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Short Communication

# Using community maternity care assistants to facilitate family-focused breastfeeding support

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**Abstract**

Increasing breastfeeding rates, particularly in lower socio-economic areas, would have considerable impact upon public health. Social support has been found to have direct and positive effects on breastfeeding rates, and fathers' attitudes have an important influence on the initiation and continuation of breastfeeding. In the UK, trained maternity care assistants (MCAs) are increasingly being used to support community midwives by providing post-natal women with breastfeeding support. The current study aimed to evaluate the feasibility and acceptability of MCAs involving fathers from economically deprived communities in antenatal breastfeeding discussions to equip them to provide support and encouragement.

Eleven couples who took part in the intervention were interviewed post-natally. MCAs, midwives and midwifery managers gave their views on the intervention and role of MCAs in the community. The study showed that MCAs with appropriate training are very effective at delivering antenatal breastfeeding information, which both mothers and other family members value. MCAs found giving such breastfeeding support both enjoyable and fulfilling, while involving fathers and family members proved a practical way of encouraging them to be more supportive. Midwives and midwifery managers were positive about involving MCAs in giving the antenatal intervention, but did not see the routine introduction of this type of session for couples being possible at present due to current staffing problems.

Involving fathers in breastfeeding support may start to increase knowledge and change attitudes towards breastfeeding in communities where formula feeding is seen as the normal way to feed a baby.

*Keywords:* breastfeeding, fathers, maternity care assistants, lower socio-economic groups.

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## Introduction

Increasing breastfeeding rates, particularly in lower socio-economic areas, would have considerable impact upon public health. Several UK Department of Health strategies recognize the importance of supporting breastfeeding, including Choosing Health (Department of Health 2004a), the National Service Framework for Children and Maternity Services (Department of Health 2004b) and recent Public Service Agreement indicators to monitor breastfeeding prevalence levels at 8 weeks (Department of Health 2008).

The latest UK National Infant Feeding Survey (Bolling *et al.* 2007) has shown that in 2005, 76% of babies were breastfed at birth, dropping to 48% at 6 weeks and 25% at 6 months. In lower socio-economic groups, 65% of mothers started to breastfeed, 32% at 6 weeks and 16% at 6 months.

Social support has direct and positive effects on breastfeeding rates. Studies have shown that a supportive environment is related to successful lactation (Marchand & Morrow 1994; Ingram *et al.* 2002), and additional support can increase breastfeeding duration (Britton *et al.* 2007).

Fathers' attitudes influence breastfeeding initiation and continuation. As fathers may be key supporters or deterrents to breastfeeding, they should be better prepared for their breastfeeding support role (Giugliani *et al.* 1994; Arora *et al.* 2000; Scott *et al.* 2001; Pollock *et al.* 2002). Studies targeting breastfeeding educational packages at fathers (antenatally or post-natally) have shown improved breastfeeding continuation rates (Ingram & Johnson 2004; Pisacane *et al.* 2005).

Currently, there is a shortage of midwives in the UK, making it increasingly difficult to deliver such interventions; therefore, identifying others who could offer them successfully is important. Recently posts for community health workers have been created to assist and support midwives, commonly known as maternity care assistants (MCAs). There are no national standards for MCA training and no consistency in their title or tasks (Sandall *et al.* 2007). They usually have basic training, based on a well-established Health Care Assistant role in acute settings [with national vocational qualifications (NVQs)], combined with additional community specific training. Such health workers can successfully provide additional support for breastfeeding women, and their role was found to be acceptable to both health professionals and mothers (Dykes 2003).

The current study aimed to evaluate the feasibility of using MCAs to deliver a validated antenatal breastfeeding package to family members from economically deprived communities to enable them to support and encourage breastfeeding.

## Methods

Midwifery managers and midwives in two National Health Service Trusts gave permission to contact MCAs already working in Sure Start communities with low breastfeeding prevalence [Index of Multiple Deprivation bottom quartile (APHO 2006)]. Sure Start is a UK government-funded programme based in areas of greatest deprivation, which aimed to achieve better outcomes for children and parents by improving services and giving financial support to parents (surestart.gov.uk).

Three MCAs integrated into local midwifery teams took part in the project. Each MCA was encouraged to recruit five to eight couples over a 6-month period. Primiparous mothers, who intended to breastfeed, were invited to take part with their partner (or another family member who would be supporting them post-natally) in the intervention session. Post-natal interviews were carried out by an experienced midwifery researcher at home with the mother and her supporter. Basic demographic information was collected, and views of the antenatal intervention and the MCA role were explored. Interviews were also conducted with the MCAs, five midwives and two midwifery managers by both researchers. These interviews explored MCAs' views of recruitment and delivering the intervention, midwives' views of working with MCAs and how the intervention might work in practice, and managers' views of the MCAs' role. All interviews were digitally recorded, transcribed and coded. Both researchers analysed them using a thematic approach of sorting quotations from the transcripts into themes and subthemes (Silverman 2000).

## The intervention

The MCAs' information session was based around a breastfeeding leaflet, written specifically for partners or grandmothers, with easy-to-read text and illustrations (Ingram & Johnson 2004); together with a demonstration of breastfeeding positioning and attachment using a doll (Box 1). The session took 30 to 40 min to deliver and was given at home around 36 weeks of pregnancy. The research project funded any additional time that MCAs spent delivering the couples' intervention.

Southmead Research Ethics Committee granted ethics permission in July 2006.

**Box 1. The couple's breastfeeding intervention (Ingram and Johnson 2004)**

| | |
|---|---|
| Topics covered by the colourful leaflet on five fold-out pages | *Breastfeeding health benefits *(choosing to breastfeed)*<br>*Good positioning and attachment *(how to breastfeed)*<br>*Feed management *(how breastfeeding works)*<br>*How fathers can support breastfeeding with practical tasks *(what you can do to help)*<br>*Some helpful tips |
| Demonstration of breastfeeding positioning and attachment using a doll | Women were encouraged to try using the doll to envisage what it might feel like to achieve a good breastfeeding position and to try out different places to feed |

## Results

### Participants

The MCAs were experienced health care assistants (HCA) who had worked in local maternity hospitals, had received in-house breastfeeding training, attended UNICEF Baby-Friendly Initiative training and had extensive practical experience. One MCA retained a part-time role in the hospital and the others only worked in the community. They worked in areas where breastfeeding rates at 8 weeks were around 24%.

**Table 1.** Demographic information about the couples (10) and maternity care assistants (MCAs) (3)

| Demographics | Study participants |
|---|---|
| Mothers' average age (range) | 29 years (17–34) |
| Fathers' average age (range) | 31 years (21–39) |
| Fathers' occupations | 2 unemployed, 3 manual, 2 office based, 3 professional |
| MCAs' average age (range) | 40 years (34–53) |
| MCAs' qualifications | 2 had NVQ II; 2 were breastfeeding counsellors |

NVQ, national vocational qualification.

MCAs approached 24 couples; 16 agreed to have the antenatal intervention at home and 11 interventions took place. The remaining couples were not involved for various reasons (family illness, baby born early, moving away or no date found to deliver the intervention). Post-natal interviews were carried out at around 10 weeks with 10 of the couples; the eleventh woman declined an interview. Nine couples lived in areas of the city classified as being in the lowest 25% in the Index of Multiple Deprivation (APHO 2006). All the mothers had started to breastfeed, three stopped in the first 2 weeks, one at 6 weeks and the remaining six were still breastfeeding successfully beyond 8 weeks. Table 1 shows their demographic information.

### Views of the intervention: themes arising

#### *Couples: empowerment, information and motivation*

The mothers were very positive about the antenatal intervention and MCA involvement. They liked having the session at home with their partner, found using the doll helped them practice breastfeeding positions, felt able to ask questions without feeling silly, and it gave them confidence about being able to breastfeed. They praised the MCAs' approach towards them and felt that they had been friendly and motivating. When breastfeeding, they commented that their partners had been very supportive and had kept them going.

For some fathers, this was their only information about breastfeeding, as most had not attended antenatal classes. They appreciated being able to ask questions in a personal situation rather than a group setting. Knowing the health gains for babies made them feel positive about breastfeeding, and this helped them motivate their partners to carry on. They also liked the leaflet written specifically for them with clear pictures and messages.

None of the couples had any contact with the MCAs at home post-natally; they would have liked some communication soon after delivery to find out how breastfeeding was going and a follow-up visit at home.

*MCAs: recruitment problems, enjoyment and reality*

The MCAs experienced problems with gaining access to women for the study. As their jobs generally focused on post-natal support for vulnerable women, they had to rely on obtaining names from midwives or by attending parentcraft classes and antenatal clinics. After approaching the women, they encountered reluctance to commit to a time for the intervention to take place with their partner, despite offering a range of flexible options.

Encouragingly, they enjoyed giving the antenatal session and felt that it was very successful. They found it easy to involve couples in discussion, and it gave fathers a chance to try things out and ask questions.

Ideally, they felt this type of session should be offered to all those intending to breastfeed. Realistically, due to workload pressures, they felt that it would have to be limited to selected women only, such as first-time mothers, those not attending antenatal classes and teenagers. Midwives would also need to recognize and support the initiative for it to be integrated routinely, and possibly group sessions with couples would be more time efficient.

Training to enable delivery of this educational intervention was discussed. MCAs felt that basic HCA training (with in-house breastfeeding training) combined with hands-on breastfeeding experience in hospital was important and gave them confidence to advise women effectively.

*Midwives and managers: management issues, training and MCA roles*

The appointment of MCAs was a recent innovation in the study areas, and midwives described initial feelings of uncertainty. However, once they experienced working with MCAs and could trust their level of expertise, they found them invaluable. Despite the fact that the MCAs' tasks were developing around support for vulnerable women in the *post-natal* period, midwives felt that this antenatal breastfeeding intervention was relevant and had the potential to fit in well with their work.

Midwives felt that MCAs' previous experience in hospital-based maternity care was vital, because this developed both communication skills and the ability to work alone. They had to feel confident in MCAs knowing when to ask for help or refer women back to them. Breastfeeding training is essential, and Baby Friendly Initiative training, an NVQ in breastfeeding and practical experience were thought to be important. They emphasized that MCAs should be embedded into the system, offering support and enhanced visiting to specific women, especially teenagers.

Community midwifery managers, however, did not see the possibility of MCAs offering ongoing antenatal breastfeeding support within current staffing levels. Instead, they felt that partners should be encouraged to attend antenatal classes and appointments to enable them to be more involved.

## Discussion

The study shows that MCAs with appropriate training are capable of delivering a package of antenatal breastfeeding advice, which mothers and fathers value. MCAs found giving breastfeeding information to couples enjoyable and fulfilling, and involving fathers and other family members proved a feasible way to help them be more supportive to breastfeeding. Both midwives and midwifery managers were positive about MCAs giving breastfeeding advice, but saw the routine introduction of this type of session for couples as difficult within current staffing levels.

Limitations of the study are the small numbers of women and MCAs involved. Despite this, it has

highlighted some of the current issues in the provision of UK community post-natal care and the role of involving maternity care support workers. The participants' demographics were more mixed than expected, and so perhaps not representative of economically deprived areas, but this could reflect the recruitment difficulties experienced by the MCAs.

Currently, routine antenatal home visiting is not achievable for many UK midwives, so targeting specific women or being opportunistic about involving family members in breastfeeding discussions are possible options. Suitably trained MCAs could complement this with antenatal family-focused breastfeeding sessions. Their training should include detailed breastfeeding knowledge, combined with sufficient supervised practical experience and the opportunity to explore attitudes and beliefs around breastfeeding to enable them to be effective breastfeeding ambassadors.

In 2007, the Department of Health (2007) reported that effective initiatives in the maternity services included maternity support workers working with qualified midwives, thus enabling midwives to focus on their specialist role. MCAs can be a valuable asset post-natally, as they can give the time and support that breastfeeding women need, so perhaps also involving them antenatally would enhance continuity of care. Beake *et al.* (2005) reported that maternity support workers offered a more practical experiential approach to breastfeeding, reinforced by theoretical information in the form of 'tips and ideas', which women felt to be empowering. Hoddinott & Pill (2000) also found that women prefer their own decision making to be facilitated rather than being advised what to do, and in our study, it was suggested that MCAs might be better at this communication style than health professionals.

The debate about the role of MCAs is causing confusion among managers and midwives (Sandall *et al.* 2007). Our findings confirm Sandall's view that there is enthusiasm for the contribution that these support workers make to maternity teamwork, particularly breastfeeding support. Our study also indicates that provision of antenatal breastfeeding education for families is an important contribution that appropriately trained MCAs could make towards improving the quality of maternity care.

This type of family-focused intervention by health workers integrated into the midwifery team could be part of a comprehensive approach (including targeted health professional education and peer support) towards improving breastfeeding rates. Increasing the duration of breastfeeding in areas of high health inequalities will benefit the short and long-term health of infants and mothers. Involving family members in breastfeeding support may start to increase knowledge and change attitudes towards breastfeeding in communities where formula feeding is seen as the normal way to feed a baby.

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## Conflict of interests

The authors have no conflict of interest.

**Key messages**

- Maternity care assistants (MCAs) can deliver antenatal breastfeeding advice in a feasible intervention that mothers and fathers value and MCAs find fulfilling.
- MCAs breastfeeding training is important and should include an adequate amount of practical supervision to enable them to deliver such a package.
- Midwives and managers see this as a possible role for MCAs, but not within the current staffing situation.
- Involving fathers may start to increase knowledge and change attitudes towards breastfeeding in communities where formula feeding is seen as the normal way to feed a baby.

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