Infant Feeding Initiative

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This report evaluates the 79 best breastfeeding practice projects funded through the infant feeding initiative between 1999–2002. It provides a synthesis of the key challenges and findings from the projects as well as making recommendations on how best to support mothers who choose to breastfeed.

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www.doh.gov.uk/infantfeeding
# Contents

1 Executive Summary 5

2 Background 7
   2.1 Inequalities in breastfeeding rates 7
   2.2 Strategic Government Action 7
   2.3 Infant Feeding Initiative 8

3 Best Breastfeeding Practice Projects 9
   3.1 Criteria for the projects 9
   3.2 Method for evaluating the projects 9
   3.3 Methodological issues generated by the projects 10
   3.4 Project list 13

4 Thematic Summary of the Projects 18
   4.1 Exploratory studies 18
   4.2 Breastfeeding peer support programme 21
   4.3 Breastfeeding support centres 29
   4.4 Antenatal workshops/education programmes 35
   4.5 Health care assistant role 39
   4.6 Projects primarily involving qualified breastfeeding counsellors/supporters 43
   4.7 Education and training for health professionals 46
   4.8 School education 49
   4.9 Women from minority ethnic communities 54
   4.10 Adolescent mothers 58
   4.11 Significant others 61
   4.12 Miscellaneous 63

5 Project References and Summaries 67

6 Future Directions 202

7 References 208
This evaluation was funded by the Department of Health through their Public Health Development Fund. It is the culmination of the enormous commitment and work undertaken by the 79 project coordinators over the past three years. It reflects the depth of enthusiasm and creativity shown by the project teams in raising breastfeeding awareness and supporting those women who are least likely to breastfeed. The one-year projects were overseen by Christine Carson and Rosemary Thompson, National Infant Feeding Advisers at the Department of Health. Their vision, support and co-ordination were crucial to the development and completion of the projects. Thanks must be conveyed to the diverse range of participants engaged by the 79 projects teams for providing crucial feedback on interventions.

Thanks go to those who provided support to Fiona Dykes in conducting the final evaluation. This includes:

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### Glossary of Terms

<table>
<thead>
<tr>
<th>Term</th>
<th>Abbreviation</th>
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<tr>
<td>Association of Breastfeeding Mothers</td>
<td>ABM</td>
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<td>Breastfeeding Network</td>
<td>BfN</td>
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<tr>
<td>Department of Health</td>
<td>DH</td>
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<tr>
<td>General Practitioner</td>
<td>GP</td>
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<td>Health Care Assistant</td>
<td>HCA</td>
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<td>La Leche League</td>
<td>LLL</td>
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<td>The Local Infant Feeding Audit</td>
<td>LIFA</td>
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<tr>
<td>Maternity Services Liaison Committee</td>
<td>MSLC</td>
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<td>National Childbirth Trust</td>
<td>NCT</td>
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<tr>
<td>Personal Social Health Education</td>
<td>PSHE</td>
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<tr>
<td>Primary Care Group</td>
<td>PCG</td>
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<tr>
<td>Primary Care Trust</td>
<td>PCT</td>
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<td>DH Priority and Planning Framework</td>
<td>PPF</td>
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<tr>
<td>Randomised Controlled Trial</td>
<td>RCT</td>
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<td>World Health Organisation</td>
<td>WHO</td>
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</table>
The Department of Health (DH) has recognised the potential impact upon public health to be gained by increasing rates of breastfeeding with particular focus upon socially excluded groups. Further commitment to this goal is reflected in the DH document *Improvement, Expansion and Reform: The Next Three Years. Priority and Planning Framework 2003-2006* (DH 2002a). This requires all Primary Care Trusts (PCTs) to increase their breastfeeding initiation rates by 2 percentage points per year with particular focus on women from disadvantaged groups.

Commitment to this goal of reducing health inequalities has included funding a range of innovative projects both in practice settings and universities, that aim to empower socially disadvantaged women to breastfeed. Seventy-nine Infant Feeding Projects were funded between 1999 and 2002 by the DH through their Public Health Development Fund. The projects centred upon the development of innovative practices that aimed to increase the incidence and duration of breastfeeding. The target groups were those least likely to breastfeed. Each project ran over one year. The majority of projects were developmental and capacity building rather than empirical research, although ten academic projects were funded during the third year.

This evaluation provides a synthesis of the key challenges and findings derived from the projects. In section 2 the background to the Government's Infant Feeding Initiative is described. In section 3 the criteria for the projects and the method for evaluating the projects are specified and some of the methodological issues raised by the evaluation are discussed. Section 4 provides a summary of key considerations for practice raised by each report. These are grouped under the following headings:

- Exploratory studies
- Breastfeeding peer support programmes
- Breastfeeding support centres
- Antenatal workshops/Educational programmes
- Health care assistant role
- Projects primarily involving qualified breastfeeding counsellors/supporters
- Education and training for health professionals
- School Education
- Women from minority ethnic communities
- Adolescent mothers
- Significant others
- Miscellaneous

1 Executive Summary
Section 5 contains a full summary of each project. Section 6 makes recommendations for future practice developments. References are provided in section 7.

The projects included in this evaluation provide an important contribution to understanding ways in which women in communities least likely to breastfeed may be supported and encouraged to initiate and continue breastfeeding. They provide a guide to the realities and practicalities involved in changing cultures in which breastfeeding is a marginal activity that is rarely seen and little talked about. Many teams have remained committed to their aims and have gone on to secure further funding to expand and improve their services. The critical mass of innovation encapsulated by these projects holds considerable promise for enabling the government targets related to breastfeeding to be met.
2 Background

2.1 Inequalities in breastfeeding rates

Breastfeeding is now well established as having a major role in the health of mothers and babies (WHO 2002). The World Health Organisation (WHO) recommends that the optimum form of infant feeding is exclusive breastfeeding for six months or beyond (Kramer and Kakuma 2003) followed by partial breastfeeding for 2 years or more (WHO 2002).

The National Infant Feeding Surveys, which were instigated in 1975 and carried out at 5-yearly intervals, provide a review of infant feeding trends in the UK. The fifth and sixth Infant Feeding surveys provide data for the past ten years (Foster et al 1997, Hamlyn et al 2002). The surveys show an improvement in breastfeeding rates since 1990 in all countries of the UK with the overall initiation rate being 66% in 1995 and 69% in 2000. In 2000 only 42% of mothers were breastfeeding (partial or exclusive) at 6 weeks and only 21% at 6 months. Over 80% of women who stopped breastfeeding before 4 months stated that they would have liked to have continued for longer.

2.2 Strategic Government action

There are striking differences in initiation and continuation rates of breastfeeding related to educational levels, geographical location and age. For example, 78% of mothers aged 30 or above commenced breastfeeding compared to 46% of mothers aged less than 20. The incidence of breastfeeding in London and South East is 81% compared to 61% in the North of England. These variations are generally assumed to be the result of differing socio-demographic characteristics, in particular the greater concentration of mothers from the higher socio-economic groups resident in London and the South East. Although an increase in the women in socially excluded areas commencing breastfeeding is evident in the 2000 data there are still striking differentials. In the UK, 85% of mothers classified to higher occupations breastfed initially. This compared with 73% of mothers in intermediate and 59% in lower occupations. The lowest initiation rate was evident among those mothers who had never worked, this figure being 52% (Hamlyn et al 2002).

The government inquiry focusing upon inequalities in health (DH 1999) highlights infant feeding practices as an issue related to inequity. The report recommends increasing the prevalence of breastfeeding. The potential impact of increasing breastfeeding rates upon public health has also been recognised in the Government’s NHS Plan where a commitment to increase support for breastfeeding by 2004 forms part of the proposed strategy to improve diet and nutrition (DH 2000). The NHS Plan prioritises the reduction of health inequalities and so draws attention to the wide variation in breastfeeding prevalence in the different socio-economic groups. Lack of breastfeeding contributes to the increased morbidity and mortality seen in the lowest socio-economic groups and research evidence suggests that at least two of the designated priority areas for action, namely cancers and coronary health, could be positively impacted by increasing breastfeeding rates. The newly published document ‘Modernising Maternity Care: A Commissioning Toolkit for Primary Care Trusts in England’ (Maternity Care Working Party 2001) endorses this suggestion and, in order to achieve such improvements, advocates that service providers demonstrate effective and appropriate breastfeeding policies and provide ongoing support to mothers experiencing breastfeeding problems.
Further commitment to this goal is reflected in the DH document *Improvement, Expansion and Reform: The Next Three years Priority and Planning Framework 2003-2006* (DH 2002). This requires all Primary Care Trusts (PCTs) to increase their breastfeeding initiation rates by 2 percentage points per year with particular focus on women from disadvantaged groups. The Performance and Planning Framework (PPF) provides guidance on operationalisation of this and also requires PCTs to monitor their activities in relation to national breastfeeding targets.

### 2.3 Infant Feeding Initiative

In 1999 as part of the government commitment to improving inequalities in health the Infant Feeding Initiative was launched. This 3-year project was funded through the Public Health Development Fund. The aim of the initiative was to increase the incidence and duration of breastfeeding amongst those groups of the population who were least likely to breastfeed. Two national infant feeding advisers were appointed, Christine Carson and Rosemary Thompson. This provided an infrastructure for the development and dissemination of strategies for promoting breastfeeding (Carson 2001). Over the three years of the Infant Feeding Initiative, money was allocated from the Public Health Development Fund to support projects that identified and developed innovative practices that aimed to increase breastfeeding initiation and duration rates. In line with Government policy to reduce health inequalities the projects were aimed specifically at populations who were least likely to breastfeed. Seventy-nine proposed projects were successful in obtaining funding. These projects are evaluated in the remainder of this report. A summary report is also available on the website: www.doh.gov.uk/infantfeeding
3 Best Breastfeeding Practice Projects

3.1 Criteria for the projects

As stated, in line with Government policy to reduce health inequalities the projects were aimed specifically at populations who were least likely to breastfeed. This was a criterion for all projects. Each project ran over one year. The full list of funded projects is included in chapter 5.

Projects for the first year (1999-2000) fell into two categories, best practice in increasing breastfeeding rates among mothers on low incomes and parent friendly approaches to infant feeding, particularly those that targeted young people. Priority was given to existing projects so that they could be evaluated. Funds could be used to write up, publish and disseminate the lessons learned from these projects. Thirty-one projects were successful in gaining funds.

Projects for the second year (2000-2001) were required to reflect best practice in increasing breastfeeding rates among mothers on low income. The Department of Health was particularly interested to receive projects that were using existing professional staff to change practice in increasing breastfeeding rates among women least likely to breastfeed. The projects were to recommend policies that increased the prevalence and/or duration of breastfeeding among women least likely to breastfeed. Twenty-four projects were successful in gaining funds.

Projects for the third year (2001-2002) were again required to reflect best practice in increasing breastfeeding rates among mothers on low income. Innovative projects reflecting novel approaches were given priority. Emphasis was placed upon good practice and sustainability. During the third year, in addition to funding practice projects, ten academic projects were also funded. These could include: health economics and inequalities to inform policy; effective partnerships between academic institutions and service providers to improve breastfeeding rates; evaluation of existing practice and its effectiveness in relation to breastfeeding. It was expected that these projects would inform policy. Twenty-four projects were successful in gaining funds.

The practice projects were complex in nature and involved the implementation and evaluation of several new strategies for service delivery. Most were set up as developmental, capacity building and reflexive. There was therefore considerable heterogeneity in relation to project methods and outcomes.

3.2 Method for evaluating the projects

Given the practice, experiential and developmental focus of the majority of the studies and their heterogeneity the approach to reviewing the reports was necessarily broad and inclusive of all the projects. The process of collating the projects aimed to:

- Summarise and evaluate the information generated by the individual projects
- Produce a synthesis of common themes across projects
- Provide insights into innovative ways of delivering services
Identify good areas of practice which may be transferable

Inform national infant feeding policy

Make recommendations for areas in the field of infant feeding that would warrant further research.

Particular focus was placed upon drawing out key issues that relate to the practicalities of implementing innovations. Emphasis was placed on ways in which projects incorporated sustainability through further funding and employment of additional personnel. It was not the intended aim of this evaluation to conduct an evaluation that adhered to formal systematic review procedures, meta-analysis or meta-synthesis. However, some of the principles of meta-synthesis of qualitative research were applied (Sherwood 1997).

The evaluation commenced with the development of data/information extraction forms that would enable each study to be summarised under standard headings. These headings were broad enough to allow for the heterogeneity and practice focus of the studies. Each study was then read and summarised under the relevant headings. Statistical support was provided for those projects utilising various forms of quantitative data. The project summaries are presented in chapter 5. These enable the reader to obtain an overview of each project. Associated publications and peer reviewed conference presentations are listed with each project summary.

Project co-ordinators were contacted to request missing or follow-up data, to clarify project details and to seek conclusions or information on ways in which the projects have been sustained. Contact was made by phone or email with 77 of the 79 project co-ordinators or designated others. Despite several attempts it was not possible to locate two of the project teams. Details of contacts were carefully audited. Despite contacting project leaders a considerable number of projects still had missing, insufficiently detailed or incomplete data. Therefore, the evaluation was conducted to the best of the author’s ability based on the data provided.

Commonalities between projects were organised primarily by grouping projects that focused on specific practice issues, e.g. establishment of breastfeeding peer support programmes. Reports were then organised, condensed and summarised accordingly. These thematic groupings are presented in chapter 4. Within each grouping recommendations are made regarding areas that may merit further research.

Central to these recommendations is the government target of increasing breastfeeding rates by 2 percentage points for each of the next three years with particular focus on women from disadvantaged groups.

It is outside the scope of this evaluation to provide a review of available breastfeeding research or to integrate the evaluations with existing research. Systematic reviews focusing upon breastfeeding practices may be readily accessed through the Cochrane Library (Fairbank et al 2003, Kramer and Kakuma 2003, Renfrew et al 2003, Sikorski et al 2003) and related publications (Tedstone et al 1998, Fairbank et al 2000, Renfrew et al 2000, Couto de Oliveira 2001). It is recommended that when further research and/or interventions in practice are planned, the available systematic reviews should be studied in conjunction with the findings of this evaluation.

### 3.3 Methodological issues generated by the projects

As stated, most of the projects were set up as developmental, capacity building and reflexive. The majority involved some form of intervention, e.g. setting up a peer support programme or providing an antenatal workshop. Most projects referred directly or indirectly to their ultimate aim of increasing
initiation and duration of breastfeeding in their target group. However, as authors went on to acknowledge this aim was neither achievable nor demonstrable within one year but might well be when data was collected in two to three years time. They therefore appropriately demonstrated their findings with descriptive statistics rather than utilising inferential statistics. Demonstrating statistically significant increases would generally require large samples and a concurrent, comparable, control group that did not receive the intervention being studied. Many of the projects had a key and highly relevant component of in-depth qualitative work with small-to-moderate sized groups of mothers or service providers. It would therefore be difficult to provide sophisticated quantitative analyses and achieve the qualitative aims within the same study.

Although five studies adopted an experimental or quasi-experimental design (Shanahan and Morris 2001, Winterburn and Jiwa 2001, Sikorski et al 2002, Kendall 2002, Spencer et al 2002) the use of historical controls was the commonest approach utilised to demonstrate an effect of an intervention on breastfeeding rates. However, most authors referred to considerable difficulties in obtaining accurate pre-study audit data on breastfeeding rates. Firstly, there was lack of clarity and consensus between data sets and indeed data collectors on the definitions of breastfeeding. Secondly, the data collection points were often different in the pre-study data. Thirdly, pre-study data had not included demographic data on, e.g. socio-economic status.

Finally, there was often a lack of a co-ordinated approach to data collection. This was particularly evident across the hospital/community interface. Some maternity services relied on a combination of data base figures and data collected and collated by individuals, e.g. health visitors. In the latter case the data had sometimes to be extracted from individual records. When a specific area was focused upon to provide an intervention, e.g. a ‘drop-in’ centre in a Sure Start area, it was particularly difficult to gather accurate historical data. Likewise there were special problems if the project was focusing on a sub-group of women in the area, e.g. a specific minority ethnic group. For some very mobile populations it was difficult to obtain follow-up data on the women participating in the study. Some studies relied upon self-reported data obtained through postal questionnaires regarding breastfeeding duration. However, difficulties with retrospective recall and incomplete data limited conclusions that could be drawn.

Difficulties were also experienced in collecting and collating data following interventions. This often relied upon an admirable tenacity and persistence on the part of the project co-ordinator(s). This was often very time consuming. These difficulties led in some cases to a review of database usage and data collection procedures and subsequently these were substantially improved upon. This was an important additional outcome of a number of projects.

Projects that reported breastfeeding rates tended to show an increase associated with the intervention of interest. However, authors correctly urged caution in attributing cause and effect, because the influence of other factors such as seasonal or random variation or other unidentified changes could not be excluded. Some of the studies were conducted in association with maternity services that were engaging with the UNICEF UK Baby Friendly Initiative. The practice changes involved in meeting the criteria to achieve the UNICEF award would undoubtedly have confounding effects.

These examples illustrate the difficulties in interpretation of such data. These problems with interpretation persist even where a statistical test would have shown a significant difference. Self-selection may, for example, skew results and this may be particularly evident when recruiting from socially excluded communities. It may occur at three points in the intervention: people may self-select to participate, to avail themselves of a service, or to be involved in an evaluation. Figures are likely to be biased by the self-selection of women who have a prior disposition towards breastfeeding. In some cases less than a quarter of women approached agreed to participate in a study. Only a few studies specifically reported the characteristics of non-participants, although some went to some lengths to interview those who did not wish to utilise a service offered. Equally there was a high degree of self-selection evident in
some studies due to low response rates to evaluation methods, e.g. questionnaires, and again only a few studies reported on the characteristics of respondents versus non-respondents. As is common in quantitative research, making different assumptions about the missing data from mothers who did not respond in a study may have potentially changed the conclusions in some projects.

Most studies do however illustrate a trend towards increases in breastfeeding initiation and/or continuation rates measured in percentage points. The qualitative data in many of the studies suggests a strong impact of a number of interventions upon individual women's breastfeeding experiences. It was commonly stated that women would have stopped breastfeeding earlier than intended had it not been for the intervention. This impact will be discussed in more depth under the section headings in the next chapter. In addition to women's reports, many of the projects made important changes in deeply ingrained bottle feeding cultures where some women had never seen a baby at the breast. The effects of these changes are likely to be seen in a gradual acceptance of breastfeeding as both possible and achievable and this is a key route to ultimately producing sustainable changes to breastfeeding rates. The authors of the projects often demonstrated highly developed levels of reflexivity and this, combined with their honesty about the challenges and constraints related to managing change, provided material for this report that is illuminating, challenging and informative. This type of material is often missing from standard published papers and therefore becomes invisible.

Some studies were specifically exploratory generating qualitative data related to women's attitudes and experiences and/or existing practices. These were mostly third-year academic projects under the criteria of 'evaluating existing practice' (Baker et al 2002, Clarke et al 2002b, Cloherty et al 2002, Hall Moran et al 2002, Shaw and Wallace 2002 and Toole 2002), although one was conducted during the first year (Hawkins and Heard 2001). These make important contributions to the body of knowledge related to existing perceptions and practices in relation to infant feeding in groups least likely to breastfeed. Another particularly useful methodology utilised was action research. This provided an important critical perspective to issues such as peer support (Clarke et al 2002a), one-to-one support (Williams and Tatman 2000), midwifery practice (Price 2002), education in schools (Lockey and Hart 2002) and attitudes of significant others, e.g. men (Best 2002). This methodology is very much in line with the government's policy to capacity build and empower communities.

In the next chapter, studies are grouped and placed in sections by theme to enable the drawing out of commonalities across studies. Some studies are referred to in more than one section as they have relevance to two or more themes, e.g. adolescents and women from minority ethnic groups. This leads to some degree of repetition but it enables a reader to turn to a specific section and gain an overview of all studies relevant to that theme. Cross referencing to a more comprehensive summary in chapter 5 may then be carried out if required.
### 3.4 Project List

<table>
<thead>
<tr>
<th>Author(s)</th>
<th>Year</th>
<th>Title *</th>
<th>Intervention/Area explored</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adams L, Cundy A, Carrick I, McNamara L</td>
<td>Yr.1 2001</td>
<td>Breastfeeding Friendly Award</td>
<td>Development and evaluation of an accreditation and award scheme for ‘Breastfeeding Friendly’ premises.</td>
</tr>
<tr>
<td>Bachelor G, Brackstone C</td>
<td>Yr.1 2001</td>
<td>Breastfeeding Peer breastfeeding Support Project</td>
<td>Establishment and evaluation of a peer support scheme.</td>
</tr>
<tr>
<td>Barker C</td>
<td>Yr.1 2001</td>
<td>Breastfeeding Training</td>
<td>Provision of an antenatal breastfeeding workshop for women and their grandmothers or significant other.</td>
</tr>
<tr>
<td>Banarsee R</td>
<td>Yr.1 2001a</td>
<td>A collaborative model for the promotion of breastfeeding: an implementation of a guide to good practice</td>
<td>Conduct of an action orientated audit methodology and establishment of a breastfeeding clinic and programme of staff education.</td>
</tr>
<tr>
<td>Banarsee R</td>
<td>Yr.1 2001b</td>
<td>Altogether better: working towards a multi-agency approach to breastfeeding</td>
<td>Conduct of an interagency audit of rates and implementation of multi-disciplinary staff education.</td>
</tr>
<tr>
<td>Bartlett B, Cook P</td>
<td>Yr.1 2001</td>
<td>Streetwise Breastfeeding</td>
<td>Provision and evaluation of additional antenatal teaching and postnatal support related to breastfeeding for adolescents.</td>
</tr>
<tr>
<td>Battersby S</td>
<td>Yr.1 2001a</td>
<td>Simply the Breast, Evaluation of a Peer Support Programme</td>
<td>Establishment of a breastfeeding peer support project and linkage with the neighbouring ‘Wordly Wise’ project with ongoing evaluation.</td>
</tr>
<tr>
<td>Battersby S</td>
<td>Yr.1 2001b</td>
<td>The Wordly Wise Project: An evaluation of non-professional mature women as breastfeeding supporters</td>
<td>Appointment, training and evaluation of non-professional mature women as breastfeeding supporters.</td>
</tr>
<tr>
<td>Battersby S</td>
<td>Yr.3 2002</td>
<td>Breastfeeding is Best Supporters (BIBS) (Practice)</td>
<td>Amalgamation of two breastfeeding peer support programmes ‘Simply the Breast’ and the ‘Wordly Wise’ project to form the ‘Breastfeeding is Best Supporters’ (BIBS) project. Ongoing evaluation conducted.</td>
</tr>
<tr>
<td>Beake S, McCourt C</td>
<td>Yr.3 2002</td>
<td>Evaluation of the use of health care assistants to support disadvantaged women breastfeeding in the community (Academic)</td>
<td>Establishment and evaluation of a health care assistant role to support disadvantaged women with breastfeeding in the community.</td>
</tr>
<tr>
<td>Beresford B</td>
<td>Yr.2 2002</td>
<td>Breastfeeding for us</td>
<td>Production and evaluation of a breastfeeding education video.</td>
</tr>
<tr>
<td>Best L</td>
<td>Yr.2 2002</td>
<td>Breastfeeding – it’s a man thing!</td>
<td>Participatory action research utilising forum theatre to raise male awareness of the benefits of breastfeeding.</td>
</tr>
<tr>
<td>Author(s)</td>
<td>Year</td>
<td>Title *</td>
<td>Intervention/Area explored</td>
</tr>
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</tr>
<tr>
<td>Brown S, Draisey A</td>
<td>Yr.1 2001</td>
<td>Dickens Diners.</td>
<td>Establishment and evaluation of a breastfeeding peer support scheme.</td>
</tr>
<tr>
<td>Buchanan P, Broadfoot, Hastings M, Purtill E, Macfarlane A, Barnett S</td>
<td>Yr.3 2002</td>
<td>‘Supporterline’ Project. Only a call away; accessing breastfeeding support by phone, the evaluation of the telephone support</td>
<td>Extension and evaluation of an existing Breastfeeding Network (BN) ‘Supporterline’ to increase accessibility in areas of low breastfeeding.</td>
</tr>
<tr>
<td>Charlton J, Meredith E, Jennings C</td>
<td>Yr.1 2001</td>
<td>Supporting active breastfeeding mothers</td>
<td>Establishment and evaluation of an antenatal support group and education programme related to breastfeeding.</td>
</tr>
<tr>
<td>Childs L, Jessop G, Wood M</td>
<td>Yr.1 2001</td>
<td>Breastfeeding Initiative</td>
<td>Establishment and evaluation of an antenatal visiting initiative and breastfeeding support groups.</td>
</tr>
<tr>
<td>Clarke C, Gibb C, Dowling G</td>
<td>Yr.3 2002b</td>
<td>Breastfeeding: Service and Practice Models, the role of the reflective cycle in developing practice (Academic)</td>
<td>Qualitative study to identify key characteristics of service delivery, professional education and clinical practices that influence breastfeeding management.</td>
</tr>
<tr>
<td>Cloherty M, Alexander J, Holloway I</td>
<td>Yr.3 2002</td>
<td>An ethnography concerning the supplementation of breastfed babies (Academic)</td>
<td>Ethnographic exploration of the beliefs, expectations and experiences of breastfeeding mothers and health professionals in relation to the supplementation of babies in hospital.</td>
</tr>
<tr>
<td>Coutts J</td>
<td>Yr.2 2002</td>
<td>Peer breastfeeding support for teenage mothers</td>
<td>Establishment of a breastfeeding peer support programme.</td>
</tr>
<tr>
<td>Curtis P, Stapleton H, Kirkham M, Smale M</td>
<td>Yr.1 2001</td>
<td>Breastfriends</td>
<td>Establishment and evaluation of breastfeeding peer support scheme with emphasis upon younger mothers.</td>
</tr>
<tr>
<td>Dassut W, Ridgers I</td>
<td>Yr.2 2002</td>
<td>Breastfeeding Peer Support Group</td>
<td>Establishment and evaluation of a breastfeeding peer support scheme.</td>
</tr>
<tr>
<td>de Waymarn S</td>
<td>Yr.2 2002</td>
<td>Breastfeeding support within Sure Start project (SWISS).</td>
<td>Establishment and evaluation of a breastfeeding peer support scheme.</td>
</tr>
<tr>
<td>Dore M, Parker L, Sherrif D</td>
<td>Yr.3 2002</td>
<td>Breastfeeding Regenerating project (Practice)</td>
<td>Establishment and evaluation of a breastfeeding ‘drop-in’ centre in a diverse multiethnic community.</td>
</tr>
<tr>
<td>Dowling G</td>
<td>Yr.2 2002</td>
<td>B.E.B.E.P Black and Ethnic Breastfeeding Education Programme</td>
<td>Establishment and evaluation of a breastfeeding workshop for black and minority ethnic groups.</td>
</tr>
<tr>
<td>Dye J</td>
<td>Yr.1 2001</td>
<td>La Leche League Breastfeeding Peer Counsellor Programme Evaluation Project</td>
<td>Expansion and evaluation of a recently established breastfeeding peer support programme.</td>
</tr>
<tr>
<td>Etherington S</td>
<td>Yr.1 2001</td>
<td>BreastFriends Project</td>
<td>Establishment and evaluation of a breastfeeding peer support scheme.</td>
</tr>
<tr>
<td>Author(s)</td>
<td>Year</td>
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<td>Evans G</td>
<td>Yr.3</td>
<td>2002  Breastfeeding Advocacy Project</td>
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<tr>
<td>Farrell S</td>
<td>Yr.3</td>
<td>2002  Increasing breastfeeding rates among mothers in a prison (Practice)</td>
<td>Establishment of workshops and related activities to raise awareness of breastfeeding and support for breastfeeding women in prison.</td>
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<tr>
<td>Finigan V, Hughes T, Brears D</td>
<td>Yr.1</td>
<td>2001 BreastFeeding Reassurance and Guidance Group (BRAGG)</td>
<td>Evaluation of existing breastfeeding support groups, training of Urdu and Bangla peer supporters and exploratory research into the needs of local minority ethnic women</td>
</tr>
<tr>
<td>Flynn M, Savage J</td>
<td>Yr.1</td>
<td>2001 Empowering Mums through education</td>
<td>Re-launch and evaluation of an existing teenage mothers’ support group to incorporate ante and postnatal education and support related to breastfeeding.</td>
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<tr>
<td>Foyle S, Wilson K</td>
<td>Yr.1</td>
<td>2001 Breastfeeding support for women on low incomes</td>
<td>Employment and training of a community health care assistant to provide breastfeeding education and support for women during pregnancy and the postnatal period.</td>
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<tr>
<td>Geaney L</td>
<td>Yr.2</td>
<td>2002 ‘One to Mum’ – Peer support</td>
<td>Establishment and evaluation of a breastfeeding peer support scheme.</td>
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<tr>
<td>Gill S, Murdock H</td>
<td>Yr.1</td>
<td>2001 Community Breastfeeding Classes</td>
<td>Provision and evaluation of antenatal breastfeeding classes.</td>
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<tr>
<td>Ginty L, Umusu J</td>
<td>Yr.2</td>
<td>2002 Breastfeeding Project</td>
<td>Employment and evaluation of an NCT breastfeeding counsellor to provide additional support to breastfeeding women. Staff education.</td>
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<tr>
<td>Hall Moran V, Dykes F, Edwards J, Burt S</td>
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<td>2001 Breastfeeding Support – Targeting Teenagers</td>
<td>Exploration of the acceptability of a variety of supportive approaches to adolescent mothers related to breastfeeding their babies.</td>
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<td>Hammond P</td>
<td>Yr.1</td>
<td>2001 Designed for Health – Breastfeeding volunteer support programme</td>
<td>Establishment and evaluation of a breastfeeding peer support scheme.</td>
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<tr>
<td>Hastings J, Whitmore M, Buchanan P, Sachs M, Broadfoot M, Britten J, Lamont C, Hands A, Morton H</td>
<td>Yr.1</td>
<td>2001 Breastfeeding support is for everyone, meeting the needs of all women.</td>
<td>Establishment and evaluation of two Breastfeeding Network (BfN) Support Centres.</td>
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<td>Hawkins A, Heard S</td>
<td>Yr.1</td>
<td>2001 An investigation of the factors which may affect the duration of breastfeeding by first time mothers from low income groups</td>
<td>Exploration of breastfeeding expectations and experiences of mothers on low income</td>
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<td>Hodgson E, Burns I</td>
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<td>2001 Peer Support Groups</td>
<td>Establishment and evaluation of a breastfeeding peer support scheme.</td>
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<tr>
<td>Ingram J, Johnson D</td>
<td>Yr.2</td>
<td>2002a Managing Breastfeeding Problems</td>
<td>Production and evaluation of evidence-based leaflets on breastfeeding problem management for women.</td>
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<td>Ingram J, Johnson D</td>
<td>Yr.3</td>
<td>2002b Asian Grandmothers’ influence on breastfeeding (Academic)</td>
<td>Development and evaluation of an intervention in which grandmothers participated in antenatal education and support for South Asian women.</td>
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<td>Kallat M</td>
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<td>Provision and evaluation of an antenatal workshop and postnatal home visit.</td>
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<td>Kendall S, Entwistle F</td>
<td>Yr.3 2002</td>
<td>Breastfeeding Education Training Awareness (BETA). A comparative study to evaluate the effect of training on midwives’ ability to promote breastfeeding among low income women (Academic)</td>
<td>Quasi-experimental study to evaluate the effect of the UNICEF UK Baby Friendly Initiative Breastfeeding Management course on the ability of midwives to promote breastfeeding among low income women.</td>
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<td>Kirkham M</td>
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<td>Breastfriends in Education (Practice)</td>
<td>Extension and evaluation of an existing breastfeeding peer support project ‘Breastfriends’ into educational settings.</td>
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<td>Lincoln J, Jones L</td>
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<td>BABES Babies and Breastfeeding Encouragement and Support</td>
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<td>Locke J</td>
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<td>Lockey R, Hart A</td>
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<td>Addressing Inequalities in Health: The Breast Benefits project</td>
<td>Action research project involving implementation and evaluation of breastfeeding education in schools</td>
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<td>Mason B</td>
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<td>Feeding 4 Health</td>
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<td>McFadden K</td>
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<td>Mothers Helping Mothers</td>
<td>Establishment and evaluation of an antenatal breastfeeding work-shop supplemented by postnatal home support.</td>
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<td>McNabb M</td>
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<td>CATCH – An evidence-based breastfeeding project</td>
<td>Establishment and evaluation of a biological nurturing strategy for supporting breastfeeding mothers.</td>
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<td>Middlemiss A</td>
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<td>Implementation and evaluation of a breastfeeding education in schools package.</td>
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<td>Pardoe C, Williams J</td>
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<td>The Baby Café</td>
<td>Establishment and evaluation of a breastfeeding support centre called the Baby Café.</td>
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<td>Price M</td>
<td>Yr.3 2002</td>
<td>An action research project to facilitate skin-to-skin contact at birth and breastfeeding (Academic)</td>
<td>An action research project involving working in collaboration with mothers and midwives to facilitate the implementation of early skin-to-skin contact and breastfeeding.</td>
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<td>Shanahan H, Morris S</td>
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<td>Initiative in Breastfeeding (CRIB).</td>
<td>An experimental study to assess the value of an antenatal teaching session upon postnatal positioning and attachment ability, satisfaction and duration of breastfeeding.</td>
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<tr>
<td>Shaw R, Wallace L</td>
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<td>Young Mothers Infant Feeding Study (Academic)</td>
<td>Exploration of young Asian, Black and White mothers’ experiences of infant feeding</td>
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<td>Sikorski J, Cruise K, Raikes N</td>
<td>Yr.2 2002</td>
<td>A Qualitative Study of Lay Breastfeeding Support</td>
<td>An experimental study to test the effectiveness of a peer support scheme in increasing breastfeeding prevalence.</td>
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<tr>
<td>Sookhoo M, King A</td>
<td>Yr.3 2002</td>
<td>Assistants with Breastfeeding (Practice)</td>
<td>Establishment and evaluation of the training and employment of health care assistants to provide additional support to breastfeeding women on postnatal wards.</td>
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*Note: CRIB stands for ‘Comprehensive Relationship Identification and Breathing’. It is an antenatal teaching session aimed at improving postnatal positioning and attachment ability, satisfaction and duration of breastfeeding.*
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<tr>
<th>Author(s)</th>
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<td>Spencer SA, Jones EA, Dimmick PW</td>
<td>Yr.2 2002</td>
<td>Increasing Breastfeeding Rates</td>
<td>A pre-post test study to assess the effectiveness of a research-based programme of education upon the knowledge and practice of neonatal staff.</td>
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<td>Spiby H, Ker R, Smale M, D’Souza L, Renfrew M</td>
<td>Yr.2 2002</td>
<td>Introducing a Consumer-Practitioner into breastfeeding practice</td>
<td>Development and evaluation of a 'consumer-practitioner' to work in health, social and educational settings to utilise evidence in the promotion and support of breastfeeding from consumer perspectives.</td>
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<td>Breastfeeding Supporters.</td>
<td>Evaluation of an existing peer support programme and extension into a neighbouring area.</td>
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<td>Thompson E</td>
<td>Yr.3 2002</td>
<td>Breastfeeding and Thrush Research Programme (Academic)</td>
<td>Research on Candida and nipple/breast pain.</td>
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<td>Toole G, McFadden A</td>
<td>Yr.3 2002</td>
<td>Breastfeeding: A Fresh Start (Practice)</td>
<td>Exploratory research to elicit the views and experiences of low-income women related to breastfeeding.</td>
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<td>Waugh J, Subhedar NV</td>
<td>Yr.2 2002</td>
<td>Breastfeeding Sick Babies</td>
<td>Establishment and evaluation of a key worker scheme within a neonatal unit to increase the proportion of mothers of sick and premature babies who initiate and maintain breastfeeding.</td>
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<tr>
<td>Westman J</td>
<td>Yr.1 2001</td>
<td>Bridging the gap – the video approach</td>
<td>Development and evaluation of a breastfeeding video in Sylheti Bengali, English, Punjabi and Urdu.</td>
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<td>Whitmore M, Burt S, Vearncombe D</td>
<td>Yr.3 2002</td>
<td>Raising the profile of breastfeeding in lower income groups through general practice</td>
<td>Development, delivery and evaluation of practice-based breastfeeding awareness training for general practitioners and practice staff.</td>
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<tr>
<td>Willcocks D, Carden K</td>
<td>Yr.1 2001</td>
<td>Bumps ‘n’ Babes Project</td>
<td>Establishment and evaluation of a breastfeeding peer support scheme.</td>
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<td>Winterburn S, Jiwa M</td>
<td>Yr.1 2001</td>
<td>The impact of involving a female confidante of the mother’s own choice on the duration of breastfeeding</td>
<td>A randomised controlled trial to test the hypothesis that a close female confidante of the mother’s own choice if educated about breastfeeding could increase initiation and continuation of breastfeeding.</td>
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<td>Breastfeeding Supporter Project</td>
<td>Establishment and evaluation of a breastfeeding peer support scheme.</td>
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<td>Woodward V</td>
<td>Yr.3 2002</td>
<td>Peer breastfeeding support at home. An evaluation of a peer breastfeeding support at home service (Practice)</td>
<td>Establishment and evaluation of a breastfeeding peer support scheme.</td>
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</table>

* Place names have been removed from the project titles to ensure anonymity and confidentiality.
4 Thematic Summary of the Projects

4.1 Exploratory studies

<table>
<thead>
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<th>Table 1. Exploratory studies</th>
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<tr>
<td>Clarke et al (2002b)</td>
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<tr>
<td>Shaw, Wallace (2002)</td>
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<td>Toole, McFadden (2002)</td>
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Several studies were specifically exploratory in nature. These studies were all conducted with considerable methodological rigour and covered a diverse range of topics. They provide some valuable data that may be used to inform future interventions directed at socially excluded communities.

Hawkins and Heard (2001) conducted a series of in-depth interviews with pregnant and first time mothers on low incomes. Key influences upon their decision to breastfeed were family, friends and magazines. There had been very little exposure to positive role models for breastfeeding. The women’s expectations of breastfeeding were largely negative related to anticipated difficulty, pain and low milk supply. The postnatal interviews revealed that women were concerned that their milk was qualitatively and quantitatively inadequate. The reality of the experience often differed markedly from expectations, in some cases negatively but in some positively. Women felt inadequately supported by health professionals during the hospital stay but more supported by community staff once at home. Insufficient attention appeared to be given by health professionals to the establishment of effective positioning and attachment, with several women being given nipple shields for sore nipples. Supplementary feeds were offered and appeared to be related to concerns about inadequate weight gain. There was a strong antipathy towards breastfeeding in public related to embarrassment. This study provides considerable insight into the influences upon infant feeding decisions made by low income women.

Baker et al (2001) conducted a longitudinal qualitative study with 24 women and their families (66 participants in total). Five key themes emerged from the analysis: experiences of breastfeeding; feelings associated with breastfeeding; influences of family and friends; influences of health professionals; recommendations for improvement. The experiences of breastfeeding centred upon both negative aspects, e.g. nipple soreness and tiredness and positive aspects, e.g. breastfeeding being healthy and natural. Feelings included embarrassment, guilt, pressure, indifference, but on the other hand the sense that breastfeeding was special brought pride/joy and was associated with bravery. Influences of family members were both positive and negative, some being supportive and encouraging, others unsupportive.
and critical. Likewise some health professionals were perceived as supportive and helpful and others not. Finally the families made some important recommendations. These included a more flexible antenatal teaching system, which enabled men to attend and participate, offer of home videos and family centred teaching. The use of the media to popularise breastfeeding was suggested and the provision of private places to enable breastfeeding in public without embarrassment. This study adopted a unique approach, that of engaging significant others in the research process. This provides a crucial perspective when considering ways of promoting and supporting breastfeeding in the groups least likely to breastfeed. Further reference to this study is made in section 4.10.

Shaw and Wallace (2002) conducted qualitative research to elicit health professionals’ perceptions of young Asian and White mothers from socio-economically disadvantaged environments and to elicit the nature of young Asian, Black and White mothers’ experiences of infant feeding. The research illustrated a gap between health professionals’ perceptions and those of the young women. Infant feeding decisions and behaviours appeared to be less heterogeneous across ethnic groups than anticipated by health professionals. Most women expressed surprise at the work involved in motherhood and tended to seek their own mother’s views on baby care. The young mothers tended to perceive breastfeeding as difficult and inconvenient compared to bottle feeding and this outweighed their obvious knowledge that breastfeeding was better for the baby. However, when they did bottle feed this too was found to be time consuming and inconvenient. The study provides a useful addition to the body of knowledge related to the gaps between health professionals’ perceptions of behaviours and actual behaviours. The authors highlight the requirement to educate health professionals more appropriately for understanding the range of cultural beliefs and values. Further reference to this study is made in sections 4.9 and 4.10.

Toole and McFadden (2002) conducted qualitative research to elicit the views and experiences of low income women related to breastfeeding. Five key themes emerged from the data. Firstly, the women commented upon society’s attitudes towards breastfeeding, particularly in public. They referred to their embarrassment and the lack of facilities available. The second theme centred upon factors that influence women in their choice of infant feeding method. Here the strength of the bottle feeding culture and its influence became evident. Significant others had a strong influence. The third theme related to a general lack of knowledge about breastfeeding. The fourth theme centred upon perceptions of professional support. Women valued the support they received to initiate breastfeeding but it was felt that midwives were very busy and that they gave conflicting advice. Finally women referred to positive and negative experiences of breastfeeding. Some women emphasised positive aspects of breastfeeding, e.g. convenience and cheapness as well as emotional and physical benefits. However, they tended to see breastfeeding as potentially complicated, difficult and restrictive to lifestyle. This was reinforced when they encountered challenges and problems. They tended to feel tentative in their decision to breastfeed due to lack of confidence. Frequent feeding and the concern that the baby ‘wasn’t getting enough milk’ were the most common complaints.

Hall Moran et al (2002) explored the acceptability of a variety of supportive approaches to adolescent mothers breastfeeding their babies. They also compared the approaches of midwives and Breastfeeding Network (BfN) supporters in meeting the support needs of adolescents who breastfeed their babies. Five themes related to adolescents’ experiences of breastfeeding were developed from the data: lacking confidence; feeling watched and judged; tiredness; discomfort and the desire to share accountability. Five areas of support need were identified by the adolescents: practical/instrumental; emotional; esteem; informational and peer/network. Comparison between the BfN supporters and midwives highlighted a greater emphasis by BfN supporters than the midwife group upon active listening, eliciting previous experience, encouraging the exploration of feelings and the suggestion of strategies for coping. Assessment of knowledge and skill produced statistically significantly higher results for the BfN supporters than the midwives. This study provides a detailed analysis of the support needs of breastfeeding teenage mothers and exposes some crucial issues in relation to the supportive approaches of health professionals as compared to qualified breastfeeding supporters.
Cloherty et al (2002) adopted an ethnographic approach to explore the beliefs, expectations and experiences of breastfeeding mothers and health professionals in relation to the supplementation of babies in hospital. Supplementation was not always seen by health professionals as a significant ‘intervention’. Few staff appeared to be fully aware that supplementation is associated with earlier discontinuation of breastfeeding. Staff placed emphasis upon ways of supplementing but less on avoiding supplementation altogether. Supplementation was often seen as a short term pragmatic solution to problems by both midwives and doctors. Many midwives appeared to feel that they had a responsibility to protect women from tiredness, distress and guilt. Some appeared to experience conflict between their role in alleviating the immediate distress of the mother and that of promoting and facilitating effective breastfeeding. Other midwives went to considerable lengths to support women and were more able to balance the agendas of tiredness/distress and breastfeeding with supporting breastfeeding without resorting to supplements. This exploratory study contributes considerable insight into both mothers’ and midwives’ experiences in relation to supplementation.

Clarke et al (2002b) conducted a qualitative study to identify key characteristics of service delivery, professional education and clinical practices that influence breastfeeding management. The study revealed the structural barriers in midwifery services that could sometimes obstruct the implementation of breastfeeding support, and so contribute to compromised learning for midwives as practitioners and for the mothers. These included: lack of time and lack of privacy on the wards; uncertainty about when to offer the support for breastfeeding; assumptions that mothers will manage independently and inadequate communication with colleagues especially on discharge. Midwives identified organisational systems that enabled them to offer breastfeeding support and promote organisational and professional learning. These included: continuity of care on the postnatal ward resulting from 12 hour shift patterns; flexibility of care in the community (team midwives) allowing extended visits to mothers requiring intensive breastfeeding support; transfer of information between midwifery team members; reunions of mothers after transfer of care to the health visitor organised by the community midwives. This study highlights the need for integration between learning, practice and research/knowledge development. It points to the need to focus upon the structural changes required within the maternity services to ensure that the reflective cycle of professional practice is respected. It also highlights the imperative to restore a way of ensuring that consistent care is provided through a shared value base and approach. Without this perspective efforts to change practice may simply lead to frustration and do little to improve care and support offered to breastfeeding women.

Conclusions

These studies highlight the barriers and constraints with which women from socially excluded groups are confronted. In cultures where breastfeeding is a marginal activity women appear to have negative expectations and a deep lack of confidence in breastfeeding. Sexualisation of the breasts and related embarrassment about feeding in public remains a major hurdle. Significant others play a key role in ongoing decision-making. These groups of women are most in need of consistent and appropriate professional support and yet these studies suggest that this is not always available to them within the current system. The two midwifery practice studies (Clarke et al 2002b, Cloherty et al 2002) highlight a continuing lack of integration between research/knowledge generation, learning and practice in midwifery. They also highlight the structural barriers to providing either continuity of care or carer. It becomes clear that within the current system midwives are often basing their information upon short-term considerations without necessarily understanding the long-term ramifications.

The studies highlight the need for improved information and support for women from cultures in which bottle feeding is the norm and breastfeeding a marginal activity. This should involve significant others where possible. Facilities for women to breastfeed in public need to be improved. Support initiatives are needed that are tailored to meet the needs of those women who are less likely to access existing services.
Organisations providing support for women need to address the inability of staff to provide either continuity of care or carer to breastfeeding women. Finally, there are clear staff education and clinical supervision implications generated by these studies. For example, there needs to be more emphasis upon the integration of research and reflective practice so that health professionals are equipped with the knowledge and confidence to support women in those groups least likely to breastfeed. The range of intervention studies referred to in this evaluation highlights many of these issues.

Related publications by project teams


### 4.2 Peer Support projects

<table>
<thead>
<tr>
<th>Table 2. Peer support projects</th>
<th>Recruit/Train Peer Supporters</th>
<th>Train Health Professionals</th>
<th>Establish a support group/drop-in centre</th>
<th>Evaluate current project</th>
<th>Evaluate pre-existing project</th>
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Breastfeeding peer support schemes involve mothers who have breastfed their babies supporting other mothers in their local community usually on a voluntary basis. The supporters are normally prepared for this role through a short course facilitated by qualified members from one of the voluntary breastfeeding organisations or by health professionals.

There were 26 projects that focused on peer support programmes. Most entailed setting up a new programme of peer support while a few evaluated existing peer support programmes. Most projects were practice focused and involved planning, implementing and evaluating a comprehensive programme of support for breastfeeding mothers. Aspects of this programme included recruiting and training peer supporters, providing training for health visitors and midwives associated with the project and setting up a support group/drop-in centre. See table 2 above and also chapter 5 for specific details of each project.

The projects focused upon community capacity building and creating cultural change in demographically defined areas with high levels of social deprivation and accompanying low breastfeeding rates.

There were several stages involved in setting up a peer support programme, although the process cannot and should not be seen as linear, e.g. evaluation should be an ongoing process throughout a project. These stages include:

- Assessment of local culture/needs analysis
- Planning the project
- Recruiting and training peer supporters
- Informing and training health professionals
- Setting up an associated support group/drop in centre
- Publicising the scheme
- Maintaining the programme
- Evaluating the programme.

The projects that were particularly well evaluated by those involved and which were able to sustain high levels of recruitment and retention of peer supporters and high interest from mothers were the ones that addressed all of these stages. This was necessarily time consuming and meant that for some the project was only “getting off the ground” by the end of the funded year. Those projects that omitted key stages, e.g. planning and information giving were more likely to find that numbers and commitment of peer support

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**Table 2. Peer support projects (continued)**

<table>
<thead>
<tr>
<th></th>
<th>Recruit/Train Peer Supporters</th>
<th>Train Health Professionals</th>
<th>Establish a support group/drop-in centre</th>
<th>Evaluate current project</th>
<th>Evaluate pre-existing project</th>
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<td>Woodward (2002)</td>
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supporters and mothers accessing the service were low and sustainability under threat. Each of these stages will now be discussed to highlight key issues derived from the studies.

Assessment of local culture/needs analysis

Studies that conducted some form of local analysis and needs assessment were then well placed to proceed with knowledge of local cultural issues. Some of the most effective projects in terms of numbers accessing them and positive evaluations had extended existing projects into other areas, see e.g. Anderson et al (2002) and Battersby (2001a,b, 2002). These projects built on existing infrastructure and through comprehensive evaluation built on the strengths and addressed areas for development. Battersby (2002) describes the development and comprehensive evaluation of two neighbouring projects, ‘Simply the Breast’ and the ‘Wordly Wise’ project and their subsequent amalgamation to form one larger project, ‘Breastfeeding is Best Supporters’ (BIBS).

Planning the project

A number of projects demonstrated a strategic approach involving setting up of a multi-agency steering group, e.g. Evans (2002). This then formed part of a comprehensive communication strategy as described by Etherington (2001), involving, e.g. the maternity unit breastfeeding adviser, midwifery managers, midwives, a local leader from a national breastfeeding support organisation, local GPs, PCGs, the health promotion unit, councils and local businesses.

Projects that appointed a co-ordinator with designated time and a supporting planning team appeared to be more successful in the ensuing stages. The co-ordinator was either a health visitor, qualified breastfeeding supporter/counsellor, midwife and/or infant feeding specialist. This role included recruitment, training, co-ordination and supporting peer supporters, co-ordinating the breastfeeding support group, educating health professionals, liaising with other individuals and organisations to raise awareness and co-ordinating record keeping/data collection. Where this person was a qualified breastfeeding supporter/counsellor she liaised with health professionals to ensure that they were aware of any role they were required to fulfil in the programme. There also needed to be a back-up person or team. Some projects were delayed because of lack of contingency plans for a co-ordinator being ill or changing job.

Effective planning also included making provision for time to process peer supporters through the ‘system’, e.g. the police clearance system as noted by Suppiah (2002). Such procedures were time consuming and caused delays in a number of projects. A sound administrative system appeared to be essential to the maintenance of programmes.

Recruiting and training peer supporters

Peer supporters were usually selected by health professionals. They are breastfeeding mothers who appear to be motivated to want to support others. Some co-ordinators emphasised the necessary thoroughness of this process, see e.g. Suppiah (2002). As projects evolved in some cases the emphasis shifted to peer supporters volunteering themselves, e.g. Curtis et al (2001).

The most commonly used training programme was the well established La Leche League (LLL) peer counsellors training programme, see Dye (2001). Some projects involved the development and delivery of their own courses or adapted a related course, e.g. Curtis et al (2001) utilised principles from the National Childbirth Trust (NCT) training programme in a short course. The model was developed by a
highly experienced NCT counsellor and tutor. The course was based on the NCT counselling skills approach. Whichever training model was utilised course content typically included principles of breastfeeding and ways of supporting mothers, debriefing on personal experiences, self awareness, listening skills, role boundaries and responsibilities, record keeping, child protection issues, confidentiality, working safely in other’s homes and support mechanisms, e.g. Woodward (2002). Within all programmes there was a general recognition that peer supporters were there to listen to women, to validate their experiences, to facilitate and to empower, as described by Clarke et al (2002a). Most programmes consisted of approximately 10-20 hours of learning time over the course of several weeks. Follow up sessions were usually provided to maintain ongoing support and interest. de Weymarn (2002) highlighted the need to develop a rolling programme so that subsequent supporters were trained to minimise any loss of impetus created by staff leaving.

In all of the projects that evaluated peer supporters experiences of the training and their role the training was commented upon very positively. Supporters tended to refer to the personal growth they underwent and feelings of being empowered. Areas that were also highlighted as important by peer supporters were training which specifically built confidence in supporting others, awareness of child protection issues, interpersonal skills and knowing how to avoid pressuring women into accepting their service. They appreciated a programme that was flexible and adaptable in terms of time and content. Opportunities to explore personal experiences were valued. They also highlighted the need for ongoing update sessions. On site child-care facilities were much appreciated.

Informing and training health professionals

Health professionals repeatedly highlighted the importance of being equipped to administer these programmes effectively and with confidence, see e.g. Etherington (2001). A number of projects utilised the LLL ‘Peer counsellor programme administrators’ training. Whichever form of preparation was offered it needed to include: exploring personal and vicarious experiences; knowledge related to supporting women with breastfeeding; understanding group dynamics; facilitating and educating groups; dealing with uncertainty and effectively communicating information whereby women may make informed decisions. Role play was suggested as a way of teaching some of these skills (Battersby 2001b). Some projects provided midwives and/or health visitors with the 3 day UNICEF UK Baby Friendly Initiative Breastfeeding Management Course, e.g. Willcocks and Carden (2001). Some project co-ordinators reported difficulties in engaging health professionals with the role even once prepared through a course. This tended to relate to a lack of designated time, e.g. Dye (2001).

Setting up an associated support group/drop in centre

Setting up an accessible and appropriate support group was a crucial aspect to the success of the peer support projects. As a number of projects focused specifically on setting up such groups this issue is discussed in section 4.3.

Publicising the scheme

Those projects that conducted an ongoing and comprehensive programme of publicity to raise awareness of the scheme were then successful in establishing and maintaining remaining aspects of the support scheme, see e.g. Hammond (2001). Hammond notes that this phase of the project established a community that was adaptable to change and clients who were receptive to helping their peers. Having created community receptivity a peer support training programme was planned. Some projects that were having difficult recruiting then stopped for a while to address this need and then resumed with more
success. Having some form of brand name for supporters was reported to assist with marketing, e.g. 'Bosom Buddies' (Anderson et al 2002), 'BEST team' (Breastfeeding Encouragement Support Team) de Weymarn (2002), 'Breastfriends' (Curtis et al 2001, Kirkham 2002).

Maintaining the programme

Maintenance of programmes was most effective when there was clear understanding of the complementary nature of peer supporters and health professional roles and these roles were carefully clarified and integrated (Clarke et al 2001a, de Weymarn 2002, Woodward 2002). This appeared to increase the numbers of women to whom health professionals would recommend the service. In a number of studies health professional recommendations/referrals appeared to be important in giving women confidence to use a new service. An area of concern was identified by Woodward (2002) who reported that health professionals were less likely to suggest/refer to peer supporters if women appeared to be uncommitted to continuing to breastfeed. This selectivity meant that those living in areas of greatest deprivation with complex socio-economic issues might be less likely to be offered the service.

Where health professionals or qualified breastfeeding supporters/counsellors co-ordinated the schemes there were varying degrees of monitoring. For example Woodward (2002) refers to the breastfeeding co-ordinator (a lactation consultant and a BfN tutor) receiving the phone calls, assessing the complexity of the situation and then deciding whether she or a peer supporter should visit. The time of the supporter’s departure and return were also monitored to maximise their personal safety. Other schemes involved a more informal approach based more on community networking. In-depth studies highlighted some of these complex boundary issues between health professionals and peer supporters. Curtis et al (2001) for example referred to clear power issues at play with midwives tending to maintain a “gatekeeping role” and expecting the peer supporters not to “overstep the mark” or develop too much autonomy. Clearly these issues need to be addressed sensitively. Hammond (2001) reported a range of health professional attitudes from “professional possessiveness” to willingness to participate in schemes.

Schemes need to extend across the hospital/community interface (Clarke et al 2001a). However, peer supporters did not always feel comfortable in the hospital setting, see Dye (2001). They tended to feel particularly alienated if staff in the hospital did not acknowledge them or introduce them to women. As recommended by Dye (2001) health professionals needed to act as a co-ordinator and mediator between the supporters and mothers, particularly within medicalised settings. She suggests that in such settings peer supporters might work in twos. Peer supporters also need improved access to antenatal clinics and designated space to set up a stand.

Women accessing schemes where they saw the peer supporter for the first time during the postnatal period commented that they would like to have met during the antenatal period. This access was introduced during the course of a number of projects. Schemes ideally need to enable peer supporters to engage with women during their pregnancies and then follow through to the early postnatal period enabling the building of a relationship (Dye 2001, Battersby 2001a). Peer supporters need access to a range of health care facilities. A workable phoning and home visiting system needs to be in place.

As Dye (2001) notes, peer supporters need ongoing support, e.g. meetings and continuing opportunities to update their skills. This assists in maintaining their interest and motivation. A heavy and cumbersome administrative load may be demotivating. Too much emphasis upon keeping detailed written records is relatively alien in some communities. Battersby (2001a,b, 2002) audited workloads and as a result reduced and streamlined administrative tasks. Some schemes paid peer supporters, e.g. Battersby (2001a,b, 2002). However if the supporters felt that their paid hours were exceeded they sometimes became demoralised. Therefore employment hours need to be realistic. Some schemes reimbursed general expenses for child care, e.g Woodward (2002). Others provided a small weekly reimbursement,
Evaluating the programme

As stated, evaluation should progress throughout the project so that changes can be made accordingly. Comprehensive evaluation data was gathered in many of the projects to include the views of service users, the peer supporters and associated health professionals. The evaluations centred upon gathering demographic data, auditing breastfeeding initiation and continuation rates and seeking the views of providers and service users. The latter was usually carried out through questionnaires, focus groups or interviews. As stated in section 3.3, studies were not able to make causal statements related to the relationship between the project and breastfeeding rates although the trends were almost always positive. However, the impressive volume of qualitative data from the projects consistently highlighted the range of ways in which women felt supported and peer supporters empowered and enabled. The evaluations that identified the percentage of attendees from low income families or from the targeted area, e.g. Anderson et al (2002), and those that elicited the views of those who chose not to utilise the service were particularly useful. The views of service users are of course key indicators of the success or otherwise of outreach projects and these are summarised next.

Service users views

Women consistently reported that the peer support schemes enabled them to overcome barriers and constraints that otherwise might have led them to cease to breastfeed. They commonly reported breastfeeding for longer than originally stated. Women valued the experiential knowledge of peer supporters, the role modelling and practical support. They felt that the peer supporters brought a practical realism to breastfeeding. Midwives tended to be seen by mothers as prioritising formal evidence-based information and advice-giving rather than having more facilitative styles of communication. This contrasted with peer supporters’ focus upon and acknowledgement of women’s embodied experiences. Women often found the peer supporter easier to communicate with than health professionals based on common experiences of living in the same area and their ability to share breastfeeding and mothering experiences in a friendly, “chatty” way. Some referred to the building of friendships and relationships with the supporter(s). Many referred to the confidence building effect of the peer support programme.

Some women expressed the need to feel that they have autonomy within the peer supporter-supported relationship. This included being able to choose a home visit or telephone contact and, where possible, having some choice related to the peer supporter to whom they are allocated. Some mothers had their own support networks and therefore didn’t require additional support.
Conclusion

While the design of these projects precludes definitive statements being made related to a causal relationship between the interventions and breastfeeding outcomes there was a positive trend shown in most towards increased continuation of breastfeeding. Throughout the projects there were consistent reports from mothers to indicate that the peer supporters helped them at a time when they were strongly considering stopping breastfeeding. As these projects expand and connect with neighbouring projects they have the potential to consistently positively influence acceptance of breastfeeding within deeply entrenched bottle feeding cultures. With appropriate infrastructure, i.e. co-ordination, staffing, and funding, these small projects are likely to grow and develop and hold promise for increasing both breastfeeding initiation and continuation rates. Their capacity to empower those living within socially excluded communities should not be underestimated.

Practice pointers

• Assess the needs of the local culture carefully and build on the knowledge of local people.

• Where possible learn from, link with, and extend an existing scheme, e.g. in a neighbouring Sure Start area.

• Establish clear aims and plan the project carefully involving key stakeholders, voluntary organisations, health professionals and relevant members of the community.

• Ensure that those responsible for co-ordinating and facilitating the scheme have funded and designated time out to do so.

• Develop a clear strategy for recruiting, training and supporting the peer supporters. There are a number of existing models to assist with this, e.g. the La Leche League programme. The model should be one of empowerment to include encouraging communities to value their own capacity.

• Inform and train health professionals. This needs to equip them with opportunities to explore personal and vicarious experiences, knowledge of supporting breastfeeding women and group dynamics and facilitation.

• Set up an associated support group/drop in centre that enables mother-to-mother support facilitated by peer supporters with health professionals and/or qualified breastfeeding counsellor/supporters in the 'background' to offer specific support for breastfeeding problems (see section 4.3).

• Provide a range of breastfeeding resources at these centres, e.g. literature, breast pumps.

• Publicise the scheme through the local media, community facilities and the health system.

• Maintain the programme through creating clear ongoing dialogue between peer supporters and health professionals as to the complementary nature of the roles.

• Encourage contacts to be made between peer supporters and mothers during the antenatal period and provide as many venues and access points as possible. The scheme should cross the hospital/community interface.
• Build in robust, ongoing evaluation of the scheme, both related to breastfeeding rates and service user and provider views. This should include the views of those who do not self-select into the scheme, particularly as they may represent the most socially excluded groups.

• Be prepared to make changes based on the outcome of ongoing evaluation.

Research pointers

Further research generated by this evaluation may include:

• In-depth qualitative research focusing upon understandings, relationships and partnerships between health professionals and peer supporters.

• In-depth research related to defining theoretically and practically what constitutes supportive encounters with peer supporters from a service-user perspective.

• Exploratory research with groups who are least likely to access peer support programmes.

• An evaluation of the various methods of training peer counsellors in terms of their effectiveness in meeting the needs of both supporters and mothers.

• An evaluation of the effectiveness of various methods of preparing health professionals for a facilitative role in peer support programmes.

• Further evaluation of paid peer supporter schemes.

• The development of mentoring systems for new peer supporters i.e. peer supporter-to-peer supporter.

• Large multi-site cluster randomised controlled trial to assess the impact of peer support on breastfeeding rates within socially excluded communities.

Related publications by project teams


4.3 Breastfeeding support centres

<table>
<thead>
<tr>
<th>Table 3. Breastfeeding support centres</th>
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<tr>
<td>(Excludes those referred to as part of a more comprehensive peer support scheme)</td>
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<tr>
<td></td>
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<tr>
<td>Banarsee (2001a)</td>
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<tr>
<td>Banarsee (2001b)</td>
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<td>Charlton et al (2001)</td>
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<tr>
<td>Dore (2002)</td>
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<tr>
<td>Flynn, Savage (2001)</td>
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<td>Finigan et al (2001)</td>
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<tr>
<td>Hastings et al (2001)</td>
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<tr>
<td>Lincoln, Jones (2002)</td>
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<tr>
<td>Pardoe, Williams (2001)</td>
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<tr>
<td>Shaw-Flach, Shulver (2001)</td>
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</tbody>
</table>

There were 29 projects that involved the setting up or evaluation of a centre where women could come for support with breastfeeding. Eighteen were set up in association with a broader peer support programme, see table 1. The 11 projects listed in table 3 focused specifically on support centres. The discussion in this section is drawn from the experiences of all 25 projects. Some of the support centres were classed as ‘drop-in’ facilities. These were commonly related to a peer support programme with peer supporters being the key facilitators with support from health professionals. The function of these was primarily to facilitate networking with other women in a similar situation. Health professionals were commonly available for referral purposes should women have a specific challenge or problem that they needed to discuss.
Other groups were organised and managed by health professionals with the focus being upon women attending to see a health professional with specific problems, i.e. they were problem orientated. These functioned more as ‘clinics’. The breastfeeding support centres set up by the Breastfeeding Network (BfN) were co-ordinated by qualified Breastfeeding Supporters with BfN supporters being available to support women with specific challenges (Hastings et al 2001).

Some facilities were targeted to appeal to specific groups, e.g. Dore et al (2002) set up their ‘drop-in’ in a local African-Caribbean centre and Flynn and Savage (2001) focused on adolescent mothers. These are referred to again in sections 4.9 and 4.10.

There were several stages involved in setting up a support centre. These stages included:

- Assessment of local culture/needs analysis
- Planning the project
- Recruiting personnel to run the centre
- Publicising the programme
- Maintaining the programme
- Evaluating the programme.

As with peer support programmes the projects which had high attendance rates from target areas and were particularly well evaluated by users and providers were the ones that addressed all of these stages, e.g. Hastings et al (2001).

Assessment of local culture/needs analysis

Studies that conducted some form of local needs assessment were then well placed to proceed with knowledge of local cultural issues, e.g. Banarsee (2001a) utilised an action orientated audit methodology to provide a full assessment of local infant feeding practices. This was then used to inform the management of change that included the setting up of a breastfeeding clinic. It then enabled monitoring of the effectiveness of the changes.

Planning the project

Time spent engaging those likely to be involved and other key stakeholders ensured that the infrastructure was available for the project to run successfully. This included ensuring that health professionals were provided with designated time to facilitate and support the scheme from commencement of the project. Where this was not addressed, with appropriate contingency plans for absence or a key person moving, problems often arose with ongoing maintenance. Some projects involved joint working with a voluntary organisation, e.g. Brown et al (2001) collaborated with the BfN.

Clear aims as to what the scheme should achieve needed to be established and communicated, e.g. whether the centre was a focus for mother-to-mother support and/or a base for peer counsellors or a clinic that focused upon supporting women with specific problems and challenges. These functions were combined in some schemes and so required careful planning, management and facilitation. Where there were ambiguities this led to problems with recruitment, e.g. referring to a ‘drop-in’ centre as a clinic gave
the wrong messages to women. Lincoln and Jones (2001) changed the name of their ‘drop-in’ centre to remove the word ‘clinic’ in response to negative comments from mothers about the term. As Anderson et al (2002) note, a ‘drop-in’ should be informal with emphasis on social support, friendship and normalising breastfeeding. It is not a breastfeeding clinic that is solely problem orientated. Likewise they note that the underlying philosophy should centre on valuing motherhood, helping each other and providing mutual support, praise and encouragement.

Recruiting supporters and /or health professionals to run the centre

As stated, those co-ordinating support groups needed to have designated time. They also needed to liaise effectively with breastfeeding support organisations and health professionals to maximise the chances of women being informed about the group. Finally they needed to be confident in providing breastfeeding support and facilitating support groups. This was identified at the outset of some projects and part way through in others. Courses provided included the LLL course, an ‘in-house’ course, the UNICEF UK Baby Friendly Breastfeeding Management course or a course provided by the NCT or BfN for this purpose.

Publicising the programme

The publicity issues referred to in section 4.2 apply here.

Maintaining the programme

Those projects that provided a support centre less than once a week invariably had difficulties in attracting women. Those that were best attended were held at least once a week. Another key to success in attracting women was the placing of the clinic in a building where other activities, e.g. baby clinics were conducted. When the ‘drop-in’ was held after the clinic women could call in after having seen a health visitor or midwife. Childs et al (2001) held a support group at the same time as a ‘Midwifery Satellite Clinic.’ Willcocks and Carden (2001) report that their support group was attended by two midwives, one who gave booked or ad-hoc antenatal care while the other circulated, giving advice as necessary. A health visitor attended to perform developmental checks, weigh babies and give advice. Videos relevant to parenting and breastfeeding were shown. Availability of these services contributed to high attendance rates. Clarke et al (2002a) established a breastfeeding support group on a postnatal ward. This enabled women to access the service whilst on the postnatal ward and then provided contact opportunities with peer supporters after discharge.

Facilities needed to be attractive, accessible and non-medical in emphasis. If they were accessing women from a council estate, for example, they needed to be central within that estate but avoiding premises that were disliked for other reasons, e.g. associated with high levels of vandalism. A number of projects reported that the venue was changed part way through the project, e.g. Brackstone and Bachelor (2001), Brown et al (2001), Gill and Murdock (2001). Some form of brand image was helpful, e.g. The Baby Café (Pardoe and Williams 2001). Here there was emphasis upon creation of an atmosphere and ethos that appealed to local women. Projects in Sure Start areas were able to utilise Sure Start premises, e.g. Rosser (2002).

Another key to attracting women centred on making the service available to pregnant women, see e.g. Anderson et al (2002). This enabled women to see and discuss breastfeeding during their pregnancy and increased their likelihood of returning afterwards. Friendships could be made earlier rather than later. Simple matters such as the co-ordinator introducing mothers to each other were felt to be important to women (Hodgson and Burns 2001).
Combining informal mother-to-mother contact with the availability of professional and/or qualified breastfeeding counsellor support appeared to be particularly appreciated by women, e.g. Hodgson and Burns (2001), Pardoe and Williams (2001), Anderson et al (2002). In these projects health professionals adopted a ‘background’ facilitative role but provided skilled evidence-based support when required. This ‘background’ presence enabled women with ongoing challenges to receive regular support if they felt they needed it.

The BABES project by Hill and Jones (2002) involved situating the clinic in the market place so that mothers might drop in and breastfed their babies while breastfeeding. Free fresh fruit and vegetables were provided for the mothers to eat while on the premises or to take home. This acted as an additional incentive for mothers to call in as well as providing health promotion messages through advocating nutritious foods. The support group referred to by Rosser (2002) served women with a hot lunch.

Another way of ensuring good attendance and sustainability was illustrated by Brown and Draisey (2001). This project linked with existing local breastfeeding support groups and peer support schemes and this assisted in influencing local culture over a wider geographical area. It also assisted in building infrastructure to expand the initiative further. The authors comment that the peer supporters were invaluable in the setting up and maintenance of the support clinics. The peer supporters have subsequently extended the services themselves to include regular meetings in each other’s houses.

Other aspects that were important to women were baby-changing facilities, activities and toys for babies and toddlers (Hodgson and Burns 2001).

Support groups that linked with existing Sure Start programmes and tapped into additional resources from, e.g. Sure Start, Health Action Zone monies or PCT funding were able to develop strong and sustainable infrastructure. Clinics run by health professionals were commonly NHS funded, e.g. Shaw-Flach and Shulver (2001), Finnigan (2001).

**Evaluating the programme.**

The evaluations centred upon gathering demographic data related to attendees, reasons for attendance, auditing breastfeeding initiation and continuation rates and seeking the views of providers and service users. The latter were usually carried out through questionnaires, focus groups or interviews. Some projects involved interviewing both attendees and non-attendees. Lincoln and Jones (2002) achieved this effectively by providing women with a £10 incentive to be interviewed. They became aware that only 20% of attendees were on low income or income support. Interviewing non-attendees is crucial in ensuring that facilities meet the needs of those they target. Clarke et al (2002a) interviewed a third group, those to whom the service was not available. Although most studies were not designed to be able to make definitive statements between the project and breastfeeding rates, those that collated breastfeeding continuation rates showed positive trends. In addition, the qualitative data from the projects consistently highlighted the range of ways in which women felt supported.

**Service users’ views:**

The most important aspect of the support groups for women was the opportunity to develop friendships and network support. Secondly, women reported that attendance at support groups enabled them to overcome barriers and constraints which otherwise might well have caused them to cease breastfeeding. They commonly reported breastfeeding for longer than originally stated. Confidence building and encouragement were mentioned very frequently. There may be emerging theories from some of the qualitative studies conducted with women, e.g. Locke (2001) provided details of an in-depth qualitative
study related to women’s experiences of a support group. Health belief theory guided the analysis and five interrelated themes were identified: support, experience, information, barriers and benefits. Effective support and information giving assisted in overcoming barriers that included negative personal and vicarious experiences. The perceived benefits of breastfeeding influenced behaviour in an interactive way with the experiences. This illustrates ways in which support programmes assist women in maintaining positive health beliefs and behaviours in relation to breastfeeding.

The most frequent breastfeeding concerns were striking in their similarity across projects. These were sore/cracked nipples, anxiety about milk supply related to frequent or lengthy feeds or poor weight gain, colicky/unsettled baby, problems with attaching the baby to the breast, blocked ducts or mastitis and concerns about returning to work.

The groups that were evaluated very positively were those in which peer support was combined with ‘background’ availability of specialist help from a qualified breastfeeding counsellor, health visitor or midwife. Secondly, those that provided opportunities for women to access wider aspects of peer support were seen to be meeting the broadest range of needs. The BfN model, although not utilising peer supporters, appeared to provide a form of support that met both the networking and support needs of breastfeeding women (Hastings et al 2001).

Conclusion

While the design of these projects precludes definitive statements being made about a causal relationship between attendance at support groups and breastfeeding outcomes those that collated breastfeeding continuation rates showed positive trends. The qualitative data highlighted that women tended to report breastfeeding for longer than anticipated. There were consistent reports from mothers that indicated that attendance at the group helped them at a time when they were strongly considering stopping breastfeeding.

Practice pointers

- Assess the needs of the local culture carefully and build on the knowledge of local people.
- Before setting up a support centre explore existing models, e.g. BfN centres, ‘drop-in centres’ that combine peer supporters support with ‘background’ health professional availability and hospital-based clinics.
- Establish clear aims and plan the project carefully involving key stakeholders, breastfeeding support organisations, health professionals and relevant members of the community.
- Carefully consider ‘place’ i.e. where to site the venue. If possible link with other activities, e.g. a baby clinic.
- Carefully consider the name of the ‘drop-in’. It should be culturally sensitive and appealing.
- Run the service at least weekly.
- Endeavour to make the service available for antenatal women as well as postnatal.
- Ensure that those responsible for co-ordinating the scheme have funded and designated time out to do so.
Ensure that those involved, e.g. health professionals and peer supporters, are appropriately prepared through training. This needs to equip them with opportunities to explore personal and vicarious experiences, knowledge of supporting breastfeeding women and group dynamics and facilitation.

Publicise the scheme through the local media, community facilities and the health system.

Maintain the programme through creating clear ongoing dialogue between those involved, e.g. service users, peer supporters, qualified breastfeeding counsellors/supporters and health professionals.

Build in robust, ongoing evaluation of the scheme, both related to breastfeeding rates and service user and provider views. This should include the views of those who do not self-select into the scheme as they may represent the most socially excluded groups.

Be prepared to make changes based on the outcome of ongoing evaluation.

Further research

Further research generated by this evaluation may include:

- Evaluation of the comparative effectiveness of the problem solving clinic approach in contrast to the drop-in with background specialist support in meeting women’s needs and effects upon breastfeeding rates.

- Further exploration of the Breastfeeding Network (BfN) model to include impact upon breastfeeding rates (Hastings et al 2001).

- Further exploration of the postnatal ward peer support group model to include impact upon breastfeeding rates (Clarke et al 2002a).

- Exploration of the most effective ways in which peer supporters, qualified breastfeeding counsellor/supporters and health professionals may work in collaboration in providing support groups.

- Utilisation of psychological and sociological theory to aid understanding of the effects of support groups upon health beliefs and behaviours related to infant feeding practices.

Related publications by project teams


### 4.4 Antenatal Education/workshops

#### Table 4. Antenatal education/workshops

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<td>Kallat (2001)</td>
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<td>Mason (2002)</td>
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<td>McFadden (2001)</td>
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<td>Shanahan, Morris (2001)</td>
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<td>Thompson et al (2002)</td>
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<td>Westman (2001)</td>
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<td>Williams, Tatman (2002)</td>
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<tr>
<td>Winterburn, Jiwa (2001)</td>
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Seventeen studies specifically involved the provision of one or more antenatal education sessions. Several stages were involved in the setting up of these packages:

- Assessment of local culture/needs analysis
- Planning the project
- Publicising the scheme
- Delivering the project
- Evaluating the programme

#### Assessment of local culture/needs analysis

Most education packages were developed in response to a local needs assessment and were then well placed to proceed with knowledge of specific socio-cultural issues. Some focused on specific groups such as women from minority ethnic communities (Westman 2001, Dowling 2002, Ingram and Johnson 2002b) or adolescents (Bartlett 2001, Kallat 2001, Thompson et al 2002). These will be referred to again in sections 4.9 and 4.10. Four projects specifically targeted the mother along with a confidante, see Table 4 and section 4.11.
Planning the project

Following identification of local need the education packages were planned accordingly. The format usually adopted was a workshop approach. Typically this involved the use of dolls to demonstrate positioning and attachment and a selected video to provide role modelling and to further reinforce positioning and attachment. Other topics commonly covered included the health gains of breastfeeding, basic physiology, skin-to-skin contact and baby-led feeding. Overcoming breastfeeding difficulties included psycho-social, physiological and practical aspects. This included issues such as family support and feeding in public. The combined emphasis upon the acquisition of embodied knowledge through visualisation, a practical skills approach and discussion around issues such as feeding in public suggests that project leaders were well aware of evidence underpinning effective education for breastfeeding women from bottle feeding cultures.

Two projects specifically involved the production of a video. Beresford (2002) engaged local women from the low-income target group in the production of a video that was culturally appropriate. This video was extensively piloted with women and is now available to lend to women to view at home. Westman (2001) produced a video that is now available to women to borrow. This was produced in four languages to accommodate the four main ethnic groupings in the community.

Publicising the scheme

Publicising the classes through the health facilities was crucial to encouraging attendance. This publicity needed to specifically focus upon the target group, e.g. low income, otherwise attendance tended to come from surrounding areas by women who were not representative of the target group. When a breastfeeding support group provided the workshops then close liaison with health professionals was conducted to increase publicity. Gill and Murdock (2001) conducted a launch event to which all health visitors, midwives, and relevant managers from the area were invited. A seminar was conducted to inform these groups about the project and to engage their support. The project co-ordinator also attended established antenatal classes and invited women personally.

Delivering the project

An infant feeding specialist, health visitor or midwife, commonly delivered the workshops. Foyle and Wilson (2002) utilised a health care assistant (see section 4.5). In some cases a member of a breastfeeding support organisation, e.g. La Leche League (Gill and Murdock 2001) facilitated them. When health professionals delivered the workshops they needed to be given designated time otherwise competing priorities made it difficult to achieve. This was particularly the case for health visitors in socially excluded areas in which there were many other pressing issues and agendas generated by social deprivation, as noted by Childs et al (2001). In a hospital setting if the workshop was designated to one individual, e.g. the infant feeding co-ordinator, then if s/he left or the post was discontinued the workshops tended to cease.

Classes were commonly provided for women during the third trimester. Some were also open to postnatal women. Some projects provided an antenatal workshop at the local maternity unit while others took the session into the woman’s home, see Table 4. When a venue other than home was utilised careful consideration was required as to where to locate the workshop. Childs et al (2001) situated their workshop at the same venue as a midwifery satellite clinic during the clinic hours. This enabled women to attend both and even those who did not formally participate were able to listen to the discussion and watch the video while waiting to see the midwife. Gill and Murdock (2001) changed the venue from a local hall to health centres in response to low attendance. Additional resources were sometimes provided.
for women, e.g. Gill and Murdock (2001) provided each participant with a copy of the LLL book, *The Womanly Art of Breastfeeding*.

Evaluating the programme

Various means of evaluating the effectiveness of the interventions were utilised. For reasons discussed in section 3.3 conclusions about the influence of specific packages upon breastfeeding rates were difficult to extrapolate. However, when breastfeeding initiation and continuation rates were measured they showed positive trends in relation to the interventions. Demonstrating impact was more difficult in studies in which the antenatal education was one part of a package of interventions, e.g. Childs et al (2001), McFadden (2001).

Two projects adopted an experimental design in order to measure effectiveness (Shanahan and Morris 2001, Winterburn and Jiwa 2001). However, as the authors note, there were a number of methodological issues that needed to be considered in interpreting the results. Shanahan and Morris (2001) provided an intervention that consisted of the provision of a one-hour antenatal workshop in addition to existing antenatal education. However, they reported difficulties related to the short time frame for conducting the study whereby there was insufficient time to inform all concerned regarding the project. Difficulties with random allocation to groups occurred as women declined to take part and therefore two-thirds of women were invited to join the experimental group rather than half. This meant that the groups could not be described as comparable. The assessor was not blinded and the authors reported that advice was provided to women in the control group during the postnatal period if required. It was felt to be unethical not to provide additional support if needed. Information on those who declined to participate both before and after allocation is not provided. Therefore the results only generalise to a subset of the target population and this subset is difficult to define. Conclusions that may be drawn are therefore limited. However, the figures suggest a trend towards increasing breastfeeding continuation rates.

Winterburn and Jiwa (2001) tested the hypothesis that a close female confidante of the mother’s own choice, if educated about breastfeeding, could increase the initiation and continuation of breastfeeding. A randomised controlled trial was conducted. The small sample was insufficient to give statistical power to the results and the study was therefore presented as a pilot. The intervention showed no statistically significant difference between the control and intervention groups in the initiation of breastfeeding or the duration of breastfeeding although the trends are clinically important. The data relating to the duration of breastfeeding was analysed for any trends but this was again not significant. However, the longer duration in the intervention group approached statistical significance. The study group as a whole was analysed for any association between breastfeeding (initiation and/or duration) of this child, having previous children, breastfeeding a previous child and mother’s age. No significant results were found. The breastfeeding initiation rates for the study were significantly higher than the baseline rates for the maternity service. It is possible that the women declining to take part in the study were more likely to artificially feed. Alternatively the study may have created a situation in which the increased attention encouraged the women to initiate breastfeeding (the ‘Hawthorne’ effect). Despite the limitations the longer duration in the intervention group is encouraging and warrants further exploration.

Service users views

A collective review of the comments from women about the usefulness of the workshop highlights that the workshops were invariably felt to be beneficial. In essence women valued the practical skills approach, particularly the opportunity to learn skills for effectively positioning and attaching their baby to the breast. They also valued the videos as they provided visual information about the realities of
breastfeeding and further practical information. The combined emphasis upon psycho-social, physiological and practical aspects enhanced women’s confidence. It also assisted them in knowing what to expect and understanding how breastfeeding works. The combination of increased understanding and confidence were viewed by women as enabling them to overcome breastfeeding difficulties.

Conclusion

The quantitative data suggests that the workshop-style package of antenatal education produces a trend towards increasing both initiation and continuation rates for breastfeeding. The qualitative data supports this, particularly in relation to giving women the confidence to commence and continue. Offering women opportunities to see and become familiar with the practicalities of breastfeeding, including positioning and attachment, is particularly important for those women from areas where there is a strong bottle feeding culture. The separate effects of having a confidante present during the workshop appear to be positive and are referred to in section 4.11. From the data in this evaluation it is not possible to comment on the differential effect of home versus health care delivery of the workshops. Home visiting may be preferred by specific groups, e.g. some minority ethnic groups (see section 4.9).

Practice pointers

• Conduct an assessment of local cultural needs.

• Develop a workshop to include exploration of breastfeeding difficulties from a psycho-social, physiological and practical aspect. This includes issues such as family support and feeding in public. Focus should be placed upon health gains of breastfeeding, basic physiology, positioning and attachment, skin-to-skin contact and baby-led feeding. The use of dolls to enable practice of positioning and attachment and an appropriate video are particularly useful.

• Ensure that the language is appropriate for the groups attending. This may involve using videos in other languages.

• Provide additional resources, e.g. practical leaflets and/or a video to borrow.

• Publicise the classes through the health facilities as this seems crucial to encouraging attendance. This publicity needs to specifically focus upon the target group.

• Ensure that there are several individuals capable of delivering the workshops and ensure that they have designated time to do so.

• Choose a venue that is likely to attract women, e.g. run the workshop during a midwifery satellite clinic.

• For some groups consider delivering the programme at home if preferred.

• Encourage women to invite significant others with them if they wish to do so.

• Evaluate the views of attendees and non-attendees.
Further research

Further research generated by this evaluation may include:

- Testing experimentally the specific effect of an antenatal workshop upon initiation and continuation of breastfeeding rates.
- Utilising learning theory to examine the most effective ways to teach positioning and attachment during the antenatal period.
- Further exploration of the home visit versus group workshop approach in terms of effect upon initiation and continuation of breastfeeding and service user satisfaction.
- Further exploration of the effect of having a confidante present in relation to initiation and continuation of breastfeeding and service user satisfaction.
- Further exploration of the effect of lending women culturally sensitive videos in relation to initiation and continuation of breastfeeding and service user satisfaction.
- Exploration of models of education offered by breastfeeding organisations.
- Engagement of mothers and/or peer supporters in the antenatal education process and evaluation of women’s responses to this.

4.5 Health care assistants

<table>
<thead>
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<th>Table 5. Health Care Assistants</th>
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<tr>
<td>Training programme</td>
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<td>Beake, McCourt (2002)</td>
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<td>Sookhoo, King (2002)</td>
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Three projects explored development of the health care assistant role to provide additional support for breastfeeding women. Beake and McCourt (2002) and Foyle and Wilson (2002) utilised the health care assistants in the community and provided support for women during pregnancy and the postnatal period. Sookhoo and King’s (2002) project was hospital based and focused upon the postnatal period. Although different names were given to the health care assistants this name will be used throughout for simplicity and will be abbreviated as HCA.

The projects involved several stages:

- Establishing the aims
- Planning the project
- Recruiting and training the health care assistant(s)
- Maintaining the programme
- Evaluating the programme.
Establishing the aims

All projects aimed to evaluate the potential contribution of HCAs in supporting breastfeeding mothers from socially excluded communities. In addition, Beake and McCourt (2002) aimed to develop more communication and inter-disciplinary work between agencies such as Sure Start, the health visiting and midwifery services. They also sought to explore how far the role of a maternity HCA could be shifted from a hospital to a community base.

Planning the project

Beake and McCourt (2002) describe the careful planning that took place to establish and negotiate the most appropriate ways of working for the supporter, given the complexities of her employment and the newness of her role. This project was set up as a collaboration between a local Sure Start programme and the maternity services of the local NHS Trust. Foyle and Wilson (2002) likewise undertook a detailed consultation process with key stakeholders. Sookhoo and King (2002) involved three maternity services in the planning phase of the project.

Recruiting and training the health care assistant

Beake and McCourt (2002) refer to the qualities sought in the post-holder when recruited. These were ability to listen, ability to understand and work with women and family needs, interpersonal and communication skills, maturity and life experience, ability to manage autonomy and boundaries, ability to ‘engage’ rather than ‘teach’, some personal experience of breastfeeding and some relevant experience in this area.

Foyle and Wilson’s project involved the employment of a health care support worker (0.5wte) on a part-time basis to support a community midwifery team. She was called a ‘midwifery assistant’. Training included orientation to a community practice setting, child protection training and breastfeeding training. The La Leche League (LLL) peer counsellor programme was utilised plus some in-service education.

Sookhoo and King’s (2002) project involved the employment of 6 HCAs, two from each of three maternity services involved. Six mentors were appointed to support and oversee the work of the HCAs. A competency-based training programme was devised for breastfeeding assistants on the postnatal wards of local maternity units. This was delivered at the local university and consisted of 48 hours of programmed learning, 18 formal hours and 30 practice-based hours supported by a designated mentor. Six mentors received 3 hours of formal training regarding the expectations of the role.

Managing/Maintaining the programme

In all three studies clear management arrangements were put into place to ensure that the programme would be appropriately maintained and monitored. This included ongoing support for the HCAs. Beake and McCourt (2002) describe the HCA’s role as centring upon provision of additional support for women, focused around breastfeeding but not limited to infant feeding. Support was offered to women as they required from 32 weeks up to 4 months postnatally. Women were informed in writing about the availability of the supporter so that they could access her directly. Some women were referred via health professionals. Foyle and Wilson (2002) adopted a more structured approach to providing support for women. They recruited by telephone and offered the package of additional support. This included two antenatal home visits. The first involved the provision of information regarding breastfeeding and this
included use of videos. A second visit at 34 weeks enabled a general discussion to take place including issues raised at the earlier visit. Subsequent antenatal visits were held if required. Postnatal visits in hospital and at home were provided up to 6 weeks following the birth to provide additional support with feeding. The midwifery assistant carried a mobile phone and liaised with the midwives as appropriate. Sookhoo and King’s (2002) project involved the midwife mentors selecting breastfeeding women on postnatal wards to receive additional support by the HCAs. The HCAs then provided support as required to these mothers under the supervision of the midwife mentors. The type of support required was largely determined by the difficulties mothers experienced during breastfeeding.

Evaluating the programme

Foyle and Wilson (2002) and Beake and McCourt (2002) collected and collated data related to breastfeeding rates. Both were fairly small scale studies and utilised historical comparisons with associated limitations. In addition, as Beake and McCourt (2002) note, self-selection in responding to questionnaires may have skewed results. In spite of acknowledged limitations Beake and McCourt (2002) showed a trend towards improvement in exclusive breastfeeding both initially and at 6-8 weeks postnatally using both the maternal questionnaires and the HCAs’ records. Fifty percent of women attended by the HCAs were exclusively breastfeeding at 4 months and 21% partially. Foyle and Wilson reported that intention to breastfeed rates and the initiation rates rose by 10 percentage points from pre-to-post project. However, the 6 week breastfeeding rate did not change from pre-to-post project.

All three projects provided comprehensive qualitative data related to the views of those involved. The qualitative evidence generated by eliciting service users’ views supported the trends towards the intervention increasing breastfeeding rates. Beake and McCourt (2002) identified key ways in which women felt supported. Women were generally positive about the availability of additional support and there were indications that the support assisted them in overcoming challenges which otherwise would have led to supplementation. There were two key forms of knowledge that women relied upon to different degrees, theoretical (formal) and experiential (tacit). They saw the HCA as being ‘with woman’, listening, observing and giving general encouragement, tips and ideas rather than expert advice. They appreciated the practical support, information, general and social support. The latter included confidence building, encouragement, the opportunity for continuity and building a relationship with someone with time available. Their concepts of breastfeeding varied with some finding breastfeeding to be normal, natural and everyday and others expressing dissonance between their expectations and the reality. There was a tendency to want external reassurance of the adequacy of their milk supply in addition to their own observation and embodied experiences.

Foyle and Wilson (2002) likewise showed that the midwifery assistant was highly valued by the women for ongoing support, encouragement and practical help. She was valued because she had more time to enable the building of a relationship. Women also appreciated the designated role for breastfeeding support. Sookhoo and King’s (2002) findings were resonant with the above. Women referred to the practical assistance and information provided by midwives and the supporting and encouraging approach from the HCAs. They felt confident in putting the baby to the breast. Most women felt that the HCAs were knowledgeable, skilful and available. Qualities identified by respondents as important for those who support breastfeeding were categorised as communication, personal attributes, knowledge and skills.

In all three projects the HCAs expressed a high degree of satisfaction with the role. Beake and McCourt’s (2002) data on the HCAs experiences and perceptions highlighted that she saw the need to listen to women, to sit with them and encourage them as central in her role. She recognised that other broader problems impacted upon breastfeeding. Complex issues were referred to the Sure Start health visitor. The HCA identified key aspects of her role as encouraging women to make themselves comfortable,
supporting them in feeling confident about the sufficiency of their milk and not expecting life to go 'by the book'. She reinforced their knowledge, supported them during the period of establishing breastfeeding, gave more general help to women who lacked social support and referred to others when appropriate. Foyle and Wilson's (2002) thematic analysis of the midwifery assistant's diary highlighted three themes: the level and type of activity she was engaged in, difficulties experienced and personal development. She clearly responded to individuals according to individual need, and referred to midwives when appropriate. The main difficulty centred upon the growing demand for the service. Sookhoo and King (2002) again illustrated the positive experiences of the HCAs.

Beake and McCourt (2002) highlighted that midwives and health visitors generally welcomed the initiative and regarded the project as having been positive. Midwives initially expressed concerns about competence, training, support and referral. These boundary issues improved as their confidence grew. They felt that the role should be clearly focused on infant feeding with other support networks being encouraged for more general support. Particular aspects valued were the giving of reassurance and confidence building, having time and flexibility and being able to give continued support. The midwives in Foyle and Wilson's study were very positive about the role as they felt it was useful to have someone who could spend time with the women. They felt that the role definition and boundaries were clear and therefore did not see it as threatening. Sookhoo and King (2002) also demonstrated a positive response. There were some tensions with a minority of health staff linked with conflicting role expectations and minor organisational problems.

Conclusion

The three projects, all with comprehensive evaluations explored an innovative means of providing support to women in a flexible, adaptable woman-centred way. The role appeared to be very acceptable to health professionals, mothers and the HCAs in both the community and hospital. These projects when viewed collectively appear to provide support for the efficacy of the role of health care assistant in supporting women in overcoming barriers to breastfeeding initiation and continuation. The studies all illustrate issues related to interdisciplinary work such as the notion of boundaries. These issues were addressed through careful planning with clear lines of communication and accountability established while maintaining flexibility.

Practice pointers

- Clearly define the aims of the programme.
- Endeavour to involve other agencies, e.g. Sure Start.
- Conduct a detailed consultation process with key stakeholders.
- Plan a role that crosses the community/hospital interface.
- Commence the support during the antenatal period.
- Develop a clear recruitment strategy to include criteria sought by the HCA.
- Develop an appropriate education programme.
- Clearly define the role of the HCA, to include accountability. Make this explicit to HCAs and health professionals.
• Establish clear lines of communication.

• Evaluate the programme from all perspectives; service users, providers and related personnel.

Further research

Further research generated by this evaluation may include:

• Further exploration and evaluation of various models of providing HCA support in a range of settings, in terms of, user and provider satisfaction and impact upon breastfeeding rates.

• Utilising learning theory to identify the most appropriate method for training HCAs.

• Further exploration of the mentor role in relation to supporting health care assistants during and after training.

• Exploration of the differences between peer support programmes and HCA support programmes in terms of user and provider satisfaction and impact upon breastfeeding rates.

• Once a larger body of qualitative research is available a cluster randomised controlled trial is required to test outcomes in terms of breastfeeding rates.

4.6 Projects primarily involving qualified breastfeeding counsellors/supporters

| Table 6. Projects primarily involving the qualified breastfeeding counsellors/supporters |
|---|---|---|---|
| (excludes peer support schemes). | Establishing/evaluating a Breastfeeding centre | Establishing/evaluating telephone support | Educating counsellors/supporters | Counsellor employed as practitioner |
| Buchanan et al (2002) | ✓ | | | |
| Gill, Murdock (2001) | | | | |
| Ginty, Umusu (2002) | | ✓ | | |
| Hastings et al (2001) | ✓ | | ✓ | |

This section focuses upon projects initiated by or centring upon the voluntary organisations engaged in supporting breastfeeding women. It excludes peer support programmes. There are four organisations providing support to breastfeeding women in the UK, each with its own particular philosophy and aims. These are the Association of Breastfeeding Mothers (ABM), the Breastfeeding Network (BfN), La Leche League (LLL) and the National Childbirth Trust (NCT). At this point it is useful to distinguish between peer supporters who receive approximately 20 hours of education and qualified counsellors or supporters who receive 1-2 years of intensive education to prepare them to listen to, counsel and support breastfeeding mothers. The latter group are referred to as Breastfeeding Supporters by, e.g. the Breastfeeding Network (BfN) and Breastfeeding Counsellors by, e.g. The National Childbirth Trust (NCT).
Two projects extended existing BfN services. Hastings et al (2001) utilised the DH funding to establish two breastfeeding support centres, one in an area with high levels of social exclusion in the north of England and one in the South. The latter was established in a Bangladeshi community and will be referred to again in section 4.9. The support centres are based at health centres and staffed by paid BfN supporters. They provide support to women with specific challenges related to breastfeeding and in addition provide an environment that encourages networking between women. Hastings et al (2001) also extended the ‘Supporterline’, a confidential phone service offered to women. Further funding provided to the BfN by the DH enabled Buchanan et al (2002) to extend and improve the accessibility of the ‘Supporterline’ in areas of low breastfeeding rates. The combination of the centres, ‘Supporterline’ and one-to-one support from supporters for mothers, set up in a strategic way led to high attendance rates and very positive evaluations. The design of the evaluations did not enable a causal relationship to be established between the support services and breastfeeding rates. However, the comprehensive descriptive data provides detailed information related to reasons for women accessing the services and the high levels of support received in overcoming breastfeeding challenges. The service is successfully reaching women from communities least likely to breastfeed.

The support centre staff liaise closely with health professionals, some of whom drop in to sessions. As a result of this close collaboration with health visitors and midwives these two groups of health professionals have subsequently requested further training from the BfN. This has now been conducted in a number of areas. The northern centre has now been funded by local PCTs for a further two years. Success of this centre has led to a neighbouring PCT funding a centre in 2001 that now has an attendance of up to 23 women per week, and another nearby PCT has funded a third centre. The southern centre is funded through the local acute NHS Trust. The BfN now has 12 centres across the UK with more planned. The supporters are paid for their services. A number of mothers who have attended have gone on to train and qualify as breastfeeding supporters with the BfN. This model of providing support appears to offer a way forward for supporting breastfeeding women and for optimising collaboration between breastfeeding supporters and health professionals.

Two initiatives involved the employment of NCT breastfeeding counsellors. Spiby et al (2002) developed a new role, the ‘consumer-practitioner’, a post held as a job-share by two experienced NCT breastfeeding counsellors. The post-holders worked in health, social and educational settings. The aim of the role was to utilise evidence in the promotion and support of breastfeeding from consumer perspectives. This work took place in a range of settings to include; provision of antenatal education groups for women with their partner/mother in community and hospital settings, ‘drop in sessions’, a parent education session targeted at grandparents and significant others. They supported women on the hospital antenatal ward and postnatal ward and provided sessions with fathers and other men in the local prison. They taught students at a local school and held sessions with teenage mothers-to-be at the YMCA. The Consumer-Practitioners contributed to the education of a wide range of health professional courses. They also worked in the community engaging with Parent Partnership and Women’s Health Matters (an independent community based agency). Evaluation through a ‘mapping’ exercise identified a wide range of agencies and groups who may appreciate such input. Evaluations of educational input were overwhelmingly positive with particular comment being made about the participative nature of the interaction. There was support for the continuation and extension of the initiative in community, hospital settings and with particular groups of women. This model warrants further exploration, funding and expansion.

Ginty and Umusu (2002) targeted women attending a maternity unit in a low income area. As part of the intervention an NCT breastfeeding counsellor was appointed for 15 hours a week to provide additional support to breastfeeding women. This included talking to women while waiting in the antenatal clinic, visiting women at home and telephone conversations with women who contacted her.
via the project. A weekly postnatal breastfeeding support group was provided. Conclusions are limited as only 13% (37/280) of women responded to the evaluation questionnaire and the project has not been maintained.

Finally, Gill and Murdock (2001) initiated LLL breastfeeding workshops in a socially excluded community. This positively evaluated scheme was referred to in more detail in section 4.4.

**Conclusion**

The range of initiatives illustrate the extensive and effective role that may be played by the breastfeeding organisations. The interagency and interdisciplinary collaboration achieved through these projects is crucial to developing a coherent and cohesive approach to education for those supporting breastfeeding women and to the general support infrastructure for breastfeeding women. Further and extensive funding of initiatives such as the BfN and the consumer-practitioner role would appear to be worthwhile.

**Practice Pointers**

- The BfN model for supporting breastfeeding women warrants further expansion, particularly within socially excluded communities.

- The Consumer-Practitioner role also warrants further expansion but needs to be appropriately funded to enable the multi-faceted role to be conducted.

**Further Research**

Further research generated by this evaluation may include:

- Further evaluation of the BfN centre activities encompassing:
  - Impact upon breastfeeding continuation rates.
  - Exploration of the person-centred counselling approach.
  - Impact of the ‘Supporterline’ on women’s breastfeeding trajectories.

- Further evaluation of the consumer-practitioner role including:
  - Action research to explore its participatory potential.
  - Impact upon breastfeeding education programmes.
  - Impact upon women’s breastfeeding trajectories.
4.7 Education and training for health professionals

Table 7. Education and training for health professionals
(excludes those associated with peer support schemes)

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<thead>
<tr>
<th>Health visitors</th>
<th>Midwives</th>
<th>Neonatal nurses</th>
<th>Doctors</th>
<th>Health Care Assistants</th>
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<tr>
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<td>Beake, McCourt (2002)</td>
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<td>Farrell (2002)</td>
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<td>Ingram, Johnson (2002b)</td>
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<td>Sookhoo, King (2002)</td>
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<td>Spencer et al (2002)</td>
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<td>Williams,Tatman (2002)</td>
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Most of the peer support projects involved training of relevant health professionals. The most common course provided was the La Leche League training developed for those engaged with administering/facilitating the course. This prepared them as “peer counsellor programme administrators”. These are not listed in Table 7.

A number of projects, referred to in Table 7, provided staff education as one aspect of a range of interventions. In some cases the need for staff education was identified following the outset of the project, e.g. Banarsee (2000a) through action-orientated methodology identified the need for training of health professionals. This was subsequently implemented as part of the project.

A range of packages was utilised including courses developed by the project team, the UNICEF UK Baby Friendly Initiative 3 day Breastfeeding Management Course, courses developed and provided by the voluntary breastfeeding organisations and University accredited courses. The projects focused upon in this section are those that specifically aimed to implement and evaluate training of staff as a key focus of the study. They will be referred to in turn as they are diverse in nature and not easily described under subheadings.

Kendall and Entwistle (2002) conducted a quasi-experimental study to evaluate the effect of training on midwives’ ability to promote breastfeeding among low income women. The intervention midwives worked in one geographically defined area and the control midwives in another. A pre and post-test evaluation tool was developed and piloted. Midwives in both arms of the study completed a pre-test and post intervention test that explored knowledge and attitudes at 2 weeks and 4 months. The questions were based on the UNICEF UK Baby Friendly Initiative Ten Steps to Successful Breastfeeding. There were no statistically significant differences between groups in the pre to post intervention results.
data were collated of the breastfeeding statistics at discharge from the two NHS Trusts for the 3 pre-
intervention months prior to and 3 post intervention months. Overall the intervention group showed
a rise in the breastfeeding rate on discharge from hospital of 4.36 percentage points, 2.02 percentage
points greater than the comparative group. Both groups would meet the government target of a 2
percentage point increase. It may be noted that there were some differences between the two sites
adopted for this quasi-experimental study in terms of staffing profiles and related problems. Some
quantitative and qualitative data are still being analysed. This will provide a more complete picture.

Spencer et al (2002) provided a research-based programme of education for neonatal staff to monitor
the effect of a staff training programme upon knowledge and practice of neonatal staff. A research-based
programme of education was designed consisting of five short sessions/modules (total of 10 hours of
teaching). A pre and post-test questionnaire was developed and validated for the measurement of
theoretical knowledge and clinical skills before and after the educational programme. The questions
took the form of 18 short hypothetical vignettes. Pre and post-tests were separated by a minimum of 2
months. The post-test median score was significantly higher statistically than the pre-test median score.
The clinical audit data showed a significant increase in the numbers of babies receiving expressed breast
milk, routine skin-to-skin contact, cup feeds offered in mother’s absence and babies put to the breast.
There was an increase in breastfeeding at discharge but this result was not statistically significant. With a
pre-post-test design the impact of concurrent changes taking place in the unit may have had an impact
upon the clinical outcomes audit data. However, this project highlights the potential of a breastfeeding
course in improving practice and breastfeeding rates in a neonatal unit. This specialist programme of
education is now mandatory for all neonatal nurses on the unit.

Price (2002) conducted an action research project to improve knowledge of the importance of skin-to-
skin contact between mother and baby at birth and of breastfeeding in general. This was achieved by
increasing midwives’ knowledge, improving women’s choices and facilitating the implementation of best
practice. She worked in collaboration with mothers and midwives to facilitate the implementation of
evidence-based practice through role modelling, teaching, encouraging and communicating. Ongoing
teaching sessions were held in a flexible opportunistic way, with an emphasis on visual and practical
skills. This was potentially empowering for midwives to enable them to offer and facilitate skin-to-skin
contact between mother and baby at birth. It also gave practical knowledge of ‘how to do it’, to help
those who had not yet tried. Being able to share this information helped both the teaching sessions and
added depth to the discussions in the clinical areas. Several levels of knowledge were identified, one level
of knowledge involved viewing a video and talking about the benefits of skin-to-skin contact. A deeper
level was gained through observing a baby becoming better oxygenated and contented. An even deeper
level of knowledge was gained through witnessing the innate ability of the newborn to move towards and
attach itself to the mother’s breast. The value of these observations seemed especially important when
discussions took place informally between midwives during the working day.

McNabb M (2002) introduced an approach to supporting breastfeeding mothers based on a ‘biological
nurturing strategy’. Twelve experienced midwives working in geographical areas with high levels of social
derprivation were seconded to attend a series of 2-day educational retreats. The focus of the workshops
was on the biological and interactive aspects of maternal-infant attachment, the transition from fetal to
neonatal metabolism and the metabolic characteristics of the suckling period.

Following this the team were able to facilitate breastfeeding using a biological nurturing strategy, develop
skills to assess maternal/infant well-being and provide skilled counselling for mothers. They were
equipped to develop hospital policies and clinical materials with exclusive breastfeeding defined as the
norm, act as mentors for other staff within their areas of practice and lead a rolling programme for other
staff. The project is being evaluated and has been extended to the whole NHS Trust. In-service training
for staff in metabolic adaptation is ongoing.
Whitmore et al (2002) developed and delivered practice-based breastfeeding awareness training for general practitioners, practice nurses and ancillary staff. This aimed to improve the general level and quality of support to all breastfeeding mothers, but particularly those in disadvantaged social and economic groups. The team developed and delivered an hour-long awareness session encompassing topics identified by the local GPs at an earlier audit as of particular relevance to their practice. The project team was drawn from the breastfeeding subgroup of the local Maternity Services Liaison Committee (MSLC) and comprised a BfN tutor, a midwife employed as an infant feeding specialist in a local hospital and a health visitor who is also a BfN Supporter. By the end of the funded period 22 practices had received the session. Thrush and insufficient milk syndrome were the two topics most frequently judged to have contained new and relevant information. General comments about the session were very favourable. Postal questionnaires were sent to all participants of the first 15 sessions three months after each session. GPs reported being more supportive and more proactive in encouraging women to initiate or continue breastfeeding for up to six months. Greater confidence in dealing with breastfeeding difficulties was also mentioned. There were high response rates with very positive feedback from participants. The format of the session was clearly acceptable to most participants. These were however practices that had expressed an interest in training and presumably therefore may have been more favourably disposed towards breastfeeding.

Conclusions

This series of educational interventions was varied and diverse making collective conclusions difficult. The combination of the assessment of knowledge and clinical outcomes illustrated by the work of Kendall and Entwistle (2002) and Spencer et al (2002) provides an important perspective related to impact of breastfeeding education not only for staff but for service users. However, the limitations of the quasi-experimental approach utilised by Kendall and Entwistle (2002) require results to be interpreted with caution. The tailoring of breastfeeding education specifically to neonatal staff described by Spencer et al (2002) would appear to be important and is an area warranting further study. The outcomes of McNabb’s (2002) project will add further knowledge regarding impact on practices. The GP training provided by Whitmore et al (2002) appears to offer a model that is very acceptable to this group. There is much literature about the theory/practice gap, where knowledge is available about best practice, but never implemented. The action research methodology adopted by Price (2002) is a way of facilitating practitioners to bridge that gap and implement practice in a way that is relevant for them and works in their particular culture. As Price (2002) states “changes tend to come from collaboration rather than imposition of values from outside the group”.

Practice pointers

- Decide upon what the education programme needs to achieve.
- Consider the training packages already in existence as developing a new course is very time consuming.
- Explore the most appropriate model, e.g. for GPs a one-hour session may be all that they are able to attend (Whitmore et al 2002).
- For specialist groups, e.g. neonatal staff consider adapting a course for their specific needs, e.g. Spencer et al (2002).
- Consider an action research approach (Price 2002).
• Remember to maximise reflective learning, see e.g. Price (2002).

• Utilise a tool that will evaluate knowledge, attitudes and skills of staff along with practice outcomes to include breastfeeding rates.

Further Research

Further research generated by this evaluation may include:

• Exploring and identifying the most appropriate models of staff training for different groups.

• Exploring the influences of debriefing and person centred counselling approaches as advocated by the breastfeeding support organisations.

• Exploring the ways in which reflective practice may best be facilitated.

• Exploring ways in which evidence may best be translated into practice.

• Ultimately the setting up of a large multi-centre cluster RCT with additional qualitative research would enable evaluation of specific programmes of education in relation to providing appropriate support to breastfeeding women and increasing breastfeeding rates.

4.8 School education

<table>
<thead>
<tr>
<th>Table 8. School education</th>
<th>Develop a pack for schools</th>
<th>Develop a video for schools</th>
<th>Secondary school</th>
<th>Primary school</th>
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<tr>
<td>Bachelor, Brackstone (2001)</td>
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<td>Best (2002)</td>
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<td>Kirkham (2002)</td>
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<td>Middlemiss (2002)</td>
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Several projects conducted schools work as part of a broader project (Bachelor and Brackstone 2001, Charlton et al 2001, Best 2002, Spiby et al 2002). However, this section will refer to the four projects that specifically focused upon school education (Kirkham 2002, Lockey and Hart 2002, Wilkinson and Greenwood 2002, Middlemiss 2002). The projects were conducted in several stages:

• Planning the project

• Assessment of local culture/needs analysis

• Developing the pack
Planning the project

In each case a multidisciplinary group was set up to develop a breastfeeding teaching pack for schools education and to plan the strategy for accessing schools and delivering the programme.

Assessment of local culture/needs analysis

Potential target schools were identified and discussions were then held with groups of school children to elicit their needs. For example, Wilkinson and Greenwood (2002) were granted school access for several discussions to be held with a group of children from a local high school. This facilitated the development of the learning materials. Lockey and Hart (2002) adopted an action research approach. This methodology enabled flexibility and adaptability in responding to research participants’ feedback/evaluation as the project progressed. The first stage involved the conduct of three focus groups: one with girls aged 13-15 years, one with boys aged 13-15 years and one with young mothers. These highlighted underlying attitudes towards breastfeeding to assist with the development of the pack.

Developing the pack

The development of teaching materials formed a considerable part of the projects, for example, Middlemiss (2002) produced a video with the collaboration of young actors from a local college, a breastfeeding co-ordinator and a group of breastfeeding mothers. It also involved peer educators. The teaching package was developed, piloted, evaluated and changed to meet the needs of young people. Lockey and Hart (2002) produced a video developed through interviews with people on the local streets about attitudes to breastfeeding along with clips of a mother breastfeeding. The team also introduced a range of photographs of women breastfeeding to stimulate discussion. Wilkinson and Greenwood (2002) also utilised visual images as a part of their package. The projects all developed interactive and visual methods to facilitate the exploration of cultural beliefs, attitudes and knowledge.

Preparing the trainers

The project adopted varying approaches to trainer preparation. Kirkham (2002) utilised peer supporters to conduct the schools’ programme education. This was achieved through extending an existing peer support project ‘Breastfriends’ (Curtis et al 2001) also funded originally by the DH. A group of ‘Breastfriends’ were provided with additional training conducted by an NCT tutor and counsellor.

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1 Peer educators are a group of students who have attended an education programme about various issues that teenagers may want to know about. This then allows them to be a support for other students who may want to talk to someone of their own age rather than a teacher/adult.
It was highly experiential, similar to the existing 'Breastfriends' training but with more emphasis on working with groups than with one-to-one. It consisted of six days of contact time, i.e. 12 sessions each two hours long over a three week period. The experiential learning course focused on the participants' ways of learning and the purposes of going into schools. The 'Breastfriends' then facilitated the school sessions in pairs with their babies and accompanied by a midwife. A teacher was also present. Wilkinson and Greenwood prepared school nurses and midwives to deliver the pilot training. Lockey and Hart (2002) acknowledging difficulties with access and joined up-working developed the pack so that teachers themselves could deliver the session.

Accessing schools

Accessing schools provided a major challenge for some of the projects. Kirkham (2002) reported that considerable negotiation was required through a number of 'gatekeepers' in order to gain access to schools. This was very time consuming. Two state high schools were identified for the education programme in the target area. The breastfeeding teaching was fitted into existing educational programmes all with different agendas ranging from 'Citizenship', 'Childcare' and 'Personal Social Health Education' (PSHE). This required considerable flexibility from the team. The primary schools were particularly reluctant to permit breastfeeding education as they saw it as an issue to be screened as with sex education sessions. Out of nine primary schools approached only one gave permission for a teaching session. This session was linked with 'Citizenship' education. It became clear to the team that breastfeeding had "no place, in its own right, in the national curriculum" (p.17). Other settings in which the 'Breastfriends' taught included a local college in which two groups of Nursery nurses were taught. A session was provided at a local young people's drop-in and also at a local young parents' project.

Lockey and Hart (2002), following discussion with teachers and other educationalists fitted the education into PSHE. They also reported a general reluctance among teachers to discuss breastfeeding. When teachers were approached regarding breastfeeding education they appeared to associate it with teenage pregnancy. The education was packaged under the issue of 'Primary health/Nutrition' so as to avoid it being classed as sex education with all the parental consent issues. The team developed working relationships with the local PSHE advisory team and with PSHE teachers in two local secondary schools. The project leader was a qualified youth worker in addition to being a health visitor. Teaching sessions were developed and delivered at a local college and to year 9 students at a school. Twelve sessions were delivered to six groups, aged 13-14. Breastfeeding materials were displayed at the college during breastfeeding week.

Wilkinson and Greenwood (2002) accessed two schools. School 1 had a mixed race population and school 2 had a mainly white population. In school 1 the breastfeeding session was time-tabled within the year 10 PSHE. In school 2 time was allocated within the year 10 'Religious Studies' programme.

Delivering the programme

All four project teams provided sessions that encouraged the students to explore their attitudes to breastfeeding through a range of visual, experiential and interactive ways of teaching. The sessions raised awareness of and personalised the topic of breastfeeding which is normally not discussed within these communities.
Evaluating the programme

A range of comprehensive evaluation tools were utilised, e.g. Wilkinson and Greenwood (2002) issued pre and post teaching questionnaires and workbooks to participating school children. These used a quiz format including a word search to elicit knowledge gained about breastfeeding. A questionnaire was issued to staff, both teaching and nursing, who had observed the teaching session and to those who had used the teaching pack. The heads of PSHE in seven other High schools were asked to review the pack and comment. It became evident that breasts were seen as primarily sexual but positive attitude and knowledge changes were evident in both female and male students following the teaching sessions. Staff were generally positive about the teaching pack feeling that it met the learning outcomes. The main improvement suggested was related to the video that was not specifically tailored to this group and thus not felt to provide appropriate role modelling for the target group. Secondly, it was felt that groups of no more than 15 students were appropriate. Four out of seven heads returned comments. Two Islamic schools preferred not to look at the pack. Three felt that their teachers could use the pack and one felt that it would be better used by the school nurse. All four felt that the pack could be a useful resource for years 9 and 10 in line with the National Healthy Schools Standard (NHSS).

Kirkham (2002) provided evaluation sheets to pupils and elicited the views of ‘Breastfriends’ and teachers. Pupils evaluated the sessions positively. They particularly valued the opportunity to discuss breastfeeding and the interaction with mothers and babies. They highlighted their acquisition of new knowledge on breastfeeding. The volunteers grew in confidence and skill. The teachers and midwives present with them described them as flexible, confident and responsive.

Lockey and Hart (2002) obtained written feedback from students (male and female). Results of post-session student evaluation showed that most students thought the subject was ‘interesting’, had learnt something, and felt comfortable with breasts and breastfeeding as a subject in a mixed sex class. Girls considered the session to be more relevant than boys. Many students who were unsure about whether they would choose to breastfeed said they would now consider it. The students suggested more visual material, more structure to the session and interesting ways of presenting material. This was addressed as described above. A clearer lesson plan addressed the issue of structure.

Sustaining the programme

Sustaining these programmes provides an ongoing challenge. Middlemiss (2002) reports that Sure Start funding has enabled the pack ‘Breastfeeding for a New Generation’ to be printed and marketed. The project co-ordinator continues in her role as health visitor to provide schools education on breastfeeding. Wilkinson and Greenwood (2002) intend to extend the training to other high schools and possibly primary schools. Kirkham (2002) highlights some of the difficulties with funding for initiatives like this. She notes that many agencies want to utilise ‘Breastfriends’ but they may not feel that it is part of their remit to contribute funding to their training. Mainstream services do not necessarily see it as part of their role to fund projects which bridge health and education. Lockey and Hart (2002) now supply the pack free of charge to people working locally. Teachers, health visitors, lay people, voluntary sector organisations, infant feeding specialists and midwives have taken it up. The pack is for sale to others. The pack is described as “eye-catching, funky and young person friendly”.

Infant Feeding Initiative
Conclusions

There are many close connections between these projects although they utilised different approaches to deliver the course. These projects, the materials they have produced and the challenges they describe will undoubtedly provide useful information for others embarking on schools education. The evaluations for all four projects were very positive. This area of work is undoubtedly crucial across the country and particularly in communities with low rates of breastfeeding. The needs of schools specifically serving minority ethnic children need to be evaluated.

The challenge of bridging health and education is eloquently summarised by Lockey and Hart (2002)

"Without a strong central lead, it is unlikely that schools will individually seek out material of this nature. This is because teaching about the benefits of breastfeeding has to compete with other topics within an already over-stretched curriculum. Furthermore infant nutrition is not always seen as an important subject despite the implication for increasing/reducing health inequalities…. The cultural barriers towards discussing breastfeeding, which we have identified during the research process remain an issue for many teachers and health professionals. This needs addressing, since our research has shown that it is possible to work with young people in this way and that they are appreciative of it” (p.11).

"Active co-ordination and promotion is needed between the Department of Health and the Department for Education and Skills at the level of central government to ensure education about breastfeeding takes place in secondary schools” (p.1).

Practice Pointers

• Draw on the experiences of others who have set up schools projects.

• Carefully plan the project involving a multidisciplinary team that bridges health and education.

• Assess local culture/needs through discussions/focus groups with local people.

• Consider utilising an existing pack produced by one of the schools projects.

• Decide who will be delivering the training and arrange for preparation. This may be teachers, peer supporters, school nurses, health visitors, midwives or a combination. Consider sustainability when making this decision.

• Accessing schools may be challenging. Involving them from the start helps. Consider the best place to locate the sessions within existing curricula. Avoid associations with teenage pregnancy and sex education.

• Deliver the programme in an interactive and flexible way. Utilise visual images and a culturally appropriate video.

• Aim for no more than 15 students per session.

• Evaluate the programme through eliciting the views of students, teachers and those delivering the programme. This should be ongoing and cyclical.

• Seek sustainable sources of funding to enable the programme to continue.
Further Research

Further research generated by this evaluation may include:

- Evaluating the most appropriate place to locate education within the curricula.
- Exploring the use of the packs developed by these projects in other schools.
- Evaluating the most appropriate personnel to deliver the teaching.
- Exploring extension of projects to pre-school, primary school and colleges.
- Exploring the most effective ways of strategically bridging health and education.
- Developing and evaluating materials in collaboration with minority ethnic communities that are acceptable to specific cultural groups and religious schools.

Related publications by project teams


4.9 Women from minority ethnic communities

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<td>Explorer</td>
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<tr>
<td>Dowling (2002)</td>
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<tr>
<td>Finigan et al (2001)</td>
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<td>Hastings et al (2001)</td>
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<td>Ingram, Johnson (2002b)</td>
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<td>Westman (2001)</td>
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<td>Shaw, Wallace (2002)</td>
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A number of studies focused specifically on women from minority ethnic communities (see Table 9). Other projects made reference or additional provision for these communities in a range of ways. This section mainly focuses upon projects that specifically sought to target members of minority ethnic communities. As the nature of these projects is diverse they will be referred to in turn rather than applying specific subheadings. Some general conclusions are then drawn.

Dore et al (2002) set up a breastfeeding drop-in centre in an area with a diverse multi-ethnic population. The centre was established at the local African-Caribbean centre. This provided a venue for conducting a breastfeeding workshop and clinic, accommodating both pregnant women and breastfeeding mothers. The group was named 'Tea for Two'. However, five months into the project only 2-4 women were attending each workshop/clinic. The women who attended evaluated the workshop positively but the choice of venue posed some barriers to women from ethnic groups other than African-Caribbean as it was associated with one specific minority ethnic group. The project team also realised that the name ‘Tea
for Two’ was culturally inappropriate. The name of the group and venue were subsequently changed to make it more accessible to all cultural groups and this increased attendance. Data on breastfeeding rates is not available.

Dowling (2002) focused on local black and minority ethnic women in a demographically defined geographical area. Existing one-day antenatal workshops were felt to be inaccessible to women from local ethnic minority groups for whom English was not their first language. A specific monthly workshop was developed utilising translated material, both audio and visual. An interpreter was present at all the workshops. Transport to and from the workshops was offered and an interpreter made available. Attendance ranged from 0-12 with a total of 30 women attending over 12 months. Questionnaires in Urdu and Bengali were issued to mothers at the end of the workshop day. (An interpreter was on hand to assist with the completion). Interviews were also conducted in five mothers’ own homes after the birth. The sessions were positively evaluated, however women felt that a one-to-one session in their own home would have better met their needs. It then became evident that women from some of these ethnic groups needed permission to leave the home and antenatal education was not viewed as an important reason for them to be away from the home. Data were not collected on breastfeeding rates in the target group.

Finigan et al (2001) evaluated two existing breastfeeding support groups, one hospital-based and the other community-based, serving an area with a large Bangladeshi and Pakistani population. The DH funding also enabled the training of three Bangla speaking women who promoted consistent advice within the hospital and also Urdu and Bangla speaking peer supporters who attended the support groups. Finigan et al (2001) aimed to ascertain reasons why certain groups of the population did not feel that the group would meet their needs. They conducted focus groups and semi-structured interviews with Bangladeshi and Pakistani mothers to elicit their specific needs (Asian link workers were involved). Some women were unaware of the group's existence. It also became apparent from the Bangladeshi women that it was considered unsafe to leave the home and travel on a bus. Fear of racism was cited. They preferred to attend groups to which they could walk as they did not necessarily drive or have access to a car. This is an important study in that it elicits reasons why women may not wish to avail themselves of a support group. The authors comment that the Asian women were reluctant to participate in the study. This clearly points to the need to explore ways of eliciting their views that would be more acceptable to these communities.

Hastings et al (2001) set up a BfN breastfeeding support group in an area that had a large Bangladeshi community and a smaller Afro-Caribbean community. One of the BfN supporters was a Bengali Health Advocate who also worked in the local maternity unit. She was also a breastfeeding mother and therefore acted as a role model. The success of this Centre in attracting women from the Bangladeshi community appeared to be related to the known presence of a supporter from the same ethnic group. In her role as Bengali Health Advocate she had met women earlier in the maternity unit. The women therefore knew that when they came back they would see her again. The Bengali supporter utilised personal experience to enable women to consider an alternative to their cultural norm. Recognising that Bengali women commonly combine breast with infant formula feeding and feel embarrassed about breastfeeding in front of others, the supporter explained that she expressed her breast milk so that she could give it from a bottle if visitors arrived. This enabled her to exclusively breastfeed. This is an example of the importance of providing supporters for women who understand the local culture. It also highlights the value of the opportunity to establish a relationship with a known appropriate other. Finally, it identifies a key way in which exclusive breastfeeding may be promoted in communities where there are cultural barriers to this practice. This centre is now funded through the local acute NHS Trust.

Ingram and Johnson (2002b) conducted a project in an area with a high Asian population (Bangladeshi, Indian and Pakistani) in which grandparents were recognised to have a powerful influence. They designed and delivered an antenatal workshop in the homes of Asian mothers accompanied by
grandmothers. To develop the intervention appropriately they firstly assessed Asian grandmothers’ beliefs and cultural practices around infant feeding, knowledge of breastfeeding and their ability to support successful breastfeeding through focus groups and home interviews. (A senior link worker was involved in the recruitment.) The focus group interviews highlighted specific cultural traditions around birth and breastfeeding and related support. Interviews were again conducted eight weeks post birth in mothers’ homes. These revealed that women and their mothers felt very positive about the antenatal session and found the accompanying leaflet to be very helpful. Attitudes and behaviour towards giving colostrum, exclusively breastfeeding and reducing dummy usage appeared to have changed positively. Collation of breastfeeding statistics showed positive trends towards the intervention increasing exclusive breastfeeding. All 14 of the mothers who commenced breastfeeding gave colostrum. The use of focus groups and interviews to explore the cultural beliefs of mothers and grandmothers is an example of identification of baseline cultural issues before moving on to develop a culturally sensitive intervention. Link worker involvement at all stages of the process was important to the success of this study.

Westman (2001) produced a video Breastfeeding – A Gift for Life that provided breastfeeding information in line with the Baby Friendly Initiative. The video was developed in four languages; Sylheti Bengali, English, Punjabi and Urdu. The videos were offered to all antenatal women and then collected during the postnatal period. A draft version of the video was previewed by Asian health support workers, UNICEF UK Baby Friendly Initiative, midwives from the maternity unit, members of the National Network of Breastfeeding Co-ordinators in the region and by pregnant women and their partners at parentcraft sessions. Changes were made in response. The video Breastfeeding – A Gift for Life, is currently offered to all women who book for care at the relevant NHS Trust. They are requested to return it when they have finished with it. The video is available for sale enabling the project to become self-funding.

Shaw and Wallace (2002) conducted qualitative research to elicit health professionals’ perceptions of young Asian and White mothers and to elicit the nature of young Asian, Black and White mothers’ experiences of infant feeding. The purposive sample consisted of 1 ‘Bangladeshi’, 1 Black ‘Other’, 1 Black ‘Caribbean/White’, 3 ‘Pakistani’ and 5 ‘White’ women. Ages ranged from 16-21 years. Semi-structured interviews were conducted both antenatally and postnatally. Focus groups with health professionals highlighted gaps in their knowledge regarding cultural understandings of Asian mothers and adolescents in general. The use of interpreters for two young women made the exploration of lived experience through language difficult. The authors recommend that research interviews should be conducted in the women’s own first language. However, the study provides a useful addition to the body of knowledge related to the gaps between health professionals’ perceptions of behaviours and actual behaviours. In this study infant feeding decisions and behaviours appeared to be more homogenous across ethnic groups than anticipated by health professionals. The authors highlight the requirement to educate health professionals more appropriately for understanding specific cultural beliefs and values. The authors recommend that research now needs to focus on ways in which the benefits of breastfeeding can be promoted to the multicultural communities living in socio-economically disadvantaged settings.

Conclusions

This range of studies was not structured in order to specifically make causal statements about the influence of interventions upon breastfeeding rates. However, collectively they provide considerable insight into some of the needs and challenges related to providing breastfeeding support to specific minority ethnic groups. They highlight the need to explore cultural attitudes, beliefs and values before developing interventions to support breastfeeding women. They illustrate the importance of involving grandparents and key members of communities in making change. They illuminate the advantages of employing supporters from the same ethnic background who speak the same language. Finally, they provide information on the development of appropriate resources for specific cultural groups.
combination of these initiatives is likely to support women in both initiating and continuing to breastfeed.

Practice Pointers

- Before implementing a service become familiar with local cultural beliefs and norms.
- Engage key members of the local community in the management of change.
- Avoid stereotyping, homogenising and making assumptions about other ethnic groups.
- When interviewing ensure that this is conducted in the person’s own language, not via an interpreter.
- Select appropriate venues for the ethnic mix of the target group.
- Select culturally sensitive names for support groups/drop-ins etc.
- Provide a choice of home education.
- When providing support groups ensure that they are within a short walking distance for women.
- Recognise the importance of grandparents.
- Employ/engage supporters from the same ethnic groups with common interests.
- Check out resources developed and available from other projects, e.g. videos and leaflets.
- Ensure that health professionals and other supporters receive training related to specific cultural beliefs and needs.

Further research

Further research generated by this evaluation may include:

- Further exploration related to the involvement of grandparents in supporting breastfeeding.
- Further exploration of cultural beliefs of specific minority ethnic groups with regard to infant feeding.
- Exploration of the use of role models from the same ethnic communities.
- Eliciting further the views of those who do not avail themselves of breastfeeding support services.
4.10  Adolescents

<table>
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<th>Table 10. Adolescents</th>
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<tr>
<td>Exploratory study</td>
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<td>Kallat (2002)</td>
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<td>Flynn, Savage, (2001)</td>
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<td>Shaw, Wallace (2002)</td>
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<td>Thompson et al (2002)</td>
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A number of projects referred to young women and adolescents as a part of their project aims, e.g. Battersby (2001a), Curtis et al (2001). This section, however, focuses upon the studies that placed their central focus upon adolescents and breastfeeding. It excludes schools projects. The projects were diverse in nature and are therefore referred to individually rather than under subheadings.

Bartlett (2001) provided a one-to-one home education session during the antenatal period for eighty adolescents receiving maternity care in a socio-economically deprived group within a designated demographic area. The scheme was referred to as the ‘Streetwise’ project. At this antenatal visit general issues were discussed related to pregnancy, birth and mothering. Breastfeeding was discussed and the adolescents were offered the opportunity to view the video, *Focusing on Attachment* that centred upon positioning and attachment and skin-to-skin contact. The project team provided additional support during the first postnatal week both in hospital and at home. Twenty-eight percent of the 72/80 questionnaire respondents were breastfeeding at 3-4 months compared with the then national average of 13%. Accurate data was not available for the target group prior to the intervention so causal statements were not made.

Hall Moran et al (2002) explored the experiences of and acceptability of a variety of supportive approaches to breastfeeding adolescent mothers through focus groups and in-depth interviews. The adolescent mothers referred to lacking confidence in breastfeeding, feeling watched and judged, tiredness, discomfort and the desire to share accountability. Five categories of support need were identified: practical/instrumental, emotional, esteem, informational and peer/network. The adolescents were particularly influenced by significant others, in particular their own mothers. Most had formed a strong relationship with the teenage pregnancy co-ordinator, also a midwife and that had formed a major source of support in the five areas identified. She provided information and practical support, they felt listened to, encouraged and cared for by her. She connected them with peers through the teenage pregnancy support group. The levels of support from health professionals were variable.

Kallat (2002) provided an antenatal home workshop to adolescents in an area with high levels of social deprivation. This was followed by a second visit conducted at 24-48 hours following the birth either in hospital or at home. Recruitment to the scheme was challenging due to reluctance of adolescents to participate. In-depth interviews with five adolescents highlighted a range of personal attitudes to breastfeeding and variable levels of support from significant others and health professionals. Support from the project midwives was felt to be helpful. Some form of peer support scheme appeared to be a favoured option. This study illustrates some of the challenges involved in engaging young women from socially excluded communities into schemes/studies. It would appear that a less formal scheme based on peer support may be more appropriate to this group.
Flynn and Savage (2001) re-launched an existing teenage mothers’ support group, ‘Stepping into Parenting’ in an area with high levels of deprivation. The group was attended by the project co-ordinator weekly along with a youth worker assigned to the teenage parenting group. Activities within the group related to breastfeeding included listening to the teenagers, discussion, providing information on practical skills and video use. The group offered antenatal and postnatal support to teenagers. Breastfeeding initiation rates for mothers under 20 years rose from 29% to 46% during the project period (sample sizes not available). This figure relates to all adolescent mothers not just attendees.

Shaw and Wallace (2002) conducted qualitative research to elicit health professionals’ perceptions of young Asian and White mothers from socio-economically disadvantaged environments and to elicit the nature of young Asian, Black and White mothers’ experiences of infant feeding. This study was referred to in section 4.9 but several general issues related to adolescent mothers are referred to here. The focus groups with health professionals highlighted that they perceived young mothers as an ‘outgroup’, being unlike themselves. Stereotyping was evident with young white women being viewed as bottle feeders due to peer pressure and role modelling. Their major concern was perceived to be centred upon restoring their previous social life. They were felt to be easily put off by perceived or actual problems with breastfeeding. The interviews with young mothers revealed that most women expressed surprise at the work involved in motherhood and tended to seek their own mother’s views on baby care. The young mothers tended to perceive breast feeding as difficult and inconvenient compared to bottle feeding and this outweighed their obvious knowledge that breastfeeding was better for the baby. However, when they did bottle feed this too was found to be time consuming and inconvenient. The authors highlight the requirement to educate health professionals more appropriately for understanding specific cultural beliefs and values. Simply informing young mothers that ‘Breast is Best’ ignores the complexities related to their feeding decision making. The authors recommend that research now needs to focus on ways in which the benefits of breastfeeding can be promoted to the multicultural communities living in lower socio-economic environments. Involvement of the extended family is advocated for adolescent mothers as they tend to be very much influenced by their mothers.

Thompson et al (2002) appointed a breastfeeding ‘guardian’ to support adolescents accessing maternity care services in a city with high levels of social deprivation. The ‘guardian’, a midwife with appropriate training offered information and support in the ante and postnatal period to adolescents who had expressed a wish to breastfeed. The project midwife met the adolescents several times and discussed issues of relevance to them. This often involved significant others who accompanied them. Topics covered during discussions were how milk is produced, what colostrum is, the difference between fore milk and hind milk and how often the baby may want to feed (realistically) in the first few days. A video made by teenage mothers in the same city was shown. The project midwife visited each adolescent in hospital after the birth to reinforce antenatal learning and to observe a breastfeed. Thereafter, she saw the mother in hospital as often as was necessary. Once discharged she contacted the mothers every day for a week by telephone and then weekly until they discontinued breastfeeding. The adolescents could initiate contact with the project midwife at any time through the hospital switchboard. The project midwife made at least one home postnatal visit. In some cases three or four visits were made. Sixty teenagers participated in the project. Twenty-five percent did not commence breastfeeding at all. The remaining adolescents breastfed for between 1 day and 8 months. The adolescents were generally positive about the support, advice and friendship received from the project midwife who supplemented support received from significant others. Qualitative analysis yielded several themes: peer support, i.e. positive reactions from friends; personal confidence/pride; closeness to the baby; disruption of life-style by breastfeeding; ways in which the project midwife helped and recognising the benefits of breastfeeding. The project midwife reflected on her roles. She felt that she had acted as an advocate, practical resource and information giver for the teenagers and their families, working sensitively with them, assessing the dynamics of the family group and the teenagers themselves and not stereotyping.
Conclusion

These studies highlight the perceptions and needs of adolescents and point towards the types of intervention that may support them in initiating and continuing breastfeeding. There is clearly a risk that health professionals and others will stereotype adolescents. This may lead to assumptions that they will not initiate breastfeeding and that those who do may not persevere. Such assumptions need to be addressed as it may be counterproductive to increasing breastfeeding rates in this group. It also becomes clear that adolescents benefit from the opportunity to build relationships with a health professional as illustrated by Thompson et al (2002) and Hall Moran et al (2002). Their own mother is often very influential and therefore it would seem to be appropriate to involve her in discussions around infant feeding. Support from a network of likeminded others is also crucial for this age group. This was facilitated in several of the studies through a designated support group for teenagers. The support provided for adolescents should include practical support, information, encouragement, confidence building, emotional support and peer/network support. It seems that a clear case is made from these studies for a designated person, e.g. a teenage pregnancy co-ordinator with appropriate knowledge in supporting women with breastfeeding to provide one-to-one support for teenagers and also co-ordinate a support group to encourage networking.

Practice Pointers

• Avoid stereotyping adolescents.

• Recognise the need for continuity and a relationship with supporters.

• Ensure that the needs for practical support, information, encouragement, confidence building, emotional support and peer/network support are all facilitated.

• A designated teenage pregnancy worker with appropriate skills in supporting breastfeeding should be strongly considered.

• Provide a support group to facilitate networking with 'background' availability of an appropriate breastfeeding supporter.

• Involve significant others in dialogues about infant feeding.

Further Research

Further research generated from these projects would be useful to:

• Further explore a range of one-to-one support models for adolescents with regard to breastfeeding.

• Experimentally test the capacity of a designated supporter in increasing initiation and continuation of breastfeeding.

• Further explore ways of involving significant others in dialogues about infant feeding.
Related publications by project teams


4.11 Significant others

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<th>Table 11. Significant others</th>
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<tr>
<td><strong>Family (general)</strong></td>
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<tr>
<td>Barker (2001)</td>
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<td>Best (2002)</td>
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<tr>
<td>Ingram (2002b)</td>
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<td>Winterburn, Jiwa (2001)</td>
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Five projects focused very specifically on significant others in relation to breastfeeding. They were diverse in nature and are therefore referred to separately.

Baker et al (2002) conducted a longitudinal qualitative study with twenty-four women and their families. The study explored the impact of breastfeeding on different family members, the diversity and commonality of views between the groups of families and evaluated family views on the provision of current breastfeeding services. Family experiences of breastfeeding centred upon both negative aspects, e.g. nipple soreness and tiredness, and positive aspects, e.g. breastfeeding being healthy and natural. Feelings included, on the one hand, embarrassment, guilt, pressure and indifference, but on the other hand the sense that breastfeeding was special, brought pride/joy and was associated with bravery. Influences of family members were both positive and negative, some being supportive and encouraging, others unsupportive and critical. Families made some important recommendations. These included a more flexible antenatal teaching system, which enabled men to attend and participate, offer of home videos and family centred teaching. The use of the media to popularise breastfeeding was suggested and the provision of private places to enable breastfeeding in public without embarrassment. This study adopted a unique approach, that of engaging significant others in the research process.

Barker (2001) provided an antenatal breastfeeding workshop for women and grandmothers or significant others. Topics covered included the benefits of breastfeeding, basic physiology, babies’ feeding patterns, skin-to-skin contact, positioning and attachment, baby-led feeding and overcoming breastfeeding difficulties. Forty-four of the 115 women who attended were accompanied by a grandmother or significant other and they felt that this was useful. The most useful aspects of the workshops were positioning and attachment, skin-to-skin contact and overcoming difficulties. Data is not available as to how the presence of the significant other may have influenced women’s breastfeeding trajectories.

Best (2002) conducted an action research project to raise male awareness of the benefits of breastfeeding and to change male attitudes towards breastfeeding within an area highly ranked for social deprivation. Awareness of local cultural attitudes and knowledge related to breastfeeding was generated through focused discussions in the community to include two parent education classes for couples and a small group of year 10 teenage boys from a local comprehensive school. Considerable difficulties were experienced in accessing male views on breastfeeding and recruiting male volunteers for the theatre. Eventually an open workshop on ‘being a dad’ generated a small number of volunteers, male and female, to take part in a forum theatre production. The theatre performance was then scripted and presented in
four settings, a local pub, three year 11 forms in a local school, an antenatal couples’ class and the local football club. The taped interviews and reflective notes made by key participants yielded qualitative data. This centred on the ways in which the production made the issue of breastfeeding visible through various means including comedy, thereby raising awareness. The participants reflected on their own roles as participants and some of the difficulties and tensions experienced. Utilising community lived experiences facilitated the development of trusting relationships and productive networks and thus contributed to the development of community capacity building. This participatory project illustrates the process of generating knowledge of the local culture, of negotiating with local gatekeepers, gaining agreement and the use of community lived experience to generate awareness of and discussion around a contentious issue.

Ingram and Johnson (2002b) designed and delivered an antenatal workshop in the homes of Asian mothers accompanied by grandmothers. To develop the intervention appropriately they firstly assessed Asian grandmothers’ health beliefs and cultural practices around infant feeding, knowledge of breastfeeding and their ability to support successful breastfeeding through focus groups and home interviews. Home interviews were conducted eight weeks post birth in mothers’ homes. These revealed that women and their grandmothers felt very positive about the antenatal session and found the accompanying leaflet to be very helpful. Attitudes and behaviour towards giving colostrum, exclusively breastfeeding and reducing dummy usage appeared to have changed positively. Data collection of breastfeeding rates showed positive trends towards the intervention increasing exclusive breastfeeding in the intervention group. All 14 of the mothers who commenced breastfeeding gave colostrum. The involvement of grandmothers through all stages of the study highlights the recognition that this significant group needs to be involved for changes to take place.

Winterburn and Jiwa (2001) conducted a pilot randomised controlled trial to test the hypothesis that a close female confidante of the mother’s own choice if educated about breastfeeding could increase initiation and continuation of breastfeeding. The intervention consisted of provision of an opportunity for pregnant women and a female confidante of their own choosing to discuss breastfeeding with a midwife and/or health visitor at a third trimester home visit. The confidante needed to be someone who could support the mother with breastfeeding following the birth. Mother and confidante were visited together during the antenatal period by the midwife to discuss breastfeeding according to NHS Trust guidelines. The control group received standard antenatal care which included the same home visit to the mother only. Most women chose their own mother (n=15). Five chose their sister and two selected distant relatives or friends. The relationship of the confidante was unknown (missing data) for four women, three women did not receive the intervention and one was visited in hospital. Breastfeeding rates were compared and analysed and suggested differences of clinical importance. No statistically significant difference was demonstrated between the control and intervention groups in the initiation or duration of breastfeeding. The data relating to the duration of breastfeeding was analysed for any trends and this was again not significant. However, the longer duration in the intervention group approached statistical significance. Content analysis of telephone interviews highlighted that most mothers valued the intervention in terms of the practical and emotional support offered. Analysis of questionnaires to midwives yielded five categories of response: ‘creating a supportive culture for breastfeeding’ through the intervention; ‘difficulties in organising the visit to the woman and her confidante’; ‘the importance of a well chosen confidante’ with midwives suggesting that guidance was needed for mothers in this respect; ‘difficulties with the role of confidante’ and ‘partners as confidantes’.

**Conclusions**

The quantitative data from these studies show trends towards increasing breastfeeding rates. The qualitative data highlight the importance of involving significant others in dialogues around infant feeding. The issue raised in Winterburn and Jiwa’s (2001) study regarding the selection of a confidante
who is supportive of breastfeeding is sensitive. The woman’s key confidante may not be her main supporter with breastfeeding and indeed may be unsupportive. This was illustrated by Baker et al (2002) who highlighted a considerable range of attitudes within one family. This suggests the need to invite/engage more than one significant other in some cases.

Practice Pointers

- In socially excluded communities the strong influence of significant others needs to be recognised.
- The influence of the grandmother in some Asian communities is powerful.
- Home visits may assist in engaging significant others in discussions around infant feeding.

Further Research

Further research generated from these projects could include:

- A larger randomised controlled trial to test the influence of a significant other upon breastfeeding rates.
- An exploration of woman’s choice of confidante with regard to infant feeding.
- Further exploration of ways of engaging several significant others in dialogue.

4.12 Miscellaneous projects

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<th>Table 12. Miscellaneous projects</th>
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<td>Dominey (2002)</td>
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<td>Ingram, Johnson (2002b)</td>
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<td>Waugh, Subhedar (2002)</td>
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A number of projects do not fall under any of the themes highlighted. These will be referred to briefly here with details of individual projects being referred to in chapter 5.

Adams et al (2001) devised an accreditation and award scheme system for assessing and awarding local premises with a ‘Breastfeeding Friendly Award’. Participatory appraisal research undertaken prior to the project in deprived wards highlighted the need to encourage more women in the target area to initiate and continue breastfeeding by increasing public support and acceptance of breastfeeding and making it easier to carry out in the public domain. Public facilities were encouraged to endorse a written breastfeeding policy and to support women to feed their baby by following a set of criteria. The process involved self-assessment, a staff awareness training session, an assessment and, if successful, an award.
ceremony and certificate publicised in the media. Follow-up checks were made at six months and annually. Forty-eight premises were accredited as 'Breastfeeding Friendly'. A 'Breastfeeding Friendly' premises guide was published and distributed part way through the project. Three quarters of premises surveyed reported an increase in breastfeeding mothers. This scheme addressed a key barrier referred to in the exploratory breastfeeding studies related to difficulty and embarrassment with breastfeeding in public. The rigorous way in which this project was planned and implemented is likely to have ensured its success. A key attraction for businesses will come from the media attention, and their name being registered in a guide. The project has continued to run successfully. By 2003, 70 premises had received the 'Breastfeeding Friendly Award'. A booklet for mothers was produced that lists all 70 premises with the award. A challenge for this project team centred upon knowing who were the gatekeepers to the premises.

Dominey et al (2002) developed and evaluated a booklet and website for multi-agency professional groups and pregnant women who take illicit drugs and related substances. The project team included a pharmacist, midwifery educationalist, a drug liaison community midwife, a Sure Start health visitor, a drug information worker and a website master. A systematic search on drug usage and breastfeeding was conducted. An extensive web search and evaluation was conducted and a website developed which would act as a resource with links to relevant associated sites. The booklet for women was developed following one-to-one discussions with women who had engaged in substance misuse. It was designed to be utilised by health professionals in discussions with women about the various issues involved and then to be given to women to keep. This was made clear in the introduction. A modified Delphi technique was utilised to evaluate the project and information technology was used to send out and receive feedback on the website. Changes were made accordingly. This study illustrates the rigorous approach needed to develop resources for vulnerable groups, which are accessible, and appropriate in enabling them to make informed decisions. The effectiveness of the leaflet will depend in part upon health professionals making it available to women and secondly utilising it effectively in discussions with women. The extent to which this happens would make a useful follow-up study. The booklet is available on-line http://www.ihs.plymouth.ac.uk/~dmbf.

Farrell (2002) provided information and support to women in a local prison to ensure that all women in the prison were assisted in making an informed choice with regard to breastfeeding and to support mothers to initiate and sustain breastfeeding. Training was provided for midwives involved and for prison staff working on the mother and baby unit. This related to awareness of breastfeeding benefits and how to provide optimum support for these women. Breastfeeding workshops were provided monthly for mothers in the target group. Liaison with dietetics services supplied the catering staff with information on a healthy diet and health promotion information was disseminated to mothers. Breast pumps and designated fridges were provided to support mothers in maintaining lactation and supplying milk for their babies when separated from them. Quiet facilities were provided for expressing milk. Feedback from mothers indicated that they felt the services of the project had been helpful. For the year prior to the project 12/21 women with babies breastfed (57%). For the project year 22/28 mothers with babies breastfed (78%). Mean duration of breastfeeding increased from six weeks to three months during the project time. In total 125 women attended workshops over the 12 month period. Due to inevitable changes in the prison population the data on continuation of breastfeeding was difficult to record accurately. However, there was a substantial increase in the breastfeeding rates. The project highlights ways in which engagement with the prison and associated services may be managed and health promoting behaviours emphasised and supported. It may assist in providing a model for others in accessing and supporting women prisoners.
Ingram and Johnson (2002b) produced evidence-based leaflets on breastfeeding problem management for women. The leaflets were planned in order to provide information for women in low income groups who still appeared to be receiving conflicting advice and traditionally were less likely to access breastfeeding support groups. The project leaders held a workshop with midwives and health visitors to discuss the leaflets. Leaflets were subsequently designed and distributed to health centres. The leaflets covered positioning and attachment, mastitis, thrush and briefly sore nipples, engorged and blocked ducts and insufficient milk. All midwives and health visitors involved in distributing leaflets had attended ‘managing problems’ sessions. Mothers attending the six health centres were given a leaflet by midwives at an early postnatal visit. Health visitors distributed leaflets to all mothers who had received leaflets during a routine visit at 4-6 weeks. Laminated cards were produced and issued to health professionals. These summarised evidence-based information related to the leaflet topics. Evaluation showed that women found the leaflet useful for a range of problems and breastfeeding discontinuation rates were lower for the study group of women than the hospital rates. Comments related to the content and layout of the leaflet were largely positive. Health professionals felt that both the leaflet and laminated cards were helpful in improving the giving of evidenced-based information. The authors recommend that, given the early discharge from postnatal wards the leaflet should be issued at the first postnatal visit at home to introduce and discuss problems before they arise.

Thompson (2002) embarked on research to provide empirical evidence for Candida as a potential cause of nipple soreness and deep breast pain during breastfeeding, to establish a reliable list of symptoms that will aid the diagnosis of deep breast thrush and could possibly negate the need for routine microbiological analysis. Six groups of women were to be recruited: non-pregnant women; pregnant women; non-breastfeeding mothers; non-symptomatic breastfeeding mothers; breastfeeding mothers with nipple pain; breastfeeding mothers with nipple pain and deep breast pain. Women with nipple pain due to ineffective attachment were excluded. Nipple swabs/areola skin swabs were to be taken from all women. Expressed milk samples were to be taken from all breastfeeding women and oral swabs from the babies of the symptomatic women. Simple profile data was to be collated on all women. A pain questionnaire and baby behaviour/feeding questionnaire were used for the two symptomatic groups. Symptomatic group 1 were to be treated with topical Daktarin cream for the mother and Daktarin oral gel for the baby. Symptomatic group 2 were to be treated with topical Daktarin cream and Diflucan tablets and Daktarin oral gel for the baby. Both groups were to be reviewed weekly for six weeks until symptoms were no longer present. Specimens were to be tested for Candida albicans and other Candida, Staphylococcus Aureus, group B Streptococci, Group B Streptococci (haemolytic) and yeast. Data collection and analysis are still in progress due to a number of delays and problems during the research process. These included difficulties in culturing Candida in the laboratory.

Waugh and Subhedar (2002) developed an intervention to increase the proportion of mothers of sick and premature babies who initiate and maintain breastfeeding in a maternity unit in a city with high levels of social deprivation and breastfeeding initiation and continuation rates below the national average. Key workers were trained and employed to provide a total of 11 hours/week of additional support to breastfeeding mothers. These were neonatal nurses, paediatric nurses and nursery nurses. The key workers were placed on a rota system to enable shift cover. During the study period additional support was provided for a total of 356 mothers with an average of 60 contacts per month. In some cases mothers initiated contact and in others health professionals. A diary system assisted in this process. Types of support required included: general advice about breastfeeding; positioning and attachment; insufficient milk supply; breast problems; nipple problems. Other activities included parent education sessions taking the form of regular discussion groups with weekly video presentations tailored to the needs of the group. Sixty-nine percent of mothers wishing to breastfeed at delivery were able to provide breast milk for their sick baby admitted to the neonatal unit. During the project period 45% of mothers initiated breastfeeding compared to 41% and 43% in 1999 and 2000. Breastfeeding rates at discharge from the neonatal unit also increased with 25% of mothers still breastfeeding during the period of the
project compared with 22% in 1999. Conclusions cannot be drawn from the percentages provided but qualitative data would be useful to elicit both women's and health professional views on the scheme.

Related publications by project teams

5  Project References and Summaries

(Place names have been removed from the project titles to ensure anonymity and confidentiality).
Adams L, Cundy A, Carrick I, McNamara L (2001) Breastfeeding Friendly Award, Year 1.
Bachelor G, Brackstone C (2001) Breastfeeding Peer Support Project, Year 1
Banarsee R (2001a) A collaborative model for the promotion of breastfeeding: an implementation of a guide to good practice, Year 1.
Banarsee R (2001b) Altogether better: working towards a multi-agency approach to breastfeeding, Year 1.
Best L (2002), Breastfeeding – it’s a man thing! Year 2.
Charlton J, Meredith E, Jennings C (2001) Supporting active breastfeeding mothers, Year 1.


Hawkins A and Heard S (2001) *An investigation of the factors which may affect the duration of breastfeeding by first time mothers from low income groups*, Year 1.


Whitmore M, Burt S, Vearncombe D *Raising the profile of breastfeeding in lower income groups through general practice* Year 3 (Practice).


Adams L, Cundy A, Carrick I, McNamara L (2001) Breastfeeding Friendly Award, Year 1.

Target population/area

An area with high levels of social deprivation. Breastfeeding initiation and continuation rates are lower than the national average.

Aim(s)

Encourage more women in the target area to initiate and continue breastfeeding by increasing public support and acceptance of breastfeeding and making it easier to do in the public domain.

Encourage public facilities to endorse a written breastfeeding policy and to support women to feed their baby.

Project design and procedure

An accreditation and award scheme for Breastfeeding Friendly Premises was developed. Participatory appraisal research undertaken prior to the project in deprived wards highlighted the need for local changes. These included increasing the knowledge levels and support offered to breastfeeding mothers, making breastfeeding more acceptable in public places, increasing the number of breastfeeding friendly premises and improving advertising of Breastfeeding Friendly premises. In response to this research, public facilities were invited to endorse a written breastfeeding policy and to support women to feed their babies. An accreditation system was devised and implemented.

In order to qualify premises were required to: have a written breastfeeding policy which supported the award; ensure that a minimum of 70% of staff attended a basic training on implementing the award; provide an adequate smoke-free area if possible. Premises who sought accreditation were to agree that: mothers who choose to breastfeed in public will not be discriminated against as compared with bottle feeding mothers; anyone who is offended should be informed that “babies are welcome here, at feeding time or any other time”; public facilities should be made available that offer a welcoming environment and, if possible, an optional degree of privacy for those mothers who wish to breastfeed their babies; mothers should not be expected to breastfeed in the toilets; bottle-feeding and breastfeeding should be acceptable in the restaurant where there should be a smoke-free area.

The process involved self-assessment, a staff awareness training session facilitated by the health promotion project officers, an assessment and, if successful an award ceremony and certificate publicised in the media. Follow up checks were made at 6 months and annually. Forty-eight premises were accredited as Breastfeeding Friendly. A Breastfeeding Friendly Premises guide was published part way through the project and distributed to all new mothers via maternity hospitals, libraries and shops.

Evaluation

Questionnaire survey of 14 premises at 6 months.

Participants views of training were elicited.

A verbal questionnaire was utilised to survey new parents from two health centres to elicit their levels of awareness of the project.
Results/Findings/Outcome

Three quarters of premises surveyed reported an increase in breastfeeding mothers. The training was positively evaluated as enhancing awareness of the needs of breastfeeding parents.

Of 53 parents surveyed 43% were aware of the ‘Breastfeeding Friendly Award’.

Comments

This scheme addresses a key barrier referred to in the exploratory breastfeeding studies related to difficulty and embarrassment with breastfeeding in public. The rigorous way in which this project was planned and implemented is likely to have ensured its success. A key attraction for businesses will come from the media attention, and their name being registered in a guide.

Sustainability

The project has continued to run successfully. There are currently 70 premises that have the ‘Breastfeeding Friendly Award’. A booklet for mothers has been produced that lists all 70 premises with the award. A challenge for this project centred upon identifying the gatekeepers to the premises. The rapid turnover of staff was a potential threat to maintenance, but the training pack is made available in the premises and this has become part of the staff induction. The aim is that staff will be self-sufficient. However, remaining members of the original project team still undertake staff training on occasions. The project is funded by the Community Trust (personal communication, Carrick 2003).

**Target population/area**

An area with high levels of social deprivation. Breastfeeding initiation and continuation rates were lower than the national average.

**Aim(s)**

To provide improved breastfeeding support to women of low income in the target area.

**Project design and procedure**

A successful ‘Bosom Buddies’ breastfeeding support programme had been operating in a neighbouring area since 1996. This combined a social support group with an expert breastfeeding clinic and breastfeeding resource centre, supported by a community-based peer support programme. DH funding enabled the setting up of a similar programme in a neighbouring area in which there were high levels of unemployment and low income. Twenty five volunteer peer supporters were trained as ‘Bosom Buddies’ using two six week training courses of two hours per week developed by the team. The courses developed specifically for the project were taught by midwives, breastfeeding counsellors and health visitors. A weekly support/drop-in group was launched at the family centre in the area of low income and attracted 10-15 women per week. Pregnant women were also welcome. A programme of breastfeeding education was provided for student midwives that focused on community breastfeeding support. A programme of breastfeeding education was also provided for health visitors, midwives and general practitioners.

**Evaluation**

A postal questionnaire was sent to women who had attended the support group six weeks after their first attendance.

Two focus groups were carried out with ‘Bosom Buddies’

Two focus groups were carried out with support group attendees.

**Results/Findings/Outcome**

During the first 31 weeks, 53 breastfeeding women attended the group. One woman declined to receive the questionnaire and 45/52 women responded (87%). 20/52 (38.5%) of respondents came from areas with high or medium unemployment. 34/45 (76%) of respondents reported that they were still breastfeeding, i.e. 64% of those who attended (34/53). Of the 11 women who had discontinued, only four reported having done so for the same reasons that prompted them to first attend the group. While the greatest value of the group was considered by the women to relate to its function in supporting breastfeeding, 46% of the aspects identified by women as good related to issues of a predominantly psychosocial nature. For example, 31% of the women stated that the group had increased their confidence in their parenting.
Four focus groups were held, two with group attendees (n=15) and two with ‘Bosom Buddies’ (n=14) from both the original and new support programmes. The groups lasted 40-90 minutes. The group was very positively rated by all the focus group members. Key areas which were valued included the ease of access and the availability of expert advice. Also important was the social support and friendship they gained from the group, the power of ‘community’ and the confidence they gained. They had strong hopes for the future of the group.

Comments

The qualitative and quantitative data suggest that this package of support has had a positive effect for the women who availed themselves of the service. It appears to have assisted them to maintain breastfeeding. This scheme was clearly successful in attracting volunteers to train as supporters and in accessing women through a support group. Part of the success appears to relate to the wealth of experience gained through running a scheme in a neighbouring area. Three months was spent at the outset of the project preparing to run the project including liaising with relevant personnel and producing publicity materials. This preparatory phase is also important.

Based on their experience of running such groups the authors suggest some ‘ingredients’ for success:

• The group should be informal with emphasis on social support, friendship and normalising breastfeeding (It is not a breastfeeding clinic which would be solely problem orientated).

• In addition skilled, evidenced-based professional help from an experienced breastfeeding counsellor and/or lactation consultant should be readily available.

• Resources, e.g. breast pumps, books and leaflets should be made available to women.

• The breastfeeding counsellor introduces women to others who may have had similar difficulties. This assists women in supporting each other.

• The underlying strong philosophy of the group –that motherhood is valued-is shared amongst the key project workers and emphasised throughout the Bosom Buddy training. Women are given praise and encouragement; the simple ethos of ‘help each other’ underpins the atmosphere of mutual support and encouragement.

• Pregnant women are welcome and may come to be fitted for bras and make friends with other mothers.

• The Bosom Buddy network is the cornerstone of the group and is vital to its longevity. The momentum is maintained by training a new cohort each year.

• Finally, the group is not ‘owned’ or led by health professionals but by women themselves. A loosely formed committee of Bosom Buddies and other interested mothers meet every few weeks to discuss the group and related issues. They plan ad hoc social events and can respond flexibly to the needs of local women and families.
Sustainability

Both the original scheme and the first ‘sister’ scheme, funded through the DH grant continue to provide training for a new cohort of approximately 15 ‘Bosom Buddies’ every year. A second ‘sister’ project has been established in a Sure Start area. Over 200 ‘Bosom Buddies’ have been trained in the 3 areas. The attendance at each of the 3 groups is currently 10-20 women per week. A substantial number of Bosom Buddies are now training as breastfeeding counsellors. This will provide qualified breastfeeding counsellors in deprived areas. It is envisaged that soon the groups will run themselves with committees of women and breastfeeding counsellors from within each community. Training days/workshops are provided for health professionals providing guidance on how to set up peer support programmes (personal communication, Anderson 2003).

Related publications/presentations at peer reviewed conferences


**Target population/area**

Low income mothers

**Aim(s)**

To provide a peer counsellor support for disadvantaged women.

**Project design and procedure**

Eleven peer counsellors were trained using the La Leche League peer counsellors’ programme. Ten became active. They contacted women through antenatal classes and postnatal wards. They gave practical support on the wards where appropriate. Telephone contacts were made between mothers and supporters when needed. A breastfeeding support group was set up. Mothers were informed about the service through leaflets provided at the hospital. The peer supporters obtained a breastfeeding teaching pack for head teachers to purchase and conducted some schools education.

**Evaluation**

Audit of breastfeeding statistics.

Questionnaires (qualitative) to mothers who had utilised the service.

Review of peer counsellors log books.

**Results/Findings/Outcome**

The hospital data showed increasing breastfeeding rates but these may be attributable to the Baby Friendly Initiative agenda being engaged with (personal communication, Brackstone 2003). The log books were not consistently used and the qualitative questionnaire data was not compiled due to staff changes.

**Sustainability**

The venue for the support group was changed mid project, but was not sustained. The peer counsellors are still active.
Target population/area

An NHS Trust in an area with high levels of deprivation and breastfeeding rates lower than the national average.

Aim(s)

To explore the impact of breastfeeding on different family members.

To explore the diversity and commonality of views between the four groups of families.

To evaluate family views on the provision of current breastfeeding services.

To utilise the findings to inform current practice, to make service recommendations, inform policy and generate further hypotheses.

Project design and procedure

The study adopted a longitudinal, exploratory cohort design. Qualitative data was generated through in-depth interviews, reflective diaries and semi-structured questionnaires. A stratified purposive sampling strategy was utilised to ensure that the views of different groups were represented. Six families representing the following groups were then randomly selected on the postnatal wards: primigravida; teenagers; mothers of babies who had been on Special Care Baby Unit; Jarman UPA>30.

Twenty-four women and their families were recruited, amounting to 66 participants in total. Semi-structured questionnaires were issued to 24 women on the postnatal wards. Twenty were returned (83.3% response rate). This provided demographic and baseline feeding data. Fifteen women and 11 families completed reflective diaries. Each family member was contacted fortnightly to assist in the development of a progress report and to encourage writing of diaries. Thirty-eight in-depth interviews (16 with women and 22 with family members) were conducted, usually in the mother’s homes, after the mother had stopped breastfeeding. These included the mother and her identified network of significant others, partner, sister, maternal and paternal mother, grandmother, father, female friend, neighbour, sister-in-law). Interviews and diaries were transcribed and analysed by generating categories through the constant comparative process. Respondent validation was conducted.

Results/Findings/Outcome

Five key themes emerged from the analysis: experiences of breastfeeding; feelings associated with breastfeeding; influences of family and friends; influences of health professionals; recommendations for improvement. The experiences of breastfeeding centred upon negative aspects, e.g. nipple soreness and tiredness, and positive aspects, e.g. breastfeeding being healthy and natural. Feelings included embarrassment, guilt, pressure, indifference, but on the other hand the sense that breastfeeding was special, brought pride/joy and was associated with bravery. Influences of family members were both positive and negative some being supportive and encouraging, others unsupportive and negative. Likewise some health professionals were perceived as supportive and helpful and others not. Finally families made some important recommendations. These included a more flexible antenatal teaching system, which enabled men to attend and participate, offer of home videos and family centred teaching. The use of the media to popularise breastfeeding was suggested and the provision of private places to enable breastfeeding in public without embarrassment.
Comments

This study adopted a unique approach, that of engaging significant others in the research process. This provides a crucial perspective when considering ways of promoting and supporting breastfeeding in groups least likely to breastfeed.

Sustainability

This exploratory study identified a number of barriers to breastfeeding promotion. A need for education of a woman’s social support network is pivotal to her overall breastfeeding experience and success. The diversity of educational needs has been recognised and local strategies are now being considered to address this issue by offering a range of information, practical and educational sources (personal communication, Lavender 2003).

**Target population/area**
Maternity unit within a hospital.

**Aim(s)**
To provide an antenatal breastfeeding workshop for women and grandmothers or significant other.

**Project design and procedure**
A breastfeeding workshop was provided for pregnant women and grandmothers. Topics covered included the benefits of breastfeeding, basic physiology, babies’ feeding patterns, skin-to-skin contact, positioning and attachment, baby-led feeding and overcoming breastfeeding difficulties.

**Evaluation**
Questionnaires were sent to 115 women who had previously attended a workshop.

**Results/Findings/Outcome**
68/115 questionnaires were returned: a 59% response rate. One was excluded from analysis as the woman had not yet given birth. Women were positive about the workshop. The most useful aspects were positioning and attachment (n=47), skin-to-skin contact (n=47) and overcoming difficulties (n=43). Forty-four women attended with a grandmother or significant other and they felt that this was useful. Fifty-seven percent of mothers exclusively breastfed during their hospital stay. Fifty one percent (18/35) women were still breastfeeding at 5-6 weeks.

**Comments**
The questionnaire data are useful in highlighting the areas of teaching which the women found most useful.

**Sustainability**
The project co-ordinator has moved elsewhere and the workshops are no longer running.
Banarsee R (2001a) A collaborative model for the promotion of breastfeeding: an implementation of a guide to good practice, Year 1.

Target population/area
An area with high levels of social deprivation and a large multicultural population.

Aim(s)
To promote breastfeeding among low-income women in the defined area.

Long Term: To increase the breastfeeding initiation and continuation rates in the defined area.

Project design and procedure
Action orientated audit methodology was undertaken by midwives and health visitors. This was based on collection of infant feeding data for two cohorts of women who gave birth at a local maternity hospital. Infant feeding data was gathered at five intervals: intended feeding method; first feed; feeding method on discharge; first health visitor visit and 6-8 week developmental check. The information was disseminated widely to trigger appropriate interventions. Based on the audit findings two interventions were implemented. The first intervention consisted of a breastfeeding clinic that was set up and staffed by experienced midwives. The second intervention consisted of implementing a programme of education for midwives and health visitors.

Evaluation
Baseline audit data was collated.

Attendance at the clinic was audited to include type of feeding.

Results/Findings/Outcome
Sixteen women used the service in the first 3 months. 13/16 (81%) responded to a questionnaire. Women viewed the breastfeeding clinic positively. Audit data were utilised to assess, plan, implement and evaluate ongoing change.

Comments
The action orientated audit methodology provides a way in which a full assessment of the local infant feeding practices may then inform the management of change and monitor the effectiveness of the changes.

Sustainability
A local Sure Start project has now set an approved target of a 10 percentage point increase in the numbers of women sustaining breastfeeding to 6-8 weeks by 2004.
Banarsee R (2001b) *Altogether better: working towards a multi-agency approach to breastfeeding*, Year 1.

**Target population/area**

An area with high levels of social deprivation and a large multicultural population.

**Aim(s)**

To promote breastfeeding among low-income women in the defined area.

Long Term: To increase the breastfeeding initiation and continuation rates in a defined area.

**Project design and procedure**

To conduct an interagency audit of breastfeeding rates in the defined area. This was based on collection of infant feeding data for two cohorts of women who gave birth at a local hospital. Infant feeding data was gathered at five intervals: intended feeding method; first feed; feeding method on discharge; first health visitor visit and 6-8 week developmental check. The information was disseminated widely to trigger appropriate interventions. A programme of education in the form of four multidisciplinary workshops was implemented for health professionals including general practitioners. Emphasis was placed on the exploration of personal experiences, beliefs and behaviours.

**Evaluation**

Attendance at a breastfeeding clinic was audited.

Audit data on breastfeeding intention and continuation was collated before and after the training.

**Results/Findings/Outcome**

Following the training breastfeeding continuation rates in the community increased. There were 184 women in each cohort. In the cohort before the intervention 148/184 (80%) intended to breastfeed and 62/184 (34%) were still breastfeeding at the 6-8 week health visitor check. In the cohort after the intervention (130/184) 71% intended to breastfeed but 82/184 (45%) were breastfeeding at the 6-8 week check. Women viewed the breastfeeding clinic positively.

**Comments**

This study shows a trend towards a reduction in the rate of decline in breastfeeding. The action orientated audit methodology provides a way in which a full assessment of the local infant feeding practices may be used to inform the management of change and monitor the effectiveness of the changes.

**Sustainability**

A local Sure Start project has now set an approved target of 10 percentage point increase in the numbers of women sustaining breastfeeding to 6-8 weeks by 2004.

Target population/area

Adolescent women (aged 19 years or below) receiving maternity care in a socio-economically deprived group within a designated area. The area has a high teenage pregnancy rate.

Aim(s)

To provide one-to-one education on breastfeeding during the antenatal period.

To provide one-to-one support with breastfeeding during the postnatal period.

Project design and procedure

Teenage mothers accessing the maternity care system were visited at home by a member of the project group. At this antenatal visit general issues were discussed related to pregnancy, birth and mothering. Breastfeeding was discussed and they were offered the opportunity to view a video, Focusing on Attachment, that centred upon positioning and attachment and skin-to-skin contact.

Additional support was provided during the first postnatal week both in hospital and at home by the project team.

Evaluation

Telephone contact was made with the adolescents 6 months after the birth.

A questionnaire survey was conducted 9 months after the birth.

Results/Findings/Outcome

A total of 72/80 questionnaires were returned, a response rate of 90%. Of the respondents 70% of adolescents reported receiving help from the “Streetwise project” and 25% reported not receiving help from the project. 28% were breastfeeding at 3-4 months compared with the then national average of 13%.

Comments

Accurate data was not available for the target group prior to the intervention.

Sustainability

The project has not been sustained in its current form but a number of teenage parenting groups are currently funded through Sure Start schemes (personal communication, Bartlett 2003).
Target population/area

An area with high levels of social deprivation which qualified for Single Regeneration Budget (SRB5) status and as a Health Action Zone. Breastfeeding initiation and continuation rates were lower than the national average.

Aim(s)

To educate local women in supporting women, who wish to breastfeed, through late pregnancy and in the postnatal period.

To support 100-150 women in the first two years, who live in an area of socio-economic disadvantage.

To increase the number of babies being breastfed at birth three fold.

To increase the length of time babies are breastfed.

Ultimately to create a culture of breastfeeding as normal and ‘first choice’.

Project design and procedure

A peer support project was established and linked with a neighbouring project, the ‘Wordly Wise project’ (Battersby 2001b). A Sure Start Midwife was appointed to co-ordinate the programme. The La Leche League (LLL) trained the health professionals as ‘peer counsellor programme administrators,’ utilising the LLL Training of Trainers programme (5 day programme). Seven completed the course. Eight peer supporters were trained using the LLL programme by the Sure Start midwife and a community midwife working jointly with the ‘Wordly Wise project.’ The programme consisted of 24 hours of training over 4 weeks. Four peer supporters were employed and worked alongside four volunteers. Their activities included visiting antenatal clinics, home visits, organising and facilitating breastfeeding support groups and telephoning mothers. Each local GP surgery had a named supporter attached. One group was designated for adolescent mothers.

Evaluation

Focus groups were conducted with peer supporters to evaluate their training; 6 month evaluation form; field work diaries; six month questionnaire.

Interviews were conducted with mothers who had received peer support to elicit their uptake and experiences of support.

Questionnaires were issued to health professionals to elicit their views of the training and of the service.

A review of local breastfeeding audit data was conducted.
Results/Findings/Outcome

Volunteers (n=4) and paid supporters (n=4) were positive about the training meeting both personal needs and needs and those required for the supporter role. However, there were some tensions with the volunteers feeling less valued than the paid supporters. Five mothers were interviewed. They viewed the peer support programme positively. Peer supporters were knowledgeable and had time for them. The theme of friendship between the mother and peer supporter was strong. The Sure Start venue was felt to be homely, welcoming and non-threatening. 8/12 questionnaires to health professionals who had attended the training were returned. The midwives and health visitors felt positive about the breastfeeding knowledge they gained but less positive regarding their ability to train peer supporter and facilitate peer support programmes. This included the debriefing and group dynamic aspects. The 3 GP respondents were all aware of the service and its aims, with 2 feeling that it was worthwhile and one that it might be worthwhile. For audit data see Battersby (2002), BIBS project.

Comments

Interview data with mothers suggested that they had breastfed for longer than anticipated. This trend may be seen in the data for the BIBS project (Battersby 2002). If sustained these local cultural changes towards promoting, protecting and supporting breastfeeding appear likely to have an impact in raising breastfeeding initiation and continuation rates. One of the challenges encountered related to the midwife applicant for the position of co-ordinator. She was employed by an organisation other than the NHS and this meant that she was then seen to be working as ‘an independent midwife’ with subsequent professional indemnity insurance implications. Another challenge for this project involved putting all the volunteers through the police clearing system, a time consuming process. Another challenge centred upon the project being accepted by health professionals.

Sustainability

The project has been sustained and extended. It has now merged with the ‘Wordly Wise’ project to become the ‘Breastfeeding is Best Supporters Project’ (BIBS). The project currently employs 5 paid workers working alongside 10 volunteers. Single Regeneration Budget (SRB 5) funding has been secured until 2004 (personal communication, Battersby 2003).

Related publications/peer reviewed conference presentations:


Battersby S (2001b) *The Worldly Wise Project: An evaluation of non-professional mature women as breastfeeding supporters, Year 1.*

**Target population/area**

An area with high levels of social deprivation designated for Single Regeneration Monies and as a Health Action Zone. Breastfeeding initiation and continuation rates are lower than the national average. There is a strong extended family culture.

**Aim(s)**

To evaluate the effectiveness of local, non-professional mature women who will support women to initiate and continue breastfeeding.

To increase the breastfeeding initiation and continuation rates.

To create a culture of breastfeeding as the norm.

**Project design and procedure**

Two mature peer supporters were appointed, trained and employed with payment for 6 hours a week. The training utilised the La Leche League (LLL) peer supporters programme with the addition of content on confidentiality, child protection, record keeping and personal safety (24 hours over 8 weeks). The supporters were paid to work for six hours a week to include visiting hospital clinics, GP clinics, postnatal mothers’ homes and telephone support. A training programme for midwives and health visitors in administration of a peer support programme was carried out. This utilised the LLL Training of Trainers programme (5 day programme). Seven completed the course.

**Evaluation**

Field work diaries and interviews were conducted to elicit peer supporters’ activities and experiences.

A 6 month peer support training evaluation was conducted.

Interviews were conducted with mothers who had received peer support to determine uptake and experiences of support.

Health professionals’ views of the service were surveyed.

Local breastfeeding audit data was reviewed.

**Results/Findings/Outcome**

Peer supporters felt positive about the training that built their confidence. They identified the need to meet mothers during the antenatal period, not just when there was a problem. There was some concern expressed related to avoiding pressuring women into accepting the service. Their hours of work often exceeded their stated employment hours of 6 hours per week. Administration was time consuming, taking 31% of their time.
Five mothers were interviewed. They appreciated the support and generally found the peer supporters easier to communicate with than health professionals, based on common experiences and a less formal approach. They appreciated the supporters phoning them and giving them the option of a home visit. There was no evidence that the age/maturity of the supporters made them more or less acceptable to the mothers. They felt that more antenatal input would be valuable. They generally felt that they breast fed for longer than originally stated. This related in part to increased confidence.

A total of 8/12 questionnaires to health professionals who had attended the training were returned. They viewed the training very positively. However, they highlighted the importance of being equipped to administer these programmes effectively and with confidence. This should include: understanding group dynamics; facilitating and educating groups; dealing with uncertainty; exploring personal and vicarious experiences and effectively communicating information upon which women may make informed decisions. Role-play was suggested as a way of learning some of these skills. For audit data see Battersby (2002), BIBS project.

Comments:

The evaluation was comprehensive and meaningful in that it focused upon three key perspectives: peer supporters, mothers and health professionals. Interview data with mothers suggested that they had breastfed for longer than anticipated. If sustained, these local cultural changes towards promoting, protecting and supporting breastfeeding appear likely to have an impact in raising breastfeeding initiation and continuation rates. This scheme was strengthened by the project co-ordinator linking the project with a neighbouring existing Sure Start programmes “Simply the Breast”. This increased the chances of sustainability and wider cultural change.

Sustainability

The project has been sustained and extended. It has now merged with a neighbouring project ‘Simply the Breast’ to become the breastfeeding is Best Supporters Project (BIBS). Single Regeneration Budget (SRB 5) funding has been secured until 2004 (personal communication, Battersby 2003).

Publications/Presentations at peer reviewed conferences:


Battersby S (2002) Breastfeeding is Best Supporters (BIBS): Spreading the Word, Year 3, Practice project.

**Target population/area**

An area with high levels of social deprivation which qualified for Single Regeneration Budget (SRB 5) funding.

**Aim(s)**

To amalgamate two existing peer support programmes and incorporate a third.

To encourage local women to initiate and sustain natural feeding methods, through the provision of high quality and consistent information giving and peer support.

To develop support networks that will provide social and leisure activities for breastfeeding mothers.

To develop a network of role models who will in the long term influence and enable cultural change so that breastfeeding is accepted as normal and 'first choice'.
Ninety seven percent of mothers who received this support rated it as very good or good. There were 19 mothers who stated that they had continued to breastfeed for longer that they had intended because of the excellent support they had received from the support workers.

Breastfeeding rates were compared for the target group between 1999 and 2002. The initiation rate rose from 22% (number of women not recorded) to 49.05% (n=103). The timing of the data collection was not identical in the two data sets but at 4 weeks 31.5% of mothers were still breastfeeding in 2002. Moreover, by 6 months 11.0% (n=23) were still breastfeeding compared with 2.5% (number of women not recorded) in 1999. There were more mothers breastfeeding at 6 months in 2002 than there were at six weeks in 1998.

Comments

The author went to considerable lengths to obtain historical data for the target population that could then be related to the same target group two years later. Her report and personal communications (Battersby 2003) highlight the complexities of achieving this. Although some data are incomplete there appears to be a marked increase in the initiation and continuation rates for this target area. This project highlights the development of a strategic approach to amalgamating, consolidating and expanding peer support programmes. The project drew on existing infrastructure and through comprehensive evaluation of all three projects built on strengths and addressed areas for development. The author recommends the adoption of the Local Infant Feeding Audit (LIFA) as described by Carson and Thompson (2000), Carson (2001).

Sustainability

Single Regeneration Budget (SRB 5) funding has been secured until 2004 (personal communication, Battersby 2003).
Beake S, McCourt C (2002) *Evaluation of the use of health care assistants to support disadvantaged women breastfeeding in the community, Year 3, Academic project.*

**Target population/area**

Maternity service within a Sure Start area.

**Aim(s)**

To increase the rates of women making an informed choice to breastfeed in a diverse area with pockets of deprivation.

To enhance general levels of support to new mothers.

To develop more communication and inter-disciplinary work between agencies such as Sure Start health visiting and midwifery services.

To explore how far the role of a health care assistant in maternity could be shifted from a hospital to a community base.

**Project design and procedure**

A health care assistant (HCA) was funded to support women in the community with infant feeding. The project was set up as a collaboration between a local Sure Start programme and the maternity services of the local NHS Trust. The role involved the provision of additional support for women, focused around breastfeeding but not limited to infant feeding. Support was offered to women as they required from 32 weeks up to 4 months postnataally. Women were informed in writing about the availability of the supporter so that they could access her directly. Some women were referred via health professionals.

**Evaluation**

The project team used a comparative, longitudinal design for the evaluation. Three stages were involved. Firstly, baseline data were collected during the pre-implementation period and this included: collation of routine records on pre-project breastfeeding rates for women giving birth within the Trust and living locally; audit of midwifery records of postnatal visiting and support for feeding and women's self-reports of infant feeding in pre-implementation questionnaires.

Process data collected included: unstructured interviews with members of the working group; analysis of HCA record forms; women's comments about care from a self completion questionnaire; focus groups with midwives on perceptions and experiences of the scheme; interviews with the HCA on perceptions and experiences of the scheme; individual semi-structured interviews with 6 women who had been offered health care assistant support (6 weeks postnataally) and audit of midwifery postnatal support during the scheme.

Outcome data included: breastfeeding rates following implementation these being collated from three sources; routine hospital records; health care assistant record forms and women's self-reports on questionnaires. The data referred to rates of full breastfeeding or mixed feeding at birth, 6 weeks and 4 months postnataally.
Results/Findings/Outcome

Eighty four women were recruited with 33/59 (56%) questionnaires before HCA input were returned and 11/25 (44%) during the implementation period. Six interviews were conducted with women (9 approached). Mothers identified key ways in which they felt supported: practical/technical support; information and general and social support. The latter included confidence building, encouragement, the opportunity for continuity and building a relationship with someone with time available. Their concepts of breastfeeding varied with some finding breastfeeding to be normal, natural and everyday and others expressing dissonance between the expectations and the reality. There was a tendency to want external reassurance of the adequacy of their milk in addition to their own observation and embodied experiences. There were two key forms of knowledge that women relied upon to different degrees, theoretical (formal) and experiential (tacit). Women were generally positive about the availability of additional support. There were some indications that the support assisted them in overcoming challenges which otherwise would have led to supplementation. They saw the HCA as being with woman, listening, observing and giving general encouragement, tips and ideas rather than expert advice.

Data on the HCA's experiences and perceptions highlighted that she saw the need to listen to women, to sit with them and encourage them as central to their role. She recognised that other broader problems impacted upon breastfeeding. Complex issues were referred to the Sure Start health visitor. She identified key aspects of her role as encouraging women to make themselves comfortable, supporting them in feeling confident about the sufficiency of their milk and not expecting life to go 'by the book'. She reinforced their knowledge, supported them during the period of establishing breastfeeding, gave more general help to women who lacked social support and referred to others when appropriate.

Twenty three of the 84 midwives returned their record forms. Only two related to the HCA input period. During the period of the project, the community midwifery services were changed with caseload midwifery being extended to the whole community service. Fourteen midwives attended the focus group. Midwives and health visitors generally welcomed the initiative and regarded the project as having been positive. Midwives initially expressed concerns about competence, training, support and referral. These boundary issues improved as their confidence grew. They felt that the role should be clearly focused on infant feeding with other support groups and networks being encouraged for more general support. Particular aspects valued were the giving of reassurance, confidence building, having time and flexibility, being able to continue giving support after the midwives had discharged the mother and being able to put women in touch with others.

Data from hospital maternity systems showed that for women in the area before HCA input 59% (60/102 women) exclusively breastfed compared to 67% (43/64 women) with HCA input. Data from the women's returned questionnaires (44/84) showed that the rate of exclusive breastfeeding at approximately 6-8 weeks postnatally was 55% (18/33 women) before HCA input and 64% (7/11) with HCA input. Feeding patterns from the HCA records showed that 71% (20/28) were exclusively breastfeeding at birth, 69% (19/28) at 6 weeks and 50% (14/28) at 4 months. Percentages partially breastfeeding were 11%, 18% and 21% respectively.

Comments

Despite the acknowledged limitations of the study design there appears to be a trend towards an increase in exclusive breastfeeding rates as a result of the intervention. The qualitative data illustrates the supportive nature of the intervention. This comprehensive evaluation study explored an innovative means of providing support to women in a flexible, adaptable woman-centred way. The role appeared to be very acceptable to all. The study also illustrates issues related to establishment of effective inter-agency and interdisciplinary work.

Sustainability

Sure Start funds the HCA post (personal communication, McCourt 2003).
Beresford B (2002) *Breastfeeding for us, Year 2.*

**Target population/area**

Three defined areas two of which had high levels of social deprivation. One of the wards was situated in the 6% most deprived wards in England. Breastfeeding initiation and continuation rates were lower than the national average.

**Aim(s)**

To produce a breastfeeding education video for mothers from a largely non-breastfeeding culture.

**Project design and procedure**

A video was produced utilising local mothers breastfeeding babies from first skin-to-skin contact through to feeding babies of 12 weeks old. Topics covered included: how breastfeeding works; how to position and attach a baby; how to maintain a good milk supply; and how to avoid common problems relating to breastfeeding. Spontaneous conversations and opinions were included along with easy to follow narration. The video was piloted with 30 women, ante and postnatal. Women watched the video during the latter stages of their pregnancy. This was supported by discussion from the appropriate health professional.

**Evaluation**

Three questionnaires were issued to mothers in the pilot project. The first was issued at a home visit by the project co-ordinator one week after the baby was born. During this visit the mothers were given appropriate breastfeeding advice and support and part two of the questionnaire was issued for them to complete at their leisure. Mothers who were still breastfeeding were issued with part three of the questionnaire and asked to complete this when they stopped breastfeeding.

Baseline data on breastfeeding was collated.

**Results/Findings/Outcome**

Mothers who took part felt that the extra support they had received helped them establish breastfeeding and that they had a more detailed knowledge of the way in which breastfeeding works. They reported that knowing what to expect made a difference to how they viewed breastfeeding.

**Comments**

The qualitative data suggest that this package has enhanced women’s experiences of breastfeeding and therefore has potential to support women to continue breastfeeding.

**Sustainability**

The video is utilised in parentcraft sessions and loaned to interested mothers (personal communication, Beresford 2003).
Best L (2002), *Breastfeeding – it’s a man thing! Year 2.*

**Target population/area**

An area with high levels of social deprivation. As a highly ranked area for social deprivation on the Index of Multiple Deprivation 2000 the area was designated for Sure Start plus funding. Breastfeeding initiation and continuation rates were lower than the national average.

**Aim(s)**

To raise male awareness of the benefits of breastfeeding.

To change male attitudes towards breastfeeding.

**Project design and procedure**

Two male workers were recruited. One was an experienced community development worker and part-time worker for the ‘Healthy People’ campaign. He knew the local area and culture. The other was a community theatre activist experienced in the use of “Forum theatre”\(^2\). A local community midwife and a health visitor provided support to the workers. Knowledge of local cultural attitudes and knowledge related to breastfeeding was generated through focused discussions in the community to include two parent education couples classes and a small group of year 10 teenage boys from a local comprehensive school. Considerable difficulties were experienced in accessing male views on breastfeeding and recruiting male volunteers for the theatre. Eventually, an open workshop on ‘being a dad’ generated a small number of volunteers male and female to take part in a forum theatre production. The theatre performance was scripted and presented in four settings, a local pub, three year 11 forms in a local school, an antenatal couples class and the local football club.

**Evaluation**

Qualitative analysis of video footage of discussions generated by the theatre.

Qualitative analysis of taped interviews with performers/key participants.

Reflective notes made by performers/key participants were analysed.

Collection and collation of local statistics.

**Results/Findings/Outcome**

There were practical and technical difficulties with the process of generating and capturing discussions on video. The taped interviews with and reflective notes made by key participants yielded qualitative data. This data centred on the ways in which the production made the issue of breastfeeding more visible through various means including comedy and therefore raised awareness. The participants reflected on

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\(^2\) Forum theatre was conceptualised by Boal (1979) ‘Theatre of the Oppressed’. It is an art form which seeks to empower oppressed, ‘grass roots’ individuals who may be seen contextually as passive spectators of their own lives. It seeks to encourage collectives of individuals to tell their stories. Its underlying principles are those of participation, ownership and dialogue enabling participants to ‘see’ their experience as a product of a cultural context. The central tenet of forum theatre rests on the target population talking about their experiences on a given topic to the theatre producers. The producers then construct and present back these experiences in the form of a short piece of theatre. This in turn stimulates debate on the issue.
their own roles as participants and some of the difficulties and tensions. Utilising community-lived experiences contributed to the development of trusting relationships and productive networks and thus contributed to the development of community capacity building. The author states:

“The project fulfilled its aims by raising male awareness of breastfeeding in a way that was considered to be true to life, non-threatening and enjoyable. Through the generating of ‘community conversations’ the project was instrumental in making breastfeeding ‘visible’ within the public domain of the community’s social life. The project’s second aim: to influence male attitudes in support of breastfeeding, could not be estimated due the relative short time between the theatre presentations and the completion of the project’s life. However, the images and debates generated across different points of the community created the cognitive space to make individual change possible” (p.4).

Collection and collation of local statistics proved to be problematic.

Comments

This project was truly participatory in nature. It illustrates the process of generating knowledge of the local culture, of negotiating with local gatekeepers, gaining agreement and the use of community lived experience to generate awareness of and discussion around of a contentious issue. As the author acknowledges a project of this nature must employ skilled facilitators.

Sustainability

The authors intend to seek funding for professional production of the video (personal communication, Best 2003).

Target population/area

An area with high levels of social deprivation including a local Sure Start area. Breastfeeding initiation and continuation rates are lower than the national average.

Aim(s)

To raise the target areas general awareness of the benefits of breastfeeding.

To empower women to consider breastfeeding as an option.

For those commencing breastfeeding to encourage them to continue for longer.

Project design and procedure

This project involved the establishment of a breastfeeding peer support programme. This included the setting up of a weekly breastfeeding support group for mothers. This also linked with two similar groups set up locally. Peer supporters were trained using an existing 3 week programme with half a day per week of training. Liaison took place with local community, schools and voluntary groups. A health professional facilitator was appointed to co-ordinate the project.

Evaluation

Audit data (questionnaire) of client/ mother satisfaction.

Questionnaire to peer supporters following training.

Results/Findings/Outcome

Mothers felt that the support group assisted them in continuing to breastfeed. They valued the social networking opportunities. Peer supporters all evaluated the course positively. They commented that in order to concentrate they would like crèche facilities for their babies to enable them to concentrate more easily. Breastfeeding continuation rates were not audited due to a range of constraints. However, qualitative data from the audit suggested that the support group was supporting women to continue to breastfeed.

Comments

This project linked with existing local breastfeeding support groups and peer support schemes. This assisted in influencing local culture over a wider geographical area. It also facilitated the building of an infrastructure to expand the initiative further. The authors commented that the peer supporters were invaluable in the setting up and maintenance of the support clinics. On their own initiative the peer supporters have extended the services to include regular meetings in each other’s houses.

Sustainability

The project is now incorporated into a Sure Start scheme (Personal communication, Brown 2003).
Target population/area

An area with high levels of social deprivation as defined by the Jarman index.

Aim(s)

To establish a breastfeeding peer support programme and support group.

Project design and procedure

A breastfeeding support group was established at a designated venue for one afternoon a week. This was organised jointly by qualified Breastfeeding Network (BfN) Supporters and Health Professionals. A peer support training programme was co-ordinated by the project leader and a BfN supporter (not the BfN training). Six hours of training were provided in 3 two hour sessions held over 3 weeks. Leaflets were made available to publicise the service. The peer supporters were then engaged in running the support group.

Evaluation

A comparative survey using a questionnaire compared details of attendees versus non-attendees.

Results/Findings/Outcome

A total of 8/20 (40%) attendees responded to the questionnaires and 13/20 (65%) non-attendees responded. Of the non-attendees, 9/13 (70%) found breastfeeding “easy” compared with 3/8 (38%) of attendees which may indicate a higher use of the centre by those experiencing difficulties. Eighty-eight percent of attendees and 69% of non-attendees had breastfed for as long as they wanted to. Sixty percent of non-attendees and 62% of attendees had received written information about the group. This suggests fairly effective leafleting. The group was seen as helpful for specific breastfeeding queries/problems and as a source of support. However, the latter need was not always met due to low attendance rates. Following negative evaluations about the venue the support centre was relocated. This was more successful.

Comments

The small sample sizes and project design limit the conclusions that may be drawn. The health visitor involved in running this project did not have designated time-out from her caseload. This was highlighted as a particular problem. The BfN supporters gave their services voluntarily.

Sustainability

The peer support programme is being maintained with further cohorts of peer supporters being subsequently trained. It is funded through the Health Visitor service. Funding for equipment and housekeeping facilities was obtained for a period from local authority monies (Personal communication, Brown 2003).
Target population/area

Women from geographically defined areas across England known to have breastfeeding rates lower than the national average.

Aim(s)

To improve the accessibility of an established breastfeeding support telephone service, the Breastfeeding Network, (BfN) ‘Supporterline’ in areas of low breastfeeding rates.

To assess acceptability of the phone line to callers.

Project design and procedure

Phase 1 involved the transfer of ‘Supporterline’ to a new technology allowing the technical director web access control of the helpline. This enabled the ‘Supporterline’ to cover the whole of the UK including mobile calls. The technical supporter was then able to access the web link daily to organise supporter on call and call lines. The line was open from 09.30am to 9.30 pm, 7 days a week. The phone was answered by a local supporter but if she did not answer within 6 rings the call diverted to another local supporter. Phase 2 involved the development of new call record sheets, a questionnaire and publicity materials.

Evaluation

Every mother who called the supporter line was asked for permission to be contacted by a researcher on the telephone 4 weeks after the call to complete a questionnaire about her experience of using ‘Supporterline’. The project covered defined areas across England known to have breastfeeding rates lower than the national average. Supporters taking calls completed a record sheet for each caller which included comprehensive demographic details and summaries of issues raised.

Results/Findings/Outcome

Ninety seven callers were invited to participate. Demographic and breastfeeding data were collated on all. Six declined to complete a follow up questionnaire and data on 23 women were incomplete or the telephone number unobtainable on call back. Sixty eight questionnaires were completed. The call line was accessed by a wide range of individuals, e.g. 13% were non-white, 36% completed education by 18, 33% were under 30. The majority of those questioned were positive about the ‘Supporterline’. ‘Supporterline’ was rated as ‘excellent’ by 57% of callers and ‘good’ by a further 35%. Ninety-four percent said that they would recommend it to friends. This high level of approval was consistent across different ethnic groups, callers for whom English was not the first language, younger and older callers and callers with differing lengths of education. Approximately one third of calls related to positioning and attachment difficulties and a quarter of women were finding breastfeeding painful. Four fifths called about a specific difficulty and only one fifth called for general support. The open questionnaire responses in the ‘any other comments’ section of the questionnaire highlighted that the ‘Supporterline’ had assisted women in continuing to breastfeed.

Project References and Summaries

3 The BfN Supporter Line offers a confidential service to breastfeeding women who want to access a qualified BfN supporter. Women may request a home visit or discuss their concerns over the phone. The service is described by Broadfoot et al (1999).
Comments

The ‘Supporterline’ accessed women from a wide range of socio-cultural backgrounds. The questionnaire data suggests the service is much appreciated by the women and is likely to assist in overcoming barriers to breastfeeding.

Sustainability

The ‘Supporterline’ is an established and ongoing aspect of the BfN’s work. Funding through a private source is available for next year, but long term funding continues to be an issue (personal communication, Buchanan 2003).
Charlton J, Meredith E, Jennings C (2001) Supporting active breastfeeding mothers, Year 1.

Target population/area

An area with high levels of social deprivation. Breastfeeding initiation and continuation rates are lower than the national average.

Aim(s)

To improve the level of breastfeeding by mothers on low income.

Project design and procedure

A health visitor was appointed full time as a project co-ordinator. She set up a support group. In response to the concerns of health professionals and mothers a series of eight antenatal education sessions on antenatal care and parenting were subsequently set up. Two mothers attending the breastfeeding support group also went into a local school to discuss breastfeeding with teenage girls.

Evaluation

Breastfeeding statistics were collected in 1999 and 2000 for the specific area.

Results/Findings/Outcome

There were 100 births in 1999 and 75 in 2000 and of these the percentage of women breastfeeding at ten days rose from 42% to 58% and breastfeeding at 6 weeks increased from 29% to 40%. Of the 8 mothers under 18 in 2000, 4 were breastfeeding at 6 weeks in 2000.

Comments

The authors did not apply a statistical test to these increases but they show a marked increase. However, there were two interventions implemented, the support group and a programme of antenatal education. It may therefore be the combined effect of these which is influential. A number of difficulties arose which made conduct of the project challenging. These included extensive and noisy renovations of the flats where the community room was based. There was a considerable amount of movement of the population from one of the estates in the area and this affected access to mothers. The project lacked adequate health professional staffing at times. The community room was not available during school holidays requiring relocation to a health centre.

Sustainability

A midwife has recently been appointed to the project 3 days a week. Antenatal classes continue and a support group has been established with peer supporters. The supporters are trained by a midwife and NCT trainer. During the two years since the project was developed breastfeeding rates in the Trust have risen from 49% to 73% (sample sizes not supplied), (personal communication, Charlton 2003).

**Target population/area**

An area incorporating two outer urban council estates with high levels of social deprivation. Breastfeeding initiation and continuation rates are lower than the national average.

**Aim(s)**

To compare initiation and duration rates for breastfeeding for clients of health visitors in the target areas.

To analyse breastfeeding and associated epidemiological data from the local hospital.

To analyse data on GP records related to infant feeding practices and attendance patterns.

To introduce antenatal visiting by designated health visitors to promote breastfeeding.

To establish breastfeeding support groups.

**Project design and procedure**

The project team consisted of two health visitors and a part-time audit research officer. Two interventions were implemented in the designated health visitor caseload areas in which breastfeeding rates were particularly low. Firstly, the introduction of an antenatal visit by project health visitor 1 and, secondly the setting up of two breastfeeding support groups by project health visitors 1 and 2. The antenatal visit consisted of discussion on reasons for breastfeeding, disadvantages of bottle feeding, practicalities of breastfeeding and social issues, e.g. embarrassment and family support.

One support group was specifically targeted at antenatal women and consisted of a monthly one and a half hour teaching session held at the midwives’ satellite clinic. This covered the mechanics of breastfeeding including the physiology of breastfeeding, effective positioning and attachment, the benefits of breastfeeding and social implications/effects. The Sue Cox video *Mother and Baby – Getting it Right*, was used to show positioning and attachment and written information supplemented the session. A total of 11, out of an invited 36, attended the first and second antenatal group. Only one woman attended the third and fourth session. However, women who were attending the midwifery satellite clinic appeared to be listening and watching although not actively taking part.

The second support group was also held monthly but was more of an informal support group for ante and postnatal clients with the emphasis being placed on facilitation of discussion about breastfeeding between mothers and pregnant women. Issues of concern discussed were those raised by mothers on the day.

**Evaluation**

Baseline and ongoing 6 monthly audit of details related to the initiation and continuation of breastfeeding.

A comprehensive audit was conducted which assessed the impact of each intervention and compared the data with the data from areas where the interventions had not been implemented.
Two audits of babies born over the one year period were used to identify the effects of breastfeeding in comparison to bottle feeding with reference to the infant’s attendance at the GP’s surgery. In the first audit a sample of 33 infants was surveyed. Seventeen infants were breastfed and 16 bottle fed. In the second audit a random sample of 16 infants, 8 breastfed and 8 bottle fed was audited. Information collated related to attendance for gastrointestinal problems, ear infections, breathing difficulties, viral infections and simple colds.

Questionnaire to evaluate the antenatal support group attendees views of the session.

**Results/Findings/Outcome**

The breastfeeding initiation rates for Health Visitor 1’s caseload rose from 14% to 34% over the 6 month period during which the antenatal visit had been implemented. Of these 70% continued to breastfeed for 6 months or more. In contrast not only did the initiation rates not increase in neighbouring caseloads but actually decreased from 45% to 40% with 38% continuing to breastfeed at 6 months. Over the second 6 month period the breastfeeding initiation rates for Health Visitor 1’s caseload were 32% with 50% continuing to breastfeed for 6 months or more. This compared with 34% and 32% for the neighbouring caseloads. Statistics for health visitor 2 were difficult to interpret due to changes to her caseload during the project. The antenatal support group sessions were evaluated very positively with attendees reporting enhanced knowledge and understanding of and confidence in breastfeeding. One mother stated that watching the video gave her an opportunity to see a woman breastfeeding for the first time in her life. The data from the GP attendance audit suggested that attendance rates for common illnesses were lower in the breastfed babies. However, without careful control for confounding variables and an analysis of the length of breastfeeding and its relationship this evidence is inconclusive.

**Comments**

It is important to note that the baseline initiation and continuation rates in Health Visitor 1’s caseload were very much lower than in the comparison groups. It may be that the antenatal intervention is particularly useful within caseloads where the rates are particularly low. It is possible that that above a certain ceiling in initiation rates this effect becomes less. It is difficult to separate out the differential effect of the two interventions, the antenatal visit and the support group. It would be interesting to study in depth the nature of this antenatal consultation as conducted by this specific health visitor. A similar antenatal visit by another health visitor with the same content may yield different results related to the nature of encounter rather than the content of the session. A probable strength of the antenatal support group was the location, i.e. held at the same time as the midwifery satellite clinic.

**Sustainability**

The project is now incorporated within the Sure Start programme. Two breastfeeding support groups now operate in Sure Start centres, one meets twice a week and the other once a week. Two groups of peer supporters have now been trained by an NCT trainer (personal communication, Jessop 2003).
Infant Feeding Initiative


Target population/area

Women accessing the maternity services in a city hospital and in particular those from areas of social exclusion such as mothers on low income.

Aim(s)

To improve breastfeeding rates by improving immediate support for women intending to breastfeed, and in particular for those from areas of social exclusion such as mothers on low income.

To improve communications and continuity between all professional /lay groups supporting new parents.

To provide a network of local breastfeeding support to new mothers that extends beyond discharge from midwifery care.

Project design and procedure

This multi-method action research study sought to establish the impact of the use of peer counsellors on the breastfeeding initiation and continuation rates of mothers, particularly those on low-income. La Leche League (LLL) peer counsellors were appointed to hold support sessions for mothers in the post-natal area of the maternity unit. The weekly sessions were available to any mothers who chose to attend. The sessions were also attended by a midwife and aimed to dispel the myths that surround breastfeeding and discuss any concerns that mothers had related to breastfeeding. Forty-eight sessions took place during the study period with the number of women attending ranging from 1-8 (approx 100-110 in total). The sessions gave mothers the opportunity to meet peer counsellors. Contact details were provided so that those who wished to obtain support following discharge could do so.

Evaluation

The evaluation sought to assess impact, acceptability and peer-professional interface.

A questionnaire was issued to all women who attended the maternity unit over a 9 month period and who were breastfeeding on discharge.

A postal questionnaire was sent to women 12 weeks postnatally. This included outcomes of breastfeeding duration, introduction of mixed feeding, Self-Esteem scale and Parenting Sense of Competence Scale.

Post-session questionnaires were completed each week by women attending.

Five collaborative learning groups were held with LLL counsellors and midwives to explore lay: professional working and to contribute to the development of the intervention.

A questionnaire was completed by midwives on the maternity unit.
Results/Findings/Outcome

A total of 865/1515 outcome data questionnaires were returned (57%). The sample included; women who attended the peer counselling session, women for whom the session was available but who chose not to or were unable to attend and women for whom the session was not available (described by the authors as a natural control group).

Seventy-six session evaluation questionnaires were returned representing 27/48 sessions. Women appreciated the informality of the sessions which made them feel comfortable with asking questions and learning from the experience of the peer counsellors and other mothers. Over 80% rated the sessions ‘good’ or ‘excellent’.

A total of 80/167 midwives questionnaires were returned (48% response rate). Thirteen of the midwives had participated in the peer group sessions. The collaborative learning groups created a dialogue between the peer counsellors and the midwives which sought to promote learning between all parties, focussing on the learning of skills together, multi-disciplinary working and the boundaries between peer and professional workers. However, the numbers of midwives available was disappointing. The pressure of work was given as the main reason for non-attendance.

Peer counsellors offered breastfeeding support that was distinct from the work of midwives. Their approach was one of mutual exchange and validation of experience. Peer supporters saw themselves as facilitative and empowering for women. They identified their role as supporting a woman with whatever decision she made and helping her to arrive at that decision by listening to her problems. Their approach was more orientated towards supporting mothers to make decisions and acting as a guide by virtue of their shared experiences of breastfeeding. They did not see themselves as being able to provide the level of practical assistance to women that a midwife might.

Midwives were positive about the collaborative communication and empowerment strategies utilised by the peer supporters. Some reservations were expressed related to the peer supporters’ limited knowledge and expertise, their reliability and ability to respond to women when needed. A few women continued to attend the range of services offered by peer counsellors in the community.

Comments

The peer support sessions offered within a maternity unit appeared to provide a highly valued service. They were accessed by women with a wider socio-economic profile than those otherwise accessing LLL/NCT support. However, more of the mothers who had accessed the peer support had occupations in the professional and managerial groupings when compared with the sample of all mothers. It was therefore difficult to identify the separate effect of receiving advice from voluntary organisations from a predisposition to breastfeed or other factors related to duration of breastfeeding. This study highlights an effective way of providing support for breastfeeding women which is both collaborative and extends across the hospital/community. The data exploring the lay: professional interface and roles is very important. The authors note that the roles of peer counsellors need to be fully clarified and they highlight the complementary nature of peer support and midwifery support.

Sustainability

The project has been sustained but at their request the peer supporters visit the ward on a more ‘ad hoc, drop-in’ basis as a regular weekly visit was too much of a commitment for them (personal communication, Clarke 2003).
Related Publications/presentations at peer reviewed conferences.


Clarke C, Gibb C, Dowling G (2002b) Breastfeeding: Service and Practice Models, the role of the reflective cycle in developing practice, Year 3, Academic project.

Target population/area

Thirteen maternity units in one region.

Aim(s)

To identify key characteristics of service delivery, professional education and clinical practices that influence breastfeeding management.

To analyse the influence of ‘buffering’ on aspects of nipple and other breastfeeding management.

Project design and procedure

Following modifications to the research design based on delays in securing ethical approval two methods of study were employed:

1. A service and practice model survey was conducted through interviews with 10 midwifery managers representing the 13 maternity units.

2. Focus group interviews were conducted with three groups of midwives: hospital midwives working entirely on the postnatal wards (2); team midwives whose work rotated between the maternity unit and the community (5); and community midwives working entirely within the community (4). The focus group interviews explored the nature of information and education midwives give to women choosing to breastfeed, their risk assessments of breastfeeding problems and factors that they perceive to influence their breastfeeding support.

Results/Findings/Outcome

The study revealed the structural barriers in midwifery services that sometimes obstructed the implementation of breastfeeding support, and so contributed to compromised learning for midwives as practitioners and for the mothers. These included: lack of time and lack of privacy on the wards; uncertainty about when to offer support for breastfeeding; assumptions that mothers will manage independently; and inadequate communication with colleagues, especially on discharge.

Midwives were very positive about the current use of the ‘Bloomsbury breastfeeding workshops’ provided for themselves and the women. They identified organisational systems that did enable them to offer breastfeeding support and promote organisational and professional learning. These included: continuity of care on the postnatal ward resulting from 12 hour shift patterns; flexibility of care in the community (team midwives) allowing extended visits to mothers requiring intensive breastfeeding support; transfer of information between midwifery team members; reunions of mothers after transfer of care to the health visitor organised by the community midwives. In conclusion the authors advocate:

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4 Buffering occurs when one is unable to see the results of one’s actions, and are therefore unable to close the reflective/reflexive practice loop. e.g. a wholly hospital based midwife may not witness the consequences of support that may have been initiated in hospital.
“Promoting continuity in both aspects of care and carer need to be attended to, the explanatory framework being the need to promote the simultaneous development of professional and organisational learning. In this way, the reflective cycle of professional practice is respected and the services are structured to maximise consistent care through a shared value base and approach” (p.4).

Comments

This study provides a conceptual advance in knowledge related to the integration, or lack of integration between learning, practice and research/knowledge development in this field. It points to the need to focus upon the structural changes required within the maternity services to ensure that the reflective cycle of professional practice is respected. It also highlights the imperative to restore a way of ensuring that consistent care is provided through a shared value base and approach. Without this perspective efforts to change practice may simply lead to frustration and do little to improve the care and support offered to breastfeeding women.

Target population/area
A maternity unit with an annual birth rate of 2,000-2,500.

Aim(s)
To explore the beliefs, expectations and experiences of breastfeeding mothers and health professionals in relation to the supplementation of babies on the postnatal wards and newborn unit.

Project design and procedure
A qualitative study utilising an ethnographic approach was conducted. This involved participant observation and interviews. Data collection and analysis were conducted concurrently and the Grounded theory principles of theoretical sampling informed ongoing selection of participants to observe and interview. Over 300 hours of observations were conducted. Thirty mothers and 30 health professionals to include midwives, doctors, and nurses were interviewed over the period of 9 months.

Results/Findings/Outcome
Supplementation was not always seen by health professionals as the significant ‘intervention’ that it is. Few staff appeared to be fully aware that supplementation is associated with earlier discontinuation of breastfeeding. Staff placed emphasis upon ways of supplementing but less on avoiding supplementation altogether. They were concerned that supplements should be given by the method least likely to prejudice ultimate breastfeeding success. Supplementation was often seen as a short term pragmatic solution to problems by both midwives and doctors. There is currently insufficient evidence as to the ‘best’ method for giving supplementary feeds. This appears to result in health professionals advocating a wide range of methods. The ‘nipple-teat confusion’ literature appeared to be the most prominent in their decision making despite it being contentious. Concerns about nipple-teat confusion outbalanced concerns about supplementation. This led on occasions to invasive procedures, e.g. insertion of nasogastric tubes on babies and subsequent issue of supplements. The mothers found that this was particularly distressing.

Many midwives appeared to feel that they had a responsibility to protect women from tiredness, distress and guilt. Some appeared to experience conflict between their role in alleviating the immediate distress of the mother and that of promoting and facilitating effective breastfeeding. Other midwives went to considerable lengths to support women in continuing to breastfeed not only by providing assistance with positioning but also by explaining the physiological processes involved. They both role modelled and carried out other ‘mothering’ activities to settle the baby. They were more able to balance the agendas of supporting with tiredness/distress and breastfeeding without resorting to supplements.

Mothers tended to see health professionals as being the experts and ‘knowing best’. They were generally not involved in the decision-making process as to whether supplementary feeding was needed but they were almost always asked to give their consent. Some mothers were involved in making the decision as to what method of supplementation should be used but given the current lack of evidence as to which is the ‘best’ method the information the staff could give them was limited. The main and often only disadvantage that mothers seemed to be aware of was ‘nipple-teat confusion’. Only a minimal number of mothers appeared to be aware that supplementation could adversely affect their milk supply and longer-term chances of breastfeeding successfully. Mothers appeared to be well aware of the advantages...
of breastfeeding but some seemed to have unrealistic expectations as to what the early days of breastfeeding would be like. They often lacked understanding of some of the physiological processes involved such as the role of frequent feeding in stimulating milk production.

The lack of consensus between health professionals as to which method of supplementation would be used in a given situation created conflicting advice to women that they found to be unsettling. In a small number of cases the mother could mainly remember the suggestion to supplement. This had powerful and lasting effects.

Recommendations are made by the authors. Supplementation should always be considered as an intervention. A clear policy is needed regarding supplementation and methods of supplementation. Midwives need to become aware that short term help for mothers may be hindering them in the longer term. Unless required for medical reasons considerable caution should be exercised before supplementation is discussed with mothers as it may be perceived as a recommendation. Mothers should be provided with accurate information and fully involved in the decision making process. Each time a supplement is given the reason for it and for the method chosen should be recorded. Interprofessional education needs to be provided to equip staff with the knowledge required to support women in relation to these issues. Ways should be considered of giving staff feedback on the longer term outcomes for mothers who have had their babies supplemented. All of the above would lessen conflicting information given to women. The authors highlight the need for a randomised controlled trial to investigate the relative efficacy of the various methods of supplementation.

Comments

This rigorous exploratory study contributes considerable insight into both mothers’ and midwives’ experiences in relation to supplementation. Practices around supplementation are addressed by step 6 of the WHO/UNICEF Baby Friendly Initiative and often prove to be challenging to change. This study will assist those involved in the management of change to understand some of the complex underlying motivations for resisting change in this area. The issue of ensuring that midwives are supported in taking a longer term view needs to be facilitated through reflective practice and related education.

Publications/presentations at peer reviewed conferences


Target population/area

An area with high levels of social deprivation. Breastfeeding initiation and continuation rates are lower than the national average. The large relatively stable population has had an entrenched artificial feeding culture for three generations.

Aim(s)

To establish a peer support programme with emphasis upon younger mothers.

To empower those involved in the programme.

Project design and procedure

Two training courses were delivered consisting of 20 hours of learning activities taking place over several weeks. The course was based on the National Childbirth Trust (NCT) counselling skills approach. The emphasis was on empowerment of the peer supporters to become advocates of breastfeeding. A model was developed for the training which considered breastfeeding from three perspectives, the social world of the mother, the personal, i.e. the meaning the mother gives to what is happening, and information, the biological reality. Ongoing training was provided informally through the support infrastructure for peer supporters. The peer supporters were called ‘Breastfriends’. The project was co-ordinated by health professionals with ‘Breastfriends’ contacting mothers through clinic, classes, drop-in centres or hospital visits.

Evaluation

Evaluation of training course for ‘Breastfriends’ through three focus groups with 7 participants. Data were analysed utilising the principles of grounded theory.

Focus groups with four mothers.

Focus group with 9 health professionals (midwives and health visitors).

Audit data on breastfeeding initiation rates.

Results/Findings/Outcome

The ‘Breastfriends’ were positive about their training and new role. They valued the flexibility and adaptability of the trainers and training, they appreciated the methods used for teaching and learning and they experienced personal growth and empowerment. Relationships with health professionals were generally positive although they recognised that time constraints were problematic for hospital staff. They felt valued by mothers and health professionals. They identified their growth in independence. There was a high retention rate which is further evidence of satisfaction with the role.

Health professionals were positive about the breastfeeding supporters. They felt that through their activities and role modelling they were contributing to a change of attitude towards breastfeeding and a consequent cultural change. Health professionals focused on formal knowledge in discussions of their role and did not appear to acknowledge women’s embodied knowledge of infant feeding as being a valid source of information for other women. Knowledge about the initiative was variable. It was felt that age and social class of the ‘Breastfriends’ should be considered related to that of the mothers. There was a...
recognition that the ‘Breastfriends’ became increasingly independent and confident as they practiced in this role. There were however clear power and boundary issues at play with ‘Breastfriends’ being expected not to “overstep the mark” or develop too much autonomy. There was little evidence of health professionals learning from ‘Breastfriends’ and they maintained a ‘gatekeeping’ role over their activities.

The mothers recognised the barriers to breastfeeding within a bottle feeding culture. They felt that midwives were insufficiently aware of the peer support programme and therefore did not always provide information to mothers. Mothers felt that young ‘Breastfriends’ may be unacceptable to older mothers. Mothers recognised the effectiveness of role modelling. They also referred to the differences between the time health professionals had and that of ‘Breastfriends’. ‘Breastfriends’ were seen to offer experiential and embodied knowledge and practical support related to integrating breastfeeding into busy lives.

The breastfeeding initiation rates collated by the local hospital increased slightly from 51-56% to 55-59% during the period of the study but this data does not relate specifically to the target group.

Comments

It is not possible through this evaluation to demonstrate that any increase in breastfeeding is causally related to the activities of the support project. However, the qualitative data suggests that the ‘Breastfriends’ programme is likely to increase the number of women who continue to breastfeed.

There are a number of strengths of this project. The media were involved to increase publicity. The planning team included NCT representatives, midwives and health visitors thus providing a range of perspectives. This team was joined by the first group of ‘Breastfriends’. Recruitment of the first cohort was through recommendations by health professionals. This evolved into potential supporters volunteering themselves. The latter was favoured by supporters and is likely to lead to higher levels of motivation. Adjustments to the training programme were made in response to ‘Breastfriends’ evaluations. The evaluations were comprehensive involving mothers, ‘Breastfriends’ and health professionals. The focus group method yielded useful qualitative data. The issue of power relationships is raised which is absent in most other reports. The concept of experiential embodied knowledge centring on practical matters integrated into real life situations is contrasted with the increasingly formal, evidence-based knowledge of the health professionals.

Sustainability

There are now two other ‘Breastfriends’ project areas and a third proposed. All are tied in with Sure Start areas. Funding is largely through Sure Start initiatives but, in addition, there is funding from the NHS Trust. This supports midwifery input to the initiative (Personal communication, Kirkham 2003).

Related publications:


**Target population/area**

A maternity service in an area with a predominantly bottle feeding culture and low breastfeeding continuation rates.

**Aim(s)**

To promote and increase the duration of breastfeeding in a deprived area.

To raise awareness of the benefits of breastfeeding within the local community.

To improve the social acceptability of breastfeeding within the local community.

**Project design and procedure**

The breastfeeding initiation rates had been improved in the maternity unit following the adoption of UNICEF UK Baby Friendly Initiative ‘Ten Steps to Successful Breastfeeding’. However the continuation rates were low. A multidisciplinary team was set up to plan and monitor the project. A six week peer training package was provided by the project co-ordinators, one an NCT trainer and the other a Lactation Consultant. Twenty mothers were recruited for training. Support was put in place for the peer supporters.

A ‘drop-in’ breastfeeding support group was organised as a point of contact between the peer supporters and mothers. The scheme was advertised in the local media and through leaflets and flyers in health facilities and shops. The ‘drop-in’ was poorly attended and despite renewed attempts to involve health professionals in promoting the scheme and increases in advertising attendances did not improve. This led to the gradual demotivation of the peer supporters. However at the close of the project one peer supporter was supporting mothers via the internet, one had set up a local breastfeeding support group within a local mother and baby group and another has become a health care assistant in the maternity unit. Six peer supporters set up a telephone support line for breastfeeding mothers.

**Evaluation**

Interviews with mothers.

Interviews with midwives.

**Results/Findings/Outcome**

Twenty mothers and 12 midwives were interviewed. Both groups felt that the drop-in facility was a good idea.

**Comments**

Conclusions cannot be drawn from this study about impact on breastfeeding continuation rates which were reported to be increasing anyway.

**Sustainability**

Although the ‘drop-in’ has not continued, peer supporters have continued to support each other and meet as a mother and toddler group (personal communication, Dassut 2003).
**Target population/area**

A low income area serviced by a Sure Start programme. Breastfeeding initiation and continuation rates were below the national average.

**Aim(s)**

To establish a breastfeeding peer support programme.

**Project design and procedure**

A team of health visitor and midwife Sure Start workers were trained utilising the La Leche League (LLL) Peer Administrator’s course. This was developed into a rolling programme so that subsequent Sure Start workers would also be trained to minimise any loss of impetus created by staff leaving. Antenatal breastfeeding workshops were established within the Sure Start premises. These were open to all women accessing the maternity service not just Sure Start women. The format consisted of 3 weekly sessions for pregnant women. These were attended by over 100 women.

The peer support training was carried out by health professionals. The volunteer supporters called themselves the BEST team (Breastfeeding Encouragement Support Team). Eleven peer supporters were trained in two cohorts. The BEST supporters were accessible to mothers and health professionals via mobile phones. They worked on a rota system (voluntarily). A support group for both ante and postnatal women was also established on the Sure Start premises. This was attended by midwives, health visitors and BEST supporters. Appropriate publicity, e.g. leaflets was developed to advertise the range of services offered by the peer supporters.

**Evaluation**

A retrospective survey of attendees from the first workshop was conducted by telephone.

Development of a system for the collection and collation of breastfeeding statistics.

**Results/Findings/Outcome**

Ten women were telephoned 90% (9/10) of whom breastfed. Seventy percent (7/10) of mothers breastfed for 3 months and 60% of women breastfed exclusively for at least 4 months. A computerised data collection system was developed to collect data on infant feeding practices at birth, discharge from hospital, the health visitor primary visit, 6 weeks, 4 months, 6 months and 8 months.

**Comments**

A strength of the project is the development of a rolling programme so that subsequent Sure Start workers would also be trained to minimise any loss of impetus created by staff leaving. The development of an improved data collection system has now enabled evaluations of breastfeeding rates to be conducted. Exclusive breastfeeding rates in the Sure Start postcode area have risen from 24% in 2001-2002 to 42% in 2002-2003 at 6 weeks. At 4 months they have risen from 13.5% to 33% (sample sizes not provided). (Personal communication, de Waymarn 2003). This striking increase at two key points suggests that the project is impacting upon the duration of exclusive breastfeeding. The computerised data system devised is now used across the county.
Sustainability

The project is now funded through Sure Start. Three more Sure Start workers have received breastfeeding training. A third group of peer supporters have been trained. The peer supporter training has been approved through the Open College Network and counts as one credit at level 1. Antenatal workshops continue and are fully booked. It is estimated that 25% of attendees are from the Sure Start area (personal communication, De Weymarn 2003).

Target population/area

Women who are pregnant or breastfeeding who take illicit drugs and related substances.

Aim(s)

To establish sources of information both for multi-agency professional groups and pregnant women.

Project design and procedure

A booklet was developed for pregnant women to provide them with information with which to make informed choices. A web site was developed for health professionals to provide them with access to sources of information. The project team included a pharmacist, midwifery educationalist, a drug liaison community midwife, a Sure Start health visitor, a drug information worker and a web site master.

A systematic search on drug usage and breastfeeding was conducted. An extensive web search and evaluation was conducted and a web-site developed which would act as a resource with links to relevant associated sites. The booklet for women was developed following one-to-one discussions with women who had engaged in substance misuse. It was designed to be utilised by health professionals in discussions with women about the various issues involved and then to be given to women to keep. This was made clear in the introduction.

Evaluation

A modified Delphi technique was utilised to evaluate the project and information technology was used to send out and receive feedback on the web-site.

A questionnaire was directed to a panel of five experts with backgrounds in pharmacology, breastfeeding, obstetric care provision for pregnant drug users and experience in designing information web sites. The questionnaire invited evaluation on web-site navigation and design, content in terms of suitability and value for professionals and reliability of the sources included.

A second evaluation of the web site was conducted by a small multi-professional group that was invited to participate in an evaluation during a drug misuse in pregnancy study day.

A simple questionnaire was issued to ten women with a history of substance misuse asking them to evaluate style and appearance of the booklet, ease of reading and finally whether the information would help them in making an informed choice regarding method of feeding.

Evaluative comments were obtained from a range of health professionals on the content and usefulness of the booklet.

Results/Findings/Outcome

Constructive comments and suggestions were made by the panel that were subsequently addressed by the project team in improving the web site. All ten women invited to evaluate the booklet did so and it was felt to be a useful resource for women in making decisions around infant feeding methods. Amendments were made in response to evaluations.
Comments

This study illustrates the rigorous approach needed to develop resources for vulnerable groups, which are accessible, and appropriate in enabling them to make informed decisions. The effectiveness of the leaflet will depend in part upon health professionals making it available to women and secondly utilising it effectively in discussions with women. The extent to which this happens would make a useful follow up study.

Sustainability

Midwives utilise the booklet as appropriate during ante and postnatal care to discuss issues with women. Evaluation of the booklet continues via the web site. In association with this project a second multidisciplinary group has developed a care pathway for drug using pregnant women (personal communication, Dominey 2003).

Publications:


**Target population/area**

Sure Start area in a port city with a diverse multi-ethnic population. Breastfeeding initiation and continuation rates were lower than the national average.

**Aim(s)**

To raise the profile of breastfeeding within a very disadvantaged community area.

To encourage an increase in the number of women who initiate breastfeeding and the length of time they continue to breastfeed.

To offer support and reduce conflicting advice to the breastfeeding mother and assist with problems that occur within the community setting that cause cessation of breastfeeding.

**Project design and procedure**

A breastfeeding drop in centre was established at the local African-Caribbean centre. This provided a venue for conducting a breastfeeding workshop and clinic, accommodating both pregnant women and breastfeeding mothers. The group was named ‘Tea for Two’. Five months into the project 2-4 women were attending each workshop/clinic.

**Evaluation**

Two questionnaires were developed, one for antenatal women and one for postnatal women.

**Results/Findings/Outcome**

The antenatal questionnaire highlighted that women enjoyed the video, learning how to hold a baby, talking to other mothers and the friendly group. The postnatal questionnaire highlighted that women were highly satisfied with the information and support provided at the clinic. They referred to its effect of increasing their confidence. No data is available on initiation and duration rates.

**Comments**

The choice of venue posed some barriers to women from ethnic groups other than African-Caribbeans as it was associated with one specific ethnic group. The project team also realised that the name ‘Tea for Two’ was culturally inappropriate.

**Sustainability**

The group is still running but has evolved into a peer support group with an associated training programme. This was developed in response to requests from women. The venue has been changed to make it more accessible to all cultural groups and is now being regularly attended by 7-8 women (personal communication, Dore 2003).
**Target population/area**

Local black and ethnic minority women in a specific geographical area.

**Aim(s)**

To raise the breastfeeding initiation and continuation rates in black and minority ethnic groups.

**Project design and procedure**

Existing one day antenatal workshops were felt to be inaccessible to women from local ethnic minority groups for whom English was not their first language. A specific monthly workshop was developed utilising translated material both audio and visual. An interpreter was present at all the workshops. Women were recruited to the workshop by the community midwives. Three midwives were trained to run the workshops. Transport to and from the workshops was offered and an interpreter made available. Four women attended the first workshop. Renewed efforts to publicise the workshops through the midwifery service, posters and leaflets had some impact. Attendance ranged from 0-12 with a total of 30 women attending over 12 months.

**Evaluation**

Questionnaires in Urdu and Bengali issued to mothers at the end of the workshop day. An interpreter was on hand to assist with the completion.

Interviews in the mothers’ own homes after the birth.

**Results/Findings/Outcome**

All ten of the end of workshop evaluations issued were received with 78% of mothers reporting that the workshop was either very valuable or valuable. The majority of mothers (84%) said that meeting other mothers was the most valuable part of the day. The information on breastfeeding was considered to be useful. Five mothers were interviewed in their homes following the birth of their babies. All had discontinued breastfeeding. All felt that a one-to-one session in their own home would have better met their needs.

**Comments**

Data were not collected on breastfeeding rates in the target group. A number of challenges affected this project. There were delays in the dissemination of information to community midwives about the project. Some women from these ethnic groups needed permission to leave the home and antenatal education was not viewed as an important reason for them to be away from the home. It would be worthwhile to interview non-attendees to determine reasons for preferring not to attend.

**Sustainability**

There is now a Sure Start scheme in the area. The project as described has not been maintained and although a breastfeeding workshop is still provided for women it is not specifically for a minority ethnic group (personal communication, Dowling 2003).
Target population/area
An area with high levels of social deprivation, high unemployment, high mobility.

Aim(s)
To evaluate a recently established breastfeeding peer supporter programme to identify factors that are effective in recruiting mothers to become peer supporters and enabling them to help other mothers breastfeed.

Project design and procedure
The La Leche League (LLL) peer counsellor’s programme was utilised to train a second cohort of peer counsellors.

Analysis/Evaluation
Focus groups and in-depth interviews conducted to elicit the experiences of newly trained peer supporters.

Interviews conducted with health professionals to elicit views on the role of co-ordinator.

Audit of breastfeeding statistics.

Audit of mother’s views.

Results/Findings/Outcome
A steady increase in the initiation and duration rates was observed over a two year period, i.e. the year the project was set up and the second year during which DH funding was received. Initiation rates for the target area increased between 1998 and the first six months of 2000 from 48% to 67% (number of babies born: 44 and 33 respectively). It is stated that the rates of breastfeeding at 3-4 months increased from 19% to 33% during the same period.

Health visitors were the main health professionals participating. They felt that the course improved their practice. However, they did not appear to place much emphasis on administering the peer support programme with only one of six being able to designate sufficient time to this role. Midwives were less involved in the programme generally. A range of reasons for becoming peer supporters were elicited. Peer supporters generally felt positive about the training which built their confidence and gave them a sense of achievement. They did, however, often feel uncomfortable in a hospital setting particularly when the midwives did not acknowledge them, or introduce them to women. Mothers welcomed peer support and felt encouraged by it.
The author recommends that a health professional needs to act as co-ordinator and mediator between the supporters and mothers within medicalised settings. It is suggested that in such settings peer supporters might work in pairs. Peer supporters need improved access to antenatal clinics and designated space to set up a stand. They need to meet mothers during the antenatal period. Where this is not possible they need to meet the mother early in the postnatal period, not simply when problems arise. Ways of motivating and maintaining the enthusiasm of the peer supporters need to be considered at all stages of the programme. The LLL model recommends regular monthly meetings for this purpose.

Comments

There were other initiatives in place at this time, e.g. the local maternity unit was implementing the UNICEF UK Baby Friendly Initiative agenda, so causality cannot be attributed. However, local cultural changes towards promoting, protecting and supporting breastfeeding are likely to have a gradual impact in raising breastfeeding initiation and duration rates. There were a number of challenges. These included: establishing and maintaining the motivation and interest of health professionals; recruiting peer supporters was very difficult; maintaining the motivation of peer supporters; ensuring effective communications between the peer supporters and health professionals. This project’s strength lies in the ways in which it built upon existing infrastructure around peer counselling. The evaluation focused on the views of peer supporters, mothers and health professionals. The reflexive style of the report highlights areas for consideration in organising peer supporter programmes.

Sustainability:

This evaluation exercise served to confirm to LLL that there was a need to provide ongoing support to their peer supporters. The quoted cost of any peer support training programme now routinely includes 3 years of ongoing support after the programme finishes. This takes the form of telephone discussions as necessary, 2 support visits per year and/or attendance at LLL ‘enrichment’ days held at various locations around the country. The peer supporters also receive the LLL newsletter, Breastfeeding Abstract service and may borrow from the LLL library (personal communication, Dye 2003).

**Target population/area**

An area with high levels of social deprivation. Breastfeeding initiation and continuation rates were lower than the national average.

**Aim(s)**

To improve the breastfeeding rates, particularly among women on a low income, by the provision of correct and consistent information from which mothers can make an informed choice about feeding their baby.

To help encourage continuation of breastfeeding through peer support and effective communication networks.

To raise the awareness of the benefits of breastfeeding and provide support and breastfeeding education to parents, health and other professionals.

To co-ordinate and promote breastfeeding activities in the area and influence the wider community so that they, in turn, can support individual mothers.

**Project design and procedure**

The project involved the establishment of a breastfeeding peer support project. A breastfeeding support clinic was set up. A health visitor was appointed to administer the project. Mothers were recruited to train to become peer supporters ‘Breastfriends’ to other breastfeeding mothers. Seventeen mothers were trained. The peer supporters offered breastfeeding support to all mothers in the region by means of telephone contact, home visits, health visitor clinics, parentcraft classes or clinic-based support group meetings. A programme of breastfeeding education was provided for health visitors and midwives.

**Evaluation**

Audit data collected on breastfeeding initiation and continuation rates.

Audit of client/mother satisfaction.

Audit of peer supporters’ views.

Audit of health visitors’ views.

**Results/Findings/Outcome**

Exclusive breastfeeding rates at 16 weeks rose from 39% to 45% (sample sizes not provided) in the health centre area where the support clinic was set up. However, audit data collected for local areas suggested some general changes in rates with exclusive breastfeeding being sustained for longer in the areas surrounding the centre. Audit of the views of health visitors connected with the project highlighted that they were generally very positive about the support programme. Thirty-eight percent commented that they felt inadequately trained to be able to support those with breastfeeding problems. Some commented that some of the mothers had their own support networks and therefore didn’t require additional support. Peer supporters were highly positive and welcomed the network of friends and supportive others that this project generated. They felt valued in their new role. Thirty two percent of
mothers who received peer support completed an evaluation form. They had accessed aspects of the range of peer support as they required. They greatly valued this form of network support seeing it as assisting them to overcome various barriers, e.g. cultural negativity towards breastfeeding.

Comments

The appointment of a health visitor for 12 hours a week to co-ordinate the project appears to be a key strength. A strategic approach to the project was adopted by involving and communicating with the maternity unit breastfeeding adviser, midwifery managers, midwives, a local leader from a national breastfeeding support organisation, local GPs, PCGs, the health promotion unit, councils and local businesses. Encouraging mothers to access the service presented an ongoing challenge. Emphasis was placed on facilitating peer support for supporters. Three of the peer supporters subsequently undertook a full breastfeeding counsellors training with one of the national voluntary breastfeeding organisations. In response to the health visitors’ comments about the inadequacy of their training, education is now being provided.

Sustainability

Further financial support from the local council has enabled the project to be extended. The ‘Breastfriends’ support clinic and peer support network continues with input from the ‘Breastfriends’ Health Visitor (Personal communication, Etherington 2003).

Target population/area
An area with high levels of social deprivation and an ethnically diverse population.

Aim(s)
To provide a breastfeeding support service.
To raise the profile of breastfeeding in the local community.
To build a supportive informal environment within the community to expectant and new mothers.
To provide information and advice to women least likely to breastfeed.

Project design and procedure
A multi-agency steering group was established to oversee the development of a Breastfeeding Advocacy Project (BBAP). A specialist adviser, a midwife with a particular interest in breastfeeding and 2 breastfeeding advocates (mothers) were recruited to the project. The advocates underwent the UNICEF UK Breastfeeding Management Training. One also completed the LLL peer supporter training. BBAP established a weekly, 3 hour long ‘drop-in’ service and outreach for expectant and new mothers on the designated housing estate. The sessions were held on the estate but women from a wider area were welcome. In addition the advocates attended a range of related services and venues to outreach and assist women in connecting with others. The project was well publicised.

Evaluation
A baseline survey using structured questionnaires of attitudes and practices regarding breastfeeding on the Barnfield estate was conducted with local mothers of children under age 2 years. These were identified through the health visitor registers. The questionnaires were completed at home visits.

Audit of breastfeeding practice from hospital and health visitor records was intended but not achieved.

Results/Findings/Outcome
Of the women identified 28/100 (28%) were found to be at home of whom 24 responded. The survey provided demographic data, information on breastfeeding initiation and duration, reasons for infant feeding decisions, information received regarding breastfeeding and issues related to constraints upon breastfeeding and what would make breastfeeding easier. Of the 24, a total of 6 (54%) of women initiated breastfeeding. The rates at 1, 3 and 6 months were comparable to national and regional pictures. Various misconceptions about breastfeeding became evident and the difficulties of breastfeeding in a bottle feeding culture were highlighted. Key suggestions for making breastfeeding easier were a more positive community attitude and more places to breastfeed when away from home. Key indications for action from the survey were: To provide consistent up to date information about breastfeeding across all groups that work with/support pregnant women and new mothers; to reduce the stigma of breastfeeding in the local community; to work towards integrating breastfeeding into more general health education, e.g. schools.
Comments

Whilst this project does not provide outcome measures for its effectiveness it highlights the importance of gaining baseline demographic and breastfeeding data to include attitudinal data. This should assist the identification of issues relevant to specific ethnic groups within the local population. The author highlights the importance of partnership working in the community with local residents being actively involved. She also emphasises the extensive time it takes to undergo development work before the delivery stage of a project. Likewise it takes considerable time to approach and engage the community and then sustain interest and/or involvement. Finally she recognises that the local stigma of breastfeeding makes it difficult to ‘sell’.

Sustainability

The project is being sustained through a local Sure Start initiative. Funding will include a part-time project development officer.

**Target population/area**

Women in a local prison.

**Aim(s)**

To ensure that all women in the prison are assisted in making an informed choice with regard to breastfeeding.

To support mothers to initiate and sustain breastfeeding.

To encourage and increase exclusive and continued breastfeeding within the mother and baby unit.

To promote co-operation between health care staff, breastfeeding support groups, mothers themselves and prison staff on the mother and baby unit.

**Project design and procedure**

Staff involved undertook the 3 day UNICEF UK Baby Friendly Initiative Breastfeeding management training. Training was also provided for prison staff working on the mother and baby unit. This related to awareness of breastfeeding benefits and how to ensure optimum support for these women. An NCT counsellor was involved in the project. Breastfeeding workshops were organised monthly to mothers in the target group. Liaison with dietetic services supplied the catering staff with information on a healthy diet and health promotion information was disseminated to mothers. Breast pumps and designated fridges were provided to support mothers in maintaining lactation and supplying their own milk for their babies when separated from them. Quiet facilities were established for expressing milk. Mothers developed a network of support with others who were breastfeeding.

**Evaluation**

Feedback from mothers

Collection and collation of breastfeeding statistics.

Attendance at the breastfeeding workshops.

**Results/Findings/Outcome**

Feedback from mothers indicated that they felt that the service provided for them by the project was very helpful. For the year prior to the project 12/21 women with babies breastfed (57%). For the project year 22/28 mothers with babies breastfed (78%). Average duration of breastfeeding increased from 6 weeks to 3 months during the project time. In total 125 women attended workshops over the 12 month period.
Comments

Due to inevitable changes in the prison population the data on continuation of breastfeeding was difficult to record accurately. However, there was a substantial increase in the breastfeeding rates. In terms of the mothers’ experiences of support the scheme was clearly very much appreciated. The project highlights ways in which engagement with the prison and associated services may be managed and health-promoting behaviours emphasised and supported. It may assist in providing a model for others in accessing and supporting women prisoners.

Sustainability

Provision of midwifery services continue as before and the Head of the Health Board at the prison is likely to fund any further prison staff training or dietetics input (personal communication, Farrell 2003).

**Target population/area**

An area with high levels of social deprivation. There is a large Bangladeshi and Pakistani population accounting for over 30% of births. Breastfeeding initiation and continuation rates were lower than the national average.

**Aim(s)**

To evaluate an existing peer support group (BRAGG).

To ascertain reasons why certain groups of the population do not feel that BRAGG meets their needs.

**Project design and procedure**

This project involved evaluating two breastfeeding support groups set up in 1997 (BRAGG). One group was hospital based and the other community based. The DH funding also enabled the training of 3 Bangla speaking women who promoted consistent advice within the hospital and also Urdu and Bangla speaking peer supporters who attended the BRAGG groups.

**Evaluation**

Breastfeeding rates were collated for three ethnic groups for the NHS Trust (not specifically related to the support group attendance).

A questionnaire was issued to attendees to elicit demographic details of attendance patterns and details and duration of breastfeeding.

Focus groups were conducted with attendees to elicit reasons for attending.

Focus groups and semi-structured interviews were conducted with Bangladeshi and Pakistani mothers to elicit their specific needs (Asian link workers were involved).

**Results/Findings/Outcomes**

A total of 192 questionnaires were sent to mothers who gave birth to live infants during June and July 2000 with 115 being returned (60% response rate). Sixty-five of the questionnaires were sent to women from Asian communities with 17 returned (26% response rate). Of the 73 respondents who had never attended BRAGG, 45% said they were unaware of its existence. Breastfeeding rates for the NHS Trust were collated, but these were not specifically related to attendance at the support group. Initiation rates for Bangladesh women rose from 41% in 2000, to 46% in 2001, to 72% in 2002. The rates for Pakistani women rose from 53%, to 59% to 67% respectively and for White women from 57%, to 59% to 64% respectively. Forty-eight percent of women were breastfeeding at 28 days (sample sizes not provided).

Thirty-two mothers were interviewed, including 9 women from Asian communities. In general women felt that BRAGG was a valuable resource and commented that such a service should be available in their own localities as community based groups. They identified that they would like more antenatal information regarding the realities of breastfeeding and more practical support with breastfeeding.
It became apparent from the Bangla women that it was considered unsafe to leave the home and travel on a bus. Fear of racism was cited. They preferred to attend groups to which they could walk as they did not necessarily drive or have access to a car.

Comments

As the data on breastfeeding are not specific to the target group conclusions about the impact of BRAGG cannot be drawn. However, the trends in initiation rates are encouraging. The increase in initiation is more pronounced for Bangladeshi women who had the lowest rates in 2000. This may be in part due to the work of 3 Bangladeshi interpreters within the hospital setting. The maternity unit was also engaging with the UNICEF UK Baby Friendly Initiative agenda which is also likely to have had an impact on breastfeeding rates. This is an important study that identifies reasons why women may not wish to avail themselves of a support group. The authors comment that the Asian women were reluctant to participate in the study. This clearly points to the need to explore ways of eliciting their views that would be more acceptable within their communities.

Sustainability

Funding is maintained by the acute NHS Trust. A further BRAGG group is scheduled to commence in 2003 in a Sure Start area (Personal communication, Finigan 2003).

Publications:


Target population/area
Adolescent mothers in an area with high levels of deprivation.

Health care staff involved with adolescent mothers.

Aim(s)
To promote breastfeeding amongst all staff coming into contact with young mothers within a hospital and community setting.

Facilitate ongoing support for young mothers breastfeeding via an established teenage mother’s support group within the locality.

Project design and procedure
A programme of breastfeeding training was implemented by the project co-ordinator. At the time of submission of the report 70 midwives and 30 support staff had received training. An existing teenage mothers support group, ‘Stepping into Parenting’ was relaunched and attended by the project co-ordinator weekly along with a youth worker designated to the teenage parenting group. Activities within the group related to breastfeeding included listening to the teenagers, discussion, providing information on practical skills and video use. The group offered antenatal and postnatal support to teenagers.

Evaluation
Breastfeeding audit data were collated on breastfeeding initiation rates among adolescents.

Data were collected on attendees.

Written evaluation of staff training was obtained from course participants.

Results/Findings/Outcome
Breastfeeding initiation rates for mothers under 20 years rose from 29% to 46% during the project period. (sample sizes not available). This figure relates to all adolescent mothers not just attendees. During the project 13 adolescent women attended and 3 men. Of the women who gave birth during the project 6/10 commenced breastfeeding. All were still breastfeeding at one month, 2 exclusively and 4 partially. Evaluations by staff on the training were positive.

Sustainability
Four waves of Sure Start funding have replaced this group, but not specifically targeting adolescent mothers. However, the breastfeeding co-ordinator regularly attends a teenage parenting group. Staff training continues (personal communication, Flynn 2003).

Target population/area

Women attending a large GP practice surgery in an area with high levels of social deprivation (High DTLR deprivation score). Breastfeeding initiation and continuation rates are lower than the national average.

Aim(s)

To provide women on low incomes with additional information and support regarding breastfeeding.

To establish a best practice format that can be adopted for the whole maternity service.

To positively influence the breastfeeding intention, initiation and duration rates within this client group.

Project design and procedure

A detailed consultation process was undertaken with key stakeholders. A health care support worker was employed (0.5wte) on a part-time basis to support a community midwifery team. The support worker’s sole purpose was to provide additional information and support regarding breastfeeding to the designated group of women both in antenatal and postnatal periods. She was called a ‘midwifery assistant’. Training included orientation to community practice setting, child protection training and breastfeeding training. The La Leche League (LLL) peer counselling programme was utilised plus some in-service education. Women from a GP practice serving a deprived area were recruited by telephone and offered the package of additional information and support. This was open to any of the recruited women who wanted further information regarding infant feeding. This included two home antenatal visits. The first involved the provision of information regarding breastfeeding and involved use of videos selected from a range as appropriate. A second visit at 34 weeks enabled a general discussion to take place including issues raised at the earlier visit. Subsequent antenatal visits were made if required. Postnatal visits in hospital and at home were provided up to 6 weeks following the birth to provide additional support with feeding. The midwifery assistant carried a mobile phone. She liaised with the midwives as appropriate.

Evaluation

Audit of breastfeeding rates pre and post intervention.

Analysis of support worker documentation on feeding activities and activity during visits.

Structured interview with uses of the service (by an independent researcher).

Qualitative analysis of support worker’s reflective diary on her experiences throughout the project.

Qualitative analysis of informal discussions with team midwives.
Results/Findings/Outcome

Eighty women participated out of the ninety nine women invited to receive the additional support from the midwifery assistant. Demographic details were collated. The intention to breastfeed rates and the initiation rates rose by 10 percentage points from pre-to post project. The 6 week breastfeeding rate did not change from pre-to post project.

Thirty five users of the service were approached and asked to participate in structured interviews. The midwifery assistant was highly valued for ongoing support, encouragement, practical help. She was valued because she had more time which enabled the building of a relationship. They also appreciated the designated role for breastfeeding support.

Thematic analysis of the midwifery assistant’s diary highlighted three themes; the level and type of activity she was engaged in, difficulties experienced and personal development. She clearly responded to individuals according to individual need, and referred to midwives when appropriate. The main difficulty centred upon the growing demand for the service. Job satisfaction was high. The midwives were very positive about the role as they felt it was useful to have someone who could spend time with the women. They felt that the role definition and boundaries were clear and therefore did not see it as threatening.

Comments

The data suggest a trend towards improving intention and initiation rates although there is now a general move away from asking women about the former. The study explored an innovative means of providing additional support to women in a flexible, adaptable woman centred way. The role appeared to be very acceptable to health professionals, mothers and the midwifery assistant. The authors recommend the employment of a full time midwifery assistant for each community midwifery team. They also recommend the LLL peer counsellor training for teaching the midwifery assistants.

Sustainability

The midwifery assistant post continues to be funded by the PCT (personal communication, Foyle 2003).

Target population/area

An area with high levels of deprivation and a high teenage mother population.

Aim(s)

To recruit and train peer supporters

Project design and procedure

Volunteers were recruited through support groups, breastfeeding clinics, hospital posters and word of mouth. A taster day was provided for potential volunteers during which the role of the peer supporter was discussed using interactive methods, e.g. role play. Interviews were subsequently held for those interested and eleven mothers were recruited. Fourteen weeks of training sessions lasting 3 hours per week were provided. The programme of training was developed by the project co-ordinator, another midwife, a health visitor and a BfN breastfeeding supporter. Monthly ongoing ‘light training and debriefing sessions’ were organised once training was completed. Eleven volunteers completed the course. They subsequently provided peer support through telephone calls and home visits as required. Their contact numbers were supplied on discharge from the hospital.

Evaluation

Written evaluations of the volunteers’ perceptions of the training were obtained.

Results/Findings/Outcome

Evaluations of the course by the supporters were largely positive.

Comments

Data which compared breastfeeding rates was not provided as the author notes that the presence of a number of schemes in the area would not enable the effects of one to be evaluated separately (personal communication, Geaney 2003).

Sustainability

The project is connected with the ‘drop-in’ service referred to by Shaw-Flach and Shulver (2001). The scheme continues to operate in the same way as described. The peer supporters now visit the maternity unit at least once a week to introduce themselves to mothers. They mainly organise their own activities (personal communication, Geaney 2002).
Target population/area
An area with high levels of social deprivation, high teenage pregnancy rates and high unemployment.

Aim(s)
To raise awareness and knowledge of how breastfeeding works.
To set up continuity of support for parents with young babies.

Project design and procedure
Two 2 hour breastfeeding classes were provided for women by members of La Leche League (LLL) to include a video ‘Delivery and self attachment’. The classes were piloted in a different area with 6 women attending the first class and 5 the second. The project co-ordinator(s) then approached the local primary care groups and explained their plans for the target areas and requested support. A launch of the project was then organised and all midwives, health visitors and relevant managers from the area were invited. A seminar was held to inform these groups about the project and to engage their support. A total of 11 breastfeeding courses were conducted/organised in the target areas. Initially women (and their partners) were targeted when the women were 34 or more weeks pregnant, but due to low attendance this was lowered to 30 weeks pregnant. Following the course each participant was provided with the LLL manual, ‘The Womanly Art of Breastfeeding’. The earlier sessions were held in venues such as local halls but attendance was low. It was decided that the mothers could better be targeted through health care facilities so subsequent courses were held in health centres. The most successful way of accessing and inviting women proved to be for the La Leche League co-ordinators to attend antenatal classes and invite women personally. A weekly drop-in centre was set up to supplement the course but this was poorly attended.

Evaluation
Post seminar questionnaires were distributed to midwives regarding the seminar provided for them.

Questionnaires were issued to mothers at 3 points in time: before they attended classes to explore women’s existing experience and knowledge; following the end of the second class. (This elicited feedback on the usefulness of the course and whether expectations of breastfeeding had changed) and three months after the course to elicit impact upon experiences of breastfeeding and duration of breastfeeding.

Results/Findings/Outcome
There were 25/30 midwife questionnaires returned. The midwives recognised the need for improved antenatal education and postnatal support related to breastfeeding. They were in agreement with the co-ordinators regarding course content. Interviews were conducted with three midwives who had had involvement in the programme. Their response was positive and suggestions were made regarding times for increasing numbers, e.g. a Saturday morning. A total of 133 women attended class 1 and 96 class 2.

By completion of the project 70 questionnaires were returned at point 1, 44 at point 2 and 6 at point 3. The point 1 questionnaires revealed that women tended to have unrealistic expectations about life with a baby and breastfeeding. Others wrote ‘don’t know’ to a number of questions or left large sections blank. The point 2 questionnaire highlighted considerable gains in confidence related to ability to breastfeed and continue breastfeeding. Women also reported increased confidence in their ability to challenge, disagree and ask for help when required. The majority of mothers had changed their expectations of what the first few months of parenting would be like. Point 3 data were inconclusive at the close of the project.
Comments

While a direct effect upon initiation and continuation rates of breastfeeding cannot be shown point 2 questionnaire responses suggest that the classes assisted women in continuing to breastfeed.

Sustainability

Breastfeeding classes are still being provided, one set every two months in different parts of the city. They are now sponsored by a PCT (personal communication, Kajaz, on behalf of Gill, 2003).

Target population/area

Women attending a maternity unit in a low income area. Breastfeeding initiation and continuation rates were lower than the national average.

Aim(s)

To promote the initiation and maintenance of breastfeeding in an area of low breastfeeding rates and low income.

To provide an opportunity for pregnant women to consider breastfeeding.

To provide a range of interventions that are known to sustain breastfeeding.

To provide opportunities for social support for breastfeeding women.

To foster an interest in peer breastfeeding support.

To provide training for health professionals.

Project design and procedure

An NCT breastfeeding counsellor was appointed for 15 hours a week to provide additional support to breastfeeding women. This included talking to women while waiting at antenatal clinic, visiting women at home (n=10) and telephone conversations with women who contacted her via the project (n=28). A weekly postnatal breastfeeding support group was established but in 6 months only 7 women attended although 3 attended more than once. Training was provided for student midwives and midwives centring upon Step 3 of the UNICEF UK Baby Friendly Initiative ‘Ten Steps to Successful Breastfeeding’. This step covers the provision of antenatal information on breastfeeding to women.

Evaluation

A questionnaire was sent to women who had had antenatal contact with the project.

Results/Findings/Outcome

Only 37/280 (13%) of questionnaires were returned. The majority of women (31) had planned to breastfeed and did then initiate breastfeeding (28). Twenty five women breastfed their babies for one month or longer. The majority (34) reported discussing breastfeeding with a health professional during pregnancy. The majority of breastfeeding mothers (25) had not attended a breastfeeding group and most agreed with the statement ‘I had enough help with breastfeeding.’

Comments

The low response rate to the questionnaire limits conclusions that may be made.

Sustainability

The project has not been sustained (personal communication, Umusu 2003).
Target population/area

Adolescent mothers aged 13-19 years in an area with high teenage conception rates.

Aim(s)

To explore the acceptability of a variety of supportive approaches to breastfeeding teenage mothers.

To compare the approaches of midwives and Breastfeeding Network (BfN) supporters in meeting the support needs of adolescents who breastfeed their babies.

Project design and procedure.

A systematic review of the literature on support needs of breastfeeding adolescents was conducted. Thereafter the project was designed in 3 phases:

Phase 1 involved the conducting of two focus groups with a purposive sample of adolescent mothers who had recently given birth and had breastfed their baby. They were recruited by the teenage pregnancy co-ordinator. The focus group interviews explored the breastfeeding experiences of the mothers. Specific issues relating to the breastfeeding support needs of adolescent mothers as identified in the focus groups were developed into four vignettes.

Phase 2 involved the use of an existing breastfeeding support skills tool (UCLan BeSST) and the vignettes developed in phase 1 to measure the skills and approaches of midwives and BfN supporters to the situations identified in vignette form in phase 1. Both these groups were presented with a variety of situations and their responses assessed. This yielded both qualitative and quantitative data. A randomly selected sample of midwives and a purposive sample of BfN Supporters were assessed.

Phase 3 involved inviting all adolescent mothers who met the eligibility criteria and gave birth in the local maternity unit to be interviewed in their own home between 7 to 10 weeks. Semi-structured interviews based on a series of triggers informed from an analysis of the vignettes were conducted with the teenage mothers. Thematic networks analysis was applied to the taped and transcribed data. For all phases characteristics of non-respondents were collated.

Results/Findings/Outcomes

Seven adolescents attended the focus groups. Five themes were developed from the data: lacking confidence; feeling watched and judged; tiredness; discomfort and the desire to share accountability.

A group of 15 from a random selection of 50 midwives consented to undertake the BeSST tool and vignette assessment. Fifteen BfN supporters participated. Vignette analysis for the BfN supporters highlighted a greater emphasis than the midwife group upon active listening, eliciting previous experience, encouraging the exploration of feelings and the suggestion of strategies for coping. The UCLan BeSST tool assessment yielded scores for knowledge and skill which were statistically significantly higher for the BfN supporters (mean=42.5) than the midwives (mean=30.7), p<0.0001.

Thirteen of the 24 adolescents approached agreed to be interviewed. The interview data yielded five global categories of support need; practical/instrumental, emotional, esteem, informational and peer/network.
Comments

This study provides a detailed analysis of the support needs of breastfeeding teenage mothers. Although the adolescents were consecutively sampled and the midwives randomly selected there was a considerable degree of self-selection subsequently which is likely to have influenced findings. One of the study strengths lies in the use of focus groups to inform the project and the involvement of teenage mothers on the steering committee. The study exposes some crucial issues in relation to the supportive approaches of health professionals as compared to qualified breastfeeding supporters and highlights the need for further research in this arena.

Sustainability

The research is being utilised to support local service provision planning. Further research related to support strategies is ongoing.

Related publications/presentations at peer reviewed conferences.


**Target population/area**

Two defined areas. Area 1: An area with high levels of social deprivation and low breastfeeding initiation rates (37%). Area 2: An affluent area with high initiation rates (74%) but with 75% of these mothers discontinuing breastfeeding by 3 months.

**Aim(s)**

To train peer supporters.

To establish breastfeeding support groups.

**Project design and procedure**

Area 1: A programme of publicity was developed to raise awareness of breastfeeding. This then led to the formation of a breastfeeding support group. This phase of the project “established a community adaptable to change and clients receptive to helping their peers”. Having created community receptivity a peer support training programme was planned.

Area 2. Publicity related to plans for a peer support programme generated local interest from mothers. A breastfeeding support group was therefore established as in area 1. However, in this more affluent area this was not well received. Mothers/women were either embarrassed at expressing their need for such support or felt unable to deal with their problems within this setting. Women were tending to discontinue breastfeeding because they saw it as being incompatible with their lifestyle, returning to work and getting out generally. Identified volunteers were therefore asked to act as role models by feeding in clinics, antenatal classes and GP surgeries, illustrating that breastfeeding is acceptable, easy and adaptable. This was combined with endeavours to remove formula advertising from GP surgeries and clinics.

The peer support training programme consisted of ten two-hour training sessions at a local clinic. The time was selected to coincide with an antenatal clinic to enable discussion between pregnant mothers and volunteers. The peer support project met with mixed responses from health professionals. This ranged from ‘professional possessiveness’ to willingness to participate. In response to the range of attitudes, and the recognition that further education on breastfeeding would benefit health professionals, the UNICEF UK Baby Friendly Initiative 3 day breastfeeding management course was purchased. This was delivered in-house by the UNICEF team to 13 midwives and 12 health visitors.

**Evaluation**

Audit of breastfeeding statistics.

6 month questionnaire survey of mothers related to breastfeeding experiences and support received (n=435).
Results/Findings/Outcome

The questionnaire data elicited a range of breastfeeding experiences. It was not possible to assess the impact of the project on breastfeeding rates in either area due to health visitor caseloads and their statistics not relating to the specific area.

Comments

This project illustrates the benefits of assessing the local culture, and preparing individuals likely to be involved through publicity and education.

Sustainability

PCT boundaries have now changed but two groups still exist, one covering the original zone and the other within a different PCT. A new second group encompasses a more socially deprived area and a Health Action Zone. More peer counsellors have been trained. Hammond now has protected time to co-ordinate this project and PCT money also enables protected health visitor time. Further funding has been gained from public health monies (personal communication, Hammond 2003).
Breastfeeding support is for everyone, meeting the needs of all women, Year 1.

Target population/area

Two areas with high levels of social deprivation. One area had a large Bangladeshi community and a smaller Afro-Caribbean community.

Aim(s)

The development of two breastfeeding support centres.

To expand the use of a Breastfeeding Network (BfN)5 Telephone Supporter Line6.

To target resources towards BfN tutors responsible for training supporters in areas with low breastfeeding rates.

Project design and procedure

Two Breastfeeding Network (BfN) support centres were set up and staffed by BfN supporters. One centre was established in the South of England within a Bangladeshi community where breastfeeding continuation rates were markedly lower than the national averages. One of the supporters also worked in the local maternity unit as a Bengali Health Advocate. She was also a breastfeeding mother and therefore acted as a role model. The second centre was set up in the North of England in an area with few women from ethnic minority groups but also with breastfeeding initiation rates well below the national average.

Both support centres were based at health centres and were staffed by qualified BfN supporters. These staff received payment. The times of opening of the centres were organised to coincide with antenatal clinics to increase the likelihood of women attending the centres during their pregnancy. This was in turn felt to increase the likelihood of women feeling comfortable to visit the centre postnatally with their baby due to its familiarity. This also gave the opportunity to provide women with the ‘Supporterline’ number that they could then use after the birth of their baby if needed. Both clinics ran during the early afternoon for the convenience of the mothers. The supporters provided opportunities for group discussions/presentations on breastfeeding related topics or one-to-one support if preferred. In both centres pregnant women were encouraged to ‘drop-in’ and chat with breastfeeding mothers.

The BfN supporters are trained to approach women utilising person centred counselling skills to include listening and non-judgemental acceptance. The centres were well publicised through leafleting, posters, local press, local radio, local friendships and through health professionals. Strong partnerships were established with local health visitors and midwives two of whom were also qualified as BfN supporters. Health professionals were encouraged to drop in to sessions, which they did regularly.

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5 The BfN is a Registered Charity that prepares qualified breastfeeding supporters. The full training lasts for one year. Most BfN supporters work in a voluntary capacity and some in paid employment at the breastfeeding centres.

6 The BfN supporter line offers a confidential service to breastfeeding women who want to access a qualified BfN supporter. Women may request a home visit or discuss their concerns over the phone. The service is described by Broadfoot M et al (1999).
Evaluation

Audit of telephone calls to the supporter line to include reasons for calling and demographic data on callers.

Audit of attendance at the two centres to include details of attendees and reasons for attending.

Written feedback from attendees at the centres.

Results/Findings/Outcome

Calls to the supporter line did not increase significantly but the comprehensive data collected provided evidence on demographic data, e.g. age, ethnicity, age at which full time education was completed. The progress of the supporter line is reported in a year 3 DH funded project (Buchanan et al 2003). Written feedback from mothers was very positive. Comprehensive data were collected and collated related to attendance at both centres. Commonest reasons for attendance were for social support, sore nipples, thrush, problems with attaching the baby to the breast, sleep difficulties, mastitis, poor weight gain and blocked ducts. The project was unable to demonstrate any impact on breastfeeding figures as they were not collated effectively for the area as a whole (personal communication, Whitmore, 2003).

Comments

The success of the Centre in the South in attracting women from the Bangladeshi community appeared to be related to the known presence of a supporter from the same ethnic group. In her role as Bengali Health Advocate she had met women earlier in the maternity unit. The women therefore knew that when they came back they would see her again. The Bengali supporter utilised personal experience to enable women to consider an alternative to their cultural norm. Recognising that Bengali women commonly combine breast with bottle feeding and feel embarrassed about breastfeeding in front of others, the supporter explained that she expresses her breast milk so that she can give it from a bottle if visitors arrive. This enabled her to exclusively breastfeed.

As stated, in both centres pregnant women were encouraged to ‘drop-in’ and chat with breastfeeding mothers. The authors argue that the opportunity this gives to chat about the realities of early breastfeeding may be critical. One of the strengths lay in effective publicity and this was enhanced through development of strong partnerships with health visitors and midwives.

Sustainability

The northern centre is now funded by local PCTs for two further years. Success of this centre has led to a neighbouring PCT funding a centre in 2001 that now has an attendance of up to 23 women per week, and a nearby PCT has subsequently funded another centre in 2003. The southern centre is funded through the local acute NHS Trust. The BfN now has 12 centres across the UK with more planned. The supporters are paid for their services.

A number of mothers who have attended have gone on to train and qualify as breastfeeding supporters with the BfN (personal communication Whitmore 2003).

As result of health visitor and midwife involvement in the centres two groups of health professionals have requested further training from the BfN. This has now been conducted in a number of areas (personal communication, Whitmore 2003).
Hawkins A and Heard S (2001) An investigation of the factors which may affect the duration of breastfeeding by first time mothers from low income groups, Year 1.

**Target population/area**
Low income mothers

**Aim(s)**
To explore the factors which may affect the duration of breastfeeding in first time mothers from low income groups.

**Project design and procedure**
An exploratory study in which in-depth interviews were conducted with women, firstly during the antenatal period and secondly during the postnatal period. Interview points were, 36+ weeks during the antenatal period and 2 weeks, 4 months and 6 months postnatally. If the mothers ceased to breastfeed they were only interviewed at the next contact point and not subsequently. Thematic analysis was conducted.

**Sample selection and recruitment.**
Ten women from low-income groups were purposively selected and recruited.

**Results/Findings/Outcomes**
Antenatal interviews revealed the reasons for women deciding to breastfeed. These included the health benefits of breastfeeding, bonding, convenience and cost. However, knowledge regarding the health benefits was limited. Key influencers on the decision to breastfeed were family, friends and magazines. There had been very little exposure to positive role models for breastfeeding. The women’s expectations of breastfeeding were largely negative, relating to anticipated difficulty, pain and low milk supply.

The postnatal interviews highlighted the ways in which postnatal women felt inadequately supported by health professionals during the hospital stay but more supported by community midwives once home. They were concerned that their milk was qualitatively and quantitatively inadequate. The reality of the experience often differed markedly from expectations, in some cases negatively but others positively. Insufficient attention appeared to be given by health professionals to the establishment of effective positioning and attachment, with three women being given nipple shields for sore nipples. Supplementary feeds were offered, particularly by health visitors and appeared to be related to concerns about inadequate weight gain. There was a strong antipathy towards breastfeeding in public this being related to embarrassment.

**Comments**
This study provides considerable insight into the influences upon the infant feeding decisions made by low income women.
Sustainability

A follow up experimental study is in progress. The experimental group receive an additional antenatal visit centred upon breastfeeding and an additional postnatal visit within the first two weeks to observe a feed and discuss any problems. Both visits are made by a project worker. The control group receive standard care (Personal communication, Heard 2003).

Publications:


**Target population/area**

An NHS Trust.

**Aim(s)**

To establish a local peer support programme.

To train a group of local women as peer supporters.

To set up a network of breastfeeding support groups.

**Project design and procedure**

Eight breastfeeding support groups were set up. The infant feeding adviser trained a total of 14 peer supporters. The course consisted of weekly half day sessions over a period of 8 weeks. The peer supporters then attended the support groups with link health professionals who were appointed to run the support groups.

**Evaluation**

A postal questionnaire survey was conducted by the Community Health Council of attendees (119) and non-attendees (38) at support groups to examine user perceptions of the support groups and reasons why women chose not to attend the support groups.

**Results/Findings/Outcome**

A total of 14/38 (37%) of non-attendees responded. They were all aware of the service. The main reasons for non-attendance were: mother not breastfeeding; lack of transport; lack of time to attend or did not feel she needed a support group.

A total of 80/119 (67%) of attendees responded. There were high levels of satisfaction. The most important aspect of the groups was the network support, i.e. support of other mothers in the same situation. The addition of health professional support to network support was valued with 94% stating that they felt comfortable in the group setting, 85% feeling respected as a member of the group, 90% commenting that they got enough support from staff at the group and 86% reporting that they received enough support from other members of the group. Eighty five percent of women felt able to express their views to the group, 88% felt that their views were listened to, 93% stated that they had had the opportunity to chat with members of staff regarding any concerns they had, 88% indicated that they enjoyed attending the group and 99% would recommend other mothers to attend.

Forty-six percent of respondents who had attended made suggestions for improvements. These included venue/facilities (heating, baby-changing facilities, seating, activities for babies), support and toys for toddlers, better advertising, evening groups, a more structured schedule of presentations and discussions. They felt they would like formal introductions to new mothers with mothers leading discussions. Finally, some suggested that bottle feeding mothers should be invited.
**Comments**

The focus in the evaluation upon both user perceptions and reasons why non-attendees chose not to attend is important as the latter information is crucial to development of the service. Data on breastfeeding initiation and continuation rates were not collated specifically for women receiving peer support.

**Sustainability**

Seven support groups continue. Some funding is provided from Sure Start. PCT funding supports health professional attendance at groups (personal communication, Burns 2003).

**Target population/area**
Women receiving maternity care within 6 health centres in areas of low breastfeeding prevalence.

**Aim(s)**
To produce evidence-based leaflets on breastfeeding problem management for women.

**Project design and procedure**
The leaflets were developed to assist in providing information for women in low income groups who still appeared to be receiving conflicting advice and traditionally were less likely to access breastfeeding support groups. A workshop was held by the project leaders with midwives and health visitors to discuss the leaflets. Leaflets were subsequently designed and distributed to 3 health centres. The leaflets covered positioning and attachment, mastitis, thrush and briefly sore nipples, engorged and blocked ducts and insufficient milk. All midwives and health visitors involved in distributing leaflets had attended ‘managing problems’ sessions. Later during the project a further 3 health centres were targeted following an additional workshop covering leaflet usage and content. Mothers attending the 6 health centres were given a leaflet by midwives at an early postnatal visit. Health visitors distributed leaflets to all mothers who had not received leaflets during a routine visit at 4-6 weeks. Laminated cards were produced and issued to health professionals. These provided the evidence-based information presented in the leaflet.

**Evaluation**
Questionnaires were issued to mothers at the 4-6 week home visit
Questionnaires on the leaflet were issued to health professionals involved in the health centres.
Questionnaires relating to the laminated cards were issued to health professionals involved in the health centres.
Breastfeeding rates were audited.

**Results/Findings/Outcome**
A total of 151/229 questionnaire responses from women were collated (66% response rate). Many health visitors forgot or did not have time to distribute the leaflets so mothers who were not given leaflets were telephoned at home with 63 (42%) of responses received in this way. For each problem experienced the number finding the leaflet useful was ascertained: engorgement 57/71 (80%); sore nipples 56/84 (67%); cracked/bleeding nipples 30/38 (79%); not enough milk 15/36 (42%); mastitis 22/25 (88%) and nipple thrush 11/15 (73%). Most women (98%) described the leaflets as helpful using an adjective checklist. Comments related to the content and layout of the leaflet were largely positive.

Ninety-one percent (31/34) of health professionals responded to the questionnaire on the leaflet. When asked about when the leaflets should be distributed 60% stated ‘first postnatal visit’, 22% antenatal, 12% before discharge to the health visitor and 6% soon after birth. Most (95%) referred to the leaflets as helpful. Seventy nine percent (37/47) of health professionals returned a questionnaire on the laminated cards. This was generally felt to be helpful in improving the giving of evidenced-based information. Breastfeeding between discharge and 6-8 weeks was better sustained in women attending
the six health centres involved in the study than for the women attending the hospital. The former showed a 15 percentage point decrease in breastfeeding compared to a 23 percentage point reduction in the latter. For mothers who returned the questionnaires the decrease was 13 percentage points.

Comments

The authors suggest that the leaflets and more consistent information provided contributed to this reduction in cessation of breastfeeding. The trend is encouraging. They recommend that given the early discharge from postnatal wards the leaflet should be issued at the first postnatal visit at home to introduce and discuss problems before they arise.

Target population/area

Members of local Asian communities accessing the maternity services of an NHS Trust.

Aim(s)

To assess Asian grandmothers’ health beliefs and cultural practices around infant feeding, knowledge of breastfeeding and their ability to support successful breastfeeding.

To design and implement an antenatal intervention for grandmothers to support their breastfeeding daughters-in-law in an area of poor breastfeeding continuation.

To assess the acceptability and feasibility of the initiative by means of structured interviews and monitor its effects on breastfeeding rates.

To make recommendations to inform practice and local policy.

Project design and procedure

South Asian mothers (Bangladeshi, Indian and Pakistani) accounted for a third of mothers giving birth within the designated maternity service. In 2000/1 78%, 57% and 45% respectively initiated breastfeeding. The powerful influence of grandparents in these cultural groups was recognised. Focus groups were held with 5 Pakistani and 5 Bangladeshi grandmothers (a senior link worker was involved in the recruitment). Two researchers and two link workers were present at each group. Four Indian mother-grandmother pairs were interviewed individually in their homes. Issues covered included sources of support for new mothers, cultural practices around the birth of a baby, optimum infant feeding practices, and information sources about health. A short antenatal home teaching session based on the analysis of the interviews was provided for women and their mothers in the home. Issues covered included sources of support for new mothers, cultural practices around the birth of a baby, optimum infant feeding practices, and information sources about health. A short antenatal home teaching session based on the analysis of the interviews was provided for women and their mothers in the home. The session was based around a leaflet translated into relevant languages that was specifically written for grandmothers. A demonstration of positioning and attachment was provided using a doll. Sixteen out of 45 of women approached (36%) agreed to receive the session.

Evaluation

Postnatal interviews at 8 weeks post birth in mothers’ homes.

Data collection of breastfeeding rates to make comparisons between the intervention group and a comparison group.

Results/Findings/Outcome

The focus group interviews highlighted specific cultural traditions around birth and breastfeeding and related support. This included long periods of rest and special symbolic foods. Grandmothers played a major role in supporting women. Beliefs about colostrum, health gains of breastfeeding, management of breastfeeding, giving of supplementary water and weaning were all highlighted. Fifteen women were interviewed with their mothers present when their babies were 8 weeks old. Data from a comparative group of Asians taken before the intervention (n=42) showed that 62% were breastfeeding at 8 weeks. In the intervention group 14 (87%) commenced breastfeeding and 12 women (75%) were still
breastfeeding at 8 weeks. These rates were higher than the rates for Asian families in the target area in the previous few months but similar to the rates for the particular families involved in the intervention. All 14 of the mothers who commenced breastfeeding gave colostrum. The postnatal interviews revealed that women and their grandmothers felt very positive about the antenatal session and found the leaflet to be very helpful. Attitudes and behaviour towards giving colostrum, exclusively breastfeeding and reducing dummy usage appeared to have changed positively.

**Comments**

The use of focus groups and interviews to explore the cultural beliefs of mothers and grandmothers is an example of identification of baseline cultural issues before moving on to develop a culturally sensitive intervention. The involvement of grandmothers through all stages of the study highlights the recognition that this significant group need to be involved for changes to take place. Link worker involvement at all stages of the process was important to the success of this study. Further initiatives are being developed (personal communication, Ingram 2003).

Target population/area
An area with high levels of social deprivation based on Department of Environment and Transport index of deprivation and Townsend deprivation score.

Aim(s)
To initiate and sustain breastfeeding practices amongst women under the age of 20 within the target area.

Project design and procedure
Thirty-nine pregnant women aged 20 and under, living within the designated postcode area were invited to receive a package of additional breastfeeding support. This area was served by a community clinic staffed by 6 community midwives. Twenty women declined the offer. Only 7 were recruited to receive the package. Firstly, an antenatal home visit was made to each to invite them to an antenatal workshop. However, the two subsequent community based work-shops were very poorly attended with only one attending each. Antenatal home visit work shops were offered instead part way through the project.

A second visit was conducted 24-48 hours following the birth either in hospital or home. Four out a possible 7 were visited at this point in time. Two were bottle feeding and one was not visited due to ‘days off’. Additional postnatal support was planned to be provided by the project midwife. However, this was not carried out due to low numbers participating.

Evaluation
Interviews with 5 women aged 18-20 between 2 weeks and 6 months post birth. Four women were selected from the study group and an additional mother who fed her baby with infant formula.

Results/Findings/Outcome
Qualitative data from the interviews highlighted a range of personal attitudes to breastfeeding and variable levels of support from significant others and health professionals. Support from the project midwives was felt to be helpful. Some form of peer support scheme appeared to be a favoured option.

Comments
This study illustrates some of the challenges involved in engaging young women from socially excluded communities into schemes/studies. It would appear that a less formal scheme based on peer support may be more appropriate to this group.

Sustainability
The project as described ended but an infant feeding co-ordinator and a teenage pregnancy midwife have been appointed (personal communication, Kallat 2003).

**Target population/area**

Midwives and women within two defined areas with high levels of social deprivation.

**Aim(s)**

To evaluate the effect of training on midwives’ ability to promote breastfeeding among low income women.

**Project design and procedure**

This quasi-experimental study involved the allocation of 20 midwives to an intervention group to receive the UNICEF UK training and 35 to a comparative group who did not receive the training. The intervention midwives worked in one geographically defined area and the control midwives in another. The training provided to the intervention group consisted of the 3 day UNICEF UK Baby Friendly Initiative course in Breastfeeding Management. This was facilitated by two tutors from the UNICEF team. A total of 220 women were entered into the study, 123 from the intervention site and 97 from the comparative site. Midwives identified and recruited eligible women at the antenatal clinics. Women who consented were to either complete a questionnaire or be randomly allocated for in-depth interview.

**Evaluation**

A pre-test and post-test evaluation tool was developed and piloted. Midwives in both arms of the study completed a pre-test and post intervention test which explored knowledge and attitudes at 2 weeks and 4 months. The questions were based on the UNICEF UK Baby Friendly Initiative ‘Ten Steps to Successful Breastfeeding’. Descriptive statistics were used to show the characteristics of the sample and the frequency of breastfeeding across the two groups before and after the intervention. Within and between groups tests of significance were carried out to test differences before and after the breastfeeding training.

Three questionnaires were developed and piloted to collect data on the women’s infant feeding experiences and perceptions of support received at 10 days, 6-8 weeks and 4 months following the birth.

One-to-one interviews were conducted with a small sample of women from each arm (approx n=14). Thematic analysis was applied to the qualitative data.

Data on exclusive breastfeeding rates before and after the intervention were collated using existing data base and health visitor information.

**Results/Findings/Outcome**

By Nov 2002: 19/20 midwives in the intervention group responded to the first questionnaire and 15 to the second. By the same date 23/37 in the comparative group responded to the first questionnaire and 18 to the second. The pre and 2 week post intervention midwife questionnaire data had been analysed. This showed that there were no statistically significant differences between groups in the pre to post intervention results. Ten day, 6 week and 4 month questionnaire data from the mother are incomplete.
Qualitative data are not yet available. Audit data were collated of the breastfeeding statistics at discharge from the two NHS Trusts for the 3 pre-intervention months prior to and 3 post intervention months. Overall the intervention group showed a rise in the breastfeeding rate on discharge from hospital of 4.36 percentage points, 2.02 percentage points greater than the comparative group. Both groups would meet the government target of a 2 percentage point increase.

Comments

It may be noted that there were some differences between the two sites adopted for this quasi-experimental study in terms of staffing profiles and related problems. Some quantitative and qualitative data are still being analysed. This will provide a more complete picture. However, the combination of the assessment of knowledge, attitudes and breastfeeding outcomes provides an important contribution to the ways of assessing the impact of breastfeeding education for staff.

Sustainability

As a direct result of the study, specifically the midwife survey, an accredited multidisciplinary breastfeeding course is being developed within the designated University to explore joint breastfeeding training for midwives, maternity care assistants and other health professionals (personal communication, Kendall 2003).
Target population/area

An area with high levels of social deprivation. Breastfeeding initiation and continuation rates are lower than the national average. The large relatively stable population has had an entrenched artificial feeding culture for three generations.

Aim(s)

To extend a successful young women’s breastfeeding peer support project by training volunteers in group work in educational settings.

To integrate the project into school curricula in a socially deprived area where bottle feeding has been the norm for three generations.

To provide boys and girls with the opportunity to explore breastfeeding issues which are not part of their culture, with skilled and confident local breastfeeding volunteers.

Project design and procedure

The project is an extension of an existing peer support project ‘Breastfriends’ (Curtis et al 2001) also supported by DH funding. The training was conducted by an NCT tutor and counsellor. It was highly experiential, similar to the existing ‘Breastfriends’ training but with more emphasis on working with groups rather than one-to-one. It consisted of six days of contact time to include 12 sessions each of 2 hours long, taking place over a 3 week period. Six existing ‘Breastfriends’ attended, two local midwife specialists in breastfeeding and the project co-ordinator when possible.

The experiential learning course focused on the participants’ ways of learning and the purposes of going into schools. The social, personal and informational model of considering breastfeeding, described in the DH funded project by Curtis et al (2001), was utilised. Issues related to boundaries of responsibilities and self-disclosure were discussed. Each participant was encouraged to keep a private learning journal to reinforce learning and to assist in discussions around who would feel ready to take on the training of others in the future.

Two state high schools were identified for the education programme in the target area. The sessions were led by two ‘Breastfriends’ with their babies and a midwife. A teacher was also present. In the first school three groups of pupils had three classes time-tabled as part of their Personal Social Health Education (PSHE). In the second school although mixed only girls received the teaching as part of their Child Care teaching programme. Two groups received the session. Out of nine primary schools approached only one gave permission for a teaching session. This session was linked with Citizenship education. The school sessions encourage the students to explore their attitudes to breastfeeding through a range of innovative, interactive and visual ways of teaching to include role play. The sessions raised and personalised the topic of breastfeeding that would not otherwise have been discussed in a bottle feeding community.

Other settings in which the ‘Breastfriends’ taught included a local college in which two groups of Nursery nurses were taught. A session was provided at a local young people’s drop-in and also at a local young parent’s project.

Evaluation

Evaluation sheets were given to pupils.
Results/Findings/Outcome

Pupils evaluated the sessions positively. They particularly valued the opportunity to discuss breastfeeding and the interaction with mothers and babies. They highlighted their acquisition of new knowledge on breastfeeding. The volunteers grew in confidence and skill. The teachers and midwives present with them described them as flexible, confident and responsive.

Comments

Considerable negotiation was required through a number of ‘gatekeepers’ in order to get access to schools. This was very time consuming. The breastfeeding teaching was fitted into existing educational programmes all with different agendas ranging from citizenship, childcare and PSHE. This required considerable flexibility from the team. The primary schools were particularly reluctant to permit breastfeeding education as they saw it as an issue to be screened as with sex education sessions. It became clear to the team that breastfeeding had “no place, in its own right, in the national curriculum” (p.17).

Sustainability

The project team highlight difficulties with funding for initiatives like this. They note that many agencies want to utilise them but they may not feel that it is part of their remit to contribute funding to their training. Mainstream services do not necessarily see it as part of their role to fund projects which bridge health and education. “There seem to be no mechanisms for achieving the rhetoric of partnership even in such an obvious area of need” (p.19). It is hoped that Sure Start funding may become available (personal communication, Kirkham 2003).
Lincoln J, Jones L (2002), BABES Babies and Breastfeeding Encouragement and Support, Year 2.

Target population/area

Low income mothers.

Aim(s)

To establish a breastfeeding support group.

To create a good environment for breastfeeding whilst shopping which would appeal to low income women.

Project design and procedure

A breastfeeding support clinic was established called ‘Babies and Breastfeeding Encouragement and Support’ (BABES). The clinic, situated in the market place aimed to provide a place for breastfeeding mothers to drop into and breastfeed whilst shopping. Free fresh fruit and vegetables were provided. The clinic was run by a project worker, peer supporters and health professionals. The La Leche League peer counsellor programme was utilised for the training.

Evaluation

Eight focus groups were conducted with women who had breastfed by an experienced qualitative researcher (non-health professional). Four of the groups were held with women who had attended BABES and 4 with women who had not. Women were invited to participate and offered a £10 incentive to do so.

Results/Findings/Outcome

Thirty five women participated in the focus groups with approximately 20% estimated to be on low income and/or claiming income support. Most of the women in the focus groups had had care from the same midwife. This is thought to be a key reason to explain the lack of discernable differences between women who had attended BABES and those who had not. The research highlighted a range of reasons for, attitudes about and constraints upon breastfeeding. In relation to BABES women were positive about the friendly atmosphere and opportunity to meet like-minded women. It enabled them to get out into town with their babies and thus reduced their sense of isolation. They welcomed the opportunity to receive fruit and vegetables and felt that this gesture motivated them to eat healthily while breastfeeding. Some women would have liked to have been invited to BABES while pregnant. A number of women felt that bottle feeding mothers should not be excluded although others disagreed. Increased publicity for the group was suggested. Some women felt that once a week was too infrequent and that ideally it should be open all the time. The term clinic was disliked and ‘coffee shop for feeding mothers’ preferred.
Comments

As a result of the focus groups the times of the clinic were changed from 10.00-12.00 to 11.00-13.00. The term ‘clinic’ was no longer used. The group opened to pregnant women as well as breastfeeding mothers. Evaluation of the impact of BABES on breastfeeding initiation and continuation rates was not possible due to lack of a mechanism for auditing local figures. The innovative practice of providing free fruit and vegetables to either eat while at the group or to take home was innovative and warrants further attention as an incentive to attendance, dietary awareness and improving eating behaviours.

Sustainability

The breastfeeding support clinic continues with PCT funding for room hire and fruit and vegetables.

**Target population/area**

An area with high levels of social deprivation and a 25% ethnic minority population.

**Aim(s)**

To establish a breastfeeding peer support programme.

**Project design and procedure**

Training was provided for 5 peer supporters called ‘Mum2Mum’ breastfeeding supporters. The course consisted of 10 sessions conducted over 10 weeks. One supporter spoke Urdu and worked as an interpreter. The course was taught jointly by an NCT counsellor and health visitors. A ‘Mum2Mum’ support group was established for mothers.

**Evaluation**

An audit of local breastfeeding rates was conducted.

In-depth interviews were carried out with six women who attended the ‘Mum2Mum’ group.

**Results/Findings/Outcome**

Breastfeeding initiation rates were 40% in 1998, 44% in 1999 and 44% in 2000. The percentage of mothers still breastfeeding at 3 months was 18%, 24%, and 48% respectively (sample sizes not provided). Health belief theory guided the analysis that identified five interrelated themes, support, experience, information, barriers and benefits. Effective support and information giving assisted in overcoming barriers to include negative personal and vicarious experiences. The perceived benefits of breastfeeding influenced behaviour in an interactive way with experiences. The Mum2Mum support programme appeared to have assisted women in maintaining positive health beliefs and behaviours in relation to breastfeeding.

**Comments**

It is not possible through this type of evaluation to demonstrate that any increase in breastfeeding is causally related to the activities of the support project. However, the figures are suggestive of a positive effect of this package of support. The qualitative study associated with this project assists in understanding the nature of and value of support schemes for breastfeeding women, utilising psychological theory. When combined with sociological theory this assists in building a case for mother-to-mother support schemes.

**Sustainability**

The project continues to run with funding through Health Action Zone (HAZ). This has enabled the project co-ordinator to continue as a trainer. A part-time health visitor with expertise in breastfeeding has been appointed as a trainer and co-ordinator. This has enabled the project leader to continue in a coordination role. In response to the government target to increase initiation rates by 2 percentage points per annum further funding is being sought from the PCT (personal communication, Locke 2003).

**Target population/area**

Secondary school children.

**Aim(s)**

To approach inequalities in breastfeeding through a programme of secondary school education incorporating schools in areas with high levels of social deprivation.

**Project design and procedure**

An action research approach was adopted. This methodology enables flexibility and adaptability in responding to research participants’ feedback/evaluation as the project progresses. The first stage involved the conduct of 3 focus groups one with girls aged 13-15 years, one with boys aged 13-15 years and one with young mothers (total in 3 groups:16). These highlighted underlying attitudes towards breastfeeding to assist with the development of the pack. Early in the process the team identified where in the curriculum the session could best be placed. Following discussion with teachers and other educationalists it was felt that it best fitted with Personal, Social and Health Education (PSHE).

There was a general reluctance among teachers to discuss breastfeeding. When teachers were approached regarding breastfeeding education they appeared to associate it with teenage pregnancy. The education was packaged under the issue of ‘primary health/nutrition’ so as to avoid it being classed as sex education with all the parental consent issues. The team developed working relationships with the local PSHE advisory team and with PSHE teachers in two local secondary schools.

An educational pack was developed to assist teachers to stimulate cultural change through teaching about breast and breastfeeding. Children aged 13-15 years were targeted. The educational approach centred on opinions, attitudes and cultural beliefs around breastfeeding not on technicalities. The 55 minute session was delivered to five groups of children and then evaluated.

**Evaluation**

Written feedback was obtained from 101 students (male and female).

**Results/Findings/Outcome**

Results of post-session student evaluation showed that 88% of students thought the subject was ‘interesting’, 97% of students felt that they had learnt something, 94% stated that they were comfortable with breasts and breastfeeding as a subject in a mixed sex class and 94% of girls considered the session relevant to them compared to 42% of boys. The majority of students knew that breastfeeding had health benefits. Many students who were unsure about whether they would choose to breastfeed said they would now consider it.

The students suggested more visual material, more structure to the session and interesting ways of presenting material. As a result a video was produced which was developed through interviews with people of the local streets about attitudes to breastfeeding along with clips of a mother breastfeeding. The team also introduced a range of photographs of women breastfeeding to stimulate discussion.
An interactive quiz was developed. A clearer lesson plan addressed the issue of structure. Acknowledging difficulties with access and joined up working the pack was developed so that teachers themselves could deliver the session.

Comments
The authors state:

“Active co-ordination and promotion is needed between the Department of Health and the Department for Education and Skills at the level of central government to ensure education about breastfeeding takes place in secondary schools” (p.1).

“Without a strong central lead, it is unlikely that schools will individually seek out material of this nature. This is because teaching about the benefits of breastfeeding has to compete with other topics within an already over-stretched curriculum. Further more infant nutrition is not always seen as an important subject despite the implication for increasing/reducing health inequalities…. The cultural barriers towards discussing breastfeeding, which we have identified during the research process remain an issue for many teachers and health professionals. This needs addressing, since our research has shown that it is possible to work with young people in this way and that they are appreciative of it” (p.11).

Sustainability
Three hundred packs have been printed in total. The pack is supplied free of charge to people working locally. It has been taken up by teachers, health visitors, lay people, voluntary sector organisations, infant feeding specialists and midwives. The pack is for sale to others. The pack is described as “eye-catching, funky and young person friendly.” The logo has been a key to success (personal communication, Lockey 2003).

Publications

**Target population/area**

An area with high levels of social deprivation recently designated to become a Sure Start area.

**Aim(s)**

To improve the level of women on low incomes in the target area who consider breastfeeding, start breastfeeding and increase the length of time that they sustain feeding their babies.

**Project design and procedure**

A database was set up for the Sure Start area to monitor health-related behaviours including infant feeding practices. A programme of education was provided for health professionals. An antenatal visit was made to women when approximately 26 weeks pregnant by community midwives. A ‘breastfeeding friendly premises’ competition was held. The primary health care team were made aware of the 24 hour breastfeeding support available through a local hospital. A community support group was set up but was unsuccessful as women were already attending ‘cradle clubs’ and a successful breastfeeding support group in a neighbouring area. Due to a range of difficulties in providing trainers a peer support programme was not launched. One theatre workshop was organised but poorly attended. A subsequent workshop was cancelled due to a number of constraints. Finally a competition on breastfeeding was designed for local primary schools.

**Evaluation**

The database will enable ongoing collection of statistics for this area.

**Results/Findings/Outcome**

A number of constraints made implementation of the various aspects of the project difficult. However, it enabled the team to establish collaborative links and plans for the future which will enable the incoming Sure Start programme to launch more effectively into some of the aspects of the project.

**Comments**

This project provided a package of awareness raising initiatives. The author notes that while all aspects of the project were not achieved the building of strong collaborative relationships will prepare the way for new initiatives.

**Sustainability**

PCT and Sure Start funding are enabling further developments (personal communication, Mason 2003).
Target population/area

An area with high levels of social deprivation. Breastfeeding initiation and continuation rates are lower than the national average.

Aim(s)

To increase breastfeeding rates.

To encourage breastfeeding for 4-6 months or longer.

To facilitate a mother-to-mother support system.

To protect and support breastfeeding mothers.

To educate the general public in breastfeeding issues.

Project design and procedure

The original project aimed to set up a peer support group but due to difficulties in recruiting volunteers the nature of the project changed. This was attributed to the lack of a sense of community in the area and people feeling very private and reluctant to have their names publicised. Instead all mothers booking at the satellite booking clinic in the target area were seen by the infant feeding co-ordinator or one of the two project co-ordinators. They were offered a one-to-one teaching session in their own home or in the clinic. There was a strong preference for home visits from women. The antenatal session adopted a workshop style approach utilising a video and a doll to demonstrate positioning and attachment. This was supplemented by a postnatal contact made by the project midwife. Postnatal home support was provided in addition to normal midwifery care if required.

Evaluation

Breastfeeding statistics.

User satisfaction survey.

Findings/Results/Outcomes

Exclusive breastfeeding rates in the defined area increased from 5.9% (8/136) pre-intervention, to 9.6% (10/104) towards the close of the project. Nine months later these rose to 14.3% (8/56). Mixed feeding reduced from 10.4% (14/136) to 9.6% (10/104) to 3.6% (2/56) respectively. Pre-intervention, 20% of women intended to breastfeed and 6% of all mothers in the sample achieved this aim. Post intervention 29% of women intended to breastfeed and all 29% achieved their aim. Ninety one percent of women felt that they had had ‘excellent’ support from the midwife.

Comments

The figures suggest a trend towards the increase in exclusive breastfeeding, reduction in partial breastfeeding and an increase in women achieving their goals. The reasons why women did not feel that they wanted to become peer supporters could be further explored.
Sustainability

The scheme as described was not funded after the project year. Plans are being developed to start a peer support programme within the Sure Start area (Personal communication, McFadden 2003).

**Target population/area**

Mothers from socially deprived areas accessing maternity services of an NHS Trust.

**Aim(s)**

To introduce an approach to supporting breastfeeding mothers based on a ‘biological nurturing strategy’.

**Project design and procedure**

‘Biological nurturing’ is based on a strategy used in research examining breastfeeding and metabolic adaptations. See Colson et al (2003) listed below for further details. Twelve experienced midwives working in geographical areas with high levels of social deprivation were seconded to attend a series of 2 day educational retreats. The focus of the workshops was on the biological and interactive aspects of maternal-infant attachment, the transition from fetal to neonatal metabolism and the metabolic characteristics of the suckling period.

Following this the team were able to facilitate breastfeeding using a biological nurturing strategy, develop skills to assess maternal/infant well-being and provide skilled counselling for mothers. They were equipped to develop hospital policies and clinical materials with exclusive breastfeeding defined as the norm, act as mentors for other staff within their areas of practice and lead a rolling programme for other staff.

**Evaluation**

Monthly data were collated on breastfeeding rates at birth, hospital discharge and community discharge. Inconsistencies in the data collection led to a review of data collection procedures.

**Results/Findings/Outcome**

The data are being evaluated.

**Sustainability**

The project is continuing and has been extended to the whole NHS Trust. Free ‘Biological Nurturing’ booklets are provided to mothers. In service training for staff in metabolic adaptation is ongoing. Posters and a video have been produced to promote the concept of biological nurturing to mothers. An NCT breastfeeding counsellor is employed part time to support the project.

**Publications:**

Middlemiss A (2002) Blyth Breastfeeding and Young People Initiative, Year 3 Practice project.

Target population/area

Teenagers aged 13-16 years in an area with high levels of social deprivation and breastfeeding rates below the national average.

Aim(s)

To produce a teaching package and video to be used for educating in schools, local authority establishments, with looked-after children and to educate foster carers about the benefits of breastfeeding.

To counter cultural norms within the area and to promote breastfeeding as a normal and accepted realistic feeding option.

Project design and procedure

The project leader was a qualified youth worker in addition to being a health visitor. Teaching sessions were developed and delivered at a local college and also to year 9 students at a school. Twelve sessions were delivered to 6 groups, aged 13-14 years. They consisted of two 45 minute lessons one week apart. Breastfeeding materials were displayed at the college during breastfeeding week. The video was produced with the collaboration of young actors from a local college, a breastfeeding co-ordinator and a group of breastfeeding mothers. It also involved peer educators. Peer educators are a group of students who have attended an education programme about various issues that teenagers may want to know about. This then allows them to be a support for other students who may want to talk to someone of their own age rather than a teacher/adult. The teaching package was developed, piloted, evaluated and changed to meet the needs of young people. Breastfeeding was not delivered in the ‘looked after’ system or to foster parents, as this was declined.

Evaluation

A questionnaire was developed to assess the knowledge levels of the young people. This was issued prior to the breastfeeding sessions and 3 months following the sessions to evaluate their effectiveness.

Results/Findings/Outcome

The evaluation report is in progress but is showing a positive attitude change towards breastfeeding among the students.

Sustainability

Sure Start funding enabled the pack ‘Breastfeeding for a New Generation’ to be printed and marketed. The project co-ordinator continues in her role as health visitor to provide school education on breastfeeding (personal communication, Middlemiss 2003).

**Target population/area**

Three wards with high levels of social deprivation, child poverty and lone parents.

**Aim(s)**

To establish a breastfeeding drop-in/support group.

To utilise the group to raise local awareness of breastfeeding.

**Project design and procedure**

A lactation consultant and group facilitator, a health visitor, were appointed to set up the ‘Baby Café’. The name reflected the project leaders’ endeavours to provide the centre with a positive brand image to assist in attracting mothers. The ‘Baby Café’ was opened in a health centre in a socially deprived area. The atmosphere is described as informal and like an ‘Italian Kitchen.’ Quality refreshments were made available. The centre was officially opened and considerable publicity was generated through local media, posters and invitations. Pregnant women and mothers were invited from the defined area. The centre opened from 11am-1pm following on from a baby clinic. The facilitator and lactation consultant were always present but in the ‘background’ with the emphasis being on mother-to-mother support. However, when women presented with a problem specific support was given, e.g. assistance with positioning and attachment for sore nipples. This was provided one-to-one in a private room if desired.

**Evaluation**

Data was collected on attendance rates and demographic details.

A questionnaire (interim and final) was utilised to elicit women’s reasons for attending, views of the café and related personal feelings.

A focus group was conducted with 6 mothers.

A questionnaire (interim and final) was sent to health professionals.

**Results/Findings/Outcome**

Baseline audit data for the defined area were difficult to collate due to problems with the audit methodology. Over 36 weeks 106 mothers attended with average number of visits per mother being 7. Total face-to-face contacts were 323, 28% coming from the target area and the remainder from other local areas. The focus groups elicited data on the reasons women decided to breastfeed, issues around their partners’ attitudes and on men’s needs for information, lack of local facilities to enable discreet breastfeeding and concerns about returning to work and weaning off the breast. The interim project questionnaire to mothers produced an 85% response rate (34/40). The data highlighted the ways in which women found out about the centre: 47% through health professionals; 15% through a friend/relative and 35% through local publicity. The data also showed that 44% attended because of a problem, 56% for social reasons. Only 9% of women did not breastfeed for as long as intended.
The final project questionnaire to mothers produced a 71% response rate (60/86). The data highlighted the ways in which women found out about the centre: 5% through a friend/relative; 27% through local publicity; 7% through lay groups and the remainder through the health professionals. Of those who attended 66% went because of a problem and 34% for social reasons with 62% stating that their problem was resolved. Only 15% of women did not breastfeed for as long as intended. Women particularly welcomed health professional help, meeting other breastfeeding mothers and the atmosphere. Commonest reasons for attending were sore nipples, low milk supply, unsettled baby and low weight gain. A later audit summary collated in 2002 showed that 32% of women breastfed beyond their original intention and 59% of those no longer breastfeeding had breastfed for as long or longer than originally intended. The authors argue that the lower rates of early cessation are indicative of an impact on duration of breastfeeding.

An interim project questionnaire to health professionals produced a 70% response rate (28/40). The data revealed that 46% had referred mothers to the ‘Baby Café’. The questionnaire to which 64% responded (9/14) revealed that 100% of respondents had referred mothers to the ‘Baby Café’.

Comments

The success of this project appears to relate to a combination of factors: the choice of venue; the creation of a particular atmosphere; ethos and brand image; effective publicity and marketing of the service; involvement of local health professionals at all stages of the process; holding the drop-in following a baby clinic in a regular weekly ‘slot’. Both pregnant women and mothers were invited and both were made aware through the local maternity unit. There was a combination of informal mother-to-mother contact with the availability of professional support if required. The health professionals adopted a ‘background’ facilitative role.

Sustainability

Phase two of the project commenced at the end of the funded year. This involved inviting every mother in the three geographical wards to make an antenatal visit to the ‘Baby Café’ as part of a parentcraft programme run by community midwives. The Health professional provides an informal teaching session for antenatal women. An invitation to the ‘Baby Café’ is given to mothers on the postnatal ward at the local maternity unit. Bottle feeding mothers are not excluded from the Café but it is predominantly a breastfeeding environment. The local PCT has continued to fund the ‘Baby Café’. This has enabled the opening hours to increase. Attendances are now approximately 25 per week with a good proportion coming from the low income target area. A protocol for setting up the ‘Baby Café’ may be purchased from Williams (personal communication, Williams 2003).

Publications:

Price M, (2002) An action research project to facilitate skin-to-skin contact at birth and breastfeeding, Year 3, Academic project.

**Target population/area**

A maternity unit with an annual birth rate of less than 2000.

**Aim**

To improve knowledge of the importance of skin-to-skin contact between mother and baby at birth and of breastfeeding in general by increasing midwives knowledge, improving women's choices and facilitating the implementation of best practice.

**Project design and procedure**

The action research project involved working in collaboration with mothers and midwives to facilitate the implementation of evidence-based practice. Spirals of planning, implementing and evaluating the progress of the changes relevant to that particular unit were facilitated. Regular focus groups were held opportunistically. Data collection and analysis was ongoing, and the results fed back into the action research spirals. The project was facilitated by the researcher during the year.

**Evaluation**

Interviews were conducted with midwives.

Interviews were conducted with mothers.

Qualitative information was obtained from researcher reflection.

An audit of skin-to-skin contact was conducted.

**Results/Findings/Outcomes**

There were seen to be three main spirals in this action research process: facilitation and empowerment to change; added value from sharing of experiences and strategies to aid remembering the change, before it was incorporated into ‘normal’ practice.

Facilitation and empowerment was made possible through the researcher working on average, at least one day per week in the clinical areas as part of the team, role modelling, teaching, encouraging or communicating. Ongoing teaching sessions were held in a flexible opportunistic way, with an emphasis on visual and practical skills. This was potentially empowering for midwives to enable them to offer and facilitate skin-to-skin contact between mother and baby at birth. Information leaflets were devised to be given to women antenatally. Early in the project, evaluations were carried out to try to solve emerging problems. This was an important part of the change in practice, as a perceived threat could block progress. A potential problem identified was of being unable to cope with the new practice on a very busy day. Strategies were discussed for dealing with this if it arose.

To provide added value the information leaflets for women potentially gave them some knowledge about breastfeeding at the booking visit and about skin-to-skin contact at about 34 weeks gestation. This gave them the opportunity to think about the practicalities and value of breastfeeding and skin-to-skin contact at birth, and may have empowered them to ask about it and to expect that help would be
offered. A purposive sample of 8 women and 8 midwives who had experienced or facilitated skin-to-skin contact were interviewed, as well as opportunistic interviews on the wards. Analysis of the interviews gave powerful data to add value to the experience of skin-to-skin contact when giving feedback to other women and the midwives. It also gave practical knowledge of ‘how to do it’, to help those who had not yet tried. Being able to share this information helped both the teaching sessions and added depth to the discussions in the clinical areas. One level of knowledge is to see a video and talk about the benefits of skin-to-skin contact. A deeper level is to observe a baby becoming better oxygenated and contented, but to witness the innate ability of the newborn to move towards and attach itself to the breast is on a higher level altogether. The value of these observations seemed especially important when discussions took place informally between midwives during the working day.

Finally, remembering was facilitated recognising that new practice may be hard to incorporate into a busy day’s work. The profile was raised by discussions and wall posters. A focus group identified a problem of remembering to discuss skin-to-skin contact. An ink stamp stating ‘skin-to-skin discussed’ enabled recording of this issue in the notes. Computer questions were added to the details recorded after the birth, to allow audit. During a discussion about skin contact it was felt that the information giving before the birth could be improved. This was emphasised by an interview of a women who was said to have had skin contact, but described a disrupted experience. A comment was made about the difficulty in remembering everything about the benefits of skin-to-skin contact, so a bullet point list was produced to put in each birth room, detailing these benefits, along with eight pictures showing progress of the baby, from birth to breastfeeding. Together, these facilitated the giving of quality information about the value of skin-to-skin contact rather than just ‘do you want it?’. A complete set of information sheets and pictures of skin-to-skin contact were also put in folders for use in the antenatal ward, antenatal day unit and clinic.

Some women did not want close contact with their babies, even when given the evidence of its benefits, and this was respected. At the start of the project, almost none of the women were offered prolonged skin-to-skin contact with their babies. Figures for Jan –March 2003, following the end of the project show that the majority of women (85%) chose to experience skin-to-skin contact. Most of those who declined it were associated with operative procedures for the mother or illness of the baby.

The author recommends that when trying to implement new practices, the aim is for everyone to be involved in the change process. The facilitator should be persistent in communication even at times when there seems to be little enthusiasm for the project. Knowledge of the intervention and practical help in performing it, should be given before expecting any change in practice. There should be visible reminders of the desired practice to make working life easier, and patience is required, when change does not happen quickly.

Comments

There is much literature about the theory practice gap, where knowledge is available about best practice, but never implemented. Action research is a way of facilitating practitioners to bridge that gap and implement practice in a way that is relevant for them and works in their particular culture. Changes tend to come from collaboration rather than imposition of values from outside the group.

Sustainability

The project work will continue to develop by the appointment of a G grade midwife with special responsibilities for breastfeeding. This is a full time post for 2 years and money was applied for and obtained during the year of the project, with an almost seamless transition from the end of the project to the start of the new post (personal communication, Price 2003).

**Target population/area**

A Sure Start area servicing women on low incomes and with breastfeeding initiation and continuation rates below the national average.

**Aim(s)**

To increase the number of women in the area intending to breastfeed and breastfeeding successfully.

To provide educational material about breastfeeding.

To improve the social acceptability of breastfeeding within the community.

To provide an informal network of breastfeeding support for local women both before and after their babies are born.

To improve access to skilled support and advice for breastfeeding problems.

**Project design and procedure**

Six local women were identified by health visitors and trained to become peer supporters. The training programme developed by the author was run by three breastfeeding counsellors, two from La Leche League and one from the Association of Breastfeeding Mothers. The breastfeeding support group was set up on Sure Start premises. This ran weekly from 10.30-12.30 for pregnant women and mothers who were breastfeeding. A crèche was provided, a hot lunch served and a resource service was also made available. The number of women attending rose to 10-15 by mid-project. The group was facilitated by peer supporters with health professionals being available if required. Women were informed about the group largely through health professionals. Forty eight women accessed the peer support service and/or support group via health professional referral.

**Evaluation**

Questionnaire to peer supporters utilising visual analogue scales.

Three focus groups were held with the supporters. One just before training, one just after and one six months later.

Postal questionnaire to mothers who had attended the support group.

Short questionnaire handed to mothers by the health visitors at the 6-8 week home visit.

Interview with the breastfeeding counsellors (trainers).

Audit of breastfeeding initiation and continuation.

**Results/Findings/Outcome**

All of the 6 peer supporter questionnaires were completed. Their knowledge and confidence in both breastfeeding and listening to and supporting others increased.
Six women attended the focus group. The data highlighted the peer supporters’ progressive gain in confidence, self esteem and desire to support others with breastfeeding. They recognised the importance of a supportive environment and strong social networks for breastfeeding mothers. They emphasised the importance of women seeing others breastfeed and therefore the feeling of being ‘normal’. It was felt that the groups should be woman-led with health professionals being present to provide backup when required.

A total of 22/35 (67%) postal questionnaires were returned with 21/22 (95%) of women still breastfeeding at 6 weeks. Twenty of these women were still breastfeeding at 3 months and 8 women at 6 months. Women appreciated seeing and being able to talk about breastfeeding, receiving consistent advice, having somewhere to go to feed their babies, having access to a peer supporter, making new friends and having lunch. They reported an increase in their confidence in breastfeeding.

Fifty percent (60/120) of the short questionnaires issued by health visitors were completed. The overall breastfeeding rate in the Sure Start area was 47% compared to 55% for the questionnaire respondents. At 6 weeks, 37% of the mothers surveyed through the questionnaire were breastfeeding. Sources of support included partner, family, friends, health professionals and the support group.

Two breastfeeding counsellors (trainers) were interviewed. They were positive about the scheme but intended to utilise more role play and listening skills training for the next cohort. They felt that the role of the peer supporters needed to be defined more clearly from the beginning and that they should be more proactive in accessing and contacting mothers in a range of ways.

The audit of breastfeeding initiation and continuation before and 6 months after the setting up and running of the support group showed an increase of 6 percentage points for initiation, (45-51%), 8 percentage points at discharge (40-48%) and 8 percentage points at 6 weeks (19-27%).

**Comments**

There is a trend towards higher breastfeeding rates. However, other interventions, e.g. a training programme for health professionals, may have influenced the breastfeeding rates.

**Sustainability**

The support scheme has continued and is Sure Start funded. At least 15 women attend per week. Monthly antenatal breastfeeding workshops are held (personal communication, Rosser 2003).

**Target population/area**

Low income area with breastfeeding initiation and continuation rates being lower than the national average.

**Aim(s)**

To assess the value of teaching effective positioning and attachment during the antenatal period upon ability to position and attach the baby following the birth, duration of breastfeeding and satisfaction with the breastfeeding experience.

**Project design and procedure**

An experimental design was adopted with women being allocated to an intervention or control group. The intervention consisted of the provision of a one hour antenatal workshop in addition to existing antenatal education. This was conducted at 35-37 weeks of pregnancy. The workshop included teaching positioning and attachment using a doll. The women practised taught skills with a doll. They were shown an RCM video, *Helping a woman to breastfeed: No finer Investment*, and photographs illustrating effective positioning and attachment.

Women intending to breastfeed were approached by the community midwives. Of 234 approached, 107 (46%) agreed to participate. Forty-four women were allocated to the control group and 63 to the experimental group. Sixty initiated breastfeeding and 59 were followed up.

**Results/Findings/Outcomes**

Six weeks following the birth 45/59 (77%) in the experimental group and 23/44 (52%) in the control group (all mothers) were breastfeeding. Seventy one percent in the experimental group and 45% in the control group (first time breastfeeders) were breastfeeding.

**Comments**

One of the difficulties experienced related to the short time frame for conducting the study which did not allow sufficient time to inform all concerned regarding the project. Difficulties with random allocation to groups occurred as women declined to take part and therefore two thirds of women were invited to join the experimental group rather than half. The assessor was not blinded and the authors reported that advice was provided to women in the control group during the postnatal period if required. It was felt to be unethical to fail to provide this additional support if it was clearly needed. Information on those who declined to participate before and after allocation is not provided. This makes the subset of the target population difficult to define. Conclusions that may be drawn are therefore limited. However, the figures suggest an upward trend in the breastfeeding continuation rates.

**Sustainability:**

Recent PCT funding has been obtained for the 2 hour workshop (personal communication, Shanahan, 2003).

**Target population/area**

An area with high levels of social deprivation. High numbers of teenage pregnancy and women who parent singly. Breastfeeding initiation and continuation rates are lower than the national average.

**Aim(s)**

To evaluate a recently established breastfeeding drop-in centre.

**Project design and procedure**

The ‘drop-in’ was staffed by health professionals. The staff provided a welcoming atmosphere and elicited information from the women about their experiences and difficulties. They generally discussed issues raised by women, observed a full breastfeed and offered advice on positioning and attachment where appropriate and other breastfeeding matters.

**Evaluation**

A questionnaire was sent to all women who had attended.

The questionnaires elicited demographic data, reasons for attending the centre, accessibility, helpfulness of advice, improvement of the problem following advice, and frequency of visits.

**Results/Findings/Outcome**

Eighty-seven out of the 111 (78%) responded to the questionnaire, of these: 93% of women perceived that the advice was ‘helpful’ or ‘very helpful’; 77% reported that the problem improved following advice given at the group; 36% of women visited once; 33% twice and 20% 4-6 times. Sixty-nine percent of attendees stated that their breastfeeding problems had been resolved at which point they decided to stop attending. The commonest reasons for attending were to meet other breastfeeding women, sore/cracked nipples, frequent or lengthy feeds and colicky/unsettled baby.

**Comments**

The study was retrospective, with women needing to recall breastfeeding experiences that had occurred up to a year earlier. Recall of information may therefore have not been completely accurate. The service appears to have assisted women to gain helpful advice and resolve their problems. The high numbers visiting the clinic more than once suggests that the clinic was accessible and the staff approachable. It is not possible to separate out the impact of general support from the specific advice given.

**Sustainability**

The ‘drop-in’ continues to run through NHS funding. The service is available twice per week in the afternoons with 6-9 women attending per session. No formal appointments are required (personal communication, Refearn, 2003).
Shaw R, Wallace L (2002) Young Mothers Infant Feeding Study, Year 3 
Academic project.

Target population/area
Mothers of Asian and White origin, aged under 21 years from areas with high levels of socio-economic deprivation.

Aim(s)
To elicit health professionals’ perceptions of young Asian and White mothers from areas with high levels of socio-economic deprivation.

To elicit the nature of young Asian, Black and White mothers’ experiences of infant feeding

To explore what influences young mothers in their infant feeding decision-making process

Project design and procedure
This was an exploratory study centering upon young mothers’ experiences of infant feeding. Four focus groups were conducted with 15 health professionals to establish the type of encounters they had with young women. These aided the establishment of time points at which to interview the young mothers. Eleven young women were interviewed. The purposive sample consisted of 1 ‘Bangladeshi’, 1 ‘Black Other’, 1 Black ‘Caribbean/White’, 3 ‘Pakistani’ and 5 ‘White’ women. Ages ranged from 16-21 years. Twenty five interviews were conducted in total. Most young women were interviewed antenatally unless recruited after the birth. A second interview was conducted postnatally at a point between birth and 24 weeks. Interviews were semi-structured and included the partners. In addition a demographic questionnaire was utilised in the antenatal interview and a questionnaire about the birth at the first postnatal interview. Interpretative phenomenology guided the analysis.

Results/Findings/Outcome
The focus groups with predominantly white health professionals highlighted that they perceived young mothers as an ‘outgroup’, being unlike themselves. Asian mothers were perceived as family orientated, more naturally able to adapt to motherhood and breastfeeding. Muslim women were perceived as only breastfeeding once the breast milk came in, preferring not to give colostrum. They saw the extended family as influential, particularly in placing pressure to supplement in order to increase weight gain. Health professionals illustrated gaps in their knowledge regarding cultural understandings of Asian mothers. Young white women were viewed as bottle feeders due to peer pressure and role modelling. Their major concern was perceived to be centred upon restoring their previous social life. They were felt to be easily put off by perceived or actual problems with breastfeeding.

The interviews with young mothers revealed that the differences highlighted by health professionals were less evident in the young women’s accounts. There was a gap between health professionals’ perceptions and those of the young women. Some of the white women breastfed and some of the Asian women artificially fed. The behaviours of the whole sample could not be separated by ethnic group. Most women expressed surprise at the work involved in motherhood and tended to seek their own mother’s views on baby care. The young mothers tended to perceive breast feeding as difficult and inconvenient compared to bottle feeding and this outweighed their obvious knowledge that breastfeeding was better for the baby. However, when they did bottle feed this too was found to be time consuming and inconvenient.
Comments

The authors acknowledge the small sample size for each cultural group and note that higher numbers and larger ethnic groups would provide a fuller picture of the infant feeding behaviours of young mothers in lower socio-economic groups. Secondly, the use of interpreters for two young women made the exploration of lived experience through language difficult. They recommend that research interviews should be conducted in the women’s own first language. However, the study provides a useful addition to the body of knowledge related to the gaps between health professionals’ perceptions of behaviours and actual behaviours. In this study infant feeding decisions and behaviours appeared to be more homogenous across ethnic groups than anticipated by health professionals. The authors highlight the requirement to educate health professionals more appropriately for understanding specific cultural beliefs and values. Clearly, simply informing young mothers that ‘breast is best’ ignores the complexities related to their feeding decision making. The authors recommend that research now needs to focus on ways in which the benefits of breastfeeding can be promoted to the multicultural communities living in areas with high levels of socio-economic deprivation. Involvement of the extended family is advocated for adolescent mothers as they tend to be very much influenced by their mothers.

Sustainability

The research has informed subsequent planning of local services. Further research is ongoing to address some of the issues identified in this project (personal communication, Wallace 2003).

Publications/presentations at peer reviewed conferences


Target population/area

An area with high levels of social deprivation. Breastfeeding initiation and continuation rates are lower than the national average.

Aim(s)

To provide a mother-to-mother support service in the low income target area.

To increase breastfeeding duration measured by prevalence at 2, 3 and 4 months.

To integrate and promote midwifery, health visiting and lay breastfeeding skills in a primary care setting.

To offer the service to 800 women per year in areas of acute deprivation.

Project design and procedure

An experimental design was selected to test the effectiveness of a mother-to-mother support scheme in increasing breastfeeding prevalence. Twenty GP practices participated with 10 allocated to receive the mother-to-mother support additional programme and 10 continuing with their normal service to mothers. A 0.5 wte Health Visitor was seconded to co-ordinate the project. Ten midwives and health visitors completed the La Leche League (LLL) peer counsellor trainers programme to enable them to become health professional trainers.

The health professional trainers visited all 20 practices to provide an evidence based practice breastfeeding session to promote consistency in advice giving. The intervention GP practices then recruited 1-3 breastfeeding support mothers per practice. Eighteen supporters were trained using the LLL peer counselling training programme. The supporters were appointed to offer support and information to breastfeeding mothers referring to the health professionals when appropriate. This was to include attending the weekly antenatal clinic at the GP surgery, attending antenatal classes, one-to-one home or GP surgery visits if requested and attending child health clinics, postnatal groups and parenting groups. Leaflets and posters were displayed about the role of the supporters. A monthly supervision and mentoring group run by the health professional trainers was set up. An allowance of £10 a week was to be made to the supporters.

Evaluation

Breastfeeding data to be collected at GP surgeries at the time of the primary immunisation related to prevalence at 2, 3 and 4 months. Data for the intervention group will be compared with that of the control group.

A qualitative evaluation of the mother-to-mother service.

Results/Findings/Outcome

A number of difficulties were experienced with data collection due to lack of robust systems.

Comments

The qualitative evaluation is in progress (personal communication, Sikorski 2003).
Target population/area
Health care assistants in three maternity services.

Aim(s)
To develop and provide a training programme for health care assistants that equips them to provide postpartum breastfeeding support.
To evaluate the project in terms of client satisfaction.
To evaluate the potential contribution of health care assistants to the maternity service support for breastfeeding mothers.

Project design and procedure
Six health care assistants two from each of three maternity services were involved. They were based on the postnatal wards. A competency based training programme was devised for breastfeeding assistants on the postnatal wards of local maternity units. This was delivered at the local University and consisted of 48 hours of programmed learning, 18 formal and 30 hours practice based supported by a designated mentor. Six mentors received 3 hours of formal training regarding the expectations of the role. A convenience sample of 60 breastfeeding women on postnatal wards was selected for the intervention by the midwife mentors.

Evaluation
Focus groups were conducted with breastfeeding assistants.
A focus group was conducted with Midwife mentors and stakeholder.
An evaluation of the training through a taped discussion with participants.
Questionnaires to mothers involved in the intervention at two points, prior to leaving the postnatal ward and later by postal questionnaire.

Results/Findings/Outcome
The majority of mothers 54/60 (90%) completed the first questionnaire when their babies were aged 1-13 days old. Of these 53 were still breastfeeding. All but one felt confident in putting the baby to the breast. Support was provided from midwives (50) and breastfeeding assistants (43). Mothers referred to the practical assistance and information provided by midwives and a supporting and encouraging approach from the breastfeeding assistants. Most mothers felt that the breastfeeding assistants were knowledgeable, skilful and available. Five mothers were less positive. Qualities identified by respondents as important for those who support breastfeeding were categorised as communication skills, personal attributes, knowledge and skills. The type of support required was largely determined by the difficulties mothers experienced during breastfeeding. Fifty percent of postal questionnaires (27/54) were returned at point two. These identified some of the ongoing challenges for breastfeeding women. All breastfeeding assistants and midwife mentors participated in the focus groups. The breastfeeding assistants enjoyed
their training programme and experienced high job satisfaction. There were some tensions with a minority of health staff linked with conflicting role expectations and minor organisational problems. The model of breastfeeding assistants working under the supervision of midwives appeared to be successful. Data was not collated on impact upon breastfeeding rates as there was an absence of available comparative data.

**Comments**

This rigorously evaluated model of care appears to meet the needs of women while in hospital, to provide job satisfaction for the post holder and cost effectiveness for the maternity service.

**Sustainability**

The programme of education of and employment of health care assistants to support mothers with infant feeding has continued (personal communication, Sookhoo 2003).

**Target population/area**

Mothers in a neonatal unit in a large consultant maternity unit.

**Aim(s)**

To provide a research-based programme of education for neonatal staff.

To monitor the effect of a staff training programme upon the knowledge and practice of neonatal staff.

**Project design and procedure**

A research-based programme of education was designed consisting of five 2-hour modules (Total 10 hours). The course included the benefits of breastfeeding, the physiology of lactation, attachment and positioning, milk expression, assessing a breastfeed and breastfeeding adequacy. Forty-two staff members enrolled on the education programme with 34 completing. There were 8 neonatal intensive care paediatric nurses, 12 registered nurses, 3 paediatric nurses, 2 paediatric senior house officers and 1 paediatric registrar. A CD-ROM produced by the authors was made available to staff as an additional resource (Jones et al 1998).

**Evaluation**

A pre-test and post-test questionnaire was developed and validated for the measurement of theoretical knowledge and clinical skills before and after the educational programme. The questions took the form of 18 short hypothetical vignettes. A specialist panel reviewed the questionnaires that were then piloted on 5 neonatal nurses to evaluate validity and reliability. Pre and post-tests were separated by a minimum of 2 months.

Evaluation of the training was completed by course participants.

Breastfeeding management was audited before and after the training period utilising medical and nursing records and a breastfeeding care checklist.

**Results/Findings/Outcome**

Thirty four staff completed the programme and the pre and post-test questionnaires. The post-test median score was significantly higher than the pre-test median score (p=<0.001). Pre-test scores were median 32.5/85 (range 9-39) and post-test 44.6/85 (34-60.5). [Wilcoxon signed rank test]. None of the participants scored lower on the post-test.

The clinical audit data showed a significant increase in the numbers of babies receiving expressed breast milk, 74/86 (86%) to 72/74 (97%), routine skin-to-skin contact 15/46 (33%) to 63/64 (98%), cup feeds offered in mother’s absence 53/82 (65%) to 56/66 (85%) and babies put to the breast 57/76 (75%) to 65/69 (94%). There was an increase in breastfeeding at discharge 49/73 (67%) to 54/68 (79%) but this result was not statistically significant.
Evaluation of the education by staff was positive although some were concerned about being unable to put the theory into practice as they were allocated to intensive care. This was to be addressed through rotation. The authors comment that the education changed the ethos of the neonatal unit to one that was more proactive in promotion and support of breastfeeding.

**Comments**

As the authors note, the same questions were utilised for the pre and post-test, however there was a two month gap between tests. The training programme led to an improvement in record keeping which is a useful outcome in itself. Some of the improvement noted may have related to this rather than to changes in practice. With a pre-post-test design the impact of concurrent changes taking place in the unit may have had an impact upon the clinical outcomes audit data. This project highlights the potential of a breastfeeding course to improve practice and breastfeeding rates in a neonatal unit. The combination of the assessment of knowledge and clinical outcomes provides an important contribution to knowledge related to impact of breastfeeding education for staff. The neonatal focus also provides an addition to the body of knowledge. The tailoring of breastfeeding education specifically to neonatal staff would appear to be important and is an area warranting further study.

**Sustainability**

This specialist programme of education is now mandatory for all neonatal nurses on the unit (personal communication, Jones 2003).

**Target population/area**

Women and their families in six areas associated with a large city where women were less likely to breastfeed.

**Aim(s)**

The project aimed specifically to work with women and their families in six areas where women were less likely to breastfeed. These areas were targeted on the advice of the local Head of Midwifery.

**Project design and procedure**

This project developed a new role, that of a ‘consumer-practitioner’, a post held as a job-share by two experienced National Childbirth Trust breastfeeding counsellors. The post-holders worked in health, social and educational settings over a nine-month period (due to the limited funding available).

The aim of the role was to utilise evidence in the promotion and support of breastfeeding from consumer perspectives. This work took place in a range of settings. The consumer-practitioners had contact with the following: antenatal education groups for women with their partner/ mothers in community and hospital settings; ‘drop in sessions’; a parent education session targeted at grandparents and significant others; women on the hospital antenatal ward and postnatal ward; a session with fathers and other men in the local prison; students on the GCSE course in Child Care at a local school; a session with teenage mothers-to-be at the YMCA.

The consumer-practitioners contributed to the education of the following groups: undergraduate midwifery students; students of the Lactation and Breastfeeding Practice; course for registered midwives and health visitors; Master in Medical Science for paediatricians; student nurses; nurse prescribing course. At the Hospitals NHS Trust the consumer-practitioners contributed to: The cadet nursing course; a study day for health care assistants in support of the NVQ programme; registered nurses and midwives in paediatric and maternity areas respectively. The consumer-practitioners also contributed to the education on community programmes: Parent Partnership; GCSE course in Childcare at a local secondary school; Women’s Health Matters (an independent community based agency).

Additional activities included: input to information leaflets and materials; linkages to Sure Start projects and advice on resource materials; participation in panel discussions for parents and health professionals during ‘Immunisation week’; providing information to individual health professionals.

**Evaluation**

The initiative has been evaluated from the perspective of a wide range of stakeholders.

The initiative acted as a mapping exercise to identify the range of settings where this post could have an impact.

Educational in-put was evaluated at the conclusion of a large proportion of sessions and via feedback from course /module managers.
Focus groups, supplemented by interviews, were held with five groups of workers who had come into contact with the initiative. The aims of this component were to understand the expectations, views, perceptions and experiences of hospital and community workers in respect of the Consumer-Practitioner project. The evaluation aimed to answer the following questions: whether there was a need for the Consumer-Practitioner, its usefulness, acceptability and whether it should continue. Recommendations for the future of the initiative were sought.

Results/Findings/Outcome

The ‘mapping’ exercise identified a wide range of agencies and groups who may appreciate such in-put. Evaluations of educational in-put were overwhelmingly positive with particular comment being made about the participative nature of the interaction. There was support for the continuation and extension of the initiative in community, hospital settings and with particular groups of women.

Comments

No attempt was made to measure impact on initiation and duration of breastfeeding, as there are no robust mechanisms in place to facilitate collection of this data. In addition, the initiative was targeted at six specific areas and of a limited duration.

Sustainability

As a model, the initiative appears sustainable; although based on the workload of the post-holders and numbers of contacts received, an increase in resources would be optimal. Despite a positive evaluation and heavy use of the project workers throughout the project, attempts to identify continued support were unsuccessful for various reasons, mainly due to lack of NHS resources. However, recently, further fixed term funding from a PCT has been allocated to address the target of 2 percentage point increase in initiation of breastfeeding and the principles used in the original project will be applied. Collaborative working, funded by some Sure Start partnerships is also planned. This will again follow a similar model and work with Sure Start staff and parents (personal communication, Spiby 2003).

**Target population/area**

An area with high levels of social deprivation. Breastfeeding initiation and continuation rates are lower than the national average.

**Aim(s)**

To extend an existing breastfeeding support programme to a neighbouring area.

To implement a rigorous monitoring and evaluation strategy.

**Project design and procedure**

A breastfeeding support programme was launched in 1996. Mothers who had breastfed were recruited to become breastfeeding supporters. They were carefully selected by a very thorough process. This involved attendance at taster sessions which gave them insight into the role of supporter. It also facilitated networking. Those interested could then apply and were subsequently interviewed by the project co-ordinator and an NCT breastfeeding counsellor. A list of criteria were used as a guide. The programme involved a comprehensive locally developed ongoing training and support for peer supporters. Services offered by the supporters included meeting antenatal women in GP surgeries and provision of home visits. They attended several breastfeeding support groups and local ‘drop-in’ facilities and made visits to the local postnatal wards. There was a 24-hour pager system.

DH funding enabled the appointment of a programme co-ordinator and an external evaluator from a nearby University. A method for systematically collecting and analysing infant feeding data was developed with the collaboration of a statistician. Evaluation tools were developed and the medical statistician assisted in setting up a database compatible with a statistical package (SPSS) so that key questions could be regularly asked and meaningful statistical statements made.

The programme as described was established in a neighbouring area. This involved the training of a new cohort of five breastfeeding supporters and providing the range of services referred to above. As part of the project an attractive antenatal booklet was developed using cartoon materials that the project team developed.

**Evaluation**

Systematic infant feeding data collection by health visitors and nursery nurses.

A comprehensive evaluation package is being implemented with external input from the appointed University.

The cartoons were evaluated by the NCT and UNICEF UK Baby Friendly Initiative.
Results/Findings/Outcome

Comprehensive data have been collected, but as yet have not been analysed (personal communication, Suppiah 2003). SPSS will be utilised to conduct this. Retrospective data collected by health visitors at the 8 month check were manually collated and have provided some data for comparative purposes. Baseline data for the two project areas illustrated that the rates of initiation and continuation were lower than the national averages. Data collection between 1995 and 2000 in the first area showed an increase in the percentage of mothers who initiated breastfeeding from 32% (42/131) to 45% (20/44) of births. Breastfeeding rates at 10 days rose from 25% (33/131) to 41% (18/44). Breastfeeding at 6 weeks rose from 19% (25/131) to 29% (13/44) and at 4 months 12% (16/131) to 25% (11/44). The cartoons were adapted as a result of the evaluation and are now available for sale.

Comments

The authors did not apply a statistical test but there was a clear trend towards increasing breastfeeding rates at the key points in time. This peer support programme is comprehensively designed. The results of the full evaluation are likely to provide further information related to impact upon breastfeeding rates.

Sustainability

Funding has subsequently been secured from the European Social Fund and has been used for the skills development of the breastfeeding supporters. PCT funding will also be provided. Income is generated through the sale of the cartoons and a manual that details how to carry out training for volunteers. The project has also been sustained through training of supporters. They may either enter a programme whereby they will work as a volunteer in their own community or they may follow a pathway involving taking an NVQ. If they reach level 3 they may seek employment in the Trust (personal communication, Suppiah 2003).

**Target population/area**

Women with breast and nipple pain.

**Aim(s)**

To provide empirical evidence for Candida as a potential cause of nipple soreness and deep breast pain during breastfeeding.

To establish a reliable list of symptoms that will aid the diagnosis of deep breast thrush and could possibly negate the need for routine microbiological analysis.

Long term: To proceed into a second research phase (further funding will be sought) that will investigate the most effective treatment for nipple and deep breast thrush and its associated symptoms.

**Project design and procedure**

Six groups of women were to be recruited: non-pregnant women; pregnant women; non breastfeeding mothers; non-symptomatic breastfeeding mothers; breastfeeding mothers with nipple pain (symptomatic group 1); breastfeeding mothers with nipple pain and deep breast pain (symptomatic group 2). Women with nipple pain due to ineffective attachment were excluded.

Nipple swabs/areola skin swabs were to be taken from all women. Expressed milk samples were to be taken from all breastfeeding women and oral swabs from the babies of the symptomatic women.

Simple profile data was to be collated on all women. A pain questionnaire and baby behaviour/feeding questionnaire was used for the two symptomatic groups.

Symptomatic group 1 were to be treated with topical Daktarin cream for the mother and Daktarin oral gel for the baby. Symptomatic group 2 were to be treated with topical Dactarin cream and Diflucan tablets and Daktarin oral gel for the baby. Both groups were to be reviewed weekly for 6 weeks until symptoms were no longer present.

Specimens were to be tested for Candida Albicans and other Candida, Staphylococcus Aureus, group B Streptococci, Group B Streptococci (haemolytic) and yeast.

**Comments**

Data collection and analysis are still in progress due to a number of delays and difficulties during various stages in the research process. These have included difficulties in culturing Candida in the laboratory (personal communication, Thompson 2003).

**Target population/area**

Adolescents accessing maternity care services in a city with high levels of social deprivation and breastfeeding initiation and continuation rates lower than the national average.

**Aim(s)**

To educate teenagers about breastfeeding.

To increase the number of teenagers who opt to breastfeed.

To increase the number of teenagers breastfeeding on discharge.

To increase the duration of breastfeeding.

To raise awareness of partners/families/peers in their role of supporting the breastfeeding teenager.

**Project design and procedure**

A midwife with appropriate training was designated to offer support and advice in the ante and postnatal period to adolescents who had expressed a wish to breastfeed. Contact was made with most adolescents (aged 19 years and under) who intended to breastfeed through the initial booking scheme and computerised record system. At the first antenatal meeting the midwife introduced herself and the project aims and encouraged teenagers to participate. A future appointment was arranged usually at the next hospital appointment but sometimes at home. Topics covered at this appointment were: how milk is produced; what colostrum is; the difference between fore milk and hind milk and how often the baby may want to feed (realistically) in the first few days. A video made by teenage mothers in the same city was shown. The project midwife met the adolescents several times and discussed issues of relevance to them. This often involved significant others who came with them. The project midwife visited each adolescent in hospital after the birth to reinforce antenatal learning and to observe a breastfeed. Thereafter, the project midwife saw the mother in hospital as often as was necessary. Once discharged she contacted the mothers every day for a week by telephone and then weekly until they discontinued breastfeeding. The teenagers could initiate contact with the project midwife at any time through the hospital switch board. The project midwife made at least one home postnatal visit. In some cases 3 or 4 visits were made.

**Evaluation**

A questionnaire was issued to participating adolescents to evaluate their experiences of breastfeeding and of the support from the project midwife. This was issued at the end of their contact with the project midwife.

All teenagers were asked to complete a daily diary for a week then weekly until they ceased to breastfeed.

The project midwife reflected on her role.
Results/Findings/Outcome

Sixty teenagers participated in the project. Twenty-five percent did not commence breastfeeding at all. The remaining adolescents breastfed for between 1 day and 8 months. Of those who started breastfeeding 15/45 questionnaires were returned (33% response rate). The respondents were generally positive about the support, advice and friendship received by the project midwife who supplemented support received from significant others.

Only 6/60 diaries were returned to the project midwife. Thematic analysis generated several themes: Peer support, i.e. positive reactions from friends; personal confidence/pride; closeness to the baby; disruption of life style by breastfeeding; ways in which the project midwife helped and recognising the benefits of breastfeeding.

The project midwife reflected on her roles. She felt that she had acted as an advocate, practical resource and information giver for the teenagers and their families, working sensitively with them, assessing the dynamics of the family group and the teenagers themselves and not stereotyping.

Comments

The data are suggestive of positive effects of this one-to-one additional support upon the adolescents’ breastfeeding experiences. It therefore has the potential to support women to continue breastfeeding.

Sustainability

This study identified the need for a named midwife for teenagers, not just for breastfeeding but for other clinical, social and emotional support. As such, and in conjunction with Sure Start, a post was developed to provide local teenagers with such support. Information, which emerged from this project provided the evidence for this need and contributed to the job description. Breastfeeding support and advice remains an integral part of this role (personal communication, Lavender 2003).

**Target population/area**

Women in a Sure Start area to include those on low income, minority ethnic groups and adolescent women. Breastfeeding initiation and continuation rates were below the national average.

**Aim(s)**

Explore the needs of women in relation to breastfeeding within a Sure Start area.

Establish what influences women in relation to breastfeeding within a Sure Start area.

Find out what, if any, are the barriers to breastfeeding.

Establish baseline rates of breastfeeding within the Sure start area.

Devise a multi-professional/multi-agency breastfeeding strategy to provide accessible and appropriate care.

**Project design and procedure**

An exploratory study was conducted using focus group methodology. The information from the study will be utilised to devise a multi-professional/multi-agency breastfeeding strategy to provide accessible and appropriate care.

Seven focus groups were conducted with a total of 34 women. Women were selected who had one or more children less than four years of age or who were pregnant. Two groups focused specifically on adolescent women and one on women from a Bengali community. For the other groups women were accessed through nurseries or mother and baby groups. Twenty two of the women had breastfed or intended to breastfeed and twelve had or intended to bottle feed. It became apparent during the focus groups that some of the women were from outside the Sure Start area as they had been attending the play group from which the women were recruited.

**Results/Findings/Outcome**

Five key themes emerged from the data. Firstly the women commented upon society's attitudes towards breastfeeding, particularly in public. They referred to their embarrassment and the lack of facilities available. The second theme centred upon factors that influence women in their choice of infant feeding method. Here the strength of the bottle feeding culture and its influence became evident. Significant others had a strong influence. The third theme related to a general lack of knowledge about breastfeeding. The fourth theme centred upon perceptions of professional support. Women valued the support they received to initiate breastfeeding but it was felt that midwives were very busy and that they gave conflicting advice. Finally women referred to positive and negative experiences of breastfeeding. Some women emphasised positive aspects of breastfeeding, e.g. convenience and cheapness as well as emotional and physical benefits. However, they tended to see breastfeeding as potentially complicated, difficult and restrictive to lifestyle. This was reinforced when they encountered challenges and problems. They tended to feel tentative in their decision to breastfeed due to lack of confidence. Frequent feeding and the concern that the baby wasn’t getting enough were the most common complaints.
The authors recommend improving breastfeeding facilities for women to breastfeed in public, enhancing the provision of information for pregnant women and their families, addressing issues of conflicting advice and professional support through education of staff and implementing support initiatives, e.g. postnatal support groups and peer supporters, tailored to meet the needs of those women who are less likely to access existing services.

Comments

This exploratory study highlights the key issues for a group of women living largely within a Sure Start area although it does not appear to specifically separate out issues that relate to specific groups, e.g. adolescents and Asian women.

Sustainability

Following the completion of the project a multi-agency group has formed to implement the recommendations of the project. Some additional funding, e.g. to purchase teaching aids has been provided by Sure Start (personal communication, McFadden 2003).

**Target population/area**

Mothers of sick and premature babies at a maternity unit in a city with high levels of social deprivation and breastfeeding initiation and continuation rates below the national average.

**Aim(s)**

To increase the proportion of mothers of sick and premature babies who initiate and maintain breastfeeding.

**Project design and procedure**

Key workers were employed to provide a total of 11 hours/week of additional support to breastfeeding mothers. They were neonatal nurses, paediatric nurses and nursery nurses (the original plan was for 22 hours/week but this was not possible due to staffing and workload issues). All key workers received the 3 day UNICEF UK Baby Friendly Initiative Breastfeeding Management Training and underwent supervised practice by the project co-ordinator before participating. Monthly meetings were held to feedback and update the team.

The key workers were placed on a rota system to enable cover of the shifts. During the study period additional support was provided for a total of 356 mothers with an average of 60 contacts per month. Each contact lasted up to 60 minutes with two thirds being less than 30 minutes. A few lasted 60-90 minutes. In some cases mothers initiated contact and in others health professionals. A diary system assisted in this process. Types of support required included: general advice about breastfeeding; positioning and attachment; insufficient milk supply; infected milk; breast and nipple problems. Other activities included parent education sessions taking the form of regular discussion groups with weekly video presentations tailored to the needs of the group.

**Evaluation**

Breastfeeding statistics from the hospital neonatal unit database.

**Results/Findings/Outcome**

Sixty-nine percent of mothers wishing to breastfeed at delivery were able to provide breast milk for their sick baby admitted to neonatal unit. During the project period 45% of mothers initiated breastfeeding compared to 41% and 43% in 1999 and 2000. Breastfeeding rates at discharge from the neonatal unit also increased with 25% of mothers still breastfeeding during the period of the project compared with 22% in 1999 (sample sizes not provided).

**Comments**

Causality cannot be drawn from the percentages provided given possible time trends in the data. Qualitative data would be useful to elicit both women’s and health professional views on the scheme.

**Sustainability**

The NHS Trust continues to fund key workers (personal communication, Waugh 2003).

Target population/area
Asian community who access maternity services offered by an NHS Trust.

Aim(s)
To provide breastfeeding information in line with the Baby Friendly Initiative in the form of a video.

Project design and procedure
A video Breastfeeding – A Gift for Life was produced which provided breastfeeding information in line with the Baby Friendly Initiative. The video was produced in four languages, Sylheti Bengali, English, Punjabi and Urdu. The videos were offered to all antenatal women and then collected during the postnatal period.

Evaluation
A draft version of the video was previewed by Asian health support workers, UNICEF UK Baby Friendly Initiative, midwives from the maternity unit, members of the National Network of Breastfeeding Co-ordinators in the region and by pregnant women and their partners at parentcraft sessions. Changes were made in response to comments received.

Results/Findings/Outcome
Although it was the intention to do a consumer satisfaction survey this was not carried out. A formal audit of impact upon breastfeeding rates was not conducted. Feedback from mothers who viewed the video suggested that it was useful.

Comments
A formal evaluation of this video in terms of its acceptability and impact upon breastfeeding rates would be very useful.

Sustainability
Sales of the video have enabled the project to become self funding (personal communication, Westman 2003).
Target population

Thirty two general practices that had expressed an interest in receiving breastfeeding awareness training during a previous audit of general practices within one health authority.

Aim

To develop and deliver practice-based breastfeeding awareness training for general practitioners, practice nurses and ancillary staff.

To improve the general level and quality of support to all breastfeeding mothers, but particularly those in disadvantaged social and economic groups.

Project

The development and delivery of an hour-long awareness session encompassing topics identified by the GPs at audit as of particular relevance to their practice.

A project team was drawn from the breastfeeding subgroup of the local Maternity services liaison committee (MSLC) and comprised a Breastfeeding Network (BfN) tutor and trainer, a midwife employed as an infant feeding specialist in a local hospital and a health visitor who is a Breastfeeding Network Supporter. The session took the form of a power point presentation and was delivered by all three members of the project team to demonstrate a common purpose and high level of co-operation. The session was supplemented by a comprehensive resource pack compiled by the project team.

The topics within the session included the public health benefits of increased breastfeeding, the management of mastitis, thrush and insufficient milk syndrome and suggestions for ways in which general practices could enhance the support of breastfeeding women. It was suggested to the practices that they invite all practice-attached staff.

The session and resource pack were piloted with three practices. By the end of the funding period 22 practices had received the session. Attendances varied from a single GP to 24 members of a practice team attending within practice-protected training time. Total attendances were 170.

Evaluation

Questionnaires were completed by participants at the end of each session and a record was kept of all discussion topics and queries raised.

Postal questionnaires were sent to all participants of the first 15 sessions 3 months after each session.

A more detailed evaluation using a descriptive methodology was carried out as part of one of the project team’s MA dissertation. An illuminative evaluation model was used within a descriptive case study.
Results/Findings/Outcomes

Overall response rate to questionnaire 1 was 81% (133/164). The response rate for GPs was 90% (35/39). Thrush and insufficient milk syndrome were the two topics most frequently judged to have contained new and relevant information. Length of session, venue and the invitation to all practice staff were all favourably assessed. Thematic analysis of responses to a question enquiring about the possible influence of the session on the participants’ approach to breastfeeding women revealed a global theme best described as the protection, promotion and support of breastfeeding. The organising themes were: acquisition of greater knowledge; improved access to resources; a commitment to a more proactive approach and the provision of a breastfeeding friendly environment. General comments about the session were very favourable. The most frequently occurring suggestion for improvement of the session was the inclusion of greater opportunities for interaction or discussion but nevertheless this was only mentioned by 4/133 (3%) respondents.

Overall response rate to the postal questionnaire was 62.5% (65/104). The GP’s response rate was 84% (21/25). Sixty-seven percent of respondents considered the session to have had a positive effect on their approach to breastfeeding women. All of the 19% who felt that the session had not influenced their approach recorded that this was because they had already been very positively disposed. GPs reported being more supportive and more proactive in encouraging women to initiate or continue breastfeeding up to 6 months. Greater confidence in dealing with breastfeeding difficulties was also mentioned. Forty-four percent of GPs and 88% of health visitors reported having used the resource pack. Nine out 15 practices had displayed a poster provided within the resource pack, welcoming breastfeeding mothers.

Comments

There were high response rates with very positive feedback from participants. The format of the session was clearly acceptable to most participants. These were however practices that had expressed an interest in training and presumably therefore were favourably disposed towards breastfeeding.

Sustainability

This will be dependent on securing PCT funding – this is being actively pursued at the present time. The project will be presented by invitation at a local good practice day in the near future.

Two resource packs have been sold to other organisations and various other marketing opportunities are being explored (personal communication, Burt 2003).

**Target population/area**

Year 10 secondary school children in two schools in areas with high levels of social exclusion within SRB target areas. The schools served a population which was predominantly made up of White and Asian communities.

**Aim(s)**

To develop a resource pack that may be used to raise awareness of the health benefits of breastfeeding to mothers and their infants.

To explore attitudes towards breastfeeding with young adults within the school setting.

**Project design and procedure**

A multidisciplinary group was set up to develop a breastfeeding teaching pack for schools education. The project co-ordinator was a school nurse. Access was granted for several discussions to be held with a group of children from a local high school. This facilitated the development of the learning materials. Although pupils of both sexes, White and Asian were selected by the Head all but 6 white girls withdrew even before parental consent had been gained. A resource pack was designed to raise awareness of breastfeeding and related issues among school children. The pack included a selection of visual images that young people could discuss in small groups and challenge the attitudes of others within a safe environment. A game was designed to test students’ knowledge of the benefits, myths and misconceptions surrounding infant feeding. A section of a commercial video on breastfeeding was selected for students to view that gave opportunity for them to see breastfeeding. Some had never seen a baby at the breast. The video also reinforced the health benefits. Suggested lesson plans were included with the pack. The learning package was delivered in two pilot schools. School 1 had a mixed race population and school 2 had a mainly white population. In school 1 the breastfeeding session was time-tabled within the year 10 Personal Social Health Education (PSHE) for approximately 45-60 minutes. In school 2 time was allocated within the year 10 religious studies programme. This consisted of 2 one hour lessons delivered to 6 teaching groups.

**Evaluation**

Pre and post teaching questionnaires were issued to participating school children. These elicited knowledge of and attitudes to breastfeeding.

Workbooks were distributed to students. These used a quiz type of format including a word search to elicit knowledge gained about breastfeeding.

A questionnaire was issued to 8 staff both teaching and nursing who had observed the teaching session and 6 to those who had used the teaching pack.

The heads of Personal Social Health Education (PSHE) in 7 other high schools were asked to review the pack and comment.
Results/Findings/Outcome

Ninety-six pre-teaching questionnaires were returned in school 1 (75% of year 10) and 175 were returned in school 2 (74% of year 10). Sixty-four post teaching questionnaires were returned in school 1 (66% of pre-teaching number) and 117 in school 2 (67% of pre-teaching numbers). Breasts were seen as primarily sexual but positive attitude and knowledge changes were evident in female and male students following the teaching sessions. Forty seven out of fifty five completed workbooks showed knowledge of health benefits of breastfeeding. Questionnaires were returned by 6/8 staff who had observed the session and by 5/6 of staff who had used the pack (Three school nurses and 2 midwives). These respondents were generally positive about the teaching pack feeling that it met the learning outcomes. The main improvement suggested was the use of a video that was more specifically tailored to this group as the video used was not felt to provide appropriate role modelling for the target group. Additionally, it was felt that groups of no more than 15 students were appropriate. Four out of 7 heads returned comments. Two Islamic schools preferred not to look at the pack. Three heads felt that their teachers could use the pack and one felt that it would be better used by the school nurse. All 4 heads felt that the pack could be a useful resource for years 9 and 10 in line with National Healthy Schools Standard (NHSS).

Comments

This schools project was clearly successful in both gaining access to schools and also designing and delivering a pack which was evaluated by almost all concerned as positive. The pack appears to be suitable for use by a range of staff and therefore is more likely to be sustainable. The needs of schools specifically serving minority ethnic children need to be evaluated.

Sustainability

Training of all interested school nurses and community midwives within the Trust in the use of the pack took place at the end of the project year. Use of the teaching pack is to be extended to other high schools and possibly primary schools. Multi-agency planning to include the local University is underway to extend the research and practice potential generated by this project. It is proposed that the scheme will be extended through Sure Start schemes working with pre-school children to raise awareness about breastfeeding (personal communication, Wilkinson 2003).
Willcocks D, Carden K (2001) *Bumps ‘n’ Babes Project, Year 1.*

**Target population/area**

Women attending a health centre on a large council estate with high levels of social deprivation.

**Aim(s)**

That women from a mainly bottle feeding culture will attend and receive support, advice and encouragement to initiate and continue breastfeeding.

That women will see the normal behaviour of breastfed babies and recognise that the behaviour and sleeping pattern of a breastfed baby is different from that of a bottle-fed infant.

To engage with local mothers and prepare some to act as peer supporters.

To take a role in health promotion.

**Project design and procedure**

Ten self-nominated peer supporters were trained from the local community. Additional support was provided to breastfeeding mothers through the establishment of a support group named ‘Bumps ‘n’ Babes’ which had a particular focus upon assisting the normalisation of breastfeeding. The support group was held in a new family centre which was central to a large council estate. The group was held weekly and was open to pregnant women and mothers with babies. The group was attended by two midwives, one giving booked or ad-hoc antenatal care. The other circulated giving advice as necessary. A health visitor attended to perform developmental checks, weigh babies and give advice. Videos were shown relevant to parenting and breastfeeding. Sixteen midwives and 5 health visitors were trained on the 3 day UNICEF UK Baby Friendly Initiative Breastfeeding Management Course.

**Evaluation**

Audit of attendance rates at the group and reasons for discontinuing breastfeeding.

Audit of breastfeeding rates.

A comments sheet elicited mothers’ views of the support group. This was supplemented by verbal comments to health professionals.

**Results/Findings/Outcome**

During the project year there were 939 visits made to the ‘Bumps ‘n’ Babes’ (approx 19 per week) with 65% of attendees being under 25. Some women were still attending when their babies were 4-5 months old. Breastfeeding initiation rates rose from an estimated 50-55% to 74%. Ninety-three percent of women attending ‘Bumps ‘n’ Babes’ breastfed their babies at least once. Average duration of breastfeeding for attendees was five and a half months. The mothers viewed the service positively. The most common reasons for ceasing to breastfeed were ‘in association with weaning’ (44%); ‘mother’s desire’ (30%) and ‘perceived milk insufficiency’ (15%).
Comments

The figures show an increase in initiation rates and are suggestive of an increase in continuation rates. The high attendance rates suggest that this project was welcomed by women. The location in the centre of the council estate and provision of other services at the same time may have contributed to this success.

Sustainability

This project continues to run in the family centre with a midwife funded by the local NHS maternity service attending for two hours a week (personal communication, Willcocks 2003).

Target population/area
An area with high levels of social deprivation (Jarman score 30.7%). Breastfeeding initiation and continuation rates are lower than the national average.

Aim(s)
To provide one-to-one information to 100 women on the benefits and management of breastfeeding.
To improve postnatal outcomes for mothers by providing antenatal contact with health visitors.

Project design and procedure
An action research methodology was employed. Health visitors were provided with training that was based on the UNICEF UK Baby Friendly Initiative Breastfeeding Management course. Following ethical approval 7 women were accessed through health professionals during pregnancy. Posters were also displayed to increase awareness of the study. The intervention was represented as centring on infant feeding rather than breastfeeding. The women were provided with additional antenatal support by the health visitor following their visits to the midwife at the community clinic. The same health visitor then continued supporting them as their main health visitor. The health visitor did not previously routinely see women during the antenatal period. Information on the benefits and management of breastfeeding was provided orally with the aid of a breast model and a doll and two simply illustrated UNICEF UK Baby Friendly Initiative leaflets, ‘Breastfeeding your Baby’ and ‘Feeding your New Baby’. An adapted version of the UNICEF UK Baby Friendly Initiative antenatal infant feeding checklist was utilised as a guide to information giving and to record this.

Evaluation
Structured interview of women who had received the BIBS intervention by health visitors using a questionnaire (conducted when the baby was 8 weeks old).
Structured interview utilising a questionnaire to 3 health visitors who implemented the BIBS intervention.

Results/Findings/Outcome
The health visitors who were interviewed felt adequately trained for the role. They reported that the checklist was easy to use and facilitated women in making an informed choice. The seven mothers were interviewed and all recalled the discussions with the health visitor. Only 4 mothers could recall definitely receiving two leaflets. Six women were able to recall at least one health benefit of breastfeeding to the mother and all recalled health benefits to the baby. All 7 women were aware of the benefits of skin-to-skin contact and baby-led feeding. All 7 remembered discussions about positioning and attachment and appreciated the opportunity to practice the skill in privacy. Three mothers recalled discussions related to problems with providing bottles, teats or dummies to babies. All had gained new knowledge but only 3 felt that the information received helped them to decide how they would feed their baby. The author acknowledges that this may relate to the stronger influence of embodied knowledge through seeing breastfeeding. Six women initiated breastfeeding with 4 still breastfeeding at 10 days and 2 at 8 weeks.
Comments

The use of the UNICEF antenatal checklist provided a useful framework for implementation and evaluation of this intervention. Due to various problems smaller numbers of women were recruited than was first planned.

Sustainability

The project as described has not been maintained (personal communication, Williams 2003).

**Target population/area**

Rural area with a range of socio-economic groups.

**Aim(s)**

To test the hypothesis that a close female confidante of the mother’s own choice if educated about breastfeeding can increase initiation and continuation of breastfeeding.

**Project design and procedure**

A randomised controlled trial was conducted. This involved allocating women to either an intervention or control group by hospital number (odd numbers received the intervention, even numbers were the controls). The intervention consisted of provision of an opportunity for pregnant women and a female confidante of their own choosing to discuss breastfeeding with a midwife and/or health visitor during a third trimester home visit. The confidante needed to be someone who could support the mother with breastfeeding following the birth. Mother and confidante were visited together during the antenatal period by the midwife to discuss breastfeeding according to Trust guidelines. This included benefits of breastfeeding, value of exclusive breastfeeding, importance of skin-to-skin contact, importance of effective positioning and attachment, rooming-in, baby-led feeding, community support and discussion of leaflets. The visits lasted from 10 minutes to 1½ hours. The control group received standard antenatal care to include the same home visit to the mother only. Breastfeeding rates were then compared and analysed.

**Sample selection and recruitment.**

All antenatal women attending hospital and general practice antenatal clinics over a 4 month period within the geographical area of the Trust were invited to participate in the study. The women were invited to participate by the midwife running the antenatal clinic (GP) or the researcher (hospital clinics). Seventy-two women were recruited during the first or second trimester. Thirty received the intervention and 42 entered the control group. Thirty-one women declined to participate, of these 18 would have been in the intervention group and 13 in the control group. Most women chose their own mother (n=15). Five chose their sister and 2 selected more distant relatives or friends. The relationship of the confidante was unknown (missing data) for 4 women, 3 women did not receive the intervention and one was visited in hospital.

**Evaluation**

Statistical analysis of breastfeeding rates for the study participants was conducted. Existing audit points were used, i.e. hospital rates, 10 days, 1 month, 6 weeks, 3 months and 6 months.

Relevant demographic data were collated.

Postnatal telephone interviews were conducted with a sample of mothers from the intervention group 6 months following the birth to elicit their views on the intervention.

A questionnaire was distributed to midwives to ascertain their views on the involvement of the confidante.
Results/Findings/Outcome

The small sample was insufficient to give statistical power to the results and the study was therefore presented as a pilot. The intervention showed no statistically significant difference between the control and intervention groups in the initiation of breastfeeding or the duration of breastfeeding. However, the differences between groups would be clinically relevant. The data relating to the duration of breastfeeding were analysed for any trends, this was again not significant. However, the longer duration of breastfeeding in the intervention group approached statistical significance. The study group as a whole was analysed for any association between breastfeeding (initiation and/or duration) of this child, having previous children, breastfeeding a previous child and mother’s age. No significant results were found. The breastfeeding initiation rates for the women in the study were found to be significantly higher than the baseline for the Trust as a whole at the start of the study.

Twelve mothers were telephoned and interviewed. No further interviews were felt necessary as theoretical saturation was achieved. Content analysis of the qualitative data gained from the telephone interviews highlighted that most mothers (9/12) valued the intervention in terms of the practical and emotional support offered. A total of 9/13 midwives returned questionnaires. Content analysis yielded five categories of response: ‘creating a supportive culture for breastfeeding’ through the intervention; ‘difficulties in organising the visit to the woman and her confidante’; ‘the importance of a well chosen confidante’ with midwives suggesting that guidance was needed for mothers in this respect; ‘difficulties with the role of confidante’ and ‘partners as confidantes’.

Comments

The longer duration of breastfeeding in the intervention group, that approaches statistical significance is encouraging. The breastfeeding initiation rates for the study were significantly higher than the baseline rates for the Trust. It is possible that the women declining to take part in the study were more likely to artificially feed. Alternatively the study may have created a situation where increased attention to the women related to breastfeeding encouraged them to initiate breastfeeding (the ‘Hawthorne’ effect).

It would appear that the intervention provided a valuable opportunity to contribute towards a supportive breastfeeding culture. The issue of guidance with regards to the confidante is a sensitive one. Midwives felt that mothers needed to be encouraged to choose a confidante who was supportive of breastfeeding rather than simply someone with whom they felt comfortable with. This could influence the effect of the intervention if applied in a future study. This could also be further explored qualitatively with both mothers and midwives in a range of contexts.

Sustainability

The authors recommend that the findings of this study are worthy of further investigation through the design of a larger and more in-depth study.

Target population/area

Sure Start area with high levels of social deprivation. Breastfeeding initiation and continuation rates are lower than the national average.

Aim(s)

To encourage and maintain breastfeeding in the target area.

Project design and procedure

This peer support project aimed to build on the Sure Start aims, to build on the knowledge of local people, to recognise skills and abilities and to encourage communities to value their own capacities. The La Leche League (LLL) provided two 5 day courses for health professionals. Following this, 18 breastfeeding women who were recommended by their own health visitors or midwives were provided with the LLL peer support programme training. Nine completed the full training. The local Sure Start community centres were utilised to include use of their crèche and pre-school playgroup. The peer supporters once trained assisted with running breastfeeding antenatal workshops in the hospital. Two of them were appointed to the Maternity Services Liaison Committee (MSLC) at the hospital. Sure Start match funded the project.

Evaluation

Questionnaires were sent to 20 midwives and health visitors who had received the LLL training programme to elicit their views on the scheme.

Semi-structured interviews with midwives, health visitors, breastfeeding supporters and breastfeeding mothers.

Results/Findings/Outcome

A total of 12/20 questionnaires were returned. Nine were very positive about the scheme seeing the presence of peer supporters at breastfeeding workshops as positively changing the group dynamic and thereby making the information more relevant and acceptable to the mothers. Three were unsure. This related to concerns about the commitment of some of the supporters, time commitments for health professionals required to provide the 12 week peer supporter training sessions, and lack of clarity about their role in the programme. There was a generally positive feeling that the project had enhanced inter-professional relationships. In an attempt to resolve the issues around time constraints the training was broken down into four week blocks to enable sharing of the teaching thus reducing time commitment on individuals. One health visitor attended most sessions for continuity.

The interviews were conducted with the project co-ordinator, 6 midwives and health visitors, 6 breastfeeding supporters and 6 breastfeeding mothers who had contact with the project. The conclusions drawn from the qualitative data were that the peer support scheme was an effective means of supporting breastfeeding women that complements the role of health professionals and has specific benefits for participants. The project improved the qualitative experience of breastfeeding mothers and developed the skills of breastfeeding supporters.
Comments
The use of the local Sure Start community centres to include their crèche and pre-school playgroup appears to be an important aspect of the success of this project.

Sustainability
The project continues and is now funded through a Sure Start scheme (personal communication, Woodward 2003).

Publications
Woodward V (2002) Peer breastfeeding support at home. An evaluation of a peer breastfeeding support at home service, Year 3, Practice project.

**Target population/area**

Health Action areas in a specific city with high levels of socio-economic disadvantage.

**Aim(s)**

To establish a peer breastfeeding support at home programme to increase:

- The access to breastfeeding information and support both antenatally and postnatally to low income women;
- The initiation and duration of breastfeeding;
- The partnership between the lay and professional agencies.

**Project design and procedure**

Ten volunteer mothers were recruited and provided with ten two hourly training sessions by a breastfeeding counsellor. Follow up sessions were organised to provide ongoing support and supervision during the project year. A weekly breastfeeding support drop in clinic had recently been established and the DH funding enabled extension of this programme to home visiting by peer supporters. The scheme was well publicised in the public domain and to health professionals. All requests for home visits were managed by the breastfeeding co-ordinator who was a Lactation Consultant and BfN Tutor and Trainer. She assessed the level of complexity and where appropriate she carried out the visit or in less complex situations she referred to the supporters.

**Evaluation**

- Monthly collation of contact forms between peer supporters and mothers.
- Telephone interviews with a purposeful sample of mothers accessing the service.
- Telephone survey of the views of health professionals.
- Focus group to elicit the views of volunteers.
- Interview with the breastfeeding co-ordinator.

**Results/Findings/Outcome**

Forty nine visits to a total of 30 mothers were made by breastfeeding support workers and detailed information was gained on those accessing the service and on the nature of visits. Fifty one mothers attended the drop-in clinic during the project year. Five out of ten active peer supporters were able to attend the focus group. Of 25 women approached all consented to a telephone interview. Nineteen mothers were subsequently contactable. Thirteen mothers were called again at approximately 3 months postnatally and 7 mothers a third time when their babies were 6 months old.
Qualitative data was analysed using latent and manifest content analysis. Frequencies were utilised to summarise the information on contact forms. Mothers felt that peer supporters provided valuable support for practical, emotional and social support issues related to breastfeeding as well as encouragement. They felt valued, cared for, accepted, validated and empowered through their relationships with peer supporters. Their comments indicated that pathological conditions were promptly recognised and referred on to health professionals. Three out of four health visitors and two out of four midwives working in the project area were interviewed on the telephone. They were generally positive about the scheme as their own broader roles left them very short of time to support women with breastfeeding.

In spite of enormous publicity and availability of leaflets women felt that they were not always made aware of the service. Health professionals played a fairly active role in encouraging women to use the service that gave a number of women the confidence to do so. However, they were less likely to recommend the service to those who appeared less committed to breastfeeding. This selectivity meant that those living in areas of greatest deprivation with complex socio-economic issues were less likely to be offered the service.

Comments

This qualitative research highlights the ways in which mothers indicated that the peer supporters helped them at times when they were strongly considering stopping breastfeeding. The tendency to be less likely to recommend the service to those who appeared less committed to breastfeeding is an important finding. As the author notes these may have been the women to whom the service may have made the greatest impact.

Sustainability

The project continues with a co-ordinator being employed by a PCT (personal communication, Woodward 2003).

Publications/Papers at peer reviewed conferences

The main conclusions from each thematic section are drawn together to suggest future directions with regard to practice and policy.

**Barriers to breastfeeding**

The projects that were partially or exclusively exploratory highlighted continuing barriers and constraints to the initiation and continuation of breastfeeding in general and specifically in relation to socially excluded communities. In some communities a deeply entrenched bottle feeding culture has existed for three generations with children and adults rarely, if ever, seeing women breastfeed. Significant others who have generally been socialised through a similar culture play a key role in ongoing decision-making related to infant feeding. Within these cultures where breastfeeding is a marginal activity women commonly have negative expectations and a profound lack of confidence in breastfeeding. Sexualisation of the breasts and related embarrassment about breastfeeding in public remain a major hurdle. These groups of women are most in need of consistent and appropriate professional support and yet these studies suggest that this is not always available to them within the current system. The projects evaluated in this report provide unique insight into ways in which awareness of and confidence in breastfeeding may be increased.

**Peer support programmes**

Most of the peer support projects showed a positive trend towards increasing continuation of breastfeeding. The collective bank of qualitative data from the projects produced strikingly consistent reports from mothers that indicated that the peer supporters helped them at a time when they were strongly considering stopping breastfeeding. As continuation of breastfeeding increases this is likely to stimulate increases in initiation rates as growing numbers of people gain personal and vicarious experience of breastfeeding. Several peer support projects expanded and connected with neighbouring schemes in a strategic and effective way. With these connections and appropriate infrastructure, i.e. co-ordination, staffing, and funding, the capacity to increase both breastfeeding initiation and continuation rates is likely to grow. Peer support projects are being increasingly incorporated into Sure Start schemes with close links with the relevant PCTs and this appears to be an effective way forward. The capacity of such programmes to empower those living within socially excluded communities in a broader sense should not be underestimated.

**Breastfeeding support centres**

Breastfeeding support centres were illustrated to be a crucial component in peer support programmes. Those established outside of peer support programmes generally showed a positive trend towards increasing continuation of breastfeeding. The qualitative data highlighted a range of ways in which women considered that the support centres assisted them in continuing to breastfeed. There were consistent reports from mothers that attendance at the group helped them at a time when they were strongly considering stopping breastfeeding. Two models appeared to be viewed most favourably by
service users. Firstly, the informal ‘drop-in’ that primarily facilitated network support between women combined with the ‘background’ availability of a health professional and/or qualified breastfeeding counsellor to provide skilled evidence-based support for specific challenges as and when necessary. Ideally, this should be linked with a broader peer support scheme. Secondly, the BfN Support centres that combined mother-to-mother networking with skilled support through the services of qualified BfN supporters. Both models warrant ongoing funding through PCTs and/or Sure Start.

Antenatal education/workshops

The quantitative data suggest that the workshop style package of antenatal education produces a trend towards increasing both initiation and continuation rates for breastfeeding. The qualitative data support this, particularly in relation to giving women the confidence to commence and continue breastfeeding. The workshop should explore breastfeeding from psycho-social, physiological and practical aspects including issues such as family support and feeding in public. It should also focus upon health gains of breastfeeding, basic physiology, positioning and attachment, skin-to-skin contact and baby-led feeding. The use of dolls to enable practice of positioning and attachment and an appropriate video are particularly useful. The focus upon offering women opportunities to see and become familiar with the practicalities of breastfeeding to include positioning and attachment is particularly important in those women from areas where there is a strong bottle feeding culture. This model of education warrants ongoing funding through NHS Trusts.

Health Care Assistants

The collective data from these projects appear to demonstrate the efficacy of the role of health care assistant in supporting women in overcoming barriers to breastfeeding initiation and continuation and ultimately in increasing breastfeeding rates. The service should cross the community hospital interface. In this way it is a flexible, adaptable, cost effective and woman-centred intervention. Funding may be joint, e.g. through Sure Start and relevant Trusts. Clear lines of communication and accountability need to be established while maintaining flexibility. If this role is to be optimised it is crucial that the Health Care Assistant is adequately funded with sufficient time to meet women’s needs as this was a key feature of support that women appreciated.

Projects primarily involving the qualified breastfeeding counsellors/supporters

The range of initiatives primarily involving the qualified breastfeeding counsellors/supporters illustrates the extensive and effective role that may be played by the breastfeeding organisations. Two schemes that appear to be particularly well evaluated are the BfN Support groups with accompanying ‘Supporterline’ and the Consumer-Practitioner role. The interagency and interdisciplinary collaboration achieved through these projects are crucial to developing a coherent and cohesive approach to education for those supporting breastfeeding women and to the general support infrastructure for breastfeeding women. Further and extensive funding of these two initiatives in particular appears to be very worthwhile. This funding could be joint by, e.g. Trusts and Sure Start.
Education for health professionals

In a number of projects staff voiced their lack of confidence related to feeling inadequately equipped to support breastfeeding women. Staff education is clearly a priority particularly in light of the DH Healthy Start and Priority and Planning Framework agendas. The projects in this evaluation provide useful insights into ways in which education may not only improve knowledge and skills of staff but also make an impact upon the experiences of breastfeeding women and related clinical outcomes. The training needs to be fit for purpose, e.g. neonatal nurses appear to benefit from designated courses developed for this purpose as do general practitioners. A number of established courses were reported to meet health professional needs, e.g. the UNICEF UK Baby Friendly Initiative 3 day Breastfeeding Management Course and the La Leche League peer counsellor administrator’s course. These courses may then be reinforced through models that specifically focus upon reflective practice through action research and/or clinical supervision. Designated funding should be made available to ensure that staff are prepared to support breastfeeding women both at the pre and post registration phases of their careers. Universities preparing health visiting, midwifery, medical and neonatal staff have a key responsibility in this area. A model for guiding University curricula development for student midwives and health visitors is provided by the UNICEF UK Baby Friendly Initiative (UNICEF UK BFI 2002).

School education

The school projects highlighted both the serious need to raise awareness about breastfeeding among young students and also illustrated the challenges of teaching a subject that was often perceived as sexual in nature and ‘out of place’ in a school curriculum. The most favoured curriculum placing was ‘Personal Social Health Education’ (PSHE). Impressive teaching materials were developed for each project, some of which may now be purchased. These provide material that may be utilised by teachers, health professionals or peer supporters. This type of work is undoubtedly crucial throughout the country and particularly in communities with low rates of breastfeeding to facilitate cultural and breastfeeding rate changes. This requires strategic planning and co-ordination at governmental level between the Department of Health and the Department for Education and Skills.

Minority ethnic communities

The projects that focused on the support needs of minority ethnic communities with regard to breastfeeding, highlight the need to explore cultural attitudes, beliefs and values before developing interventions to support breastfeeding women. They illustrate the importance of involving grandparents and key members of communities in facilitating change. They reinforce the advantages of employing supporters from the same minority ethnic background who speak the same language. Finally, they provide information on the development of appropriate resources for specific cultural groups. The combination of these initiatives is likely to support women to both initiate and continue to breastfeed. Resources need to be made available to ensure that support is specifically tailored to minority groups as they may not access more general support schemes.
Adolescent mothers

The projects highlight that adolescent mothers have specific support needs with regard to breastfeeding. However, health professionals and others should avoid stereotyping adolescents as this may lead to assumptions that they will not initiate or persevere with breastfeeding. Such assumptions need to be addressed, as they may be counterproductive to increasing breastfeeding rates in this group. The adolescent’s own mother is often very influential and therefore it would seem to be appropriate to involve her in discussions around infant feeding. Support from a network of like-minded others is also crucial for this age group. It also becomes clear that adolescents benefit from the opportunity to build relationships with a health professional. A case is made from these studies for a designated person, e.g. a teenage pregnancy co-ordinator with appropriate knowledge in supporting women with breastfeeding, who may not only provide one-to-one support but also co-ordinate a support group to encourage networking. This post should cross the hospital community interface and could be funded through Primary Care or acute Trusts and/or Sure Start schemes.

Significant others

The projects illustrate the importance of involving significant others in dialogues around infant feeding. This appears to be particularly relevant within specific minority ethnic groups, adolescents and those from communities with low rates of breastfeeding. Funding through Primary Care and acute Trusts needs to enable schemes to be developed that provide education and support facilities to mothers and their significant others.

Prison population

The one project that focused on women in prison by Farrell (2002) produced not only a striking increase in the initiation and duration of breastfeeding but also other additional benefits to the women such as raising awareness about general health. This form of outreach to vulnerable populations such as prisoners should receive serious consideration for further funding by both the health and prison services.

Organisational issues

Organisations proving support for women need to address the reported inabilities of health professionals to provide sufficient time, continuity of care or carer to breastfeeding women. While other schemes complement health professional support for women, resources should still be provided to enable mothers’ expectations of support from midwives, health visitors, neonatal staff and general practitioners to be met. There is a clear need for Primary and Acute Trusts and Sure Start schemes to collaborate in producing data collection systems that are both robust and sensitive enough to collect and collate breastfeeding statistics for specific target areas and groups. The developing Local Infant Feeding Audit (LIFA) system referred to by Carson and Thompson (2000) and Carson (2001) may be utilised for this purpose. Further information and developments on LIFA will be available on the web-site: www.breastfeeding.nhs.uk.
Public facilities

One project (Adams et al 2001) specifically focused upon strategically improving public facilities for breastfeeding women. An accreditation and award scheme system for assessing and awarding local premises with a Breastfeeding Friendly Award was devised. Public facilities were encouraged to endorse a written breastfeeding policy and to support women to feed their baby. Participatory appraisal research undertaken prior to the project in deprived wards highlighted the need to increase public support and acceptance of breastfeeding. Many of the other projects drew the same conclusions. This Breastfeeding Friendly Award project is now funded by the Community Trust. It appears to be one of the most promising ways of enabling women from groups least likely to breastfeed to do so with confidence, in the public domain. Funding by Community Trusts for expansion of this initiative to other areas is strongly recommended.

The media

Several projects highlighted the influence of the media upon attitudes to breastfeeding in groups least likely to breastfeed. The use of national and local media to promote positive images of breastfeeding is an area that is strongly recommended for targeted governmental funding. The annual national Breastfeeding Awareness Week campaign, co-ordinated by the Department of Health with provision of promotional materials to health care facilities around the UK should receive continued Government funding. The range of visual images produced for this event is to be commended for innovative socio-cultural diversity.

Conclusion

The projects evaluated in this report were funded by the Department of Health through their Public Health Development Fund. The evaluation is the culmination of the enormous commitment and work undertaken by the 79 project teams over the past three years. It reflects the depth of enthusiasm and creativity shown by the project teams in raising breastfeeding awareness and supporting those women who are least likely to breastfeed. The one year projects over the three years were overseen by Christine Carson and Rosemary Thompson, National Infant Feeding Advisers at the Department of Health. Their vision, support and co-ordination was crucial to the development and completion of the projects.

The funding for the 79 projects enabled the project teams to think creatively about support for breastfeeding women. It enabled breastfeeding organisations and health professionals to innovate and develop crucial partnerships that will continue to impact upon communities in promoting and supporting breastfeeding. Many project teams have remained committed to their aims and have continued to improve their services and secure further funding from Acute Trusts, Primary Trusts and Sure Start schemes. Some projects have become effectively incorporated within Sure Start schemes. There are exciting examples of collaborations between these organisations that enable the hospital community interface to be effectively crossed. Following each project summary there is a section that highlights the ways in which projects have been sustained and further funded.

The authors of the projects often demonstrated highly developed levels of reflexivity and this, combined with their honesty about the challenges and constraints related to managing change, provided material for this report that is illuminating, challenging and informative. This type of information is often missing from standard published papers and therefore becomes invisible. The projects provide an important contribution to understanding ways in which women in communities least likely to breastfeed
may be supported and encouraged to initiate and continue to breastfeed. The collation of these projects in this report provides an important guide to the realities and practicalities involved in changing cultures in which breastfeeding is a marginal activity rarely seen and little talked about.

It is recommended that Acute Trusts, Primary Trusts and Sure Start schemes continue to collaborate and fund projects to include:

- Breastfeeding peer support programmes that are carefully co-ordinated through interagency partnerships.
- Breastfeeding support centres, both BfN and the health professional led ‘drop-in’ model.
- Antenatal interactive workshops developed with sensitivity to the local socio-cultural needs.
- Development of the health care assistant role in supporting breastfeeding women across the hospital community interface.
- Innovative projects primarily involving qualified breastfeeding counsellors/supporters, e.g. BfN Centres with ‘Supporterline’ backup and the Consumer Practitioner role.
- Education and training for health visitors, midwives, neonatal staff and doctors.
- Schemes that specifically reach and support women from minority ethnic communities.
- Projects that specifically support adolescent mothers.
- Schemes that involve significant others.
- Expansion of the Breastfeeding Friendly Award project.
- Prison outreach programmes.
- Media projects to include National Breastfeeding Awareness week.
- Health informatics systems that enable robust yet sensitive data collection and analysis using consistent time points and definitions related to infant feeding practices.

Research as highlighted in each section should aim to gather both qualitative and quantitative data to continue developing and improving services that positively impact upon breastfeeding initiation and duration rates.

With appropriate funding for the range of initiatives referred to in this report the future looks promising for PCTs in meeting the challenge of increasing their breastfeeding initiation rates by 2 percentage points per year with particular focus on women from disadvantaged groups.
References
(Excludes DH funded infant feeding projects.)


