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Breastfeeding promotion and support in Primary Care in Glasgow

**Report to Director of Nursing, Greater Glasgow
Primary Care NHS Trust**

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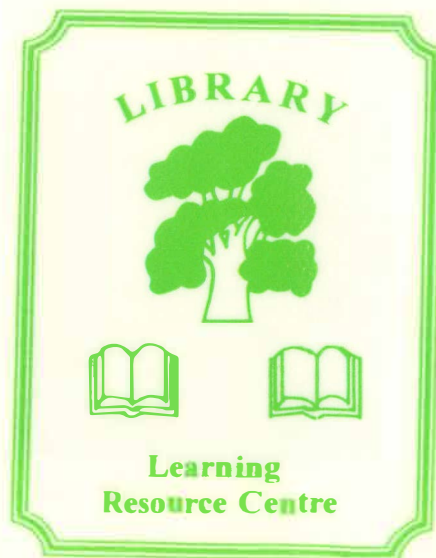
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Introduction

This report describes a survey of interventions by health visitors to promote and support breastfeeding in the primary care setting in Glasgow. The survey is the first stage in a study of the effectiveness of such interventions in increasing breastfeeding rates. The aims and objectives of the main study are described in Appendix 1.

There is widespread agreement that breastfeeding has health benefits for both babies and mothers, and government health departments are keen to increase breastfeeding rates.^{1, 2, 3, 4, 5, 6, 7, 8, 9} Yet the barriers which prevent women from breastfeeding have only recently begun to be explored in detail. Similarly, research into the effectiveness of interventions aiming to increase breastfeeding is poorly developed. Appendix 2 summarises the present state of research on these topics. Health visitors have had a role in promoting and supporting breastfeeding for many years,^{10, 11} but there has been little evaluation of their breastfeeding work. The current debates on the contribution of nurses to improving the public's health, and on which professional group should be responsible for providing post-natal care up to six weeks makes such evaluation particularly relevant.^{12, 13, 14, 15, 16}

One of the objectives of the study is to provide information to health visitor managers, and health visitors themselves, about breastfeeding work within the Trust. The Director of Nursing, Greater Glasgow Primary Care NHS Trust has supported the study and welcomed the opportunity to study breastfeeding work in the primary care setting. This report is the first stage in the feedback process, providing a description of the current role of Glasgow health visitors in promoting and supporting breastfeeding, as well as documenting other interventions in the primary care setting.

Each health visitor in Glasgow, regardless of participation in the survey, will be sent a summary of this report, together with information on her (or his) clients' breastfeeding rates at 10 days, 6 weeks and 8 months from the Child Health Surveillance Records.

To maintain confidentiality, individual health visitors and GP practices have not been identified.

Methods

Questionnaire

Data for the survey was collected by questionnaire (Appendix 3). The questionnaire covered all health visitor activities relating to the promotion and support of breastfeeding. It incorporated all topics referred to in 'The Baby Friendly in the Community - an implementation guide'.¹⁷ The questionnaire was new, as there was no evidence from the research literature of existing studies on this topic. Efforts were made, through discussion with practitioners, managers and researchers to ensure that it would be as clear and easy to complete as possible, and that the findings would be comprehensive, reliable and valid. The questionnaire was piloted outwith Glasgow.

The Iowa Infant Feeding Attitude Scale was included in the questionnaire. The Scale has been developed as a means of predicting feeding behaviour, and of identifying issues and attitudes which lead women to choose formula feeding.¹⁸ This study has provided an opportunity to explore whether the Scale is a useful tool for measuring health professional

attitudes to breastfeeding in the UK. Research suggests that health professional attitudes may need to be addressed as part of a strategy to promote breastfeeding.^{19, 20}

Survey administration

The Child Health Section of the GGHB provided a list of 229 health visitors in a permanent post with the Primary Care Trust at 12th January 2000. The list excluded Bank health visitors and health visitors with special responsibilities not normally carrying a caseload. Telephone calls were made to each of the 37 health visitor bases in the two weeks prior to sending the questionnaire to make sure that the list was accurate. As a result, eight changes were made to the list.

Questionnaires and covering letters were sent on 26th January 2000, with a return date of 3rd March 2000. At the same time, copies of the questionnaire and covering letter were sent to LHCC Managers or Interim Community Managers asking for their help in encouraging health visitors to respond. 151 reminder letters were sent on 18th February 2000. Follow-up telephone calls were made between 1st and 6th March to health visitor bases, or to LHCC managers, at the suggestion of Nurse Managers, to tell non-respondents that the deadline had been extended to 10th March and to ask that the questionnaire be completed.

Each questionnaire was marked with the HV number(s) and practice number(s), which health visitors were asked to amend if necessary.

Four prizes were offered to health visitors completing and returning questionnaires by 3rd March (subsequently extended to 10th March).

Response rate

Questionnaires were sent to 229 health visitors. 63 health visitors did not return questionnaires, 13 were long-term absent, 7 returned for some, but not all of their practices, and 146 returned in full, giving a crude return rate of 146 of 229, 63.8%, and on correction for long-term absence, 146 of 216, 67.6%. This is shown in Figure 1.

Figure 1 Health visitors questionnaire returns

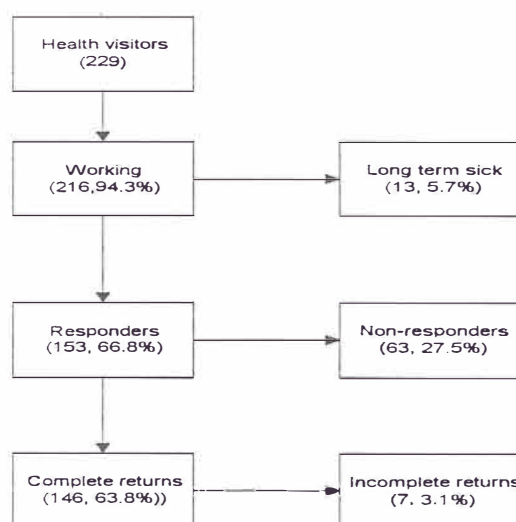
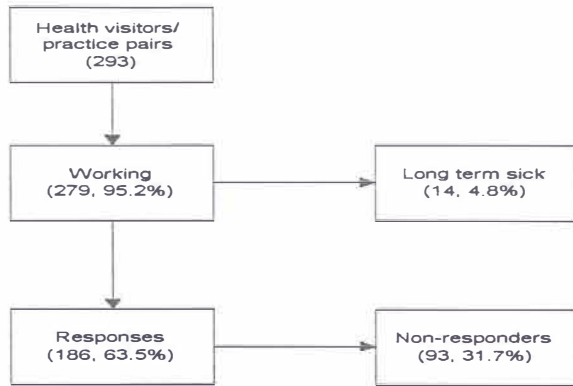


Figure 2 Health visitor/practice pair questionnaire returns

The questionnaires referred to 293 individual health visitor/ practice pairs. Of the 293 questionnaires, 93 were not returned, 14 went to health visitors who were sick or on maternity leave, and 186 were returned; 63.5% of those distributed. On correcting for long-term absence, 186 of 279 were returned, 66.7%. This is shown in Figure 2.



Similar calculations were made per questionnaire per LHCC (Table I). Considerable variation was noted in the level of response. As there were some practices outwith LHCCs, the total number of questionnaires is less than shown above. Calculations were not made per individual health visitor, as a number of health visitors work in more than one LHCC.

Table 1 Health visitor response rate by LHCC

LHCC	Possible returns including long-term sick	Questionnaires to HVs who were long term sick/mat leave	Questionnaires returned	% return overall	% returns excluding long-term sick
1	16	0	16	100.0%	100.0%
2	19	0	10	52.6%	52.6%
3	18	1	11	61.1%	64.7%
4	36	2	30	83.3%	88.2%
5	14	0	4	28.6%	28.6%
6	10	1	7	70.0%	77.8%
7	9	1	6	66.7%	75.0%
8	7	2	4	57.1%	80.0%
9	12	0	9	75.0%	75.0%
10	16	1	11	68.8%	73.3%
11	20	1	10	50.0%	52.6%
12	28	1	7	25.0%	25.9%
13	15	2	12	80.0%	92.3%
14	15	0	6	40.0%	40.0%
15	23	1	17	73.9%	77.3%
16	27	1	20	74.1%	76.9%
	285	14	180	63.2%	66.4%

Respondents length of time in present post

Respondents had been in their present post for between 2 weeks and 28 years, with a median of 5 years – that is, 50% of the health visitors had been in post for less than 5 years.

Returned questionnaires as a sample of Glasgow practice

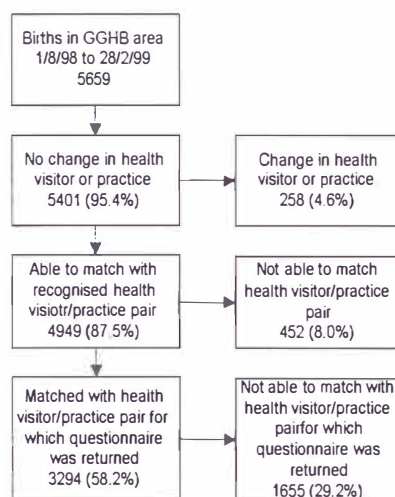
Individual health visitors can be attached to more than one GP practice, and conversely more than one health visitor can work with a single GP practice. It was felt that to ask health visitors to complete the questionnaire more than once, when much of the information would be identical, would be unnecessarily time-consuming, and also introduce error where different answers were given. It was therefore decided to ask health visitors to complete a single questionnaire, but with separate details per practice as necessary, thus minimising the time spent in completion. The questionnaires were then coded as separate entities – so 229 questionnaires were distributed, to 293 health visitor / practice pairs, and a complete return would have resulted in 293 cases being available for analysis. 186 cases were coded, a response rate of 63.5%. This represented 146 of the 229 health visitors, 63.8%.

The purpose of using health visitor / practice pairs was to allow direct matching of data from the Child Health Surveillance Programme, and to allow analysis of breastfeeding outcomes with reference to the various interventions and activities reported by the health visitor, while taking into account the demographic factors known to impact breastfeeding rates.

5659 CHSP records were available for births in the GGHB area (and remaining in the GGHB area through the three CHSP examinations) during the period 1/8/98 to 28/2/99. The start date was chosen because there were known problems with CHSP data prior to this date; the end date because the last record of interest would be taken at 9 months of age, and later births would not allow access to data in time for analysis. 5401 of these had the same health visitor and GP at each of the three examinations.

Using the health visitor / GP practice pairs to whom questionnaires were sent, it was possible to match 4949 of the 5401 possible records – that is 87.5% of the births had identifiable health visitor/GP pairs. Of the 4949 potential matches, 3294 (58.2%) of births had health visitors who had returned questionnaires.

Figure 3 Child Health Surveillance Programme records matched with health visitors



The matching allowed comparison of the caseloads of health visitors who returned questionnaires against those who had not, shown in Table 2. Within the groups of cases whose health visitor had returned a questionnaire or not, figures are given for the number and percentage of valid responses for each characteristic, and the average response. This suggests that the health visitors who returned questionnaires are a fair representation of Glasgow health visitors.

Table 2 Comparison of characteristics of children in the caseload of health visitors who returned questionnaire v health visitors who did not return questionnaire

	Questionnaire not returned (n=1655)			Questionnaire returned (n=3294)			
	Valid responses (%)	Yes	Range or %	Valid responses (%)	Yes	Range or %	
Mother's age in years – mean	1543 (93.2%)	28.27*	14 – 53*	3054 (92.7%)	28.56*	13 – 48*	
Mother in employment	1239 (74.9%)	685	55.3%	2541 (77.1%)	1478	58.2%	
Mother smoker	1330 (80.4%)	447	33.6%	2705 (82.1%)	927	34.3%	
Mother on medication	1175 (71.0%)	469	39.9%	2440 (74.1%)	1107	45.4%	
Significant problems	1030 (62.2%)	231	22.4%	2091 (63.5%)	501	24.0%	
Father's age in years – mean	1298 (78.4%)	30.85*	15 – 59*	2610 (79.2%)	30.98*	11 – 65*	
Father in employment	1253 (75.7%)	1028	82.0%	2530 (76.8%)	2098	82.9%	
Father smoker	1272 (76.9%)	582	45.8%	2646 (80.3%)	1104	41.7%	
Housing problems	Overcrowding	560 (33.8%)	129	23.0%	1322 (40.1%)	267	20.2%
	Heating	495 (29.9%)	39	7.9%	1222 (37.1%)	152	12.4%
	Damp	503 (30.4%)	47	9.3%	1188 (36.1%)	85	7.2%
	Noise	481 (29.1%)	12	2.5%	1175 (35.7%)	68	5.8%
Adult smoking in house	814 (49.2%)	496	60.9%	1819 (55.2%)	1084	59.6%	
Health care issues identified during first visit	Housing and social circumstances	584 (35.3%)	136	23.3%	1424 (43.2%)	313	22.0%
	Parenting skills	585 (35.3%)	155	26.5%	1466 (44.5%)	385	26.3%
	Feeding	598 (36.1%)	206	34.4%	1553 (47.1%)	550	35.4%
	Impairments/abnormalities of infant	515 (31.1%)	30	5.8%	1267 (38.5%)	68	5.4%
	Illness – infant	517 (31.2%)	46	8.9%	1276 (38.7%)	82	6.4%
	Illness – mother or other family member	531 (32.1%)	65	12.2%	1284 (39.0%)	159	12.4%
Carstairs deprivation category – median	1640 (99.1%)	6*	1 – 7*	3245 (98.5%)	6*	1 – 7*	
1 st exam	age at 1st examination – days (median)	1655 (100.0%)	13*	0 – 272*	3294 (100.0%)	13*	0 – 236*
	any breastfeeding at 1st exam	1399 (84.5%)	494	35.3%	2957 (89.8%)	1149	38.9%
	only breastfeeding at 1st exam	1399 (84.5%)	434	31.0%	2957 (89.8%)	1025	34.7%
2 nd exam	age at 2nd examination – days (median)	1564 (94.5%)	50*	13 – 226*	3134 (95.1%)	49*	8 – 187*
	any breastfeeding at 2nd exam	1468 (88.7%)	428	29.2%	2965 (90.0%)	948	32.0%
	only breastfeeding at 2nd exam	1468 (88.7%)	322	21.9%	2965 (90.0%)	697	23.5%
3 rd examination	age at 3rd examination – days (median)	1434 (86.6%)	251*	170 – 464*	2967 (90.1%)	249*	58 – 501*
	ever breastfed (asked at 3rd exam)	1209 (73.1%)	519	42.9%	2658 (80.7%)	1240	46.7%
	breastfeeding at 3rd exam	547 (33.1%)	103	18.8%	1301 (39.5%)	266	20.4%
	age breastfeeding stopped – weeks (mean)	1429 (86.3%)	3.18*	0 – 40*	2958 (89.8%)	3.48*	0 – 44*
Volunteers attached to practice	1652 (99.8%)	436	26.4%	3245 (98.5%)	478	14.7%	
Siblings**	1655 (100.0%)	774	46.8%	3294 (100.0%)	1632	49.5%	

* mean or median and range are given ** Data on siblings may be unreliable: based on information on older children resident in the family from 1st examination.

Results

As stated above, 146 (63.8 %) of the 229 health visitors sent questionnaires responded with data relating to every practice for which they had responsibility. The results which follow relate to those health visitors, except where otherwise stated.

Antenatal contact

Data

Table 3 Type of antenatal contact (n=146)

Contact	Number (%) health visitors	
None	1	(0.7%)
None – midwives do this	18	(12.3%)
Leaflets only	1	(0.7%)
Some	70	(47.9%)
All	47	(32.2%)
Other	4	(2.7%)
No response/don't know	5	(3.3%)

Health visitors were asked about their breastfeeding work with pregnant women. Table 3 shows that practice varies widely in 2000. Of 146 health visitors, 20 (13.7%) had no discussion with pregnant women about breastfeeding, or gave leaflets only, usually because midwives fulfilled this role. Seventy (47.9%) discussed the benefits and/or management of breastfeeding with some pregnant women, and 47 (32.2%) with all pregnant women on their caseload. Ten health visitors who reported discussing breastfeeding with some women commented that the number was small. They only saw pregnant women opportunistically, or if the woman or a family member were on the active caseload. This situation may have been more widespread amongst those who saw 'some' pregnant women.

Health visitors were also asked about their practice in 1998. Of the 115 who had given a valid response in 1998 and 2000, 102 (88.7%) had not changed their practice, 11 (9.6%) had more contact in 2000 than they had in 1998 and two (1.7%) had less contact.

Table 4 Caseload antenatal contact at 21st January 2000 (n=146)

	Number of health visitors reporting		
	Missing or not known	None (0)	Some (>0)
Antenatal women on caseload at 21 January	51 (34.9%)	8 (5.5%)	87 (59.6%)
Discussion of benefits and/or management of breastfeeding up to 21 January	42 (28.8%)	31 (21.2%)	73 (50.0%)
Discussion documented	43 (29.5%)	70 (47.9%)	33 (22.6%)
Leaflets on breastfeeding given up to 21 January	57 (39.0%)	42 (28.8%)	47 (31.2%)
Giving of leaflets documented	48 (32.9%)	86 (58.9%)	12 (8.2%)

Table 4 gives a snapshot of health visitors' antenatal breastfeeding promotion work at one particular point. Ninety five health visitors gave a number of antenatal women on their caseload on 21st January 2000. The range in this number was 0 – 64, with a mean of 23.19. Caseload numbers may need to be viewed with some caution, because of different definitions of the term caseload. Some health visitors may have interpreted it to mean 'actual' caseload, that is patients for whom they held an active case record, whereas some may have answered in relation to their 'potential' caseload, that is all known pregnant women in their practice(s).

Fifty-one health visitors did not respond or did not know the number of pregnant women on their caseload, although a number of these were able to respond on the discussion of breastfeeding or giving of leaflets.

Table 4a describes the documentation of discussion or giving of leaflets relative to the number of health visitors who reported discussing breastfeeding or giving leaflets, regardless of whether they reported a number for women on their caseload.

Table 4a Documentation of discussion of breastfeeding or giving of leaflets for all who reported any discussion of breastfeeding or giving of leaflets

	No response	No documentation	Any documentation
Health visitors who discuss breastfeeding (n=73)	1 (1.4%)	42 (57.5%)	30 (41.1%)
Health visitors who give leaflets (n=47)	1 (2.1%)	35 (74.5%)	11 (23.4%)

Table 5 Number (percentage) of Health Visitors discussing / documenting breastfeeding with a proportion of their caseload at 21st January 2000 (n = 87 health visitors)

	No response	To what proportion of women?			
		None	Some (1 – 49%)	Most (50 – 99%)	All
Benefits and/or management discussed	7 (8.0%)	15 (17.2%)	32 (36.8%)	15 (17.2%)	18 (20.7%)
Discussion documented	9 (10.3%)	49 (56.3%)	25 (28.7%)	3 (3.4%)	1 (1.1%)
Leaflets given	21 (24.1%)	27 (31.0%)	23 (26.4%)	5 (5.7%)	11 (12.6%)
Leaflet giving documented	14 (16.1%)	64 (73.6%)	8 (9.2%)	1 (1.1%)	0 (0%)

Table 5 gives further detail of the proportion of clients with whom antenatal breastfeeding discussion and documentation of discussion had taken place up to 21st January 2000, for the 87 health visitors who reported some antenatal women on their caseload (see Table 4). One health visitor had discussions/gave leaflets to more than the number of women on her caseload: she has been classified as 'All'. Fifteen health visitors (17.2%) had discussed breastfeeding with 0 women, 32 (36.8%) with some, but less than 50% of women, 15 (17.2%) with 50 – 99% of

women, and 18 (20.7%) with all of the women on their caseload. Similarly, one (1.1%) health visitor reported that she documented discussion with all of her caseload, 11 (12.6%) gave leaflets to all of their caseload, and none documented giving of leaflets with all of their caseload.

Discussion

The lack of evidence to suggest the most effective way of promoting breastfeeding has already been referred to. What research there is suggests that interventions which span the antenatal and postnatal period may be more effective in increasing breastfeeding rates, and that small informal discussion classes which emphasise the benefits of breastfeeding and provide practical advice may increase initiation rates. Whether or not continuity of carer also has an impact on rates has not been studied. These findings may have implications for the organisation and content of antenatal breastfeeding work, although further exploration is needed to identify in detail interventions which may be effective. (See Appendix 2)

Ten health visitors said that they lacked time for antenatal breastfeeding promotion. A further 14 health visitors commented further on their antenatal involvement with women. Four of these said that women from their practices obtained breastfeeding information from hospital based breastfeeding workshops. Ten expressed concern that a lack of time or space, not knowing women were pregnant or GP appointments systems prevented antenatal contact.

"Contact with pregnant girls very limited. In the past we were always notified of all new bookings at the maternity hospital but this service has now been discontinued. GP practice no longer runs antenatal clinics, see patients during normal surgery time. We have tried various ways of getting round this problem, without success." (151)

Although the percentage of women with whom health visitors had discussed, or tried to discuss breastfeeding appears low, this figure needs to be viewed with caution. Feeding discussions may have been planned for later in the pregnancy, or midwives may have covered feeding. All three Glasgow maternity units are involved in the Baby Friendly Initiative, which requires that all pregnant women are informed about the benefits and management of breastfeeding. Recent national midwifery guidance also reiterates the need for maternity care staff to provide antenatal education, both as an integral part of clinical care and through classes.²¹ Community facilities seeking Baby Friendly status are required to provide information about breastfeeding only if they provide antenatal care. It is not known what arrangements exist between the various health care professionals involved in Glasgow to ensure that the benefits and management of breastfeeding are covered with all pregnant women, but that excessive duplication is avoided.

The content and style of antenatal discussion may be important too, although it is difficult to know from the limited research, what approach works best. One US study found that both one-to-one and group antenatal breastfeeding sessions for black women, covering the benefits, myths and problems associated with breastfeeding led to an increase in initiation and duration of breastfeeding.²² Hoddinot notes the importance of finding the most effective way of communicating with women about infant feeding, which optimises maternal confidence and well-being. She found that women prefer to receive factual information on infant feeding, with suggestions for action, rather than advice, so that they retain control and responsibility for decision making.²³ A rare account of a health visitor intervention to promote breastfeeding in a low income area in northern England supports this approach.²⁴ The authors describe

approaching breastfeeding in a non-threatening way, encouraging women to discuss their attitudes and being careful to present the problems as well as the advantages of breastfeeding. The Baby Friendly Initiative in the Community implementation guide suggests that leaflets should be given first, with a more detailed discussion for all women later, whether they attend an antenatal class or not.

Table 5 shows that documentation of antenatal interventions was limited with fewer than a quarter of health visitors recording feeding discussions and fewer than 10% recording leaflet distribution. This may in part reflect the lack of an appropriate and agreed place to record antenatal action. Health visitors may open a standard 5 to 65 record for pregnant women, or they may choose not to, since such a record is normally generated for a client with a health problem and there is no special section to record antenatal input. If a 5 to 65 record is not opened, antenatal contacts may be recorded in the GP record, on the patient's computer record, on a special antenatal record devised by individual health visitors, or, most commonly, antenatal breastfeeding discussions may be treated as casual contacts and not recorded at all.

If it is agreed that health visitors have a responsibility for antenatal breastfeeding discussion, it would be helpful for a standard record to be made available, to encourage consistent practice throughout the Trust. Appendix 4 shows the sample checklist devised by the Baby Friendly Initiative.

On the general question of breastfeeding promotion, health visitors commented on low rates of breastfeeding and the need for promotion and incentives to develop a culture of breastfeeding locally.

"Initially we have to increase number of women who start feeding. This requires cultural and political change as well as work with individual women. Eg perhaps women who breastfeed could be given the difference in money between 7 pints of milk and a tin of formula when they redeem tokens for doorstep milk." (15)

"Advice, please, on how to help dads and grannies feel more involved – strong influences." (!33/4)

Postnatal contact

Data

Table 6 Health visitors' postnatal contact with breastfeeding mothers (n = 146)

	Number (%) of health visitors per type of contact	
Contact between 1 st postnatal visit and 6 week check, but less than weekly	45	(30.8%)
Weekly contact, by phone, at clinic, at support group or home visit	38	(26.0%)
Weekly home visits	30	(20.5%)
Available if mothers wish to contact, by phone, at clinic or support group	20	(13.7%)
Variable, depending on need	12	(8.2%)
Unclear/other/no response	4	(2.8%)

Health visitors were asked to describe their postnatal contact with breastfeeding mothers. Table 6 summarises their responses. The intensity of contact varied from weekly visits for 6 weeks, with additional visits in between as necessary, and regular contact after 6 weeks, to being available if mothers wish to make contact after the first postnatal visit. Twenty health visitors mentioned that contact might be more frequent than weekly, especially at first. Eleven said that contact often continued after 6 weeks. Practice had not changed significantly since 1998, when 111 (94.1%) of 118 health visitors giving a valid response to this question gave the same response. Seven (5.9%) health visitors had more postnatal contact with breastfeeding mothers in 2000 and none had reduced contact.

133 of 146 (91.1%) health visitors responded to a request for the number of breastfeeding mothers on their caseload. Nine (6.2%) reported 0 breastfeeding mothers on their caseload, 25% had under 2, 50% had under six, and 75% had less than 12. The highest number reported was 100.

The number of mothers contacting their health visitor during the week 17th to 21st January 2000 varied from one to 50. Health visitors reported they had contacted between one and 20 mothers. The number of lactation histories taken range from one to 10. Twenty five health visitors had taken one lactation history, 15 had taken two. Feeds observed range from one to 10; 30 observed one, 12 observed two.

Table 7 shows the patterns of contact between health visitors and mothers, and lactation histories taken or feeds observed.

Table 7 Postnatal contact at 17th – 21st January 2000 - number of health visitors who reported activity in respect of a given number of women (n=146)

Health visitors who reported:	Number of mothers contacted, making contact, feeds observed or lactation history taken		
	No response	0	1 or more
Mother contacted health visitor	19 (13.0%)	34 (23.3%)	93 (63.7%)
Health visitor contacted mother	22 (15.1%)	32 (21.9%)	92 (63.0%)
Lactation history taken	20 (13.7%)	71 (48.6%)	55 (37.7%)
Feed observed	17 (11.6%)	75 (51.4%)	54 (37.0%)

Since the number of breastfeeding mothers on the caseload varies widely, the proportion of the women on the caseload with whom the health visitor had contact, took a lactation history or observed feeds gives a more meaningful overview of practice. Table 8 includes only those health visitors who reported at least one breastfeeding woman on the caseload.

Table 8 Postnatal contact at 17th – 21st January 2000 - number of health visitors who reported activity in respect of a given proportion of women on their caseload (n=124)

	No response	To what proportion of women?			
		None	Some (1 – 49%)	Most (50 – 99%)	All
Mother contacted health visitor	3 (2.4%)	2 (22.6%)	41 (33.1%)	37 (29.8%)	15 (12.1%)
Health visitor contacted mother	6 (4.8%)	2 (21.0%)	56 (45.2%)	20 (16.1%)	16 (12.9%)
Lactation history taken	6 (4.8%)	6 (51.6%)	36 (29.0%)	10 (8.1%)	8 (6.5%)
Feed observed	4 (3.2%)	6 (54.0%)	37 (29.8%)	11 (8.9%)	5 (4.0%)

Of 124 health visitors who had at least one breastfeeding mother on their caseload, the proportion of breastfeeding mothers to contact them, who they contacted, from whom they took a lactation history or observed a feed was calculated. While 21.0% of the health visitors had contacted none of the women, 51.6% had not taken lactation histories, and 54.0% had not observed feeds. 41.9% of health visitors reported that 50% or more of the mothers had contacted them, while less than 15% reported that they had taken a lactation history or observed feeds for 50% or more of the mothers.

Discussion

As with antenatal contact, there is little evidence about interventions which are successful in improving breastfeeding rates, and very little work looking at consumer responses to interventions (Appendix 2). Most existing research involves introducing a new intervention, such as education about breastfeeding, or additional postnatal visits for problem solving, and comparing its effect on breastfeeding rates with current practice. In a city the size of Glasgow, current practice itself varies enormously, as Tables 6, 7 and 8 show. At one end of the spectrum, health visitors visit mothers at home weekly, or more frequently, for up to six weeks and at the other they are available at the surgery, clinic or support group if mothers wish to make contact. In the absence of research based standards, health visitors devise their own system of contact with breastfeeding women, with frequency of contact depending on the vulnerability of their caseload, and the priority which is given to breastfeeding.

Seven health visitors commented specifically that a lack of time prevented more support work with breastfeeding mothers, and a further 13 commented generally about the lack of time available for breastfeeding work.

“Need for recognition of the amount of time (breastfeeding) mothers need initially, and later re expressing / returning to work. Likewise, with commencing / maintaining support group and building links with voluntary organisations.” (131/2)

There is little evidence about what support mothers would like. What do women expect, and how helpful and accessible do they find support from health professionals? Hoddinott's study provides in-depth information on a group of lower social class women with low educational levels.²⁵ Although mothers in her study knew that help with breastfeeding was available, the majority waited for help to be offered, finding it difficult to initiate contact with people they did not know

well and to admit to having problems. Women who actively sought help were more committed to breastfeeding and more confident. A recent study of satisfaction of 'low-risk' mothers with the health visiting service during the first 9 to 12 months after birth found the overall level of satisfaction with the service to be high. A minority of women wanted more support, particularly in the first few weeks, and were dissatisfied with the lack of appointment systems at clinics, poor punctuality in home visits and inappropriate or inadequate advice.²⁶

Tables 7 and 8 shows that it was not routine for health visitors to observe feeds or take lactation histories. This may be because mothers were experiencing few problems, or because of a lack of time, or of expertise in supporting breastfeeding women. Fifty percent of health visitor respondents had less than 6 breastfeeding mothers on their caseload and it may be difficult for health visitors to develop and retain breastfeeding support skills in this situation.

Two health visitors commented on the need for specialist clinical support for breastfeeding, and one praised the help currently available from hospital midwives.

Resources (leaflets & other materials)

Data

In January 2000, 101 (69.2%) health visitors said that they gave leaflets on infant feeding to pregnant women or new mothers, while 41 (28.1%) did not. Four (2.7%) health visitors did not respond to the question. Eighty six health visitors described the leaflets given.

Table 9 Number of health visitors giving varying numbers of leaflets to mothers (n = 86)

Number of leaflets given	Number (%) of health visitors giving this number of leaflets
1	38 (44.2%)
2	25 (29.1%)
3	16 (18.6%)
4 or more	7 (8.1%)

Forty three different leaflets were mentioned by name; they have been grouped for simplicity in Table 10.

Table 10 Leaflets given to pregnant women and new mothers (n = 86 health visitors)

Leaflet	No (%) of Health Visitors distributing type
HEBS: Breastfeeding - Getting off to a good start	46 (53.5%)
HEBS and Health Promotion Departments: other leaflets	33 (38.4%)
UNICEF: Breastfeeding Your Baby / Feeding Your New Baby	23 (26.7%)
Formula company leaflets	17 (19.8%)
Other commercial company leaflets (National Dairy Council, British Meat)	13 (15.1%)
Other or title / source unclear	13 (15.1%)
HEBS: Breastfeeding - Natural for you, best for your baby	9 (10.5%)
Department of Health: Breastfeeding - You and your baby	9 (10.5%)
Voluntary organisations' leaflets	6 (7.0%)
Commercial company / voluntary organisation joint leaflets	5 (5.8%)
Glasgow Joint Breastfeeding Initiative leaflets	3 (3.5%)

(percentages do not add up to 100 as 55.8% of health visitors give more than 1 leaflet, see table 9)

Further analysis showed that leaflets produced by health departments and UNICEF were most commonly used, by 75 of 86 (87.2%) health visitors, with commercially produced leaflets distributed by 22 of 86 (25.6%) of health visitors.

Slightly more health visitors reported distributing leaflets in 2000 than in 1998. Of 114 health visitors giving valid responses in both years, 98 (86.0%) did the same in both years, 15 (13.2%) gave leaflets in 2000 but had not done so in 1998, one (0.9%) no longer gave leaflets in 2000. This may reflect the greater availability of non-commercial leaflets in 2000.

102 (69.9%) health visitors reported using infant feeding company materials, as shown in Table 11.

Table 11 Health visitors use of infant feeding company materials (n = 146)

Infant Feeding company material	Number (%) of health visitors using
Weight conversion charts	74 (50.7%)
Leaflets / posters on other aspects of child care	62 (42.5%)
Obstetric calendars / age in weeks calculator	54 (37.0%)
Leaflets / posters on milk feeding and weaning	50 (34.2%)
Calendars	50 (34.2%)
Diaries / diary covers	40 (27.4%)
Other items (mainly stationery)	16 (11.0%)

Weight conversion charts were the most frequently used item, followed by leaflets and posters on aspects of child care other than milk feeding and weaning.

Discussion

Seventeen health visitors commented on the need for more resources, or for better support from the Health Promotion Department. Since the questionnaire was completed, the Health Promotion Department has organised the distribution of leaflets and posters for Breastfeeding Awareness Week. It has also surveyed the resource needs of health visitors running breastfeeding support groups and has developed resource packs for them, and for women attending the groups. Evaluation of the resource packs is in progress.

The use of formula company materials is widespread, as Tables 10 and 11 show. Six health visitors said that they used formula company leaflets on weaning but not on milk feeding. Nine mentioned covering formula company logos on items they used, and two of this group said that these items were used because alternative, non-commercial items were unavailable. Two health visitors commented critically on the use of commercial materials:

"The WHO Code is continually being violated in the community. Calendars, pens, diary covers are on display everywhere. Formula company reps meet with staff and bring lunch or scones, leave leaflets and other materials on a regular basis. They attend some clinics, delivering talks to mothers. A policy would help to address this." (29)

The advent of the Baby Friendly Initiative has prompted discussion of the use of commercial materials by health professionals.²⁷ Baby Friendly status cannot be achieved if there is any display or distribution of any promotional material for infant formula, follow-on formula, other breastmilk substitutes, eg baby drinks and age-inappropriate weaning foods, feeding bottles, teats or dummies. This requirement is based on articles 5 and 6 of the International Code of Marketing of Breastmilk Substitutes (WHO Code). Formula company logos are, of themselves, viewed as promotional materials, wherever they appear.²⁸

Interpretation of the Code of Professional Conduct for Health Visitors varies. The Code instructs the health visitor to 'ensure that your registration status is not used in the promotion of commercial products or services,... and ensure that your professional judgement is not influenced by any commercial considerations'.²⁹

The Primary Care Trust is beginning to address this issue as it works towards Baby Friendly Community status. It may be relatively easy for individual practices to meet the requirements of the WHO Code, but in larger units such as a health centre or a LHCC, ongoing discussion, education and persistence may be required to change attitudes and practice in the use of promotional materials. It may be helpful for The Trust to decide what resources health visitors require to work effectively with breast and formula feeding mothers and to provide these from a non-commercial source.³⁰

Breastfeeding support groups

Data

Table 12 Breastfeeding support groups – summary

Venue	Start date	Day	Time	Meeting frequency	Attendance: Mean (min, max)		Number of health visitors reporting
					average	at last meeting	
Baillieston Health Centre	1999	Mon	01:30	Weekly	6 (6, 6)	4 (4, 4)	5
Bishopbriggs, Woodhall Clinic	1995	Fri	10:30	Weekly	9 (8, 11)	8 (8, 8)	5
Blantyre Health Centre	1999	Tue	11:00	Weekly	6 (4, 8)	5 (3, 6)	2
Bridgeton Health Centre	1990	Mon	01:30	Weekly	4 (3, 5)	3 (3, 4)	11
Castlemilk Health Centre	1996	Wed	12:00		4 (4, 4)	2 (2, 2)	1
Courthill Clinic	1996	Wed	10:00		5 (5, 5)	1 (1, 1)	1
Drumchapel Health Centre	1993	Tue	01:30	Weekly	4 (3, 4)	6 (3, 9)	4
Easterhouse Health Centre	1999	Fri	01:00	Weekly	1 (1, 1)		6
Gorbals Health Centre		Mon	01:00		1 (1, 1)	1 (1, 1)	2
Govanhill Health Centre	1997	Thur	12:00	Weekly	7 (7, 7)		6
Hyndland, Northcote Surgery+	1997	Tue	11:00	Weekly	6 (6, 6)	6 (6, 6)	1
Ibrox Library	2000	Tue	11:00	Weekly	7 (7, 7)	7 (7, 7)	3
Kirkintilloch, Boots the Chemist	1998	Tue	10:00	Weekly	8 (7, 10)	8 (6, 11)	8
Lennoxtown Clinic	2000	Thur		Weekly			
Maryhill Health Centre	1998	Wed	11:00	Weekly	6 (5, 7)	4 (4, 4)	3
Millbrae Centre, Mansionhouse Rd*	1999	Wed	01:30	Weekly			6
Milngavie Clinic	1992	Tues	01.30	Weekly	6 (5, 8)	7 (2, 13)	3
Milngavie Clinic	1999	Wed	10.00				
Partick Clinic	1995	Mon	10:30	Weekly	8 (3, 12)	1 (1, 1)	8
Pollok Health Centre	1993	Fri	01:30	Weekly	4 (3, 7)	4 (4, 4)	11
Queen Mother's Hospital*	1995	Thur	01.00	Weekly	29 (18, 35)	24 (24, 24)	13
Rutherglen Maternity Care Centre*	1998	Tue	02:00	Weekly	8 (5, 12)	4 (2, 5)	8
Shettleston Health Centre	1998	Fri	10:00	Weekly	4 (3, 5)	1 (1, 1)	13
Southern General Hospital*	1997	Tues	01.30	Weekly			5
Springburn Health Centre	1997	Thur	01:30	Weekly	1 (1, 1)	1 (1, 1)	10
Townhead Health Centre	1998	Fri	01:30	Weekly	2 (2, 2)	1 (1, 1)	5
Woodside, Grovepark Clinic	2000	Wed	11:00				2

* = group run mainly by midwives at hospital / hospital antenatal clinic

+ = group open only to patients of named practices; all other groups open to all

Table 12 shows the development of breastfeeding support groups in Glasgow in the last five years. In early 2000, health visitors reported 27 breastfeeding support groups, 23 run mainly by health visitors, sometimes with voluntary work or midwife input and four run mainly or exclusively by midwives on hospital premises. In addition, health visitors mentioned three other general postnatal support groups in Pollokshields, Clarkston and Pollokshaws, because these groups also function as breastfeeding support groups. One other group started in Carmyle Medical Centre but now meets in mothers' homes. The lifespan of groups may be limited and some of the groups listed in Table 12 have now closed (October 2000). Other groups may also have started.

All but two of the 27 groups are based in health premises. Twenty three of the groups were reported to meet weekly and it is likely that the other seven groups do likewise but no information was provided. The average number reported to be attending groups was around five, with the range from 0 to 35. Health visitors reported different starting dates for the groups and the most commonly reported date is given in Table 12. Nineteen groups had started since 1997. Health visitors reported a variety of ways of publicising groups. Posters, leaflets and the Health Promotion Department's breastfeeding groups' card are used in health premises and local public places, potential members may be told about the group both antenatally and postnatally by health professionals and breastfeeding volunteers, and groups may be advertised in the press and by word of mouth.

Table 13 Breastfeeding support groups available (n = 146)

Number of Support Groups available	Number (%) of health visitors
0	36 (24.7%)
1	80 (54.8%)
2	28 (19.2%)
5	1 (0.7%)
6	1 (0.7%)

Table 13 shows that over 75% of health visitors have access to one or more support group for their clients, whilst 25% do not.

Thirty one (21.2%) health visitors described a role in a support group, as shown in Table 14. Some health visitors described a role which included more than one category, and so the total exceeds 31.

Table 14 Role of HVs role in breastfeeding support groups (n=31)

Breastfeeding Support Group roles described by Health Visitors	
Advice / guidance / answer questions / problem solve	16 (51.6%)
Facilitate / run the group / leader	15 (48.4%)
Support / encouragement	12 (38.7%)
Other (encourage contact with voluntary groups; promote group (2), health education, monitor infant's health)	4 (12.9%)
Encourage social aspects / self help	2 (6.5%)

Discussion

The increase in breastfeeding support groups in Glasgow reflects a similar trend in Scotland as a whole, where the number of groups increased from four in 1992 to around 150 in 2000.³¹

Five health visitors referred to the need for a local breastfeeding support group, although two of them indicated that a local group might not be viable. Seven health visitors commented on the lack of suitable accommodation for support groups and a further 12 mentioned the lack of space to support breastfeeding mothers in general. Resources for existing groups were seen as a problem for four health visitors: two needed a creche for older children, two needed funds for refreshments and equipment. A forthcoming report from the GGHB Health Promotion Department on resource needs for breastfeeding support groups will give more information on this issue.³²

Table 14, describing how health visitors see their role in the group, suggests that there are different views about the purpose of the groups. The majority of health visitors see their role as providing advice and problem solving, but others emphasise support and encouragement, or facilitating social support and self help.

Four health visitors commented specifically on the success of the support group.

"Support Group has worked well recently – mothers enjoy the support of fellow breastfeeders". (72)

Attendance at groups varies considerably, often reflecting the breastfeeding rates locally. Seven health visitors commented on low attendance and the need for colleagues to promote the group to their clients.

"Breastfeeding support group not well attended, but from the comments they make, mothers prefer one-to-one support rather than a group, or feel they don't need a group in the health centre when they are managing well at home with appropriate support." (179/80)

As yet, there is no research on mothers' views of support groups, or of the effectiveness of such groups in meeting their aims. Whilst the long term aim for most groups is likely to be increasing the duration of breastfeeding, it is not known whether other objectives have also been set. Local audit in Bishopbriggs has shown the introduction of a breastfeeding support group in early 1996 to be associated with an increase in breastfeeding duration at the 6 week postnatal examination from 29% in 1993 to 62% in 1996/7.³³ A similar audit in a large Shettleston practice showed the potential for improving breastfeeding rates with the appointment of a breastfeeding promotion specialist.³⁴ However other changes in practice to promote and support breastfeeding took place at the same time as support groups were developed, and it is difficult to assess the impact of the support group alone. Given the increased number of groups, and resources devoted to them, further evaluation of their impact is needed.

Breastfeeding at the practice / clinic

Data

Table 15 Health visitors reporting availability of private place for breastfeeding at the practice / clinic (n = 146)

	Yes	No	Missing/don't know
Is a private breastfeeding room available in the surgery? (n=146)	57 (39.0%)	78 (53.4%)	11 (7.5%)
Date opened given (n=57)	33 (57.9%)		24 (42.1%)
If no room, are mothers told staff will try to find private place? (n=78)	68 (81.8%)	7 (9.0%)	3 (3.8%)
Is private breastfeeding room available at clinic? (n = 146)	55 (37.7%)	22 (15.1%)	69 (47.3%)

Health visitors were asked if there was a room where mothers could feed in private at the practice. Fifty seven (39.0%) reported their practices having such a facility. In some practices these were dedicated rooms, in others, a room such as a consulting room could be made available. Some of the dedicated rooms were in health centres, or an adjacent clinic, and served a number of practices. Fifty five (37.7%) clinic based health visitors reported that there was a room available for private breastfeeding at the clinic.

Table 16 Health visitors reporting staff response to public breastfeeding at practice / clinic (n = 146)

	Yes, all	Yes, some	No	Missing/don't know
Practice staff response positive?	63 (43.2%)	39 (26.7%)	2 (1.4%)	42 (28.8%)
Clinic staff response positive?	31 (21.2%)	29 (19.9%)	1 (0.7%)	85 (58.2%)

Table 16 shows that 63 (43.2%) health visitors thought all practice staff would respond positively to mothers breastfeeding in a public area such as the waiting area. In clinics the percentage was lower, at 21.2%.

Appendix 5 gives further details of facilities for breastfeeding and staff responses by practice.

Discussion

Research studies consistently report that many women prefer to breastfeed in privacy, particularly younger mothers from lower social classes.^{35, 36, 37} If breastfeeding is to be encouraged, it is important to have clearly signed private facilities available in public places visited by mothers, such as health centres and surgeries. Table 15 shows that a minority of surgeries and health centres in Glasgow had facilities available for private breastfeeding, either dedicated rooms, or rooms which could be made available on request. Seven health visitors said that there were no facilities for private breastfeeding at their surgery or health centre, often because space was a problem.

“ The health centre is a disgrace – very run down and uninviting and nowhere for baby changing or breastfeeding”. (60)

Some women are happy, and sufficiently confident, to feed in public. However Table 16 shows that fewer than half of health visitors thought all staff in the practice would respond positively if mothers breastfeed in public areas such as the waiting area. Less than a quarter of clinic based health visitors felt that all staff would respond positively. The high proportion of health visitors who did not know, or did not respond to question suggests that this matter may not have been discussed within the practice. Education for practice and clinic staff may be needed to improve this situation.

The Baby Friendly Initiative requires that a private place for breastfeeding should be made available to mothers who would like it, and that breastfeeding in public areas should also be welcomed.³⁸ Glasgow Joint Breastfeeding Initiative has produced guidelines on the provision of private breastfeeding facilities, as has the Nursing Mothers' Association of Australia.^{39, 40}

Breastfeeding policies and standards

Data

Table 17 Health visitors reporting practices /LHCCs having breastfeeding policies, standards or Baby Friendly Initiative Certificate of Commitment (n = 146)

	Yes	No	Missing / don't know
Practice policy	7 (4.8%)	134 (91.8%)	5 (3.4%)
Practice protocol	6 (4.1%)	135 (92.5%)	5 (3.4%)
LHCC policy	18 (12.3%)	82 (56.2%)	46 (31.5%)
Applied for BFI Certificate of Commitment	2 (1.4%)	135 (92.5%)	9 (6.2%)

Table 17 shows that less than 5% of health visitors were in practices with a breastfeeding policy or protocol, or which had applied for a Certificate of Commitment for the Baby Friendly in the Community award. Less than 15% of health visitors stated that their LHCC had a breastfeeding policy. This ranged from 0 for 7 of the 16 LHCCs, to 43%. Appendix 5 shows this information by practice.

Discussion

Very few GP practices or LHCCs have a written breastfeeding policy or protocol. Those with a policy have or had health visitors in post with a particular interest in breastfeeding, or have employed a dedicated member of staff to promote breastfeeding. One health visitor reported that she was Breastfeeding Adviser to her LHCC. Seven health visitors said that there was a lack of management support for breastfeeding, or that policies and protocols were lacking.

"Would appreciate more support from Management and other health professionals when trying to provide a service for breastfeeding mothers." (150)

The Primary Care Trust is currently developing a breastfeeding policy. It is possible that this policy will be the blueprint for all LHCCs, but that some may want to modify the policy slightly to take account of local circumstances. Similarly, there may be a need for protocols or other guidance for health visitors in their promotional and clinical work on breastfeeding. The development of policies and clinical guidelines is part of the concept of clinical governance now central to the NHS.^{41, 42} The first requirement of the Baby Friendly Initiative in the Community is that facilities should have a written breastfeeding policy, setting out aims, principles and standards. Guidelines for the management of the more common breastfeeding complications, such as mastitis, poor weight gain, trauma to nipples, mother taking medication and baby separated from mother are also suggested.⁴³

Breastfeeding data

Data

Of the 146 health visitor respondents, 66 (45.2%) reported that they record rates of breastfeeding initiation, whilst 46 (31.5%) record breastfeeding duration.

Discussion

Although health visitors collect data on feeding from their clients for the SIRS record, and on the first three child health surveillance records, they receive no routine feedback when this data has been collated. A small number collect other data themselves, either compiling special forms for routine use or doing one-off audit. Detailed practice breastfeeding figures are needed to meet Baby Friendly requirements.⁴⁴

One of the objectives of the study of which this survey is a part is to improve the routine dissemination of breastfeeding data to practitioners, to allow them to evaluate the impact of any intervention to support breastfeeding. This issue is also being addressed at national level by a Breastfeeding Statistics Group convened by the Scottish Breastfeeding Group.⁴⁵

Training

Data

Table 18 Health visitor training on breastfeeding, 1998 and 1999 (n = 146)

		1999						
		GGHB	Trainer	½ day	BEST	Other	None	Total
1998	GGHB	1 (0.7%)	3 (2.1%)	4 (2.7%)	0	0	15 (10.3%)	23 (15.8%)
	Trainer	0	0	0	0	0	0	0
	½ day	0	0	0	0	0	1 (0.7%)	1 (0.7%)
	BEST	7 (4.8%)	0	0	0	0	16 (11.0%)	23 (15.8%)
	Other	1 (0.7%)	1 (0.7%)	0	0	2 (1.4%)	2 (1.4%)	6 (4.1%)
	None	33 (22.6%)	3 (2.1%)	1 (0.7%)	0	2 (1.4%)	54 (37.0%)	93 (63.7%)
	Total	42 (28.8%)	7 (4.8%)	5 (3.4%)	0	4 (2.7%)	88 (60.3%)	146 (100%)

Key to Table 18

GGHB: GGHB Breastfeeding Strategy Training: 2 days plus mentoring

Trainer: Training as Trainer or Mentor

½ day: Annual ½ day Breastfeeding update for HV's in QMH catchment area

BEST: BEST 2 day workshops: training in association with Breastfeeding Initiative

Table 18 shows 92 (63.0%) respondents reported receiving breastfeeding training in 1998 or 1999. Of these, 80 (54.8%) had attended a course lasting two days or more, 64 (43.9%) attending the GGHB Breastfeeding Strategy Training and 23 (15.8%) the BEST training used in the east and south east of Glasgow by the Breastfeeding Initiative.⁴⁶ Eight (5.5%) had attended a course lasting 2 days or more in both years.

Discussion

All health visitors are due to receive the Breastfeeding Strategy Training as soon as resources permit. The training is based on the UNICEF UK Baby Friendly Initiative Course in Breastfeeding Management, adapted for local use.⁴⁷ The two day theoretical training is intended for multidisciplinary groups of staff, including qualified and student midwives, health visitors and doctors, lay breastfeeding workers, sick children's nurses and dieticians, the aim being to develop consistency of practice. Two health visitors commented on the need for better collaborative working between health professionals, and between professionals and volunteers, which may also be aided by joint training. The course covers the importance of breastfeeding, normal breastfeeding, interpersonal skills and problem solving, breastfeeding babies with special needs and the Baby Friendly Initiative and WHO Code of marketing of breastmilk substitutes. This is followed by practical work exploring attitudes and skills, under the supervision of a mentor.

In January 2000, the Primary Care Trust reported four sessional health visitor trainers in post, working with eight midwife trainers to deliver the two day training course. The Trust also reported 14 health visitors working as mentors, increasing to 16 in March 2000. By contrast, seven of those responding to the survey said they were breastfeeding trainers and 17 said they were mentors, suggesting slight confusion amongst health visitors as to the meaning of the terms trainer and mentor within the Trust.

So far, the main evaluation of training has been through hospital audit of practice, for example in the use of supplementary feeds, early skin to skin contact and rooming-in. There has also been indirect evaluation through the Area Perinatal Effectiveness Committee's Glasgow Feeding Audit, which seeks information from mothers on their feeding experiences up to 10 days. A further sample audit of training is in progress to determine knowledge of breastfeeding and its management, as well as views about the quality of the training and its effectiveness. Only the last of these audits health visitor training. Further evaluation of the training process, and its impact on health visitors, is needed. A recent review of evidence for the effectiveness of interventions to increase breastfeeding found very limited evidence for the effectiveness of breastfeeding training for health professionals.⁴⁸ However, little evaluation has yet taken place of the Baby Friendly Initiative Course in Breastfeeding Management, or other courses based on this course. One recent evaluation of midwifery skills acquisition following the WHO/UNICEF 20 hour Breastfeeding Management course found that support skills were significantly improved two weeks after the course.⁴⁹

Eighteen health visitors commented on the need for more training, or training resources, and a further two said that the new training needed to be tailored to the needs of community staff and less hospital based.

"Lack of money and support going into training – it seems to be stalling when we should be trying to get as many through as possible." (171)

"We should be able to access further information and update our skills more readily." (79)

"Breastfeeding training was very hospital oriented and long-term problems were not discussed." (71)

"My confidence in breastfeeding could be better if given the opportunity for training." (28).

Only 14 health visitors, 9.6% of all respondents reported that other staff in their practice(s) had received any breastfeeding training. Five (3.4%) reported GPs attending a breastfeeding seminar and 9 (6.2%) reported training for staff nurses, practice nurses, district nurses or receptionists. It is possible that the number of other staff having received training is under-reported, but as the person with most responsibility for breastfeeding, it is likely that the health visitor would know of training undertaken by colleagues. Information on training for other staff is shown by practice in Appendix 5.

The Baby Friendly Initiative requires that all primary care staff who have contact with breastfeeding mothers must be trained to a level appropriate to their role.⁵⁰ In their comments, 12 health visitors supported this view, mentioning particularly the need for GPs to be trained.

"It may be beneficial for reception staff, GPs, and practice nurse to attend breastfeeding workshops so everyone is giving the same advice / support and information..... At the end of the day client believes the doctor. Attitudes of staff require to be explored as part of training." (59)

Other breastfeeding resources

Data

Table 19 Health visitors reporting other breastfeeding resources (n = 146)

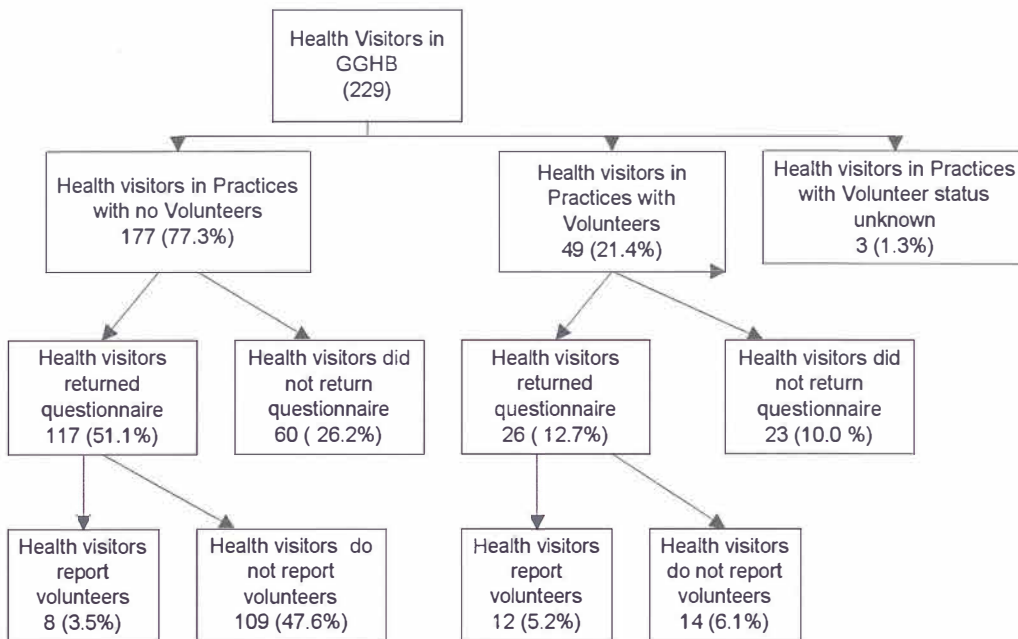
Volunteers from the Breastfeeding Initiative	20	(13.7%)
Support from other national breastfeeding organisations eg BfN, LLL, NCT	8	(5.5%)
Financial support from practice or LHCC	3	(2.1%)

Thirty one (21.2%) of health visitors reported other support for breastfeeding in the practice. Three types of support were mentioned: volunteers from the Primary Care Trust's Breastfeeding Initiative, support from lay workers from the Breastfeeding Network, the La Leche League or the National Childbirth Trust, and financial support.

The Primary Care Trust's Breastfeeding Initiative was operational in practices in the east and south east of Glasgow at the time of the survey, and was being introduced in Greater Pollok and Possilpark. There was an expectation that Health visitors would mention Breastfeeding Initiative Volunteers where they were available, and the opportunity was taken to compare responses with the distribution of Volunteers. As the implementation of Volunteers in the east and south east of Glasgow has been by practice, it was possible to obtain from the Initiative a current list of which

practices have Volunteers. This information suggested that 26 health visitors respondents would be able to mention Volunteers; 12 did so. A further 8 health visitors who were not expected to refer to the availability Volunteers did so. Five were from an area where the Initiative was being introduced. The remaining three may be making use of the Initiative despite their practices being outwith the Volunteer areas.

Figure 4 Health visitors reporting of Breastfeeding Initiative Volunteers



64 (43.8%) health visitors reported that they gave breastfeeding mothers information on lay groups providing breastfeeding support in 2000, 41 (34.2%) in 1998. By contrast, only eight (5.5%) health visitors reported lay support from national breastfeeding organisations as an additional resource available to their clients. Of the 64, 30 (46.9%) gave written information about the Association of Breastfeeding Mothers, The Breastfeeding Network, La Leche League or the National Childbirth Trust, either nationally or locally. The most commonly used information source was the GGHB Health Promotion Department card with details of breastfeeding support, mentioned by 19 (13.0%) health visitors. Four (6.3%) health visitors reported that they write information about lay support in the hand-held record, but did not specify what was written. Twenty six (40.6%) did not describe what information they provide.

Only three (2.1%) health visitors reported special funding for breastfeeding work in their practice. One reported that money received for a breastfeeding audit had been spent; another that GPs provide money for breastfeeding books and tea and coffee. A third noted that the LHCC provides some funding.

Appendix 5 shows other breastfeeding resources by practice.

Discussion

The aims and objectives of the Breastfeeding Initiative are described in Appendix 6. Evaluation of the Breastfeeding Initiative is due to start soon, and this will provide more information about progress in meeting these aims and objectives, as well on health professional views of the scheme. Research on peer support in the UK has so far been limited and its effects are unclear. Initial work in Easterhouse showed a significant effect on initiation rates, and a small, but statistically non-significant effect on the duration of breastfeeding.⁵¹ The outcome of an application for funding for a multi centre trial of peer support in the UK is awaited.⁵²

Five health visitors commented that more volunteer breastfeeding support would be useful, and two commented positively on existing volunteer support.

"The breastfeeding volunteers complement professionals, and they work together to increase breastfeeding." (86)

Conclusions

This survey has summarised the responses from a representative sample of Glasgow health visitors on their breastfeeding work. It shows considerable variation in practice both antenatally and postnatally, reflecting the general lack of policy and guidelines for breastfeeding work.

The next part of this study will relate interventions to support breastfeeding to breastfeeding rates in Glasgow, and may indicate which interventions have an impact on breastfeeding rates. However further in depth work is required to evaluate the process and impact of the interventions described in outline here, as well as their impact on breastfeeding rates. In particular, it will be important to look at the implementation, reach, acceptability and quality of specific interventions, as well as their impact on cultural attitudes and acceptability of breastfeeding.

Appendix 1

Aims and objectives of main study

Aim

To establish which of the present interventions to promote breastfeeding being used in Glasgow are effective at improving rates of breastfeeding initiation and duration as captured by routinely collected data.

Objectives

- To describe interventions to promote and support breastfeeding in the primary care setting in Glasgow in 1998 and 1999.
- To use routinely collected data on breastfeeding initiation and duration to assess the effectiveness of these intervention on breastfeeding rates
- To assess if attitude towards breastfeeding correlates with breastfeeding outcome in Scotland.
- To promote effective strategies.

Appendix 2

Research on barriers to breastfeeding and interventions to promote and support breastfeeding

There have been four recent literature reviews on these issues. These are summarised below.

1. **Reid M, Adamson H. Opportunities for and barriers to good nutritional health in women of childbearing age, pregnant women, infants under 1 and children aged 1 to 5.**

London, Health Education Authority, 1997.³⁶

Includes

- Studies in the topic area of women of childbearing age, pregnant women and infants/ children up to 5 published between 1980 and 1996 inclusive.
- All English language (or with full English abstract) studies carried out in the UK, North America, Australia and Europe.
- Quantitative and qualitative research meeting minimum methodological criteria.

Excludes:

- intervention studies – covered in the complementary study by Tedstone A et al. below.

Main findings

- Research literature on breastfeeding is mainly quantitative: women's experiences and problems rarely articulated.
- Much of the literature does not provide evidence to facilitate an improvement in breastfeeding rates.
- Hospital practices and staff attitudes are important influences.
- Barriers to successful breastfeeding more likely to be cultural than practical, although women still report practical problems in establishing and maintaining breastfeeding.
- Interventions might be designed to change negative views about breastfeeding in public.

2. **Tedstone A , Dunce N, Aviles M, Shetty P, Daniels L. Effectiveness of interventions to promote healthy feeding in infants under one year of age: a review.** London: Health Education Authority, 1998.⁵³

Includes

- All studies published in English between 1984 and 1996 inclusive from Western industrialised countries.
- Studies covering healthy eating promotion of infants of 0 to 1, covering parents of this group before and after birth, health professionals and other carers.
- Methodological framework based on guidelines from the NHS Centre for Reviews and Dissemination. Includes studies with an evaluation of outcome with experimental or quasi-experimental design, including randomised and non-randomised controlled trials, prospective cohort studies with current controls, intervention studies with historical control group or retrospective controlled studies.

Main findings

- 20 studies included, 5 from the UK.
- In the majority, interpretation of the impact of the intervention was hampered by the poor quality of the research design, and failure to fully report the methodology.
- In the UK, there is currently insufficient evidence to predict the design of successful programmes to promote breastfeeding. Research is recommended to assess the

effectiveness of different programmes in different settings. There is a need to identify issues important to mothers and their partners.

- Bearing in mind the provisos above, the review suggests that:
- The *most successful* breastfeeding promotions were based in the USA and in general were long term, spanning the pre and postnatal period, involving multiple contact with a professional or peer counsellor.
- The *least successful* breastfeeding promotions were implemented in the postnatal period only, or in countries other than the USA, involved breastfeeding as one of a number of health promotion issues, special visits to a hospital or clinic in addition to routine visits, or postnatal support provided by telephone only.
- Breastfeeding promotion and evaluation research in the UK should focus on:
 - Assessing the breastfeeding needs of pregnant and breastfeeding mothers,
 - Targeting groups with the lowest breastfeeding initiation rates,
 - Helping women who initiate breastfeeding to sustain breastfeeding,
 - Evaluating the potential role of the midwife and health visitor in breastfeeding promotion,
 - Developing effective breastfeeding training programmes for midwives, health visitors, and other professionals in a position to encourage and support breastfeeding,
 - Evaluating the effect of hospital and community services policy changes related to breastfeeding,
 - Facilitating voluntary sector and peer-support initiatives, and
 - Investigating the relevance of including women prior to pregnancy and partners in interventions.

3. **Sikorski J, Renfrew MJ. Support for breastfeeding mothers** (Cochrane Review). In: The Cochrane Library, Issue 1, 1999. Oxford: Update Software.⁵⁴

Includes

- Studies published between 1980 and March 1998 inclusive, in all languages and from all countries.
- Studies covering support offered to women intending to breastfeed or initiating breastfeeding which is supplementary to standard care and intended to facilitate continued breastfeeding.
- Randomised or quasi randomised controlled trials, with or without blinding.

Main findings

- 13 trials were included, two from the UK.
- As with Tedstone et al, caution is urged in interpreting the results of pooled data from the studies, because of methodological flaws and because of the diversity of interventions.
- As in Reid and Adamson's review, further qualitative research and pragmatic trials are recommended so that clearer recommendations on the most effective forms of support can be given.
- The provision of extra support by professionals appears to result in more mothers breastfeeding for 2 months, and more mothers breastfeeding exclusively for 2 months. One more mother will breastfeed for 2 months if support is provided to nine women. One more mother will breastfeed exclusively for 2 months if support is given to nine women.
- Studies reporting mainly face-to-face interventions showed a benefit, whilst those using mainly telephone contact failed to do so.
- There may be a small advantage in including antenatal element to support.

- No conclusions could be reached about the effectiveness of volunteer support because of the lack of research, although three studies in progress were reported.

4. Fairbank L, O'Meara S, Woolridge M, et al. Promoting the initiation of breastfeeding. A systematic review to evaluate the effectiveness of interventions to promote the initiation of breastfeeding. Health Technology Assessment, 2000 (forthcoming).⁴⁸

Includes

- All studies published up to April 2000, in any languages and from any country.
- Any type of intervention designed to promote the initiation of breastfeeding.
- Review carried out according to NHS Centre for Reviews and Dissemination guidelines.⁵⁵ Includes interventions based on randomised controlled trials (RCTs) or non-randomised controlled trials (non-RCTs), and some using before-after studies when no evidence from RCTs and/or non-RCTs.

Main findings

- 59 studies reviewed.
- Difficulty in trying to assess the relative effect of interventions noted, because of the range of different interventions, study designs and study populations, as well as the poor quality of some studies.
- The need to investigate the acceptability of interventions to women was noted.
- Some evidence from 10 RCTs that *health education interventions* using small, informal discussion classes, emphasising the benefits of breastfeeding and practical advice can increase initiation rates. Literature alone appears to have little impact.
- Six out of nine studies of *health sector initiatives* found a significant impact on outcomes (breastfeeding rates, health professionals' knowledge and skills, number of Baby Friendly steps implemented), but methodological problems were noted with three of the six successful interventions. A further six trials of *WIC* (US Department of Agriculture Special Supplemental Nutrition Programme for Women, Infants and Children) programmes to promote breastfeeding suggested they could be effective in increasing breastfeeding initiation rates, especially if there was a peer support component.
- 2 further studies of *Peer support programmes* showed significant impacts on breastfeeding rates.
- Two studies of *media campaigns* suggested local campaigns might influence attitudes to breastfeeding or breastfeeding rates, but the lack of control groups made it difficult to attribute effects to the intervention.
- *Multifaceted interventions* had designs which made it difficult to draw conclusions about effectiveness.

Appendix 3

Study questionnaire. (Attached)

Appendix 4

Sample checklist devised by the Baby Friendly Initiative. (Attached)

Appendix 5

Results by Practice

The information from GGHB on health visitors and doctors referred to 216 separate GP practices. The questionnaires returned by health visitors gave no data for 65 (30.1%) practices, data from all of the health visitors attached to the practice for 126 (58.3%) practices, and data from some of the health visitors attached to the practice for the remaining 25 (11.6%) practices.

Certain questions in the questionnaire were intended to discover what facilities and resources were available within the practice. These results have already been presented within the paper by health visitor. Appendix 5 consists of the equivalent results by practice for the 151 (69.9%) practices where questionnaires were returned by any of the attached health visitors.

Breastfeeding at the surgery / health centre / clinic

Table 1 Practices where health visitors reported availability of private place for breastfeeding at the practice / clinic (n = 151)

	Yes	No	Missing/don't know
Is a private breastfeeding room available in the surgery? (n=151)	51 (33.8%)	90 (59.6%)	10 (6.6%)
Date opened given (n=51)	29 (56.9%)		22 (43.1%)
If no room, are mothers told staff will try to find private place? (n=90)	61 (67.8%)	11 (12.2%)	18 (20.0%)
Is private breastfeeding room available at clinic? (n = 151)	67 (44.4%)	28 (18.5%)	56 (37.1%)

Health visitors were asked if there was a room where mothers could feed in private at the practice. Health visitors from 51 (33.8%) practices reported the practice having such a facility. In some practices these were dedicated rooms, in others, a room such as a consulting room could be made available. Some of the dedicated rooms were in health centres, or an adjacent clinic, and served a number of practices. Health visitors from 67 (44.4%) of practices reported that there was a room available for private breastfeeding at the clinic.

Table 2 Practices where health visitors reported staff response to public breastfeeding at practice / clinic (n = 151)

	Yes, all	Yes, some	No	Missing/don't know
Practice staff response positive?	68 (45.0%)	41 (27.2%)	4 (2.6%)	38 (25.2%)
Clinic staff response positive?	34 (22.5%)	46 (30.5%)	1 (0.7%)	70 (46.4%)

Health visitors in 68 (45.0%) practices thought all practice staff would respond positively to mothers breastfeeding in a public area such as the waiting area. In clinics the number was lower, at 34 (22.5%).

Breastfeeding policies and standards

Table 3 Practices where health visitors reported policies and protocols

	Number (%) of practices where any health visitors responded: (n=151)		
	Yes	No	Missing/ don't know
Practice policy	5 (3.3%)	141 (93.4%)	5 (3.3%)
Practice protocol	4 (2.6%)	141 (93.4%)	6 (4.0%)
LHCC policy	25 (16.6%)	86 (57.0%)	40 (26.5%)
Applied for BFI Certificate of Commitment	2 (1.3%)	141 (93.4%)	8 (5.3%)

Table 3 shows that less than 8% of practices have a breastfeeding policy or protocol, or have applied for a Certificate of Commitment for the Baby Friendly in the Community award.

Health visitors from 25 (16.6%) of practices stated that their LHCC had a BF policy.

Training

Health visitors from 14 (9.3%) practices of the 151 where any health visitors responded reported that other members of the primary care team had received any breastfeeding training. In five (3.3%) of practices GPs were reported to have attended a breastfeeding seminar and in 9 (6.0%) practices training for staff nurses, practice nurses, district nurses or receptionists was reported. It is possible that the number of other staff having received training is under-reported, but as the person with most responsibility for breastfeeding, it is likely that the health visitor would know of training undertaken by colleagues. It is also unlikely that many more have been trained, given the limited training opportunities.

Other breastfeeding resources

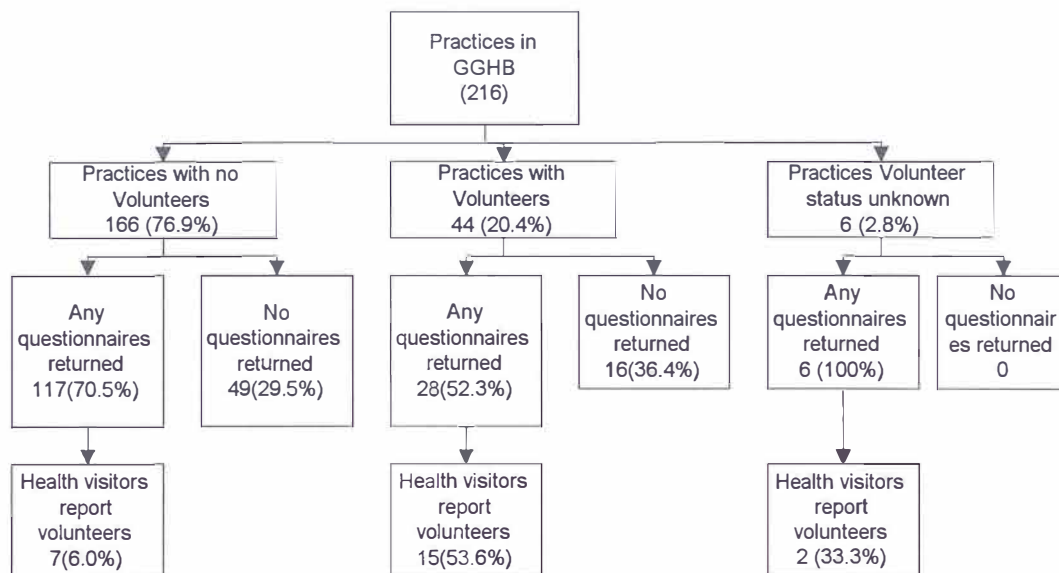
Table 4 Number of practices where health visitors reporting other breastfeeding resources (n = 151)

Volunteers from the Breastfeeding Initiative	24	(15.9%)
Support from other national breastfeeding organisations eg BfN, LLL, NCT	9	(6.0%)
Financial support from practice or LHCC	3	(2.0%)

Health visitors in 39 (25.8%) practices reported other support for breastfeeding in the practice. Three types of support were mentioned: volunteers from the Primary Care Trust's Breastfeeding

Initiative, support from lay workers from the Breastfeeding Network, the La Leche League or the National Childbirth Trust, and financial support.

Figure 1 Practices with Breastfeeding Initiative Volunteers



The Primary Care Trust's Breastfeeding Initiative was operational in practices in the east and south east of Glasgow at the time of the survey, and was being introduced into the Greater Pollok and Possilpark areas. The Initiative's aims and objectives are described in Appendix 6. As the implementation of Volunteers has been by practice, it was possible to obtain from the Initiative a current list of which practices have Volunteers. There was an expectation that health visitors would mention Breastfeeding Initiative Volunteers where they were available, and the opportunity was taken to compare responses with the distribution of Volunteers. Health visitors in 24 (15.9%) of the 151 practices mentioned Volunteers; while information from the Initiative suggested 28 (18.6%) of the 151 practices had Volunteers. Health visitors at 7 practices which were not believed to be part of the Initiative referred to Volunteers. Of the 28 practices who offered this service, and for which information was available from returned questionnaires, health visitors at 13 (46.4%) practices mentioned it. Whether health visitors at the remainder of practices were unaware of the service, or did not think to mention it is not known.

Health visitors at 66 (43.7%) practices reported that they gave information on lay groups providing breastfeeding support in 2000, 55 (36.4%) in 1998. By contrast health visitors from only 9 (6.0%) of practices reported lay support from national breastfeeding organisations as an additional resource for their clients. Of the 66, 40 (60.6%) give written information about the Association of Breastfeeding Mothers, The Breastfeeding Network, La Leche League or the National Childbirth Trust, either nationally or locally. The most commonly used information source was the GGHB Health Promotion Department card with details of breastfeeding support, mentioned at 18 (27.3%) of the 66 practices. 26 (39.4%) of the 66 practices did not describe what information they provide.

Appendix 6

Greater Glasgow Primary Care NHS Trust Breastfeeding Initiative

Aim

To contribute to an increase in the rate of breastfeeding to six weeks and beyond in each of the participating localities.

Objectives

1. To liaise with the Health Promotion Department in providing appropriate education for locality personnel involved with this Initiative
2. To recruit lay volunteers to the Initiative and provide education and ongoing support for them.
3. To identify antenatal women who would be willing to participate in the Initiative
4. To facilitate the building of a supportive relationship between the lay volunteers, the antenatal women and their families.
5. To monitor the effect of this relationship on the pattern of breastfeeding in each participating locality.

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