was an issue raised by many mothers, who spoke about a lack of consistent advice and often end up believing breastfeeding myths as a result. Around half of mothers who responded to a recent BBC Survey on experiences of infant feeding reported feelings of guilt about how they fed their babies, with many saying that they felt let down by statutory services (BBC News, 2019).

Existing support has been shown to be interrupted during Covid-19 pandemic, particularly face to face provision. Women with lower educational attainment, women from Black and minority ethnic backgrounds and those reporting more challenging living arrangements were more likely to report that challenges associated with lockdown had impacted their capacity to breastfeed (Brown & Shenker, 2020), suggesting potential widening of existing health inequalities.

Breastfeeding peer support

The World Health Organisation's (WHO)/UNICEF Global Strategy for Infant and Young Child Feeding aims to increase breastfeeding rates through pursuing the following objectives:

- to raise awareness of the main problems affecting infant and young child feeding, identify approaches to their solution, and provide a framework of essential interventions;
- to increase the commitment of governments, international organizations and other concerned parties for optimal feeding practices for infants and young children;
- to create an environment that will enable mothers, families and other caregivers in all circumstances to make - and implement - informed choices about optimal feeding practices for infants and young children.

(WHO, 2003, pp.6-7)

The Strategy recommends national governments take forward breastfeeding peer support (BFPS) interventions as part of a package of measures aimed to improve breastfeeding outcomes (WHO, 2003). This includes recommendations that national governments develop 'community-based

mother-to-mother breastfeeding support groups' and support 'lay and peer counsellors' to enhance existing services.

In the UK, this recommendation is reflected in guidance from the National Institute of Health and Clinical Excellence (NICE) on maternal and child nutrition, which recommends a suite of measures including breastfeeding peer support as part of a multi-disciplinary team (NICE, 2008). It is stated that peer supporters should have attended accredited training, be in contact with new mothers within 48 hours of giving birth and be able to offer flexible services at times and locations to suit the community.

The UNICEF UK Baby Friendly Initiative (BFI) standards enables public services to better support families with feeding and developing close and loving relationships so that all babies get the best possible start in life. Accreditation from BFI relies on services working together, providing evidence-led, joined up support for mothers when needed, including peer support (Trickey et al., 2017). Currently, 57% of babies in England are born in an accredited 'baby friendly' environment, however the NHS Long Term Plan for England 2019/2020 proposes that all maternity services begin the accreditation process of an evidenced based infant feeding programme such as the UNICEF UK Baby Friendly Initiative. To this end, a joint support offer has been agreed between NHS England, NHS Improvement and UNICEF UK BFI to support all maternity services in England to become BFI accredited by the end of 2024 (<https://www.unicef.org.uk/babyfriendly/nhs-long-term-plan/>). Recent guidance for local authorities from Public Health England on commissioning infant feeding services also cites peer support as an important aspect of evidence-led provision and also recommends embedding BFPS services within a multi-disciplinary, multi-faceted model of service delivery (PHE, 2016).

The All-Wales Breastfeeding Plan 2019-2024 also includes recommendations for a quality assurance model to set and monitor standards, stating that each Health Board in Wales should include BFPS in its co-ordinated support model and recommending production of local guidance on inclusion of peer support in NHS provision (Welsh Gov. 2019). Implicit in this recommendation is an understanding that breastfeeding is a complex biopsychosocial process and that informal networks are helpful to mothers in enabling skill-learning, problem solving and psychological adjustment, and in supporting mothers' decisions to breastfeed practically and socially over time (Trickey, 2018).

Although there are randomised controlled trials assessing the effectiveness of BFPS, conclusions from available evidence are limited by absence of consistent definitions of BFPS within studies, as well as methodological variations making data synthesis challenging (Trickey, 2013). However, other evidence is supportive of impact on those engaging with services. Qualitative studies indicate that

BFPS is highly valued by UK women, and that women often credit BFPS with saving their breastfeeding relationships (Thomson et al., 2012; Trickey, 2018). Experimental evidence (Ingram et al. 2010; Jolly et al. 2012) and evidence from realist review (Trickey et al. 2018) suggests certain features of BFPS interventions that make them more likely to be effectively implemented and taken-up by intended users. These features include achieving alignment with target population goals, ensuring good integration with existing health service provision, ensuring early proactive contact from the peer supporter to the mother, the opportunity to develop warm relationships between peer supporters and women supported, and attention to ongoing training and support for peer supporters.

Despite policy and service user support for BFPS, evidence indicates that provision is highly variable across England and Wales and may be decreasing over time. In 2014 a survey of provision of BFPS in the UK found that it was available in only 56% of NHS trust areas, and that coverage within areas was variable (Grant et al. 2018). The same research highlighted that provision of training, access to supervision and peer supporter roles varied also considerably between areas, with Infant Feeding leads suggesting poor levels of integration with other health services in around a third of areas. Grant et al. also highlighted financial constraints, which were perceived to be having a negative impact on provision in many areas. This is supported by other research suggesting that, since 2014, the experience of infant feeding leads and provider organisations is that funding for community-led breastfeeding peer support has been reduced (World Breastfeeding Trends Initiative, 2016; All-Party Parliamentary Group on Infant Feeding, 2017). In England, this is occurring within a context of shrinking spending on public health, with estimated reductions in the overall public health budget of 25% since 2016 (Health Foundation, 2016). Within this timeframe, the delivery of public health services in England has also been decentralised, with responsibility for infant feeding devolved to local authorities. Within this structure, provision of BFPS in communities remains an optional element of overall infant feeding services.

Aims of the research

This study was commissioned by the Breastfeeding Network to build on previous published research (Grant et al., 2018), with the aim of updating understanding about provision of breastfeeding peer support in England and Wales. This includes any changes to funding and service provision since 2015 and the perceived impacts of those changes on service providers and service users. It also aimed to capture the wider perceptions of service users on accessing peer support services, including experiences and benefits. The research aimed to:

1. Describe trends and patterns in commissioned BFPS provision in England and Wales since 2015.
2. Explore the current priorities for provision (mode, timing, training, target population etc.)
3. Explore experiences of provision in three case study areas from the perspective of peer supporters and supported women.

Methods

Research Design

This study utilised a mixed methods design, incorporating analysis of data obtained through Freedom of Information requests, survey data collection and analysis, and semi-structured qualitative interviews. Mixed methods research designs can obtain greater depth of information than when using qualitative or quantitative designs alone (Caruth, 2013) and is beneficial for both completeness of understanding and diversity of viewpoints on a research problem (Venkatesh et al., 2013). This approach was selected here to provide a more complete understanding of both the context of breastfeeding peer support in England and Wales and the experiences and perceptions of those within the system.

Ethics and consent

Ethical approval for the research was obtained from Cardiff University School of Social Sciences Research Ethics Board. No ethical approval was required for the Freedom of Information request process, meaning the ethical considerations focussed on survey and interview methods. All those invited to participate were adults aged over 18 and were able to provide informed consent in accordance with Social Research Association guidance (2021). This meant that all those who participated in interviews and surveys were informed that:

- Participation was voluntary
- That they were able to withdraw from participation at any point prior to report publication
- That they would be guaranteed anonymity in use and reporting of data they provided

All data was collected between February 2020 and April 2021. The intended data collection period was from February – April 2020 however, due to Covid-19 impacts, the study was suspended from March 2020 until later that year, meaning the original schedule could not be adhered to. Further details for sampling and recruitment and design of data collection tools are outlined below for each method of data collection.

Freedom of Information requests

A total of 484 Freedom of Information (FOI) requests were submitted in England and Wales, to include: Local Health Boards (Wales); Clinical Commissioning Groups, Unitary Authorities, Borough Councils, County Councils, Metropolitan Districts, Unitary Authorities and London Boroughs (England). Response rates by type of authority are outlined in the next chapter. The content of the submission was developed in consultation with Ayala Ochert of <https://betterbreastfeeding.uk/>,

who advised on the FOI study methodology. The submission included reference to the supporting legislation under which the information was being sought and requested the following information:

- Q1) Whether the receiving authority commissioned a breastfeeding peer support service between the years 2014-2019, with details of budgets per year and numbers of service users accessing per year
- Q2) Where no commissioned service existed, did the receiving authority provide funding for any other provision of breastfeeding peer support from 2014-2019 by any other health professionals, including who provided the service, budget per year and numbers of service users accessing per year
- Q3) Where no commissioned service existed, did the receiving authority provide funding for any other provision of breastfeeding peer support from 2014-2019 by any non-health professionals, including who provided the service, budget per year and numbers of service users accessing per year

Where available, a copy of the most recent service specification was also requested. Full details of responses received are presented in the next chapter, with breakdown by type of authority.

Survey design and recruitment

A survey was developed, which replicated and updated questions from a 2014 survey (Grant et al. 2018) of Infant Feeding Coordinators (IFCs) and also drew on work by Better Breastfeeding UK (see <https://betterbreastfeeding.uk/englandcuts/>). This was hosted on SurveyMonkey for online completion. The link to this survey was sent by email to all Infant Feeding Coordinators in Local Authorities in England (N=151) and Local Health Boards in Wales (N=7), with a description of study details, including information outlining data use, right of withdrawal and anonymity of responses. The survey was promoted by gatekeepers, specifically via the Baby Friendly Initiative (BFI) distribution list and the National Infant Feeding Network (NIFN) co-ordinator in England and via the Welsh Infant Feeding Network (WIFN) co-ordinator in Wales, who were asked to distribute the survey through their networks. The National Infant Feeding Network (NIFN) was established by UNICEF and the UK Government Department of Health and includes professionals with responsibility for infant feeding and parent/child relationships, as well as other public health specialists and academics. The Wales Infant Feeding Network (WIFN) is the professional forum representing health service infant feeding leads in Welsh Health Boards and includes Welsh Universities, Public Health Wales, lactation specialists and clinical representatives from maternity, health visiting, neonatal

services across Wales (see <https://www.unicef.org.uk/babyfriendly/about/infant-feeding-networks/> for details of both bodies).

This contact was then followed by a reminder, through re-sending the survey to all contacts on the BFI distribution list, followed by a further completion reminder sent by the research team to the national infant feeding networks. Consent to participate was included within the body of the survey and returned with responses. The total number of responses that completed the privacy questions received was 92 (82 for England and 10 Wales). Of these, 3 (2 England, 1 Wales) were excluded as 'no' response in not being the main person that supports/coordinates Infant Feeding and additional 18 (16 England, 3 Wales) excluded as duplicates and not completing past qualifying questions for privacy and which LA/NHS/Health Board area they represented, leaving 70 completed surveys for analysis (64 in England and 6 in Wales). Participants included representation from both hospital and community-based IFCs, including NICU (neonatal intensive care units). The survey (see Appendix 2) consisted of the following sections:

1. Personal information and background, including length of time in the IFC role, proportion of job role dedicated to the IFC role, other duties
2. History of the IFC role in that region, including any changes to funding, service delivery model
3. Awareness of national and international guidance and use of this in the role
4. Provision of breastfeeding peer support in the area since 2014, including any changes to funding, service provider, oversight
5. Perceived function of the breastfeeding peer support service in the area and integration into other health care delivery
6. Perceived reach of the breastfeeding peer support service, including any demographic groups less likely/able to access support and the impact of socioeconomic factors
7. Training provisions and skill set of the local breastfeeding peer supporters

Closed questions were a mixture of true/false response options, yes/no responses and agree/disagree statements, with open text options available for some questions.

Qualitative interviews

Semi-structured interviews were conducted with breast feeding peer supporters and peer support service users from 3 case study regions, 2 in England and 1 in Wales. These regions were selected to

represent different contexts of peer support provision, selected to represent areas with varied breastfeeding rates and where services (i) have been cut, (ii) have non-commissioned service provision is in operation, and (iii) where provision has been commissioned and remained constant since 2014. These were identified by the BfN Research Lead through extensive experience of the sector.

Information sheets and consent forms were designed by the Academic Support for the study, with information sheets attached to initial recruitment emails sent out to peer support services. Those approached were invited to reply with expressions of interest and were given an opportunity to ask any further questions about the research. They were then invited to take part in an interview, with the option of online or telephone due to Covid-19 restrictions in place at the time. This method was effective for the recruitment of peer supporters but was unsuitable for service users, who cannot be contacted directly through services due to GDPR. This meant that additional recruitment through targeted social media was carried out. Those who chose to take part were sent a consent form by email for completion and return prior to interviews taking place.

A semi-structured interview guide was developed, which included discussion of:

- Perceptions of peer support, including: perceptions of what peer support is; hopes and expectations from involvement; perceived target audiences; perceived barriers to access both for themselves and any other demographic groups
- Experience of local provision, including: routes to involvement and any barriers to access; any observed changes to services over time; the impact of any changes; positives and negatives of involvement

This content was initially developed before the pandemic, however the change in circumstances made it necessary to consider the impacts of this, therefore participants were also encouraged to consider their experiences of service provision before Covid-19 and observed changes since. In total, 12 interviews were completed with peer supporters and 14 with service users. Interviews lasted between 45-70 minutes and were audio recorded for later transcription and analysis.

Data analysis and integration

Qualitative interview recordings were transcribed for thematic analysis (Braun and Clarke, 2006). A coding frame was developed by the Academic Support, incorporating themes included in the interview topic guide and including emerging themes from open reading of the data. Transcription and analysis was then completed by the Research Lead, with ongoing discussion between the team to finalise thematic reporting. FOI request data was tabulated in Microsoft Excel and descriptive

statistics were generated using Excel. Survey data included a mix of closed and open ended questions. Descriptive statistics were generated for closed questions and themes were summarised for open ended data, drawing on the themes identified during interview analysis.

Each dataset was analysed separately but with consideration throughout of integration, defined as 'the interaction or conversation between the qualitative and quantitative components of a study' (O'Cathain et al., 2010 p.1147). Analysis aimed to synthesise findings drawn from each dataset in order to build depth of understanding.

Findings 1) Freedom of information request data

This section will present responses to, and analysis of, the submitted Freedom of Information requests (FOIs). FOI requests were sent to all London Boroughs, Unitary authorities, Metropolitan districts, County Councils, Borough Councils, CCGs and Welsh Health Boards with responses outlined in Table 1 below. A full description of the different roles and responsibilities of each of these public bodies can be found at <https://www.gov.uk/understand-how-your-council-works> . The same three questions were addressed to each authority, as outlined above.

Within tables and throughout this chapter 'bf' is used throughout as an abbreviation of 'breast feeding'.

Table 1 - Freedom of Information requests data

Relevant authority	Total number FOIs requested	Total responses	Number who responded 'No' to all 3 Qs or that referred to other contracts without any detail	Total who provided ANY data on breastfeeding support	Total commissioned breastfeeding support service (how many mentioned peer / voluntary support within)	Total that had commissioned stand-alone peer support service
London Boroughs	33	33	6	27	13 (11)	5
Unitary authorities	55	51	15	36	23 (20)	10
Metropolitan districts	36	35	2	33	24 (19)	14
County Council	26	25	4	21	11 (8)	7
Borough Council	192	184	180	4	1	1
CCG	135	128	104	24	9 (7)	7 contributed funding / commissioned a service

Wales Health boards	7	7	0	7	7 provided a support service as opposed to commissioned (5 mentioned peers)	1 offers annual grant funding to peer groups
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Table 1 illustrates that there was a good response rate from all those where the FOI request was acknowledged. Of 484 FOI requests, 463 responses were received (96%).

Responses have been recorded (column 4) where there was a 'no' response to all three questions or where the response made a direct referral to other services/authorities that are responsible for provision of breastfeeding support.

All London boroughs referred directly to their health visiting contract, with an example of a typical answer being: 'Although provided by Health Visiting, no funding over and above that provided for the core Health Visiting services was provided'. Across the UK, health visiting services are provided by specialist community public health nurses who offer advice, support and intervention for families with children up to age 5. In England, the services they provide are under the umbrella of the wider 'Healthy Child Programme', which provides recommendations for universal health care for those aged 0-19. Within this programme the 0-5 provision is led by Health Visitors. Delivery of 0-19 services is devolved to Local Authorities, who receive block funding for delivery of the HCP but have flexibility to prioritise according to local need and commission services to deliver on priority areas. This means that, while breastfeeding support services are acknowledged in the HCP as a high-impact intervention, Local Authorities are not actually required to provide standard services. However, they can commission specific breastfeeding support services if they choose to do so. This differs in Wales, where the 'Healthy Child Wales Programme' outlines universal provision – including health visitor services – from 0-7 years. This programme is funded by Welsh Government and responsibility for delivery is with Local Health Boards, with nationally aligned targets – including a recommended schedule of HV contacts with families - and quality assurance. Guidance for Wales includes breastfeeding and weaning advice as a statutory duty with delivery directly provided by Health Boards. Provision of breastfeeding peer support is not currently mandated in either England or Wales.

Full details of each programme can be found at:

[Healthy Child Wales Programme | GOV.WALES](#)

[Healthy child programme 0 to 19: health visitor and school nurse commissioning - GOV.UK](https://www.gov.uk/government/news/healthy-child-programme-0-to-19-health-visitor-and-school-nurse-commissioning)
(www.gov.uk)

Unitary authorities referred to a mix of services, over half referring to 0-19/Healthy Child Programme/health visiting (HCP/HV), with a couple referring to Children Centre services. 2 referred to the County Council and 1 to the NHS Trust. A typical answer was 'Breastfeeding support budgets were included within our block budget for 0-19 services since the local authority took over commissioning responsibility for this'. This illustrates the delivery model in operation in England, where service provision is designed at the local authority level and may not include ring-fenced funding for specific breastfeeding support.

There was a good response from Metropolitan districts and County Councils. Metropolitan districts only provided 2 responses that referred directly on to health visiting contract, with the remainder providing at least some additional data. Likewise, only 4 county councils referred directly on to other services, 3 to HCP/HV and 1 a mix of HV and Family Centres contracts. Family Centres are community-based hubs which bring together key agencies involved in supporting parents and children, providing a centralised resource for support. They can act as the base for delivery of breastfeeding support services, either through access to specialist health support and/or through hosting support groups for new mothers.

Of those Borough councils responding with no data, the vast majority referred the request directly to their County Council who hold the responsibility for delivery of public health services, again reflecting the delivery structure across England where services are commissioned at local level. A typical answer received from borough councils stated that they were within 'a two tier area and this service is not provided at a district level but by the County Council. Public health is usually dealt with by the county council'. A few did not refer to the County but to other statutory bodies including Clinical Commissioning Groups, NHS and, in one case, to the police, despite the police having no role in provision of such services.

For Clinical Commissioning Groups 104 of 128 responses referred to other services and almost all of these referred to maternity services contract and/or Councils Public Health. 1 CCG referred to their borough council (not the one that reported a scheme) and 1 to NHS England. Health Boards in Wales all provided data about how breastfeeding support was directly provided (as opposed to commissioned as in England) through the health boards.

Next, the remaining responses were counted as providing data if they gave any breastfeeding-specific reference or information in their response that was outside of those described above as a nil

response or referring to other services. These included information both for commissioning of breastfeeding but also other breastfeeding related information and/or other funding, which will be described later.

Breastfeeding support services were commissioned across all categories. Of the total responses received, 39% London boroughs, 45% Unitary authorities, 69% of metropolitan districts, 48% County Councils, 0.5% Borough Councils, 7% of CCGs, and 14% of health boards in Wales commissioned a breastfeeding support service at any point between 2014 and 2019. A high number of them included voluntary or peer support within their service, even when a stand-alone peer support provision was not commissioned.

Only 1 Borough Council reported a pilot breastfeeding service funded through a grant application from the County Council Public Health Team. This was to serve the most deprived areas in the Borough. This borough response was not included in the 44 borough councils that were covered by a total of 7 stand-alone county-level commissioned services.

Responses indicated a wide variety of services among those who provided a breastfeeding support service, including providers of health teams (midwifery, healthy child programme/health visiting) and early years services (children's and family centres), third sector providers (infant feeding specialists and others), as well as services reliant on staff roles. 6/7 Wales Health boards provided a breastfeeding support service led by Infant Feeding Coordinators/Leads across the health teams and other dedicated breastfeeding roles, 1 including a lactation consultant. 5/7 included peer or voluntary support as part of this service with only 1 outlining dedicated funding for peer support.

We asked those that commissioned a service to supply details, including budget (per year) and number of service users accessing the service for each of the years 2014-2019. This data is reported in full in Appendix 1.

Of the total number that commissioned a breastfeeding support service, we report on those that were able to provide budgets for each year of the contract/service covering the full requested period 2014-2019 as well as services/contracts that reported budgets for each but that were delivered between these dates, whether they ended before 2019 or started after 2014.

A high proportion of total services, around 50% of London borough, unitary authorities and metropolitan boroughs that commissioned a service did provide figures broken down for each year. 6/7 London boroughs provided a budget for each year even when provision/provider changed with one providing an annual figure. In some cases, an average annual figure was provided and this was taken as covering the requested period where dates were not specifically stated but they did answer

yes to commissioning a bf support service. A number of responses, noted for unitary authorities, evidenced that contracts were ongoing into 2019/2020 and commissioned beyond. A lower proportion of budgets were provided for County Councils and CCGs.

The most common reason for budgets only partially reported was where figures were provided for the years where stand-alone support services were in place initially but then not available when the service had moved to health visiting, citing 'no separate budget was identified'. Metropolitan and County Council responses reported for all 12 partial budgets between them as being unavailable when moved to health visiting, often explicitly mentioning this, with one stating 'Public Health team commissioned a breastfeeding support service 2014-2016 – it was decommissioned when the new Health Visiting contract started'.

Full budgets across the years 2014-2019 were provided for some areas where the service had moved to Health Visiting and the budget for breastfeeding was maintained within the health visiting contract, for example in the Sandwell region. Also many provided a budget for each year even when provision/provider changed.

Of the many contracts falling within the period 2014-2019, although some authorities detailed contracts ending before 2019 (3 unitary authorities), most reported contracts starting 2015/2016 and continuing up to and beyond the requested period into 2020 and beyond. 4 unitary authorities and 4 metropolitan detailed contracts starting 2015/2016 and continuing past the requested period into 2020 and beyond.

1 unitary authority reported that the service was brought in-house from 2020 onwards. 1 metropolitan and 1 County response reported a 3-year contract starting 2017/18. The single reported Borough council contract represented a 2-year pilot through a County Council grant application and this related to staff roles delivering 2 x groups per week (small budget).

In a few cases partial budgets were reported when figures were provided only in the latter years requested e.g. 2016 onwards. Partial budgets reported may represent cuts in breastfeeding service as a result of moving from stand-alone funded services to falling within a HV contract. A limited number of areas were able to provide data on secure funding as a separate budget even with the move to Health Visiting.

However, while unitary authorities had no reporting of partial budgets they also reported the highest number of budgets that decreased over time and highest number that did not provide budget data (reflecting the move of funding to other authorities).

Only 9 CCGs funded a breastfeeding support service, and of these, 3 provided budgets for each year across the full period, therefore consistently funding this element regardless of the move from NHS to local authority control. Only 2 Welsh LHBs provided budget data and again this represented a range of spending on those services, with 1 showing an increase in budget and 1 remaining unchanged across the reported time period, with an allocation of funding for BFI accreditation and peer support.

There was a high range of spending across London Boroughs, Unitary and Metropolitan Authorities which was associated with the size of the area. Reported spend ranged from £40,000 up to £400,000, however the data available is not detailed enough to draw inferences on the range and scope of service provision within each of these areas.

Looking at the budgets provided across the years, some represented an increase in funding, some a decrease and many reported consistent funding for each year. In London, 3 boroughs saw a decrease, with only 1 service increasing. Within Unitary Authorities, breastfeeding support service provision varied the most across the years and these authorities included the most reporting of cuts in spending, with 7 areas reporting decreased funding. With the exception of Unitary Authorities, the highest proportion of service budgets remained stable, without change across the years reported. Metropolitan Boroughs and County Councils were more likely to report budgets that remained unchanged across the years, although some reported fluctuations in annual budgets that were usually due to changes in how the breastfeeding support service was provided or delivered.

We looked at trends in stand-alone peer support services over the years and trends were similar compared to all breastfeeding support services. Stand-alone breastfeeding (including peer) support services also showed a range of funding (high-low value) as observed across all commissioned services. Some stand-alone services have been maintained, more often with a decrease in funding over the years, but also with examples of increases in funding. Some stand-alone services have moved to HV both with a maintained budget, but more often without a separate budget being maintained/identified, as detailed through partial budget data.

Findings 2) Analysis of IFC survey

Areas reporting no commissioned BFPS services

This section describes findings from the IFC survey in areas where responses indicated no commissioned peer support service at the time of data collection. Responses from those with no commissioned BFPS equates to all 6 responses from Wales (representing 4 Local Health Boards) and 21 responses from England. Further details on survey responses is reported in Appendix 3.

The positioning of peer support

In both England and Wales there was unanimous agreement that peer supporters play an important role in social engagement, providing opportunities for local breastfeeding mothers to meet, supporting breastfeeding and complementing the work of health professionals in their breastfeeding support role. A strong majority also stated that peer support contributes to the normalisation of breastfeeding in the community (67% Wales, 91% England), as well as providing emotional and practical support.

Despite this perceived value of the role, peer supporters were often not viewed as specialists, with 33% in Wales and 37% in England describing peer support as a specialist skill. Most were more likely to describe specialist support as that being provided by lactation consultants and health professionals however the degree of integration of peer supporters with general health service provision was limited, with 33% in Wales and 18% in England describing peer support as 'well integrated' within health teams. Despite this, a large majority in both nations stated that health teams routinely refer in to BFPS services.

Funding for BFPS

Half of respondents from Wales reported that a BFPS service had existed in 2015, indicating a significant reduction in commissioning over time. For England, only 4 reported that a commissioned service had been present in 2015 (with a further 4 unaware). Some equated this with the move of service provision (including infant feeding support) to Local Authority responsibility, where it was a part of wider agendas such as 0-19 years programmes, mirroring the FOI data previously presented. Where services had been lost there was a significant impact:

The service has now become a charity and will rely on charitable donations. There have been some job losses.

In Wales, all respondents reported that there were peer supporters currently working on a voluntary basis in their area, with 5 of 6 confirming there were no financial contributions made to this

provision. 4 out of 6 (66.67%) responses confirmed that there had been a decrease in financial support since 2015 with negative impacts on the availability of peer support, partnership working with health teams and availability of supervision for volunteers:

Since funding was withdrawn by Welsh Government they (BFPS groups) have been difficult to support.

Overall the biggest effects of these changes were reported as general reductions in the numbers of peer supporters and BFPS groups, as well as lack of support for those that remain active. This led one respondent to comment that the 'previous thriving peer support has disappeared'.

In England similarly a high number of responses (76%) said that peer supporters were offering volunteer support and only 2 respondents reporting that a financial contribution was made, with a third reporting a decrease in funding for peer supporters since 2015. Negative impacts of this reduction in support included staff having to take on additional work, reduced responsiveness to service requests for support, subsequent lack of coordination and inconsistent provision across service areas. Some suggested an increased reliance on good will, with one quoting:

We are hanging on but only because of the passion of these remarkable women who have been supported at (venue) and wish to give something back to their community.

Some reported seeking additional financial support through submitting funding bids, however this was not necessarily as far-reaching as would be preferred and meant challenges for sustainable, consistent services:

We are working really hard and have placed a bid for a peer support coordinator...the governance is always an issue when we do not have funding for insurance but want to build something sustainable. Unfortunately, at the moment we are looking at peer supporters insuring themselves and this is a barrier to peer supporters who are less affluent.

Current delivery of peer support groups

In Wales, all respondents stated that BFPS groups were currently running in their areas; one response reported an increase in support groups since 2015, with the remainder reporting a decrease or no change. Most of these groups were led by health visitors or midwives, with support from peer supporters in two regions, and led by peer supporters in one area.

In England, all but one respondent reported breastfeeding groups currently running in their area. 63% of responses reported a decrease in provision since 2015, with the remainder reporting no change or an increase in provision. A greater number of groups were led by peer supporters only

(36%) or mix of peers and health professionals (45%) than for Wales, with remaining groups led by other professionals such as health visitors, midwives, lactation consultants. In England, peer supporters were also involved in other activities, including providing support on postnatal wards, at hospital groups, antenatal support in hospitals and community, home visits and telephone support. All of these occurred at a much lower rate than group provision.

In Wales, all IFCs stated that groups were currently running in areas with low breastfeeding rates, with 73% stating this for England. Most were conscious of the need to locate groups in areas that were convenient for women to access but in some cases, pragmatic considerations were the drivers for current locations, including the availability of peer supporters:

It is where the peer supporters lived fundamentally. We are looking to address this and reach out into the less affluent areas.

Access to groups in more rural areas was noted as an ongoing challenge, particularly for those without their own cars, and this was frequently noted as impacting levels of attendance. Securing regular use of appropriate venues was also an ongoing challenge for hosting groups, specifically in terms of locations with public transport links and available at low/no cost on a regular basis. The impacts of the Covid-19 pandemic were also being felt in terms of accessibility to those who may have economic disadvantages:

A group was created in an area of deprivation to provide access for those who did not have transport. However due to COVID 19 this group has been suspended and specialist support is being offered virtually or as 1:1 support. The location of this 1:1 support is difficult for those without transport to access.

Overall, across England and Wales there were mixed views on whether mothers from the most socio-economically deprived areas and those areas with low breastfeeding rates were accessing peer support to the same extent as those who were more affluent.

Training provision for peer supporters

Overall, the provision of accredited training and ongoing supervision for peer supporters was inconsistent across England and Wales. Both nations reported a mix of accredited and non-accredited training in use, with accredited training from national breastfeeding organisations. Several used their own non-accredited, in-house training developed by staff who had previously undergone accredited training themselves. The main driver for this type of provision was financial, with in-house training a more cost-effective option for delivery and accreditation considered prohibitive:

We regularly review the training to ensure its evidence based. We have explored several avenues for accreditation but it has always been too costly.

In terms of ongoing support, significantly more respondents in England stated that peer supporters had access to reflective supervision sessions and additional skills building, such as safeguarding training, than for Wales, with one respondent describing access to supervision for peer supporters as 'non-existent'.

Additional challenges for delivering BFPS

A majority of respondents in Wales (67%) and in England (92%) reported that they would like more peer support provision, however additional challenges were noted for delivering and increasing available services, specifically in terms of time and political support.

Many IFCs roles were reported as part-time with 33% responses in Wales and 40% in England reporting as full-time IFCs. Many reported that their roles and responsibilities included running clinics, training and development for peer supporters and some reported their infant feeding role was one part of a wider remit for health such as healthy weight leads. 92% (58/63) said there was there an Infant Feeding Co-ordinator/specialist role before 2015 with 61% reporting more breastfeeding related responsibilities and 15% more non-breastfeeding related responsibilities. 78% reported that others supported them in their role with majority being other staff roles within health. Only 50% in Wales compared with 84% in England reporting that they had a specific 'infant feeding' job description for their position, with BFPS not necessarily part of this role outline:

This (BFPS) is not on my job description, the NHS view it as a Local Authority service.

The absence of time to expand BFPS was frequently noted, as well as funding constraints already outlined and, in some cases, lack of support at local commissioner level and at national policy level. It was noted that policy-level support was key to effectively embedding and expanding BFPS provision but, to date, there was limited indication of real change:

It needs to be a priority in the all Wales Breastfeeding Strategy. There's little evidence of progress since the strategy was created.

Areas reporting commissioned services

This section reports on responses from IFCs who reported a current commissioned BFPS service in their area, equating to 39 of 64 respondents (61%) from England only. Further details on survey responses for commissioned services is reported in Appendix 4.

The positioning of peer support

Over 80% of Infant Feeding Coordinators stated that peer supporters play a role in increasing social engagement, through providing opportunities for local breastfeeding mothers to meet and through providing one-to-one engagement to help with potential isolation experienced by new mothers:

I know that service users find the peer support services invaluable. They love that 'peer' professional yet approachable format. I think that the support that they give in the mother's home is so valuable and appreciated. The time they can spend observing a feed and the social interaction is something that is so difficult to do as a health professional due to workload/ time restraints.

Peer support was also valued for normalising breastfeeding in the community and providing support for breastfeeding in public. 70% felt that peer supporters provide both emotional and practical support, which is complementary to the work of other health professionals with a breastfeeding support role.

Notably, 60% suggested that peer support was helpful in reaching mothers and supporting their engagement with statutory services, indicating reciprocal benefit. A greater number of responses said their peer supporters provided skilled/specialist breastfeeding support than for those in areas with no commissioned services. However, while 90% stated that other health professionals valued the peer supporter role, less than half suggested that health professionals felt confident making referrals to peer support services for women experiencing more complex feeding issues. Some suggested that this was the correct process for dealing with more challenging problems:

Feeding problems should be addressed by health professionals, while peer supporters offer mother to mother support for breastfeeding rather than specialist assessment and care.

While others saw it as somewhat more of a missed opportunity to access additional support:

The Health Visitors tend to refer directly to the specialist clinic rather than to peer support, and I am regularly reminding them of the support that can be gained from our volunteers.

There was significant variation in the extent to which respondents felt that peer support services were integrated with other health professionals in their area. Comments suggested that integration was supported by strong relationships with health visitor services, including through receipt of in-house training. While half rated the level of integration positively, others identified numerous barriers to more effective joint working across services. These included concerns over data sharing

between services, challenges of sustainable funding and also potentially inaccurate perceptions among some professionals over the peer supporter role:

It can be hard to get some practitioners to see the value of peer support as an adjunct to professional care as they see it as a replacement. Some practitioners do not signpost to peer support.

Current delivery and impact of commissioned BFPS

Of those indicating a current commissioned service, 71% reported that a commissioned service had also existed in 2015. For current services, the majority were commissioned through the Local Authority (79%), with the remainder from the NHS, the Clinical Commissioning Group and the third sector.

There was a mixed response in terms of the levels of commissioned peer support provision over time, with 26% reporting an increase in provision, 23% a decrease, 40% stating that levels of peer support had stayed the same, with remainder unknown. Decreases were associated with reduced services as well as a reduction in opportunities for new peer supporters to access training:

As there has been no ring-fenced funding for several years, pressures within the Infant Feeding team have led to a reduction in number of Peer Support courses and number of peer supporters.

Reduced peer support was highlighted as having a range of negative effects, including increased workload for health professionals, a reduction in the range of community services available, with subsequent risk of service decommissioning due to perceived lack of impact.

Where there had been an increase in commissioned peer support services, this was observed as having had significant benefits, including increased availability of peer support in both hospital and community settings:

More volunteers trained, more groups running, more social media support, increase in local breastfeeding rates.

87% reported group-based BFPS currently running in their area, with 53% reporting direct support provision on maternity wards, and 43% of services proactively contacting women in the immediate postnatal period (e.g. within 48 hours of discharge from hospital). Further support provision included post-natal telephone support (47%) and home visits (33%), indicating a much broader range of support options available in areas with commissioned versus no commissioned services. This was

directly associated by IFCs with an increase in breastfeeding rates in their areas as an effect of increased commissioning.

As with areas with no commissioned services, there were often practical considerations which affected the placement and availability of groups. This included the availability of venues which was determined by multiple factors including cost of hire, available transport options and the proximity to where existing peer supporters lived in order to have people to run groups. Some suggested trying to make use of existing venues where mothers may be, such as well-attended playgroups, in order to maximise local awareness.

There were mixed responses in relation to whether the placement of current groups was effective in reaching those areas with lowest breastfeeding rates at present, including areas of socio-economic deprivation. A strong majority (80%) agreed that peer support services are proactive in supporting local women and families, however less than half (43%) agreed that services are currently effective in reaching those women/families that most needed support. Some suggested that the absence of available peer supporters recruited from more deprived communities was a factor, along with absence of available venues, meaning that services were being delivered where there are available settings:

We are limited in provision by availability of venues, so cannot fully focus on areas of deprivation or lower breastfeeding rates.

This may also be associated with the process for commissioning of services, with only 13% agreeing that the commissioned service tends to focus on areas with low breastfeeding rates, and 17% agreeing that commissioning of peer support tends to focus on areas with high levels of deprivation. It was acknowledged that women in more deprived areas, as well as women from black and minority ethnic groups, were not currently being reached by peer support. This tied with notions, also expressed by peer supporters and service users (see Findings 3) that BFPS is more widely accessed by specific demographics:

I think this is the current issue, probably across the UK, mothers who are most likely to access peer support are educated white women. We need to look at ways of ensuring the mothers who most need support feel able to access it.

Training provision for peer supporters

As observed in areas with no commissioned services, training for peer supporters was a mix of accredited and non-accredited, with 54% reporting use of an externally accredited programme and the same number stating that peer supporters accessed safeguarding training. Of those that noted

accredited training, this was highly valued for consistency of content and as recognition that peer support should be viewed as a role requiring skills and competencies:

Infant feeding support staff need to be appropriately trained, with people doing the job who want to be there. It is not a job for just anyone to be TUPE'd into. (The training provider) are wonderful and should be the benchmark for services across the UK.

For those who had not adopted, or had moved away from the accredited training, this was often motivated by cost and with the aim of reducing the time commitment required, for example:

...the decision was made to stop the 12-week accredited course. Lots of reasons for this, including that by the time mothers finished the course they were often going back to work. The new course is 7 weeks long and requires more reading and watching videos etc. at home. It's not accredited but it is aligned with BFI and volunteers have a face to face assessment and a 6-week induction into their placement.

Those in areas with commissioned services were more likely to state that they operated within in line with Baby Friendly Guidance (93%) and to state that peer supporters had regular access to ongoing reflective learning and support (77%).

Additional challenges for delivering BFPS

As observed in areas with no commissioned BFPS, respondents were often lacking in time to further develop provision, with only 40% acting as full time IFCs and the remainder incorporating IFC into other roles, for example managing healthy weight programmes. This put a strain on their capacity to build up BFPS services:

I am very keen to increase Peer support but with all my other responsibilities it is very difficult to find time to prioritise it.

However, IFCs in these areas were more likely to report additional support for their IFC role, from a wide range of health professionals, including midwives, health visitors, neonatal nurses and others. Most suggested that they would welcome additional BFPS within their areas but, even in areas with commissioned services funding was noted as an ongoing challenge:

It is hard to access allocated funds for peer support. I don't have budget responsibilities - I hope we will explore paid (peer support) roles.

This was felt by some to be especially challenging in the context of Covid-19 impacts, which had constrained service delivery and which make the service look less impactful through less recorded contacts with service users:

I worry that funding will be cut due to numbers being lower during COVID as they are not in attendance on the postnatal ward. And whilst we provide information to the families, they are not visible and therefore I worry that their numbers have dropped.

As in areas with no commissioned services, overall it was noted that there was an absence of policy level support for BFPS. Even though many noted that BFPS had been helpful in them gaining BFI status locally, it was still characterised by lack of ring-fenced funding and inconsistent delivery:

It is disappointing that peer support is valued so little along with the health benefits of breastfeeding that no additional funding was invested and the proposed model is being paid just lip service.

Findings 3) Interviews with peer supporters

This section presents findings from interviews with peer supporters across England and Wales. Those in England included peer supporters from areas that have experienced funding cuts to peer support services within the last 6 years, areas that have maintained funding for services and, in Wales, areas where services are provided through routes other than direct commissioning. Interview discussions included: personal journeys into becoming peer supporters and experiences of training; awareness of local and national services provision, including changes over time; perceptions of service users accessing peer support and potential barriers to access, as well as impacts of the Covid-19 pandemic on provision.

What is peer support and what are its underlying values?

Participants were asked to reflect on what peer support is and should be, and responses were similar across the different areas, with emphasis on the underlying values of the service, including trustworthy, non-judgemental and knowledgeable:

Being there in the same boat as somebody and being a non-judgmental person to lean on who is knowledgeable, who knows about the thing that you require.

The provision of support and active listening from someone identified as having been through a similar experience to themselves, was identified as being as, if not more, important than the provision of knowledge and information. It was further stated that peer support should aim to help mums to identify their own goals rather than being based on prescriptive set of ideas, with the peer supporter role being to accept those goals and allow people to explore their own feelings and ideas.

Several cited the importance of a service that was not driven by health professionals and others with a professional interest in encouraging mothers to behave in certain ways:

I'd say it provides a different path for mums, it provides a different kind of support that has completely different cause to the NHS or Public health and that might be more supportive and have more space for listening and emotional support than other services that are more medically oriented.

This was seen as essential in a space where women feel not listened to and overwhelmed by professional advice, with 'empowerment' frequently cited as a key benefit for service users. Many peer supporters felt that they may feel more relatable and have more time for relationship building with new mums compared to health professionals, providing more opportunity for a trusted relationship to be built.

As well as identifying potential benefits to individual service users, peer supporters frequently referenced wider benefits and located their roles within the overall 'world' of women's health. This included a sense that peer support groups helped to build communities of new mums which, as well as providing social support, could have a role in normalising breastfeeding more widely, with those having more positive breastfeeding experiences themselves being more likely to pass this on to friends and family.

Aims and benefits of being a peer supporter

Many interviewees noted that the types of benefits they expected service users to experience, in terms of building networks, gaining confidence and feeling supported in their own experiences, were the same benefits that they themselves gained from involvement. As well as gaining knowledge and understanding of issues around breastfeeding that could often be related to own past experiences, many reported an increase in their own self-confidence and self-worth as a result of becoming a peer supporter:

I guess in a sense embarking on any kind of bit of training there's a sense of like fulfilment for yourself, like I'm probably not articulating that very well but feeling some self-worth about learning about something new and feeling some rewards.

While this had not been the initial aim of involvement, it was identified as an unexpected bonus of participation. Peer supporters suggested that groups may also often provided a sense of community, with new friendships sometimes developing and continuing after groups had finished. Several suggested that being a peer supporter was a way to either give back after a positive personal experience of breastfeeding, or to attempt to improve the system after a negative personal experience in the hopes of negating such experiences for other women.

Pathway into involvement in peer support

Routes into becoming a peer supporter tended to vary, with no suggestion of a 'typical' trigger for involvement. For some women, a positive personal experience of breastfeeding support with their own children was as a reason for wanting to become a supporter in order to help other women have a similar experience:

...it was the kindness of those peer supporters that got me through it, actually listened and understood. We all sat in room cried our eyes out but it was just such a wonderful experience. For the first time I wasn't alone somebody in recognised why this journey was important me.

For others the opposite was true, with more negative personal experiences acting as the driver for their involvement. These experiences varied and included problems with breastfeeding, postnatal depression and feelings of loneliness and isolation as a new mother. Breastfeeding peer support was viewed as offering an opportunity for essential social contact:

We see lots of really great strong friendships between mums and babies of the same age but also with older mums as well, it's just creating that support network.

Participant experiences of training and supervision

Participant experiences of being able to access peer supporter training were varied. Access was made easier where training was being provided within the local area and where own transport was available. Difficulties in accessing training were experienced where courses were being run further from home, particularly for those in more rural areas and where courses took place during working hours. For some, this necessitated use of annual leave or flexible working hours to ensure attendance, with a supportive employer felt to be key to course completion. Others found difficulties arranging childcare for attendance at courses, with their attendance made easier by the presence of supportive partners and family members:

I had a supportive partner at home who was able to look after my other child whilst I was doing assignments, not that they are that intensive, and again, my son was in free nursery care so it wasn't paid nursery when I was volunteering. I do feel it was very easy for me I didn't have to make any sacrifices or compromises.

Once training commenced, a majority found it to be a positive experience. Peer supporters cited increased enthusiasm for breastfeeding promotion as a result of attendance, with increased motivation to help others have more positive experiences. Many reported an increase in personal self-esteem and confidence as a result of gaining the qualification, as well as gaining skills to support and actively listen to the experiences of others. The benefits of this extended beyond the peer supporter role and were frequently applied in day to day life and personal relationships, offering an unintended gain from course completion. Accreditation and feedback were valued elements of training, with several then pursuing further studies in this or related fields as a result of completing the programme.

For many, they cited a new perspective on barriers to breastfeeding which included understanding of the roles of families and social networks as barriers and facilitators to continuation, including important reflections on the pressures faced by new mothers to either stop or continue breastfeeding when they may not be ready:

It's the understanding of the different pressures on people and the different reasons why they might want to breastfeed or they might want to stop breastfeeding. Looking into the pressures that they have from the outside world, both from within the family but outside of the family, wider society as well. I learnt a huge amount about that too that would never have even have occurred to me otherwise.

An important benefit of this increased knowledge was the capacity to then reflect back on their own experiences of breastfeeding, including a feeling of greater insight into why they may have had personal struggles at the time. For several, training helped them better process their own actions and put their experiences into more context:

I felt judged breastfeeding by some people as well. I think some family members felt like they should be able to give a bottle, or they should be allowed to hold my baby. So my training showed me there are the basics of breastfeeding, but there is so much to unpick for a new mother to allow them the space to breastfeed or to make the right decisions for them.

The experience of receiving supervision after peer supporter training was widely cited as beneficial and a positive experience:

Just the support and feedback on how you might have handled things, the reflective practice really, the reassurance and the stories you hear about. It's a safe place for everybody really, it's reassuring to go somewhere other people are worried about the same things, similar experiences.

The opportunity to discuss issues in more depth and to 'offload' was seen as highly protective of taking on too much personal burden, as well as providing a safe space to reflect on and critique own practice. This was essential to becoming a more reflexive practitioner and in understanding the role of own values and beliefs within practice. Supervision was also an important avenue for keeping knowledge up to date, for example in new and emerging research findings:

I think there is so much about infant feeding that you can't just get through your volunteer course, and as a mother who has breastfed you will only face specific problems, so I think in supervision you are hearing more about things...I just think it's all that knowledge that's out there that you wouldn't know necessarily.

In terms of access, many reported that their supervision had been delivered online even prior to Covid-19 restrictions, but more frequently since the emergence of the pandemic, and this was largely seen as beneficial, by saving on unnecessary and difficult travelling time, as well as being

more flexible in working around other commitments such as childcare and work. For several, more frequent engagement in supervision had been made possible by this switch to online delivery.

Supervision had been experienced as most effective in areas where funding had been maintained, with the supervisors were themselves trained in breastfeeding peer support and linked to the training organisations, such as NCT, ABM or BfN. Less successful experiences were reported by a few participants who had received supervision through the Health Visitor service after their BFPS service had been absorbed into health visiting budgets. Some who had experienced this reported that sessions were experienced more as a teaching meeting and less as an opportunity for exploration and reflection. Others stated that they had experienced inconsistent supervision after the service moved to health visiting, impacting the perceived quality of support:

So I never really had a set supervisor, but I do know other people do have that...I think that was a bit of a downside, the people who supervise me aren't aware of the specific set up of the group that I volunteer at.

Experiences of providing BFPS and equity of provision

For those who had been primarily running groups post-training, many suggested that low attendance at groups was initially de-motivating and a challenge for newly-qualified peer supporters. Attendance was attributed to many factors, including accessibility of venues and promotion of groups by health professionals. Where groups had been able to be delivered consistently in the same venues and at the same times, attendance appeared to have remained more stable, suggesting that enforced changes to service delivery may be damaging for access and for building the reputation of a service.

Some differences were identifiable between peer supporters in areas with recent reductions in funding or with non-commissioned services, and those areas that had maintained/increased funding in recent years. Funding cuts were seen to have impacted availability of services:

I think it's harder now because there are less groups, the more groups there more, the more venues, the more times, that's a real access point because then there is a group local to most people or at a time somebody will be able to get to, so that takes that access out of the way.

In the latter, it was observed that more peer supporters were paid for running services, while the former areas suggested greater reliance on volunteers. Those who were volunteering reported more barriers to service delivery, including issues with arranging childcare for their own children, as well as having to travel further to find volunteering opportunities.

Also, in areas of England with maintained/increased funding, forms of support other than groups were more likely to have been available, for example one to one provision in hospital settings or personal phone calls in the immediate post-birth period. This was considered to have significant value:

Hospital is the most crucial, I think maybe that was the best for mums perhaps a little bit of information then and a little boost in the right direction if they were unsure or struggling, but mostly just making them aware that support exists for breastfeeding and letting them know how they can access it if they want, in the future, I think that was really the best thing the service was providing at that time.

Some reflected on their own experience of receiving support outside of group settings and the value of this to them:

When I got home, the breastfeeding team kicked in, and the following day someone came to the house, having someone come to the house and set me up to feed made a big difference. So I think it was definitely the home visit for me that made the biggest difference.

One peer supporter in an area that had experienced cuts to funding leading to the loss of such one to one services felt that this had a profound impact on engagement, particularly in the early days where problems may first arise and new mothers may most need support:

There's real value to a phone call to everybody that has had a baby in the first 3 days after having a baby just to say how are things going, how are you doing, how are you feeding your baby, and then being able to refer them somewhere else if they need that support. I think that's really valuable.

Peer supporters in Wales in particular cited lack of funding as a barrier to running groups, with limited funds to secure appropriate venues in areas accessible for transport and parking. This was felt to have impacted on attendance, with numbers increasing when accessible venues were secured and decreasing where changes to less accessible venues had been forced on the service by lack of funds:

Our venue changed...I don't know whether that put people off but we always assumed that why are numbers went down drastically when we were there, because it wasn't in the centre of town it was on the outskirts...it wasn't, you know, you could browse round the shops and call in at the breastfeeding group during your morning. You have to make a special journey to get there, I think that was a problem.

It was notable that peer supporters in Wales, where services were reliant on volunteers to run, did not discuss any provision at sites such as hospitals or other than through groups as part of usual practice. While some had attempted to keep up with women through phone calls during the pandemic, this was not a part of the service that was expected to be retained once groups were able to meet again.

In terms of equity of service provision, provision of groups was often lower in areas with lower breastfeeding rates, with a cycle of absence of perceived demand feeding absence of provision and suggesting that services may not be accessible to those most at need. Across all areas, it was noted that there was an issue of whether those involved in both providing peer support and accessing as service users, were representative of diverse populations of women who may find the service most beneficial. It was felt that support outside of groups may have more capacity to reach those who may not attend group settings, with women seen in hospital often representing a different demographic from those attending groups. For those peer supporters who had experience of delivering services within hospitals as well as within community groups, this absence was especially notable, as they observed very different populations in hospital settings than in community groups:

...as soon as I supported at the hospital I thought 'oh my god there's loads of young mums and loads of black mums and people who didn't speak English very well or refugee mums' and suddenly it was 'oh my god there is a whole different world of mums out there', who aren't just these white professional middle class mums and actually they all had their own issues and different situations, confidences, problems. But yes supporting at the hospital is a completely different picture.

Increased delivery of peer support within hospital settings, as well as promotional material in a wider range of languages reflecting the population make-up of the area, were suggested as potentially helpful in improving access to more socio-demographic groups.

However, the issue of who may 'need' the service the most was considered to be complex, with more affluent women with higher educational attainment still needing the service and benefitting significantly from it. However, the absence of diversity, including among peer supporters, was acknowledged as perhaps acting as a barrier for women from other ethnic groups in attending, again associated with the feeling that the service is not for women like them. Several peer supporters suggested that services were perceived – often accurately – as lacking diversity and being by and for white, middle-class mums, even in areas where this was not representative:

I would say both (areas worked) they are most of the time white, Caucasian not necessarily British but Caucasian and I would say they tend to be quite educated as well. So we really struggle to reach representative percentage of other groups, especially in this borough...actually in both boroughs we aren't very representative I think.

It was suggested by many that this may be seen as a barrier to attendance by those from other ethnic and socio-economic groups due to a perception that services are not meant for people like them:

...they might not have the confidence to walk into a room of posh mums with bugaboos, or might feel awkward of breastfeeding in public... I think those sorts of things can put you off a bit like the perception that's it's not what people from your background do.

Support within health services

Despite the barriers discussed above, it was observed that peer support provision had actually improved in recent years in Wales. This was often attributed primarily to having support from other health professionals, including having Infant Feeding Coordinators who were more supportive of the service and more likely to act as champions for continuance:

I think things have improved quite a lot in the last couple of years. We've been fortunate to have an infant feeding coordinator who really valued peer supporters and I think that's made a huge difference and I still think they, the peer supporters, are very much left to their own devices.

This also included communication by other health professionals who, if they were themselves more informed about BFPS, were subsequently more likely to promote peer support to new mothers:

In recent years it's been a lot easier for people to come along to the group and I think part of that is the promotion that the group is given by the midwives and health visitors. We've got a couple of very keen midwives and health visitors who will send women our way so that's really good to have a good relationship with them, that makes a huge difference I think.

In areas of England where funding had been reduced in recent years, those that had been involved with services over this period of time also cited issues that were attributed to these changes, with suggestions that peer support had become a skeleton service in recent years. Changes included reductions in the level of support peer supporters received from health professionals which, for some, was associated with the move in responsibility for service delivery from third-sector bodies to local health visiting teams. This move had been followed by a reduction in partnership working and access to supervision, as well as cuts to peer supporter training availability. Some felt that their role

was not recognised as valuable by some of those within the health visitor service, as reflected in decisions to reduce the frequency of the peer supporter training programme, resulting in potential loss of willing participants:

...the health visitor was providing that training and I think she held one course a year or something like that and that was just done one morning a week over about six weeks. I think part of the issue that we had with that was by the time mums had become interested in doing the training and then they'd waited for a course to become available their lives then moved on they were returning to work and getting involved in other groups and things and so we lost a lot of mums that way.

It was noted that the absence of a supportive coordinator in these areas could lead to reduced retention of peer supporters, loss of administrative support for organising and running groups and a loss of the sense of community among local peer supporters that was so heavily valued by so many.

It was also noted that there was no evidence to suggest that demand for services had changed even though provision had decreased, creating a gap in provision and 'letting down' new mothers.

Improving access to peer support

Participants were asked to consider other barriers that may prevent new mothers accessing breastfeeding peer support services. Many of the identified barriers were practical in nature, with lack of accessible locations, absence of good public transport and absence of weekend delivery of peer support particularly important.

Others cited systemic problems in the support provided to new mothers, including absence of signposting to peer support from hospital and GP services, some of whom were themselves unfamiliar with the services available or provided inaccurate information on what the service could offer. The knowledge and interest of those health professionals seen in the immediate post-birth days was felt to be highly significant in whether new mothers may ever access peer support or not:

But I think we are missing all these people who aren't as enthusiastic about it but would continue with it if they got more structured and more professional support at the beginning...So it's difficult in the first couple of weeks you are going to go 'ah forget it' which is fine, totally fine, but if you had more support in those weeks from the health care professionals, who had good knowledge, then you might continue...we peer supporters really put so much effort in promoting it and supporting it, but it sort of feels like banging your head against a brick wall, if the first line of people you meet aren't quite as knowledgeable about it as they should be.

Further, if inaccurate or contradictory advice had been received during this initial period, either from medical professionals unaware of peer support services, or from family members who had formula fed or had bad breastfeeding experiences, this was likely to undermine peer support at a crucial stage, with little chance of a relationship then being built. Conversely, having a family member or friend who had a positive experience of peer support, or receiving a positive recommendation from a medical professional, were seen as facilitators for women to access peer support services.

When asked to consider changes that they would like to see to service delivery, both locally and nationally, views among peer supporters were often consistent. Many suggested that, regardless of funding levels in the local area, services were too frequently reliant on volunteers and were therefore unstable as a result. As previously identified, volunteering is reliant on many structural factors such as free time, supportive partners/families and, potentially, greater financial stability, meaning it is accessible to a smaller group of women than if peer support services were funded. This was felt to be a barrier to increasing participation by peer supporters and, subsequently, among service users:

When we first started it we were able to advertise it as more of a social occasion, to get to know people while on maternity leave, make friends...As our volunteer base shrank it felt as if our base of mums shrank as well, to the point where mums didn't want to treat it as a social event anymore because there were fewer people coming and accessing it and then that shrank it further because they weren't meeting other people socially.

Absence of available funding for accessible venues and weekend or out of hours provision was also important. Some suggested that the online model of delivery, which had been enforced due to the Covid-19 pandemic, offered some potential for greater provision of services outside the traditional Monday-Friday hours, but with the caveat that this should not become simply a 'cheaper' way of delivering the whole peer support programme. Online provision offered further potential advantages of being accessible at an earlier stage, immediately post-birth, when new mothers may feel most isolated but be unable to leave the home to access support.

The way services are promoted to new mothers was also identified as an area where significant improvements could be made. Building on the previously identified barriers to access, it was felt that initial awareness raising of peer support service could be improved and not reliant on provision of an information leaflet at a time which may be ill-suited to retention of information. Suggestions for practice improvements included involvement of partners who could be informed about available peer support, weekend support, retaining the new model of videocalls, calls and emails in the days

immediately following birth to explain the service, as well as the option of home visits where possible:

Having a number or an email that could be used to reach out for support and providing video calls actually so mums don't entirely have to leave their homes especially in the early days.

It was widely perceived that overall awareness of peer support among the public was low due to lack of consistent promotion and awareness raising. This was associated with underfunding and with changes to service providers over time and, for some, was illustrative of the generally undervalued nature of the service within the wider healthcare system, despite the value placed on it by those accessing it.

Relationships with health services were often seen as vital for the functioning and effectiveness of peer support services, with suggestions that increased awareness among health professionals would be beneficial for new mothers, including awareness raising among midwives and health visitors to encourage them to promote services:

...in recent years it's been a lot easier for people to come along to the group and I think part of that is the promotion that the group is given by the midwives and health visitors. We've got a couple of very keen midwives and health visitors who will send women our way so that's really good to have a good relationship with them, that makes a huge difference I think.

As previously noted, the presence or absence of a supportive health professional, whether it be an Infant Feeding Coordinator or the local Public Health lead for the area, was seen as critical to the overall success of the service, leading to a 'postcode lottery' in provision. It was felt that this was unacceptable and that shared, nationally agreed approaches were more likely to lead to sustainable and better attended services going forward.

The impact of Covid-19 on peer support services

In considering the impacts of Covid-19 on delivery of peer support services, it was observed that this had varied considerably depending on the area, with some adjusting to an online delivery model more quickly than others. For those who had moved to offering group peer support online, some of the initially envisaged benefits – including the possibility of easier access for those who struggled to travel to groups – had materialised and it was hoped that these would be retained:

We started new forms of services through emails and phone calls which didn't exist before and I think it's actually amazing, it really benefits the mums and I hope we can keep that in the future.

This included better engagement as well as being able to offer support for those who were struggling to access other services due to pandemic restrictions, including Health Visitors.

For others, while attendance had initially been reasonable, this had reduced fairly quickly, with some suggesting that online fatigue had set in. This led to fears that for those peer supporters who were less active during the pandemic, skills and knowledge may be lost over time, with concerns over the longer term impact of this should restricted delivery continue for much longer.

Others highlighted that the format was unable to provide the same social support benefits as face to face delivery, often resembling more of a question and answer session rather than a supportive group model. This included an absence of in-person support from the peer supporters themselves, but also the chance to explore more complex issues:

I think some areas are really trying to do things with Zoom, having groups for mums to chat, but that's so superficial, sometimes you can address positioning and attachment or general questions...if you've got something complex like my baby's just not gaining weight, it's just not available...For most mums you really need somebody there to go through a whole feed with you, to look at it, it has to be face to face and that's not been available.

However, it was also highlighted that supervision had been more accessible for some peer supporters when switched to an online model, particularly for those who may have difficulties travelling to in-person sessions. Some also suggested that service improvements had been seen through additional funding arising from the pandemic however, overall, it was suggested that the pandemic was perhaps still too current for the full impacts on both peer supporters and service users to be fully understood, suggesting a need to monitor changes to provision and access over a longer period of time.

Findings 4) Interviews with service users

As with peer supporters, interviews were conducted with users of peer support services representing three different areas: one which had maintained a peer support service with no funding cuts in recent years (England); one with a peer support service where funding had reduced (England); and in Wales where non-commissioned peer support was provided.

Seeking out peer support

All interviewees were asked to consider their personal journey and how it related to them attending peer support services. As with peer supporters, there was little evidence of a 'typical' trigger to involvement. Several women reported a determination to breastfeed before giving birth, meaning they had already sought out information on available services, including through Facebook groups accessed during pregnancy. Others had been signposted to peer support from friends or family members who were aware of the services.

There was inconsistency both within and between areas on women's experience of being signposted to peer support by health professionals, with some reporting that their midwives had made them aware of the service and were well-informed about it, while others had less satisfactory experiences. This included women who had sought additional advice on breastfeeding from midwives or other health professionals but where issues had not been resolved. This had led them to seeking out information on additional support for themselves, usually through social media.

It was relatively common that seeking out peer support services was prompted by emergent difficulties with breastfeeding and, for some, receiving what they felt to be inconsistent or inadequate advice from health professionals on how to resolve the issues they were facing. This contrasted with a more personalised response within the peer support group:

I just had a lot more time from them and I do remember them saying not to sweat it if I couldn't feed in certain positions that I'd been told might be useful. And I could see there were a couple of women who'd said that they had problems like mine when they were starting out breastfeeding and were still breastfeeding a year later. And I think because I'd had this midwife very early on, say that because of the tongue tie, I wouldn't be able to feed my child for very long, I had that in the back of my mind that I might not make it.

Reflecting the observations of peer supporters, several women stated that they may have been told about peer support immediately after giving birth and had perhaps been given leaflets, but that they had struggled to retain this at a time when everything was just 'white noise', reinforcing the importance of timing in offers of support.

While many of these experiences were common regardless of the area women were from, some differences in ease of access were identified, with women in areas where funding for peer support had been maintained suggesting that finding groups that they could attend was easier than those who were in the other regions. Some women in areas with good provision were aware of friends and family in neighbouring locales who had experienced a lot more difficulty in finding peer support, making them feel fortunate to not be in a similar position:

Yeah, and I remember looking at other parts of (the area) and I remember, and like there's nothing there like. It all seems to be here...it just didn't feel like there was much going on in the other side of the borough and I just kept thinking how lucky I was that we lived in this part of the borough.

Hopes and expectations of peer support

Ahead of attending a peer support group for the first time, most women suggested that they didn't know what to expect and therefore had limited expectations of what it would be like and how it could help. Hoped for outcomes included feeling less isolated and being re-assured that you were not the only one having difficulties or not knowing what to do.

Accessing a range of different perspectives from others with shared experience was key, both for practical advice, such as on feeding positions, and for feeling able to ask questions in a more relaxed environment. The 'feel' of the group was deemed as very important, with hopes that it would be non-judgemental and not a space where breastfeeding was being 'pushed' on anyone:

Somewhere you can come, very easy going, no pressure no stress, people are there to just listen to you and be non-judgmental and just support you, in the way that you want to go forward with your feeding plan, not push on you.

This mirrors the underlying values previously discussed by peer supporters, with a person-centred approach key to effectiveness. This was especially important to women who either didn't know anyone else who was breastfeeding and were feeling isolated, or who were receiving different advice from people they knew. This included advice contradictory to their own wish to continue breastfeeding, with some experience of family members suggesting switching to bottle feeding before women felt ready to do so.

The experience of receiving peer support: group, home and hospital-based support

Several interviews suggested that they were spurred to seek out a peer support group after experiencing difficulties with breastfeeding in the early stages and their not being able to resolve the

issue with midwife support or not finding answers elsewhere. For some, attending groups was not only practical, but also helpful in addressing the potential isolation of being a new mother, with the group promising an opportunity for conversation and social support with others in the same position:

I remember well at first the support was helping me with the position and attachment and checking whether my baby was growing OK and things like that. So after about four months or something I went more for the social aspect and because it was a regular occurrence weekly and I could go and just chat to like-minded mums.

It was noted by many respondents that one of the biggest challenges they faced in engaging with peer support was the act of walking in the room in the first place, particularly in they hadn't previously known anyone who had attended a group and advised them on what to expect. It was noted that it takes a certain level of motivation and confidence to attend a new setting, with strangers, particularly at a time where confidence and well-being may be lower than normal. For some, groups became important settings for supporting mental wellbeing and the impacts of other challenges of becoming and being pregnant:

I was determined to breastfeed, nothing was going to stop me from breastfeeding... 'cause I felt like I had failed in so many other respects by having to have IVF to have a baby and so I was kind of a bit hell bent on it... I met people through that drop in service who I'm still friends with today... I'm getting a bit teary because if I hadn't had that, I would have given up breastfeeding. It probably would have impacted my depression a lot more and I would have given up.

The first experience of attending a group could be an emotional one, with the initial greeting, offer of refreshments and tone of welcome fundamental to their subsequent experiences and willingness to stay. Some observed that not all women will have the confidence to take this step, particularly if they have been confronted with competing messages or not encountered situations where breastfeeding is normalised. This was often located in wider familial and local cultures of breastfeeding – if you hadn't observed it being done in your area or your network of family and friends:

I would say I know about half a dozen of these wives of my husband's friends, and every single one of them hasn't breastfed. They have already automatically gone on to formula and I'm not sure it's because that's their group of friends, so they all think that... I'm not sure if it's just that particular group of people that I know, but they were all very anti breastfeeding.

For those who lived in areas with low breastfeeding rates, doing so was especially challenging and could be in turn, awkward and difficult, or a source of pride that you were not going along with other people's views where they contrasted with your own.

This was also associated by some with a generally unhealthy culture around breastfeeding in the UK, where it is not normalised in public spaces or in discourse, meaning that accessing breastfeeding peer support is not normalised either. Responses suggested that, while the personal benefits were understandably prioritised for service users, they also felt a sense of responsibility to challenge this unhealthy discourse around breastfeeding and change the narrative for future mothers.

What was gained from involvement

A majority of interviewees felt that they had gained positive benefits from attending peer support groups. This frequently included the opportunity to get out of the house at a time when isolation is a significant challenge, as well as the social support and opportunity to chat with others in a similar position. Being able to access a wider range of practical advice was also identified as reassuring, whether this was accessed more or less regularly, with simply knowing it was there seen as a positive. The non-medicalised form of group delivery was also widely regarded as a positive, leading to a relaxed, non-judgemental atmosphere where doubts and concerns could be freely expressed and there was little sense of pressure over behaviour. The importance of being in a setting where breastfeeding is normalised was a key benefit to many, with simply being in a room where you could feed without judgement seen as highly beneficial and, for some, in contrast with other areas of their lives.

Again, the sense of being part of a breastfeeding community and building a movement of normalised practice was valued, with frequent reference to changing things for other women and challenging harmful cultural norms:

Yeah, there's such a weird cultural thing in the UK about boobs, They're all right in porn, but they're not alright to feed your child, and I, you know, we've got a long way to go on that, but I do think breastfeeding cafes have a role in sort of empowering people to feel more comfortable, and I guess that's the benefit of the one that was held in a café. For some it was their first experience of feeding in public, but they had an army around them to make them feel a bit more protected.

Knowledge of local peer support provision

Knowledge of local provision was highly variable. Many had learned of the existence of groups from friends who had attended or from leaflets seen in clinics. Some had attended with first babies and

had wanted to continue with subsequent children. It was noted by participants in the areas that had experienced funding cuts that in recent years that the number of groups available to attend had decreased and this was directly attributed to limited funding. This was identified as limiting opportunities for local women to access peer support, as well as potentially being false economy for health service providers:

I know within that time there had been some talk about cuts to those things. Because I remember hearing about and thinking that's a really bad idea, because if you cut the funding for groups like that, which are quite probably quite easy and cheap to run, people are just going to end up going to like their doctors and to A&E and things like that when they've got problems.

This contrasted with the experience of one service user in an area where funding for services, including group support and ward-based support, had been maintained. This contact had been very positive in the key early days of feeding:

I gave birth in one of the hospitals where BfN peer supporters work on the ward so they visit the new mums every day and just see how are they getting on with feeding and you know, help them with any concerns they have. So that's what happened with me... It was like a lifeline when they came around then because I was really struggling with feeding.

In Wales, where no commissioned services existed, service users were generally aware that provision was reliant on volunteers, which meant provision of services was dependent on good will. Volunteer provision in both Wales and England was viewed as adding to the sense of the service being culturally undervalued:

I know it's not well funded if it's funded at all, and I know that sometimes they're essentially voluntary hours that people are putting in for it. Which is, you know, really kind, but if we're serious about it, you've got to start paying people for it... But you know, our country's got such a strange, strange view about breastfeeding.

Despite this, it was still generally felt that a good number of groups existed in the areas where interviewees came from, but that attendance was highly variable and often associated with the transport and accessibility of the centre hosting the group. One service user in particular was very knowledgeable of local provision and reflected that several groups which were seen as 'failing' i.e. with low attendance, had been closed or moved to new areas even where the area they had originally been in was one of high need. She observed that, for women who did want to access the

service in low use areas, it then became even more difficult to access groups, creating a cycle of low attendance-low provision.

In the area where funding for peer support provision had been maintained, several interviewees reported knowledge of high levels of support, with opportunities to access groups most days across the borough if you were able to travel. From discussions with friends and family in other areas, they were aware that this was not necessarily the norm in terms of provision, leading to feelings of being 'lucky' to live in that area and recognising the more fragmented national picture:

It's free at the point of use and widely available now so, at least in you know autumn of 2016, of 2017 when I was using the service, there was a drop in five days a week, so within sort of 20 minutes walk from where I lived... I mean I just wish that it wasn't such a postcode lottery for mums like not everywhere in in the UK has breastfeeding services available.

Reflections on users of peer support

It was widely felt that peer support could be beneficial to all mums, regardless of age or socio-economic status, but particularly to first time mums who may experience more uncertainty and isolation after giving birth. Services were also felt to be most valuable to women who may not have local and family breastfeeding cultures around them to reinforce and support their choices:

...like I said it wasn't really like the world I was used to being in with babies and mothers. It was just so supportive and calm and non-judgmental and patient. She was just always there no matter what, she could always help me and I didn't really have any other women in my life, family wise, I could have turned to and asked for that sort of help

However, in discussing who attends peer support groups in their areas, women often echoed the observations of peer supporters, with suggestions that attendees were most frequently white, middle class women who were more informed of the existence of groups in the first place. This was noted as contrasting with the local population demographic in each area:

The clientele at nearly every drop in I went to was white middle class women, so I was thinking if this is for, you know the wider community, it's not getting there to the wider community. It's the people who can probably afford to pay for lactation consultants who are here.

In Wales, groups hosted in areas of higher socio-economic deprivation were often not attended most heavily by the poorest women in the area, with more rural locations and limited access to transport felt to contribute to this, as well as frequent changes to locations of groups:

I went there one day, and for whatever reason it was closed, and they hadn't advertised it either. The failing group, it was a mile up the mountain - the road goes up the top of the mountain then comes down the other side - anyway so it was really inaccessible. If you have to go around the bus or with buggies and whatever, so nobody was going there.

In both areas in England it was observed that the groups were held in areas of high ethnic diversity yet attendees did not reflect this. Absence of services in other languages, as well as potential feelings of 'not belonging' were seen as key and, while centres had tried to increase language provision through targeting mums who spoke other languages, this hadn't yet been effective.

Many reflected on the risks of peer support being perceived as a service only for those who were more motivated to attend and had more resources to facilitate attendance, which would do little to challenge the perception of groups only being for a narrow 'type' of women.

Suggestions for service improvements

Service users offered many practical suggestions for improving the delivery of peer support services, many of which were consistent with the views of peer supporters. These included improving access to groups, particularly at weekends, but also in terms of physical access to venues. This included better provision in more rural areas and with public transport access.

Ensuring earlier contact was also highlighted as important, particularly where complications had been experienced and feeding was initially challenging:

Who needs it the most? - I do think in the early days when everything is so new and you just have no idea what's going on... I do understand why some women stop breastfeeding so early, because I think the first two weeks are just, like insane and if you don't have someone there to say to you 'this is gonna get better, it is crazy for a little while but it gets easier and you are feeding them and you are doing this' most people would stop straight away.

An absence of information in languages other than English was identified as a barrier to access to women from other ethnic groups, as was the absence of diversity currently evident both among peer supporters and group attendees.

Suggestions were also made for selection of venues conducive to bringing prams and accommodating other young children, as well as being able to provide a relatively private space not disrupted by other activities that may be occurring at the venue. It was seen as essential that services continue to be freely provided to encourage a broad range of women to go. In Wales where services are non-commissioned and often provided by volunteers, it was further stated that a

genuine statement of the value of the peer support groups to health services would be for the providers to be funded, which would add stability and consistency of delivery.

As noted above, wider local and national culture around breastfeeding was identified as something which needed to be improved, with the absence of positive breastfeeding norms and behaviours in the UK acting as a barrier to more women attending groups for support. In a cultural context where breastfeeding was prioritised more and recognised as important, peer support would function differently, with more consistent funding and recognition, including among other health professionals. At present, interactions with health professionals and their likelihood of promoting peer support was highly variable, creating an unacceptable variety of access to provision.

Impacts of Covid-19 on peer support experiences

Most service users discussed Covid-19 restrictions and their experience of services had switched to online delivery. There were mixed views of the effectiveness of this, with some enjoying the increased flexibility and accessibility but others finding that absence of face to face support and rapport to be less beneficial. Many felt that, overall, peer support had been accessed less during the pandemic, based on groups they had attended, with hopes expressed that face to face provision would be re-started as soon as possible.

However, where other service provision was limited, access to peer support had become more important than ever even with the limitations of online delivery. This was particularly due to restricted access to midwife support and other home visits, as well as constraints on partners being able to attend hospital around birth, meaning the continuation of peer support was vital:

Peer support, because of Covid, is 100% needed because all the other services shut down and we were the only ones available for quite some time on Zoom, Facebook groups. There is there is no other support available at all, midwives couldn't go to houses, all the new mums were totally on their own during lockdowns. I think even now, and when you go to hospital I don't think the dad can go in until you are you're just about to give birth...peer support is the crux I would say, that held it all together for the last year. And that is definitely needed.

Discussion

This research examined changes to breastfeeding peer support (BFPS) services in England and Wales from 2015 to 2019. It drew on multiple data sources to analyse: changes to funding allocations for BFPS; changes to the Infant Feeding Coordinator role in relation to BFPS; and the impacts of any changes on both those delivering and those accessing BFPS. This chapter summarises findings and considers implications for future policy and practice.

Changes in commissioned BFPS provision in England and Wales since 2015

FOI data provided for this research illustrated the complexity of assessing funding provision for BFPS in England, both with the challenge of identifying the relevant responsible authority and clarifying spending. In October 2015, the responsibility for commissioning children's public health (age 0-5 years) transferred from NHS England to Local Authorities (as part of the HM Government Health and Social Care Act (2012)), resulting in many infant feeding services being contracted to Health Visiting Teams within LAs as part of their 0-5 services.

Within this study data for England, most breast feeding support services were funded through Local Authority Public Health Teams. However, ring-fenced or allocated funding for peer support was difficult to assess due to the nature of financial reporting, whereby budgets for BFPS were sometimes reported as being contained within other spending, most commonly as part of a total 0-19 years services funding allocation or within 0-5 years Health Visitor contracts. This meant that, in many areas, budgets were only partially reported where stand-alone support services were in place initially but then had been subsumed into wider budgets and were no longer able to be reported on separately. This reflects the changed structure of service commissioning outlined earlier, with transfer from NHS provision to LAs. Where spending analysis on breastfeeding support was possible, findings were not consistent, with some budgets indicating an increase in funding, some a decrease and many remaining consistent. Within this, allocated funding for BFPS reflected a similar pattern, showing a range of funding across all commissioned services. While some stand-alone BFPS services have been maintained, a decrease in funding was more frequently reported over time, with infrequent examples of increase in spending on BFPS.

This approach to funding means challenges to assessing the consistency of provision from FOI financial data alone, with huge regional variation in the actual cash amount spent and in allocation of funds to service providers. There is significant reported variation in FOI data across LAs, with no statutory requirement for a BFPS service within 0-19 years spending, including changes to that provision in areas that have transitioned to providing services through other contracts, such as Health Visiting. Only one Borough Council reported a breastfeeding support service (without specific reference to peer support), which was funded through an external grant due to high levels of

deprivation in that area and provided on a time limited basis. The addition of the IFC survey data was helpful in associating spending on BFPS with service provision, with IFCs able to provide information on changes to commissioned services over time, as well as key perceptions into the impacts of any such changes. From these data it was notable that, in areas with no commissioned BFPS service provision, the range and frequency of available services had largely decreased according to IFCs. In areas where commissioning had remained more stable, BFPS services were more likely to have been maintained and also to be offered in a wider range of settings, including hospitals as well as community settings. Although hospital-based support was less frequently reported than community-based support, the immediacy of this contact was of high value to those service users who had experienced it, suggesting that this may be a key setting for increasing engagement. This may be valuable in overcoming some of the reported barriers highlighted by those attending community groups, including issues of transport to venues, awareness of available services and confidence in joining a new group. Maximising these opportunities for engagement would involve consistent implementation of on-site, hospital-based services and provision of standardised training for peer supporters (Chepkirui et al. 2020).

While several challenges were reported by those who had accessed community-based provision, the services were still highly valued where they had been used. As well as providing practical advice and support, they often provided opportunities for social contact, which is significant in challenging common feelings of isolation and loneliness in new mothers (Edwards and Sheeran, 2018). Community-based peer support can aid in promoting positive mental wellbeing in new mothers through increasing feelings of self-efficacy and self-esteem (McLeish and Redshaw, 2017), suggesting a broader range of potential health benefits and outcomes than the gains of continued breastfeeding alone.

Overall, IFCs in areas where funding for a commissioned service was in place were also much more likely to report that their infant feeding role was supported by other health professionals. While this may suggest a higher degree of integration with other health services, it is noted that, on the whole, levels of reported integration were highly variable and generally low. This reflects existing research on tensions between peer supporters and health professionals in some settings (Chang et al. 2022) and again may indicate that an opportunity is being missed in terms of referrals to BFPS if relationships with other health teams are not maximised. Improved communication across services and providing opportunities to build trust may help with integration (Chang et al. 2022).

Provision of infant feeding services was somewhat more uniform in Wales, with statutory guidance on 0-7 years services, including breastfeeding support, provided directly through Local Health Boards

(LHBs) and reported in 6 out of 7. However, BFPS is not mandated within this and has no ring-fenced budget and, while reported as being offered in 5 of 7 LHBs, this was most frequently provided through volunteers in Wales, with only one area reporting allocated funding. Interview data suggested that these volunteers often feel that they, and the service, are undervalued as a result of this, with provision often impacted by delivery challenges as seen in England, such as lack of consistent access to venues, challenges of public transport and lack of provision in hospital settings. Furthermore, training provision for peer supporters is highly variable in both England and Wales in terms of being accredited and consistently delivered. It was notable that in areas with no commissioned services, including in Wales where services are largely unfunded and provided by volunteers, access to accredited training and supervision was much lower. This again illustrates the potential benefits of consistent, ring-fenced funding in being able to consistently meet the recommended BFI standards.

In general, it was beyond the scope of this study to conclude whether services were routinely being provided in the areas of highest need (lowest breastfeeding rates) within each LA, although perceptions of peer supporters and IFCs were that this was often not the case. Although many IFCs reported group support being available in areas with lowest breastfeeding rates, provision and attendance was inconsistent. Both IFCs and peer supporters discussed several practical barriers to consistent support in areas of high need, including difficulties in recruiting peer supporters in areas of higher deprivation, lack of good transport links and lack of access to community facilities. This supports previous evidence suggesting that lower-income women may struggle to access services and that provision is highly variable across LA areas (Grant et al. 2018). Research which maps the local support services within each LA would be beneficial to fully assess whether they are reaching areas of lowest rates of breastfeeding. This may then be helpful in informing commissioning approaches, with most IFCs suggesting that current commissioning strategies are not actively targeting those areas with the greatest need. Data suggests a potential cyclical relationship between lack of funding and/or targeted commissioning, limitations to provision and the recurring theme of peer support being perceived as something predominantly by – and for – white, middle class women which, in some cases, is observed as a barrier to more equitable support and the resulting benefits.

How does the description of provision align with policy priorities and guidance?

This research supports previous findings on the value of BFPS to those accessing it, as a source of reassurance and non-judgemental support, as well as practical advice (Thomson et al. 2011). Infant Feeding Coordinators, service users and peer supporters all acknowledged the importance of the peer support service and report valuing its role in providing both social value and direct breastfeeding support to women and also in the wider normalisation of breastfeeding, which is seen

as particularly valuable in areas with low breastfeeding rates. However, this is not reflected in the perceived value of peer support at policy and strategic levels. Within National Institute of Health and Clinical Excellence (NICE) guidance on maternal and child nutrition (NICE, 2008), it is noted that peer supporters should have attended accredited training, with evidence suggesting that accredited training is effective in increasing knowledge and skills among peer supporters (Kempenaar & Darwent, 2011). Access to full-length, accredited training was inconsistent and, in some areas, impacted by changes to service funding and transfer of responsibility for service delivery to other health professionals. Consistent access to standardised training can act as a basis for providing consistent levels of BFPS services across all regions, supporting equity of access for service users and, potentially, reducing the sense of “postcode lottery” expressed here.

NICE guidance also recommends contact with new mothers within 48 hours of giving birth and that peer support should be able to offer flexible services at times and locations to meet need, including in both hospital and community settings. This research suggests that these best practice goals are frequently not being met, with limited peer support reported to be operating within hospital settings in England (and none in Wales) and, for community-based provision, continued issues of stable provision of community venues.

This study highlights barriers to equity of access to peer support, including lack of different types of support, a reliance on community groups with issues around consistent access to suitable locations for group sessions as well as limited weekend and evening provision. Data suggests that areas where funding has been maintained or increased for BFPS over time have been better able to provide consistent services, both within community-based groups and in hospital settings. Several peer supporters stated that hospital provision was significant in reaching those who may be more marginalised, and those service users who had experienced peer support within hospitals strongly valued the immediacy of this, however in most areas it was unavailable. Previous research suggests that, due to pressures on healthcare workers within hospital settings, breastfeeding advice may be limited (Wade et al. 2009), and that trained peer supporters on site may be able to provide more dedicated time and support. Inconsistent access to in-hospital support risks early disengagement where advice on breastfeeding may not be available, as well as the potential for widening existing inequities where funding for consistent BFPS in a range of settings is unavailable.

In Wales, the All-Wales Breastfeeding Plan 2019-2024 recommends that BFPS is a part of a co-ordinated, multi-faceted model of NHS provision, however this commitment is challenged by the absence of stable funding identified in this research. Although breastfeeding support is still being provided, including by health visitors and midwives in some cases, there is a strong reliance on

voluntary support with minimal reimbursement. The peer to peer benefits cited by service users, along with the advantages of community-based delivery close to where people live, risk being lost in Wales. The perception of peer support as an undervalued service is likely to persist unless a clear funding pathway, with dedicated allocation of spending, is identified.

Along with this policy-level commitment in Wales, in the 2021 Budget and Spending review for England, ([Budget and Spending Review – October 2021: What you need to know - GOV.UK \(www.gov.uk\)](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/97421/budget-and-spending-review-october-2021-what-you-need-to-know.pdf)) new funding was announced, including a commitment of £302 million for new parenting support, including the provision of bespoke breastfeeding services and parent-infant mental support, and funding to rollout Family Hubs across England. While detail is not yet forthcoming on the breakdown of this funding and any dedicated allocation for BFPS, it is important to consider how any additional funds may maximise BFPS service delivery. This report now concludes with recommendations for BFPS delivery based on study findings.

Consideration should be given to practical issues of access when selecting settings for group session, as well as – where possible – maintaining services in the same settings to increase community familiarity with the service. Increasing diversity among peer supporters would also aid in challenging the view that the service is more suited for some women than others. Consultation should be carried out with existing community groups on how to increase recruitment and access to BFPS (Hunt et al. 2021). Funding for proactive peer support work and peer supporter training in accessible, community-based locations would also contribute to this. This should include resourcing for training, supervision and, in Wales, support for volunteers.

Increasing awareness of what peer support can offer among health professionals and publicising referral pathways into peer support services would aid in increasing access for those who would benefit. Consideration should be given to how the peer support service can be consistently promoted to new parents, including the timing and location of this promotion to avoid being lost in an overwhelming amount of information.

This research further supports findings on the value of embedding peer support within existing health services (Hunt et al. 2021) as part of an overall strategic approach to improving breastfeeding experiences. This should include funding for contacting women in hospital settings, pro-active support as indicated in NICE guidance, as well as providing group support in community venues. To ensure consistency of practice, clear policy commitment to increasing both provision of, and access to, support within relevant breastfeeding strategies is recommended.

There is a strong sense within this report that BFPS is seen by those providing and using the service as under-resourced and under-valued despite the potential gains in engagement, practical support – including supporting burdens on statutory services – and normalisation of breastfeeding within society. These added-value outcomes, coupled with the cost-effectiveness of BFPS as an intervention (Battersby et al. 2013), suggest that investment in the BFPS system would be beneficial. The newly-announced spending commitments in this area represent an opportunity to do this.

Strengths and Limitations

This mixed methods research draws on a wide range of data sources to present a rich and detailed picture of the current context of breastfeeding peer support services in England and Wales. The response rate to submitted Freedom of Information requests and the insights from the data suggest that this is a feasible, and cost-effective, method of assessing changes in service delivery and commissioning over time. However, a key limitation of this data is lack of specific information available on provision of breastfeeding support within wider contracts for Health Visiting services and additional means of obtaining this data should be explored. Here, FOI was effectively supplemented with the survey data, which provided quantifiable data on service changes as well as key insights on the impacts of these changes from the perspectives of Infant Feeding Coordinators. The study benefitted from the earlier work (Grant et al., 2018) in the development of the original IFC survey tool which was adapted for use here. Due to the feasibility of these methods, it is recommended that similar funding reviews are conducted at future points to assess systemic changes.

For the qualitative components, as with similar qualitative work, the study does not make claims of representativeness in sampling, with stakeholder insights the key focus. As such, it is recommended that interviews with service users and providers in other areas are completed to assess similarities and differences to the themes identified here. As the IFC survey and qualitative interviews provide cross-sectional data, repeating this type of work with different groups over different time points will provide insights into any emerging changes and patterns in service delivery, use and changes.

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Appendices

Appendix 1 Financial data from those that reported budgets

	Total number of commissioned services who were able to provide budget figures separately for each year for the full contracted period (14-19)	Total number of commissioned services who were able to provide budget figures for the whole period (with contracts falling within the period)	Total provide budget for partial period	No budget data *	Number of budgets showing a) decrease over time b) increase c) no change d) fluctuation (increase and decreases over years)	Highest - lowest annual spend of latest year
London Boroughs (out of 13 that commissioned)	7	1	4	1	a) 3 b) 1 c) 7 d) 1	£380,000 - £40,000
Unitary authorities (out of 23)	11	8	0	4	a) 7 b) 4 c) 5 d) 3	£190,000 - £1,700 (training and supervision)
Metropolitan districts (out of 24)	12	5	5	2	a) 3 b) 2 c) 15 d) 2	£450,000 - £10,000
County Council (out of 12)	3	1	6	2)	a) 1 b) 0 c) 7 d) 2	£424,000 - £20,000
Borough Council (out of 1)		1			a) 0 b) 0 c) 1 d) 0	£7,500

CCG (out of 9)	3	4	1	1	a) 2 b) 0 c) 4 d)1 1 N/A (1 year funding)	£488,000 - £6,500
Wales Health Boards	2		0		1 increased 1 no change	£93,771 - £20,000

*Varied reasons provided for no budget data examples include: subcontracted to another provider/ commissioner changes – no records / not identified from wider contracts

Appendix 2 Infant Feeding Coordinator Survey

Page 1 (All to complete)

Q1

The Breastfeeding Network (BfN) have commissioned this research, led by Heather Trickey (Cardiff University) and Anthea Tennant-Eyles (BfN). This survey and your responses will support mapping of current breastfeeding peer support provision across England and Wales to identify changes in its provision in the past 4 years. This is why some questions explore changes in peer support availability since 2015

- o I understand and agree that The Breastfeeding Network/ Cardiff University will collect your responses and analyse and report on the data as part of a wider research project.
- o I understand and agree that we will use your data to understand and map current provision across England and Wales by local authority / health board. While you will not be named in any outputs from this research it will be possible for readers of the research to compare from locality to locality.
- o I understand that the answers to I give to more general questions about the value of peer support and about the effectiveness of commissioned services will be anonymised and care will be taken to ensure that I cannot be identified in relation to these questions.

Q2 Are you the main person that supports/coordinates Infant Feeding (IF) across your area?

Yes/no

If NO, please pass on to main person supporting IF in your area. Thank you for your help.

If YES, please provide contact details if you are happy for us to contact you to further discuss breastfeeding support in your area after you have completed this survey.

Q3 What country do you work in England / Wales

Q4 Page 2 - Which NHS or LA area do you cover?

Q5 Page 3 - Which Wales health boards

Page 4 (All to complete)

Q6 Roughly, how many births per year occur in your area?

Q7 How long have you been in your infant feeding post?

Q8 Do you have a specific Infant Feeding Coordinator job description outlining responsibility for infant feeding developments / Baby Friendly Initiative (BFI) activities in your area?

Yes/no/ please give job title that oversees IF support in your area

Q9 Is the Infant Feeding Coordinator role in your area full time?

Yes

No, (If no, please state % full time equivalent or hours per week)

Q10 Do you perform this role as part of a job share? **Yes/no/NA**

Q11 Does anyone else currently support your Infant Feeding role?

Yes/no/If yes please give details:

Q12 What are your roles and responsibilities? - tick all that apply

Training and Development – Health professionals

Training and Development – Peer Supporters

Coordinate BFI activities

Infant feeding policies and processes (create/update)

Healthy weight lead

Smoking cessation

Other please specify

Q13 Was there an Infant Feeding Co-ordinator/specialist role before 2015? (This follows a previous study from a IFC survey in 2015) **Yes/no/don't know**

Q14 Have the IFC roles and responsibilities changed over time? -

Roughly the same

More responsibilities – non-breastfeeding related

More responsibilities – breastfeeding related

Less responsibilities

Other comment on how the role has changed?

Q15 What national and international guidance currently supports you in your role as Infant Feeding Coordinator

Q16 Is there a commissioned breastfeeding peer support service in your area now?

If YES commissioned peer support service – page 5

Q17 Was there a commissioned/funded peer support service in 2015? **Yes/no /don't know**

Q18 - In the period 2015-2019, my area has seen:

an increase in availability of commissioned peer support

a decrease in availability of commissioned peer support

the level of commissioned peer support has remained about the same.

Don't know

Q19 What has been the biggest effect of this change?

Q20 Who commissions/funds the current service?

LA/Health board/NHS/CCG/Third sector/grant funding e.g. lottery/ and other box

Q21 Who has the responsibility of managing or supporting local peer supporters?

Commissioned service/IFC/HV/MW/Mix of the above/Nobody/Don't know/other please specify

Q22 Thinking about any COMMISSIONED peer support service in area, are the following statements true or false:

Response choices: True / false / don't know

The commissioned peer supporter training courses are externally accredited
(peer supporters gain an officially recognised, regulated qualification)

Peer supporter recruitment and training via the commissioned service occurs at least once every year

The commissioned service provides reflective and ongoing learning sessions for peer supporters

The commissioned peer support service works in line with Baby Friendly Guidance

All peer supporters have safeguarding training

Q23 Thinking about the FUNCTION of commissioned breastfeeding peer support service in your area, are the following statements about the service that is provided true or false

Response choices: True / false / don't know

The commissioned peer support service provides antenatal education about feeding (either group-based or one-to-one)

The commissioned peer support service provides support on the maternity ward

The commissioned peer support service proactively contacts women in the immediate postnatal period (e.g. within 48 hours of discharge from hospital)

The commissioned peer support service provides support in group-based community settings

The commissioned peer support service provides postnatal telephone support

The commissioned peer support service provides one-to-one support in women's own homes (home visits)

The commissioned peer support service accepts referrals from other services (e.g. health teams)

The commissioned service signposts/refers mothers into other services

Q24 Thinking about the INTEGRATION of the commissioned peer support service in your area, please say how strongly you agree/disagree with the following statements:

Response choices: strongly agree/agree/neither agree nor disagree/disagree/strongly disagree

There are significant barriers to integration of the commissioned peer support service with health care systems, settings or policies

Is there anything else you would like to add about integration? Please expand on your answers here

Q25 Thinking about HEALTH PROFESSIONALS EXPERIENCE of peer support in this area, please say how strongly you agree or disagree with the following statements

Health professionals value commissioned peer support as a form of social support for new parents

Health professionals feel confident to refer women experiencing more challenging feeding issues, to the commissioned peer support service

Peer support complements the work of health professionals in their breastfeeding support role

Peer supporters tend to have more time to spend with mothers than health professionals

The commissioned peer support service often provides help for feeding that is as good as or better the support that health professionals provide

Q26 Thinking about the REACH of the commissioned peer support service in this locality, please say how strongly you agree/disagree with the following statements

The commissioned service tends to focus on areas with low breastfeeding rates

The commissioned service tends to focus on areas with high levels of deprivation

The commissioned peer support service is effective in reaching the women who most need help

Women living in areas with low breastfeeding rates have a good level of access to commissioned peer support

Local women/families proactively access the breastfeeding peer support service

The peer support service proactively contacts and offers breastfeeding support to local women/families

Is there anything else you would like to add about the reach of peer support service? Please expand your answers here:

Q27 How many peer supporters are currently trained each year? Please state general changes since 2015 (e.g. increased/decreased/same)

Q28 How many breastfeeding groups currently run per week? Please state any changes since 2015 (e.g. increased/decreased/same)

Q29 Please describe why your groups are located where they are? **Open text box**

Q30 In areas with high levels of deprivation, are peer support services:

well accessed/ somewhat accessed/not well accessed/not accessed at all/do not have access to this info/do not collect this info/other – please expand below

Other comments about access to peer support: open text box

Q31 In areas with lower breastfeeding rates, are peer support services

well accessed/ somewhat accessed/not well accessed/not accessed at all/do not have access to this info/do not collect this info/other – please expand below

Other comments about access to peer support: open text box

Q32 What purpose/role do you view the commissioned peer support service in your area. Please tick all that apply:

Social engagement - opportunities for local breastfeeding mothers to meet

Normalises breastfeeding in the community

Supports breastfeeding in public

Reaching mothers to support engagement with statutory services

Providing emotional and practical support (P&A and hand expressing) – lay

Providing emotional and practical support (P&A and hand expressing) – trained

Complements the work of health professionals in their breastfeeding support role

Other please specify

Q33 Do peer supporters offer specialist / skilled breastfeeding support to mothers with more complex cases (e.g. mastitis / thrush / tongue-tie)

Yes most/yes some/no but being trained to/no

Q34 Does the peer support service provide reports to the commissioner?

Yes regularly/yes sometimes/don't know/no/further comments on commissioner reports:

Q35 Does the peer support service collect feedback from service-users?

Yes regularly/yes sometimes/don't know/no

If yes, how is this used/evaluated?

Q36 Does the peer support service collect feedback from health professionals and other relevant services?

Yes/no/don't know/If yes, how is this used/evaluated?

Q37 Is there anything else you would like to add about feedback from service users and/or health professionals?

Q38 Is there anything else you want us to know about commissioned breastfeeding peer support service in your area? **Open text**

END OF SURVEY

If NO commissioned peer support service (page 6)

Q39 Was there a commissioned/funded peer support service in 2015? **Yes/no /don't know**

Q40 If yes, what has been the biggest effect of this change e.g. on peer supporters/health teams/local mothers? **Comment box**

Q41 Are there peer supporters offering breastfeeding support, on a voluntary basis, in your area?

Yes/no /don't know

If YES peer supporters in area (page 7)

Q42 Is there a financial contribution made to breastfeeding peer support?

Yes fully/yes partly/don't know/not at all

Q43 Since 2015 has the financial contribution:

increased/decreased/stayed the same/N/A

Q44 What has been the biggest effect of this change e.g... on peer supporters, health teams, local mothers – **open text box**

Q45 Have the peer supporters in your area undergone accredited training as peer supporters?

Yes all of them / mix accredited/non accredited/ no- undergone training but not accredited/no training provided at all/currently undergoing accredited training/don't know - Anything else you want to say about training background? Comment box

Q46 How have the peer supporters been trained – tick all that apply

ABM mother supporter/ABM counsellor/BfN Helper course/BfN Supporter course/LLL/NCT peer supporter/NCT counsellor/in house training health board/NHS/IFC based on Agored course /in house training NHS/Health board/IFC - other please specific/don't know

Q47 What purpose/role do you view peer support as having in your area.

Please tick all that apply:

Social engagement - opportunities for local breastfeeding mothers to meet

Normalises breastfeeding in the community

Supports breastfeeding in public

Reaching mothers to support engagement with statutory and other local services

Providing emotional and practical support (P&A and hand expressing) – lay / trained

Provides skilled/specialist breastfeeding support

Complements the work of health professionals in their breastfeeding support role

Q48 Who has the main responsibility of managing or supporting Peer supporters?

IFC/Midwifery/Health visiting/other health prof/third sector/nobody/don't know/other please specify

Q49 Please rate the following statements:

Response choices: yes agree / yes to some extent / don't know / no but plan to / no disagree

In my area peer supporters receive regular reflective / ongoing learning sessions

In my area peer supporters have undertaken safeguarding training

In my area peer support is well integrated with health teams

In my area health teams signpost mothers to access peer support

In my area there is good peer supporter provision

In my area I would like more peer supporter provision

In my area peer support is accessed by mothers from areas of deprivation

In my area peer support is accessed by mothers from areas with low breastfeeding rates

In my area we have a clear referral pathway for mothers to access specialist support

Please provide any further comments on the above:

Q50 Who provides specialist breastfeeding support in your area for complex breastfeeding issues? Please tick all that apply:

Breastfeeding peer supporters / lactation consultants / health professional in hospital / health professionals in community / no specialist support in area / other: please specify

Q51 Is feedback collected from service-users about peer support in your area?

Yes regularly/yes sometimes/don't know/no/if yes how is service user feedback used/evaluated:

Q52 Do peer supporters provide any feedback / reports to you or local health teams? **Yes/no/don't know/** Further thoughts/comments on feedback to you/ health teams:

Q53 Are there any breastfeeding peer support groups in your area **yes/no/don't know**

If YES breastfeeding groups in area:

Q60 How the number of groups changed since 2015? Increased/decreased/stayed the same

Q61 How are the groups delivered please tick all that apply.

peer supporters only/peer and health professionals/health visitors/midwives/flying start or children's centres/lactation consultants/mix of peers, health teams, lactation consultants/other please specify.

Q62 Are breastfeeding groups located in areas with low breastfeeding rates?

Yes all/ yes some//no/don't know/NA

Q63 Please describe why the groups are located where they are: **comment box**

Q64 Who organises the delivery of groups – **list of options**

Q65 What other activities are peer supporters engaged in?

breastfeeding groups in hospital/postnatal ward/antenatal in hospital/community/home visits/telephone/targeted support via referrals/other please specify

Q66 Is there anything else you want us to know about breastfeeding peer support in your area?

END OF SURVEY

If NO/don't know groups in area:

Q67 What other activities are peer supporters in your area engaged in? Please tick all that apply

Q68 Who provides access to specialist breastfeeding support in your area for complex breastfeeding issues? **Peer supporters/lactation consultants/health professionals in hospital and community/No specialist support in area/other please specify**

Q69 Is there anything else you want us to know about breastfeeding peer support in your area?

END OF SURVEY

If No peer supporters in area:

Q54 Would you like to establish peer supporters in your area? **Yes/no/not sure**

Q55 What barriers do you face in establishing peer support? Please tick all that apply

Financial/time/attitudes and perspectives of commissioners/attitudes and perspectives of health teams/please expand on your answers if you wish.

Q56 What evidence base / guidance would you use to support a case for establishing peer support?

Is there any guidance which may be helpful for you to support a case for peer support?

Q57 Can mothers access breastfeeding support in your area?

Yes / no - If yes, where / how they can access support?

Q58 Who provides access to specialist breastfeeding support in your area for complex breastfeeding issues?
Please tick all that apply

lactation consultants / health professional in hospital / health professionals in community / no specialist support in area / any further comments – open text

Q59 Is there anything else you want tell us about breastfeeding peer support in your area?

END OF SURVEY

Appendix 3 Sample combined IFC survey responses for England and Wales (areas reporting no commissioned BFPS services).

Please rate the following statements:

		YES, AGREE	YES, TO SOME EXTENT	DON'T KNOW	NO, NOT YET	NO, DISAGREE
In my area peer supporters receive regular reflective / ongoing learning sessions	Wales	0.00% 0	16.67% 1	16.67% 1	33.33% 2	33.33% 2
	England	16.67% 2	33.33% 4	25.00% 3	16.67% 2	8.33% 1

		YES, AGREE	YES, TO SOME EXTENT	DON'T KNOW	NO, NOT YET	NO, DISAGREE
In my area peer supporters have undertaken safeguarding training	Wales	0.00% 0	33.33% 2	33.33% 2	16.67% 1	16.67% 1
	England	33.33% 4	33.33% 4	16.67% 2	8.33% 1	8.33% 1

		YES, AGREE	YES, TO SOME EXTENT	DON'T KNOW	NO, NOT YET	NO, DISAGREE
In my area peer support is well integrated with health teams	Wales	0.00% 0	33.33% 2	16.67% 1	16.67% 1	33.33% 2
	England	16.67% 2	0.00% 0	16.67% 2	50.00% 6	16.67% 2

		YES, AGREE	YES, TO SOME EXTENT	DON'T KNOW	NO, NOT YET	NO, DISAGREE
In my area health teams signpost	Wales	16.67% 1	66.67% 4	16.67% 1	0.00% 0	0.00% 0

mothers to access peer support	England	25.00% 3	50.00% 6	16.67% 2	8.33% 1	0.00% 0
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		YES, AGREE	YES, TO SOME EXTENT	DON'T KNOW	NO, NOT YET	NO, DISAGREE
In my area there is good peer supporter provision	Wales	0.00% 0	33.33% 2	16.67% 1	16.67% 1	33.33% 2
	England	16.67% 2	33.33% 4	16.67% 2	16.67% 2	16.67% 2

		YES, AGREE	YES, TO SOME EXTENT	DON'T KNOW	NO, NOT YET	NO, DISAGREE
In my area I would like more peer supporter provision	Wales	66.67% 4	0.00% 0	33.33% 2	0.00% 0	0.00% 0
	England	75.00% 9	16.67% 2	0.00% 0	8.33% 1	0.00% 0

		YES, AGREE	YES, TO SOME EXTENT	DON'T KNOW	NO, NOT YET	NO, DISAGREE
In my area peer support is accessed by mothers from areas of deprivation	Wales	0.00% 0	33.33% 2	16.67% 1	16.67% 1	33.33% 2
	England	0.00% 0	27.27% 3	18.18% 2	45.45% 5	9.09% 1

		YES, AGREE	YES, TO SOME EXTENT	DON'T KNOW	NO, NOT YET	NO, DISAGREE
In my area peer support is accessed by mothers from areas with low breastfeeding rates	Wales	0.00% 0	33.33% 2	16.67% 1	16.67% 1	33.33% 2
	England	0.00% 0	27.27% 3	27.27% 3	27.27% 3	18.18% 2

		YES, AGREE	YES, TO SOME EXTENT	DON'T KNOW	NO, NOT YET	NO, DISAGREE
In my area we have a clear referral pathway for mothers to access specialist support	Wales	66.67% 4	16.67% 1	0.00% 0	0.00% 0	16.67% 1
	England	50.00% 6	8.33% 1	8.33% 1	8.33% 1	25.00% 3

Appendix 4 Sample IFC survey responses (areas reporting commissioned BFPS services)

Thinking about any COMMISSIONED peer support service in area, are the following statements provided true or false:	True	False	Don't know
The commissioned peer supporter training courses are externally accredited (peer supporters gain an officially recognised, regulated qualification)	53.33%	30%	16.67%
Peer supporter recruitment and training via the commissioned service occurs at least once every year	79.31%	10.34%	10.34%
The commissioned service provides reflective and ongoing learning sessions for peer supporters	76.67%	13.33%	10.00%
The commissioned peer support service works in line with Baby Friendly Guidance	93.10%	0%	6.9%
All peer supporters have safeguarding training	53.33%	30%	16.67%

Thinking about the FUNCTION of commissioned breastfeeding peer support service in your area, are the following statements about the service that is provided true or false	True	False	Don't know
The commissioned peer support service provides antenatal education about feeding (either group-based or one-to-one)	53.33%	36.67%	10%
The commissioned peer support service provides support on the maternity ward	56.67% True	36.67%	6.67%
The commissioned peer support service proactively contacts women in the immediate postnatal period (e.g. within 48 hours of discharge from hospital)	43.33% True	50.00%	6.67%
The commissioned peer support service provides support in group-based community settings	86.67%	6.67%	6.67%
The commissioned peer support service provides postnatal telephone support	46.67%	43.33%	10%
The commissioned peer support service provides one-to-one support in women's own homes (home visits)	33.33%	60%	6.67%
The commissioned peer support service accepts referrals from other services (e.g. health teams)	46.67%	40%	13.33%
The commissioned service signposts/refers mothers into other services	80.00%	10%	10%

Thinking about the INTEGRATION of the commissioned peer support service in your area, please say how strongly you agree/disagree with the following statements:	strongly agree	agree	agree nor disagree	disagree	strongly disagree

There are significant barriers to integration of the commissioned peer support service with health care systems, settings or policies	13.33% 4	13.33% 4	23.33% 7	30.00% 9	20.00% 6
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Thinking about HEALTH PROFESSIONALS EXPERIENCE of peer support in this area, please say how strongly you agree or disagree with the following statements	strongly agree	agree	agree nor disagree	disagree	strongly disagree
Health professionals value commissioned peer support as a form of social support for new parents	70.00% 21	20.00% 6	3.33% 1	3.33% 1	3.33% 1
Health professionals feel confident to refer difficult cases (women experiencing tricky feeding issues) to the commissioned peer support service	26.67% 8	23.33% 7	16.67% 5	23.33% 7	10.00% 3
Peer support complements the work of health professionals in their breastfeeding support role	70.00% 21	16.67% 5	6.67% 2	3.33% 1	3.33% 1
Peer supporters tend to have more time to spend with mothers than health professionals	73.33% 22	20.00% 6	6.67% 2	0.00% 0	0.00% 0
The commissioned peer support service often provides help for feeding that is as good as, or better than, the support that health professionals provide	26.67% 8	23.33% 7	46.67% 14	3.33% 1	0.00% 0

Thinking about the REACH of the commissioned peer support service in this locality, please say how strongly you agree/disagree with the following statements	strongly agree	agree	agree nor disagree	disagree	strongly disagree
Commissioning of peer support tends to focus on areas with low breastfeeding rates	6.67% 2	6.67% 2	36.67% 11	33.33% 10	16.67% 5
Commissioning of peer support tends to focus on areas with high levels of deprivation	6.67% 2	10.00% 3	40.00% 12	23.33% 7	20.00% 6
The commissioned peer support service is effective in reaching the women/families who most need help	16.67% 5	26.67% 8	33.33% 10	13.33% 4	10.00% 3
Women living in areas with low breastfeeding rates have a good level of access to commissioned peer support	27.59% 8	24.14% 7	27.59% 8	13.79% 4	6.90% 2

Local women/families proactively access the breastfeeding peer support service	34.48% 10	37.93% 11	10.34% 3	10.34% 3	6.90% 2
The peer support service proactively offers breastfeeding peer support to local women/families	53.33% 16	26.67% 8	10.00% 3	0.00% 0	10.00% 3