Public Health Nutrition: 23(16), 3005–3015 doi:10.1017/S136898002000124X

Volunteers' experiences of providing telephone-based breast-feeding peer support in the RUBY randomised controlled trial

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Submitted 24 November 2019: Final revision received 19 March 2020: Accepted 3 April 2020: First published online 30 June 2020

Abstract

Objective: The Ringing Up About Breastfeeding earlY (RUBY) randomised controlled trial (RCT) found that a telephone-based peer volunteer support intervention increased breast-feeding duration in a setting with high breast-feeding initiation. This sub-study of the RUBY RCT describes the motivation, preparation and experiences of volunteers who provided the peer support intervention.

Design: An online survey was completed by 154 (67 %) volunteers after ceasing volunteering.

Setting: Volunteers provided peer support to primiparous women (*n* 574) who birthed at one of three public hospitals in Melbourne, Australia, between February 2013 and December 2015.

Participants: Volunteers (*n* 230) had themselves breastfed for at least 6 months and received 4 h of training for the role.

Results: The median number of mothers supported was two (range 1–11), and two-thirds of respondents supported at least one mother for 6 months. Volunteers were motivated by a strong desire to support new mothers to establish and continue breast-feeding. Most (93 %) considered the training session adequate. The majority (60 %) reported following the call schedule 'most of the time', but many commented that 'it depends on the mother'. Overall, 84 % of volunteers were satisfied with the role and reported that the experience was enjoyable (85 %) and worthwhile (90 %). Volunteers agreed that telephone support for breast-feeding was valued by women (88 %) and that the programme would be effective in helping women to breastfeed (93 %).

Conclusions: These findings are important for those developing similar peer support programmes in which recruiting volunteers and developing training requirements are an integral and recurrent part of volunteer management.

Keywords
Peer support
Breast-feeding
Breast-feeding support
Volunteer

Breast-feeding has substantial health benefits for women and children. Infants who are not breastfed are at increased risk of long-term health conditions such as sudden infant death syndrome, respiratory and gastrointestinal infections, otitis media, asthma, type 1 and type 2 diabetes and overweight and obesity[1]. Maternal benefits include enhanced spacing between pregnancies, reduced risk of ovarian and invasive breast cancer and reduced maternal depression[1]. Despite high breast-feeding initiation in Australia, cessation in the early postpartum period limits the health benefits for mothers and infants. The latest Australian national infant feeding survey, conducted in 2010, found that 96 % of infants commenced breast-feeding; however, only 15 % were exclusively breastfed to 6 months, with 60 % receiving any breast milk at 6 months[2]. This is significantly less than the 6 months of exclusive breast-feeding recommended by the WHO[3] and Australian health authorities[4,5]. There are limited effective strategies to increase breast-feeding duration in countries with high initiation rates such as Australia[6,7]. Lack of support is a risk factor for early breast-feeding cessation[8], and a systematic review found all forms of extra support, whether delivered by a professional and/or non-professional, decreased the risk of ceasing *any* breast-feeding before 6 months of age[7]. Whether

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support was received face to face, by telephone or both, also made no difference in rates of cessation of *any* breast-feeding up to 6 months[7].

The Ringing Up About Breastfeeding earlY (RUBY) randomised-controlled trial (RCT) aimed to determine whether *proactive peer* support, provided in the postnatal period by telephone, increased the proportion of infants who were breastfed for at least 6 months. Primiparous women (*n* 1152) were recruited to the study while in hospital in the first few days postpartum and were randomly allocated to receive either 'usual care' or 'usual care' plus telephone-based peer support. Woman randomised to the intervention arm received proactive telephone peer support for 6 months postpartum guided by a specific call schedule. Women in the intervention arm received their first call from a peer volunteer 4 to 6 days postpartum. Weekly calls were made until 12 weeks postpartum and monthly calls continued for 6 months postpartum. The frequency of the calls could be adjusted at the mother's request and mothers could contact the volunteers between scheduled calls. Volunteers offered breast-feeding and general parenting support and directed women to existing local services if required[9]. The study found more infants of women assigned to proactive telephone peer support were receiving *any* breast milk at 6 months of age compared with women assigned to usual care, a relative increase of 10 %: (adjusted relative risk 1·10; 95 % CI 1·02, 1·18)[10]. There was weaker evidence of an association with infants receiving *only* breast milk (adjusted relative risk 1·10; 95 % CI 0·97, 1·23)[10].

In addition to testing the effectiveness of interventions, understanding the factors that impact on intervention delivery is important. This includes providing adequate description of those who provide the intervention, especially in studies where characteristics of the provider may influence outcomes[11]. The outcomes of studies examining peer support interventions may be influenced by factors such as the number of participants providing the intervention, their background, experiences and training and whether they were specifically recruited as volunteers or were providing the intervention as part of their usual role, and provision of reimbursement or incentives[11].

The proactive telephone peer support intervention used in the RUBY RCT was based on the widely cited definition by Dennis as 'the provision of emotional, appraisal, and informational assistance by a created social network member who possesses experiential knowledge of a specific behaviour or stressor and similar characteristics as the target population'[12, p. 329]. While this definition is useful in describing the broad elements of peer support, a more focused examination of the intervention including the implementation context is required prior to scaling-up to reach a broader population or different setting. In a realist review of breast-feeding peer support, Trickey *et al.*[13] highlight the need to address factors such as congruence with existing healthcare pathways, sociodemographic characteristics of peers, including matching with participant and the peer–mother relationship. Ensuring adequate numbers of peers is available to sustain successful programmes is an important consideration prior to scaling up and increasing their reach[14,15]. Failure to recruit adequate numbers of volunteers and rapid turnover may undermine volunteer peer support programmes[16].

Although current evidence describes mostly positive outcomes for peer volunteers, the studies are diverse in terms of context, programme design and methodology[17,18]. Reported benefits to the peer supporters include the satisfaction of helping the recipient[17–20] and improved confidence and self-esteem[17–19]. Social connection between volunteers can increase their motivation to help others and reduces feelings of isolation they may experience[19]. The experience may be less satisfying if the volunteers perceive help is not valued by the recipient[20,21]. Factors that enhance the peer experience include feeling that they are reciprocating or giving back support they had received[17,19,22,23] and sharing their own experiences and knowledge[17,20,24]. Volunteers may experience anxiety related to the role[20]; however, it is also an opportunity for them to reconcile personal experiences related to the peer support role that they may have found challenging in the past[17,19]. This may involve reinterpreting their experience as something that is now of benefit to others[19] or gaining a new perspective or sense of closure[17]. Adequate training and preparation for the role and ongoing support from programme organisers can assist volunteers to overcome challenges and provide quality control[25].

To identify issues that may impact sustainability and implementation of the RUBY intervention and similar peer support interventions, we aimed to explore the experiences of the women providing telephone-based peer support within the RUBY RCT. These insights will be relevant to those developing and implementing future peer support interventions for breast-feeding women.

Methods

The Ringing Up About Breastfeeding earlY trial: volunteer recruitment and training

Volunteer peer supporters were recruited from the community primarily by advertisements in the Australian Breastfeeding Association* newsletter and electronic media (mainly from ABA Facebook page) between January 2013 and May 2015. Volunteers were eligible to participate if they had successfully breastfed for at least 6 months, had a positive attitude to breast-feeding, agreed to attend a 4-h training session and had not participated in more than 8 hours of formal breast-feeding education. Topics covered in the training session included effective communication,

*The ABA is a non-profit, volunteer organisation and Australia's largest breastfeeding information and support service (https://www.breastfeeding.asn.au/).

https://doi.org/10.1017/S136898002000124X Published online by Cambridge University Press

normal breast-feeding behaviour, resources available to new breast-feeding mothers and cultural and social factors related to infant feeding. Volunteers received an information manual which included referral resources. The training session was conducted in partnership with the Australian Breastfeeding Association.

Of the 246 volunteers who completed RUBY training, thirteen of those did not go on to be allocated a mother, mostly due to being too busy with family and work commitments, or wishing to pursue breast-feeding counsellor training, which made them ineligible to participate. Subsequently, 233 volunteers were allocated a mother to support. Of those, three volunteers provided no support due to changed personal circumstances and the mothers were reallocated. The remaining 230 volunteers provided peer support to at least one mother. A volunteer coordinator (H.A.G.) facilitated contact by providing volunteers with the mother's first name and phone number and provided ongoing support through regular phone or email contact. For clarity in this paper, those providing peer support will be referred to as the 'volunteer(s)' and recipients of the support as the 'mother(s)'.

Participants in this study

All volunteers who supported at least one mother in the RUBY RCT were invited to participate in an online survey when they completed support of their last mother in the study (*n* 230). Between September 2014 and May 2016, the volunteer coordinator emailed volunteers a cover letter and link to the self-administered online survey. The cover letter explained that participation was voluntary and that responses would be anonymous. Completion of the survey was taken as consent to participate.

All volunteers were sent two email reminders; the first 2 weeks after the initial mail out, and the second 2 weeks later. As we were unable to identify the respondents, the reminder email included a 'thank-you' for any women who had already responded.

Data collection

The survey comprised thirty-three items, which included questions about volunteers' experiences of making RUBY calls, and their overall experiences as a volunteer, including the support they received from the RUBY team. Questions about participants' characteristics and their own breast-feeding experience were also included. Most questions comprised fixed choice response options using a five- or seven-point Likert scale, with some open-ended questions to allow further comment. The survey was piloted several times by midwifery research colleagues with expertise in breast-feeding support (*n* 7) and breast-feeding women (*n* 4). Ambiguities, grammatical and typographical errors were identified and corrected. The final version of the survey was uploaded to the secure Qualtrics platform[26]. A further round of piloting ensured the electronic version was clear and functional.

One question included nineteen items that asked volunteers about their motivations, views and experiences of being a volunteer. Of the nineteen items, twelve were derived from the Volunteer Functional Inventory (VFI)[27]. The VFI is a thirty-item scale consisting of six motivational functions that assess the different motivations that people may hold regarding volunteerism and suggests people may perform the same actions to meet different individual needs[27]. The functions served by volunteering comprise a *values* function, with volunteers seeking to express values that are altruistic or related to an area of humanitarian concern; an *understanding* function, with individuals seeking to open themselves up to new learning experiences and to develop new skills; a *social* function that enables opportunities for social connection or enhanced social approval; a *career* function that motivates volunteers who want improve their career prospects; a *protective* function that allows volunteers to distract themselves from their own problems; and an *enhancement* function to improve volunteers' feelings about themselves[27,28].

The nature of this study was to explore not only the motivation of RUBY volunteers but also their experience and perception of the peer support role. After consultation with Dr Arthur Stukus, a co-developer of the VFI, we selected twelve salient items that reflected each of the six functions and modified the wording and tense to suit our context. We analysed the items as individual variables rather than composite scales, again after consultation with Dr Arthur Stukus. The modified items from the VFI were not validated with participants.

Data analysis

Quantitative data were analysed using Stata version 15[29]. Frequencies, percentages and means were used to describe the data. Likert-type items were analysed as ordinal variables and 'where indicated' collapsed to provide dichotomous responses. The twelve items derived from the VFI were analysed individually rather than as composite scales.

Responses to qualitative open-ended questions were analysed by the first author using the content analysis technique described by O'Cathain and Thomas[30]. The responses were read, and a coding frame devised to describe the thematic content of the comments. Codes were assigned, and the data were re-examined and checked by another member of the team (H.L.M.). Results are reported with the number of respondents contributing to each theme and where appropriate, verbatim comments are used to illustrate the themes.

Results

Of the 230 volunteers who were invited to participate, 154 (67 %) completed the online survey. The mean age of

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Table 1 Participants' characteristics

Participant characteristics (*n* 154)	*n*	%
Mother's age in years (*n* 145*, mean = 35·1, SD 5·4, range 23–63)		
18–25 years	2	<1
26–34 years	79	55
≥35 years	64	44
Number of children (*n* 145, range 1–7)		
One child	58	40
Two children	69	48
More than two children	18	12
Youngest baby's age at time of enrolment (months): (*n* 144, median = 24, IQR = 12·5)		
Married or living with partner (*n* 145)	135	93
Completed a degree or higher (*n* 145)	119	82
Household income before tax at time survey completed† ($AUD) (*n* 142)		
<$999 per week (<$51,999 per year)	22	16
$1000–$1999 per week ($52,000–$103,999 per year)	60	42
More than $2000 per week ($104,000 or more per year)	60	42
Country of birth (*n* 144)		
Australia	118	82
Other (UK = 8; USA = 3; NZ = 3; Argentina = 2; Afghanistan, Belarus, Brazil, Germany, India, Lebanon, Poland, South Africa, South Korea and Switzerland all = 1)	26	18
English first language (*n* 143)	137	96
Employment (*n* 145‡)		
Employed part-time	78	54
Home duties	43	30
Maternity leave	23	16
Employed full time	19	13
Student part time	10	7
Student full time	7	5
Self-employed	5	<1

*Eleven respondents did not complete some or all the demographic questions.
†In Australia, the median weekly gross household income in 2017–2018 was $1701[42].
‡Participants could choose more than one response.

respondents was 35 (SD 5) years, most were married or living with a partner (93 %), had completed a university degree (82 %) and were born in Australia (82 %). Most had English as their first language (96 %) and were employed part-time (54 %) (Table 1).

Volunteers' own breast-feeding experiences

Respondents had themselves breastfed a median of two children (range 1–7). Their longest duration of breast-feeding an individual child was a median of 21 months (range 8–51 months). The majority (59 %, 85/145) had breastfed for as long as they had planned and just over half (83/144, 58 %) felt supported during their first month of breast-feeding.

Responses to open-ended questions regarding volunteers' own breast-feeding experience suggest that nearly half experienced positive support (51/109, 47 %) from a variety of sources including health professionals, family, online forums and privately accessed lactation consultants ('*I had a relative who had breastfed three children … She was a passionate advocate and supported me a lot. In those early days, when I was really struggling I called a parents hotline but they suggested going back to the hospital lactation clinic where I gave birth, and that was the best thing I did – I highly recommend doing that to anyone I know*'). However, some described experiences of feeling unsupported by either their social group (28/109, 26 %), for example, '*I had a lot of pressure on me from my parents and one aunt to supplement with formula*', and/or health professionals (15/109, 14 %), for example, '*It almost broke me first time around! I didn't get the help I needed in hospital*'.

Volunteers' motivation to participate in Ringing Up About Breastfeeding earlY

Volunteers responded to a series of nineteen statements related to their motivations, views and experiences of being a volunteer. The statements included twelve items from the VFI[27], and responses were noted on a seven-point scale ('strongly disagree' to 'strongly agree'). Table 2 shows the strongest motivator for volunteering was related to the 'values' function. Through volunteering for RUBY, most volunteers 'agreed' or 'strongly agreed' that they were doing something for a cause that was important to them (95 %). The enhancement function which increases an individual's positive feelings towards themselves was also identified as important. Most volunteers (*n* 94, 66 %) 'agreed' or 'strongly agreed' that they were making an important contribution by volunteering with RUBY and almost 65 % of volunteers 'agreed' or 'strongly agreed' that the volunteer experience has been personally fulfilling. Items related to volunteering as a way of overcoming personal problems or enhancing their career prospects were not important motivators for most volunteers.

Volunteers' experience of providing peer support

Preparation and support for the role

Most volunteers felt supported (141/144, 98 %) and valued (142/144, 99 %) by the RUBY team. Volunteers were asked about the preparation and support they received from the RUBY team for the peer support role. The majority felt that the 4-h training session prepared them well (134/144, 93 %) and that the training manual was a useful resource (117/144, 81 %) (Fig. 1). Nearly one-third indicated that they (42/144, 29 %) would have liked ongoing training.

During the RUBY intervention, volunteers were invited to twice yearly 'social' events that aimed to foster support amongst attendees. We provided catering and facilitated a relaxed informal group discussion for approximately 2 h. Only 13 % of volunteers attended one or more of these events. We asked volunteers an open-ended question about the value of these events, and responses from those who did attend all included comments about the benefits of interacting with other volunteers in a social setting:

https://doi.org/10.1017/S136898002000124X Published online by Cambridge University Press

https://doi.org/10.1017/S136898002000124X Published online by Cambridge University Press

Table 2 Volunteers' motivation to participate

	Strongly disagree		Disagree		Somewhat disagree		Neither agree or disagree		Somewhat agree		Agree		Strongly agree	
	n	%	*n*	%	*n*	%	*n*	%	*n*	%	*n*	%	*n*	%
Values														
By volunteering for RUBY, I am doing something for a cause that is important to me* (*n* 145)	0	0	0	0	1	1	0	0	7	5	45	31	92	64
People I am genuinely concerned about were helped by me volunteering for RUBY* (*n* 143)	6	4	14	10	7	5	31	22	36	25	32	22	17	12
Enhancement														
I can make an important contribution by volunteering with RUBY (*n* 143)	0	0	3	2	7	5	12	8	27	19	50	35	44	31
My volunteer experience is personally fulfilling* (*n* 145)	0	0	4	3	8	6	13	9	26	18	52	36	42	29
I feel needed while volunteering* (*n* 145)	2	1	11	8	8	6	23	16	43	30	39	27	19	13
Social														
Volunteering is valued by my friends and family* (*n* 145)	1	1	7	5	5	4	3	2	37	26	55	38	37	26
People I am close to value the fact that I volunteer* (*n* 145)	4	3	4	3	5	4	27	19	44	30	45	31	16	11
Understanding														
I am able to learn more about the importance of breast-feeding support by volunteering with RUBY* (*n* 144)	4	3	10	7	9	6	22	15	30	21	41	29	28	19
I can learn how to deal with a variety of people through volunteering for the RUBY study* (*n* 145)	1	1	21	15	8	6	38	26	47	32	25	17	5	4
Career														
As a volunteer for RUBY, I can explore possible career options* (*n* 144)	20	14	47	33	18	13	27	19	18	13	11	8	3	2
In volunteering for the RUBY study, I can make new contacts that might help my career* (*n* 146)	34	23	51	35	9	6	33	23	12	8	5	3	2	1
Protective														
Volunteering with RUBY helps me escape my own troubles* (*n* 144)	35	24	44	31	15	10	30	21	15	10	5	3	0	0
By volunteering for RUBY, I can work through some of my own personal problems* (*n* 144)	33	23	38	26	19	13	38	26	12	8	4	3	0	0

*Twelve items are based on items included in the Volunteer Functional Inventory (VFI).

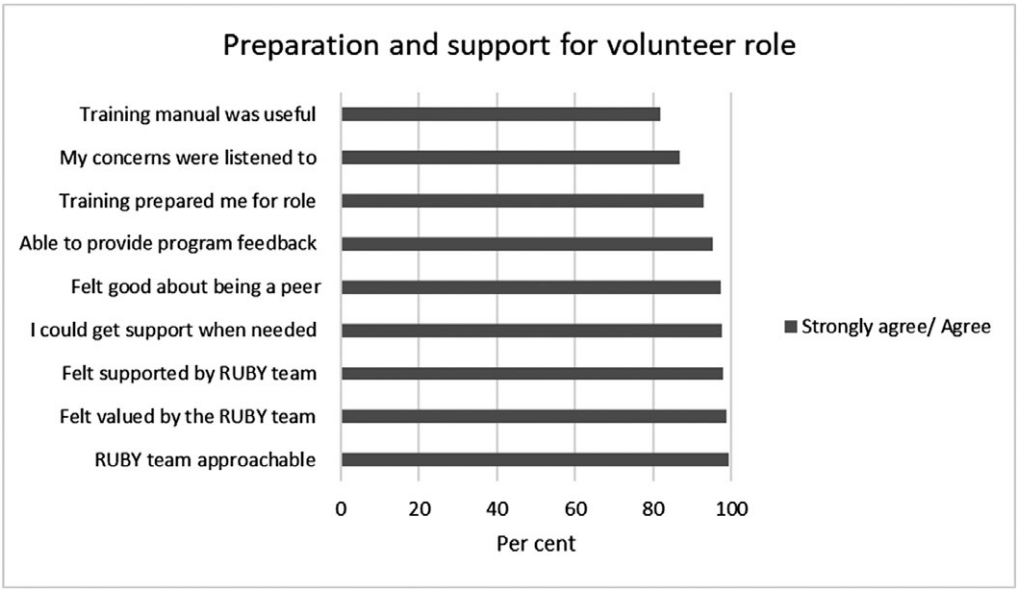

Fig. 1 Preparation and support for the volunteer role

'*This was really important to me. It was great to hear about other people's experiences and to share the experience of being a volunteer*' and '*Fabulous! I made some lifelong friends, thanks*'.

Volunteers' experience of the call schedule and duration of support

Each volunteer provided peer support to a median of two mothers (range 1–11). Approximately 51 % supported two or three mothers and 34 % supported only one mother (Table 3). Volunteers were asked how many mothers they had supported for the full 6 months. More than two-thirds responded that they had supported between one and five mothers for the full 6 months (97/151, 63 %). Approximately one-third were unable to support a mother for the full duration (52/151, 34 %), and two volunteers could not recall (Table 3). Volunteers were asked why they were unable to support a mother for the full 6 months. Of the twenty-eight open-ended responses to the question, the most frequent reasons were being unable to contact the mother (*n* 15), the mother ceased breast-feeding (*n* 14) and the mother requesting no further contact (*n* 6). Six volunteers reported that the mothers were not having any difficulties and did not need further support. Only three volunteers ended the period of support before 6 months because they themselves were unable to continue (pending birth of their child, moved overseas).

When asked what they thought about the length of time they were asked to provide support, 63 % (94/150) felt that it was 'about right' and 24 % (36/150) felt that it was 'too long'. The call schedule directed volunteers to telephone mothers at weekly intervals until the baby was 12 weeks of age and then monthly until the baby was 6 months of age. Nearly 60 % (90/150) responded that they followed the call schedule most of the time.

Table 3 Number of mothers and duration of support provided

	n	%
Number of mothers volunteers' supported (excluding those who volunteer was unable to contact) *n* 150		
One mother	51	34
Two mothers	38	25
Three mothers	39	26
Four mothers	11	7
Five mothers	2	1
Six mothers	5	3
Eleven mothers	1	<1
Cannot recall	3	<1
Mothers volunteers supported for full 6 months (*n* 151)		
I was unable to support any mothers for 6 months	52	34
I cannot recall	2	1
One mother	51	33
Two mothers	29	19
Three mothers	14	9
Four mothers	2	1
Five mothers	1	<1

Volunteers' experience of providing support

A global question assessed satisfaction with the peer support role with a single item 'Overall, how satisfied were you with your role as a volunteer in the RUBY study' using a five-point scale ranging from 'very dissatisfied' to 'very satisfied'. Overall, 84 % of volunteers were satisfied with the role ('satisfied' 73/145, 50 % or 'very satisfied' 49/145, 34 %). The volunteers were also asked a range of specific questions related to their satisfaction with the peer support role using a 7-point scale from 'strongly disagree' to 'strongly agree' (Fig. 2). The majority agreed that the

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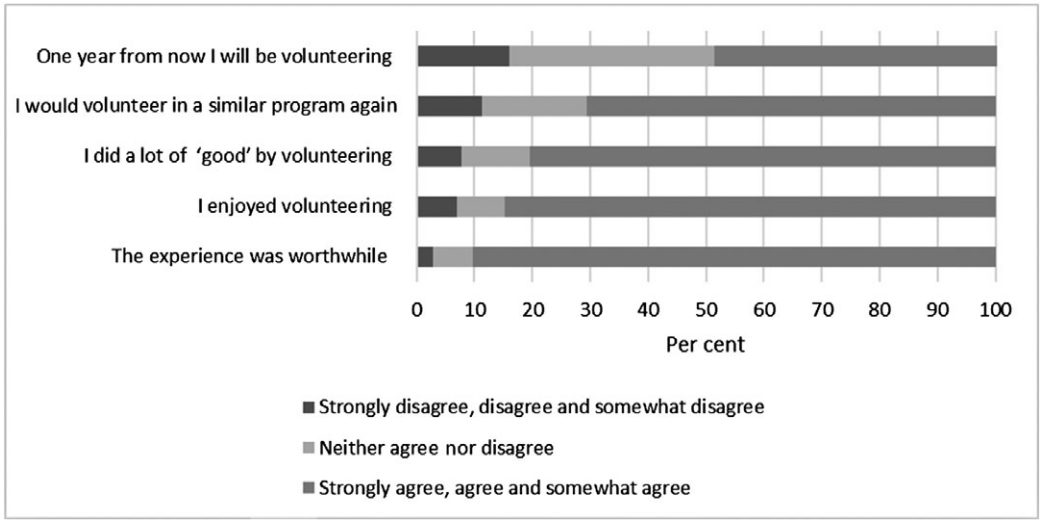

Fig. 2 Agreement with statements related to enjoyment of the role and future intention to volunteer

experience was worthwhile (90 %), that they enjoyed their volunteer experience (85 %) and that they would volunteer to provide telephone support in the future if a programme like RUBY was offered (71 %).

Using open-ended questions, we explored volunteers' views regarding positive and negative aspects of the role. The number of respondents making comments related to the themes is provided in brackets. The main themes related to positive aspects of the role were personal reward (*n* 46) ('*It was very rewarding being able to assist someone in their breastfeeding and parenting journey and there was a real sense of accomplishment that was shared by the mother and myself on completion of the 6 months*'); enjoyment (*n* 33) ('*I enjoyed supporting mothers when often they felt unsupported. I felt joy in supporting breast-feeding and felt that it was my investment toward a child regardless of who they were.*'); and empathy (*n* 23) ('*It was lovely to support a new mother in those early days. It brought back all sorts of memories of my own experiences, which I think helped me provide better support*').

Of the 142 responses to the question asking about challenges associated with the role, the main challenges were initiating and maintaining contact with the mothers (*n* 44), competing demands (*n* 29) and managing situations where the mother did not need breast-feeding support (*n* 21) such as '*one mother required little help, breastfeeding was a breeze and I didn't feel like much help most of the time*'. Volunteers described how '*continually trying to contact hard to reach mothers – it could become quite time consuming*' and '*finding the time to call – both in the preparation, actual call time, and post with paperwork – can be challenging when juggling small children and a busy schedule*'. Other challenges related to not taking things personally (*n* 20) typified by the comment '*It was quite depressing giving of your own time to then be spoken to rudely, messages or calls not responded to, not even answering when asked if they would like the contact to cease*' and communicating with women from non-English speaking backgrounds (*n* 18).

Why volunteers stopped volunteering in the Ringing Up About Breastfeeding earlY study?

We asked volunteers a closed-ended question about why they stopped volunteering in the RUBY study. A change in family commitments was the most common reason given (46/151, 30 %) followed by the RUBY study finishing (44/151, 29 %). Almost 15 % (22/151) cited return to work as the reason and one wanted to start ABA breast-feeding counsellor training. Seven percent indicated that they were dissatisfied with their experience (10/151) and 19 % chose the 'Other' option. The most frequent 'Other' responses were related to increased work/ study commitments (9/29) ('*I was feeling stressed trying to balance this among my return work and family commitments*'). Responses also included uncertainty about whether they were doing 'a good job' (6/29 responses) ('*I don't think I have the personality/skill set to be a volunteer mother*').

Volunteers' views on the value of the peer support programme

Volunteers were given a list of statements regarding their perception of the value of the peer support programme and asked to respond to on a five-point scale with responses ranging from '*strongly disagree*' to '*strongly agree*'. The volunteers agreed that telephone support for breast-feeding was valued by women (125/142, 88 %) and that the RUBY programme would be effective in helping women to breastfeed (132/143, 93 %). Most volunteers would recommend the type of telephone support provided in the RUBY study to new mothers (133/144, 93 %).

https://doi.org/10.1017/S136898002000124X Published online by Cambridge University Press

Discussion

The RUBY trial demonstrated that proactive telephone peer support in the postnatal period was effective in reducing the risk of stopping breast-feeding before 6 months postpartum in a high-income setting such as Australia[10]. Understanding the experience of volunteers who provided the peer support intervention is important for upscaling and sustainability of similar programmes. We found that volunteers were highly motivated to support new mothers and described the role as personally rewarding and enjoyable. This paper focuses on the experience of volunteers. The experiences of mothers who received the peer support intervention were very positive and have been reported elsewhere[10], with more detailed data currently being analysed for reporting in forthcoming papers.

Motivation to volunteer

In this study, there was strong interest in the peer support role, mainly from mothers whose most recent experience of breast-feeding was within the previous 2 years. Almost all were motivated because the role enabled them to act upon strong beliefs in the value of supporting breast-feeding and to engage socially with new mothers. Motivations such as feeling compassion towards and helping new mothers navigate the challenges of early breast-feeding (values motivation), and social motivations have been previously linked to interpersonal volunteering, such as providing peer support[31]. It has also been suggested that a volunteer's feelings about an organisation or sense of affiliation may be an important factor in participation[32,33]. The extent to which our collaboration with the Australian Breastfeeding Association (ABA) influenced volunteers' decision to participate was not explored. However, we did notice increased interest from potential volunteers following exposure on ABA social media platforms.

Preparation and support for the role

Those developing peer support programmes must decide the extent to which peers will be trained for the role. Extensive training may increase a peer's knowledge to that of para-professional and diminish 'peer' support[18]. This study used a 4-h training session which was perceived as adequate by most volunteers; however, nearly one-third would have liked ongoing training whilst participating. The call for ongoing training has been made by previous studies of the experiences of peer supporters[17,18,25,34]. It may be that peers are seeking not only additional knowledge but also reassurance and connection with other peers[19]. Training of peers is an important consideration in terms of sustainability of programmes as it is a recurrent expense and time commitment. Based on our findings, extending the duration of training is not warranted prior to commencing the peer support role, but opportunities for further education during their participation would be valued by some peers.

Volunteers valued the support provided by regular contact from the volunteer coordinator. Regular contact supports the integrity of the intervention, assists peers to overcome challenges[35] and highlights necessary changes to the programme. Opportunities for social interaction enabled volunteers to share their stories, both related to the peer support role, but also their own experience of motherhood. Social connection with other volunteers has been suggested as important in previous studies[19], but in this study, few volunteers attended planned social events. Uptake may have been greater if social events had a specific educational focus related to the role given the volunteers' request for ongoing training.

The frequency and timing of calls

Proactive peer support programmes usually have a protocol for the timing of contacts which may range from 'less intensive' (<5 planned contacts) to 'intensive' (≥12 planned contacts)[36]. However, the nature of the intervention necessitates that it be responsive to the needs of both recipient and provider. Although most volunteers in this study reported following the call schedule 'most of the time', many commented that 'it depends on the mother' and her need for support. The intensity of the intervention may have a bearing on its effectiveness and a balance must be struck between flexibility and effectiveness. In a systematic review of peer support for breast-feeding continuation, Jolly *et al.*[36] reported that ≥5 planned contacts reduced the risk of not breast-feeding at follow-up. This is consistent with the RUBY study in which the mothers received an average of six calls[10]. The approach to the frequency and timing of calls in this study is consistent with what Trickey *et al.*[13] describe as 'a negotiated proactive' model of peer support where a minimum number of calls is specified whilst allowing the number of calls beyond that to be tailored to the mother's needs.

The personal impact of providing support

Volunteers reported a high level of satisfaction and identified positively with the peer support role. Positive aspects of their experience reflected pro-social values including expression of empathy, altruism and social connectedness. Volunteering has been widely reported to increase self-esteem, self-efficacy and social connectedness[37,38], and sharing experiences may offer therapeutic benefits to the peer[17].

Volunteer satisfaction was assessed from a retrospective 'global' view when volunteers ceased participation and may have been reflective of the volunteers' optimal relationship(s). More nuanced findings may be achieved if volunteer satisfaction is assessed at the end of individual peer relationships. We used a single measure of satisfaction; however, multidimensional measures have also been

https://doi.org/10.1017/S136898002000124X Published online by Cambridge University Press

proposed[39]. One such measure expands the overall construct of volunteer satisfaction to include motive satisfaction, satisfaction with the task and satisfaction with volunteer management[40]. Satisfaction alone is not the only predictor of volunteering duration and needs to be considered in relation to the volunteer's intended period of service[40]. Although the experience of volunteering is likely to alter the duration, regardless of intention, examining the intended duration in comparison to the actual duration of service may in itself be a proxy measure of satisfaction.

Challenges with the role

Alongside high levels of satisfaction, volunteers identified two main challenges that reflect generic issues associated with telephone support interventions: initiating and maintaining contact and communicating effectively with people from linguistically diverse backgrounds. In this study, despite screening for English language proficiency during a face-to-face recruitment of mothers by a research midwife, a small number of volunteers commented about difficulty with telephone communication. Unlike face-to-face peer support where communication is enhanced by non-verbal cues, telephone communication may pose more challenges. Whilst this does not seem to have had a significant impact overall, it does need to be considered when screening women if volunteers are only English speaking.

Retention of volunteers

Despite increasing interest in peer support programmes, funding is often limited and may undermine service provision[41]. Retaining volunteers reduces training and recruitment costs for programme organisers. Encouraging volunteers to complete at least one period of support and if they choose to cease participation, to do so at the end of a support period decreases disruption to mother/peer relationships. Previous studies of breast-feeding peers have reported that although providing breast-feeding peer support was rewarding, participation was not sustained due to changed personal circumstances[34], including return to paid work. A similar pattern was observed in the RUBY study. We enabled volunteers to defer participation during busy times in their lives (e.g. following the birth of a child), and this was a useful strategy. However, return to paid employment was frequently given as a reason to cease volunteering, due to time constraints. Return to work may have also enabled volunteers to re-establish workplace social connections, reducing the need to seek such connections through volunteering.

These findings relate to data collected within an RCT, and volunteers in this context may have had different motivations from those who volunteer in other settings. However, the RUBY study was a pragmatic trial, and delivery of the intervention was responsive to the needs of volunteers and recipients. Consequently, the experience of providing proactive telephone peer support described here is likely to be relevant to peer support programmes in other settings. A limitation is that the views expressed by volunteers who responded to the survey may not be representative of those who did not respond. The extent to which non-responders had a more positive or negative experience is unable to be determined.

Conclusion

The RUBY trial demonstrated that proactive telephone peer support reduced the risk of stopping breast-feeding before 6 months postpartum in a high-income setting[10]. This study highlights the acceptability of the peer support role to the volunteers providing the RUBY intervention. Almost all volunteers were motivated because the role resonated with their belief in the value of breast-feeding support and enabled them to engage socially with new mothers. A high level of satisfaction and positive identity with the role were reported. Volunteers shared valuable experiential knowledge and felt adequately prepared after attending a 4-h training session. Opportunities for additional training after starting the role would be valued by some volunteers. A recommendation for those designing call schedules for future programmes would be to specify a minimum number of calls based on previous research, and tailoring the number of calls beyond that, to the mother's needs. The results presented here give insights into the experiences of peer volunteers in the RUBY trial are important in terms of potential sustainability and upscaling of similar programmes.

Acknowledgements

Acknowledgements: The authors wish to thank the RUBY volunteers who participated in this study. The authors also thank the mothers who participated in the RUBY study during a special time in their lives. The authors would also like to acknowledge the partnership with the Australian Breastfeeding Association who provided training for the peer supporters and thank Dr Arthur Stukus for advice regarding the Volunteer Functional Inventory used in our survey. The RUBY trial was jointly funded by the Felton Bequest and a PhD scholarship from La Trobe University, Melbourne, Australia, both of whom we would like to acknowledge. *Conflict of interest:* The authors declare that they have no competing interests. *Authorship*: H.G. drafted the paper and T.S. and H.G. led data analysis in collaboration with H.M. and D.F. All authors participated in data collection and editing of the paper. D.F. is the Chief Investigator on the RUBY study. H.M. was a principle investigator and T.S. was a co-investigator. *Ethics of human subject participation:* The RUBY study was conducted according to the guidelines

https://doi.org/10.1017/S136898002000124X Published online by Cambridge University Press

laid down in the Declaration of Helsinki and all procedures involving research study participants were approved by the La Trobe University (12-08), the Royal Women's Hospital (12/25), Sunshine Hospital (HREC/12.WH/107) and Monash Medical Centre (12251B) and was registered with the Australian and New Zealand Clinical Trials Registry (ACTRN12612001024831). Written informed consent was obtained from all study participants.

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https://doi.org/10.1017/S136898002000124X Published online by Cambridge University Press