Peer Support/Self-Help in Maternal, Newborn and Family Health: 
Highlights from the Literature

Introduction
The following provides an overview of the literature on peer support/self-help within the context of maternal, newborn and family health. It is not a comprehensive literature review but rather is intended to provide those working in the field with a snapshot of the research highlights on a range of topical areas within the maternal, child and family health fields as they relate to peer support/self-help.

Social Support and Health
There has been an ever-increasing body of research across a wide range of disciplines exploring the importance of social relationships in the promotion of health and wellness and prevention of disease (Cohen, 2000). This work builds on the pioneering ideas of researchers such as Cassel (1974), Caplan (1974), and Cobb (1976) all of whom emphasized the importance of social support as a buffer against stress and essential for enhancing health and wellness. Cobb’s definition of social support as information leading a subject to believe that he or she is cared for, loved, esteemed and valued, and that he or she belongs to a network of communication and obligation (1976), is still one of the most widely accepted (Ellison, 1987). Research has also indicated that perceived support may have a stronger influence on specific health outcomes than actual, enacted support (Wethington & Kessler, 1986) and that it may be the quality of social interactions and supports as opposed to the quantity that is most strongly linked with positive health outcomes (Israel, 1985, Dennis et al, 2003).

That social support impacts on health status and behaviour is reflected in recent trends in health care focusing on health promotion and prevention, which often emphasize the development of supportive relationships within interpersonal networks (Stewart and Tilden, 1995). The World Health Organization has identified the strengthening of social relationships as a health promotion strategy (1998). In 1986, Health Canada released Achieving Health for All, which identified three mechanisms intrinsic to health promotion. These mechanisms were self-care, healthy environments, and "mutual aid, or the actions people take to help each other cope" (Epp, 1986, p.2). The Ottawa Charter for Health Promotion similarly stated that health promotion action involves the creation of supportive environments, "The overall guiding principle for the world, nations, regions and communities alike is the need to encourage reciprocal maintenance-to take care of each other.." (Ottawa Charter, 1986).

Dunst, Trivette and Deal (1986) have described the significance of informal support networks in the context of supporting families in the following way:

There is one major and consistent finding from the available social support research, regardless of the population that is studied.
Informal support from personal support networks has powerful stress-buffering and health promoting influences. The effects of informal support are generally greater than that attributable to formal support services. In our own research, the effects of informal support are so great that these influences cannot be ignored as a major form of intervention. Indeed, we should go so far as to say that, to the extent possible, family needs should be met by promoting the use of informal rather than formal support services (p.32).

Due to recent trends in the shift of health care delivery to the community, and demographic changes, there has been an increased emphasis on the centrality of social networks in meeting health care and social support needs of individuals (Stewart and Tilden 1995). As a form of social support, peer support and self-help groups or interventions are considered one aspect of a social support/social network and have received increasing attention as an effective, inexpensive and health promoting strategy (Henderson, 1998).

Definitions of Peer Support

Dennis (2003), in her in-depth examination of the types or attributes of peer support as it occurs in the health context, concludes that peer support interventions offer three general types of support: informational, appraisal (affirmation), and emotional. To a lesser extent there are also examples in the literature on peer support of those offering practical or instrumental support (e.g. respite child care for parents of multiple newborns, assistance with household chores for the new parent etc.). The review also describes the various ways that peer support is structured or delivered: (through individual one-to-one settings, telephone support, self-help/support groups, on-line computer-mediated groups, or within educational programs), in settings for delivery (e.g. home, hospital, community organization, school, via telephone/computer etc.), through various providers (community groups/organizations, public health units, volunteer organizations, hospital settings etc.), in various possible provider roles (e.g. volunteer, peer educator, professional facilitator, home visitor, health worker, leader, counselor, advocate), with varying degrees of involvement or structure (informal to formal) and on various topics (general to specific). (Dennis, 2003). Regardless of the variations in applications of peer support strategies, the literature typically describes some common attributes or characteristics of peer support.

Peer support is thought to provide emotional or self-esteem support which involves interactions that include expressions of caring, encouragement, attentive listening, validation, reflection etc. (Helgenson and Gottlieb, 2000), which can lead to feelings of being accepted, cared for, admired, empathized, respected and valued even when experiencing challenges i.e. empowerment (Cobb, 1976, Cronenwett 1980, and Shinar, 1999). Peer support can also be provided in the form of informational assistance (Wills and Shinar, 2000) or affirmational support such as motivation to continue despite challenges or help in enduring frustration (Wills 1985).
Peer support is often distinguished from professional support in that peers are viewed as providing role-modelling and credible, accessible, non-threatening, shared support that takes into account the broader context of the whole lives of those involved (Cox, 1993).

There are debates about the relative benefits of “professional” versus “peer” support especially for women who are socially disadvantaged. Social support from a woman with similar socio-economic and ethno-cultural backgrounds who is experiencing similar stressors may be very different from support from a health professional who does not share the same experience, knowledge or concerns (Hodnett and Fredericks, 2003).

It is also important to note that some authors discuss some potentially negative aspects of peer support, for example it can be exploitative if it is used to download work to already overburdened individuals (usually women) in the name of cost-effectiveness. It should rather come out of an actual stated need in the community. Henderson (1995) expresses concern that although peer support as a form of social support is often viewed as relatively harm free, inexpensive and effective, it is important for there to be reciprocity in the giver/receiver supportive relationship (both parties need to have their needs met). The needs of the receiver are relatively clear but the needs of the giver are not as universally recognized.

Due to the variability of how peer support/self help interventions in the pre-postnatal periods are applied, and the lack of uniformity in how peer support is defined in the literature, it is difficult to interpret and compare studies. The following studies highlighted therefore provide an overview of the range of available types of support (e.g. telephone vs. support group) and those with differing structures (e.g. member-led vs. professionally led). A section on lay home visiting programs that use “paraprofessionals” is included. Paraprofessionals are typically peers that are paid, although there is some debate over whether paraprofessionals continue to be “peers” when they undergo training, supervision and receive a salary for their work (Eng and Smith, 1995). The available literature on peer support tends to focus on some topics (e.g. breastfeeding and postpartum depression) more than others.

**Search Strategy**
The following databases were searched: Medline from January 1980 to March 2004; Cinahl from January 1980 to March 2004; Embase from January 1980 to March 2004; PsychINFO from January 1980 to March 2004 and the Cochrane Library. The occasional article that was dated before 1980 but was given special attention by a number of authors was included, and 84 articles were reviewed in total. The MeSh headings or search terms used were: peer support, peer education, peer counseling and self-help groups which were combined with the following terms: prenatal care, pregnancy, childbirth, postnatal period, postpartum period, breastfeeding, postpartum depression, postnatal depression, parenting. The terms home visiting and lay home visiting were also used. Searches were also done on first authors where particularly relevant.
Prenatal period

In their review of the literature on the use of peer interventions to enhance prenatal care among low-income women, Lapierre et al (1995) concluded that in response to the challenges of engaging low-income women in prenatal care, that well-structured prenatal peer counseling (involving training and supervision of volunteers) should be considered as a complimentary strategy to professional prenatal programs. Heins et al (1987), similarly found that social support given by mothers in the community to pregnant adolescents positively affected access to prenatal services and led to greater birthweight and increased gestational age. Clark also discussed the benefits of a peer support program involving young mothers providing support to young pregnant women in a clinical setting (Clark, 2000). In a study that looked at outcomes of a peer counseling program for low-income mothers by Gagne et al (1991), results indicated that bonding among the volunteer mothers and the pregnant women diminished isolation, fostered solidarity and enhanced cooperation. Another study by Crockenberg (1986) found that 75% of the adolescents in the study (most who were living in poverty) preferred prenatal counseling that was offered by their peers in the community, as opposed to professionally-based counseling. A study by Mahon et al (1991) found that more than 2000 Hispanic women at risk for not accessing early prenatal care were reached by volunteer mothers in a community partnership program and therefore had benefited from adequate prenatal supervision. In findings from an evaluation of a prenatal program for Hispanic migrant farmworker families using peer health workers, the authors concluded that the program was appropriate and successful for the participants and their families who reported easier labours, greater feeling of well-being and a sense of feeling cared for and encouraged by those providing the peer support (Warrick et al, 1992).

Some authors have recommended the use of a peer support “Mentor Mothers” intervention as a potential strategy to prevent abuse during pregnancy (McFarlane & Wiist, 1997), to prevent postnatal depression (Elliott et al, 1988), and to provide positive outcomes for drug-dependent pregnant women (Svikis, 1998). Maloni and Kutil (2000), concluded that unstructured support group that provides pregnant women on hospital bed rest with an opportunity to talk in a confidential and supportive environment may be an important postpartum intervention for helping women cope under these circumstances.

Childbirth

Historically and cross-culturally women have been supported by other women during labour and birth, however the majority of women now give birth without that continuous support from someone whose sole purpose is to attend to her in labour. There has been recent concern about the need to provide this constant one-to-one support for labouring women in the form of emotional, informational, practical and advocacy support (Klaus, 2002). Evidence shows that not only does continuous labour support appear to reduce the likelihood of operative birth (e.g. c-sections) and subsequent complications, enhance women’s feelings of control and satisfaction with their childbirth experiences (Hodnett, 2002a), but that in fact these effects seem to vary by type of provider. These positive effects on birth outcomes were more prevalent for non-professional (or staff) providers of the labour support (Hodnett et al, 2003, Scott et al, 1999, Madi et al, 1999). More research is needed into examining the reasons for this discrepancy and into the nature of informal labour support (e.g. is this type of support more effective when those providing
the support are paid or unpaid, trained or untrained, a member of the woman’s personal support network or not etc.). Lipson (1982) found that support groups for women who had experienced cesarean birth, especially when unexpected, play an important role in the prevention of emotional distress by facilitating the resolution of the birth experiences and allowing women to plan and prepare for more positive birth experiences in the future.

Parenting
Since the first mention in the North American literature of peer or lay support programs for parents in the postpartum period (Cronenwett, 1976), it has been acknowledged on a theoretical and practical level that informal social support during the postpartum and early parenting period can greatly lessen the stress of adjusting to a new baby and assuming the parent role, especially given trends such as increasing family mobility and lack of extended family networks. Some authors have pointed out that the transition to new parenthood is a stressful time as parents learn to care for their infant and negotiate their new roles (Mercer, 1995, Barclay et al, 1997, McVeigh, 2000 and Rogan 1997), and that when families do not have adequate supports at home and in the community, there may be negative outcomes in the short or long-term for the mother, child and family (Hanna 2002).

There is some evidence that parenting programs including professionally-facilitated peer support groups for new parents are highly beneficial at enhancing social support during this transition (Scott et al., 2001, Hanna et al., 2002, Barlow and Coren 2001, Sanderson and Curry, 1996) and are therefore a useful primary prevention strategy. There are different types of peer support groups; those that are member-led, self-help groups, professionally-led groups with more of an “educational” focus, structured, time-limited groups and unstructured, drop-in support programs that provide participants with informal opportunities to connect with one another. The term “support group” has been used to indicate that the group offers mutual support and not therapy or counseling (Kurtz, 1997).

These groups are perceived as providing parents with a way to dissipate the stress of the early parenting period and to help them in developing parenting skills, social networks, and confidence in their abilities. They can also help meet the gap that exists for new parents that are isolated and without personal support networks and/or do not have previous experience with, information about or skills in parenting (Hanna et al, 2002).

One author of a study on long-term benefits of first time parent support groups in the state of Victoria in Australia, concluded that the majority of the new parent groups (attended by 75% of new parents throughout the State), evolved into on-going self-sustaining social networks that lasted well beyond the time frame for the group, and sometimes for years (Scott et al., 2001). The authors noted that there is some evidence that this continuation of social support is more likely to continue if the group is facilitated in a way that creates an atmosphere of trust and builds a sense of group cohesion.
In their Cochrane Systematic review of parenting programs aimed at improving maternal psychosocial health, Barlow and Coren (2001), concluded that they can make a significant contribution to the short-term psychosocial health of mothers. They stressed the importance of the facilitator in establishing an atmosphere of trust and openness between the parents and to offer respect, support and understanding, in order to maintain the group. Other studies have reported the value of professionally-led parenting groups (Johnson et al., 2000, Clarke et al., 1995, Gordon et al, 1995 and Abriola 1990) and others have advocated for lay or member-led, self-help groups for new parents, which can lead participants to have increased self-esteem, coping ability, competency in the parenting role and recognition of the normalcy of the parenting experience (Cronenwett, 1980).

Snyder (1988), discussed the benefits of peer support groups for “high-risk” parents who are experiencing unexpected crisis related to childbearing (e.g. c-section or the loss of an infant). Others have described benefits of peer support postpartum interventions involving telephone support (Gosha and Brucker, 1986, Creedy, & Dennis, 2003). There is also evidence that peer support for new fathers is beneficial and an area gaining increasing attention in the literature and in practice, in the form of professionally-led postpartum support groups (Taubenheim & Silbernagel, 1988), through the internet (Hudson et al., 2003) and as a way of supporting breastfeeding (Strewell and Lovera, 2004).

Peer support has also shown to be effective for parents with babies or children who have disabilities or special needs (Hartman et al, 1992). A cohort study of a hospital parent “buddy” program for mothers of very preterm infants found that support from individual, trained volunteers was found to be effective in helping mothers deal with the stress of having a preterm baby. The mothers in the study reported having less stress, state anxiety and depression that those in the control group (Preyde and Ardal 2003). In a previous study by the same authors on women’s perceptions of the peer support, the mothers reported that their interaction with their “buddy” helped to reduce their feelings of isolation, provided validation of their emotional experiences, provided understanding and helped to normalize the situation (Preyde et al, 2001).

Two earlier studies that evaluated a professionally-led peer support group (Minde et al, 1980), and individual peer support for parents while their infants were in the neonatal intensive care unit (Roman et al, 1995) also showed positive results of their respective peer interventions. There have also been studies that have looked at the benefits of mutual support groups for parents of children who have died (Schwab, 1995), for parents of high risk infants (Boukydis and Zachariah, 2000) and for parents of children with disabilities (Solomon, 2001, and Santelli et al, 1997).

In 1998 The Ministry of Health and Long-Term Care in Ontario launched the Healthy Babies, Healthy Children Program that is delivered by each of the province’s 37 health units. One aspect of the HBHC program involves training parents from the community to be “lay home visitors” who provide information and in-home support to parents and
families (with extra attention to those who are deemed “at risk”), with the aim of increasing parenting competence and promoting child health and development.

Despite the great discrepancies in variation between peer support interventions for parents in structure and function, a 1999 Ontario Public Health Branch review of the literature on peer and paraprofessional interventions for parents, concluded that programs using peers/paraprofessionals can have an impact on parent-child interaction and child development if they begin prenatally and are high in intensity (weekly or bi-weekly visits for at least a year) and if they are part of a larger program with multiple components and/or professional interventions. The authors noted that the evidence on the impact of such interventions on outcomes such as health care utilization, child health status, child behaviour, child abuse and neglect and maternal psychosocial health status is tentative, as few high quality studies have examined this relationship. It should be noted that most of the studies included in the review were targeted to high-risk populations so it is not clear how these strategies benefit the wider population. The authors also recommended that further research be conducted on impacts of peer/paraprofessional interventions on the above mentioned outcomes, and that there is a need for more qualitative research to contribute to an understanding of the relationship of peers/paraprofessionals with those they are supporting (Wade et al, 1999).

Cox (1993) described the two main “befriending” or peer support initiatives in the United Kingdom, which involve providing lay home support for mothers and children with significant psychosocial morbidity and concluded that these schemes when provided in compliment to professional services can improve the mental health of mothers and children.

Breastfeeding

Various peer support breastfeeding interventions have been shown to be effective in improving breastfeeding outcomes. Peer support has been identified in the literature as highly beneficial for prolonging exclusive breastfeeding especially amongst marginalized groups, as it is thought to involve shared cultural and socioeconomic characteristics and understanding of a communities health beliefs and barriers (Bronner, 2002). The well-established mother-to-mother peer support group model such as La Leche League have been shown to increase the duration of breastfeeding (Raj and Plitcha, 1998). Although La Leche League has spread throughout the world since 1956 when the first group began, the women that have joined the League have tended to be older, well-educated, higher-income, professional women. Therefore, many marginalized women especially low-income women and teenagers may not be able to identify with LLL support groups or leaders who they may not view as their “peers” (Lawrence, 2002).

A recent Cochrane systematic review of the literature support for breastfeeding mothers showed that there is substantial evidence that “lay” or peer support interventions do improve the exclusivity and duration of breastfeeding (Sikorski et al, 2002). However there are vast differences in the models of peer or lay support cited in the literature as
well as the different research methodologies used which makes it difficult to compare and assess the efficacy of such programs though they appear to be very promising.

Breastfeeding peer or lay support programs have increasingly been initiated throughout the world in order to increase breastfeeding duration and exclusivity within varying contexts and based on different models. These programs usually involve the recruitment and training of women in their local community who have experience breastfeeding and can provide practical and emotional assistance to new breastfeeding mothers. Many of these peer support interventions use either telephone or group based support.


In her randomized controlled trial on peer telephone breastfeeding support, Dennis (2002) found that mothers that received proactive telephone support from an experienced mother were two times more likely to continue to breastfeed for 3 months postpartum than mothers that did not receive this support. Mothers in the peer support group were also likely to be exclusively breastfeeding at 1 and 3 months postpartum and satisfied with their breastfeeding experience. The authors concluded that telephone-based peer support in conjunction with professional support and the influence of the Baby-Friendly Hospital Initiative might help new mothers to continue to breastfeed. They also noted that peer support resulted in mothers evaluating themselves and their breastfeeding experiences more positively, which led to higher maternal satisfaction with the infant feeding method. Another preliminary finding from this study suggests that peer volunteers may be an effective mediating link between mothers in the community (especially those that are socially disadvantaged) and health professionals.

Increasingly peer or lay breastfeeding programs have been initiated in community and hospital settings across Ontario.

**Postpartum depression (ppd)**

Peer support has been used to provide support and facilitate adjustment in women experiencing postpartum depression (ppd). Support group programs (primarily professionally facilitated), have been found to be effective in helping women cope with ppd (Jones 1995, Berchtold & Burrough, 1990, Eastwood et al, 1995, Foyster, 1995, Jones et al, 1995, Pitts, 1995, Olson et al, 1991, Milgrom, 1994 and Morgan et al, 1997) although the structure and methods of delivery of the interventions in these studies were varied.

* Note that recently the term postpartum mood disorders (ppmd) has replaced postpartum depression (ppd) because it encompasses a broader range of conditions and states. However, most literature still uses the term ppd.
Few controlled studies however have actually measured ppd parameters in women before and after participating in a support group or intervention. Findings from a randomized controlled trial in Taiwan assessing the effects of support group intervention on women with ppd found that there were significant psychosocial benefits for the group participants. Beneficial effects were noted in relation to depression, stress and perceptions of social support in participants (Chen, 2001). Based on a review of predictive studies Dennis (2003) found that the risk of ppd greatly increased when the following social deficiencies were present: not having someone to talk openly with who has shared and understood a similar problem and not receiving support without asking (Brugha et al, 1998), feeling socially isolated (Mills et al, 1995) and not having a friend or confidante to converse with (Paykel et al, 1980, Roman et al, 1993, Romito & Saurel-Cubizolles, 1999). Studies show that when women experience companionship and a sense of belonging to a group with similar attributes that this may protect against ppd (Cutrona, 1989) and women who have themselves experienced ppd have emphasized the importance of receiving support from other mothers (Munro, 2002 and Small et al, 1997).

The author concluded that there is therefore evidence that support provided by another mother that has experienced ppd may be an effective strategy in addressing ppd and helping prevent its negative effects on mothers and infants. A pilot randomized controlled trial was therefore conducted to evaluate the effect of mother-to-mother telephone support on depressive symptomatology among new mothers, and found a significant decrease in depressive symptomatology among the mothers who received the support. The authors state that while promising, these preliminary findings warrant further research in this area. It is interesting to note that in this study as well as a study looking at telephone-based peer support for breastfeeding mothers (Dennis, 2002), both the peer volunteers and the mothers evaluated their peer-support experience positively.

**Conclusion**

The above research highlights generally confirm that peer support is a beneficial strategy for meeting diverse needs of populations within the pre/postnatal and parenting periods. Although these highlights covered a large range of type, topical focus and structure of peer support, there were commonalities in the positive outcomes attained. Peer support strategies that are aimed at marginalized or “high risk” populations seem to be especially effective according to the research highlighted here. It is also clear that further research needs to be undertaken in order to expand knowledge and to improve practical applications of peer support strategies in the maternal, child and parenting periods.
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General

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**Parenting**


Breastfeeding


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