

Peer support for breastfeeding in the UK

Government policy is to recommend exclusive breastfeeding for the first 6 months, with continued breastfeeding while solid foods are introduced.¹ Current breastfeeding data does not include rates of exclusive breastfeeding but the UK has one of the lowest rates of breastfeeding worldwide, especially among families from disadvantaged groups.² A marked feature is the rapid decline over the first few weeks. Although 69% of babies in 2000 were put to the breast at least once, one-fifth (21%) of breastfeeding mothers stopped within the first 2 weeks and over a third (36%) by 6 weeks after the birth.³ Only one in 10 of these women had fed for as long as she intended; nine out of 10 would have liked to have breastfed for longer.

The reasons mothers give for stopping; babies rejecting the breast, painful breasts or nipples and perceived insufficient milk, suggest that many women do not receive adequate information and skilled support in the early days.

Babies who are not breastfed are more likely to suffer gastroenteritis, ear and urinary tract infections and respiratory disease requiring admission to hospital. In the longer term, there is a greater risk of increased blood pressure, diabetes and obesity.² Beyond the immediate discomfort and medical problems, low rates of breastfeeding can therefore cause increased disruption and anxiety for families, and the costs associated with increased use of primary and secondary care.⁴

The recently published *Effective Action Briefing on the Initiation and Duration of Breastfeeding* summarises the evidence and presents practical recommendations for promoting the initiation and/or duration of breastfeeding, particularly among population groups where breastfeeding rates are low.² Core recommendations include multifaceted interventions, such as implementation of the Baby Friendly Initiative across NHS Trusts, and specific 'education and support programmes delivered by both health professionals and peer supporters' as well as:

'Peer support programmes offered to ... women on low incomes in either the antenatal or both the antenatal and postnatal periods to increase initiation and duration rates'.²

The overarching recommendation is that each locality should consider the best package of interventions to address the diverse needs of their local population groups.

'Peer support' is an approach in which women who have personal, practical experience of breastfeeding offer support to other mothers. This kind of mother-to-mother support has happened since the dawn of civilisation but has only recently been more formally set up and evaluated as a way of improving support for breastfeeding women.

The authors of one systematic review define contemporary breastfeeding peer supporters as '... trained and knowledgeable experts outside of a professional capacity ... who have breastfed successfully themselves and have undergone some training on breastfeeding', who typically work 'in a voluntary capacity within their resident community'.⁵

Peer support schemes have been set up primarily in disadvantaged neighbourhoods so that support is provided by women from the same community. Such women tend to be seen as more approachable and are more likely to understand the social and cultural influences in the area. These peer supporters have training measured in days and are encouraged to refer mothers who have more complex or unresolved conditions to health professionals or other breastfeeding specialists. However, in some research the term peer support has also been used for much more extensively trained supporters who have personal experience of breastfeeding, such as breastfeeding counsellors. National Childbirth Trust (NCT) breastfeeding counsellors have all had personal experience of breastfeeding as well as formal knowledge and skills enhanced through several years of training. In

planning further research or setting up new programmes, it is important to take account of these differences and their potential influence on the way that supporters are viewed by health professionals and women in the communities they serve.

Increasingly, health professionals and NCT breastfeeding counsellors are devising peer supporter training schemes with the aim of responding flexibly to local needs. The La Leche League peer support scheme trains health professionals who then cascade the training. There will be differences in emphasis and ethos in these training schemes, which may well have an impact on the outcomes.

Systematic reviews suggest that peer support seems to work well when combined with other activities, and may be a key component of the effectiveness of some multifaceted interventions, such as schemes combining peer support with local media campaigns.^{5,6} Multiple intervention programmes associated with increased initiation often included peer support.⁵

In a mapping exercise of initiatives intended to limit the impact of poverty and disadvantage on the health and wellbeing of low-income women and their babies,⁷ D'Souza and Garcia found that:

- peer support as a stand-alone intervention is very likely to increase breastfeeding initiation rates among low-income women who express the wish to breastfeed;
- support from a mother experienced in breastfeeding, complemented by professional services, is very likely to increase the duration of breastfeeding; and
- peer volunteers are particularly beneficial in mediating between low income mothers and healthcare professionals.

D'Souza and Garcia describe two qualitative UK based studies that provide valuable insights into low income women's views, suggesting that women felt prepared to breastfeed if they had high exposure to

new-born babies, constant support from someone with mothering experience and a partner who was not against them breastfeeding. Women said they valued breastfeeding care providers who had knowledge of correct information, established supportive relationships with them, referred them to breastfeeding specialists for problems, showed enthusiasm, and facilitated breastfeeding through concrete actions in antenatal/intrapartum and postnatal periods. Unhelpful providers were described as those who missed opportunities to discuss breastfeeding, gave misleading information, encouraged formula feeding, provided perfunctory breastfeeding care and were difficult to contact when problems arose.

The study reported by Muirhead *et al* on page 191 found no difference in breastfeeding rates between groups randomised to peer support and those who received normal professional breastfeeding support, although there seemed to be a greater difference between groups who were first-time breastfeeding mothers, and those who actually received the peer support.⁸ The training course provided is not described in detail but did not seem to include debriefing of the peer supporters own breastfeeding experience. This may have an impact on the way peer supporters help women and their ability to empathise with others.

The success of the Baby Friendly Initiative⁹ and some peer support schemes¹⁰⁻¹² may be partly related to mothers' experience of their first breastfeeds. The rapid decline in breastfeeding in the first few weeks in the UK is likely to be related to poor information and unrealistic expectations in the antenatal period and support in the

immediate postnatal period. Both the intervention and control groups in this study received traditional professional support until discharge from hospital and many women had stopped breastfeeding before they first saw a peer supporter.

Muirhead and colleagues' paper adds to the body of knowledge on peer support and does show an effect on first-time mothers, which is likely to follow through to success in breastfeeding subsequent babies with the beneficial health impact this will have.⁸ It is important that the training itself is examined more closely and a recognised, validated approach is taken so that variables in future research are reduced. Peer support training is particularly important because it is an effective intervention with the most disadvantaged groups, who are least likely to breastfeed.

The National Service Framework for Children, the development of Children's Centres and the evidence base about what works to increase both initiation and duration of breastfeeding, provide an opportunity to act. We can no longer accept the old mantra of 'women's choice'. It is clear that many women in the UK do not feel they have a choice to breastfeed; either because they do not know anyone who has breastfed or even anyone who was breastfed, or because they have not received accurate information and sufficient support to enable them to continue to breastfeed for as long as they like. The *Effective Action Briefing* gives the health service and the wider community the tools to change this.²

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Genetics, Big Brother and the GP

The imperative to promote primary care involvement with genetics is a familiar story.^{1,2} If new and more scientific understandings of disease and risk are to be the expected legacy of the Human Genome Project, and if the genetic revolution is

transforming medicine in the way that some commentators have claimed, then it will be because genetics has changed both its location — from specialist centres to neighbourhood surgeries — and its focus — from rare single gene conditions to common

disease. The 2003 White Paper, *Our Inheritance, Our Future*³ is the latest high profile attempt to promote and realise this vision.

High expectation of imminent clinical benefit from genetic research is almost