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**CHASE**

Centre for Health and Social Evaluation

Exploring Infant Feeding and  
Breastfeeding Peer Support  
Services in Middlesbrough and  
Redcar & Cleveland



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# **Exploring Infant Feeding and Breastfeeding Peer Support Services in Middlesbrough and Redcar & Cleveland**

**A report prepared for  
the Public Health teams of Middlesbrough Council and  
Redcar & Cleveland Borough Council**

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## **Glossary**

BFI	Breastfeeding Friendly Initiative
CHASE	Centre for Health & Social Evaluation
DH	Department of Health
FAQ	Frequently Asked Questions
GP	General Practitioner
NCT	National Childbirth Trust
NHS	National Health Service
NMC	Nursing & Midwifery Council
OCN	Open College Network
PCT	Primary Care Trust
SIDS	Sudden Infant Death Syndrome
WHO	World Health Organisation



# 1. Introduction

The Centre for Health & Social Evaluation (CHASE) at Teesside University was commissioned by Middlesbrough Council and Redcar & Cleveland Borough Council's Public Health Departments to carry out an exploration of infant feeding and breastfeeding support services across both local authority areas. The re-commissioning of support services for breastfeeding is under consideration in autumn 2014 and further information to guide that decision making process was required.

## Structure of the report

This report starts with a short review in section 2 of existing literature around breastfeeding which sets the context for concerns about low breastfeeding rates in the Tees Valley area and also looks at the policy context and evidence for effectiveness of interventions on breastfeeding. This section helps to sensitise the researcher and the reader to the main issues that surround this topic and helped guide the format of questions at the data gathering stage.

Section 3 includes a review of available breastfeeding data and Section 4 describes the research methods used in the study.

In section 5 the report draws together the views of a wide range of people across the two local authority areas under the following headings:

- The Breastfeeding delivery pathway
  - Elaboration of delivery structures
  - Commissioning of services
  - Statutory and discretionary services
- Breastfeeding initiation
  - Issues
  - Data collection
  - Information
  - Women's experiences
  - Mixed messages
- Sustaining breastfeeding
  - Support
  - Specialist Support Services
  - Information
  - Mixed messages
  - Women's experiences
  - Partnership Working
  - Resources

The final section draws some conclusions and offers some recommendations to guide and support future commissioning decisions.

## 2. Context

Breastfeeding has been associated with many health benefits for the baby, such as a reduction in the risk of acute otitis media, non-specific gastroenteritis, severe lower respiratory tract infections, atopic dermatitis, asthma, obesity, type 1 and 2 diabetes, childhood leukaemia, sudden infant death syndrome (SIDS) and necrotizing enterocolitis (Cheung et al 2007). In terms of health benefits for the mother, breastfeeding is linked to a reduced risk of type 2 diabetes, and breast and ovarian cancer (Cheung et al 2007).

The benefits of breastfeeding have caused leading health organisations, such as the World Health Organisation (WHO) and UNICEF to recommend breast feeding for mothers. The WHO recommended, in 2000, that babies be fed exclusively on breast milk for the first six months of their life. The UK Government's policy on breastfeeding has been broadly in line with this (McAndrew et al 2012).

Despite this strong endorsement from the WHO, UK breastfeeding rates remain low. Using data from 2005, the UK's rate of breastfeeding at three months (35%) is less than half that of Finland (75%). At six months, the UK rate is only 25%, while Finland's rate remains high at 60%. Other European countries, such as Italy, the Netherlands, and the Czech Republic, all have much higher breastfeeding rates than the UK (Green 2010, WHO 2009, Bolling 2007). McAndrew goes so far as to state that Britain has one of the lowest rates of breastfeeding in the world, over the course of the last fifty years (WHO Global Databank).

Even when mothers initiate breastfeeding, the drop away after a short period of time is very noticeable. In England in 2010, for instance, 81% of mothers' breastfed their baby at birth, but this dropped rapidly to only 69% at one week, 55% at six weeks, and only 34% at six months (McAndrew et al 2012). The exclusive breastfeeding rates are lower than this (identified in the Infant Feeding Survey. Wales', Scotland's, and Northern Ireland's rates were all considerably lower than this.

Within England, different regions vary hugely in their breastfeeding rates. The North-East of England has the lowest breastfeeding initiation rate in England, with a breastfeeding initiation rate of only 65%, compared to the 83% breastfeeding initiation average in England. The rate of breastfeeding in Middlesbrough is even lower than the North-East average, with an initiation rate of only 45%. In Redcar and Cleveland, the rate is slightly higher, at 52%, but this is still significantly lower than the national average. More worryingly, while rates of breastfeeding have gone up in England as a whole, the rate in Middlesbrough and Redcar has stagnated, and has not gone up significantly at all over the past six years. In 2005/2006, breastfeeding initiation in Middlesbrough was at 43%, and in Redcar it was 54%. In 2011/2012, it was 46% in Middlesbrough and 52% in Redcar. Over the same period, the national average had gone up from 67% to 74%. Nearby regions, such as Doncaster, Gateshead and Darlington, had followed this national trend, with their breastfeeding initiation rates rising significantly over the same time frame

(Green 2013), so the stagnant rates in the Tees Valley area are a cause for some concern.

Even within the region of Middlesbrough and Redcar and Cleveland, breastfeeding initiation rates vary dramatically. In Nunthorpe, for example, 68.5% of new mothers initially breastfed their babies, compared to only 17.5% in Thornthorpe 2010-2013 (Green 2013).

One of the most obvious underlying factors determining breastfeeding is poverty and deprivation. In the more deprived areas of Middlesbrough and Redcar and Cleveland, mothers are less likely to breastfeed. People who live in the least deprived areas of the region are twice as likely (63.6%) as those in the most deprived areas (31.8%) to initiate breastfeeding of their children (Green 2013). Deprivation has commonly been given as a reason why some areas have a far lower rate of breastfeeding than others (McFadden et al 2006). This could be because mothers in more deprived areas lack the material resources to which wealthier mothers have access, although bottle-feeding is clearly a more expensive option. However, it is also true that mothers in relatively deprived areas are more likely to have to return to work, and to return to work sooner, than wealthier mothers (Noble 2001). This could easily affect their decision to breastfeed, as many find breastfeeding to be very difficult once they are back in the workplace, given that night feeds cannot be shared with partners and that expression of breast milk can be a cumbersome process (McFadden et al 2006).

Commonly, far fewer young mothers breastfeed than their older counterparts (Ineichen et al 1997). In South Tees, only one in five teenage mothers initiates breastfeeding compared with half of mothers aged over 30 (Green 2013). This issue is not divorced from that of deprivation; Griffiths suggests that young mothers in more deprived areas are far less likely to breastfeed than young mothers in less deprived areas, or older mothers in deprived areas (Griffiths et al 2005).

Ethnicity is another major factor that influences breastfeeding. Mothers from White British backgrounds are less likely to breastfeed than BME mothers. In a study into breastfeeding cessation in Bradford, Agboado et al (2010) found that White mothers were 69% more likely to stop breastfeeding than non-White mothers (Agboado et al 2010). In the 2010 Infant Feeding Survey, it is stated that more than nine in ten mothers who classified themselves as Asian (95%), Black (96%), or Chinese or other ethnic origin (97%) initially breastfed compared with just under nine in ten (89%) mothers of mixed race and around four in five White mothers (79%) (McAndrew et al 2012). On a national level, then, it can also be seen that fewer White mothers breastfeed than non-white mothers. As with age, ethnicity is not easily separated from deprivation in the case of breastfeeding. However, interestingly, a higher percentage of non-white mothers live in deprived areas than white mothers, yet the breastfeeding rates are still higher in BME communities than in people from White British backgrounds (Griffiths et al 2005). This suggests that cultural attitudes towards breastfeeding may play a large part in deciding whether to breastfeed or not. These attitudes can cause women to stop breastfeeding due to

shyness or embarrassment, with the expectation that they may need to breastfeed in public and therefore be perceived as “dirty” or “rude” (Bailey et al 2004). Partners and family members are also critical to the decision making process but may not be aware of the health benefits of breastfeeding (Kornides & Kinsantas 2013)

Cultural attitudes can also affect the way that mothers access, or do not access, support services. While there are support services available, it is unclear how well-known they are to new mothers, how freely available they are in different areas, and how helpful they actually are.

The National Institute for Health and Care Excellence put forward several recommendations for breastfeeding support. These include advising commissioners and managers to implement a structured programme to:

- encourage breastfeeding within their organisations
- encourage breastfeeding by providing information, practical advice and ongoing support
- encourage breastfeeding peer supporters
- encourage parents to introduce children to nutritious solid food only once they have reached the age of six months.

GPs, health visitors and midwives are the primary points of contact for new mothers. The midwife is usually the first person to help a new mother to breastfeed, while she is still in hospital. This part of the support for new mothers is therefore crucial.

UNICEF’s Baby Friendly Initiative (BFI) was originally established in 1992 and subsequently introduced to the UK in 1995. The recently revised BFI Standards (UNICEF 2012) update and expand on the previous standards, incorporating the contemporary evidence base relating to optimal infant nutrition, the critical significance of early parent-infant relationships but also the need for an “educated workforce”.

The UNICEF UK BFI is an accredited programme based on the global WHO/UNICEF BFI. The UNICEF UK BFI focuses on the health and wellbeing of all babies and stipulates that a strong mother-baby relationship is the basis for this and that breastfeeding supports this bond.

UNICEF have developed evidence-based standards for maternity, neo-natal, health visitors, public health nursing and children centre services as a way of improving the care and support that pregnant women and new mothers and their families receive, in order to build those strong relationships, feed and care for the baby.

This is a 3-stage programme:

- Build a firm foundation – including the development of an infant feeding policy, plan for staff training and protocols and develop guidelines which underpin how staff will implement the standards

- Develop an educated workforce – all staff caring for mothers, babies and their families should be trained in order to implement the standards
- Monitor parents' experiences – to ensure that the standards being implemented are benefiting the mothers and babies and achieving improved outcomes.  
([http://www.unicef.org.uk/Documents/Baby\\_Friendly/Guidance/Baby\\_Friendly\\_guidance\\_2012.pdf](http://www.unicef.org.uk/Documents/Baby_Friendly/Guidance/Baby_Friendly_guidance_2012.pdf))

These new standards incorporate the previous standards as specified in the Ten Steps to Successful Breastfeeding and Seven Point Plan. The revised Standards draw on the widening evidence base. These standards focus on the optimal infant feeding and responsive feeding. The main purpose of the revised standards is to continue to increase breastfeeding initiation and prevalence and to support health professionals in enabling mothers and their families in establishing close relationships with their baby.  
(UNICEF 2013)

The maternity wards at James Cook Hospital in Middlesbrough are fully UNICEF Baby Friendly accredited and due for reassessment in 2015. However, Bartington et al (2006) have suggested that although Baby Friendly accredited maternity wards may help to initiate breastfeeding, this scheme appears to have no impact on the duration of breastfeeding. Most new mothers leave hospital after a day or so and they are then officially in the care of community midwives who are also fully accredited. Both accreditations are due to be reassessed in 2015.

However, once home, they lose the immediate possibility of help and support with the baby's feeding and the possibility of peer support and advice from any other new mothers that they may have had on the wards in hospital.

The Midwives' Rules and Standards (NMC 2012) clearly stipulate the professional responsibility of mothers and babies not being discharged from midwifery care before 10 days postnatally. The majority of women's and babies' transfer of care to the family health visitor usually occurs at this point in the postnatal period; however, ongoing care can be provided by the midwife if necessary. The health visitor sees the baby and new mother at least four times in the first year after the birth. However, as health visitors can be in charge of a large number of babies, it may be difficult for parents to ask questions, or gain information, and this level of contact is unlikely to be sufficient to support breastfeeding maintenance when the going gets rough for new mothers. During this period mothers also have access to their GP services of course. Academic trials (Labarere et al 2005) indicate that increased training for primary care physicians can make them an important part of an early intervention pathway for improving maintenance of breastfeeding but very few UK GPs have these enhanced levels of training.

Sure Start Children's Centres are locally based centres that aim to improve outcomes for young children and their families, with a particular focus on the most disadvantaged families, in order to reduce inequalities in child

development. Such Centres often offer breastfeeding support groups, to which women can be referred or can refer themselves. Within many Centres there are Breastfeeding Peer Supporters, who are breastfeeding mothers who have received additional training to provide support to women thinking about, or wishing to breastfeed.

Critically, women are offered support both during the antenatal period, in order for them to make an informed decision on whether or not to breastfeed, and after the baby is born to enable women to breastfeed for as long as they can.

Antenatal contact may be absolutely pivotal in preparing women for a successful breastfeeding experience.

Others sources of support come from leaflets and books, as they always have, but these are now joined by online sources of information, both from official sites such as NHS Choices, with its videos and FAQs to MumsNet and other websites.

Other organisations that aim to support breastfeeding include charitable institutions, such as the National Childbirth Trust (NCT), the La Leche League, Tommy's, Best Beginnings, the Breastfeeding Network and the Association of Breastfeeding Mothers. Many of these organisations have national helplines, websites and local meetings, such as the NCT, which has a local branch in Teesside. However, as NCT courses are not free, and parents must pay to attend, it tends to be the wealthier, older mothers who are accessing these services. It must be noted that the NCT are trying to attract mothers from less privileged backgrounds by holding Nearly-New-Sales, where second-hand clothing, toys and furniture for babies are sold cheaply, and offering discounted fees for courses to parents from more deprived backgrounds. Awareness of these organisations may be a problem.

Responsibility for encouraging and supporting breastfeeding is, then, shared among a number of different agencies, not all of whom will be in regular contact with one another. Recent structural changes to the NHS have exacerbated this fragmentation, with different patterns of commissioning of service being undertaken through Foundation Hospital Trusts, through Clinical Commissioning Groups and through Public Health departments in Local Authorities, and different services being offered by GPs, community health and hospital services, local authorities, as well as through voluntary and community groups. It is very little wonder that women, especially those living in settings of disadvantage, find it difficult to navigate their way through this maze.

In a systematic review of 36 studies looking at professional support of breastfeeding, Hannula et al (2008) suggest that interventions delivered from pregnancy to the intrapartum period and throughout the postnatal period were more effective than interventions concentrating on a shorter period. In addition, a combination of different types of service (such as written information, combined with presentations, one-on-one conversations with health visitors, and peer support classes) may be more successful than single

service approaches (Hannula et al 2008). During pregnancy – in the preparation period for breastfeeding - the effective interventions were interactive, involving mothers in meaningful conversations which extend into the postnatal period (UNICEF/BFI 2014). Practical “hands off” teaching when combined with facilitative support and encouragement are also effective approaches (Schmied et al 2011). Additionally, what was most effective in maintaining breastfeeding were home visits, telephone support and breastfeeding centres, combined with peer support.

Hannula et al also point out that professionals themselves need breastfeeding education and support of their organisations to act as breastfeeding supporters. Overall the authors conclude that mothers benefit from breastfeeding encouragement and guidance that supports their self-efficacy and feelings of being capable and empowered, and which is tailored to their individual needs. Training for professionals thus needs to take them beyond didacticism to a place where they can work with women in this way.

Renfrew et al (2012) went on to argue that all women should be offered support to breastfeed in order to increase the duration and exclusivity of breastfeeding. They point out that such support tends to be more effective in areas with high initiation rates, so interventions to further increase initiation rates need to be in place. They also recognised that face to face support is more likely to be successful but that support needs to be proactive not reactive. (Renfrew et al 2012)

Jolly et al (2012) also agreed that peer support interventions do increase breastfeeding continuation but suggested that this does not apply to “high income” countries such as the UK, due to the fact that breastfeeding support is part of routine healthcare and as a result, low intensity peer support is not effective. They go on to argue that new peer support services in high income countries should undergo a concurrent evaluation. (Jolly et al 2012)

### 3. Review of breastfeeding data

#### England

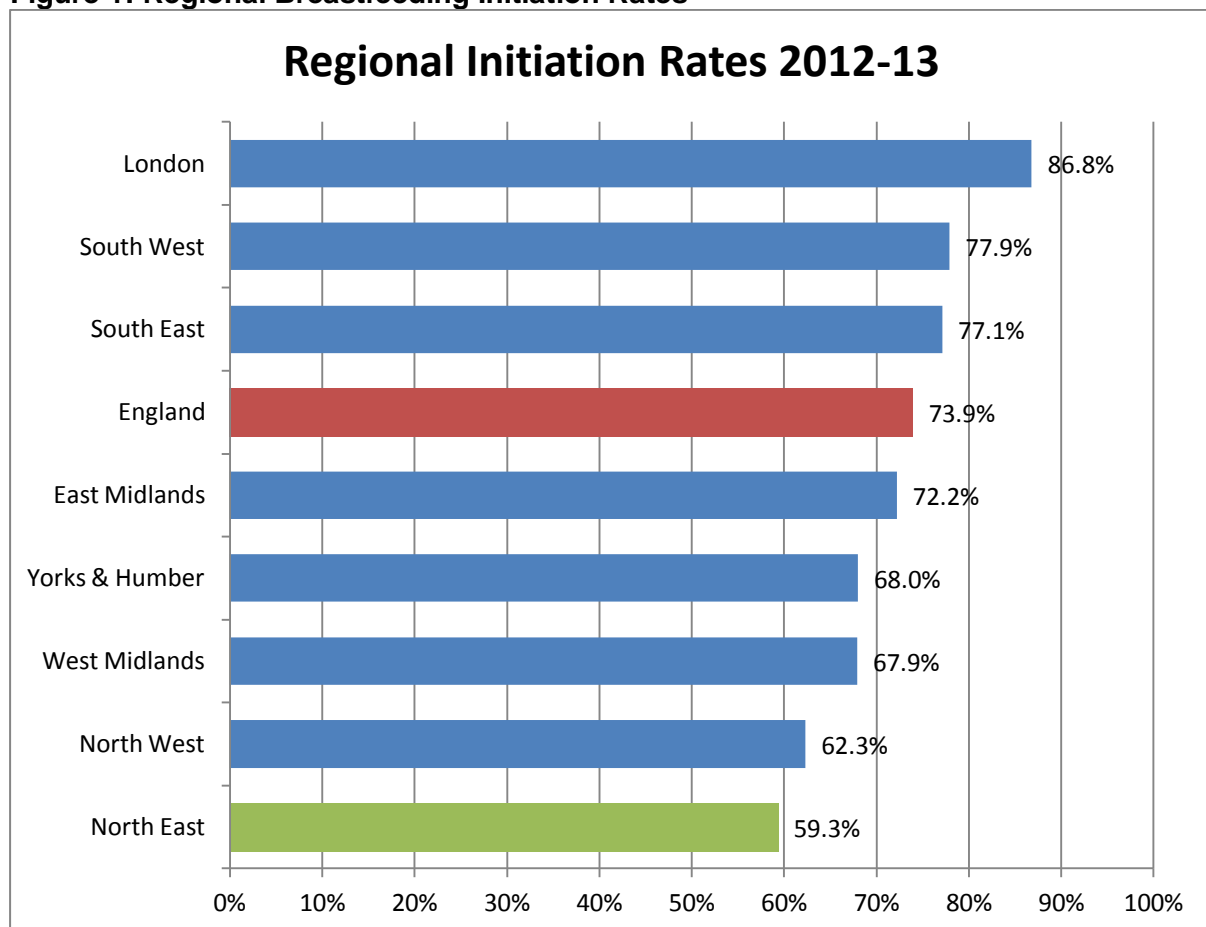
Overall, prevalence of breast feeding initiation in England has steadily and significantly increased year on year since 2005/6, with the exception of 2012/13, where it reduced, albeit not significantly (DH 2013 T1\_Ini\_National).

In England, prevalence of breastfeeding at 6 to 8 weeks (fully / partially) has also steadily and significantly increased since 2009 / 10, with the exception of 2012 / 13, when it stayed the same (DH 2013 T2\_Prev\_National) as the previous year.

In England, the drop off rate (from initiation to 6 to 8 weeks) has steadily reduced from 38.5% in 2009 /10 to 36.1% in 2012/13.

Regional figures clearly highlight that the North East region has the lowest rate of breastfeeding initiation in the country. It is also clear that breastfeeding rates in the south of the country are significantly higher than those in the north. Only London, the South East and South West achieved higher than national average breastfeeding initiation rates in 2013. London has a particularly high initiation rate (86.8) possibly due to the high ethnic population in that area, as there is evidence to suggest that the ethnic population has a higher preponderance of breastfeeding.

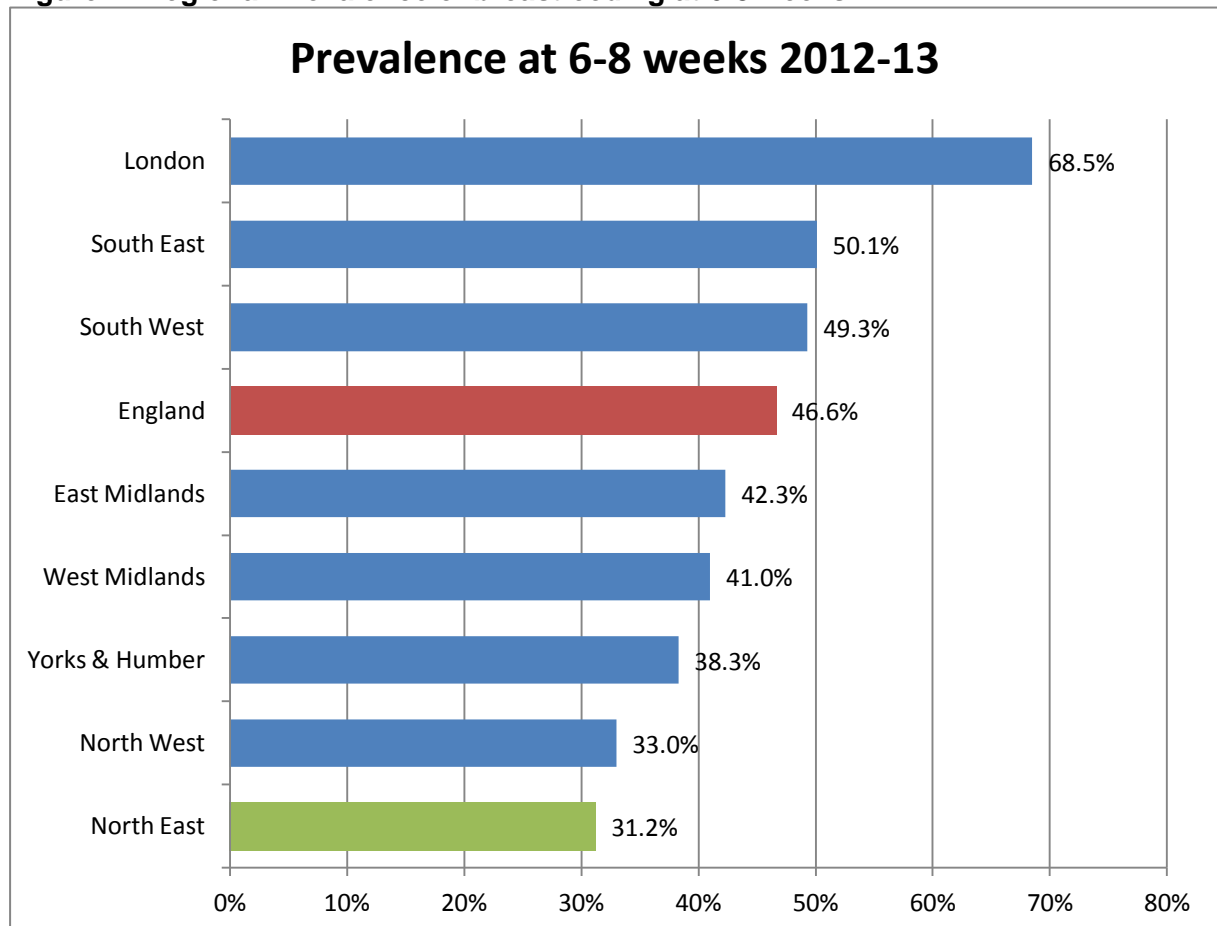
**Figure 1: Regional Breastfeeding Initiation Rates**





The regional rates for the prevalence of breastfeeding at 6-8 weeks appear to follow the regional patterns of breastfeeding initiation. However, only London has a higher rate of prevalence than the national average. The South East and South West fall below the national average in maintaining breastfeeding, although this continues to be higher than other regions.

**Figure 2: Regional Prevalence of breastfeeding at 6-8 weeks**

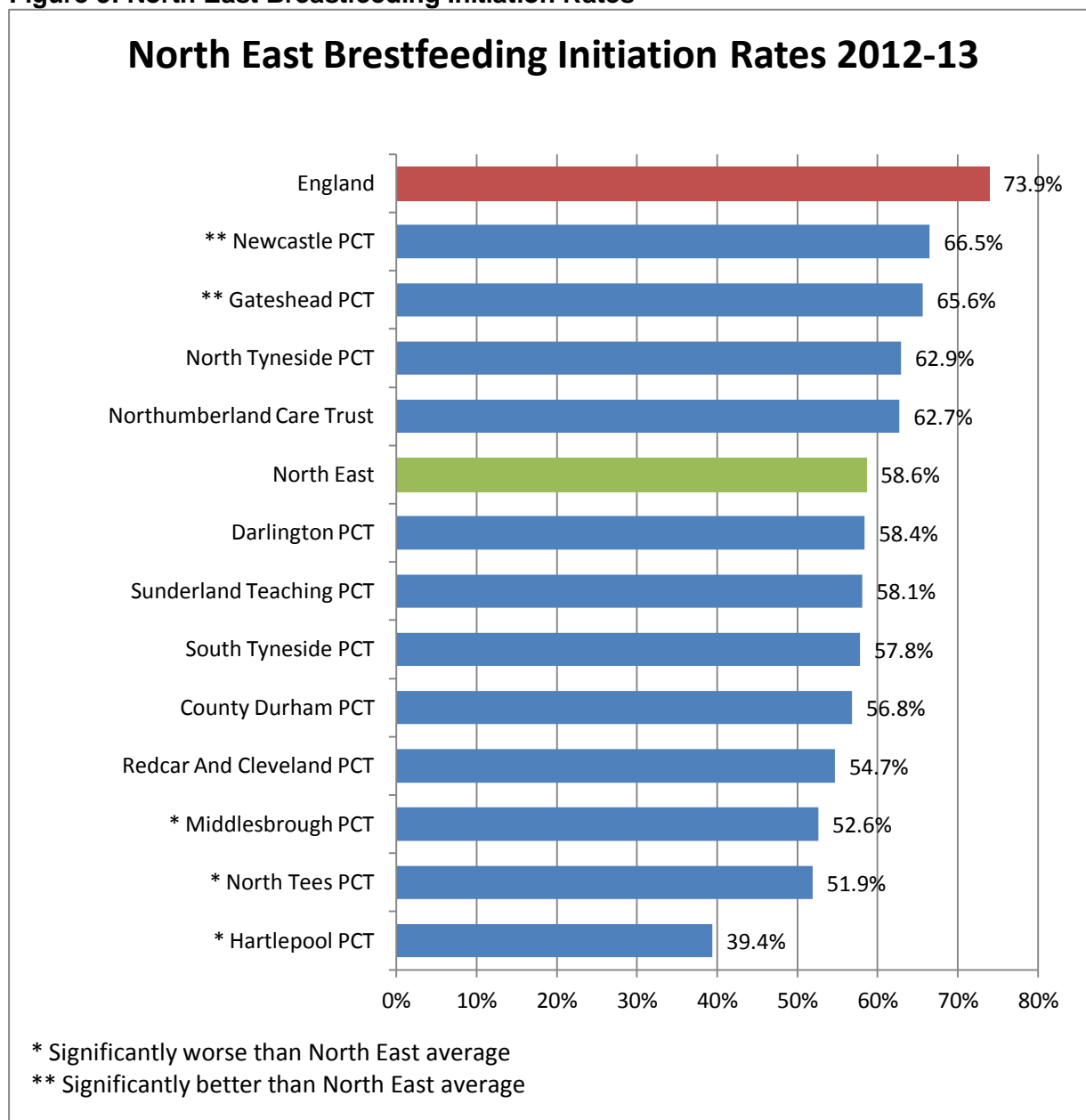


### North East – Breast feeding initiation

In looking at the initiation rates for the North East regions (2012/13 Q4), we can see that Hartlepool has the lowest rate for the North East, and Newcastle has the best.

Although both Middlesbrough and Redcar and Cleveland fall below the North East average, only Middlesbrough has proportions significantly lower than the North East average. Both Gateshead and Newcastle PCT have rates significantly better than the North East average in this quarter. (DH 2013 T4\_Init\_Trend\_PCT)

**Figure 3: North East Breastfeeding Initiation Rates**

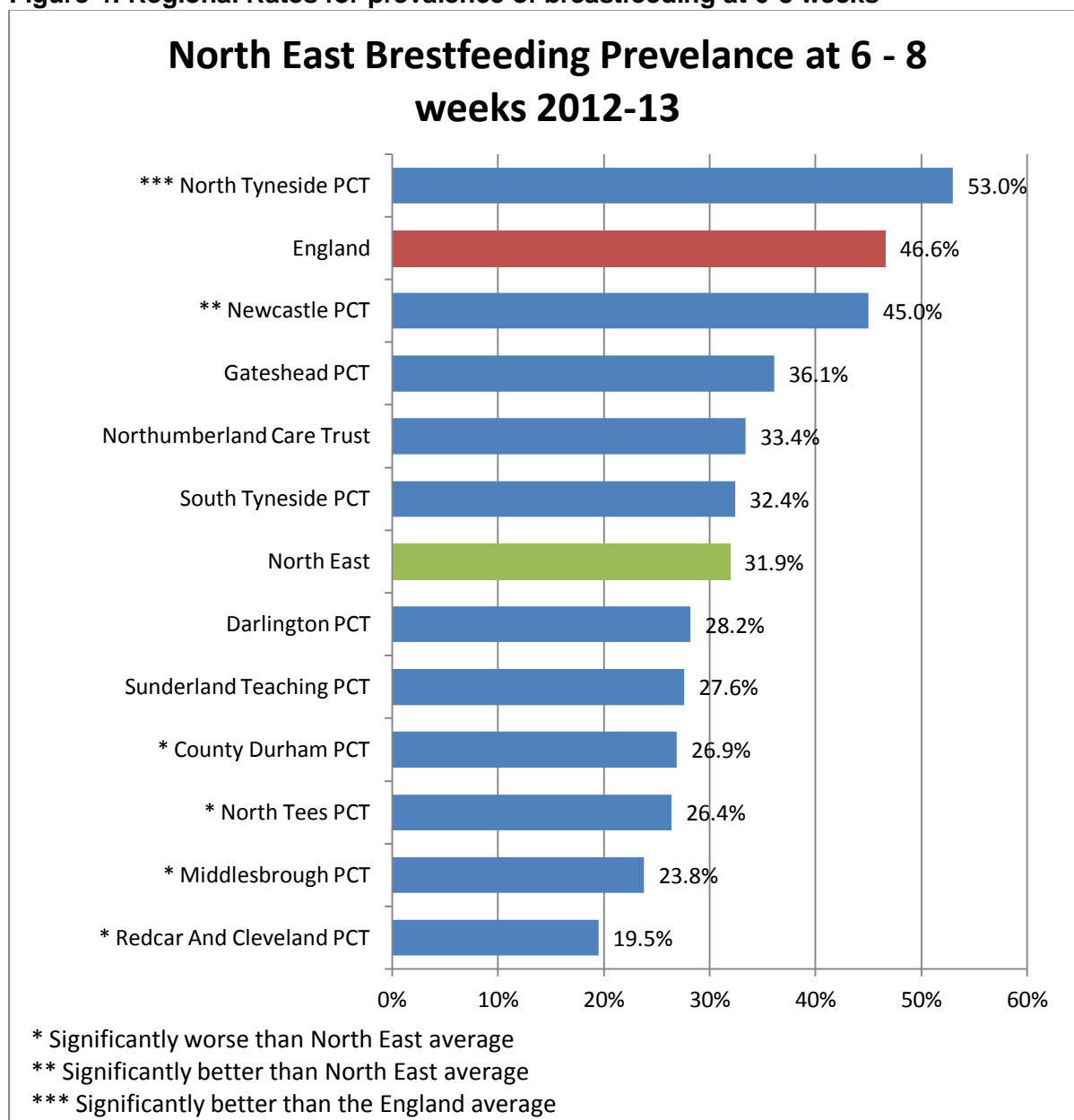


### North East – Prevalence of breast feeding at 6 – 8 weeks

In looking at the rates for breastfeeding at 6 to 8 weeks, for the North East regions (2012/13 Q4), we can see that there is no data for Hartlepool. This is because the data did not meet the validation criteria.

We can also see from this data that both Middlesbrough and Redcar and Cleveland have breast feeding rates at 6 to 8 weeks significantly lower than the North East average. Although the data is not available to confirm, we can anticipate that Hartlepool has the worst rate in the North East, based on past data. Once again, Newcastle has the best rates, which are also significantly better than the North East average. (DH 2013 T5viii\_Prev68\_1213Q4\_PCT)

**Figure 4: Regional Rates for prevalence of breastfeeding at 6-8 weeks**



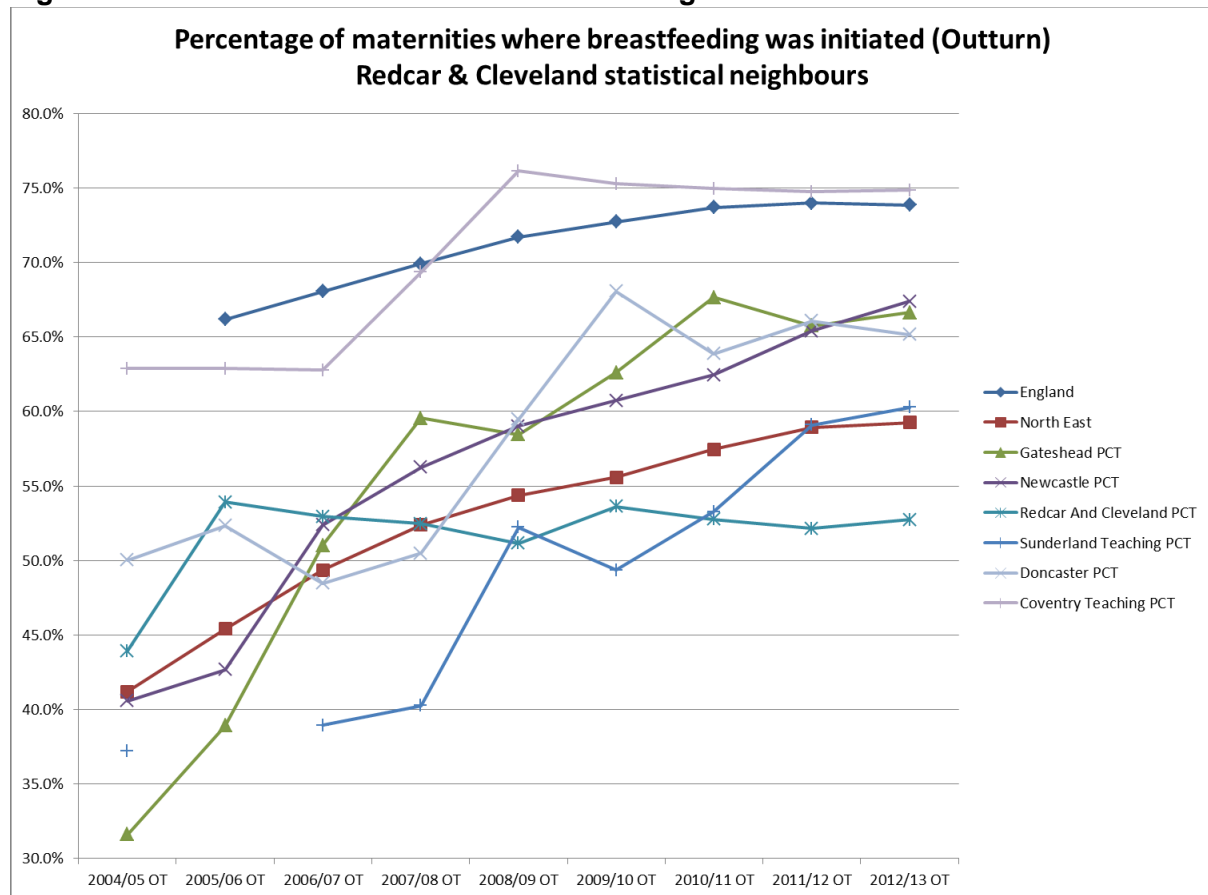
## Statistical Neighbours<sup>1</sup>

### Initiation

Comparisons of both Middlesbrough and Redcar & Cleveland with their statistical neighbours show a steady increase in the rates of both initiation and breastfeeding prevalence at 6-8 week from the onset of data collection in 2004/05 to 2012/13 figures. However, these increases are not linear and show some that figures do go up or down year on year.

<sup>1</sup> The statistical neighbours were originally defined by the local authorities and have previously been used by them in their analyses.

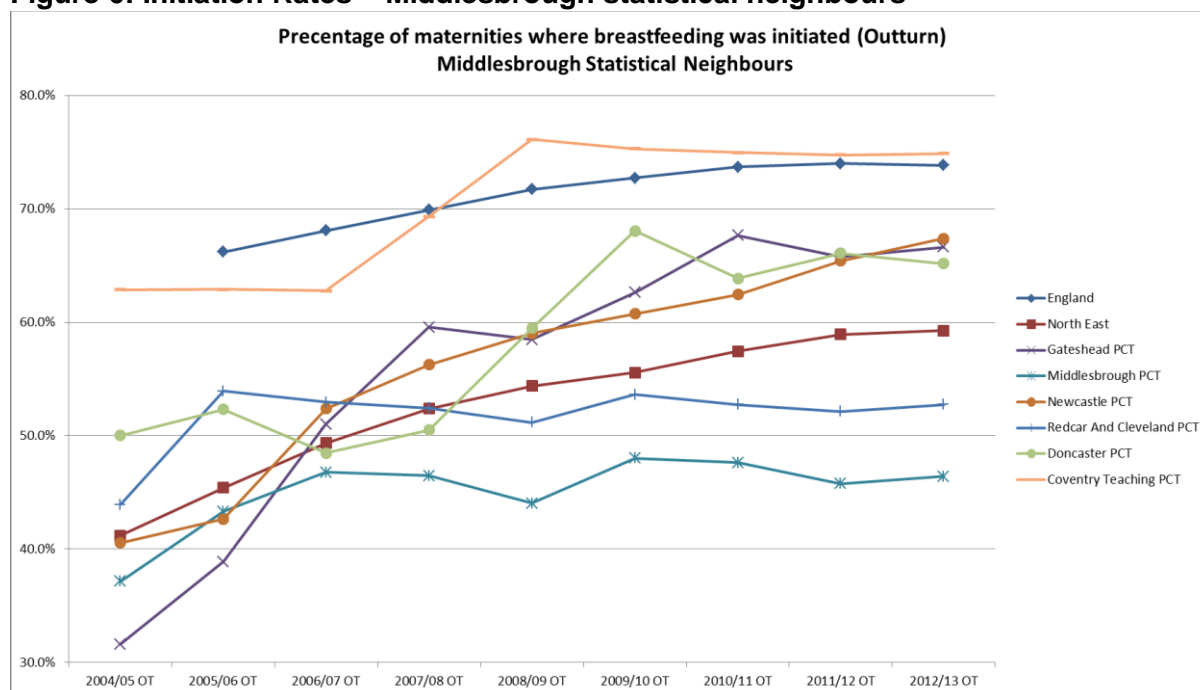
**Figure 5: Initiation Rates – Redcar statistical neighbours**



Since the beginning of data collection Gateshead has had a 35 percentage rate increase in initiation figures. This is even more significant when bearing in mind that at the beginning they had the lowest rates of initiation and now have the fourth highest. This success indicates that they may have a model of delivery which is worthy of further investigation. Over the same time period Newcastle also shows a 26.8 and Sunderland a 23.1 percentage rate increase. Redcar & Cleveland show a 7.9 percentage rate increase for that period, showing a slow increase but one which is still significantly lower than the national average.

Middlesbrough shows the poorest initiation rates amongst all of its statistical neighbours. However, it does show a 9.3 percentage rate increase over the last 10 years which is a similar rate increase achieved by many of its neighbours. Again Gateshead and Newcastle are highlighted as having achieved the highest increase over that time period.

**Figure 6: Initiation Rates – Middlesbrough statistical neighbours**



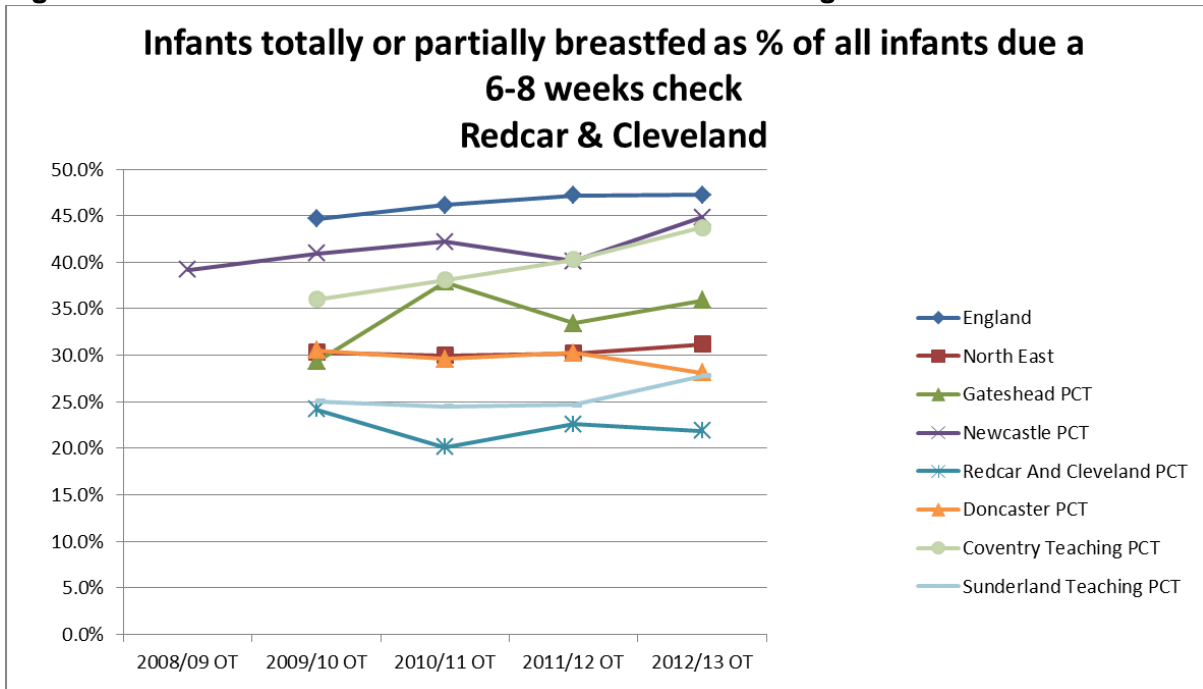
Coventry shows a marked stepped increase from 06/07-08/09 and Doncaster between 08/08-09/10. It is likely that during those times they changed their model of delivery and, while both have steadied since those rises, they have maintained the original increase. Again it may be beneficial to identify the models adopted for further examination.

***Prevalence at 6-8 weeks check***

Data collection for the prevalence of breastfeeding at the 6-8 week check started in 2008/09 but does not appear to have been routinely collected until 2009/10. Maintaining breastfeeding up until the 6-8 week check often proves problematic and this is reflected in the prevalence rates.

Of all the statistical neighbours for Redcar & Cleveland only Southwark (a London Borough) has a significantly higher prevalence rate at 6-8 weeks than the national average. Improvement by other statistical neighbours since 2008/08 has been stagnant, with few showing any marked improvement.

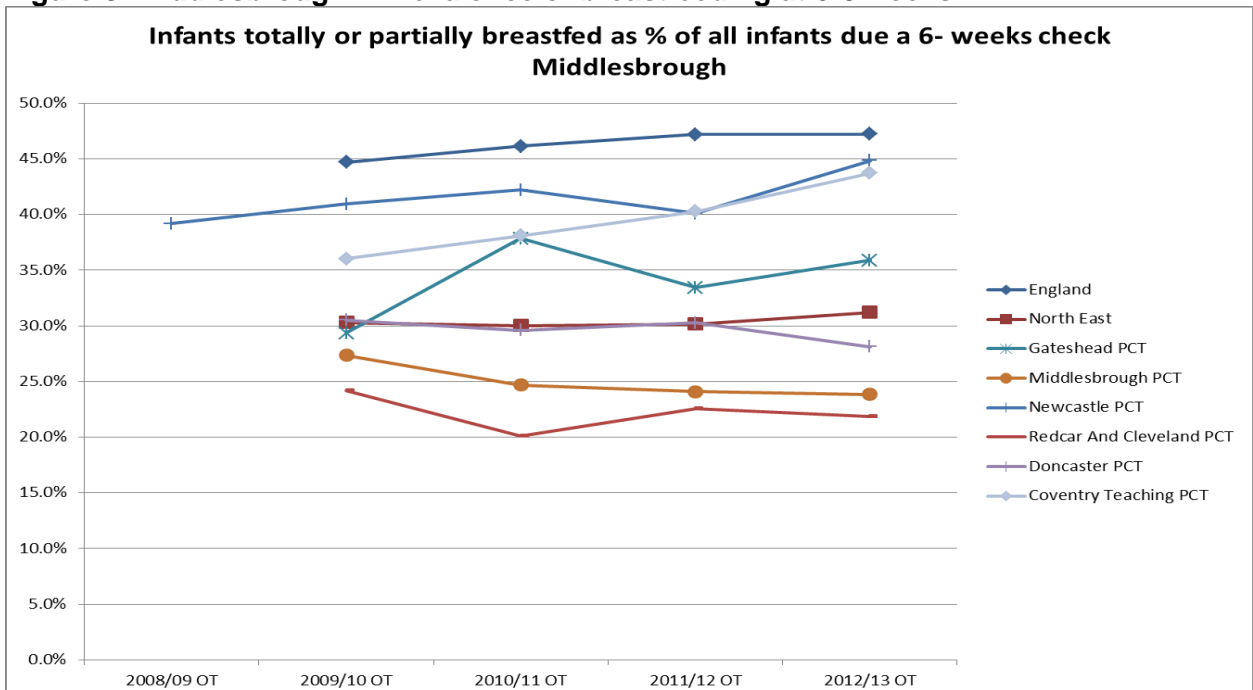
**Figure 7: Redcar & Cleveland – Prevalence of breastfeeding at 6-8 weeks**



All of Middlesbrough’s statistical neighbours fall below the national average. While Coventry has improved its prevalence rates by 21% and Newcastle by 11.4% since 2008/09, improvement across other statistical neighbours shows little improvement over that same period.

However, both Redcar and Middlesbrough show a reduction in prevalence rates, with Middlesbrough showing a 13.1% and Redcar & Cleveland a 6% reduction in prevalence rates.

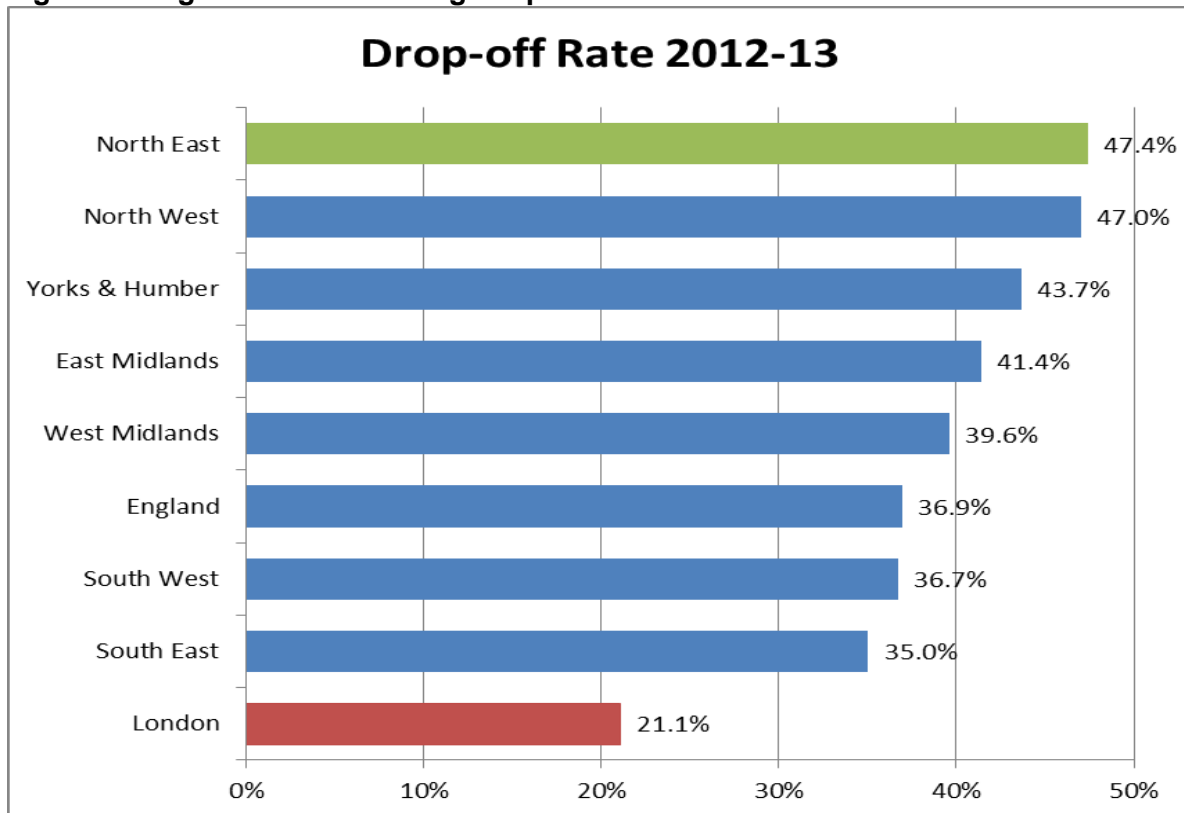
**Figure 8: Middlesbrough – Prevalence of breastfeeding at 6-8 weeks**



### Drop-off Rates

Most regions across the country show a significant drop off rate from initiation to prevalence at 6-8 week checks.

**Figure 9: Regional Breastfeeding Drop-off Rates**

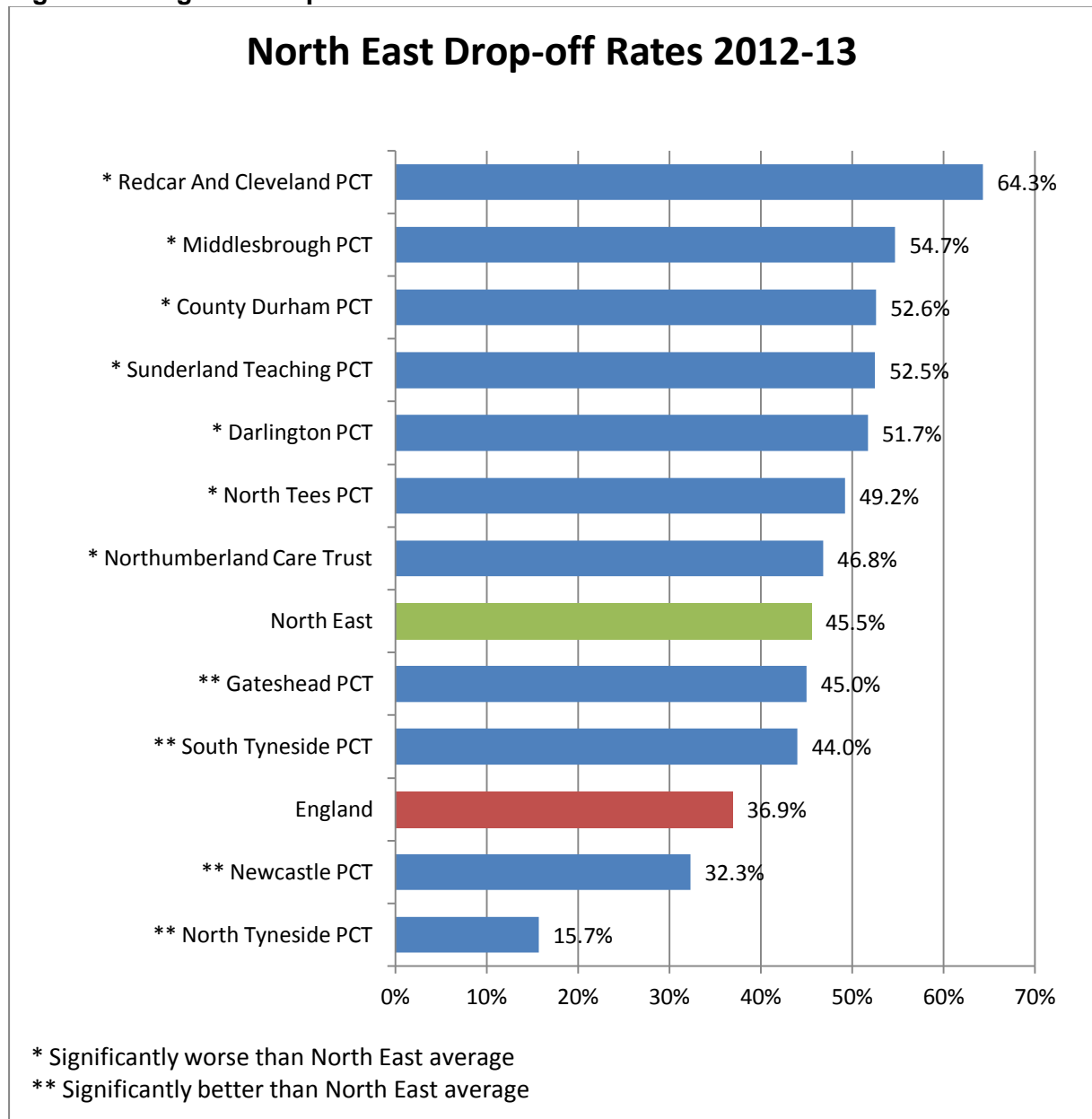


Nationally, the North East region has the highest drop-off rate from initiation to 6-8 weeks. Also despite the higher prevalence rates in London, their drop-off rate is substantially lower than other regions.

### North East – drop off between Initiation and 6-8 weeks (2012/13)

We do not have confidence intervals calculated for 'drop off' rates, and so cannot determine if these differences are significant or not. However, we can see that both Middlesbrough and Redcar & Cleveland have drop off rates which are higher than the North East average (2012/13). Newcastle PCT and North Tyneside PCT have rates which are better than the England average. (DH 2013)

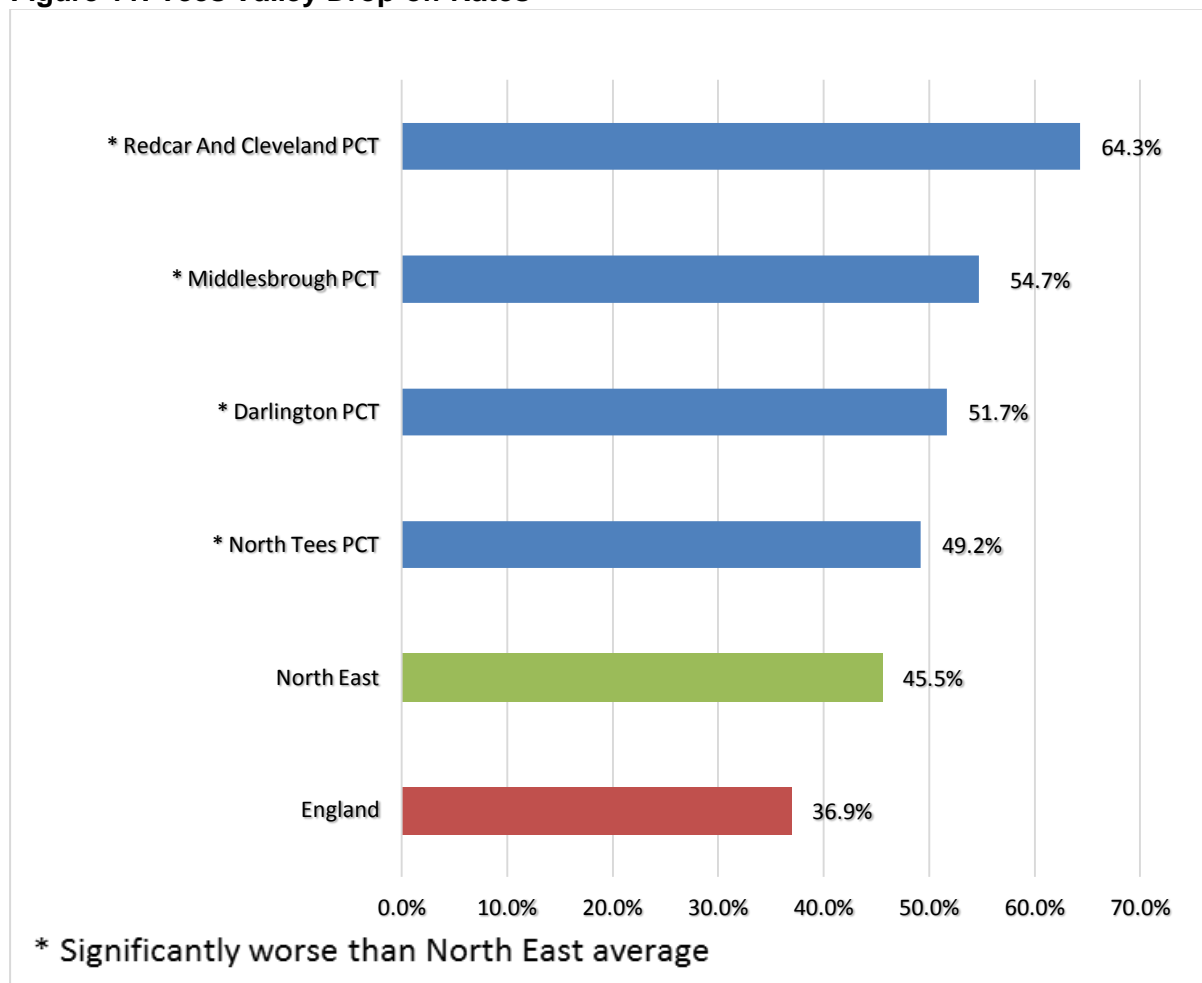
Figure 10: Regional Drop-off rates



A similar picture emerges in terms of the drop-off rate more locally within the Tees Valley area. Redcar & Cleveland has a current drop-off rate of 64.3% which is almost double that of England. Middlesbrough has a drop-off rate of 54.7% and both are significantly worse than the North East average.



**Figure 11: Tees Valley Drop-off Rates**



## Summary

- Nationally the breastfeeding initiation rates are increasing steadily year on year
- Only 3 regions (all in the south) are reaching the national average rates and the North East has the poorest initiation rates
- Redcar & Cleveland has the highest drop-off rate at 6-8 weeks in the North East
- Redcar & Cleveland and Middlesbrough continue to fare worse in breastfeeding initiation than many of their statistical neighbours
- Redcar & Cleveland and Middlesbrough continue to fare much worse in the breastfeeding prevalence at 6-8 weeks than the majority of their statistical neighbours
- Redcar & Cleveland has the highest drop-off rate (initiation to prevalence at 6-8 weeks) in the North East.

## 4. Methodology

### Aims

The aim of the study was to explore infant feeding and breastfeeding peer support services in Middlesbrough and Redcar & Cleveland.

The key objectives of the study were:

- To carry out a review of existing literature
- To gain an understanding of what services are available
- To explore the effectiveness of those services
- To make recommendations for future commissioning.

### Methods

A mixed method study design was used, comprising of:

- a narrative review of existing literature to identify benefits, uptake, reasons for differences in uptake, support services and peer support. Themes identified from the review were used to inform the development of an interview schedule to guide a series of interviews and focus groups with people involved in breastfeeding
- analysis of existing statistics
- face to face and telephone interviews and focus groups with stakeholders.

### Ethical considerations

Ethical approval for this evaluation was provided by the Teesside University School of Health & Social Care Research Ethics and Governance Committee prior to the start of this project. Further approval was granted by Redcar & Cleveland Borough Council and also the South Tees Hospitals NHS Foundation Trust Research & Development Unit to include Trust staff (hospital and community).

Confidentiality and anonymity were key ethical issues highlighted in this study. Hence, given the relatively small number of interviews and focus group participants involved, it is not possible to link quotations, for example, with the organisational roles of participants as this could identify those involved. Every effort has been made to ensure that participants cannot be identified.

### Sample

A total of 22 interviews and 10 focus groups were undertaken as part of this study. The breakdown of these participants by local authority area is as follows:

**Table 1: Breakdown of participants by area**

<b>Middlesbrough</b>		<b>Redcar &amp; Cleveland</b>		<b>South Tees Hospital Foundation Trust</b>	
Interviews	9	Interviews	7	Interviews	6
Focus Groups	5	Focus Groups	5		

A purposive sampling strategy was employed to ensure relevant people were included who had a role to play in the breastfeeding agenda. This sample frame was further stratified to ensure that a range of stakeholders were included. Participants thus included:

- Foundation Trust staff in the acute setting
- Community health staff
  - Midwives
  - Health Visitors
- Local Authority staff
  - Children’s centres
  - 0-19 Service
  - Teenage Pregnancy group
- Breastfeeding mothers
- BME community
- Fathers
- Women who had chosen to bottle feed their babies.

Prior to the interviews and focus groups contact was made with key stakeholders, and both written and verbal information was provided to participants. Interview participants were asked to complete a consent form. Focus group participants registered their consent to participate. Most interviews took place in professional settings. Notes were taken at the interviews and focus groups and transcribed immediately following the event. Members of the public taking part in focus groups were offered a High Street shopping voucher to thank them for their time and had their expenses reimbursed.

Individual interview participants (n= 22) included service providers within the Foundation Trust (n=3), Community Health (n=6), the local authority (n=7), the voluntary sector (n=1), breastfeeding education (n=1) and peer supporters (n=1). A small number of interviews (n=3) were also carried out with mothers from the BME community.

A total of 58 participants attended the focus groups. Further breakdown of the focus groups completed was as follows:

**Table 2: Breakdown of Focus Groups**

<b>Nature of Group</b>	<b>Number of Groups</b>	<b>Number of Participants</b>
Breastfeeding support	1	10
Peer support	2	16
Infant feeding*	3	18
Drop-in health clinic	1	5
Teenage pregnancy	1	3
Fathers group	1	3
BME community	1	3

\*Infant Feeding groups include breast and bottle feeding mums

## **Data Analysis**

A thematic analysis was conducted (Charmaz 2006) and NVivo10, a qualitative data analysis programme, was used to manage the data and aid analysis.

## 5. Findings

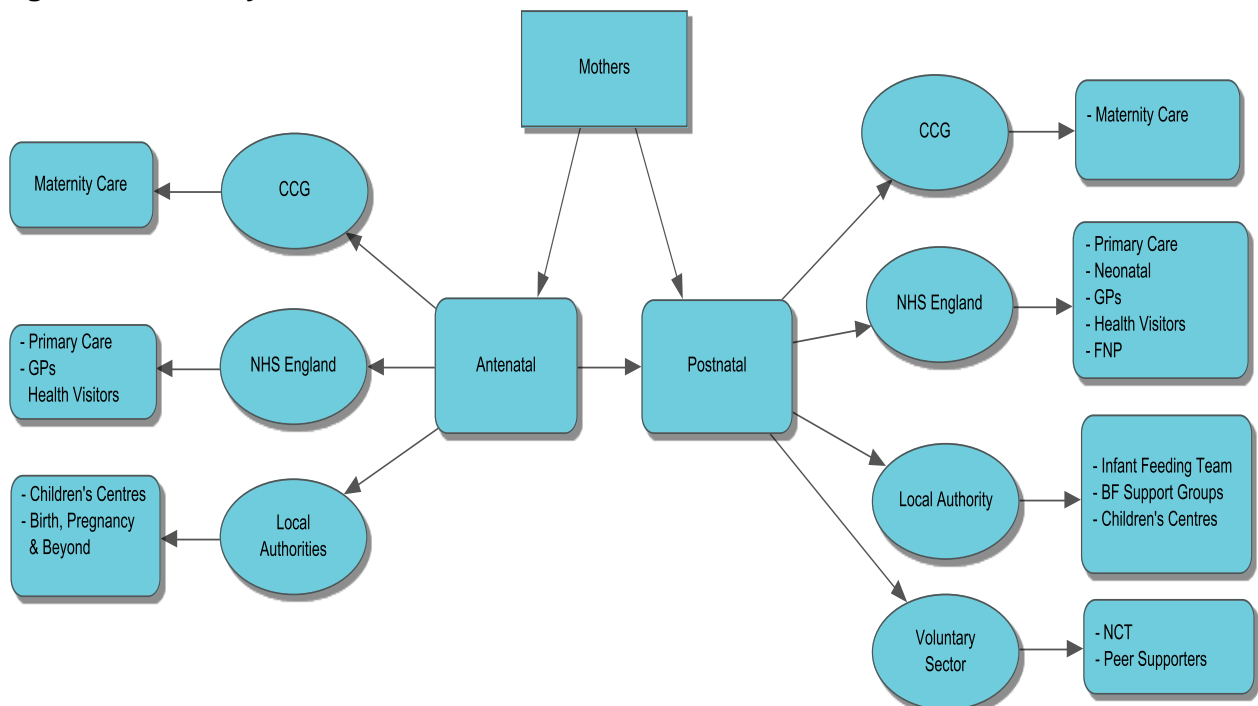
In this section we review the findings from the interviews and focus groups undertaken with a range of stakeholders from service planners to delivery staff to mothers and fathers themselves. The section starts by looking at the complex structure of the service delivery system around breastfeeding and at the ways in which the different parts of this system do or do not align.

### Breastfeeding delivery pathway

Breastfeeding support is delivered in a number of ways, at different levels and by a wide range of people. This is a complex pathway involving the NHS, local authorities and the voluntary sector.

### Delivery Structures

Figure 12: Delivery Structure



During the antenatal phase, women access midwives both at the hospital and in the community for antenatal checks which include advice and support for breastfeeding. Maternity healthcare assistants support the midwives but are also trained in breastfeeding support and take a role in providing the Early Bird sessions and some parent education. These sessions generally take place in local children's centres with the support of children's centre staff.

Breastfeeding support during this phase is designed to provide information to pregnant women in order to help them make an informed decision. It generally consists of a breastfeeding class/workshop and the distribution of leaflets and general advice and information from staff.

Postnatal support follows the birth and is available initially from NHS staff within the hospital setting, then continues in the home following discharge by midwives, health visitors and the infant nutrition team, although other agencies such as children’s centres and the voluntary sector also have key roles to play in providing local support services.

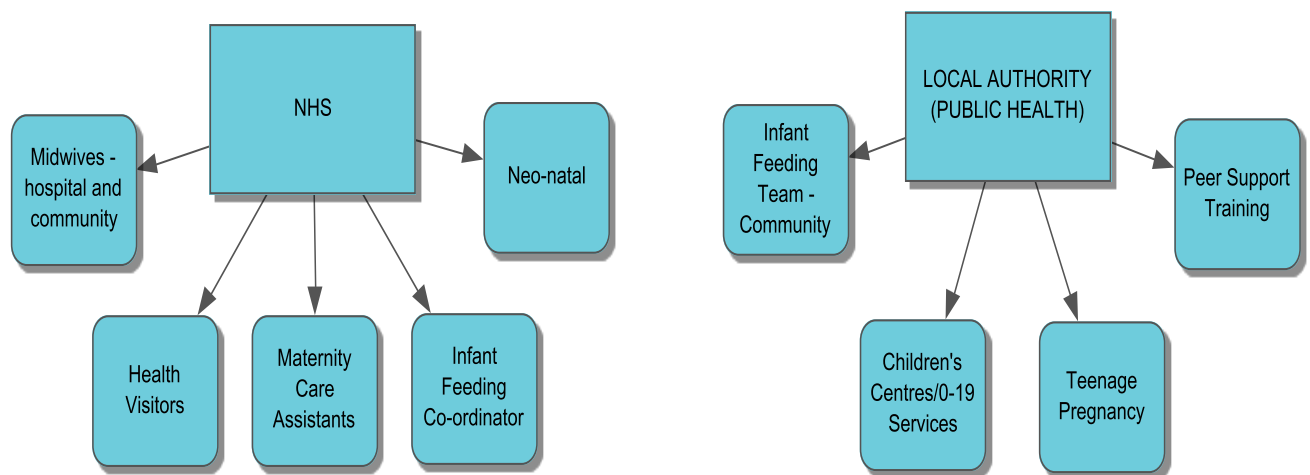
**Commissioning of services**

Breastfeeding initiation and prevalence is a key priority within public health so Local Authorities commission and support breastfeeding activity in their area. The amount of funding is dependent on a number of things, one being the level of priority given to breastfeeding and another being the availability of resources more generally.

Local Authorities commission the Infant Nutrition Team based in Guisborough and also provide services within the children’s centres which include breastfeeding support groups, infant feeding groups. They also commission staff training and teenage pregnancy services.

The NHS Maternity Contract is responsible for funding the health professionals – midwives, health visitors, maternity care assistants and the infant feeding midwife based in the hospital.

**Figure 13: Commissioning of Breastfeeding Support Services**



**Statutory and discretionary Services**

Antenatal and postnatal support is universally available to all pregnant women through the NHS. This provides access to midwives, health visitors and specialist infant feeding support. Breastfeeding support forms part of this service provision.

Breastfeeding support in the locality areas can be varied and provided by a wider range of people and services. The services provided are more discretionary in the sense that there is no legal requirement to provide such services, although the local authority public health team tends to have breastfeeding initiation and prevalence as a target area for improvement. However, although such services continue to be theoretically available to all mothers, take up is variable.

## **Breastfeeding support services**

As indicated in section 2, responsibility for delivering services to support breastfeeding has always been fragmented as women pass from antenatal to acute services and then back into the community during their pregnancy journey. That journey has become even more complex of late with NHS reorganisation shifting many functions out of the NHS and back into local authorities. We start by looking at the pre-pregnancy journey before looking at what happens at and post the birth of the child.

### ***Antenatal services***

The South Tees Hospitals NHS Foundation Trust staff play a key role in providing support for breast feeding, both at antenatal and post natal stages. Hospital midwives have a lead role to play in antenatal services, seeing women individually when they come to hospital or clinic to book their antenatal care, to be screened and so on. The number of antenatal visits will vary according to different aspects of women's pregnancy.

Midwives have a lot of ground to cover at each antenatal appointment. In addition to routine monitoring of women's health and the actual pregnancy, they must include discussion of family health issues, family dynamics, diet, safeguarding, smoking and so on. In practice, the prioritisation of breastfeeding as a topic was dependent not on the training received but on personal experiences and views. One midwife stated:

*We have a lot of things to cover at an antenatal session. As I am a breastfeeding key worker with an extended role within breastfeeding, I am passionate about breastfeeding so take more time to discuss this. I also teach other midwives, family breastfeeding, parenthood education and aqua natal. (Interview 5)*

A major concern identified in this study is that despite the revised UNICEF BFI Standards pregnant woman continue to be asked the question: 'Are you intending to breast or bottle feed?' This can happen at varying times throughout the pregnancy. Once the answer is recorded on case notes, this subject is not always revisited. Focus group participants confirmed this and reported that this approach did have an effect on the amount of breastfeeding information provided. The fact that mothers frequently saw a different midwife at each appointment was also considered as a factor (Parent, Focus Groups 2, 5, 6), each new midwife taking it on trust that the previous person had raised the matter satisfactorily.

A recent change is that health visitors now also offer all mothers-to-be an antenatal visit at home. However, it appears that this visit is primarily an introductory one and there is little consistency as to whether any discussions around infant feeding are initiated at this point. It could be argued that health visitors are following the UNICEF guidelines; however, there is also a view amongst health visitors and mothers that this is a missed opportunity.

Midwives involved in this study reported some involvement in antenatal breastfeeding workshops/ classes but also that such classes were not generally well

attended. It is also noted that earlier involvement in “Early bird” sessions for newly pregnant woman is now carried out by maternity healthcare assistants.

A number of issues were identified with regard to the breastfeeding antenatal session. These included the following points:

- That attendance levels are low and vary significantly according to area
- That classes are mostly run during the working day, making it difficult for fathers to attend
- That a “breastfeeding” workshop is likely to appeal to those who have already decided to breastfeed
- That content is often described as ‘prescriptive’ and mothers often feel they might be ‘bulldozed’ into breastfeeding.

These points are now elaborated below.

Numbers attending were often dependent on the area in which they were offered, with breastfeeding sessions in the most deprived areas often being cancelled because of lack of uptake. People involved in setting up and supporting these sessions largely felt that the majority of those attending had already decided that they were going to breastfeed. As a result they felt they served little purpose in encouraging the ‘undecided’ to opt for breastfeeding. Some interviewees reported the view that this was a ‘missed opportunity’.

Focus group participants generally held a view that these sessions were not well publicised and that many had no knowledge of them at all. This raises the question as to the effectiveness of the GP practice and midwife role in signposting and ensuring that pregnant women at least know about them, particularly if they do wish to breastfeed, but also to provide an opportunity for others to develop an understanding of the importance and benefits of breastfeeding in order for them to make a more informed choice.

This is particularly pertinent in the more deprived areas where there is always a lower rate for breastfeeding. In these areas, the responsibility for publicising such sessions often falls to Children’s Centre staff, as the sessions are often based in their buildings. There is no evidence to support that having such sessions in the locality serves to improve attendance in those areas where historically people lean towards bottle feeding.

Midwives are also involved in more general antenatal Parent Education sessions but, again, attendance at these sessions is variable.

Another issue raised by parents was that the majority of these sessions were held during the day and were often difficult for fathers or working mothers to attend. It was recognised that some antenatal hospital visits were scheduled during the early evening, and there was a view that a similar arrangement with the antenatal breastfeeding sessions might go some way to improving engagement for both parents.



It was reported that the content of these sessions generally focused on the benefits of breastfeeding for the baby but that they lacked any real information about the practicalities of breastfeeding and the impact it can have on mothers and also on issues that may arise with their babies.

One mother commented:

*We need open, friendly antenatal classes where they tell us the truth about things. Frank and open discussions would be ideal. (Parent, Focus Group 1)*

The way any professional approaches the issue of breastfeeding during the antenatal phase appears to be critical. For many years it was felt to be a tick box exercise and there was actually a tick list for maternity staff to complete. However, more recently this does appear to be changing. The new UNICEF Standards are already resulting in different styles of antenatal support being offered in the communities. A more holistic approach (Start for Life), which includes emphasising brain development, skin to skin contact, nurturing etc. is being rolled out and researchers were told that in-house evaluations are already beginning to show (anecdotally) that many of the mothers are deciding to initiate breastfeeding. However, numbers remain low in some areas and more work is needed to improve early understanding and attendance.

Midwives are also involved in Parent Education sessions across the area and also aqua-natal sessions at Loftus Leisure Centre and at the Neptune Centre in Middlesbrough. At Loftus they follow the session in the water with another in the café, where the midwife uses this time to include breastfeeding information in the discussion, along with other things that mothers want to discuss. No attendance figures for these groups were made available to the evaluation team.

### ***Post-natal***

Breastfeeding support postnatally consists of a wider range of stakeholder involvement. Key figures include the Infant Nutrition Team, midwives – hospital and community (up-to 10 days following discharge, although this can be extended), health visitors, Children’s Centre staff and peer supporters.

Breastfeeding support in hospital is reported as variable. The general view of focus group participants was that they received little support from midwives while in hospital.

A number of factors were identified as reasons for lack of support. These included:

- Short term stay of women in hospital (sometimes as little as six hours)
- Hospital maternity wards are very busy
- Staffing levels
- Impact of caesarean section or stitches on ability to lift baby for feeding
- Issues around breastfeeding for babies admitted to the Neonatal Unit.

These points are now discussed in more detail.

It must be noted that some mothers reported good support from midwives on the ward and that they had left hospital feeling they had received useful advice.

One midwife commented:

*It's all about getting women into the mind frame and midwives are often just so busy that they simply give lip service to supporting breastfeeding. Also if people see that there is help out there they are more likely to continue [breastfeeding]. (Interview 1)*

Some of those mothers wanting to breastfeed reported feeling unsupported while in the hospital. There was a view that staff did not always have the time to give to individual patients, and that in some cases they failed to take account of the fact that the mother was unable to physically take the baby from the cot (because of a Caesarean or post birth stitches), let alone put it to the breast. Some mothers had gone home without being confident that the baby was latching properly (Focus Groups 1, 2, 4).

Also, given that some mothers leave hospital quite quickly after the birth, there is not always enough time to ensure breastfeeding initiation takes place prior to discharge. As a result, this can have a knock-on effect for community health staff. Some mothers do hold the view that they should not be discharged from the ward until initiation has been properly achieved. This would also ensure that initiation rates are better recorded. However, it is also accepted that some mothers do want to be discharged at the earliest possible time and that this option may not suit all mothers.

There was no criticism of the midwives or ward staff but an acceptance that the maternity wards are very busy and it is not always possible to get individual support. However, for new mothers, this meant they were often discharged still not knowing what they needed to do to successfully initiate breastfeeding.

It also appears that mothers can be discharged without being provided with information on breastfeeding support groups in the area or contact details for the community based Infant Feeding Co-ordinator. This lack of information can increase stress levels for mothers encountering difficulties. One mother commented:

*I knew nothing about breastfeeding support groups or the infant feeding team when I came out of hospital. It wasn't until I started having some problems and asked the health visitor who could help me and she gave me some details about groups. (Parent, Focus Group 5)*

The general view of antenatal support is that bottle feeders hold a view that they are made to feel that they should be breastfeeding and that they are often side-lined and feel unsupported. There is a view among bottle feeders that there is an abundance of support available for breast feeders whereas there is very little for bottle feeders and that many did not even have the basic knowledge needed to ensure safe feeding at the start.

There also appears to be a tendency amongst some midwives to make an assumption that mothers who have breastfed before do not need further support.

Mothers in the focus groups refuted this for a number of reasons. Comments included:

- No two breastfeeding experiences are the same
- No checks were made as to whether previous experiences were positive
- Breastfeeding mothers were not always signposted to other available support in their community.

These issues were identified as a cause for concern for many mothers involved in this study. Key hospital staff reported already making some changes to their practice to address some of these issues (Interviews 1, 2).

Community midwives reiterated some of the issues raised by mothers that breastfeeding had not always been successfully initiated within the hospital environment (Interviews 6, 7) and that they then had to provide additional support. The key issue identified was that of “time”, as breastfeeding support was only one of many tasks required at each visit. To this end, maternity healthcare assistants were originally employed to provide breastfeeding support both on the ward and out in the community. However, this role has since expanded to include other tasks, including running antenatal clinics and staffing early bird sessions, and there is a view that, as a result, the amount of their time available for breastfeeding support has eroded significantly.

Following discharge of women from the midwife care (usually ten days post birth), health visitors then take over. Efforts are made to ensure some consistency in terms of the health visitors involved with families. They do operate an allocation process and this means that the majority of the time families would see the same health visitor. Mothers, particularly, felt that this was important.

In terms of breastfeeding support, again there would appear to be some inconsistency. Health visitors do receive breastfeeding training and there is some discussion currently about holding joint training between midwives and health visitors as a way of building up relationships among the two, improving the consistency of information and support and also improving the sharing of information. However, no decision has been reached at this time. Both midwives and health visitors reported a view that this was a positive step forward. (Interviews 4, 5, 7, 8)

It appears that health visitor visits are more sporadic (particularly for those mothers viewed as coping well). Some mothers reported difficulties in contacting their health visitors and that their relationships with health visitors were very mixed. (Focus Groups)

Comments included:

*I think they are absolutely brilliant compared to the midwives. The midwives are like “You have to do it like this”.*

*My first meeting with them [health visitor] was not great but after that everything was great.*

*They [health visitors] are inconsistent; mine only works 2 days a week.*

It is noted that health visitor teams do have an allocated breastfeeding lead. Some health visitors have undergone training with midwives from the neo natal unit and now work to clear guidelines for identifying babies that are not putting on the right amount of weight or not regaining birth weight. There is now a pathway that health visitors follow, and health visitors involved in this study are feeling positive about these developments and more confident about their role. In terms of breastfeeding support, health visitors, following basic support around attachment, methods etc tend to direct mothers to breastfeeding groups operating across the areas where more specialist support can be provided (Interview 4).

Within the hospital setting there is an Infant Feeding Co-ordinator with a remit to work across both Middlesbrough and Redcar and Cleveland and the whole of the South Tees Hospitals NHS Foundation Trust area. She co-ordinates the efforts of 30 infant feeding key workers (midwives) – existing staff members with a level of additional specialist training - working in clinical areas within the hospital and community. The co-ordinator role includes staff education and influencing parenthood education. There is a midwife or Band 3 maternity care assistant who is the recognised person involved with the Infant Nutrition Team within all clinical areas. This also includes six Band 6 midwives working in the community to provide additional support to other staff out in the community.

There have been some major changes in the way midwives now introduce discussion about breastfeeding with mothers at both antenatal and postnatal stages. The approach is now described as “softly, softly”. More focus is placed on the mother developing bonds with baby, building up the connection between mothers and baby, and breastfeeding is incorporated as one way of achieving these aims. One member of staff at a Children’s Centre commented:

*I think the whole concept is how it’s pitched. If you call it a workshop on breastfeeding per se, then you’re only going to get the women who’ve made that informed choice who want to do it that will attend. For the whole, it’s about rethinking the model, and talking about other things, and threading the benefits of breastfeeding inside something about the best start for babies, rather than it just being about breastfeeding per se. It’s about baby brain development, it’s about nurturing, parenting, and all these different things threaded through in a very holistic way, whereas if we just brand it, then I think you do get those that vote with their feet and say ‘no, I’m making an informed choice here and I don’t want to do that’, or they might not be making an informed choice – that’s the problem. So we run things here called Start for Life, and we haven’t called it anything to do with breastfeeding. We’ve touched on it, we’ve talked about the benefits of it, we’ve talked about how it benefits the baby’s brain development, but we’ve kept it very low key way, and the things that we’ve trialled through that model, actually all the parents, not large numbers, but all the parents who’ve come through actually made a choice to initiate breastfeeding, because they learned about it from another pitch, not just about ‘breastfeeding’s best and that’s it’. (Interview 15)*

## **Breastfeeding initiation**

### ***Issues***

The South Tees Hospitals NHS Foundation Trust have adopted the UNICEF Baby Friendly standards as a way of improving breastfeeding rates and ensuring staff are trained to an acceptable standard in order to support, advise and encourage breastfeeding across the two local authority areas it serves. It is acknowledged that the new standards are much improved, as they include the involvement of health visitors to a greater extent and are more inclusive of formula feeding. While still promoting breastfeeding they now include showing mothers how to bottle feed safely and properly although this continues to be on an individual basis. However, the new guidelines, although agreed nationally by the DH are not yet fully integrated within local policy and service delivery at this point.

The use of the UNICEF Standards was generally applauded among the key stakeholders interviewed for this study. Most are happy to see the implementation of a measure which they perceive as being properly evidence based. There is also a view that the guidelines have developed (and improved) over time and that they are now more user friendly than in the past.

A primary focus of the UNICEF Standards is to encourage mothers not to make a decision as to whether they will breast or bottle feed until after the birth of their baby. There is a strong view from participants – midwives, health visitors, infant nutrition teams and mothers themselves that this is all very well in theory, but is not a practical option and that this decision is made by women prior to the birth in most cases. This is exacerbated by the fact that hospitals no longer provide formula milk and mothers must take their own supply into hospital with them. As a result, decisions need to be made earlier. All the mothers included in this study reported having made the decision on feeding method prior to hospital admission (focus group participants).

Another area of concern is that the standards are open to different interpretations and this is particularly pertinent in terms of support for bottle feeding. The general thrust of the UNICEF Standards is that information on bottle feeding should not be provided in a group setting and that this must be provided on an individual basis. As a result of this there appears to be a perception (by mothers but also by health and local authority staff) that there is an imbalance in the support available for breast and bottle feeding across both Middlesbrough and Redcar & Cleveland. There also continues to be an issue with consistency of information and support provided.

### ***Data Collection***

The local statistics around breastfeeding were discussed in an earlier section but it was noted by many professionals that the recording of some of these is very flawed, though this is probably a national problem, not just a local one. This is particularly relevant to the initiation statistics, as initiation is often recorded as positive in response to the question “Are you going to breastfeed?” as opposed to an observation of the actual introduction of the child to the breast. As a result, some mothers leave hospital before any attempt to breastfeed and, once home, they choose to bottle feed. Professionals felt quite strongly that substantial numbers of mothers recorded as having initiated breastfeeding never actually put the baby to the

breast (health and community health interviews). This view was supported by some mothers participating in the focus groups who had changed their minds once home, some of whom felt they did not know what to do to successfully breastfeed. A range of reasons was given by women for changing their minds including lack of support and information, family pressures, panic, guilt. One mother stated:

*I wanted to try but didn't get any help so when I got home I just panicked and decided to put her on the bottle. I felt terrible, like I had failed and that I couldn't do anything right. (Parent, Focus Group 9)*

Breastfeeding initiation rates are therefore probably much lower even than suggested by the official figures.

There are also some issues around the consistency of data collection for the 6-8 week breastfeeding postpartum statistics. It became apparent from interviews that collection of the data on breastfeeding is heavily dependent on who is involved. Health visitors admit that this information is not always requested at development checks, and infant nutrition teams and other breastfeeding support staff hold the view that GP practices rarely pick up on this information at post natal checks. Again this calls into doubt the accuracy of statistics at 6-8 weeks reporting sustained breastfeeding, or allowing any sort of accurate estimate of how much breastfeeding rates fall away over the first two months of a child's life.

### **Information**

Access to information and the nature of what was available was identified as a key issue for breastfeeding mothers. This included both written and verbal information.

There appears to be written information in existence, although the availability and effectiveness of such information remains questionable, according to both professionals and mothers.

There were contradictory reports as to the availability of written information. While some participants reported being given a lot of leaflets or booklets, others reported receiving none at all. What is not clear at this point is where this inconsistency lay – was it that such information was not readily available or was it that the people providing the information were not consistent in ensuring that everyone received the information. According to some participants, it is both.

One participant commented:

*There is not a huge amount of information around. It can be found in libraries, doctor's surgeries, council buildings, some of the children's centres have put up displays and some posters have been placed in some venue but there isn't that much really. The main one is the South Tees Breastfeeding Support leaflet (Change 4 Life) which is "supposed" to be given out to all new birth mothers. (Interview 12)*

Available leaflets include "Off to the Best Start" which is a DH publication, Change for Life (South Tees), BLISS (for premature deliveries). There is also a UNICEF magazine but this has a cost attached and is not currently available to mothers

unless they purchase it directly. There was some debate as to whether written information is the best format for helping mothers, and views were divided on this. Some felt happy to be given written information; for others, something more interactive was preferred e.g. a DVD or an App. It would seem that this is entirely a matter of preference and that a mix of media is needed to ensure ease of access for all. This view is largely accepted by the majority of participants.

Verbal information was more readily accessible if you knew where to find it. Awareness of breastfeeding support groups was generally low and it was clear that midwives and health visitors did not routinely provide information on such groups to mothers. Throughout the focus group data collection processes it became clear that those mothers who had made the decision to breastfeed would find out anything they needed to know. The internet was reported as a good source of information and also children's centres. However, it also became clear that there is a need for information about support groups, the infant nutrition team and the possibility of peer supporters to be made available in the antenatal phase to avoid the stress of parents having to search postnatally when in the midst of a feeding 'crisis', which is what tends to happen, according to mothers.

There is little doubt that information is available, and that there are people who can help, but the key issue is that mothers do not always know where it is or how to access information or personal support.

Information for mothers from ethnic groups appears to be even more sparse. According to participants they received no written information about breastfeeding. They were unsure as to whether any had been translated for distribution to these groups. In terms of verbal information, this is generally on a more individual level and again is very dependent on women's access to children's centres; otherwise it would seem that they would see the GP.

There was a view that professionals should not be didactic, but should provide information aimed at ensuring mothers could make an informed choice as to which feeding method to use. However, in practice, both professionals and mothers believed that 'informed choice' was a bit of a misnomer, implying, as it does, that decisions were made on the basis of a rational evaluation of the choices available, based on the benefits for mother and baby in health terms. Instead, decisions as to whether or not to breastfeed were often based on cultural beliefs, personal or family experiences, a wish to do the right thing.

Choice and decisions to breastfeed were more often based on instinct or wish, as opposed to weighing up all the information available and then making a decision based on that information. The consensus amongst mothers participating in the focus groups was that very few had made an informed choice but had made a choice. There was some debate as to the value of informed choice and whether it would increase rates etc. One of the core principles of UNICEF BFI is to enable mothers to make an informed choice but, for the mothers involved in this study, this did not appear to be the case.

There is also a disparity in the amount and depth of information available for breast and bottle feeders. Although there is a view that breast feeding information can be

somewhat limited or inconsistent, bottle feeding information as already mentioned tends to be less readily available in a printed format and verbal information is provided on an individual basis in line with the UNICEF BFI Standards.

The level and quality of available information does appear to be a factor in this but ultimately it would seem that those mothers deciding to breastfeed do so because they want to, as opposed to feeling they should. It also seems that the more committed mothers are to breastfeeding, the longer they are likely to maintain it, and that information plays a very minor role. Also the more confident they become, the more likely they are to provide peer support, both formally and informally.

In order to improve informed choice and decision-making there is a need for more consistent, factual information which is received by every pregnant mother. This does not appear to be the case at this time. Some concerns were raised by staff as to the negative impact on breastfeeding rates of more factual information e.g. cracked nipples, mastitis etc. However, mothers generally felt that this would be minimal but would ensure they were better prepared and therefore have a positive impact on maintaining breastfeeding

### ***Mixed Messages***

The consistency of verbal information is often called into question. Many of the focus group participants provided stories of clear contradictions in information provided to them. Much headway has been made in ensuring the quality and consistency of the training staff receive. However, personal experiences appear to continue to inform the information staff provide. This is a difficult issue, as not only does personal experiences appear to dictate how health service staff show a mother what to do, but also how they even broach the topic. The differences emerge not only between midwives and health visitors but within each of the teams, so quite often a mother is given different advice and techniques from different midwives or health visitors. Several participants complained that different midwives all promoted different breastfeeding techniques, which was very confusing for mothers (Focus Group 5, 6).

It appears that even though they all do the same training, there is often a difference in the interpretation of that training by staff. There is a need to ensure that all advice and support is based on the evidence base which currently exists within the UNICEF Standards. Personal and anecdotal experiences should not inform practice. The training is standardised as a way of combatting such influences. However, it would appear that this is something that needs revisiting. The inclusion of personal experiences actually weakens the effectiveness of the support provided and, for some mothers it hinders the breastfeeding process and the length of time breastfeeding is sustained. Mixed information at times of crisis was not deemed helpful. One mother stated:

*All I wanted was for someone to tell me what to do to get through it. One midwife told me to put the baby on a bottle until things settled down. This was wrong. The GP told me to stop breastfeeding. When I went to the group they [other mothers and the staff] told me what I needed to do and keep breastfeeding. Without that I would have stopped and that was not what I wanted. (Focus Group 6)*



Another mother commented:

*I saw 3 different midwives, one in the hospital and the other two at home and they all told me to hold the baby to the breast in a different way. How was I supposed to know what was the right way? (Focus Group 2)*

## **Sustaining breastfeeding**

Generally people know that breastfeeding is best for a baby. This does not appear to be a point of contention. However, the attitudes to breastfeeding, the practicalities and full understanding of the impact of breastfeeding on new mothers and external factors, such as family support and culture, make this a complex issue.

Both health professionals and mothers commented on the 'danger zones' encountered throughout the breastfeeding experience.

Midwives are clear that the first five days are the most important, and have already begun to implement more intensive support in the home for breastfeeding mothers. On the other hand, although health visitors agree that this is an important time, they would also argue that the whole of the first two weeks is the time when drop-off most generally occurs and that access to support for mothers during this time is essential if breastfeeding levels are to be improved.

The majority of mothers participating in this study reported that these danger zones were days 1-3 and weeks 1-3. These are the points in time when mothers more generally encounter difficulties with breastfeeding. They are also the times when mothers feel more vulnerable and therefore the most likely time when mothers will stop breastfeeding. However, it is also noted that some mothers do experience them at other times.

Providing good quality support to mothers during these danger points is essential if we are to reduce the drop-off rate up to and beyond the 6-8 weeks. There is a wide range of support available for breastfeeding mothers. These include:

- Midwife – usually 10 days but can be up to 28 days
- Health Visitor support
- Infant Nutrition Team
- Breastfeeding Support Groups
- Children's Centres/0-19 Service
- Peer Supporters
- Other key stakeholders – fathers, family.

### ***Breastfeeding Support Services***

These will now be discussed in more detail.

#### *Midwives*

Midwives provide support to mother and baby initially in the hospital until discharge and then in the home up until day 10. The majority of mothers are then discharged into the care of health visitors. However, this discharge may be later dependent on

the circumstances. During the first 10 days the midwife will provide breastfeeding support to the mother.

Breastfeeding training is provided to all midwives although some go on to do specialist training and are nominated as key workers.

A recent change aimed at reducing drop-off rates has been the introduction of 5 day intensive support to all breastfeeding mothers. This does not guarantee daily home visits but will include a telephone consultation on those days where no visit will be made. One mother stated:

*I received more intensive support from the midwives, not every day but they did ring me to check things were going ok. I thought it was really helpful to have that sort of contact. (Focus Group 5)*

#### *Health Visitors*

Midwives discharge all mothers into the health visitor services (usually around 10 days after the birth). Although they offer a wider service to mothers and babies, breastfeeding support is part of their remit. Health visitors also provide drop-in clinics in many of the localities and support the Pregnancy, Birth and Beyond and other education programmes. They tend to be the main source of information and support for bottle feeding mothers. The majority of health visitors are now trained to UNICEF Standards and this training is on a rolling programme to include new staff and continuous updating.

Health visitors provide home support and also work within the Children's Centres. A small group of health visitors act as the direct link to the infant feeding co-ordinator. These are the health visitors that have a special interest in taking the breastfeeding agenda forward.

#### *Infant Nutrition Team– Community*

The Infant Feeding Co-ordinator (Community) provides the ongoing support for mothers leaving hospital and being discharged by the midwives. This appears to be an overarching role with involvement in training of health and local authority staff as well as peer supporters. This role has both clinical and support elements to it and is funded through the public health budget within the local authority.

The co-ordinator leads on the implementation of UNICEF BFI and the auditing of that information, peer support training, breastfeeding welcome scheme as well as direct support for women with complex breastfeeding needs.

It became very clear throughout this study just how important key stakeholders felt the role of the community infant nutrition team in support and training to be. Both professionals and mothers were very positive about the support they received from this team. However, it is noted that recent cuts in spending resulted in a reduction of staffing and that the long term sickness of one member has meant that the team is currently operating with only one person.

This team is often the first port of call for both professionals and mothers and demand appears to be high. The team offers training to professionals, peer support training and support to mothers on a group and individual basis. The team operates

a social media page for breastfeeding mothers and mothers are confident that they can get some response to a crisis out of hours using this page, as it is regularly checked on evenings and weekends.

The Infant Feeding Co-ordinator also provides direct support at breastfeeding support groups across the two areas. These groups are very well attended and the input from the Infant Team Co-ordinator is highly valued by mothers. There is little doubt as to the depth of experience and knowledge available through this team, nor of its ability to ensure that mothers receive not only crisis support but general day-to-day support.

The reduction in capacity of this team has impacted on the level of service they can offer at this time. The most recent peer support training has had to be shelved until September and the regularity of attendance at groups has also changed. However, steps have been taken to ensure that other trained professionals are available at these sessions as a way of ensuring the availability of support.

There is also little doubt as to the commitment of this team and how they are valued by both professionals and mothers. To some extent it is the “glue” that holds everything together (Interviews 4, 8, 15 and Focus Groups 6, 7). However, capacity is a growing concern.

#### *Breastfeeding Support Groups*

There is a mix of breastfeeding support groups across the two areas. Some are led by the infant nutrition team, others by children’s centre staff and others by peer supporters. Currently there is breastfeeding support available most weekdays across the whole of Middlesbrough and Redcar.

Classes include:

1. Monday – Thorntree
2. Tuesday – Loftus
3. Wednesday – Redcar and Hemlington
4. Thursday – Guisborough
5. Friday – Ormesby.

This is welcomed by breastfeeding mothers, many of who are happy to travel if they deem it necessary. However, it is noted that all of these sessions are offered during the day and that none are currently available over the weekend.

Some of these groups are led by peer supporters (Hemlington and Ormesby); infant nutrition team-led groups include Thorntree and Redcar. The groups in Loftus and Guisborough are led by children’s centre staff who have completed the training. Health visitors also attend some of these groups to weigh the babies.

Many of these groups are well established and well attended. However, early attempts to establish a breastfeeding group in Thorntree failed, and a decision was made to provide an infant feeding group for both breast and bottle in that area. While numbers remain low (generally 4-6), they appear to be consistent and do include both breast and bottle feeders.

Establishing breastfeeding groups in other areas has also proven problematic. In Grangetown the group was cancelled because no-one attended.

#### *Children's Centres/0-19 Service*

Recent changes within the local authority structure have resulted in an integration of Children's Centres (post Sure-Start) and youth services into the 0-19 service. This development is in its early days and staff are currently dealing with the impact of these changes on their roles and responsibilities.

However, Children's Centre staff appear to be committed to promoting the breastfeeding agenda both antenatally and postnatally, and in recent years have tested a number of different models as a way of achieving this. More recently children's centre staff are playing a major role in piloting some new initiatives such as "Start for Life" and "Pregnancy, Birth and Beyond". In the Start for Life programme (which appears to be a hybrid of Pregnancy, Birth and Beyond adapted to suit the locality), while "breastfeeding" is not included in the course title, it is an underlying thread and, as a result, there is some anecdotal evidence to support the claim that many of the mothers who have completed this programme (relatively small numbers) have made the choice to initiate breastfeeding. This would suggest that this low-key approach has potential to be effective. One member of staff suggested:

*It's about how you pitch it, it can't be just 'breastfeeding is best'. I don't think there's enough of that kind of pitching in the antenatal period to give more women that non-threatening information in a way that will allow them to make more informed choices (Interview 15).*

The majority of breastfeeding support groups are situated within children's centres. The principle idea was to provide support within local communities. For some communities, this appears to be vital. There is a view that people in some areas are more mobile and willing and able to travel than in other areas. For instance, mothers participating in focus groups in the Redcar locality reported regularly travelling to other groups throughout the week if they felt in need of support (Focus Groups 5, 6), whereas mothers attending the Loftus group appeared less likely to travel, given the poor transport links to the area (Focus Group 3).

Participation in group activities in the more deprived areas of Middlesbrough was identified as lower. Areas such as Thorntree, Park End, Berwick Hills were also identified as "less engaging with groups generally, not just breastfeeding" (Interview 8). Localised services are important to mothers in areas of this nature. Even though numbers are generally low for group sessions, support is more likely to be sought at local level on an individual basis (Interview 10).

All children's centres are deemed "breastfeeding friendly", meaning mothers are able to breastfeed anywhere in the centre but can also offer private space for breastfeeding if that is what mothers prefer.

However, it is also noted that facilities in children's centres do vary and that some groups are operating in rooms not really "fit for purpose". Some centres are designed in a way to provide larger rooms, can run a breastfeeding group at the same time as a baby clinic and also better play space and equipment. There are no

expectations that these factors are likely to change, but it was identified as a factor in terms of engagement and also choice of group to attend.

Some children's centres also employ "Dad's Workers" who provide support to fathers on a range of topics, breastfeeding being one of them. Middlesbrough generally provides more individual support for fathers, as group sessions were not well attended. There are two Dads' Groups running in Redcar supported by children's centre staff, who also provide targeted individual support. It appears that breastfeeding support, although included, is not a major element of support provided.

However, mothers attending focus groups regularly commented that some of their husbands/partners would benefit from such support and that some of them would welcome such an opportunity. A major factor is that these groups tend to operate during work hours, which is not viable for working fathers.

### *Peer Support*

Peer support is not new to the area. It has been around for a long time but this is much more formalised now, with good quality training being offered. In the past it was generally women who had breastfeeding experience passing their knowledge and experience on to new breastfeeding mothers. This continues to be the case today, but the scheme also includes trained peer supporters establishing and leading support groups. There is a general view that peer support has a huge role to play in supporting women who breastfeed (Focus Group 5).

Peer support training is available and 18 peer supporters are now fully trained, with a further 24 currently in training. All of the peer supporters are volunteers and although all fully committed to breastfeeding, their availability is limited due to personal family/ work commitments. It is also worthy of note that there tends to be a turnover of peer supporters, as people begin to return to work, and therefore it is necessary to provide a rolling programme of training. This means there needs to be a cycle of recruitment and training processes which can capitalise on the enthusiasm and willingness of breastfeeding mothers at the point of their lives when they can offer the support. This is a common concept with volunteering in general.

Costs for peer support training are regarded as minimal and good value for money. Peer supporters were trained by the National Childbirth Trust initially, although this role now falls to the Infant Nutrition Team. The team also has management responsibility of the voluntary peer supporters.

Peer supporters are now being rolled out on the wards as a way of providing additional support to breastfeeding mothers. This is in its very early stages and no evidence has yet been collected as to the impact this may have. However, there was some concern raised that peer supporters might begin to be regarded as the answer to support problems within the wards and that clarity around their roles is necessary and that midwives fully understand that this is not a shift removing responsibility from them, but additional support (Interviews 9, 15).

There is some debate within the literature as to the effectiveness of peer support. There is little doubt that it can increase the duration of breastfeeding and that it cannot be a standalone intervention. Breastfeeding mothers included this study are

very positive about peer supporters. There is a view that peer supporters are a “useful tool” to have, as they have personal knowledge of breastfeeding experiences that they are able to pass on to other people in their community. One interview participant stated:

*They [peer supporters] can actually change culture, because they come from the community, they are part of community networks, they have family and friends and neighbours that they can begin to influence.*  
(Interview 15)

The move to a more structured approach for peer supporters has not been unproblematic. Introducing peer supporters on the wards has taken a very long time and there has been many hurdles included permissions to be on the wards, police checks, insurance and issues around professionalism.

Peer supporters are currently unable to provide support to individuals in the home but group support is seen as most beneficial to most mothers. Comments from mothers attending breastfeeding groups led by peer supporters focused on:

- The opportunity to share actual experiences
- The need for the truth
- The value of sharing information
- Spending time with others
- These group “normalise” breastfeeding
- Relieves feelings of guilt.

Such comments reinforce the view that, for those attending such groups, they are a very effective source of information and support. They also provide the opportunity for mothers to develop new social networks which often extend outside of group hours, which is another positive outcome for such groups. (Focus Groups 2, 5, 6)

Some peer supporters are also exploring ways to normalise breastfeeding in community settings. Generally mothers felt quite positive and comfortable about feeding in the group settings but others remained wary of breastfeeding in public. For some, confidence was a big issue but for others it was a way of circumventing negative reactions from members of the public. Many of the mothers had stories to tell about their experiences of breastfeeding in public. For some, the negative reactions had built a resolve to challenge such attitudes, but for others it has meant exploring more discreet ways of feeding a baby in public spaces or identifying private space to do so.

### *GPs*

GPs are not expected to provide general breastfeeding help and support to mothers, although there is an expectation that they would have some knowledge and understanding of the issues mothers often face while breastfeeding. However, mothers do tend to make an appointment to see their GP if they are in pain, sometimes anxious or in need of some medication, or if they have worries about the health of the child.

Focus group participants reported strained relationships with their GPs, primarily as a result of GPs' general attitude to breastfeeding and a tendency to recommend that mothers simply stop breastfeeding and switch to the bottle. Generally there was a view that many GPs did not have up-to-date information on suitable medication for breastfeeding mothers and that GPs were also reluctant to accept information provided through the Infant Feeding Team.

A training programme specifically for GPs as a way of updating their knowledge and understanding has been purchased and offered by the Infant Feeding Team, but take-up to date has been minimal.

There is some evidence to suggest that advice given by GPs is not accurate. Comments from participants include:

*My GP told me there was no nutritional value in breast milk, so why was I still feeding my baby at 11 months. (Interview 9)*

*A practice nurse asked me who was I still feeding for? Me or the baby? (Interview 9)*

*A mam went along to her GP with query mastitis. He diagnosed mastitis, gave her antibiotics – good move, but told her to stop breastfeeding the baby on that side and to just throw the milk away. She's got mastitis on the other side now. They haven't got the evidence; they haven't got the up-to-date training. I'm not saying all of them, because some GPs will give very, very good advice to breastfeeding mams, but there are those that give advice that's outdated, that's not evidence-based, that can actually be devastating for that breastfeeding experience for that mam. (Interview 15)*

*I went to ask [GP] about trouble with breastfeeding and was told just to wean the baby. (Parent, Focus Group 6))*

*The doctor tried to press formula on me. (Parent, Focus Group 2)*

Generally mothers felt let down by GPs, with some saying they only contact their GP as a very last resort. There was a view that breastfeeding is not a high priority for many GPs and as a result mothers have been given conflicting information, some had even switched to bottle on the advice, only to find out later that this was not a necessary course of action.

#### *Other key stakeholders*

While breastfeeding falls primarily on the mother, other people have a key role to play in promoting and supporting breastfeeding. Fathers have a clear role in providing support to the mother but also in establishing a bond with the baby. Fathers need to have a good understanding of what breastfeeding entails and what to expect, as well as how to deal with things which can range from ensuring the mother has a drink available during feeding to providing comfort at times when baby has been feeding constantly for many hours.

Grandparents often play a key role, not only in offering ongoing support, but also in the decision on whether or not to initiate breastfeeding. Many of the breastfeeding mothers involved in the groups had opted to breastfeed because their mothers had breastfed them or other family members had breastfed, so they were familiar with the concept as well as the potential benefits to mother and baby. For many of these mothers, breastfeeding was the “norm”. However, where this is not the case grandparents can often become an obstruction to continued breastfeeding. Some mothers reported really having to “stand their ground” and found this disturbing. For those grandparents who believed bottle feeding was the “norm”, then such a conflict of ideas was often problematic.

### *Breastfeeding Friendly Places*

It would appear that good headway has been made in encouraging businesses in the area to become “breastfeeding friendly”. A lot of work has been done with businesses and organisations in order for them to achieve this status. All public buildings e.g. libraries, children’s centres are recognised as breastfeeding friendly by mothers. Places like Relish, Costa, Boots, Marks & Spencer, George (Asda) have also developed a good reputation among mothers for their breastfeeding facilities and supportive staff. Some even provide free drinks to mothers who are breastfeeding on their premises.

This is regarded as a major step forward, although it is acknowledged that there is still more work to be done. Some places still cannot offer any private space for breastfeeding, making it difficult for mothers who would rather feed in private. However, it is a marked move away from the expectation that mothers should breastfeed their baby in a toilet.

Not all mothers are happy to feed in public. Some lack the confidence; others just don’t want to. Some mothers worry about public attitudes towards them if they breastfeed in public, so private space is important. This is particularly pertinent for women of ethnic origin.

### ***Specialist Support Services***

This is a term which relates to support for particular groups of people. For the purposes of this report they include:

- Young Mothers (Teenage Pregnancy)
- Fathers
- Breastfeeding women from BME groups.

Each of these will now be discussed in turn.

#### *Young Mothers (Teenage Pregnancy)*

Support for teenage/young mothers is generally provided through the Family Nurse Partnership (FNP). The Family Nurse Partnership is a home visiting service for first-time mothers aged 19 and under. This service is delivered in over 90 areas across England, and is commissioned by NHS England for the local delivery of the service. Pregnant mothers can access this service through their midwife. A specially trained family nurse then visits the mother from pregnancy until the baby is two. The nurse



uses a psycho-educational approach to provide ongoing, intensive support through structured home visits.

The partnership hopes to enable mothers to have a healthy pregnancy, improve their child's health and development, and to plan their own futures and achieve aspirations. It is a preventive programme, and has the potential to improve the life chances of some of the most disadvantaged children and families in society, improve social mobility and break the cycle of intergenerational disadvantage. Research has shown that it improves pregnancy health and behaviours, reduces child abuse and neglect, improves school readiness, improves the mother's life course and economic self-sufficiency, and provides significant economic returns.

The 0-19 service also provides support to teenage mothers at the antenatal stage but also further support following the birth. However, the likelihood is that they will be referred on to the children's centre staff at a point after the birth. No firm length of involvement is set and length of support is dependent on need. Young mothers are referred into the service by schools, midwives, colleges or they can self-refer. They are also referred to the FNP.

Teenage pregnancy support from the 0-19 team is very much focused on the Infant Feeding Policy. They do promote breastfeeding as part of their support but operate on a "pro-choice" basis. In other words they support people to make the right choice for them, to make an informed choice. They work towards achieving a balance and do not force any choice on the mothers. This is particularly important to this group if they are to maintain engagement.

Young mothers involved in this study showed little interest in breastfeeding. All had opted to bottle feed and were seeking information on that method. It appeared unlikely that the provision of breastfeeding information would change that course of action. (Focus Group 4) Breastfeeding rates amongst young mothers in the area are reported as very low.

A member of staff involved in supporting this group stated:

*Breastfeeding is not the norm. It becomes a conscious choice to breastfeed as opposed to an unconscious choice to bottle feed. It is just not out there – it is just not what people do or they can be shocked if they do. When they are pregnant they have already decided which formula they are going to use. They have made that decision and it is just not the norm out there. Also with young mothers it is the body. The body is just becoming a sexual object and they are not that used to exposing themselves. At that age everything is awkward. (Interview 11)*

It is also noted that teenage mothers rarely access either breastfeeding or infant feeding groups following the birth. One mother attending a baby drop-in clinic at a children's centre reported attending the clinic so she could seek any advice or ask for support from the health visitor or children centre staff. She had no interest in attending an infant feeding group.

### *Fathers*

Little active support for fathers was identified. There is potential for them to attend the breastfeeding support groups with their wife/partner and this does happen on occasion but is not a regular occurrence. Some mothers reported they did not feel comfortable feeding with males in the group. As previously mentioned there is support available through the Dads' Workers within the children's centres, although this tends to be targeted and does not have a breastfeeding focus. Generally there is a view that groups generally do not appeal to fathers. However, there is also a view that fathers should be able to access information on breastfeeding, as they have a key role to play in supporting their wives/partners to breastfeed and quite often they do not have either the knowledge or understanding to enable them to do this.

It was also reported that quite often fathers are unable to attend ante-natal classes because they are often at work. Some do attend the early bird session although these are not high numbers. There is scope for fathers to attend classes such as Start for Life or Birth, Pregnancy and Beyond, as the course includes a lot of material about relationships, but again participation of fathers tends to be low (Interview 4).

A common thread is that many fathers would not opt to attend group sessions, regardless of whether they would be beneficial to them. Sometimes there are legitimate reasons for failure to participate, but the general view is that groups are not appealing to men in general and that the topic of breastfeeding tends to make them even less so.

However, it is clear that in order for fathers to be supportive of breastfeeding, they do need a good understanding of the intricacies of breastfeeding – not only the benefits but also the issues that may occur and possible solutions. There is a need for them to understand the way the baby develops and how this can impact on feeding processes and most importantly who to contact for help. There is little doubt that this is something that the majority of fathers do not have, particularly those from the more deprived areas, who are even less likely to engage than those from more affluent areas. Attempts to engage with fathers around breastfeeding have proved futile in the past and little work is currently being undertaken to improve this situation. However, again it is noted that if fathers do want information to help them support their wives/partners, there is information available and they can access it. Some examples of this happening were identified within the focus groups (Focus Group 6).

The experience of support from fathers/partners amongst breastfeeding mothers was very mixed, with some mothers commenting on really good levels of support from their husbands/partners and other reporting practically no support.

Mothers generally held the view that most men just did not understand the practicalities or intricacies of breastfeeding, how it can impact on family life and what roles they can take on to reduce stress levels. In some cases fathers were the first to suggest switching to the bottle. This was reported as both a cause for concern and a major frustration for mothers. This indicates that there is a need for a deeper understanding of breastfeeding amongst fathers whose wives/partners are doing so.

However, this is a complex issue and it would seem that solutions will not be “a one size fits all” and that more individual solutions may be required.

#### *Breastfeeding for women from ethnic groups*

A total of seven participants included in this study were from ethnic groups. All reported that breastfeeding was the usual way to feed in their culture. This included women from:

- Pakistan
- India
- Sri Lanka
- Thailand.

One participant commented:

*Never, ever allowed powdered milk. You should be able to breastfeed your baby. It's a very strong desire for every woman living in our country. Even when they are living here they do the same. I stopped feeding at eleven and a half months because the breast milk wouldn't come. I would have preferred to continue.* (Focus Group 9)

All of these participants had followed their own culture and had opted for breastfeeding. For them breastfeeding was the “norm” and anything else was not. Some of them found this contrast interesting. Another point for this group was the cost saving in breast feeding; formula was so expensive and yet people from the UK generally rarely think about that aspect. There is a firm belief that breastfeeding is best for the child and the mother.

Breastfeeding support in hospitals was reported by these mothers as poor. There was a view that staff on the wards were not fully supportive of breastfeeding, and the women were surprised at the question “do you want to breastfeed or bottle feed?” Even after living in the UK for a long time, this tradition still holds and women continue to be encouraged by their mothers and other family members to breastfeed and they find it difficult to understand why this is not the case for people from other cultures.

Some support was available to them in terms of Abingdon Road Children's Centre, where language barriers had been resolved, but they rarely attended anywhere else.

Language barriers for this group were regarded as a problem. Much of the available information was not available in their languages and access to interpreters was not always easy. Family or friends would often take on a role in translating information. Another participant commented that:

*If parents have a language problem they wouldn't step into the Surestart [children's centre] sometimes because they can't speak in English and when they go to the GP they only go to the GP's room – speak to them- come out. If the leaflets are there, they can't even read them. People have to give them (women) proper information or keep the interpreters next to them. Sometimes people need signposting. If English is not their*

*first language then it will be a big trouble because Middlesbrough covers all cultural people here. (Interview 20).*

Another issue highlighted for many breastfeeding mothers from ethnic groups is that they would not consider it at all appropriate to breastfeed in public and so private space is absolutely necessary if they are to feed their baby outside of the home. They had very little awareness of private space being available for breastfeeding, apart from in Boots, where there were often large queues. They reported being allowed to feed at someone else's home, but only if no men are present. As a result, many breastfeeding mothers simply stay at home. This raises the question as to whether breastfeeding serves to further isolate these women.

Only one woman attending a breastfeeding support group was not British. She reported that breastfeeding was the natural choice in her culture. There were no language barriers and she had decided immediately that she would breastfeed. However, she had some problems in the early days which required intensive support, so had found a group that could help her. She is not a regular attender but will attend if the need arises and has found the group to be most helpful, to the extent that, without the support, she may have had to switch to the bottle and this would have upset her greatly.

Support for this group appears to be dependent on geographical location. Only two children's centres (Abingdon and North Ormesby) highlighted specific support for ethnic women. To some extent this is to be expected, given the size of the ethnic minority population in and around those areas. However, it begs the question as to how women from minority ethnic groups living in the wider Middlesbrough and Redcar and Cleveland access regular support. It would appear that access for those mothers is mainly dependent on midwives and health visitors and that some question can be raised as to their awareness of other available support.

### **Information**

Awareness of breastfeeding support groups was generally low, and it was clear that midwives and health visitors did not routinely provide information on such groups to mothers. Throughout the focus group data collection processes it became clear that those mothers who had made the decision to breastfeed would find out anything they needed to know. The internet was reported as a good source of information and also children's centres. However, it also became clear that there is a need for information about support groups, infant nutrition team and peer supporters, and this needs to be made available in the antenatal phase to avoid the stress of having to search when in the midst of a crisis, which is what often happens according to mothers.

There is little doubt that information is available, that there are people who can help, but the key issue is that mothers do not always know how to access them.

It would appear that the approach taken for written information is primarily around the benefits of breastfeeding. While this is important and necessary, mothers were clear that they need more practical information about breastfeeding. Understanding the benefits of breastfeeding may be helpful if you are making a decision. However, once that decision has been made, there is a real need for information to prepare them for the practicalities of breastfeeding.

It became apparent that while mothers who have breastfed previously had a better idea of what the practicalities and issues that may arise were, new mothers were largely unaware and were often caught off-guard. Most mothers felt that they could be better prepared if they had a better understanding, as quite often they had no knowledge of the particular issue and generally ended up in crisis. This is often the point when they begin to attend a group or make contact with the Infant Nutrition Team. Quite often mothers were in a state of panic at this point, which is not really conducive to a positive breastfeeding experience.

There was a strong view from breastfeeding mothers that earlier access to such practical information as opposed to them having to deal with things they do not understand as they arise would be more beneficial in sustaining breastfeeding.

The principle gaps in information were:

1. Contact names and numbers where support could be found
2. Practical information on feeding.

Contact names and numbers of breastfeeding support personnel or groups do not appear to be provided as a matter of routine. Focus group participants felt that knowing who to contact for what was important. However, they also held a view that if they were committed to breastfeeding they were more likely to find out that information themselves, if they were less committed, they felt they would be more likely to use the lack of such information as an excuse to switch (Focus Group 6).

The need for more practical information was deemed as really important to mothers, particularly those who were breastfeeding for the first time, as they had little idea of issues and their effects on breastfeeding. Issues included:

- Tongue-tie
- Cluster feeding
- Growth spurts
- Feeding on demand
- Mastitis/infection
- Failure to latch properly
- Weight loss
- Expressing milk.

Many mothers had no idea about any of these prior to actually encountering them and they had no idea what to do about them or who to speak to. Many reported feeling helpless, being a failure, not being a good mother and guilty. According to group participants, this information should be made available to all mothers who initiate breastfeeding so that, if it does happen, they not only know about it, but also know who to contact for help. There was a strong view that this style of information would be much more effective, as it could relieve stress in these situations and increase a mother's ability to cope (Focus Groups).

It would also seem that some hospital and community health staff also lack information/ knowledge on some of the above issues. It is understood that the ability to feed and the degree of tongue-tie is not an easy distinction. However, mothers

regularly reported that tongue-tie was not picked up in the hospital or by the GP, or if it was, there was disagreement as to the extent of the problem and the impact this may have on the baby. There is specialist training available that includes identification and treatment of tongue-tie, and the infant feeding co-ordinators have completed this training. They are now able to refer a child directly to Newcastle for treatment, which does speed up the process but does not address the initial worry and panic that parents go through prior to diagnosis.

There is a clear need for improved information, both verbal and written and also additional effort afforded to the provision of more consistent information across all the key stakeholders in breastfeeding support. However, in terms of written information, this will have cost implications.

Social media was identified as a good source of information. Many of the mothers involved were actively involved with the Facebook page for the South Tees Infant Nutrition Team. The page is used to ask questions and contact people for help, particularly out of hours. One mother commented that:

*Their greatest source of information, beside the group they belong to, is via social media. (Focus Group 2)*

Another mother commented:

*I actually found out about the group through Facebook. (Focus Group 7)*

A member of staff from a children's centre stated that:

*I think it [social media] has a way of reducing isolation and networking mums to a common thread. We have NetMums and others. These Facebook pages do work. However, they also have the potential to be dangerous if the wrong people decide to use them without proper training. All the children's centres also have Facebook pages and we encourage mothers to "like us" because if they do and the team puts anything on the page, it has a way of transferring. (Interview 15)*

Information is regularly posted on the site, and mothers know that it is checked sporadically out of hours and weekends. The main reason for this is to show mothers that they are not alone and that someone is on hand when doubts start to creep in or they are worried about something.

One mother stated:

*I was worried about my baby's bowel movements, so posted a picture of his poo on the page so that someone could tell me that it was normal. (Focus Group 6)*

Developments in recent years appear to have seen an increase not only in the use of Facebook and other social media for breastfeeding but also in how breastfeeding is portrayed. One participant mentioned that Facebook allows pictures of breastfeeding now, whereas they would have been removed in the past (Interview

19) Some mothers also felt that social media was an important tool in normalising breastfeeding.

There are also a number of apps available for breastfeeding and some of the mothers have used these and found them useful.

Social media is a commonly used tool these days which is turning into a useful platform for mothers to interact with others and access advice quickly. However, it is essential that these sites are strictly monitored to ensure wrong information is not passed on. However, this is an area which could be explored further.

### ***Mixed Messages***

As within antenatal support, personal experiences appear to continue to inform the information provided postnatally. This is a difficult issue, as not only does personal experiences appear to dictate how they show a mother what to do but also how they even broach the topic. The differences arise not only between midwives and health visitors but within each of the teams, so quite often a mother is given different advice and techniques from different midwives or health visitors. Several participants complained that different midwives all had different breastfeeding techniques, which was very confusing for mothers (Focus Group 5, 6).

It appears that even though they all do the same training, there is often a difference in the interpretation of that training. There is a need to ensure that all advice and support is based on the evidence base which currently exists within the UNICEF guidelines. These inconsistencies are often picked up within the groups and can result in a strained relationship between the mother and the health professionals concerned. Personal and anecdotal experiences should not inform practice. The training is standardised as a way of combating such an influence. However, it would appear that this is something that needs revisiting. The inclusion of personal experiences actually weakens the effectiveness of the support provided and for some hinders the breastfeeding process and the length of time breastfeeding is sustained.

### ***Women's Experiences***

All the mothers involved in this study were aware of the infant nutrition team and how to access them. How they had come across that information varied. Some had come across it while surfing the internet for breastfeeding help at time of crisis; others had been given the contact details by midwives, health visitors or children's centre staff. However, once contact with the team had been initiated, the quality of support was deemed as very good, it was felt to be consistent and staff were very knowledgeable. Mothers viewed the role of this team as pivotal to their support requirements, as while support was available from other avenues, it was not as all-encompassing as that provided by the infant nutrition team. Mothers reported feeling really lucky to have an NHS expert out in the community who was approachable, flexible, and with an ability to offer such a wide range of support. The links the team had with hospital staff and other health professionals, particularly Newcastle staff around tongue-tie, were described as invaluable. (Focus Groups 3, 4, 6, 8) On this particular issue the Infant Feeding Co-ordinator had played a major role in supporting the maintenance of breastfeeding throughout such a difficult period. This included not only positioning and latching but also expressing. However, the biggest

thing for most mothers who had had a baby with tongue tie was the fact that it was the team who had identified a problem which had not been picked up by other health professionals and that they were able to work alongside parents to reach the solution. One mother stated:

*It was horrendous, the baby wasn't feeding, I was in pain and the GP had no clue what was going on. I came to a group to see if someone could help me and it was Vicky who told me what it was and she made the referral to the hospital. It was all sorted out really quickly after that (Focus Group 6).*

In terms of breastfeeding support groups, availability is reported as more than adequate. Breastfeeding mothers are able to access group support every weekday and while none of them reported needing such intensive support at this time, the fact that it was available meant that mothers viewed it as a safety net for most mothers. Another mother stated:

*I often come to more than one group a week, it depends on how things are going. If I feel OK I might stay at home but sometimes you just need to be around people who are in a similar situation as you (Focus Group 7).*

The fact that such groups operated within many localities was also regarded as a major benefit and allowed for mothers to choose which group suited them best. As mentioned some mothers did attend more than one group on a regular basis but they did view the group as a good opportunity to meet other mothers and develop wider social networks, often with like-minded people, which would not otherwise be possible.

Support from GPs for breastfeeding mothers was generally described as “negligible”. There was a strong view that GPs had little expertise in this area, that the information they had was often outdated and that they often went for “the easy option” of recommending switching to bottle feeding as a response to any problems.

Mothers reported various stories of feeling very unsupported by the GPs. Health professionals also commented on the fact that they often do not have the up-to-date information about suitable medications for breastfeeding mothers and quite often tell mothers to stop breastfeeding when this is not really necessary. It is acknowledged that some mothers would be happy to use this advice as an excuse to stop, particularly if they are in pain or very tired, but for those wishing to continue breastfeeding, they are then placed in the position of having to disregard doctor's advice. The infant nutrition team often provide information to doctors and have purchased a training package aimed at GPs but, to date, take up has been very low.

Mothers reported that this level of support from GPs is totally unsatisfactory and that such a lack of understanding and support does have an impact on the patient/doctor relationship. There is a clear need for GPs to have a good understanding of breastfeeding, issues and suitable medications. There is also a need for them to help find satisfactory solutions whereby breastfeeding can be maintained.



### ***Partnership working***

There is a clear need for partnership working to ensure a seamless service between hospital and community. There are also other partnerships in operation across the breastfeeding landscape. The partnerships within the breastfeeding arena are complex and achieve varying levels of success as successful breastfeeding involves a pathway involving many parties, all of whom are required to work alongside/together to provide the best possible care and support for mothers. The breastfeeding agenda is a national policy implemented locally and this in itself requires good levels of partnership.

What is clear is that levels of partnership working across these areas are very variable. Relationships within the hospital infant nutrition team and breast feeding lead midwives appear good, including with midwives working out in the community.

There are also some differences between Middlesbrough and Redcar. There is a view that these differences are the result of how priorities are defined within each of the local authorities, with one being more engaged with and supportive of the breastfeeding agenda than the other. It would seem that while improving breastfeeding rates and reducing drop-off rates remains a priority for both, how they prioritise this in comparison with other issues does differ (Interview 9).

Communication was identified as a problematic issue between hospital and community level services. Access to information is also reported as difficult as each of these agencies use different systems which do not interact. This impacts on the sharing of information. It has recently been agreed that the infant feeding team based in the community will be included on System 1 (the NHS recording system). It is anticipated that this may help improve the information sharing between hospital community NHS staff.

While it was not possible to carry out a full partnership analysis, given the short timescale of this project, it would seem that people come together to provide training and do so successfully. Communication between midwives and health visitors has been difficult at times and the level of detail included in midwife reports in the red book (parent held health record) is described as variable.

On reflection it does seem that there are some issues at a more strategic level that require further work but that on the ground, practice level partnerships are more positive, with different team members coming together on a regular basis. Work in both arenas is continuing to develop at a pace but both strands appear to be developing separately when in fact they could come together and develop together bearing in mind that many of the midwives operate in both arenas.

Communication between midwives and health visitors was reported as problematic although this has been recognised and some plans are already in place to break down some of these barriers, improve information exchange and ensure more consistency in recording processes. This should be made easier bearing in mind that recent changes mean that both midwives and health visitors now come under the same directorate within the Trust. One health visitor stated:

*The way we communicate with health visitors in through the red books but they are often not filled in as they should be and the breastfeeding assessment is not always completed so we don't always know what's been happening. (Interview 6)*

Midwives work well with children's centre staff to provide antenatal sessions and health visits with children's centre staff to provide drop-in clinics, weighing at support groups. Most stakeholders report good relationships with the Community infant nutrition team both in terms of training, peer support and practical support. These relationships appear to be developing well.

### **Resources**

Resources were identified as a key issue in terms of support services. This was a key issue within both health and community health services and also for local authorities in terms of Children's Centres and 0-19 services. At this time of austerity, funding is not so readily available either within the NHS or the local authorities and appears to be dependent on the priority given to breastfeeding within those organisations. South Tees Hospitals NHS Foundation Trust has a commitment to increasing breastfeeding rates both within the hospital and in the community. The two local authorities involved in this study both agree that breastfeeding rates are a priority, although there appears to be some disparity as to the financial commitment made in order to achieve this. One interview participant stated:

*We have a Chief Exec in Redcar who really sees the value of it [breastfeeding] and she wants this to be the way forward. We don't seem to have that level of commitment to breastfeeding in Middlesbrough (Interview 9).*

What became clear throughout this evaluation was that the majority of those deciding to breastfeed will make a very positive choice to do so. They will also find any information they feel they need, seek out professionals to provide information and support and identify existing groups that may be of help to them should they need it. A mother's decision to breastfeed can be the result of many factors ranging from "just wanting to try it" to "I want to give my baby the best start in life" to "it helps with weight loss and reducing women-related cancers" (Focus groups 2, 6, 7). None of the women involved in the focus group had made their decision based on information available to them. As previously mentioned, all had made the decision prior to birth and none had undergone a change of heart from bottle to breastfeeding following the birth (Focus Groups 1, 3, 7).

## 6. Conclusions

The evidence suggests that while breastfeeding rates in the area remain low in comparison to other parts of the country there have been some significant developments in the provision of services to support breastfeeding. The South Tees Infant Nutrition Team is well established, and received many plaudits during this research study, but there have been some significant reductions to the community team more recently. It would appear that while the commitment to promote and support breastfeeding across the area continues, the resources to facilitate this have reduced and it has been difficult to maintain support levels and facilitate and deliver training for staff and peer supporters.

While the UNICEF guidelines form the basis of the South Tees Breastfeeding Policy, this study has highlighted some worrying aspects of the implementation of those guidelines. Interpretation of the guidelines is one issue; another is that of formal evidence-based advice and support being diluted by health professionals using personal experiences as a base for advising women. These are issues that need to be addressed in future training.

A major problem within the guidelines is the recommendation that decisions on feeding are not made until after the birth. In reality this rarely happens. Mothers have often made the decision as part of their preparation for the birth. It is now necessary for mothers-to-be to take formula into hospital if they intend to bottle feed, so this needs to be available in advance, which makes it even more difficult to make the decision following the birth.

For many mothers, the timing of the decision is not really relevant. What is more important is the information available to them on which to base that decision. Antenatal support for breastfeeding is variable. Workers often find it difficult to engage people with the antenatal breast feeding classes, particularly in areas of deprivation, and engagement with fathers is even more sporadic, although they are more likely to attend the classes for pain management or labour than they are breastfeeding.

Post-natal support is in the process of changing, with midwives providing 5 day intensive support to all breastfeeding mothers. This does not necessarily mean daily home visits but can include telephone consultations. This is viewed as a real step forward to improving support immediately following the birth, although there is some question as to how this can be provided for all breastfeeding mothers, given the fact that no additional resources have been made available for this intervention.

Post natal wards are very busy and staffing levels sometimes mean midwives are not available to provide individual level breastfeeding support. The introduction of maternity healthcare assistants has been one way to address this, as their primary role initially was to provide breastfeeding support. However, more recently their roles have been extended and they now spend only a small amount of their time on breastfeeding support. As a result the gap has re-emerged and ideally lower level staffing could be introduced on the ward to provide only breastfeeding support. This would require additional funding but it may be possible to explore the feasibility, potential benefits and value for money that such an option could offer.

There is some doubt cast on the accuracy of initiation figures and also on the consistent recording of 6-8 week figures. If we are to truly understand the impact of these changes and future developments, there is a need to ensure the robustness of these figures.

There is also little doubt as to the importance placed by stakeholders and mothers on the role of the infant nutrition team. Not only do these staff lead on the implementation of UNICEF and the baby friendly initiative, but they also provide good quality support for both breast and bottle feeding mothers and also train community health staff and train and supervise peer supporters. The flexibility they provide in their support is a welcome aspect and mothers show high levels of confidence in approaching the team.

Certainly in some areas culture has a key role to play in this. Engagement in breastfeeding in the more deprived areas is more difficult to achieve. In those areas bottle feeding is seen to be the norm, and this is a familiar pathway that most pregnant women will take. Understanding of the benefits of breastfeeding can be low in these areas and there is often an unwillingness to even explore this option. This can prove difficult for health staff attempting to encourage breastfeeding for mothers in these areas. Grandparents appear to have a major role to play, not only in terms of support of the mother, but also in terms of their influence on any antenatal decisions to breastfeed. An information pack for grandparents could also be considered and attempts made to include grandparents in both ante and post natal breastfeeding support where this is felt to be desirable.

Breaking down these cultural barriers will only be achieved through education, and this will inevitably take longer and is unlikely to be addressed simply through brief interventions. It has become apparent that the hard core attitude of “breast is best” is not very successful and generally only results in women who fail to initiate or sustain breastfeeding feeling like they are unfit parents. Improved training has already resulted in some changes to the way breastfeeding is promoted, using a softer approach and avoiding recrimination. Mothers appear to prefer this approach although it is too early to say if it has made any significant difference to breastfeeding initiation or has helped women sustain breastfeeding.

It is very important that there is equity of support services for both breast and bottle feeders. Ultimately, it is a choice and people should not be judged on the choice they make or miss out on support because it is not viewed as the ‘right’ choice.

The provision of any support for mothers is dependent on a range of stakeholders, and partnership working is critical if services are properly to meet the needs of mothers in the community. Partnership working on some levels appears to be working well, although this could be improved particularly in terms of hospital and community health staff where the communication is not particularly effective, which has some influence on achieving the seamless service between the hospital ward and community.

Availability of written information continues to be an issue. To some extent there is a real difference of opinion about this, with staff saying there is information available but mothers reporting they do not get a lot. The processes for distributing

information need to be made clearer and followed by staff at set points throughout the pregnancy and beyond. However, the debate as to whether written information is the most effective medium continues, and there is a view that other forms of communication such as social media should be further explored.

Mothers also identified a need for more practical information on breastfeeding. They felt that this would better prepare them for what lies ahead and that this information should be provided either prior to the birth or as close to the birth as possible. They identified a need for honest information, and a Q&A paper on the issues generally associated with breastfeeding would be most beneficial. Generally breastfeeding mothers are unprepared and not knowledgeable about many of the issues and problems that can occur, and this is not always conducive to continued breastfeeding. It is felt that the benefit of giving such honest information would far outweigh the possibility of putting people off breastfeeding.

The consistency of verbal information is a major area of complaint. Part of this does appear to be the result of staff incorporating personal experiences into the advice provided. This is a specific issue that should be incorporated in all future training as a way of ensuring more standardised interpretation and delivery.

The concept of 'informed choice' appears to be a slight misnomer when it comes to breastfeeding. Women's choice is often based more on personal or cultural factors than on any coldly rational analysis of evidence or information. Of the sample of breastfeeding mothers involved in this study, none had made their choice to breastfeed based on the information they had been given. What was more likely was that, following a decision to breastfeed, they then went on to find any information they felt they might need. However, this does not negate the importance of good quality and practical information being available, but the main purpose of this would appear to be more in line with sustaining breast feeding than initiating it.

There is also a lack of information available for bottle feeding mothers. Their access to support lies mainly with health visitors or within children's centres. It needs to be recognised that bottle feeding mothers also experience problems, albeit they are a different set of problems from breastfeeding mothers, but still with potential for serious consequences for child health, and there is a need to ensure more equity in service provision. There are currently 3 infant feeding groups which include both breast and bottle feeders across the two local authority areas, although it is also noticeable that the groups emerged because their original remit of breastfeeding support resulted in a very poor uptake. However, input from the infant nutrition team to these groups has served to improve engagement of both breast and bottle feeding mothers, although numbers remain quite low.

Breastfeeding support groups operate on a daily basis across the two areas. Some of these groups are well established and appeal to people outside of the locality. Mothers can attend as many group sessions as they wish and they often do so for social purposes. The groups play a major role in building up the confidence of mothers to breastfeed in public, as well as helping them find the technique best suited to them, so these groups serve multiple purposes. However, the majority of these groups take place in the morning and breastfeeding mothers report that this is not always the best time for breastfeeding mothers and that group times should be

staggered or varied and also include some early evening groups that fathers would be able to attend if they wished.

Peer support is regarded as a major step forward in providing breastfeeding support. Some headway has been made, with 29 women fully trained as peer supporters. However, only 17 of those remain active and are currently offering some degree of support. The drop-off means that there is a need for a continuous rolling programme of training and recruitment. The current training programme has been halted, although is due to recommence shortly. On completion a further 25 women will be fully trained as peer supporters. Another new development is the introduction of peer supporters onto the wards. Again, this is viewed as a positive step forward and a good way of improving the skills of the peer supporters as well as the support available for mothers. It is also likely to relieve some of the pressure on midwives on the ward and improve the mothers' perception of post natal support on the wards.

While there is some evidence to suggest that peer support is more effective in areas with high initiation rates, this study found that, even in Redcar & Cleveland which has low initiation rates, participants were very clear about the effectiveness of peer support in sustaining breastfeeding and the importance of ongoing support.

Women's confidence in GPs as a support for breastfeeding is very low. Many very negative experiences were highlighted as part of this study, indicating that there is a lack of knowledge in this area, and many GPs and staff in GP surgeries are basing treatment on out-of-date evidence. There is a need for GPs to take an active role in developing their knowledge and understanding of the breastfeeding policy drivers, the modern, evidence-based approaches to support breastfeeding, but also particularly to undertake training in order to better understand issues such as tongue-tie on which mothers might consult them.

Engagement in breastfeeding support for mothers from ethnic groups appears to be low. It would appear that high proportions of women from these groups breastfeed as it is part of their culture. Culture is also a reason for their lack of engagement in support services, partly because breastfeeding is the normal course of action and very natural to this group but also because they are not allowed to breastfeed in public and many stay in the home. However, they do tend to access children's centre services, health visitor support and GP services. They reported little in terms of information available to them, and language barriers were often a problem. They were unaware of any information being printed in different languages

There is a stark difference in perception of which feeding method is in fact the norm. The breastfeeding mothers are very clear that they are the minority and that bottle feeding is the norm. Bottle feeding mothers believe the opposite and that breastfeeding is the norm, and the fact that the majority of services are now aimed at breastfeeding mothers reinforces this belief. There is a view that the UNICEF guidelines do not facilitate an equity of support across the two feeding modes, and this is something that needs to be considered.

Overall it seems fair to say that there is a wide range of support available across the two local authority areas, both within the hospital and in the community. Breastfeeding rates across the two areas continue to be low and there is a view that

this is unlikely to change suddenly or significantly. The consistency and effectiveness of information (both written and verbal) is indeed variable and a more standardised approach would be welcomed by mothers.

However, there is a wealth of knowledge and expertise available amongst those who are already exploring creative ways of engaging mothers, fathers, families and encouraging breastfeeding and that time needs to be given to test out some of these recent changes and an evaluation of the outcomes and impacts carried out to inform future development.

## 7. Recommendations

After reviewing the evidence collected in this study, the following recommendations are offered for discussion with commissioners:

1. That further training with health service staff is required to reinforce the primacy of the evidence base as opposed to them mixing this at will with personal experience and anecdote. The resulting inconsistency in the advice given to women is seriously undermining of confidence in their professional expertise
2. That questions about breastfeeding are properly built into antenatal care pathways at each encounter with pregnant women, and that these are formulated in such a way that it is not performed as a tick box exercise by staff
3. That antenatal programmes on breastfeeding are held as twilight sessions as well as during the daytime, in order to encourage the attendance of working mothers and fathers
4. That consideration is given to improving women's access in hospital to maternity care assistants and peer supporters, to ensure that all women wishing to breastfeed are not discharged until they have been given the support necessary to ensure successful initiation of feeding
5. That no woman wishing to breastfeed is discharged without full information on where she might call for telephone support, especially out of hours
6. That the Community Infant Nutrition Team be strengthened and its role reinforced.
7. That GP surgeries be brought fully up to date with the UNICEF BFI principles through training of practice staff and GPs themselves, and that GPs be given some additional specific training around the more medical problems (like tongue tie) that might bring a breastfeeding woman to the surgery
8. That a review of the forms of breastfeeding information available to mothers and other family members is undertaken, taking into account the following:
  - a) Whether low cost written materials are currently routinely offered and available to mothers antenatally and postnatally, and are made available in different languages
  - b) Whether there would be benefit in forming a small group with representation from midwives, health visitors, children's centres and breastfeeding mothers to design a Q&A paper for distribution to breastfeeding mothers
  - c) Whether an information pack for grandparents and fathers could be cheaply developed to improve their understanding and support for breastfeeding women, but also to begin to break down some of the historical/cultural issues which operate as barriers in terms of normalising breastfeeding.



- d) Whether new forms of media could be used to convey information. Smartphones are very common, often providing instant access to the internet. New apps are being developed, and it may be beneficial to test some of these out to examine if they are more effective than written information.
9. That the value of peer support schemes in enhancing and improving the duration of breastfeeding be fully acknowledged and that financial provision is made for the continuous programme of recruitment and training that will always be necessary in using such a resource.
  10. That consideration is given to the fact that a woman-friendly service would support bottle feeding women as well as those who choose to breastfeed, partly for reasons of equity of service, but also on the basis that breastfeeding women may need to resort to the use of the bottle and, conversely, a woman who has bottle fed one child might still aspire to breastfeed on a subsequent occasion
  11. That the principles of the UNICEF Breastfeeding Friendly Initiative continue to be pursued on the basis that they provide an enlightened, evidence-based framework for advising and supporting women on the best and most healthy outcomes for themselves and their children
  12. That an attempt is made to improve the recording of data on breastfeeding in two ways:
    - a. Midwives/maternity care assistants are instructed to record breastfeeding initiation only following actual observation of initiation on the ward or following discharge. This may impact on initiation rates but will also reflect in reduced drop-off rates
    - b. Health visitors and GP practices are informed of the desirability of an accurate assessment of breastfeeding status at the 6-8 week check.

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