

Model for breastfeeding with a role model outcome for recruitment

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Abstract

Many policy drivers have identified the need for and importance of peer support for breastfeeding. The Marmot Review (2009) recognises that support for breastfeeding mothers can help to increase breastfeeding rates and in turn reduce health and social inequalities. Breastfeeding peer support groups offer much more to a community than is measurable in terms of money. Deprived areas of the UK are seen as having 'lost skills' in breastfeeding; they have no experience or tradition of breastfeeding to draw upon and therefore are unable to view it as an everyday activity which impacts on an intention to breastfeed and leads to bottle feeding. South Tyneside is one of the most deprived areas in the UK, as such has integrated and implemented peer counsellor training into the support model for new mothers and the training model with other professionals with high success rate and spin off of more than a fifth moving on to nurse education.

Keywords

Breastfeeding, peer counsellors, breastfeeding training, health visitors, mothers, deprivation.

Setting the scene

When the breastfeeding world is experiencing a clandestine time falling between NHS and local authority commissioning. I thought it important to promote the brilliant shared work between the two in our geographical area.

With the advent of commissioning ownership this has brought about issues itself in my experience as both leader and worker in breastfeeding.

However despite this I have been able to develop a model that utilises the skills of both children's centre and health services together to support mothers across the authority and hopefully this will continue with whoever picks up the gauntlet of breastfeeding.

Whatever the model, clinical supervision needs to be at the heart of breastfeeding support to ensure a clear accurate message for mothers and professionals alike. This message needs to be co-ordinated and in a non-conflicting way with the excellence of UNICEF at the heart. Even if breastfeeding friendly initiative status is not sought or achieved. Clear leadership and direction of which resources to use are imperative in a world where search engines churn out utter nonsense to breastfeeding mothers and workers often backed by well meaning "experts" who only serve to confuse and fuel toe conflict in a society where bottle-feeding is now the norm. With this in mind and over 26 years as a mother, midwife and health visitor in the breastfeeding arena the Menzies model was born.

Reflection of peer supporters-

In 2016 a decision was made by the trust to discontinue la leche funding within the trust, for the previous ten years I had been a la leche facilitator delivering and supporting the peer supporter programme in South Tyneside. This would leave a big hole in the breastfeeding support services and the pathway for the enthusiastic mums who wanted to take breastfeeding further. This coincided with me completing the UNICEF professional training and as such the perfect opportunity to rewrite peer counsellor training to amalgamate the UNICEF standards and integrate peer counsellors into updates with professional staff.

The proposal to do this was to achieve shared aims:

- Successful initiation of breastfeeding and On-going support to extend duration of feeding beyond exclusive 6 months (WHO 2005, Simard 2005).

- Maximum longitudinal health protection for all children obesity, diabetes , heart disease, atopic conditions.(UNICEF 2017)
- Better parent infant attachment reduction of infant attachment and postnatal /maternal mental health concerns. (UNICEF 2005/2017)
- Use of learnt skills to promote breastfeeding within the community. (Haroon et al 2015).
- Utilise peer counsellor skills in groups promoting breastfeeding in groups antenatally, postnatally.
- To develop community capacity by utilising volunteers alongside collaborative work between health services and local authority children's centres.

A Cochrane study by Britton et al (2009) determined that while professional support may increase the duration of breastfeeding it may not be effective in increasing the promotion of the prevalence of exclusive breastfeeding, in fact, they identified that lay support was more effective in promoting exclusive breastfeeding. Many of the supporters who had trained had returned to work and the capacity to attend updates annually was limited and the support was thinly spread. South Tyneside is one of the most deprived areas in the UK, as such has integrated and implemented peer counsellor training into the support model for new mothers and the training model with other professionals with high success rate and spin off of more than a fifth moving on to nurse education.

Many policy drivers have identified the need for and importance of peer support for breastfeeding. The Healthy Child Programme (2009) stipulates providing peer support, especially during the early weeks as part of how to promote breastfeeding. The Marmot Review (2009) recognises that support for breastfeeding mothers can help to increase breastfeeding rates and in turn reduce health and social inequalities. According to calculations in the Lancet and research by UNICEF UK, stronger

integrated breastfeeding support could actually save the NHS over £48 million a year, and result in a boost of billions to the UK economy in increased cognitive ability across the whole population.

Breastfeeding is a public health priority, and an investment in every child's future. It is essential that effective support services and skills are commissioned and well integrated into existing services, to avoid families falling through the gaps. (IHV 2018)

Battersby et al (2002) acknowledged that while there is sufficient research into the cost effectiveness of breastfeeding, there is little research to show the cost effectiveness of peer support. With this in mind I set about persuading the trust and managers that a new programme of training based on UNICEF principles I would write, would allow peer supporters to continue to train, be able to attend updates with all other staff and develop a model of support to help retention of peer supporters and thus increase the support available in the community/workforce.

Battersby et al (2002) reports that breastfeeding peer support groups offer much more to a community than is measureable in terms of money, a study by Oakley et al (1996), to identify the benefits of peer support, demonstrated there were considerable savings to the NHS by increasing the number of breastfed babies; they are less likely to have serious accidents, maternal mental health is improved as is mother and child relationship. It is identified that the cost saving to the NHS in the first 6 weeks of life in terms of less gastrointestinal and ear,urinary and chest infections are unquantifiable(UNICEF 2017). Both importantly recognise the benefits the peer support workers give to the community, especially those areas of poor socio-economic deprivation. South Tyneside is one of the most deprived areas in England with some of the poorest initiation and continuation rates for breastfeeding.

Raine and Woodward (2003) ascertained that deprived areas of the UK are seen as having 'lost skills' in breastfeeding; they have no experience or tradition of breastfeeding to draw upon and therefore are unable to view it as an everyday activity which impacts on an intention to breastfeed and leads to

bottle feeding. (Giles 2010). While the majority of mothers saw the breastfeeding support group as a positive initiative it is important to recognise that some women will find breastfeeding difficult and a group of peer support should be diverse enough to be able to account for this and not just account for positive experiences and those who are passionate about breastfeeding (Giles 2010). It is also important to ensure mothers of not made to feel like a failure or inadequate.

A Cochrane systemic review of the effectiveness of breastfeeding support concluded that all forms of extra breastfeeding support showed an increase in the duration of breastfeeding and face to face support had a greater impact than telephone support (Renfrew et al 2015). The initiation of breastfeeding Support and the model utilised to provide geographical coverage acknowledges this. Wade (2009) identifies that peer support can not only increase breastfeeding duration but it can help to improve maternal mental health, parenting skills and increased confidence and self-esteem.

Previous breastfeeding support had failed due to lack of robust support and supervision for the peer supporters so I mapped each children's centre and breastfeeding support group in South Tyneside with a named health visitor and outreach worker and the Menzies model was devised (see diagram 1).

With myself and public health midwife as lead, this system was put forward to maternity and health visiting managers who approved and put forward to children's centre managers. The UNICEF training 2 day and annual updates were offered to all midwifery ,health visiting and children's centre staff this has developed a strategic view of breastfeeding between both local authority and NHS staff giving core values and standardised the information given to those requiring breastfeeding support and those supporting peer counsellors in practice. The peer counsellors are voluntary and this has proven to be a stumbling block for the centres who wanted to rely on them as employees i.e. Rostering commitment. However the close relationships have fostered relationships to discuss this and rectify it with clear guidance of peer counsellor expectation. The close working relationship and combined training updates between professionals and peer supporters has proved a positive driver and role

modelling benefit to the system with a fifth going on to successfully pursue nurse /midwifery training at local universities and develop a workforce resource .The integrated working and training between midwifery and health visiting and local authority children's staff ensures that discussion in multiagency training enables the deeper understanding between members in relation to the breastfeeding roles. The peer counsellors support the breastfeeding groups within the children's centres and the antenatal workshops within the community. The positive generational impact is longitudinal and enables them to positively promote breastfeeding in immeasurable terms of day to day contacts at school, with friends and family and with wider community interactions.

Evaluation/Conclusion

Whilst the model has yet to influence breastfeeding rates.

Evaluation of the group's children's centre OFSTEAD and friends and family show an invaluable and positive impact on the women and communities attending. Evaluations from staff and peer supporters show that they value a joined up way of working and clear direction of line management/clinical supervision which removes the conflicting perspectives and advice.

The evaluations demonstrate the practical application of breastfeeding combined by multi-professional approach in training to be beneficial providing opportunity to see situations outside of their own sphere if practice and give a wider view of the breastfeeding

In a changing world of health visiting with political drivers and finances directing practice .I hope that the Menzies model will continue to support women, babies and practitioners in a unified approach not only to increase the importance and profile of breastfeeding for future generations and improve public health and rates of initiation and continuation with continued emphasis and not just sticking plaster measures. Not only health benefits for mothers and babies but a whole world of influence on recruiting future health professionals from an alternate route.

Reflective questions

How can we in our own geographical area empower communities to support breastfeeding?

What models are we using in breastfeeding unification of services across sectors?

How does my practice help increase initiation and continuation duration?

Breastfeeding Peer Counsellor development and support Model



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