Improving public health through breastfeeding support

Summary

Breastfeeding rates in the UK are amongst the lowest in the world, (Victora, 2016). There are geo-demographic variations (McAndrew, 2012) which have wide ranging impact on communities with low breastfeeding rates such as an increased incidence of obesity and childhood illnesses with more GP visits and hospital admissions such as gastroenteritis (Victora, 2016, Pokhrel, 2014, McConnachie, 2004). There may also be higher rates of postnatal depression (Borra, 2015). For mothers who wanted to breastfeed and found they couldn’t, research suggests the risk of postnatal depression increases significantly (Borra, 2015. Brown, 2016).

Policy developments between 2005 and 2010, including the commissioning of peer support projects, have had an impact in helping mothers sustain breastfeeding for longer; a third of mothers were breastfeeding at 6 months in 2010 compared to quarter in 2005. (McAndrew, 2012). These developments also narrowed inequalities as breastfeeding prevalence rates, show greater improvement in more disadvantaged communities; increasing 10% among routine and manual occupations at 6 weeks (R&M 2010: 42%, 2005: 32%) compared to 5% among mothers in managerial and professional occupations (M&P 2010: 70%, 2005: 65%) (Bolling, 2005, McAndrew, 2010).

However, this progress is being jeopardised. In England, the public health budget has been cut by £200 million. It is little wonder then that Local Authorities – newly charged with responsibility for public health services – are looking for savings wherever they can, and closing down the very services that help mothers to continue breastfeeding. This short term thinking is likely to have serious consequences for child and maternal physical and mental health.

As the Lancet report co-author Dr Nigel Rollins of the World Health Organisation (WHO), said:

"The success or failure of breastfeeding should not be seen solely as the responsibility of the woman. Her ability to breastfeed is very much shaped by the support and the environment in which she lives. There is a broader responsibility of governments and society to support women through policies and programmes in the community."

Skilled support, from those who are properly trained, is essential. The economic and environmental consequences of improving breastfeeding rates and thus public health are significant. Yet we know that access to support for breastfeeding services is at best patchy with the majority of women stopping breastfeeding before they wanted to because of lack of support at the right time. With cuts to local
government budgets we are hearing from parents that local children centres and breastfeeding groups are being lost from local areas or drastically reduced leading to a crisis of lack of support.

Although breastfeeding is an individual choice for mothers, when looked at a population level, it is also an important determinant of public health and these variations in health suggest they can change – for better or worse. 'In health care, geography is destiny' (Wennberg, 2010).

Many families and communities start from a low level of confidence and knowledge about breastfeeding, some mothers may be the first in their family to have ever tried breastfeeding (Darwent, 2014) and yet are expected to be able to make an informed decision and to breastfeed successfully.

"... my mum never done it so she could not understand why I was doing it." (Darwent, 2014)

BfN gives important attention to raising awareness of the relationship between improved maternal mental health and breastfeeding. The evidence suggests that breastfeeding can have a preventative effect on mental illness developing. A large scale research study published in 2014 showed that mothers who planned to breastfeed and who actually went on to breastfeed were around 50% less likely to become depressed that mothers who had not planned to, and who did not, breastfeed. Mothers who planned to breastfeed but who did not go on to breastfeed were over twice as likely to become depressed as mothers who had not planned to, and who did not breastfeed. (Borra 2015)

This is where peer support is so valuable. Breastfeeding Network (BfN) and the Association of Breastfeeding Mothers support over 60,000 families across the UK every year. Peer support combines essential qualities including training, experience, listening-skills, non-judgmental approach and a belief in supporting choice in infant feeding. Between the two organisations, they train and supervise peer supporters, run local projects and drop in groups, and volunteers trained by both charities run the National Breastfeeding Helpline. The information and support provided is evidence based, non-judgmental, and mother-centered. The BfN also runs a specialist Drugs in Breastmilk Helpline which receives over 7000 enquiries per year, over 15% of callers present with mental health issues. This line is currently unfunded and costs are met through the charity’s reserves and fundraised income.

Both organisations work to independently inform and support women, families and communities on infant feeding. We are particularly driven to support women who face highest barriers to breastfeeding and in areas where rates are low.

BfN peer support helps families negotiate their breastfeeding journey. Feedback from a recent evaluation is illustrated in these wordle drawings showing how women felt before and after BfN support.

Figure 1. Mums attending our focus group were asked for a word or phrase to describe their situation before contact with BfN. The majority were facing a difficult situation, while others who were seeking information described themselves as “hopeful”, “curious” or “learning.” The results are shown below
However, reduction in funds and vital services being delivered solely through volunteers is pressurising and unsustainable. With no opportunities to offer training to potential volunteer mothers on the waiting list who

Figure 2. We asked the same focus group women who had given us a relatively negative set of words describing their ‘before’ situation to give a word or phrase for how they felt after receiving BfN support. The results are shown below. In addition the telephone interviews established the contrast for mums after receiving support with phrases including “totally different”, “less alone”, “much happier and still going”, and “reassured.”

However, reduction in funds and vital services being delivered solely through volunteers is pressurising and unsustainable. With no opportunities to offer training to potential volunteer mothers on the waiting list who
could share the load we have seen a worrying trend of our volunteers dropping out through burn-out and pressure despite efforts of the charity to support through regular meetings and activities, for example BfN lost 119 volunteers between 2013-14, taking our numbers below 1000 for the first time in several years. This collective knowledge is being lost from the charity and also vitally from communities.

The below is a list of areas where BfN work is facing uncertainty due to funding cuts and reduced funds:-

- North Lancashire
- Reading, Wokingham and West Berkshire
- Tameside & Glossop
- Gloucestershire
- London Borough of Hackney
- London Borough of Homerton
- London Borough of Tower Hamlets
- Gosport and Havant
- Portsmouth
- Windsor, Ascot & Maidenhead
- Bracknell Forest

We would like Public Health England to offer guidance to local authorities to improve their commissioning and de-commissioning decisions to include:

- Local leadership for infant feeding and young child health
- Understanding that although there may be more health visitors, there is no evidence that they either have the capacity to cover all the services lost in addition to their other wide-ranging responsibilities such as safeguarding, child protection and universal provision. In many areas, like other providers BfN volunteers and qualified practitioners have worked alongside health professionals to provide services successfully.
- Ensure that UNICEF Baby Friendly accreditation becomes a minimum requirement for all maternity and community settings, as recommended by NICE and following the examples set by Scotland and Northern Ireland
- Ensure that all mothers, regardless of where they live, receive skilled evidence-based breastfeeding support, as recommended by NICE, by making this provision a mandatory responsibility of Local Authorities
- Enable Local Authorities to carry out this responsibility by safeguarding the public health budget for universal health visiting services and breastfeeding support and include an assessment of impact to ensure they are meeting the needs of families least likely to breastfeed, as some services can widen inequalities.
- Protect all families from marketing by formula manufacturers by involving trading standards/ environmental health departments to enforce the UK law so that supermarkets and other retailers do not promote brands of infant formula
- Ensure Children’s Centres do not accept branded goods from infant feeding companies.
- Encourage local authorities, as employers, to set a good example by providing breaks to employees who are breastfeeding mothers to allow them to breastfeed or express milk at work.
Nationally the establishment of a multi-sectoral National Breastfeeding Committee, to develop and monitor the implementation of a National Breastfeeding Strategy is essential, particularly when so much change is happening.

References


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