Breastfeeding , Weaning and Health Eating:
A synthesis of Sure Start Local Programme Evaluation Findings

Paula Latham
Shraddha Kapoor
Patrick Myers
Jacqueline Barnes

NESS
NATIONAL EVALUATION OF SURE START

March 2006

CONTENTS

Executive Summary

Background

Nutrition has been identified as a key target area for Sure Start Local Programmes and has continued to be an important area for child and adult health with the rise in obesity and low rates of breastfeeding in disvantaged areas. A wide range of interventions are being implemented locally through Sure Start to provide information and guidance on nutrition and related areas such as breastfeeding, weaning and healthy eating. This NESS synthesis report brings together information on the evaluation of support for breastfeeding, weaning and healthy eating provision of Sure Start local programmes (SSLPs).

Methodology

All reports received at NESS up to January 2006 were examined for any evaluation findings relating to breastfeeding, weaning and nutrition support provision. The review yielded 80 programme reports, approximately 9% of all report received by NESS, which were then utilised for this synthesis report. Content analysis was used to identify and record common themes of evidence in relation to breastfeeding, weaning and healthy eating. SSLPs implemented a range of methods for evaluation, generating a complex range of useful primary and secondary data sources. Limitations of health databases are being addressed by some SSLPs to improve the quality of the available data on breastfeeding, and to a lesser extent weaning.

Findings

The review of SSLP evaluation reports found that progress has been made in supporting children and families with nutritional support in relation to breastfeeding, weaning and healthy eating. Of the 80 reports, 58 included examples of breastfeeding support, 10 included weaning work and 32 included healthy eating activities. Education-based group activities were popular interventions for all aspects of nutrition work providing learning in a fun and sociable way.

Overall there were 63 examples of process evaluation findings that contained information of how programmes have implemented nutrition support. Each report was reviewed for evidence of what difference nutrition interventions have had for children and parents. Thirty-nine reports contained examples of outcomes for children. Outcomes for children were linked to either breastfeeding and/or healthy eating initiatives and the majority of these were positive outcomes. There was some evidence of an increase in the 'initiation and duration' of breastfeeding rates measured over specific time scales. Children (including parents and staff) have developed their understanding of healthy snacks with some examples of child-taste preferences changing with the increased consumption of fruit.

There were 42 examples of outcomes for parents and these were mainly for mothers. Outcomes for mothers related to an increase in nutrition and level of self-confidence linked to either breastfeeding and/or healthy eating. Some of the main outcomes of nutritional activities reported by SSLPs included increases in knowledge and information about nutrition, family diet, confidence and cooking skills. Breastfeeding training for both staff and local mothers provided additional benefits. Twenty-four reports detailed evidence of models of work where mothers received practical help with breastfeeding and 18 of these were models of work led by parents.

There were some examples of some outcomes for staff linked to satisfaction for working in innovative ways to meet local families needs and engaging with children, whose parents are young and/or ethnic minority families. Twenty-eight reports detailed evidence of professionals leading and delivering breastfeeding support to local mothers and there was evidence of multi-disciplinary working in 8 reports. Pre-project findings that have informed service developments have provided staff with learning and training opportunities to develop their understanding of appropriate provision for working in low socio-economic areas.

Conclusions

While evaluations had limitations relating to sample representation, incomplete datasets and research design, some show promising early benefits of SSLP nutrition work, particularly breastfeeding and cookery course interventions. Some programmes have reported an increase in breastfeeding rates since the implementation of Sure Start provision and support. In addition, there are some examples of changes in families' nutritional habits. Group activities were the most common models of service delivery for all areas. There was evidence of multi-disciplinary teams delivering all aspects of breastfeeding, weaning and healthy eating support, with improved staff satisfaction. There was evidence of parents being supported to deliver breastfeeding support. The review found a few examples of innovative work with families such as young parents and ethnic minority families in delivering services in informal and stimulating ways, where previously these families were difficult to engage with. Evaluation also provided important evidence of the needs of specific groups and how programmes had implemented nutrition provision, based on these findings, such as culturally appropriate activities with language support and Sunday activities with fathers and their children.

Training courses in nutrition and breastfeeding were popular with parents, mainly mothers, and outcomes included: capacity building, confidence building and stimulating interest in further study, volunteering and employment. Programmes are collecting evidence that they are working towards Sure Start objectives such as 'improving health', 'social and emotional development' and 'strengthening families and communities' through services that offer advice and support on nutrition. These objectives also relate to the more recent framework of Every Child Matters and will be useful for the sustainability of good practise in nutrition for future childrens centres.

1. INTRODUCTION

1.1 Sure Start Local Programmes (SSLPs) are a key element in the Government's effort to improve the life chances of children in areas of greatest challenge and need. They represent integrated approaches to service delivery specifically aimed at contributing to the five outcomes for children, articulated in Every Child Matters[1] to support children from birth to 19 years old to:

- Be Healthy
- Stay Safe
- Enjoy and Achieve
- Make a positive contribution
- Achieve economic well-being

1.2 This framework provides existing services, agencies and regeneration programmes an opportunity to work towards a common and joint agenda to improve provision for children and families. Sure Start health and public health targets have similarities relating to improving nutrition and diet for children and families providing further opportunities for joint working and the enhancement of existing services. Specific to Sure Start has been the DfES Birth to 3 Matters[2] framework to support children and families from birth to 3 years old. There are important aspects of this framework that relate to child health including early mental health well-being indicators such as child 'self-esteem and identity'*:

- A strong child*
- A Skilful communicator
- A competent learner
- A healthy child*

1.3 SSLPs are required to undertake local evaluation examining the process of service delivery and the impacts and outcomes that have resulted from their activities. Evaluation outputs such as annual evaluation reports and findings reports are submitted to the National Evaluation of Sure Start (NESS). NESS is committed to developing the evidence base of the impacts of programmes, detecting any causal links, as well as assessing the cost effectiveness and changes that occur in programmes locality over time. NESS also provides support to local programmes in conducting their local evaluation.

1.4 NESS acts as a repository of all evaluation outputs from the 524 SSLPs. The collation and dissemination of information relating to local evaluation is an important part of the work of NESS, and is facilitated through the NESS website (www.ness.bbk.ac.uk) and through regional workshops and networks. Synthesis reports are an amalgamation of evaluation findings on a particular theme. This report on breastfeeding and nutrition is the 3rd synthesis report by NESS. Other NESS synthesis reports are available on the NESS website, www.ness.bbk.ac.uk and include:

- Speech and Language services in Sure Start Local Programmes Findings from Local Evaluations

- Partnership Working in Sure Start Local Programmes. Early Findings.

1.5 In relation to improving child diet and nutrition, Sure Start programmes are required to provide '*information and guidance on breastfeeding, hygiene, nutrition [and safety*].' Sure Start Programmes have responded to this through a range of approaches that have included:

- Promotion and support to women breastfeeding
- Providing support and information about good weaning practice
- Activities orientated to educating parents about diet
- Providing children with healthy food and drinks.

1.6 The aim of this report is to synthesize evidence of the services directed to raising awareness of issues related to the 3 aspects of nutrition: breastfeeding, weaning and healthy eating. The synthesis was also designed to provide evidence of the beneficiaries of these nutrition support activities and in particular seek evidence of outcomes for children. All received local evaluation reports (n=745 at 1/2006) were reviewed for any content relating to breastfeeding, weaning and healthy eating. Eighty reports, which represents approximately 9% of evaluation reports received by NESS, provided sufficient detail to enable further review and assessment of the findings. Each report was read and reviewed applying the method of content analysis to identify and record common themes. Details of all the reports examined in the production of this report are given in Appendix A.

2. WHY IMPROVING CHILD AND FAMILY NUTRITION IS IMPORTANT FOR SURE START LOCAL PROGRAMMES

2.1 The World Health Organisation (WHO) emphasises that those who develop healthy eating habits early in life do maintain them into adolescence and adulthood with the added benefits of better health status such as reduced risks of cardiovascular disease, certain cancers and diabetes[3]. More recently, obesity, a diet-related disease, is one of the biggest public health issues facing England[4] The prevalence of obesity among children aged 2-10, rose between 1995-2003, from 10% to 14%. The largest rise, of 6%, was among children aged 8-10. The rise in childhood obesity is seen as a precursor to less favourable health status in later life, as well as having more immediate impacts on the child[4].

2.2 Diet-related disease, poor health, including mental health, has increased research into the causal links between healthy eating that requires appropriate nutrients in regular diets, and good health. There has been a growth in the understanding of what are 'good' and 'bad' foods, and the nutrients essential for our good health which have informed guidance and initiatives i.e. Food Standards Agency www.food.gov.uk and Department of Health www.dh.gov.uk and Salt www.salt.gov.uk The key message being that childrens' diet should be: low in fat, sugar, and salt including processed foods and fizzy drinks, and high in fruit and vegetables. Of particular interest to SSLPs is the fact that socio-economics have found to be linked with diet deficiencies. Households with the lowest levels of household incomes, those areas where SSLPs are located:

- Have higher rates of obesity than children from households with the highest levels of income[5].
- Have lowest levels of breastfeeding activity:
  the lowest breastfeeding initiation rates, the lowest of which is in mothers that had never worked (52%)[6] and the highest in mothers in higher paid occupations (85%)[7]. Breastfeeding initiation rates remain relatively low in the UK and other high-income countries, particularly among women in lower income groups[8].
- Have limited family finances to access healthy food due to lack of transport and food selection within the locality[9]

2.3 The links between early infant feeding and the weaning transition in child diet indicate that this is an important aspect for child health. Some of the guidance on the implications of poor weaning practises emphasize this point:

- Children introduced to solid foods before the age of 4 months can have later health problems[10]
- Children who are weaned early require more medical visits[11]
- Children weaned early have increased body fat at age7[12].

2.4 The development of good weaning practice therefore, is an appropriate activity for SSLPs to undertake because poor eating habits start early and begin at the time of weaning and the 1st few years of life. Much current advice around weaning is derived from the COMA[13] report which recommends:

- Solid foods should usually not be given before 4 months
- Milk or water should constitute the majority of drinks given
- First foods should be non-wheat cereals and pureed fruit and vegetables.

2.5 It is obvious that family culture and local food selection will determine childrens' diet. In addition there are other important factors[9], such as:

- Parent/carers food preferences
- Influence exerted over the diet of young children based on cultural attitudes, beliefs and values
- Lack of parental/carer knowledge of healthy foods
- Lack of parental/carer healthy culinary skills.

2.6 Infant feeding became an important area for SSLP early intervention, for the improvement of child diet and nutrition. The key aim being that infant feeding started and continued with breastfeeding milk. To monitor the progress of this early intervention, breastfeeding rates became a key performance indicator of SSLP progress towards achieving better outcomes for children. Socio-economic[7] status and associated factors have an influence on the initiation and duration of breastfeeding and these have had to be considered in the development of provision. Specific factors such as the mothers education, and age, and family dynamics have all been recognised as factors that influence breastfeeding activity:

- Education of mother. The initiation and duration of breastfeeding rates of mothers who left school at aged 16 or younger was lower compared to mothers who remained in full time education post-18 years of age [6]

- Age of mothers. Younger mothers may choose bottle-feeding as the easier option. Breastfeeding duration rates were low: 54% of young mothers that start breastfeeding their child at birth, by the time the baby was 4 months old this figure had dropped to just 16%[6]

- Family dynamics. Where there was a lack of partner or lack of family support bottle feeding was the chosen method of feeding[6]

2.7 NESS Early Impact[14] findings confirm some of these socio-economic effects. The research involved studying the initial 150 SSLPs compared to a comparison group (50 Sure Start-to-be programme areas that are now part of the Round 5 and 6 SSLPs). The early findings show that the initial SSLPs are significantly less deprived compared to the comparison group in terms of household income and mother's education.

2.8 There were also more ethnic minority and non-English speaking families living in the Sure Start-to-be areas, hence, the more deprived areas. Data were collected on a variety of outcomes that were likely to be affected by SSLPs and the following child physical health variables, for 9-month-old babies, relate to this synthesis report:

- Birth weight
- Child ever breastfed
- Child breastfed through 1st 6 weeks.

2.9 There was no significant difference of the age of mothers in each of the groups however, the findings show that 9-month-old babies, of teen mothers, were less likely to be breastfed for a minimum of 6 weeks. The data show that 59.5% of babies living in SSLPs areas were breastfed (i.e. ever breastfed variable) and 63.9% in the comparison group which shows a slightly adverse SSLP effect. This same trend was found with the duration of breastfeeding (breastfed through 1st 6 weeks) with a greater percentage of babies being breastfed in the comparison area. With evidence that slightly more babies living in the comparison group area, which are more deprived areas, are more likely to be breastfeed and for longer these findings are important to consider for the evaluation of SSLPs' nutrition work. It will be important to understand for instance, whether ethnicity, as well as the age, and qualifications of the mothers and the household income do continue to have an influence on infant feeding options and what interventions are introduced to support early nutrition for babies living in these different types of households.

2.10 At the same time, there has been a growing body of evidence supporting the short and long-term benefits of breastfeeding for both children and mothers. For children breastfeeding:

- Provides the perfect nutrition for the baby's first six months [3]
- Protects against chest infections, asthma, eczema and allergies [15]
- Exclusively breastfeeding for 6 months can reduce morbidity from gastrointestinal infection compared to 3-4 months of mixed breastfeeding[16].
- Babies that are breastfed longer are leaner – there is a decrease in risk of being overweight. [17]

For mothers breastfeeding:

- Helps the womb to return to normal[18]
- Long-term health benefits reducing the risk of pre-menopausal breast and ovarian cancer and hip fractures in later life[15]
- Helps mothers to regain their body shape by using an extra 500 calories a day[18]
- Contributes to prolonged lactational amenorrhea.[16]

2.11 Together with the understanding that breast milk is free and therefore, more cost-effective for families than formula infant feeding, there is growing understanding that the activity of breastfeeding is the more natural, and symbiotic, method of infant feeding. The fact that breastfeeding has positive implications as a contraceptive[16] will be of additional interest regarding unplanned pregnancies and high birth rates.

2.12 The Department of Health[18] also support the idea that breastfeeding helps to develop a strong emotional bond between mother and child. Strengthening emotional bonds between parents and infants is an important aspect of Sure Start work to support the social and emotional development of

babies. Research on fathers' support with infant breastfeeding conducted in support of National Breastfeeding Awareness Week 2005[18], found that 79% of those surveyed said they would want their children to be breast-fed.

2.13 Despite these widely documented benefits and support for breastfeeding there remains communities with 'non-breastfeeding' cultures. As part of the initiative to drive change the Department of Health and Primary Care Trusts are required to increase breastfeeding rates, by 2% per annum. A strategy to tackle the 'non-breastfeeding' culture that has developed in the UK is the United Nations International Emergency Fund (UNICEF) Baby Friendly Initiative which states that*: Implementing the Baby Friendly practise standard is a proven way of increasing breastfeeding rates*.[19] The aim of the Baby Friendly Initiative is to ensure that all parents are helped to make informed decisions about feeding their babies and that they are then supported in their chosen feeding method. Box 2.1. gives details of the progress to date of this initiative (see Appendix B for details of the 2 different awards).

2.14 Local hospitals, health centres and general community services including GP's and local pharmacists can apply for Baby Friendly Awareness awards. Service providers, including SSLPs, have had to reconsider how to provide opportunities for parents to learn, understand and be supported in the benefits and techniques for breastfeeding their babies.

Box 2.1.
UK Baby Friendly Awards progress at 23rd January 2006

- 7 community health care facilities in the UK have received the 'full' Baby Friendly accreditation, 3 are Sure Start programmes in England
- 16 community health care facilities in the UK have a received a Certificate of Commitment, 7 are Sure Start programmes in England
- 27 Strategic Health Authorities in England have received full Baby Friendly accreditation.
- 48 Strategic Health Authorities in England have received Certificates of Commitment
- Overall, 114 maternity hospitals in the UK have received full Baby Friendly accreditation or a Certificate of Commitment – this is organised by country and, within England, by Strategic Health Authority

Source: http://www.babyfriendly.org.uk

2.15 Research trials in the USA involving 1388 women, 5 of the 7 trials included 582 women on low incomes, showed that breastfeeding support provided as an educational intervention had a significant effect on increasing initiation rates compared to routine care[20]. The evidence supports the need for educational interventions to increase parent knowledge of diet and nutrition. Together with efforts to provide easier access to food that provides adequate nutrition to ensure optimal

development and expose children to develop a taste for healthy foods become important for Sure Start.

2.16 SSLPs have been in an excellent position to explore and introduce interventions for child health: interventions that consider nutrition and diet from birth, to improve outcomes for children and families. The following sections include the methodology and results of the synthesis of nutrition related activities, as reported in SSLP local evaluation findings.

3. METHODS USED TO EVALUATE NUTRITION SERVICES in SSLPs

3.1 The available evidence

3.1.1 This synthesis report differentiates between process evaluations that rely more on description of implementation and delivery, and those evaluations that sought to report changes and outcomes, both short-term and those that may take longer to materialise (see Box 3.1) It also differentiates between reports that deal with breast feeding, weaning and healthy eating and each of these is dealt with separately although some reports deal with more than one of these topics.

Box 3.1
Results of content analysis (N=80)

Number of reports that include examples of nutrition evaluations – some reports included examples of more than one area of nutrition.			Number of reports that contain examples of nutrition related outcome or process findings		
Breast Feeding	Weaning	Healthy Eating	Outcome for children	Outcome for parents	Process evaluation
58	10	32	39	42	63

3.2. Methods used to evaluate breastfeeding, weaning and healthy eating services in SSLPs

3.2.1 An examination of the 80 relevant evaluation reports found that SSLPs had used a combination of methods to evaluate nutrition related activities (see Box 3.2). The most popular evaluation methods were questionnaires (32) to collect primary data (new information which they themselves collected) and there were 34 examples of reviewing existing (secondary) data sources. The most common target for questionnaires were parents and health workers. Other reports dealt with reviews of a range of data such as the statistics sent to the Sure Start Unit for monitoring purposes, staff case notes, and other available documents.

Box 3.2 **Methods reported by SSLPs in their evaluation reports**	Number of reports
Participants/Respondents:	
• Parents	54
• Health workers	17
• Volunteers	8
• Multi-disciplinary workers	5
• Nursery nurses	3
• Early years workers	2
Primary Data collection methods:	
• Questionnaires	32
• Interview	21
• Focus group	7
• Participatory Appraisal	4
• Observation	2
• Food Diaries	2
Secondary data collection methods:	
• Review of existing data	34
Involving parents in the evaluation work:	
• Parents as evaluators	10

3.3 Primary data collection methods

3.3.1 Methods used to collect original evaluation data are described as primary data collection methods. These methods are useful when the evaluation requires information that is not already available and is needed to demonstrate the process and impact of service delivery activities.

3.3.2 Questionnaires have been used for audit purposes: to collect information on parents' views of their children's diet and nutrition, parental diet, and what type of nutrition services parents want. They have also been used to collect evidence of short-term changes in nutritional habits and parent confidence. They have been administered by post and face-to-face with local parents and staff. Parents (in 10 reports) were trained as evaluators and administered questionnaires in the community. There were no follow-up samplings to measure changes after nutrition interventions. There were very few details of how questionnaires were sampled and sample sizes varied, some were small. Only one report detailed the data analysis technique.

3.3.3 Interviews have been used to collect information about staff and parent perceptions of and satisfaction with SSLP work prior to being involved in SSLPs and after involvement. Interviews included face-to-face questionnaires and more commonly the semi-structured qualitative method. Tape recorders were not reported as being used to collect data. This type of information has

been used to demonstrate the short-term impact that SSLP nutrition work has had for children, parents and staff. Sampling details are rarely mentioned and mostly involve service users, operational staff and SSLP parent volunteers. Lessons learnt from one pilot evaluation involving parent evaluators revealed that the interview method had low validity. In this particular programme planned a more structured approach for future evaluations to ensure that there was an improvement in the validity of evaluation findings. When involving parents in the evaluation process this programme also wanted to ensure that the collection of qualitative data was more manageable for parents evaluators but there were no further details of how this would be achieved.

3.3.4 Focus groups have been used to collect information on parents' views of child and family diet and nutrition. Incorporating participatory appraisal methods (4) parents' views have been collected on what type of nutrition services they would like to attend. Local parents have been invited to focus groups and some have then become involved in other areas of the SSLP. Some SSLP staff have incorporated a style of focus group interviewing at the end of sessions such as infant feeding support and cooking courses. Post-it notes, comment books, evaluation forms and flipcharts have been used to collect the views of attendees. Parents' views are generally listed in reports, with no analysis.

3.3.5 Observation has been used by staff to report child and parent participation, involvement in and satisfaction with new nutrition projects. In some cases reflections by staff have been used and not structured observation techniques with inter-rater reliability checks. There were no details of sampling size and no follow-up samplings to measure changes after nutrition interventions. A food mapping exercise, which included the technique of observation, was completed by one SSLP area to document the availability of food outlets locally, including transport to these, choice and cost of healthy foods.

3.3.6 Food diaries have been used by nutritionists in 2 programmes, for initial diagnostic purposes. Parents attending nutrition courses have also kept food diaries and parent and child meals have been recorded by the mother. The information in the diaries has been used by staff to plan nutrition interventions with parents. With inter-rater reliability checks this method has the potential to measure changes in child-diet and provide evidence of 'good' and 'bad' diets.

3.3.7 Participatory Appraisal (PA) has been used to support parents and SSLP staff to be involved in evaluation as evaluators (4). Some training has been accredited. Evaluators have used various traditional and more innovative creative arts activities for informative and outcome evaluations. Creative arts style stimuli have included: wish trees, sunflower charts, photographs and artwork while more traditional methods have included questionnaires. To improve the representation of a sample for a community satisfaction questionnaire, parent evaluators, adopting a market research approach to sampling, interviewed local parents in various public places: local

schools, nurseries, local shopping areas, maternity hospital, community centres, in the street, drop-ins, playgroups, library, bingo and cafes.

3.4 Secondary data analysis methods

3.4.1 When evaluation findings and monitoring data already exist from previous evaluations or current monitoring systems they are described as secondary data. These need to be organised and handled in a way that ensures that the same level of ethical and robustness applies as necessary when working with primary data. The synthesis review found 34 examples where SSLPs had used the method of reviewing existing data, most consulting more than one source of data, involving the following secondary sources:

- Health records and data
- Sure Start monitoring data
- Programme specific information
    1. Staff case notes
    2. Activity evaluation forms
    3. Key strategic documents such as the delivery plan
    4. Six monthly risk assessment summaries
    5. Project appraisal documents
    6. Other research findings.

3.4.2 Sure Start programmes are complex in that they generally provide integrated services with a range of delivery styles. Evaluating the effectiveness of integrated services can present challenges. Using data for the local evaluation from records kept by health workers and other health data was popular. However, some programmes that used data from health visitors, hospitals and PCT's found that they needed to be interpreted with caution due to their incompleteness, making them unreliable when measuring changes (see Box 3.3).

3.4.3 Data collected for the purpose of meeting the Sure Start Unit monitoring requirements can be utilised for the local evaluation. A small number of programmes utilised these data to demonstrate changes in breastfeeding activity over 2 and/or 3-year timescales.

Box 3.3 **Improving the reliability of secondary data**
Efforts to improve the reliability of data have included developments in accuracy checking. One SSLP midwife checked different sources of information by comparing the local PCT child health data, mothers' self-reporting and staff observations during visits, to produce more accurate and reliable data to monitoring changes in breastfeeding activity.

3.4.4 SSLPs have evolved in independent ways and this is also partly, reflected in the range of internal programme information that is collected and utilised for local evaluations. Whilst there maybe standardised documents

and information that SSLPs could utilise, the review found a range of secondary source information. Some programmes, for instance, had a collection of secondary data sources which ranged from findings of specific evaluation activities and appraisal documents containing evidence of satisfaction and service delivery progress. Other programmes held case notes on families and specific activities. SSLP delivery plan and risk assessment documents were also used by some programmes for evaluation purposes.

3.5 Aims of Evaluation

3.5.1 Whilst SSLP evaluation aims varied there were some common themes:

- Needs analysis and feasibility - formative work to find out from local people, their perceived needs and nutrition issues, thus enabling new projects to be shaped
- Service delivery
- Parent user satisfaction
- Attendance rates and participation.

3.6 Respondents

3.6.1 In order to generalise from results it is important to know how representative research participants are, of either the whole population of eligible families in a SSLP area, or of those participating in a particular service. Fifty-four reports detailed that parents were sampled for their views of services, but not all of these reports included the size of the sample. Based on 32 reports that did provide sampling details, the minimum parents involved in an evaluation was 2 and the maximum was 335 parents. The following sections include evidence of the process and outcome evaluation findings generated by SSLPs using the methods described in this section.

4. BREASTFEEDING SUPPORT

4.1 Introduction

4.1.1 The review was able to locate 58 reports that provided process or outcome evaluation findings that concerned SSLP breastfeeding support work. Findings have been themed by the type of breastfeeding support work, by whether they reported on rates of breastfeeding initiation and duration, and then additional outcomes for mothers, babies and staff. The material is organised such that reports concerned with providing support in hospital are discussed first, then the kinds of support made available once mothers are home are described, with any evidence regarding outcomes (though this is not always the case). Strategies are grouped into those that rely for the most part on other mothers, and those that involve the provision or resources, a place to meet, or that engage a range of professionals. Finally evidence of rates of breastfeeding are presented, and discussion of ways that data systems could be enhanced so that more robust findings might be possible in the future.

4.2 Improving access to breastfeeding support for mothers in hospital

4.2.1 Several reports noted that the promotion of breastfeeding after birth was too late. One programme found that 68% of mothers had made decisions about whether or not breastfeed during the antenatal stage after being supported by the Sure Start breastfeeding workers.

4.2.2 Twelve reports gave recommendations for hospitals that reflect a 'social model' approach to breastfeeding and to deter from initially offering, formula feeding to mothers. Allowing trained breastfeeding peer volunteers onto postnatal wards to support mothers was recommended in some reports as a new cost-effective model of working. Three reports detailed how this type of work had started to take place. Some midwives in the Southern Region, have implemented this new model by supporting 'peer educators' who offer breastfeeding support to mothers in hospital through the Breastfeeding Babes facilities, at the local hospital and through its telephone helpline.

4.2.3 A programme in the Yorkshire and Humber Region also made a recommendation for hospitals, but this was related to the effect of the routine antibiotics given on postnatal wards and breast thrush development, which then creates problems for breastfeeding. Hence, the recommendation for attempting to reduce the production of breast thrush was to:

> *'Consider the routine antibiotics given on postnatal wards and offer acidophilus and/or live yoghurt on the postnatal ward instead, to see if this reduces the problem – and refer mothers to a local cranial osteopath – to reduce problems associated with instrumental births'*

4.2.4 Baseline surveys in a number of programmes showed that professional support was lacking in hospitals immediately after birth: health professionals were too busy and mothers were left on their own to struggle or rely on family to offer advice and most suggested bottles whenever there was a problem. In

the South West, local mothers are now trained and qualified breastfeeding counsellors and support local mothers.

4.2.5 In the South, parents were involved in informing the style of breastfeeding information and services both through peer support groups and through involvement in Sure Start. Parents who trained as 'peer educators' attended meetings with chief executives of partner organisations, including hospitals, and were involved in decisions affecting the development of future Sure Start activities and facilities. The review found common suggestions in SSLP reports, to improve mothers' experiences whilst in hospital (see Box 4.1).

Box 4.1
What can hospitals do to support mothers from birth with breastfeeding?

A summary of suggestions in SSLP evaluation reports:

- To link in with a hospital volunteer scheme to support women on the post-natal wards. Develop 'shared' protocols for trained peer breastfeeding support volunteers to work on hospital wards
- Support the development of mothers being visited by volunteers as Buddies on the wards
- Breastfeeding volunteers to be represented at the antenatal clinics within the community and at hospitals – to engage with mothers well before birth and mainly at antenatal clinics.
- Breastfeeding awareness to be raised at the antenatal stage by all health professionals and volunteers
- Continue funding for peer breastfeeding support
- Qualified peer breastfeeding supporters to be acknowledged as experts

4.2.6 One programme found that fathers had poor experiences of hospitals. In response to this a 'dads group' was established:

> *'…..after concerns expressed by fathers during the antenatal period, particularly around their feelings that hospitals were resistant to encouraging fathers to be involved. This group meets once a month and has been going for over four years now.'*

4.2.7 There were many examples of ways that Sure Start programmes worked with the whole family and had developed a family centred approach. The next section includes details of this when professionals work alongside parents, in partnership, to deliver services to other local parents.

4.3 Breastfeeding services in the community implemented by SSLPs

4.3.1 SSLPs had implemented a variety of community-based services to improve outcomes for children. This section provides details of the different approaches that SSLPs have used to improve breastfeeding support. Evaluation reports sometimes offer information on innovative ways of working to support breastfeeding, though not all follow this up with evidence of their impact on actual behaviour.

4.3.2 The review found examples of different models of breastfeeding support provided by SSLPs and these were delivered in groups or one-to-one sessions, at the Sure Start centre or during home visits. Groups differed and were either led by SSLP staff (28), multi-disciplinary teams (8) and/or parents (18). The supporter ranged and a number of different models were identified:

Volunteer peer support worker	Health Visitor
Bangladeshi breastfeeding supporter	Midwife
Dual language link worker	Midwifery tutor
Health Care Assistant	Nursery nurse
Infant feeding advisor	Lactation consultant
Breastfeeding counsellor	Family link worker
Bilingual support worker	Health Co-ordinator
Family support worker	Interpreter.

4.3.3 There were three cross-cutting common themes relating to the different models of support:

- Positive baby friendliness. (10)
- Parent social networks to combat isolation. (21)
- Breastfeeding training for parents and staff. (24)

These 3 themes appear to be key factors related to the improvement of initiation and continuation of breastfeeding. Ten reports mentioned the Baby Friendly Initiative (see Box 4.2) and some of these included detail of innovative ways of working in partnership with local community services. Two reports detailed how the whole Sure Start team had been provided with breastfeeding training, including the male cleaners and administrative staff. The aim being to promote breastfeeding as the 'natural' way to feed babies and for all staff to adopt this ethos.

Box 4.2
Attitudes to the Baby Friendly Initiative
Working in partnership with schools and the local authority

Aim: to raise children's' awareness of the benefits of breastfeeding

Strategy implemented:
Initially, the curriculum lead for the local authority was contacted, to ask: How can the topic of breastfeeding be introduced in schools?
With encouragement from the local authority - working in partnership with the local school health nurses a letter was drafted and sent to all (6) local head teachers

Outcome:
Head teachers' feedback was positive and school health nurses agreed to introduce breastfeeding as a topic in the puberty talks they give to year 6 children. This was put into place immediately, and all the schools are now receiving a breastfeeding talk, and will continue to do so, as a part of their curriculum.

4.3.4 Two programmes carried out an audit of services in the local community to record which services were open and encouraging of breastfeeding mothers (see Box 4.3).

Box 4.3
Promoting the Baby Friendly Initiative
An audit of local community services

As part of the celebrations of National Breastfeeding Week 2005 an audit of local community services was carried out by a SSLP, to ascertain attitudes to breastfeeding and whether they welcome breastfeeding women on their premises.

Outcome:

- A 'breastfeeding directory' for local parents was then published and given out to help raise confidence in the community.
- At a glance, parents can see which services will welcome them, when breastfeeding.
- The directory lists schools, nurseries, health centres, GP surgeries, restaurants, places of worship, shops and general services and is a good example of partnership working at the local level inclusive of a range of disciplines.
- The directory contains 49 services which are all breastfeeding friendly and more than 50% of these have a separate room available.

4.3.4 Three reports referred to breastfeeding training being delivered at the school level. All of these programmes found that there was potential for partnership working with local schools. They found that breastfeeding was not a topic included in any of the talks given to children, at local schools, by the teachers or the health professionals. It was felt that a good way to start influencing local women was by starting young.

4.4 Peer support

4.4.1 Groups led by parents (some with some without staff) were popular ways to improve access to breastfeeding support. Parent groups have evolved in SSLPs to support breastfeeding and other interests. These groups vary but have common aspects such as they are attended by parents and trained peer support breast feeders, and are a place where parents can offer other parents support. Some of the groups are recognised by some of the names below and for further details of acronyms see Appendix C:

- Bambinos
- Best Start group
- Bosom Buddies
- Breast Feeding Mums Group
- Mum2Mum

BEST
BIBS
Breast Mates
Breast Friends
MILK

4.4.2 A number of baseline studies for breastfeeding rates showed that some Sure Start local areas were below the national average and that mothers were not being supported from birth, due to staffing issues in the hospital, or at home. Health professionals were not up to date with breastfeeding advice, they often referred to the breastfeeding counsellor. Due to busy schedules and days off, continuous support from community midwives was not available. Parent-led groups have been a popular response for Sure Start to develop the

gap in service provision. Two breastfeeding support groups and peer supporter training programmes were launched in one programme, between 1996 and 2003. Both groups are now run independently by Bosom Buddies (see Box 4.4).

Box 4.4
Bosom Buddies. Peer support groups providing practical and emotional support to local mothers

SSLP 1: Group meet once a week at a Sure Start centre in the South West. Facilitated by a breastfeeding counsellor with help from Sure Start project workers and on average 18 Bosom Buddies. The group provide a positive environment for mothers to continue to feed for at least 6 weeks following their 1st attendance. Buddies are also trained to do outreach work/home visits, to provide practical and emotional support in the home to mothers that are referred by the Sure Start midwife. The group provided a strong social support network for new mothers – who would otherwise feel isolated. Moms can be helped initially, by being 'taken' or 'accompanied' to the 1st group meeting. Older children can attend with mother and baby and benefit from socialising with other children.

Outcome:
mothers had 'high satisfaction' of the Bosom Buddies services. The mothers felt that the group's success was mainly due to the enthusiasm and openness of the facilitator and the way in which she welcomed new mothers and maintained support.

4.4.3 A Breast Mates project in the North West aimed to increase breastfeeding rates in the area and trained local parents to be peer supporters (see Box 4.5).

Box 4.5
Breast Mates project to increase breastfeeding

La Leche League trained local mothers started the peer support Breast Mates project to support other local mothers in breastfeeding. The Breast Mates project includes working towards tackling Public Health Targets and issues such as breastfeeding, obesity, gastro-enteritis, diabetes, breast and ovarian cancer and a reduction in glue ear.

Breast Mate peers have CRB checks and offer support in drop-in sessions at seven locations where mothers already attend.

Outcome:
12 peer supporters trained in 2004
Breastfeeding rates increased by 16% in 3 years

4.4.4 The development of peer support was sometimes focussed on parents who had been 'hard to reach' by traditional services, such as parents from minority ethnic groups (see Box 4.6 for an example).

Box 4.6
Peer support for Bangladeshi families

The Sure Start funding was to provide the Healthcare Trust and the Breastfeeding Network an increase in support at the centre, by providing breastfeeding support and education to local women. Like many other programmes, this was to enhance the ongoing work of the 2 [job share] practise development midwives who were already working at the London hospital and through one-to-one support and drop-in sessions at the centre.

The model of work required training and supervision for a Bangladeshi breastfeeding supporter and training for at least 6 local women volunteers, who have breastfed, as peer supporters to act as positive role models. Women were identified by visits to the hospital wards and also through referrals from midwives, Bangladeshi advocates and health visitors.

There were 194 births in the Sure Start area from Sept 2001 to August 2002.

Outcomes:
80 mothers received support from the Sure Start bilingual support worker and another 44 received support from the breastfeeding team.

- 9 had intended to breastfeed and 11 actually did (n=15)
- 6 mothers said that they had exclusively breastfed within the 1st month
- 3 had exclusively breastfed for up to 3 months.
- 2 mothers had breastfeed for up to 7 months and both said they had been influenced to breastfeed for longer by either, the support worker or the midwife.
- Bottle-feeding was popular in the 1st couple of days in hospital, after birth, and although 7 of the women had started breastfeeding from birth only 3 were exclusively breastfeeding while in hospital.
- 3 started breastfeeding within 2-4 days of birth and 1 started within 5-10 days of birth
- All mothers had received some form of antenatal care: 6 received support from the support worker, 4 received support from the midwife (not Sure Start).
- 8 women found support received from the support worker to be the most helpful in terms of breastfeeding. 3 were influenced 'a lot' by the support worker to breastfeed and others said the same for other health professionals.
- 6 said they received 'no help' in hospital. During the hospital stay 3 received support from the support worker and 4 received support from the midwife.

4.4.5 While breastfeeding support was offered on an individual basis group activities were more commonly reported. One of the main benefits of group work was that mothers were able to share experiences and tips, and 18 reports provided evidence of groups led by trained parents. Box 4.7 is a summary of examples that demonstrate why parents found group support useful.

Box 4.7
The advantages of group support for breastfeeding mothers

- Mothers develop and experience more social support

There were 21 examples of parents developing and having social support networks, via breastfeeding support, that they did not have prior to being involved with Sure Start.

- Mothers deal with 'non-breastfeeding' attitudes

Mothers gained reassurance, that they were 'doing it right', from the group and this was a key factor that influenced the continuation of feeding. The support and experience of the group, provided mothers with the confidence to ignore outside pressures from friends, the public and work colleagues, and in some cases to educate those around them of the benefits of breastfeeding. Parent: 'I would never have imagined me breastfeeding out in public places, but apart from a few strange looks while shopping I feel really good about it and know it's because of the group'.

- Mothers breastfeed for longer

Mothers have access to others with similar experiences and difficulties. Sharing these experiences and learning from peers has helped mothers to continue breastfeeding for longer.

4.4.6 There was evidence that Sure Start programmes were reviewing their services and exploring ways of engaging with more families in the community. Whilst the breastfeeding peer training was acknowledged as a success with interests in sustainability of this approach already underway in at least 3 PCTs, there was also concern that the more disadvantaged mothers were not involved in this training because they were not engaged with the Sure Start programme. An evaluation in the South West found that the average age of peers was 25-30 years and mainly from middle class backgrounds.

4.5 Training for local parents to increase breastfeeding support

4.5.1 Twenty six reports gave information on peer breastfeeding training that prepared mothers to be 'peer supporters' though these were referred to by a number of different terms, the most common being peer educators, buddies, breastfeeding counsellors and peer counsellors. Some reports demonstrated positive outcomes of breastfeeding peer training for local parents, both those currently being encouraged to breastfeed and their supporters. SSLP evaluation findings indicate that the specific and technical support that mothers receive from their trained peers influenced mothers satisfaction of the provision. Mothers were more satisfied with the informal and sociable approach of the peer supporter when compared to the more clinical support received previously from health professionals.

4.5.2 Some reports included details such as how many mothers received the training and how many were working as trained breastfeeding support volunteers. The most popular training course implemented by SSLPs was the La Leche League, an international charity, who have had input into the design of the Baby Friendly Initiative. The La Leche Peer Counsellor Programme was started in the US and was designed specifically for low-income minority

groups (see Box 4.8). The aims of the La Leche League Peer Counsellor Programme are consistent with Sure Start and public health targets, and are:

- To raise awareness of breastfeeding amongst mothers who choose to breastfeed
- To raise, in the long term, the incidence of breastfeeding
- To increase the confidence of those mothers who participate in the programme.

4.5.3 La Leche League training has been popular with SSLPs and reports detailed a range of staff that have received training such as: midwife, health co-ordinator, community nursery nurse, public health and local health visitors, community midwives and local mothers.

Box 4.8
La Leche League Peer Support Breastfeeding Training

Peer Administrators are initially trained and they then become trainers and supporters for other staff and volunteers. Peer Administrators are usually either La Leche League Leaders or Health professionals, but in some Sure Start programmes they also have other roles such as community workers.

Mothers are accepted on the training course, to become Peer Administrators:

- If they have had an enjoyable breastfeeding experience with at least one child and
- have an enthusiasm for promoting breastfeeding within their peer group.

Provides in- depth training on anatomy and physiology of breastfeeding, cross cultural issues, barriers in breastfeeding and listening skills.

SSLP 1: The La Leche League training took place over 12 x 2 hour sessions, facilitated by Health visitors and Midwives who have undergone a package of training for the facilitation and administration of the project. This training consists of 5 full days over a 3-week period. The package includes all resources, a library of reference books, record keeping log books, 2 support visits a year from La Leche, an annual 'Enrichment Day' – to meet with other peer supporters in the North West and a 3 year overarching management support package. Cost: Training for Health visitors and Midwives to facilitate peer counsellor training = £3,100. Training for peer counsellors including resources = £2450.

- 12 peer supporters trained in 2004
- Breastfeeding rates: 16% increase in 3 years
- Monitoring of breastfeeding has improved

8 reports detailed the La Leche League training programme and 2 provided information of the process, cost and short-term outcomes of the service.

2 PCTs plan to fund and roll-out the La Leche League training to other areas in the PCT - due to the impacts on initiatives preventing clinical, stroke and obesity in children.

2 SSLP peer breastfeeding supporters are now visiting parents on hospital wards.

4.5.4 There were positive outcomes for those mothers who received the training to offer support. In a South West programme, 28 mothers had trained and become qualified breastfeeding counsellors. They formed Bosom Buddies and were offering breastfeeding support to mothers. The local evaluation found that all the Buddies were extremely positive about the

training they had received and felt confident to pass that knowledge onto others. Many reports detailed the benefits that mothers gained from training and working as a breastfeeding support volunteer (see Box 4.9).

Box 4.9
Local mothers as peer support volunteers
A summary of the benefits for local peer mothers

- SSLPs reported that mothers who have trained and worked as peer breastfeeding supporters had an increase in confidence.

Peer parent comment: 'You learnt other things about parenting. In my culture you don't show your children love – you are taught the opposite – it taught me a lot about myself'.

18 reports detailed examples of mothers gaining confidence in the following specific areas of personal development:

- developed communication skills -
  Parent: 'I learnt at what level to pitch comprehension that you don't have to go into such great depth. Breastfeeding can be quite technical but it's important to pitch it at the right level'
  Parent: 'The role play had been beneficial in teaching listening skills. I find it hard to listen and it gave me good ideas about techniques'.
- developed social skills – Parent: 'It gave me a lot more confidence in speaking to people'
- developed local social support networks with other mothers. The review found in total 21 reports with examples of this and how mothers had forged new friendships with like minded mothers
- developed a sense of personal achievement
- increase in self-motivation
- developed skills and confidence to consider employment
- developed interest and confidence to lead other Sure Start activities. The review found 18 reports in total that provided evidence of groups led by trained parents

SSLP 1: after La Leche peer support training, the group of mothers have gone on to be:

- strong advocates within the local community, offering good quality advice in informal settings such as at the school gates, to friends who are pregnant, at local parent and toddler groups etc.
- lead in encouraging local businesses to be more supportive of women breastfeeding in public through a 'Breastfeeding Friendly Business' scheme, and adopt a breastfeeding policy that supports a woman's right to breastfeed her child discretely in public areas.
- promoting breastfeeding on the local market and at antenatal clinics throughout Breastfeeding Awareness Week.

SSLP 2: Parent: 'It made me realise I can achieve something. I usually give up. I can look at my badge and feel very proud. It gave me the confidence to know that I have to do what I feel is right even though people try to tell me differently, I can't just do what they [family members, friends] tell me anymore'

4.5.5 Once mothers had completed the breastfeeding training they were said to have felt a great sense of pride in having done something worthwhile. Mothers in one SSLP were given recognition of their efforts when awarded as 'runners up' for a national regeneration initiative (see Box 4.10).

Box 4.10
Best Buddies, the most transferable project, 2004 WM Region

In the West Midlands, a Best Buddies project supported by a SSLP, was runner up for the most transferable project. Volunteers now lead practical advice and support for women wishing to breastfeed. The group is supported by health visiting and midwifery services. Successful breastfeeding mothers are recruited to become volunteers, who are available at the end of a telephone or able to visit the mother in her own home.

Outcome:

In 2004, 8 successful breastfeeding mothers were recruited to become 'Best Buddies'.

- Through home visits these Buddies have supported 49 mothers.
- A further 20 received telephone support.
- The service is now well established and the Health Visiting Service now employs one of the volunteers in order to help co-ordinate the initiative.

4.5.6 For sustainability purposes most programmes recognised the need for peer supervision for parents as breastfeeding workers. Support for peer supervision, from midwives and health visitors was recommended and Box 4.11 summarises some of the other most popular proposals.

Box 4.11
Recommendations to support the sustainability of effective services delivered by parents - the following were popular suggestions in SSLP reports.

- Trained breastfeeding supporters to be supervised by local health professionals
- More support from professionals for mothers to put their new learning and skills into practise - 'At first you need some one to listen to you giving advice, to say 'Yes you did that well' or ' you didn't do that very well'.
- That the crucial role of the midwife in recruiting group members and providing informal support is recognised and that this provision continues.
- To empower the parent group to be more self-sufficient as a constituted community group with skills to run a committee and bid for independent funding.
- To continue an annual recruitment and training programme to replace volunteers who 'move on' to other things or return to work.
- Organisations, such as NCH, to consider the criteria and processing of volunteers to enable volunteers to actively participate in programmes more quickly
- To encourage young parents to join the training programme
- To encourage and support women who do not speak English to join the training.
- To role out La Leche training across regions via Children's centres
- To lobby local councils to become 'Breastfeeding Friendly' so that all public buildings are included

4.6 Practical help with breastfeeding

4.6.1 Twenty-four reports detailed evidence of models of work where mothers received 'practical' help with breastfeeding, 18 of which were group work led by parents. There were some common elements with regard to the type of 'practical' support that mothers received (see Box 4.12). However, it would have been useful to have more information about the extent to which they were used.

Box 4.12
Common types of 'practical' help provided to mothers during group work

- Lactation
- Breast positions
- Using breast pumps & expressing breast milk
- Freezing breast milk – for working mothers
- Weaning onto health foods
- Travelling with a baby
- Flying with baby
- Ideas for breastfeeding venues in town
- Growth charts in red book are for bottle feeders – babies grow differently if breastfed – so these charts can't be used.
- Dealing with family and friends not familiar with breastfeeding

4.6.2 Twelve reports described practical and free resources offered to breastfeeding mothers in order to promote and prolong breastfeeding. These resources were either free or available to loan (see Box 4.13). Some programmes work with the health visitor to make some of these resources available such as the loan of electric breast pumps. Programmes have found that breast pumps are constantly out on loan and there is a very high demand for this service, but again this was rarely backed-up by statistics that indicated who had been eligible.

Box 4.13

Free resources available to mothers to support breastfeeding

- Free breast pads x 2 weekly for the first 12 weeks
- Nipple shields
- Baby wipes x 2 weekly for the first 12 weeks
- Vouchers for breastfeeding bras (after feeding for 6 weeks), to be fitted by a local bra shop
- A library of videos, books and leaflets that were free to loan
- Electronic breast pumps that could be loaned free of charge
- Mobile phone support from breastfeeding peer

SSLP 1: Outcome:

- Rise in breast pump loans: in 2002/3, 3 women loaned a breast pump and in 2004/5 this rose to 23.
- 'the service was still constrained by the low number of breast pumps available'

SSLP 2: Breast pumps are available to borrow and mothers are shown how to use them.

- One mother who went back to work found the pump very useful because she was then still able to continue breastfeeding.

4.6.3 Improving the quality of experience for mothers breastfeeding their babies in public places can increase the initiation and duration of breastfeeding. Helping to normalise the activity of breastfeeding is an aim of the Breastfeeding Friendly Initiative. One SSLP working with young mothers found that a key barrier for these mothers, to breastfeed their babies was the perception that the female body is sexual and this conflicted with infant feeding. SSLPs are continually reviewing how to work with different families who may not normally or regularly access services for their children. Some of these families such as young parent families and ethnic minority families, have been identified as more difficult to engage with and thus, hard to reach.

4.6.4 The 'Baby Café' has become a popular place for SSLPs to deliver services, and a way to 'normalise' breastfeeding in a (semi)public place. The common purpose of a Baby Café is to offer a more social and informal environment for local parents. Easy access with the drop-in facility and planned group activities. A place where mothers can relax, feed their baby, meet other mothers and know that professional and/or peer support advice is available if needed. Nine reports described this service as a way of delivering breastfeeding support to families. The review found that SSLP Baby Cafés provide a location for partnership working to develop, for local volunteers to work and a place where social support networks with other local parents, can develop.

4.6.5 A SSLP in the West Midlands, opened a Baby Café in an existing family centre and the average attendance was 20-25 mothers and babies. The midwives audit, 2003-04, found that 52% of babies were breastfed at birth (n=186). A range of services were available at the Baby Café to support antenatal and postnatal mothers:

- Antenatal examination with the Sure Start midwife
- Bump massage
- Baby weighing
- Advice from outreach workers
- Advice and support form peer parents: BEST
- Support from Health visitors
- Benefit advice from the Citizens Advice Bureau

4.6.6 Women initially attended the Baby Café in a programme in Yorkshire and the Humber because they had problems with feeding such as, pain, soreness, frequent feeding, and babies having poor weight gain. This programme was described as a centre of excellence and reported that collaborative working had been supported in the Café (see Box 4.14).

4.6.7 Common positive outcomes for families who attend the Baby Café services included mothers developing confidence, building social networks and expanding their interests. Many mothers are depressed when they 1st visit the baby café – but seem to recover as they share experiences and make new friends – they feel less isolated, more confident and more involved in their community. Meeting at the café is described as informal and fun.

Box 4.14
Baby Café
A social and informal place for local families to meet

SSLP 1: In York and Humberside a Sure Start, PCT and the NHS Trust work together to support breastfeeding support. SSLP funds 4 hours of midwifery time and hosts the café. An additional 4 hours are funded by the NHS Trust. Publicity is funded by the PCT. It offers a range of resources for mothers to borrow including books and videos are available. 50% of babies are born by Caesarean section in the area (whereas the local rate is 22%) and breast thrush can be a common problem also.

Monitoring data, of the attendance, at the Baby Café showed:
- In the 1st 20 sessions 45 women and 44 babies attended
- Mothers attend an average of 4.5 sessions .
- The average attendance at any time was 10 women (range 2-17)

Outcome:
- The Baby Café has facilitated collaborative working.
- Breastfeeding rates increased by 7% in 6 months

4.6.8 SSLPs report that mothers go onto developing their own parent groups, smaller groups, and meet new friends outside of Sure Start, in each others homes. Evaluations also provided evidence of the uptake and duration of breastfeeding, of Baby Café attendees. One mother attended 13 times with her 1st baby, who took 7 weeks to regain birth weight but she was still breastfeeding at 5 months and the baby was thriving; the mother said:

> *'I've enjoyed the Baby Café and found it extremely useful both in terms of advice from yourselves and the opportunity to share experiences (and some horror stories) with new mothers having similar problems.'*

4.6.9 Supporting mothers to make informed decisions on infant feeding and to provide breast milk to their babies for longer, is an important aim of Sure Start and there was evidence that this could be an outcome of attendance at a café (see Box 4.15).

Box 4.15
Babies breastfeed for longer at the Baby Café

- 3 mothers who attended a Baby Cafe only once were still exclusively breastfeeding at 8, 9 and 12 weeks.
- One mother had intended to breastfeed for 6 weeks but after attending the Baby Café 5 times with her 1st baby continued to breastfeed for 12 weeks. This mother only stopped breastfeeding because of returning to work.
- Café is an invaluable support unit for new mothers who want to breastfeed. Parent: 'I would have given in an put my daughter on the bottle if it was not for the expert advice, help and support I received at Baby Café. Also the social support from meeting other new mothers helped as well. Keep up the good work and more cafes please'.
- Breastfeeding rates have increased by 7.9% with the addition of local peer supporter work and Baby Café (2002) and 4.4% increase in the duration of breastfeeding at 4 months old
- 13 mothers in one programme evaluation, said that attending the Baby Café had helped them to continue breastfeeding

4.6.10 Average attendance at the Baby Café has been reported as low by some SSLPs and these programmes have had to reconsider the purpose and provision available. Healthy eating activities and volunteering work have been introduced for instance, to increase general attendance. Whilst other SSLPs have reduced the opening times to lower costs.

4.7 Rates of breastfeeding and related factors

4.7.1 Information about rates of breastfeeding may come from parent surveys or from health databases. Several studies indicated that they had evidence of improved rates (see Box 4.16). Other reports noted factors associated with the level of breastfeeding. Parent evaluators conducting interviews in one London area found that there were no significant differences in the rates of breastfeeding between lone mothers and mothers with partners (n=172) but breastfeeding rates were linked to maternal age. Older mothers (21 years old upwards) were more likely to breastfeed and the 3 teenage mothers sampled did not breastfeed. The most common age of mother that breastfed was 31-40 years old.

Box 4.16
Examples of reported changes in rates of breastfeeding

Over a 3 year period:
- Increase in babies breastfed at birth ranged from 16% to 40%
- 17% increase in babies breastfed at 6 weeks old

Over a 2 year period:
- Increase in babies breastfed at birth ranged from 7.9% to 14.83%
- 18% in babies breastfed at 6 weeks old
- 7.8% increase in babies breastfed at 17 weeks

4.7.2 Another programme in the North East also found, from a baseline survey involving 243 mothers, that breastfeeding was less popular with younger parents than older parents. Results produced were as follows:

- under 20 years old - 27% had breastfed at least one child
- 20-34 years old - 38.5% had breastfed
- 35-49 years old - 45% had breastfed
- 50-64 years old - 41% had breastfed
- 65+ years old - 76.5% had breastfed

4.7.3 The findings also showed that only 29.5% of mothers had been breastfed as babies themselves. Many SSLPs are working with communities that have established non-breastfeeding cultures and therefore, these findings confirm that more mothers that are not breastfed themselves as infants, will most likely not breastfeed their own babies. To tackle these issues, some programmes have started to deliver services to young parents via mobile phones and text to stimulate their interest and offer a style of delivery that meets their lifestyle (see Box 4.17). Six young mothers attended one session

offered by another SSLP. The session originally started with breastfeeding and developed into careers support with work in the health service. This programme has introduced a screening tool which has the potential to detect 'anxiety over breastfeeding' and referrals will then be made to the health visitor. There were no further details of design and implementation.

Box 4.17
Using technology to support young breastfeeding mothers

- 62 mothers had received support either by phone or in person.
- An evaluation showed that 97% were more than satisfied with the support from the programme.
- Support workers were valued for the caring approach, their availability and their knowledge.
- No adverse comments were received.

4.7.4 Midwifes working with a teenage parent group in another programme at the antenatal and postnatal stages gave particular advice about smoking and breastfeeding and other issues. The programme monitoring data showed the impact of this work, that there were 9 teenage pregnancies and 5 of these mothers breastfed their babies.

4.7.5 Some services were targeted at supporting ethnic minority children and families. Baseline surveys and audits have provided important early information for programmes to plan their services and target specific needs. Early evaluations in 2 programmes found that the local community needed interpreters because many parents found it difficult attending health appointments, due to language barriers:

> *'There's a lack of Arabic translators. Even though it's a multi-cultural area, you don't get a lot of interpreters'*.

4.7.6 There was very little information produced in community languages about breastfeeding for mothers who did not read or speak English. One programme (see SSLP 1 in Box 4.18) conducted a baseline study to establish breast feeding rates prior to the introduction of Sure Start, that is, how popular breastfeeding was in the community and whether there were any factors that currently influenced families to breastfeed their baby. Findings indicated that children were more likely to be breastfed if they were from ethnic minority backgrounds. Bottle-feeding was much more common amongst white families.

4.7.7 Audit data from a programme in the London Region showed that this pattern was not necessarily common to all minority ethnic groups. They found that breastfeeding rates and duration of breastfeeding were low amongst Bangladeshi women. Using these findings, this SSLP enhanced a local service run by Social Services, the aim of which was to improve uptake and duration of breastfeeding for Bangladeshi babies, through antenatal and postnatal support and education for women living in the SSLP area. Like findings from other programmes, 7 mothers requested more breastfeeding support during their stay in the hospital and comments such as:

'Help in hospital after delivery, demonstration on how to feed, position baby and myself….. postnatal home visits' ……. 'more social support through delivery and with actually feeding baby at hospital'

Box 4.18
Are ethnic minority babies more likely to be breastfeed?

SSLP 1: In the North East, 274 females and 61 males were sampled and the findings showed that 105 mothers breastfed their children. The findings indicated that ethnicity could influence feeding decisions:

- 52% of white mothers had solely bottle fed their children
- 12.5% of ethnic minority mothers had solely bottle fed.
- Of all white fathers, 14% of their partners solely breastfeed their children whilst 62% of ethnic minority children were breastfed

SSLP 2: In London 6 parent evaluators sampled 194 families.

Whilst the overall rate of breastfeeding was 63% in this community, Black African and Asian mothers were much more likely to breastfeed:

- 93% of Black African mothers breastfed their babies
- 100% of Asian mothers breastfeed their babies.

4.7.8 The findings have been used to address these concerns and the support worker and local volunteer supporters' hours have been increased to spend more time in the hospital ward. In this area, more local women, with different ethnicities, are to be employed by the health services and work with the support worker. The aim is to develop the role so that the support worker is an expert in breastfeeding support and is the first port of call for mothers.

Box 4.19
Multi-disciplinary working to support the needs of ethnic minority families

SSLP developed the BEST group, run by midwives and the family link workers, including 'dual language link' workers and peer supporters. To address language barriers and to encourage participation of the Asian population in SSLP activities. Peer supporters were identified and received training. The group offered a range of support and advice to breastfeeding mums, on both a group and a one-to-one basis.

Outcome:

- The group has been successful, and provides a buddying scheme and telephone support between mums.
- The percentage of women breastfeeding at 6 weeks has increased over the duration of the programme, rising from 26% in 2002-2003 to 43% in December 2004.
- The evaluation found that the success of the project could be linked to the support offered by the BEST group and the multi-disciplinary approach.

4.7.9 Evaluation found that Bangladeshi mothers received a lot more support from their family and from the Sure Start support worker than from friends, health visitor or midwives. Information was generally given by health

professionals and the support worker, while practical support like bathing baby and other domestic help around the house, came from members of their social network. To address language barriers and increase local participation in services, SSLPs have developed teams with complex skill mixes such as the example in Box 4.19.

4.8 Improving information about rates of breastfeeding

4.8.1 To find out whether more babies are being breastfed after involvement in a SSLP, monitoring systems have had to be developed to drive this development forward. An evaluation of the use of 'health care assistants' (HCA) to support breastfeeding work in a programme in the London Region, found that outcome data suggested that rates of initiation and continuation of breastfeeding maybe increasing in association with the implementation of the Health Care Assistant (HCA) project (see Boxes 4.20, 4.21 & 4.22).

4.8.2 Pre and post-implementation records were utilised, to analyse and compare rates of 3 different feeding methods: breastfeeding, formula feeding and mixed. Three sources of data were collected: women's self-reported feeding patterns (see Box 4.20); feeding patterns from routine maternity data (see Box 4.21) and feeding patterns from project records (Box 4.22). Each of these data sets shows that a higher percentage of mothers breastfed their babies, than fed their babies in other ways, after the introduction of the HCA support. The feeding pattern data shows an increase in mixed and exclusively breastfed babies. The number of mothers in each group are not equal but analysis of the data using percentages shows an increase.

4.8.3 An analysis of the 'routine maternity' data showed an increase in the percentage of breastfed babies after the HCA support. However, each data set contained missing data. Although this is an appropriate method for measuring the impact of service delivery the missing data make conclusions problematic and efforts need to be made to ensure that more complete records are kept by health professionals to accurately measure the impact of the new breastfeeding support work in the future.

4.8.4 The records show that with the support of the HCA project, more mothers started breastfeeding than feeding their babies in other ways. The feeding patterns records from HCA project (Box 4.22) show that 20 mothers started to exclusively breastfeed their babies from birth and this was 71% of all mothers with new born babies. At 6 weeks, 69% of all mothers were still breastfeeding their babies exclusively, and 50% of all mothers at 4 months.

Box 4.20 **Changes in infant feeding with Health Care Assistant support** **Utilising data from women's self-reported feeding patterns** **at a mean 6-8 weeks postnatal**		
	Data from group 1: before HCA input	Data from group 2: With HCA input
Exclusive breastfeeding	18 mothers exclusively breastfed and this was 55% of all mothers	7 mothers exclusively breastfed and this was 64% of all mothers
Mixed feeding	8 mothers fed their babies a mix of breastmilk and formula milk. This was 24% of all mothers	4 mothers fed their babies a mix of breastmilk and formula milk. This was 36% of all mothers
Formula feeding	7 mothers fed their babies formula milk only and this was 21% of all mothers	0 – no babies were fed exclusive on formula milk.

Box 4.21 **Changes in infant feeding with Health Care Assistant support** **Utilising data from routine maternity data of feeding patterns** **at a mean 6-8 weeks postnatal**		
Feeding at birth	Data before HCA input Sept-April 2002	Data collection with HCA input May –August 2002
Exclusive breastfeeding	60 mothers exclusively breastfeed and this was 59% of all mothers	43 mothers exclusively breastfeed and this was 67% of all mothers
Mixed feeding	0	0
Standard Formula feeding	4 mothers 4% of all mothers	3 mothers and this was 5% of all mothers
Special Formula feeding	9 mothers and this was 9% of all mothers	3 mothers and this was 5% of all mothers
Missing data	29 mothers feeding data was missing and this was 28% of all mothers	15 mothers feeding data was missing and this was 23% of all mothers

Box 4.22
Duration of feeding with the support of the Health Care Assistant Utilising HCA project records

	at birth	at 6 weeks	at 4 months
Exclusive breastfeeding	20 (71%)	19 (69%)	14 (50%)
Mixed	3 (11%)	5 (18%)	6 (21%)
Formula	3 (11%)	2 (7%)	2 (7%)
Missing	2 (7%)	2 (7%)	6 (21%)

4.8.5 The carefully planned evaluation summarised in Box 4.22 has produced evidence of the impact of a Sure Start intervention by collecting records of different types of data to monitor infant feeding activity, over a specific timescale. Other programmes have explored the reliability of health monitoring data and records to measure changes of breastfeeding activity in the local community, to establish if more babies were being breastfed after being involved with the Sure Start programme and partners.

4.8.6 As part of one evaluation, existing data were utilised to show that 28%-32% of mothers were breastfeeding their babies at 28 days in the Sure Start area. The evaluation also found that there were no data recorded at the hospital for the initiation of feeding and, once discharged from the midwife, the health visitor recorded the feeding at the 6-8 week visit. There was no comprehensive set of data, for feeding, for the whole of the city. The only data available prior to Sure Start were those from the health visitors caseload audit (1998) which showed:

Breastfeeding at birth	22%
Breastfeeding at 6 weeks	10%
Breastfeeding at 4 months	2.5%

4.8.7 Initially, the SSLP only recorded the feeding intention at birth, no further information was collected. A second database was then created (see Box 4.23) for the BIBS peer project and infant feeding was then collected at birth, one month, 3 months, and 6 months. The pre-and post data sets were analysed and showed that the initiation rate increased from 22% to 49%, which showed twice as many mothers initiated breastfeeding in 2002 than were doing so in 1998. Whilst the data are not identical in timescale – it would seem that more breastfeeding occurred after 4 weeks and up to 6 months in 2002 than in 1998.

Box 4.23
New monitoring system for early infant feeding

Over the period of the evaluation 210 births were recorded on the BIBS and Sure Start database between 1.4.01 – 31.3.02 as well as the following feeding patterns:

No data	15	7.15%
Initiated breastfeeding	103	49.05%
Initiated formula	92	43.80%
Total	**210**	**100%**

Still breastfeeding at 4 weeks	66	31.50%
Sill breastfeeding at 3 mths	39	18.60%
Still breastfeeding at 6mths	23	11.00%

4.9 Improving existing services and multidisciplinary working

4.9.1 This section includes the enhancement of existing services. SSLPs have provided opportunities for professionals to be innovative in meeting the needs of the local community.

4.9.2 Six reports detailed the 'caseload' model of midwifery. Midwives and mothers were said to prefer a caseload model because then they are able to develop relationships with mothers. Pre-project early findings found that mothers felt they met too many different midwives and that their meetings with midwives were brief and rushed. Parents have reported that they feel there are a shortage of midwives and on the postnatal wards women noticed a distinct lack of midwives to support them with breastfeeding. Findings detailed how mothers described receiving 'discontinuity of care' from midwives they perceived as strangers and this made them feel anxious, frustrated, isolated and alone.

4.9.3 Where caseload midwifery had been implemented, findings from a programme in the North West region, showed evidence that Sure Start had enhanced midwifery work and that midwives were more satisfied with their work (see Box 4.24). With Sure Start, midwives work and support had been advertised widely, in local Sure Start newsletters and flyers within the community, and had given more scope for working with more families, in an autonomous way. Midwives have also been given the opportunity to support all families which in turn has given them more job satisfaction.

4.9.4 Working locally with parents had improved midwife contact with families. Being able to develop relationships with families was also seen as an outcome for midwives and this was facilitated by the various ways that midwives were in contact with families. Delivering services in groups and home visits, for instance:

> *'Midwives have been able to access "hard to reach" families by having more time to increase the number of home visits. Everyone now gets a visit as opposed to "the select few". This in turn leads to more continuity of care reducing the number of unfamiliar midwives involved with the family.*

Box 4.24
Enhancing midwifery breastfeeding support work

SSLP 1: Midwives were asked to consider what differences the Sure Start approach had made to their way of working and what improvements there had been in the services for pregnant women and families with new babies?

Evaluation outcomes:

- breastfeeding has increased by 20% since 2002
- increased job satisfaction - due to increased partnership working
- Increased and better referral partnerships: 'Referral into such services as Family Support, Drugs and Alcohol support and the Volunteer Network
- There were more informal contacts with families. Aprox. 15-25 parents attended groups at the Baby Cafes & Parentcraft sessions .
  'Sure Start has allowed us to set up smaller groups and more Parentcraft classes for families to access locally rather than having to travel to access large groups with an unfamiliar midwife. This has resulted in increased attendance'.
- parents find Parentcraft more personal, giving women and their families more confidence and increasing their ability to cope with pregnancy, labour and life with baby.
- Funding otherwise not provided by mainstream has allowed us to set up groups such as teenage pregnant mums, midwives drop in for confidential advice, pre conceptual advice, antenatal and postnatal checks, breast and infant feeding support and provided a suitable site from which to deliver these groups. Young parents attend the informal sessions: average 10 parents for one SSLP
- The purchasing of a midwives mobile phone has allowed women a wider access to a local midwife (receiving advice locally at no extra cost to the NHS)

4.9.5 Midwives were able to access additional funding with Sure Start. This has enabled them to improve their knowledge and skills as professionals and educators, where this type of training and professional development would have been self-funded previously. The decision at one SSLP, to employ nursery nurses was based on the findings of a consultation with local midwives and health visitors, who decided that they needed help with introducing 'practical skills' to parents and working with those families that do not traditionally access services (see Box 4.25).

4.9.6 This example provides insight into the work of enhancing midwifery, multi-disciplinary working and working with peer parents in group activities. It was decided that nursery nurses would be more appropriate for this role, rather than a midwife, as more practical input would be necessary. A programme in Yorkshire & Humberside region also implemented a voluntary project to enhance the existing work of midwives. Volunteers work alongside peer Support Workers and midwives (see Box 4.26).

Box 4.25
Nursery nurses and peer parents working together
Breastfriends breastfeeding group

Health Visitor and Midwife support the development of Nursery Nurses to enhance the existing breastfeeding support to local mothers. 2 nursery nurses were employed in 2001 initially for 18 ½ hours a week to do Home Visits. The aim was to meet 100% expectant mothers and encourage breastfeeding, prevent oral thrush by introducing good sterilising techniques within the home, to prevent less admittance to hospital with gastroenteritis & to promote good safety and hygiene.

The cost of running a Breastfriends group was put into the nursery nurses budget. All peer parents have breastfed successfully and undergone peer training. Group meetings were weekly, for 2 hours and include lunch. Issues of mothers' isolation and loneliness were common themes that Breastfriends supported mothers with.

2 case studies demonstrate support provided to mothers that were having difficulties with breastfeeding.

Outcome:
The total attendance ranged from 6.67 to 16.85 for all mothers and for Sure Start mothers the total attendance range was 5.25 to 10.

- Breastfeeding rates have risen in the area and mothers tend to be breastfeeding for longer.
- Many mothers who attended the group said that they 'would not have continued to feed if it was not for them coming to the group'.

Box 4.26
Enhancing midwifery
Working together to support breastfeeding mothers

The project is run by midwives to create a culture of breastfeeding as first choice. A network of role models has developed, mothers who have breastfed, some La Leche League trained.

- 23 women trained as La Leche League breastfeeding supporters
- 7 trained mothers are in post as Support Workers
- 6 trained mothers are active volunteers

Outcome:
- In 2001-02, 284 women were supported by the project and 1,120 contacts were made varying from antenatal and postnatal individual visits, groups and telephone calls.
- Breastfeeding rates have increased from 22% to 47%
- This success was reported as being due to an increase of breastfeeding support networks and groups, from 2 to 6
- 173 mothers initiated breastfeeding and 56 mothers had initiated exclusive breastfeeding for their current child
- 61% (55) of mothers had met the support worker during the antenatal period
- 89% of mothers rated the support worker as helpful and informative.
- 67% found that the support received by the support workers was the same as that from th health professionals and 33% said it was different.

4.9.7 The main difference between the support worker and the health professionals was that the support workers gave more 'detailed' and 'up to date information' in a manner that was 'geared towards the mother and baby and not science and facts'. However, when difficulties were encountered the person who assisted mothers most was the midwife (69%) and support worker (56%). This type of project aims to enhance midwifery work and not replace it and therefore, this latter finding shows the confidence that local parents have developed for this new way of working.

4.9.8 Twenty-eight reports included evidence of professionals leading and delivering breastfeeding support to local mothers and there was evidence of multi-disciplinary working in 8 reports (see one example in Box 4.27). The team found that the breastfeeding rate at birth, and the duration of breastfeeding, appeared to have increased with the skill mix and style of delivery of midwifery service practised by the Sure Start team. There were many similar experiences of how models of work had evolved over periods of time to meet local needs and available skills.

4.9.9 Developing a skills-mix and multi-disciplinary team starts with training and providing shared learning opportunities for workers to learn about other roles. Proximity being a key factor to successful shared learning opportunities. Breastfeeding groups, such as Bosom Buddies, have provided opportunities for programmes to offer shared training and bring together workers from different disciplines (see Box 4.28).

Box 4.27
Multiple disciplines working together to support breastfeeding

The Link Midwife and Best Start group developed a skills mix approach and employed a maternity care assistant in 2003. Referral to the breastfeeding group was a combination of GP, midwife, friends, family and Sure Start leaflets.
The aim of the work was to encourage mothers to give up smoking and to try breastfeeding at birth
Outcome:

- The team supported 198 live births in 2002/03
- 3 mothers thought that the worker understood their needs, they felt that they got the help, advice and support they expected and would encourage others to use this service
- there was a high rate of satisfaction with the service
- Parent: '….that going to the Best Start group had….. 'more determined to breastfeed for longer and not to give my child a dummy'
- 8 parents said that the midwife had helped them to breastfeed and that 2 of these had never intended to breastfeed.

Box 4.28 **Shared learning opportunities for multi-disciplines** **Breastfeeding support training**
Bosom Buddies breastfeeding training, 6 sessions of 2 hours, no fees or exams. Training sessions involve the midwife, health visitor, breastfeeding counsellor, midwifery tutor and counsellor. Attendees: mothers, breastfeeding counsellors, midwives, counsellors, health visitors, home visitors, outreach workers, crèche, childcare, receptionists, family support workers.

4.10 Summary

4.10.1 The reports reviewed contained common areas of development related to Sure Start breastfeeding support work. Staff and parents have been educated by Sure Start in breastfeeding benefits and skills. Learning has also extended to understanding the importance of monitoring infant feeding and there were some early indicators that Sure Start has been instrumental in the development of more robust systems.

4.10.2 Partnership working including mixed-skilled teams, have developed and there were early indicators of multi-disciplinary work that has increased the initiation and duration of breastfeeding. There are some SSLP examples where breastfeeding is the more popular infant feed. Sure Start work, in line with DoH guidance on infant early feeding, has therefore, increased outcomes for babies and mothers. Programmes have started to use evaluations to measure outcomes for children, mothers and staff. SSLPs have rich information on issues relating to the initiation and duration of infant feeding and this knowledge and lessons can be used to develop provision further to meet the needs of local families.

4.10.3 Sure Start has provided opportunities for staff and parents to work together in ways that have increased satisfaction for all parties involved. Parents have developed social networks for support in breastfeeding initially and these networks are starting to be sustained in areas beyond breastfeeding. Breastfeeding parent peer groups have flourished and provide opportunities for SSLPs to offer shared training and bring together workers from different disciplines. There are early indications that midwifery provision has been enhanced and that more families are being supported in innovative informal ways at antenatal and postnatal stages. Referral partnerships and systems have improved and staff are developing breastfeeding provision in specific ways to meet local needs including those of young parents and ethnic minority families.

4.10.4 The adoption of the La Leche League Parent Peer training and the Baby Friendly Initiative have supported the increase of skills and knowledge, of Sure Start teams and partners. Some PCT's have recognised the

usefulness of La Leche League, part of the baby friendly approach, and have started to consider sustaining the training of La Leche League. There are early signs that the 'baby friendly' values and ethos have started to influence services and businesses in local communities, working towards, generally, tackling the 'non-breastfeeding cultures'. Mothers were more confident with breastfeeding after receiving breastfeeding education and training. Local mothers have been supported by SSLPs to train as volunteer breastfeeding peers and deliver services to other families. Parent-led groups have been a popular response for Sure Start to develop gaps in service provision and compliment the more popular staff-led groups. Mothers have gained additional benefits with Sure Start in social skills development, qualifications and training, a sense of personal achievement and increased motivation. With some mothers becoming advocates in their communities offering good quality advice and promoting breastfeeding.

5. WEANING SUPPORT

5.1 Strategies used to improve weaning methods

5.1.1 Providing support to mothers to breastfeed, and to continue for longer, is an important step in the improvement of early child nutrition. The next stage is to ensure that babies are introduced appropriately to nutritious foods when breast milk is reduced in their diet. To promote early healthy infant feeding the duration of breastfeeding needs to be lengthened and the introduction of solid foods delayed. One SSLP evaluation, for example, showed that over a third of parents (n=38) were weaning their children before 4 months old. Almost three quarters (73%) offered drinks other than milk and water through a bottle such as fruit juices and tea. SSLPs have started to monitor and evaluate nutrition work and this data will be useful for measuring changes in the future. There were 10 reports that included useful detail for Sure Start weaning support.

5.1.2 SSLPs have been involved in many activities to promote appropriate weaning practices in families with young children. Group sessions and individual home visits were offered, identified as:

- Weaning clubs/workshops/parties/picnics
- Feeding frenzy
- Meet a Mum feeding support group
- Breastfeed support group
- Feeding your baby group
- Health Arts session

5.1.3 The group sessions are similar to breastfeeding support, and in some cases are the same group, where parents can receive regular support. For most programmes, weaning parties were an occasional, one-off, event where all families with age appropriate children were invited with an average attendance of 10-50 families. The weaning parties were sociable, informal and an opportunity for mothers to meet other local mothers. Advice and support was delivered though demonstrations and discussions to promote safe weaning practice following World Health Organisation (WHO) to encourage the postponement of weaning until 6 months. Demonstrations were given about preparing weaning foods and the use of cups rather than bottles is promoted. Food was cooked at some weaning parties and tasted at the end of sessions to encourage parents and children to develop their taste preferences by trying different and new healthy foods in a fun and social way.

5.1.4 An important aspect of the weaning party was for the SSLP to make contact with families and register them for other support and services and hence, provide a marketing opportunity. Weaning support has been provided to families in different ways and by different professionals such as:

Health visitor	Dietician
Asian link worker – bilingual	Interpreter
Nutrition assistant	Midwife
Infant feeding advisor	Health Coordinator
Family support worker	Early years worker
Nursery nurse.	

5.1.5 Similar to breastfeeding support, free resources were provided to families by some programmes, to support healthy weaning practice such as a weaning pack (see Box 5.1).

Box 5.1
Free resources - Weaning packs

Weaning packs are available to SSLP families to support the weaning stage. Weaning packs generally contain:

- Spoon
- Bowl
- Cup
- Spillage mat – splat mat – for use with a high chair
- Healthy recipes to introduce baby to new foods

To encourage home cooked weaning foods and more economic meals that can be frozen, blenders and ice trays were provided by some SSLPs. Some SSLPs loaned blenders to parents for 3 months for no charge.

5.1.6 The key aim of all group sessions and weaning support are educational. To impart knowledge to parents of practical information on introducing their baby to a healthy diet of solid foods, generally after breastfeeding, at the appropriate times. This requires offering opportunities to support parents to change their attitudes towards foods and develop cooking skills for preparing healthy meals. The review found common aspects of provision to support parents with weaning and these were often part of a health promotion, integrated approach and generally included parents learning about some of the following:

food hygiene
weaning foods
sleep management
express and storage of breast milk
infant feeding and returning to work.
weaning tips
healthy eating
gentle exercise

5.1.7 One programme provided 'Feeding Frenzy' occasional events, for carers of babies aged 6-12 months specifically, to address some of the feeding problems that can occur in the second 6 months of life (see Box 5.2). Staff attend who were experienced and understand that there can be minor feeding problems at this stage with the aim to support infant feeding. The importance of introducing a weaning cup to babies, for instance, was emphasized and parents were shown how to make suitable family foods to include babies. The outcomes were in terms of parents descriptions of new strategies that they would take as their weaned their infants, though of course it would also have been useful to find out if these were in fact carried out once home.

Box 5.2
Feeding Frenzy evaluation

SSLP: The food is prepared and cooked in front of families and a taster session helps to encourage the tasting of different foods. Highchairs are provided so that carers can see how to feed baby in the chair and for babies to try out foods cooked/prepared such as finger foods and 'lumpy' family foods. To encourage attendance a crèche for older siblings is provided. All attendees receive a weaning pack/goody bag.

Outcome:
8 sessions have been held and 24 families attended in total
Parents reported that as a result of the session they would experiment more with different foods:

- Try more finger foods, including peanuts, and be more adventurous with them
- Try to cook from scratch and try foods
- Start feeding with family foods
- Try to cook instead of using baby jars
- Never buy 2nd stage weaning foods
- Cut down on formula milk
- Not to puree all meals
- Use the appropriate beaker given by Sure Start
- Be unafraid to bath him after his dinner

Sessions have been more popular than the initial weaning workshop – parents come with their infant feeding problems.

5.1.8 However, the evaluation of weaning parties was much more commonly reported in terms of high attendance. Families, mainly mothers and babies attend and one local evaluation shows that parents feel they have learnt a lot about weaning and receive a weaning pack. One SSLP reported some positive findings for healthy weaning which related to the use of the weaning cup and moving away from feeding children with bottles:

- 36% had stopped using the bottle by 12 months
- there had been changes in the use of a cup with children
- 22% had introduced their child to using a cup at the recommended age.

5.1.9 Overall, however, there was very little evidence of the difference that the weaning party or free resources had on healthy diets for babies. There was no information specifically related to supporting young parents with weaning. Three reports included useful information on supporting ethnic minority families with weaning.

5.2 Supporting ethnic minority children and families

5.2.1 To help reduce health inequalities SSLPs need to consider, as with breastfeeding support, how to support ethnic minority families in their weaning practices. Ensuring that staff have knowledge of cultural differences relating to lifestyle and cuisine have been important aspects for staff development and training. There were 4 programmes that had identified iron deficiency in childrens' diets – 3 of these were linked with the early weaning of Asian babies. Programmes introduced interpreting support for ethnic minority

families and culturally appropriate information on weaning foods that are rich in iron.

5.2.2 In one programme the Dietician and Asian Link Worker introduced an intervention to pilot weaning support for Asian families, to address the current guidelines on weaning and the concerns for iron-deficient diets in this population. Ten families were seen and mothers were all non-English speaking. Five families were re-visited when the babies were 8.5-9.5 months old to discuss how they had been weaned (see Box 5.3). Previously, advice was given to start on suitable family foods including meat and other iron sources. Other advice given was to continue with formula milk as the main drink until 12 months and to always give solids from a spoon and not in a bottle.

Box 5.3
Outcome of Asian baby weaning support work in the West Midlands

Joint work of Dietician and Asian Link Worker to support iron-deficient diets

5 families were revisited after initial weaning support – to discuss how baby was weaned.

- 3 babies started solids at 6 months, the others at 4.5 and 5.5 months
- 4 were having family food including meat by 8-9 months.
- 1 had cows milk at 8.5 months
- 1 had yogurt and rice pudding in a bottle at 8.5 months

5.2.3 Overall the dietician felt that the advice was not very effective, only 1 out of 5, families followed all the advice given. However, more families introduced iron-rich food at an earlier age than previously, which was the main nutritional problem seen in Asian children.

5.2.4 A programme in London, had more encouraging findings when 5 babies were introduced to solid healthy family foods, after 6 months of breastfeeding (see Box 5.4).

Box 5.4
Outcome of weaning support in London for Asian families

14 Bangladeshi and 1 Pakistani women, were interviewed after receiving weaning support and asked when was baby introduced to solid foods?

- 9 babies were given solid foods at 3.5 to 4.5 months old
- 1 started at 7 months
- 4 started 9-11 months

Solid foods introduced to children were the daily family food: rice, vegetables, chicken, chapatti, fruit such as bananas, apples and oranges
1 baby was introduced to organic food but there were no details as to the type of foods.

5.2.5 Another programme in the West Midlands invited carers of babies under 6 months old to a weaning party run by the family support workers. Supporting the mixed ethnic community, weaning support alternated between general and Asian foods with Punjabi interpreters where needed. Practical information on all aspects of infant feeding was covered including the key aspects above and free resources provided. During the weaning party, food was cooked and tasted at the end of sessions to encourage parents and children to develop their taste preferences. To increase attendance it was decided that a dietician would work with the family support team in the future.

5.2.6 One popular output of SSLPs, are the production of healthy recipe resources for both white and ethnic minority cultures. SSLPs identified that there was a lack of information on weaning, diet and nutrition suitable for disadvantaged communities. To address this problem SSLPs provided, and in many cases designed, appropriate recipe books. This ranged from parents being supported to create their own recipe books to books being provided as a free resource. Recipe books were created and designed as books, calendars, posters, flyers and some of the following key criteria were included:

- easy recipes for home made weaning foods
- content of vitamins for specific foods and meals
- iron rich foods
- culturally appropriate foods for ethnic minority children
- age-appropriate healthy foods
- starting on solid foods
- introducing lumps and pieces from 6-9 months
- moving on to family meals from 9-12 months.

5.2.7 There is no information on the outcome of these resources, how often they are used and whether some recipes are more commonly used for weaning purposes than others.

5.3 Summary

5.3.1 Sure Start support for baby infant feeding from birth onwards and the weaning off milk onto healthy solid foods at the appropriate age of 6 months, is an important stage in nutrient intake and the development in taste preference for babies. The weaning stage can influence taste preference and future child-diet which can be difficult to change with age. There were some useful findings from pre-project data relating to baby-diet and weaning habits of ethnic minority families such as the use of bottles. Some staff have developed rich knowledge of the cultural differences relating to lifestyle and cuisine in the local area and have been supported with interpreters to work with non-English speaking families.

5.3.2 There were reports of some useful process evaluations, of new ways to provide weaning support to families. In social one-off events, parent-led culturally appropriate recipe design and mixed-skill team home visits. There was no information specifically relating to supporting young parents with

weaning. There were some small encouraging advances in outcomes with ethnic minority babies. Only one SSLP reported outcomes for children and these related to the use of the weaning cup and moving away from feeding children with bottles.

5.3.3 One-off weaning group activities are popular and attract large numbers of local families. They provide social events for families to learn about weaning techniques, healthy foods and nutrients but there was no evaluation of the outcome of these innovative activities. There was no information about follow-up visits or activities to monitor how useful families find the free weaning resources, how often they are used in the home and the impact on the weaning process. This information will be useful to start to understand how weaning practises in disadvantaged communities have developed as a response to the SSLP intervention. In general there was sparse evidence of the difference that the weaning party or free resources might have on introducing babies to healthy diets.

5.3.4 To promote early healthy infant feeding the duration of breastfeeding needs to be lengthened and solid foods delayed. Early findings show that infant feeding approaches are ingrained in many communities and families, and any changes in behaviour are likely to be slow. .

6. HEALTHY EATING SUPPORT

6.1 Available evidence

6.1.1 The review found 32 evaluation reports that included details of healthy eating examples and they contained overall 2 main types of evaluation that either involved:

- baseline surveys to establish what type of foods families consume before any SSLP support – see section 6.2
- surveys of how access to SSLP support had improved child and family healthy eating. Healthy eating initiatives were mainly educational based providing children and parents opportunities to learn about healthy foods.

6.2 Baseline surveys

6.2.1 Small-scale surveys were described in 5 reports and gave pre-project findings of views and opinions of parents in the local community about nutrition and healthy eating. One SSLP found out what type of foods 38 families were eating:

- 79% of people ate at least one cooked meal a day
- 70% eat pre prepared meals at least once a week
- 32% do not eat fruit and vegetables daily
- 30% would eat more fruits and vegetable if they were cheaper and
- 23% if they were better available.
- 80% believe they are eating healthy.

6.2.2 The findings were used to plan nutrition programmes to increase parent knowledge of the nutritional content of foods and cook economical healthy meals. Four reports provided useful findings of why families do not eat healthy foods (see Box 6.1).

Box 6.1
Why don't families eat fruit and vegetables?

SSLP 1: families said that the following stopped them from eating more fruit and vegetables – there were no details of the sample size:

- 32.5% said the price
- 25.9% said the time
- 15.6% said the quality of produce

SSLP 2: 165 families were sampled and parents were:

- aware that fruit and vegetables were good for health though a 1/5th did not know about government recommendations of eating 5 portions of fruit and vegetables everyday.
- 3 things that discouraged parents from buying fruits were – cost, quality and fruit going off too quickly.
- Almost ½ of the parents in a survey said their children ate less-healthy snacks most days of the week
- 1/3rd of the parents find it difficult to refuse less healthy snacks to their children

SSLP 3: Dieticians ran a quiz and held food tastings, at the SSLP Annual General Meeting. Findings of the quiz showed that parents had a lack of nutritional knowledge:

- only 30% knew that tangerines could be counted as a portion of fruit
- less than 20% knew that steak and mince were good sources of iron
- only 50% knew that Vitamin A can be harmful during pregnancy

SSLP 4: Multi-ethnic minority community: nutrition in some ethnic groups was a clear health need. Specifically, in one ethnic group most children were not given fruit, particularly before the age of one year. The diet was also very high in milk, resulting in anemia.

6.2.3 A survey of food diaries of 11 children was conducted by one programme in the West Midlands, to assess the nutritional content of children's' meals. Results indicate that 2/3rd of the children were eating 2 or fewer fruit and vegetables a day. The local dietician collected and recorded the Body Mass Indicator (BMI) data for local 3-year olds and this indicated that 16% of the children were obese. Together with additional knowledge:

- that nutrition during pregnancy has short and long term consequences for children
- that mothers in low income households tend to have more low birth weight babies than their more affluent peers
- that low birth weight can be the starting point for child obesity

The team designed a screening tool to identify mothers at risk (see Box 6.2).

Box 6.2
Nutrition screening tool for pregnant women

This will be used for monitoring the nutritional status of pregnant women. Women who have BMI below 19 will be invited to a session to look at why healthy eating is important in pregnancy and what constitutes a healthy diet during pregnancy.

The nutritional tool was developed and piloted in antenatal clinics by family support workers, the community food advisor and dietician.

6.2.4 In most of the reports reviewed, the focus of the evaluations have been the implementation, service delivery, participation and satisfaction of initiatives in SSLPs, rather than outcomes of these on the nutritional status of children and families. The next section gives findings of how SSLPs provide healthy eating support to families.

6.3 Improving access to healthy eating

6.3.1 All the SSLP initiatives for improving child and family nutrition were designed with an educational purpose. Some reports provide useful detail about how the programmes are improving the knowledge and access to information on healthy eating. In addition to cooking courses (see section 6.4), the following healthy eating activities were described with a range of interesting titles:

Fruit as a snack	Food vouchers
Horticultural project	Story Telling
Free pack lunch campaign	Story Stacks
Dads & Kids Breakfast Club	Mums @ Lunch
Parentcraft	Food Fun Day
Teenage Breakfast Club	Mr Banana Head Show
In Betweenies	Weigh-To-Go

6.3.2. Opportunities for healthy eating have been introduced in a more integrated way during childcare sessions such as providing healthy snacks such as fruit at crèches and local toddler groups with the aim of encouraging children to ask for these snacks at home as well. Educational sessions with health promotion purposes have been provided to children at Story Telling and Story Stacks sessions. Where both child, and sometimes parent, learn about different healthy foods in a fun and familiar environment. Sessions for parents have included food advisors visiting Sure Start services and demonstrating healthy snacks and meals to those families attending. One SSLP report detailed 18 activities that provide aspects of health support to families and 6 of these were directly related to infant feeding, 2 were specialist services such as teenage pregnancy work and dental hygiene.

6.3.3 There was evidence that Sure Start had facilitated the delivery of healthy eating initiatives in various ways with practitioners sharing their knowledge and skills, with other colleagues, parents and children. The following practitioners from a range of disciplinary backgrounds were involved in SSLP healthy eating initiatives:

Nursery staff	Healthy eating worker
PCT Nursery Nurse	Food workers
Early years workers	Food advisor
College lecturers	Food and hygiene worker
Horticultural worker	Community food advisor
Family support worker	PCT dietician
Volunteers	Community dietician
Parent Forum volunteers	Community nutrition worker
Health visitor	Nutrition assistant
Asian link worker	Nutritionist
Infant health link worker	Librarians
Play and Learning team	

6.3.4 Finding innovative ways to engage with the community has been an ongoing issue for SSLPs. Reports give descriptions of how promotional, occasional and one-off events, have provided opportunities for SSLPs to reach out to the community and encourage parents to access services with their children. Numerous themes have been the focus for events and some programmes have utilized this approach for the promotion of healthy eating. Specific campaigns such as 5-a-day and Free Pack Lunches have also been implemented (see Box 6.3).

Box 6.3
Occasional campaign: Free Packed Lunches

SSLP:
A week long campaign - healthy packed lunch project - was held in the family centre to offer advice on how to make packed lunches healthy. The main aims were to achieve awareness of what a healthy lunch comprises, to promote the balance of good health with the 5-a-day campaign and to demonstrate to parents that their children will eat healthy food if it is offered to them, even if they may have refused items before. Balanced healthy lunch boxes were prepared and were given free to all families taking part.

Outcome:

- Feedback from parents was positive
- handouts were well received- parents said they would use them at home.
- 17% participants felt more advice could have been offered on dairy products and catering for special diets.

6.3.5 To address low-income issues one SSLP reported on a food voucher scheme. Parents were given a Co-op £2 voucher to exchange for fruit and vegetables. Around 10 women per week received vouchers. The majority of respondents (n=16) suggested their families eating habits had improved as a result of the voucher scheme.

6.3.6 Supporting young parents with nutritious meals for themselves and their children presents issues such as: low income, lack of cooking skills and lack of knowledge of recipes. Three reports included details of working with young parents. Two in the South West have worked with an existing young mothers project (see Box 6.4). Together with the young mothers, the 2 SSLPs provided the mothers with healthy eating support as part of an integrated approach at health and well-being workshops on self-esteem, postnatal illness, stress, sexual health and relationships. .

6.3.7 Providing an integrated and holistic approach to young mothers was seen to be important to help support their complex needs as young adults and as mothers. In the North West, a SSLP Teenage Breakfast Club had developed from a group that originally offered emotional and peer support to socially isolated young mothers. The mothers meet once a week to cook and eat a healthy breakfast whilst offering peer support to each other including on issues such as parenting. To ensure that support for all mothers is sustained Sure Start supports mothers as they become older and they have evolved into a new group.

Box 6.4
SSLPs working with existing young mothers groups

Working with WILD: an established learning and development project in Cornwall for young parents under 25 and their children. Single gender groups and projects with free childcare, offer peer support, accreditation, new skills, volunteer and peer education opportunities, training and issue-based work.

WILD:

- is a specialist service for young parents.
- seeks to provide provision for the needs of young parents.
- has been involved in national research i.e. Social Exclusion Unit's research on teenage pregnancy.
- are members of the National Members Teenage Parent Research and Practice Group.

With a Bitesize grant from the Eatsome project, the SSLP worked with WILD mums.

Outcomes:

- Young mums planned and prepared healthy meals and picnics for themselves and their children.
- Those moms organising these events used the experience towards higher-level Youth Achievement Awards, a nationally recognised award, and 24 young parents gained Youth Achievement Awards.
- Young parents are supported to gain experiences and skills in a variety of ways with SS:
- 14 young parents did voluntary work with WILD
- 13 young parents delivered peer education workshops and other young parents have gained employment and qualifications since being involved with a Sure Start programme in the South West
- Have been more successful with young mums and work with dads has been more challenging.

6.3.8 Involving fathers in SSLPs has been a national aim. Programmes have had opportunities to explore innovative ways of engaging with fathers. The review found low rates of father participation and challenges similar to the NESS early findings: Fathers in Sure Start programmes (www.ness.bbk.ac.uk). Many SSLPs have facilitated local fathers to set-up their own groups and activities, to ensure that their interests are satisfied. Fathers have planned activities that meet their interests at a time in the week/day when they can be involved. A popular Dads group in a South West SSLP went onto set up further activities, one involving a meal, for fathers and children in a social environment (see Box 6.5).

6.3.9 Ten reports reported on process findings on ways that SSLPs had supported ethnic minority families and common strategies were (not surprisingly) dissemination of information in an appropriate language; looking at specific nutritional needs; and respecting food habits of ethnic groups. An existing clinic, for instance, to support parents with childhood anemia in an ethnic minority community was identified as having a low impact. The SSLP and local parents worked with the clinic to improve the participation and local awareness (see Box 6.6).

Box 6.5
Involving fathers: Dads and kids Sunday morning breakfast club

9.30- 12 noon every Sunday at the local Family Centre, run by Dads Group and Home Visitor

Purpose: To give fathers the opportunity to meet together and to spend quality time and provide breakfast for their children

The aim of service is to encourage the relationship between fathers and their children; give fathers the opportunity to provide some of the practical aspects of their children's care; encouraging and supporting fathers to provide and discuss practical care and food preparation for their children; to allow fathers to undertake their Health and Hygiene Certificate

Integrated project: Social meal with play activities for dads and children

Outcome:

- Highest attendance – 8. Lowest - 3

Feedback from dads:

- Real chance to spend time with kids
- I've learnt how difficult it is to cook and watch the children at the same time
- I earn brownie points from the wife for having the children on Sunday morning
- It's great to sit and chat with other dads and see how my children interact with other children

Box 6.6
Ethnic minority mothers develop an existing project to support the cultural and nutritional needs of local families

Due to concerns that Asian babies had iron deficient diets, mothers were invited to develop an existing project to reduce the incidence of childhood anaemia. A screening at 13 months was currently held at the clinic. Key function of the clinic was to provide information on the importance of iron in the diet. It also explains the different types of food that contain higher levels of iron, offered verbally and in leaflet to families.

Mothers attended a 'participatory arts' day to support the development of culturally appropriate foods and resources to increase participation at the clinic.

Outcome:

- Mothers developed user-friendly & culturally appropriate publicity information
  1. A educational booklet for culturally appropriate weaning foods that are rich in iron for weaning from 4-6 months.
  2. Health Visitor letters are translated to community languages
- Anaemia clinic is now available for all 13 months old children living in the inner city area
- Referrals to the clinic are made from health visitors and GP's with specific concerns about children
- Families are telephoned
- Attendance has increased

6.3.10 A dietetic service was developed by another SSLP with the PCT, to ensure that appropriate nutrition resources were available for local families. This was done by consulting with local parents who suggested topic areas for the dietetic service to explore. The evaluation identified the different ethnic minority groups within the area and their languages, and support for families was then developed. Joint working was developed as the more appropriate way to work to meet local families needs (see Box 6.7).

Box 6.7
Joint working to meet the needs of ethnic minority families

SSLP and PCT supported the development of joint working involving the following: Bengali bilingual infant link worker, family support workers and the community dietician.

The work involved increasing:

- awareness of healthy food and nutritional advice by targeting families at clinics and nurseries.
- participation at SSLP healthy eating initiatives

6.3.11 New cooking activities were implemented that involved parents and children: Clever Cooks and Cooking on Budget. A practical aim of the activities were that parents and children are supported in making together, a low cost meal to take home that day, and that it was culturally appropriate (see Box 6.8).

Box 6.8
Developing a culturally appropriate healthy eating activity

SSLP experience: Courses on food hygiene and healthy eating were planned in consultation with the Primary Care Trust (PCT) dietician. The consultation highlighted that Community Education on diet, nutrition and healthy lifestyles will be delivered through Adult community learning with the support of the PCT's dietician. The PCT gave funding and trainer support.

Courses such as Clever Cooks and Cooking on Budget had to consider community aspects such as:

- Cultural differences
- Ethnic foods such as halal food
- availability of crèche
- language support

Courses were delivered in English, Punjabi and Urdu. Dictaphone, pictures from magazines, drawing and art were used to support women not literate in any language.

Outcome:
167 women received nutritional and healthy eating support between 2002 and 2004.
9 parents have completed an OCN Nutrition course and were undertaking Food Hygiene course.

6.4 Cooking courses

6.4.1 Nine reports included details of group cooking activities for parents as a way of Sure Start programmes imparting nutrition knowledge to families, broadly based on the community cooking class method. Courses were aimed at improving knowledge of healthy eating, food hygiene and cooking on a budget. These activities were delivered in various ways: sessions varied from one-off events, occasional, to 10 weeks courses. Reports show that nutrition work has been delivered by a range of staff who have developed an understanding of the cultural and socio-economics of the local community and the family needs Participation in some courses was dependent on the availability of childcare facilities. Crèche provision was either provided by SSLP or other external providers when needed, but this was not consistent for all programmes. It was found that parents did not attend cooking sessions when appropriate childcare was not provided.

6.4.2 The following cooking activities were described in reports:

Cook and Eat	Lets Cook and Eat
Great Cooking, Small Budget	Cooking on a Budget
Cooking from Scratch	Basic Cookery Course
Clever Cooks	Getting Cooking

6.4.3 The activities had a number of general educational aims and in most cases these were said to have been achieved in SSLP reports:

- improve knowledge of nutrients in foods
- improve basic cooking skills for producing more nutritious foods
- develop parent/child taste for more nutritious new foods
- develop new healthy recipes for baby and family
- improve knowledge of food hygiene
- improve knowledge of cooking on a budget
- improve mothers confidence in the kitchen
- improve learning to cook with a microwave
- develop social aspects and fun into cooking healthy foods
- show that a lot of effort was not needed to produce nutritious and economic meals.

6.4.4 The reports indicated that the SSLPs aim to deliver cooking courses that are appropriate for parents on low incomes, culturally appropriate and support families in various circumstances such as, children living in sheltered housing (see Box 6.9). Most reports highlighted parent enthusiasm about attending cooking activities and many programmes had waiting list for their courses. Cooking activities were popular and a way of engaging with some families for the first time and therefore, a useful strategy for increasing contact with the community. Some courses provided parents with recognition of completion and achievement of the session with certificates and accreditation. One programme offered a series of four courses to encourage healthy eating and were funded by New Opportunities Fund and childcare was provided. There was evidence that some parents develop confidence that then empowers them to access other services, work and further college study after being involved with Sure Start cooking courses (see Box 6.10).

Box 6.9
Supporting children and their families in sheltered housing
basic cooking skills with a nutrition assistant

¾'s of the people attending the sessions have made some changes to their diet as a result of the sessions. The report notes that success in changing the diets of people living in sheltered accommodation was limited, but that this group benefited from other positive aspects, such as opportunity to socialize.

Box 6.10
Increasing parents' confidence – the 'Cook and Eat' session

5-week group course with crèche provided - promoted through nurseries and by Early Year Workers.

Parents had an opportunity to learn about basic nutrition, healthier cooking methods, cooking on a budget, simple food hygiene and taste new foods with baby/toddler. Parents tried out new recipes from a bank of recipes without the risk of wasting money if the families did not enjoy the particular foods cooked that week.

Outcome:
34 registered parents attended the course
21% completed the whole course.

- All the responses about the course were positive.
- 5 parents expressed an interest in volunteering for the Community Café**.**
- Some mothers had gained confidence within these groups and were accessing other Sure Start services.
- 6 parents became interested in attending a Nutrition and Food Hygiene course at the local college after completing the Sure Start course.
- Parents felt that the children were willing try a wider range of foods whilst with the other children from the crèche. Where venue allows, simple cooking with the children in the crèche, was also done. The most common problem raised at the sessions was fussy eating in toddlers.

There was a waiting list of parents interested in the Cook and Eat sessions.

6.4.6 There were reports of Sure Start programmes working in partnership with local colleges and universities to develop, accredit and run healthy eating courses. An existing Cook and Scratch course that had been running at a local college for 2 years was supported further by a SSLP with the aim to increase participation and help recruit participants (see Box 6.11). The community dietician developed the course and the Food and Hygiene worker taught the course. The Food and Hygiene worker brought all the ingredients with costing sheets, discussed hygiene and nutrition, helped participants prepare a meal and provided recipe handouts. Each week the course had a mix of theory and practical. Information about the course was posted to people on the Sure Start database for recruitment purposes.

Box 6.11
Cook and Scratch accredited cooking course
SSLP in partnership with local college

SSLP 1: Nine 'Cooking from Scratch' courses were completed from September 2001 to December 2003. The college paid the crèche and course fees. Each course was for 30 hours over 10 weeks.

Outcome:
Each course had 5-6 participants and 45 local people had attended courses overall, aged between 17-54. 2 fathers had attended with their wives. A hearing impaired woman also attended the course.

The findings showed that there was agreement that the course was able:

- To introduce a wide range of healthy foods and meals to participants and their family
- Parents learnt budgeting and time management
- It also motivated them to undertake healthier diets
- Parents were motivated to become more involved with Sure Start and other courses
- Parents felt more confident
- The course gave them opportunity to make new friends

Satisfaction with the course was also very high

- Parents were satisfied with the tutor, venue and crèche provision.
- Some suggestions to improve the course were to have more meals for children, more focus on hygiene and that the course could be longer.

6.5 Outcome of healthy eating initiatives for children, parents and staff

6.5.1 Evaluation findings indicated that parents who attend cooking courses were likely to acquire new knowledge and skills. There were examples of how parents had started to apply this new knowledge and skills to their everyday lives. Parents were shopping differently and eating more healthy foods (see Box 6.12 for an example).

6.5.2 Fruit has been distributed to children in SSLPs as a snack when they attend any of the programme activities or Sure Start funded childcare. Five evaluation reports detail the programmes' commitment to healthy eating through distribution of fruits as a healthy snack during Sure Start activities. Fruit For Nursery (FFN) scheme, for instance, funded by a SSLP provides free fruit to children aged birth-4 years attending nine nurseries, playgroups and parents and toddler groups (see Box 6.13 for some early outcomes).

6.5.3 Thus there is evidence that some parents, children and childcare staff have increased their nutrition knowledge since being involved with SSLPs. Parents have been involved in various aspects of planning and decision-making in SSLPs and one report detailed how the Parent Forum group had developed a policy for a healthy snack at Sure Start groups and crèche.

Box 6.12
SSLP changes in family shopping and consumption of healthier foods

SSLP 1: N= 143 parents interviewed by 16 parent volunteers.

- Provision of free fruit to all SS group childcare provision has influenced the shopping habits of 54% of parents/carers questioned.

SSLP 2: Evaluation was carried out of 'lets cook and eat' courses. 89 people had attended the course from 2000 to 2004. 42 were interviewed:

- 90% said they believed the course had shown them how to cook and eat more healthily.
- 84% said that they make changes to recipes to make them healthier at least some of the time,
- 88% read food labels at least some of the time after attending the course.
- 76% said they eat more fruit and vegetable and
- 88% said they eat more fruit and vegetable at least some time compared to what they ate before the course.

Box 6.13
Changes in nutrition consumption and knowledge
Healthy snacks in nursery

SSLP 1: Evaluation findings showed that up to a 1/3rd of parents said that since going to nursery, and eating fruit there, their child is asking for fruit more often at home, is eating larger amounts and a wider variety of fruits.

The proportion of children eating fruit most days at home has increased by 10% since children started at nursery.

SSLP 2: (N=143)

- 63% of children and 32% of parents eat the fruit provided by Sure Start at nursery/playgroup/crèche/other groups.
- The provision of free fruit at all group childcare provision within the Sure Start area has had an impact on 54% parents' shopping choice.
- Parent tried wide range of fruits after attending Sure Start groups.

15 staff members were interviewed and 165 local parents took part in a survey, interview and focus group discussion to measure the difference that fruit has on children eating healthier in nursery and at home.

Outcome:

- All nurseries were highly satisfied with the amount, variety and quality of fruit delivered to them.
- Nurseries estimate that almost all children were eating fruits.
- Children who at first refused fruit soon joined in as they got used to the nursery routine.
- Staff felt children were eating fruit everyday and a wider variety of fruits.
- Since getting free fruit, staff felt they have learnt more about fruits themselves, become more aware about healthy eating and were able to promote fruit more actively and teach children more about healthy eating.

6. 6 Improving access to healthy eating in innovative ways with children

6.6.1 SSLP work to provide new services for local communities as well as enhance those existing ones. Both integrated and more specific activities for nutrition support have been implemented where there appears to be a gap in services. This section provides examples of some SSLP educational approaches to support childrens' healthy eating such as:

- horticultural project
- dental hygiene and oral health
- story telling
- story stacks

6.6.2 The aim of a horticulture project in one programme, for instance, was to introduce children to new types of fruits and vegetables in a non-threatening way through the project where this type of work could not be implemented at the nursery. They felt that children were likely to try fruit and vegetables if others had tried and enjoyed it. The FFN and horticulture project aimed to encourage children to have a positive attitude to fruit and vegetables at home.

6.6.3 Programmes that have recognised that access to fresh foods has been difficult have introduced gardening and vegetable growing activities. During these families learn about self-sufficiency and managing vegetable gardens. In one programme, a project specifically for children was organised by the horticulture worker that involved a range of different activities with children including exploring soil, planting seeds and bulbs, tasting unfamiliar fruit and vegetables and cooking food together. 4-10 children were involved in each session. The length of session ranged from 30 minutes to 2 hours.

6.6.4 Programmes need to be innovative when delivering certain activities and services to local families. 4 programmes reported on dental hygiene and oral health. SSLP families learn about the link between oral health and healthy eating. Children learn how to brush their teeth and one SSLP reported that:

- 71% of parents said that their children were brushing their teeth more often.
- Parents said that their children were consuming reduced levels of sugar after attending SSLP oral health activities.
- 86% of parents were satisfied with the SSLP oral health service.

6.6.5 Another educational technique used with children, and parents, was 'story telling', aimed to stimulate children's' learning of new foods by introducing a variety of healthy foods to children in a fun way. It includes the technique of modelling to parents to demonstrate and support them to encourage children to eat foods that they might not like. Vegetables and other food items were given names in the story and then given to children after the story to be eaten (Box 6.14). Other programmers also incorporate 'art' into the delivery of their healthy eating work and a popular mode was in the form of Story Sacks. The early years workers work with health visitors to promote healthy eating and develop child, and parent literacy, speaking and listening skills through Story Sacks. A practical aim of the session has been parents to make their own Story Sack and contribute to a recipe book (see Box 6.15).

Box 6.14
Use of Story Telling to introduce new food

Healthy food story telling – the community food advisor ran 13 Story Telling activities at stay and plays, nursery and libraries. Parents were shown how this can be a popular way to introduce vegetables to their children. Activities included books i.e. 'I will not never ever eat a tomato' where a fussy little girl who won't eat lots of foods until her big brother renames them (e.g. carrots became twiglets from Jupiter).

Outcome:

- 274 children took part.
- Children reluctant to eat certain food tried them once they had been given the names in the story.
- The activity was popular with parents, carers, children and staff.

Box 6.15
Story Sacks healthy eating activity

Benefits of attending Story Sacks include:
For parents:

- To focus on speaking and listening skills (linked to the Adult Core Curriculum)
- To look at progress towards opportunities
- Look at a balanced diet
- Receive information on hygiene and nutrition
- Consider childrens likes and dislikes
- Discuss food from other cultures
- Focus on communication skills

For children:

- Focus on communication skills and early interaction
- Developing role play and extend language through discussion
- Taste new foods
- Make choices of healthy foods

Outcomes:

- 10 children attended with parents and 8 children took part.

Evaluation feedback was positive from parents and outcomes/ achievements that worked well were reported as:

- multi-cultural food was shared with children and adults
- new skills learnt by all adults
- adults keen to take work home (to finish the sack)
- children able to check in with parents – worked well for children
- finished Story Sacks were given to the local library and Mobile Toy library for families to borrow
- parents developed interests in other courses

Parent and children discover the benefits of reading, talking and playing together and high quality crèche provision is provided.

6.6.7 SSLPs have been encouraged to reflect and develop activities in all aspects of delivery and in particular those SSLP activities where participation and interest are low after the initial implementation. Activities such as Food Checks, Family Café, Vegetable Boxes, Food Co-operatives and soup kitchens have been acknowledged as areas for further development for their effectiveness as activities to support healthy eating.

6.7 Summary

6.7.1 The review found examples where SSLPs have educated children, parents and staff on what healthy foods are, and there are some early positive outcomes of this work. Taste preference and knowledge of fruits in particular were developed in childcare activities during play activities and snacks. Parents reported that their children were eating more fruit and in some cases have a preference for fruit over other foods. The information from available evaluation reports suggests that parents, children and childcare staff have increased their nutrition knowledge of fruits since being involved with SSLPs. , The evidence, however, is based on small-scale evaluation projects and more detailed work needs to be completed.

6.7.2 Useful pre-project evaluation findings have helped a few SSLPs to understand the nutrient needs of local families, shopping habits and cooking styles and the reasons why certain foods are not consumed. Factors such as location of shops, price, time and quality of local foods influence shopping behaviour.

6.7.3 Together with this local knowledge SSLPs have implemented and targeted specific education interventions such as group cooking courses and health promotion activities. Dieticians, nutritionists and development workers mainly lead these interventions. Interventions aim to take into consideration the local socio-economics, cultural differences, lack of nutrition knowledge and lack of cooking skills of local communities. Aiming to demonstrate that cooking can be effortless, interesting, sociable and low in cost, which have been important aspects of SSLP work, specifically with young mothers. Cooking courses generally have been very popular with waiting lists. There was evidence of Sure Start working in partnership with local colleges and universities to develop, accredit and run healthy eating courses and parents have received recognition of their new skills and knowledge.

6.7.4 There are early indications that mothers are more confident cooking healthy foods since attending a Sure Start cooking course. Some had started to change their diets after attending nutrition activities by consuming more fruit and vegetables. Children, whose parents had learnt about the links between sugar, diet and oral health, were consuming less sugar. Social activities including childcare settings, where children and parents could socialize with others and share meals and new food experiences, had a positive influence for tasting new foods.

6.7.5 Finding innovative ways to engage with the community has been a continual and key aspect for SSLPs. Promotional, occasional and one-off

events, have provided opportunities for SSLPs to reach out to the community and encourage parents to access services with their children. Some programmes have utilized this approach for the promotion of healthy eating and incorporated 5-a-day themes. SSLP occasional and one-off events are popular and well attended by local families. They provide numerous benefits for SSLPs such as opportunities to observe families, their communication, culture and interests, gather basic information on diet and promote Sure Start services, team and ethos.

7. CONCLUSIONS

7.1 Approximately 9% of SSLP evaluation reports received by NESS were utilised for this nutrition synthesis report. Whilst evaluation approaches had several limitations relating to the lack of significant testing, sample representation and inter-reliability, the reports reviewed have shown that there are promising early benefits of SSLP nutrition work, particularly breastfeeding and cookery course interventions.

7.2 Education based interventions have developed child, parent and staff nutrition knowledge and skills and there are early examples of families consuming more nutritious foods such as fruit, vegetables, iron-rich foods and breast milk. A few children, whose parents had learnt about the links between sugar, diet and oral health, are also starting to consume less sugar. Social activities including childcare settings, where children and parents socialize with others, share meals and new food experiences, have had a positive influence on tasting new foods. Additional benefits to families have been the parent social networks that SSLPs have supported by facilitation with initial group work and these networks are starting to be sustained in areas beyond nutrition.

7.3 Sure Start has provided opportunities for staff and parents to work together in ways that have increased satisfaction for all parties involved. Partnership working with mixed-skilled teams have developed including early indicators of multi-disciplinary work with interpreters that have increased the attendance, participation and satisfaction for staff and parents relating to nutrition activities. Breastfeeding parent volunteer peer groups have flourished and provide opportunities for SSLPs to offer shared training and bring together workers from different disciplines. Parent-led groups have been a popular response from Sure Start to develop gaps in service provision and compliment the more popular staff-led groups with babies starting to be breastfed for longer. Mothers have gained additional benefits from Sure Start in social skills development, qualifications and training, a sense of personal achievement and increased motivation. With some mothers becoming advocates in their communities offering good quality advice and in particular promoting breastfeeding.

7.4 There are a few early indications that existing provision such as midwifery has been enhanced and that more families are being supported in innovative informal ways at antenatal and postnatal stages. Referral partnerships and systems have improved and staff are developing breastfeeding provision in specific ways to meet local needs including those of young parent and ethnic minority families.

7.5 Mothers were more confident breast feeders after receiving breastfeeding education and training and there were some SSLP examples where breastfeeding is the more popular infant feed. There were some encouraging examples of increased initiation and duration rates of breastfeeding. Sure Start work has therefore, started to increase outcomes for babies and mothers' nutrition health and well-being in line with the World Health

Organisation guidelines and health objectives of Sure Start and the Every Child Matters Framework.

7.6 Increased mother-infant contact during breastfeeding provides an additional opportunity to increase attachment and emotional bonding. Further research and evaluation to measure the impact on childrens' emotional, mental health well-being and general health development are needed and the DFES Birth to 3 Matters Framework, i.e. 'strong child', provides an appropriate framework for this.

7.7 Staff are developing a rich knowledge of the socio-economic-cultural differences relating to lifestyle and cuisine that impact on nutrition, in the local area and have designed some provision to meet specific family needs. Useful pre-project evaluation findings have helped a few SSLPs to understand the nutrient needs of local families, shopping habits and cooking styles and the reasons why certain foods are not consumed. Factors such as location of shops, price, time and quality of local foods influence shopping behaviour. Staff have been supported with interpreters to work with non-English speaking families.

7.8 The adoption of the La Leche League Parent Peer training and the Baby Friendly Initiative have supported the increase of skills and knowledge, of Sure Start teams and partners. To achieve the 'full' Baby Friendly Initiative award, breastfeeding monitoring systems need to be implemented and thus will be pivotal in producing reliable and appropriate data for research and evaluation purposes. Some PCT's have recognised the usefulness of La Leche, part of the 'baby friendly approach', and have started to consider sustaining the training of La Leche League. There are early signs that the 'baby friendly' values and ethos have started to influence services and businesses in local communities, working towards, generally, tackling the 'non-breastfeeding cultures'.

7.9 Sure Start supports baby infant feeding from birth onwards and the weaning off milk, onto healthy solid foods at the appropriate age of 6 months. This is an important stage in nutrient intake and development in taste preference for babies. The weaning stage can influence taste preference and future child-diet, which can be difficult to change with age. Weaning support has been provided in social one-off events with free weaning resources, parent-led culturally appropriate recipe design and mixed-skill team home visits. The review found in general, very little evidence of the difference that the one-off events such as weaning parties or free resources, have on introducing babies to healthy diets. Evaluation of weaning practices will therefore, be a useful management tool to start to understand how weaning in disadvantaged communities changes over time as a response to the SSLP intervention.

7.10 Finding innovative ways to engage with the community has been a continual and key aspect for SSLPs. Promotional, occasional and one-off events, have provided opportunities for SSLPs to reach out to the community and encourage parents to access services with their children. Some

programmes have utilized this approach for the promotion of healthy eating and weaning, and incorporated 5-a-day themes. SSLP occasional and one-off events are popular and well attended by local families. They provide numerous benefits for SSLPs such as opportunities to observe families, their communication, culture and interests, gather basic information on diet and promote Sure Start services, team and ethos.

7.11 SSLP learning has also extended to understanding the importance of monitoring infant feeding and there were some early indicators that Sure Start has been instrumental in the development of more robust systems. Evaluation has started to be used to measure outcomes for children, mothers and staff. Hopefully other programmes will follow this lead and collect regular information about infant feeding practices and other important nutrition related behaviour to provide reliable evidence for policy development recommendations.

7.12 Overall, this review has found examples of Sure Start work that demonstrate approaches to increase nutrition in child, and family diets, that link to both antenatal and postnatal primary health care provision.

Appendix A

Programme reports included in the synthesis and each report's overall focus

District – in alphabetical order	Programme	Report title	Nutrition Findings			Report contains		
			Breast Feeding	Weaning	Healthy Eating	Outcome for children	Outcome for parents	Process evaluation
Arun	Littlehampton	An evaluation of the Breastfeeding Peer Support	✓					✓
Bassetlaw	West Bassetlaw	Annual Evaluation Report 2002-3			✓	✓		✓
Birmingham	Balsall Heath	Having a baby – Midwifery Report 2005	✓					✓
Birmingham	Balsall Heath	Annual Evaluation Report 2003	✓				✓	
Birmingham	Chinnbrook	Billesley Annual evaluation Report 2004	✓			✓	✓	
Bournemouth	Bournemouth	Healthy Eating Evaluation Report 2004			✓			✓
Bournemouth	Bournemouth	West Howe Breast feeding Support Report 2004	✓			✓	✓	
Bradford	Shipley	Dietetics Report 2004			✓			✓
Brighton & Hove	Brighton & Hove Central Seafront	Annual Evaluation Report 2002-03	✓			✓	✓	
Burnley	Duke Bar Burnley Wood	Annual evaluation report 2005	✓					✓

District – in alphabetical order	Programme	Report title	Nutrition Findings			Report contains		
			Breast Feeding	Weaning	Healthy Eating	Outcome for children	Outcome for parents	Process evaluation
Carrick	Pebbles	Annual Evaluation Report 2004	✓	✓	✓			✓
Crawley	Crawley	An Evaluation of Breast Start 2003	✓				✓	✓
Derby	Rosehill	Annual Evaluation Report 2003	✓				✓	✓
Doncaster	Intake & Belle Vue	Annual evaluation Report 2004-2005	✓					✓
Dover	Dover	Annual evaluation report 2005	✓				✓	
Ealing	South Acton & Acton Vale	Annual Evaluation Report 2005	✓					✓
East Riding	Bridlington South	Breastfeeding Report 2005	✓			✓	✓	
East Riding	Bridlington South	3 year report 2005	✓			✓	✓	✓
Gateshead	Newbiggin Hall	Annual Evaluation Report 2005			✓			✓
Halifax	Elland	Baby Café: A partnership approach to breast feeding support 2003	✓			✓	✓	✓
Hammersmith & Fulham	Coningham	Coningham Breast feeding and Health care Assistant Report 2002	✓			✓	✓	✓
Haringey	Roundway	User Satisfaction Report 2004	✓			✓	✓	
Havering	Hilldene and Gooshays	Examining the impact of Sure Start Team Midwifery from Client and a Professional Perspective 2004	✓			✓	✓	✓
Kerrier	Trevu	Annual Evaluation Report 2002	✓			✓	✓	
Kerrier	Trevu	Three Year Report 2005	✓			✓	✓	✓
Kingston upon Hull	Longhill & Bilton Grange	Annual Evaluation Report 2004-5		✓	✓			✓
Kingston upon Hull	Marfleet	Year three Annual Evaluation Report 2005		✓	✓			✓
Kingston upon Hull	Marfleet	Food and Health Survey Report 2002		✓	✓			✓
Kingston upon Hull	Newington &	A review of the evaluation activity	✓					

	Gypsyville	2005						
Lambeth	Kennington	Benefits of Sure Start Caseload Midwifery, Vol.8.No.10 Midwives: The Official Journal of Royal College of Midwife	✓			✓		✓
Lancaster	North Lancaster	3 year review 2003	✓		✓			✓
Leicester	Beaumont Leys and Stocking Farm	Annual Evaluation Report 2003	✓			✓	✓	
Leicester	Beaumont Leys and Stocking Farm	Annual Evaluation Report 2004	✓			✓	✓	✓
Mansfield	Ravensdale	Feeding Support Group Report 2003	✓	✓		✓	✓	✓
Mansfield	Ravensdale	Breastfeeding survey 2003	✓			✓	✓	✓
Middlesborough	Pallister Park end & Berwick Hills	An interim evaluation report of process and outcomes 2004			✓	✓		✓
Newcastle	Newbiggin Hall	Annual report 2005			✓			✓
Newcastle	Newcastle East & Fossway	2004 Interim Report 5: Sure start Newcastle East Service Delivery in Breastfeeding, Smoking Cessation and Speech and Language Development	✓			✓	✓	
Newcastle under Lyme	Newcastle under Lyme	Three Year Report 2005	✓			✓	✓	✓
Newham	Little Ilford	Year 3 Evaluation Report 2005			✓	✓	✓	✓
North Devon	Ilfracombe	Year Three Annual Evaluation Report 2005	✓			✓	✓	✓
North East Lincolnshire	Nunsthorpe and Bradley Park	Three Year Evaluation Report 2005	✓	✓	✓			✓
North East Lincolnshire	West Marsh & Yarbury	Annual Evaluation Report 2004			✓			✓
Northampton	Northampton	Annual Evaluation Report 2003-04	✓		✓	✓	✓	✓
Northumberland	Bedlington & Scotland	Three Year Report 2005	✓		✓			✓

District – in alphabetical order	Programme	Report title	Nutrition Findings			Report contains		
			Breast Feeding	Weaning	Healthy Eating	Outcome for children	Outcome for parents	Process evaluation
North Tyneside	Shiremoor & Killingworth	Annual Evaluation Report 2003-04	✓					✓
Norwich	Thorpe Hamlet	3 year report	✓			✓	✓	
Oswestry	Oswestry	Breast feeding Audit Report 2005	✓			✓	✓	
Oswestry	Oswestry	Three Year Evaluation Report 2004			✓			✓
Rossendale	Bacup & Stacksteads	Health Theme Report 2004	✓		✓	✓	✓	✓
Rossendale	Bacup & Stacksteads	Community Café Report 2005			✓		✓	
Salford	Little Hulton	Annual Evaluation Report 2003-04	✓					✓
Salford	Little Hulton	Evaluation Report 2005			✓			✓
Sedgemoor	Bridgewater	Horticulture Project Evaluation Report 2002			✓			✓
Sheffield	Burngreave & Fir Vale	Three Year Report 2005	✓			✓	✓	✓
Sheffield	Foxhill & Parsons Cross	Breastfeeding Report 2002	✓			✓	✓	✓
Sheffield	Tinsley	Annual Evaluation Report 2005	✓			✓	✓	✓
Slough	Britwell Northborough	3 year evaluation 2005	✓			✓	✓	
Southampton	Southampton Central	External Breastfeeding Evaluation 2005	✓					✓
Southwark	Aylesbury Plus	Shopping Basket Evaluation Report 2003			✓	✓	✓	
Southwark	Brunswick	Fruits for Nurseries Report 2004			✓	✓	✓	✓
Staffordshire Moorlands	Staffordshire Moorlands	Mum2Mum Report 2005	✓			✓	✓	✓
Stockport	Adswood and Bridgehall	3 year evaluation 2005	✓			✓	✓	
Stoke on Trent	Sure Start 4U	Annual Evaluation Report 2004	✓			✓	✓	

District – in alphabetical order	Programme	Report title	Nutrition Findings			Report contains		
			Breast Feeding	Weaning	Healthy Eating	Outcome for children	Outcome for parents	Process evaluation
Stoke on Trent	Stoke on Trent North	Asian Weaning Report 2005		✓	✓			✓
Sunderland	Ford	Annual Evaluation Report 2004	✓	✓	✓			✓
Sunderland	Hetton & Houghton	User Satisfaction Survey 2005	✓					✓
Sunderland	Coldfields North Monument	User Satisfaction Survey report 2005			✓			✓
Sunderland	North West	Initial Evaluation report 2004	✓					✓
Tameside	Ashton	Annual Evaluation Report 2004		✓	✓		✓	✓
Tameside	Hyde	Annual Evaluation Report 2004	✓		✓			✓
Telford	Lawley Plus	Baby Café Review 2004-05	✓					✓
Telford	Lawley Plus	Maternity Audit	✓			✓	✓	✓
Tower Hamlets	On the Ocean	Breast Feeding Report 2002	✓					✓
Tower Hamlets	Weavers & Spitalfields	Evaluation Report 2003-4			✓			✓
Wakefield Lupset	Wakefield West	Café Evaluation Report 2005			✓			✓
Weymouth & Portland	Weymouth & Portland	Annual Evaluation Report 2004	✓			✓	✓	✓
Wolverhampton	Eight Village	Breastfeeding Support Group 2005	✓	✓	✓	✓	✓	✓
Wolverhampton	Whitmore Reans & Dunstall	Nutrition Programme Report 2004			✓			✓
Wolverhampton	Whitmore Reans & Dunstall	Family Support Report 2005	✓					✓
Total of 80 reports			58	10	32	39	42	63

Appendix B

UK Baby Friendly Awards progress at 23rd January 2006.

Source: http://www.babyfriendly.org.uk/htables/all_awards_list.asp#community

List of maternity hospitals, community health care facilities and university teaching departments that have either:

1. Full Baby Friendly accreditation
2. Certificate of Commitment – of working towards Baby Friendly status

A Certificate of Commitment is the first step towards the full award and is assessed by post and via an action-planning visit. Certificate of Commitment recognises that a Trust is working to bring its practices into line with the Ten Steps or the Seven Point Plan and that it is working towards assessment and full accreditation. It is also a Trust's statement of commitment to make improvements to the services it provides to mothers and babies. The Certificate will feature the signatures of the Trust Chief Executive and the Head of Maternity or Health Visiting Services. A health care facility will be awarded a Certificate of Commitment if it fulfils specific requirements including – '*Has a formal mechanism for recording breastfeeding statistics'*

Full accreditation requires a more rigorous assessment of all the best practice standards.

114 UK maternity hospitals with full Baby Friendly accreditation or a Certificate of Commitment. In England 75: Full accreditation = 27, Certificate of commitment = 48

The following 7 community health care facilities have full Baby Friendly accreditation:

- Northgate Surgery, Pontefract
- Foyle Health and Social Services Trust, Londonderry
- Sure Start Peterlee, Co. Durham
- Anniesland, Bearsden & Milngavie LHCC, Glasgow
- Osmaston/Allenton Sure Start, Derby
- Homefirst Community & Social Services Trust, Ballymena
- Sure Start Bedlington and District Children's Centre, Northumberland, including Bedlingtonshire Medical Group, The Gables Health Centre and Guide Post Medical Group

The following 16 community health care facilities have a Certificate of Commitment:

- Belford Medical Practice, Northumberland
- Sure Start Pinehurst and Penhill, Swindon
- Eastern Cheshire Primary Care Trust
- Sure Start East Cleveland
- Central Derby Primary Care Trust
- Sure Start Ashfield, Nottinghamshire
- Sure Start Wave 3, Darlington
- Middlesbrough Primary Care Trust
- Sure Start Longton South, Stoke-on-Trent
- Chesterfield Sure Start and Healthy Living Centre
- Eastern Hull Primary Care Trust (Bransholme Locailty) & Sure Start Noddle Hill
- Sure Start Redcar Coast and Dormanstown & Sure Start West Redcar
- Sure Start Highfields, Leicester

Baby Friendly Progress by country as at 23rd January 2006-01-25

Country	% of births in Baby Friendly Hospitals
England	9.20%
Northern Ireland	34.14%
Other areas covered	24.31%
Scotland	58.18%
Wales	34.10%

Appendix C
Parent Peer Breastfeeding Groups

This appendix includes a list of the parent peer breastfeeding groups found in SSLP reports

- Bambinos
  Breastfeeding Advice for Mothers with Babies in Oswestry
- BEST
  Breastfeeding Encouragement and Support Team
- Best Start group
- BIBS - Breast is Best
- Bosom Buddies
- Breast Mates
- Breast Feeding Mums group
- Breast Friends
- Mum2Mum
- MILK

REFERENCES

[1] http://www.everychildmatters.gov.uk

[2] http://www.surestart.gov.uk/resources/childcareworkers/birthtothreematters/ 2006

[3] World Health Organization (20O3) *Diet Nutrition and the prevention of chronic diseases* http://whqlibdoc.who.int/trs/WHO_TRS_916

[4] DoH (2006) *Measuring Childhood Obesity: Guidance to Primary Care Trusts*

[5] Joint Health Surveys Unit (2005) *Obesity among children under 11*. National Statistics. London

[6] Hamlyn B, Brooker S, Oleinikova & Wands S (2002) Infant Feeding 2000, The Stationery Office, London 2002 0113225709. 6th national survey carried out by BMRB Social Research on behalf of the Department of Health, the Scottish Executive, The Assembly for Wales and the Department of Health, Social Services and Public Safety in Northern Ireland in UNICEF Baby Friendly Initiative website 2006: http://www.babyfriendly.org.uk/ukstats.asp

[7] Dykes F, (2003) Infant Feeding Initiative: A Report Evaluating the Breastfeeding Practise Projects 1999-2002, University of Central Lancashire, www.doh.gov.uk/infantfeeding

[8] Lobstein T, Rigby N & Leach R (2005) Internal Obesity Task Force, EU Platform on Diet, Physical Activity and Health, Europe Association for the Study of Obesity (EASO), Brussels http://europa.eu.int/comm/health/ph_determinants/life_style/nutrition/documents/iotf_en.pdf

[9] Office of National Statistics. (2001)The national food survey 2000: Annual report on food expenditure, consumption and nutrient intake, Department for Environment Food and Rural Affairs

[10] Martin RM, McCarthy A, Smith GD, Davies DP, and Ben-Shlomo, Y (2003). Infant nutrition and blood pressure in early adulthood: the Barry Caerphilly Growth study. *American Journal of Clinical Nutrition*, 77, 1489-1497.

[11] Forsyth JS, Ogston SA, Clark A, du V Florey C, Howie PW (1993). Relation between early introduction of solid food to infants and their weight and illness during the first two years of life. *British Medical Journal,* 306, 1571-1576

[12] Wilson AC, Forsyth JS, Greene SA, Irvine L, Hau C, Howie PW (1998). Relation of infant diet to childhood health: seven year follow-up of cohort of children in Dundee infant study. *British Medical Journal,* 316, 21-25

[13] Department for Health (2004) *Committee on the medical aspects of Food policy (COMA) report on weaning and the weaning diet*. HMSO London

[14] NESS (2005) Early Impacts of Sure Start local Programmes on Children and Families Report 013 DFES HMSO
http://www.ness.bbk.ac.uk/documents/activities/impact/1183.pdf

[15] Public Health (2002) Annual Report of the Director of Public Health, Scotland
www.nhslothian.scot.nhs.uk/publications/annual_reports/public_health/2002/datasets/about_breastfeeding.html

[16] Kramer M S & Kakuma R. (2002) Optimal duration of exclusive breastfeeding. *The Cochrane Database of Systematic Reviews* 2002, Issue 1. Art. No.: CD003517. DOI: 10.1002/14651858.CD003517.

[17] Harder T el al (2005) Duration of Breastfeeding and Risk of Overweight: A Meta-Analysis. Am. J. Epidemiol 162: 397-403 www.babyfriendly.org.uk 21.1.2006.

[18] Department for Health (2005) National Breastfeeding Awareness Week 2005,
http://www.dh.gov.uk/NewsHome/NewsArticle/fs/en?CONTENT_ID=4109600&chk=JXN6ZE

[19] Baby Friendly Initiative www.babyfriendly.org.uk

[20] Dyson L, McCormick F, Renfrew MJ, (2006) Interventions for promoting the initiation of breastfeeding, The Cochrane Database of Systematic Reviews, Issue 1. The Cochrane Collaboration.