A review of the

Northern Ireland breastfeeding strategy

HSC Public Health Agency

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During the course of this consultation, restructuring of the health service arising from the Review of Public Administration (RPA) saw the Health and Social Care (HSC) Board replace the four Health and Social Services (HSS) Boards, and the HSS Trusts consolidated into six HSC Trusts (including the Northern Ireland Ambulance Service Trust). In addition, the Health Promotion Agency (HPA) became part of the new Public Health Agency (PHA). Our language reflects this restructuring as well as the language used in the strategy itself, which was implemented in the legacy set-up.

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Contents Page

Acronyms and abbreviations ... 4

Executive summary ... 6

Introduction ... 13

Method ... 14

Action point 1: Coordinating activities ... 16

Action point 2: Commissioning services ... 30

Action point 3: Collecting regional information ... 39

Action point 4: Focusing research ... 46

Action point 5: Training health professionals ... 54

Action point 6: Supporting special needs infants and their mothers .. 61

Action point 7: Raising public awareness ... 66

Action point 8: Limiting promotion of artificial milks ... 80

Action point 9: Legislative change ... 85

Health professionals’ overview and future vision ... 90

References ... 95

Appendix 1: Methods ... 97

Appendix 2: Action point 1 ... 100

Appendx 3: Action point 4 ... 105

Appendix 4: Action point 7 ... 110

Acronyms and abbreviations

ABM	Association of Breastfeeding Mothers
ALCI	Association of Lactation Consultants Ireland
AP	Action point
BF	Breastfeeding
BFI	Baby Friendly Initiative
BHSCT	Belfast Health and Social Care Trust
BMIMS	Breastfeeding Motivational Instructional Measurement Scale
BSIG	Breastfeeding strategy implementation group
CCEA	Council for the Curriculum, Examinations and Assessment
CD	Compact disc
CHIP	Centre for Health, Intervention and Prevention
CHS	Child Health System
CHS IM	Child Health System information manager
COSLA	Convention of Scottish Local Authorities
CSP	Children's Services Planning (also monitors breastfeeding rates in Sure Start areas with information received from CHS)
DEL	Department for Employment and Learning
DH	Department of Health (England)
DHFETE	UK Department of Higher and Further Education Training and Employment
DHSS	Department of Health and Social Services
DHSSPS	Department of Health, Social Services and Public Safety
DVD	Digital video disc
EC	European Commission
EHSSB	Eastern Health and Social Services Board
EU	European Union
FSA	Food Standards Agency
GB	Great Britain
GP	General practitioner
HAZ	Health Action Zone
HPA	Health Promotion Agency
HR	Human Resources
HPSS	Health and Personal Social Services
HSC	Health and Social Care
HSCT	Health and Social Care Trust
HSS	Health and Social Services
HSSB	Health and Social Services Board
HSWB	Health and Social Wellbeing Survey
HV	Health visitor
IBLCE	International Board Lactation Consultants Examiners
IfH	Investing for Health
IFS	Infant Feeding Survey
IgA	Immunoglobin A
ILCA	International Lactation Consultants Association

IT	Information Technology
KQI	Key Quality Indicator
LCG	Local commissioning group
LHSCG	Local health and social care group
LLL	La Leche League
NBAW	National Breastfeeding Awareness Week
NCT	National Childbirth Trust
NHS	National Health Service
NHSCT	Northern Health and Social Care Trust
NHSSB	Northern Health and Social Services Board
NI	Northern Ireland
NICE	National Institute for Health and Clinical Excellence
NICHE	Northern Ireland Centre for Food and Health
NIMATS	Northern Ireland Maternity System
NIMDTA	Northern Ireland Medical and Dental Training Agency
ONS	Office for National Statistics
PCHR	Personal Child Health Record
PEHO	Principal Environmental Health Officer
PFA	Priorities for Action
PHA	Public Health Agency
PIC	Public information campaign
PPI	Personal and Public Involvement
PSA	Public Service Agreement
QUB	Queen's University Belfast
R&D	Research and Development Office
RoI	Republic of Ireland
RPA	Review of Public Administration
SAM	School Aged Mothers
SE	Scottish Executive
SEHSCT	South Eastern Health and Social Care Trust
SGEHC	Southern Group Environmental Health Committee
SHSCT	Southern Health and Social Care Trust
SHSSB	Southern Health and Social Services Board
UK	United Kingdom
UKAMB	UK Association for Milk Banking
UK BFI	UK Baby Friendly Initiative
UNICEF	United Nations Children's Fund
UU	University of Ulster
WHO	World Health Organization
WHSCT	Western Health and Social Care Trust

Executive summary

The *Breastfeeding strategy for Northern Ireland* was published by the Department of Health and Social Services (DHSS) in 1999. The document set out the aims and objectives of the government to promote and support breastfeeding among mothers in Northern Ireland (NI). A Breastfeeding Strategy Implementation Group (BSIG) took on the task of overseeing implementation of the strategy, whose aims were:

- to ensure parents had a fully informed choice on infant feeding;
- to support the promotion of breastfeeding;
- to facilitate an increase in breastfeeding rates.

This review of that strategy, led by the Breastfeeding Strategy Review Group and carried out by the PHA, aimed to examine progress on the recommendations of the document and identify potential barriers to implementation, by consulting widely with key stakeholders.

A consultation with all those named 'Agents for action' in the strategy (including the country breastfeeding coordinators in the Republic of Ireland – RoI, England, Scotland and Wales) was conducted between September 2008 and February 2009. In addition, focus groups with mothers of babies aged under one year, who were breastfeeding or had ceased breastfeeding earlier than intended, were undertaken in November 2008 to provide a personal and public involvement (PPI) perspective.

From the consultation with the various stakeholder groups, and reflections of achievements under each action point of the strategy, a number of suggestions on the way forward towards formulating a new strategy also emerged. Thus the following sections summarise both the extent to which the recommendations under each action point were accomplished and suggestions for future activity.

Action point 1: Coordinating activities

- Breastfeeding coordinator posts are now in place within 7 of 10 maternity units, with less than half (3) working in a dual role and without protected time (2). There are eight appointed community breastfeeding coordinators and one unique post of breastfeeding advocate within the Northern Health and Social Care Trust (NHSCT). While each Trust has at least one breastfeeding coordinator in a hospital or community setting, on-site access to expertise and leadership in breastfeeding is not available in all facilities. The breastfeeding coordinators, in particular, have proven valuable in terms of improving practice standards, training and support; yet, post insecurity adversely affects their functioning.
- Commissioners met two to three times a year, while the breastfeeding coordinators' forum met four times a year, with most coordinators being able to attend all meetings.
- Cross-country communication and collaboration have been established successfully and provide opportunities for further joint working. The sharing of information and practice proved successful at the level of coordinators, but the cascading down of this information to staff on the ground needs improved.

Suggestions for way forward

- There is a need to ensure that all 10 maternity units have access to a breastfeeding coordinator with protected time in line with National Institute for Health and Clinical Excellence (NICE) guidance published in 2008. Furthermore, the roles of community breastfeeding coordinators need to be implemented in all five Trusts. RPA and ongoing restructuring may provide the opportunity to increase access to a lead professional for breastfeeding within each Trust.
- There are further opportunities for expanding the collaboration with Great Britain (GB) and RoI in relation to research and evaluation, resource development, activities to promote and support breastfeeding, as well as tackling issues around the regulations for advertising and promotion of breast milk substitutes.

Action point 2: Commissioning services

- According to commissioners, breastfeeding-specific services have been included in strategic planning documents. BSIG reported that breastfeeding coordinator posts and breastfeeding education and support (eg peer support groups) are among the key achievements of the commissioning process.
- Good progress in achieving United Kingdom (UK) Baby Friendly Initiative (BFI) accreditation has been made, with widespread implementation. This has resulted in positive changes in breastfeeding rates through improved practices. Those leading implementation of BFI have been provided with advice and support to develop training and audit health care practice. However, commissioning of the process and provision of sufficient resources (funding, protected time) were varied.
- Annual meetings of commissioners responsible for breastfeeding services did not occur regularly, with a further lack of information-sharing due to the precedence of other health promotion strategies.

Suggestions for way forward

- Integrate breastfeeding into all health-related policies and strategies and further support and expand UK BFI accreditation by making it compulsory for both community and hospital based Trusts. Participate in United Nations Children's Fund (UNICEF) BFI university standards.

Action point 3: Collecting regional information

- The Child Health System (CHS) is not meeting its data-capturing function fully, with the lack of appropriate software the key problem. Further training for health professionals is required to eliminate inaccurate or incomplete recording of feeding behaviour.
- Participation in the UK-wide *Infant feeding survey* (IFS) was considered invaluable for providing reliable data for comparison and tracking trends.

Suggestions for way forward

- Improve the functioning of the CHS by appropriate software, further training in recording breastfeeding information, review of depth of data collected, and timing of data recording. Emphasis should be placed on agreed definitions for collating breastfeeding statistics.
- With the introduction of the new centile charts, more training will be required. Breastfeeding coordinators should be involved in training delivery to ensure a strong focus on breastfeeding.

Action point 4: Focus on research

- Some research has been carried out to address all areas outlined in Action point 4. However, the majority has focused on 'the most effective methods of promoting and supporting breastfeeding'. Less research was undertaken on the 'effects of women's working patterns and maternity leave', 'reasons for early cessation', and 'reasons for breastfeeding variations in different areas of NI'.
- Several studies have examined attitudes of young people and the development of breastfeeding education in schools. Yet, BSIG members and health professionals suggested this area for future research on outcome and process evaluations – indicating a potential lack of awareness of this work carried out by academic departments.
- Two respondents were critical of UK BFI interference with breastfeeding research due to its monopoly in promoting and supporting breastfeeding, thus preventing the investigation of new and innovative approaches of breastfeeding promotion and support.
- This provided an overview of the extent to which research had been carried out in a number of areas. Further investigation is needed to assess how the studies may have influenced practice and lead to interventions. This level of enquiry requires an in-depth appraisal of the research, which is beyond the scope of this consultation.

Suggestions for way forward

- Further research into breastfeeding promotion and support in NI is required in six main areas: attitudinal and motivational issues, service approaches to support, support for breastfeeding, breastfeeding difficulties, breastfeeding uptake and duration of breastfeeding, breastfeeding and young people. Stronger research focus is needed on reasons for early cessation and how to reach those least likely to breastfeed.

Action point 5: Training health professionals

- According to BSIG members, teaching about promotion and management of breastfeeding to medical undergraduates can be improved. However, it is difficult to validate this without feedback from Queen's University Belfast (QUB) School of Medicine, Dentistry and Biomedical Sciences (as the sole provider of undergraduate training in NI).
- Regional provision of breastfeeding education for general practitioners (GPs) is delivered through the Child Health Surveillance training programme. Breastfeeding coordinators also provide breastfeeding training to medical staff. Despite progress, not all hospital doctors or GP registrars receive breastfeeding training as had been recommended.
- For non-medical staff, in-service breastfeeding training has been devised and provided by breastfeeding and Sure Start coordinators and the Beeches Management Centre. A postgraduate module has been developed and provided by QUB. Student midwives (QUB) and health visitors (University of Ulster – UU) are provided with breastfeeding education as part of their training programme. Although improvements have been noted, gaps in the provision and uptake of training of midwives and health visitors were reported, with midwives more likely to receive training than health visitors, paediatric nurses and dietitians.
- Time for release and financial constraints remain as barriers in professional development for health professionals.

Suggestions for way forward

- A mandatory training programme, including communication skills, is needed to explore attitudes to breastfeeding among staff who have primary responsibility in caring for breastfeeding mothers. Following the implementation of NICE guidance and BFI standards, a mandatory training programme (eg e-learning, training pack) for all doctors is required. In addition, pharmacists need to receive continued training as mothers often seek their advice.
- In terms of professional development, there is further need for breastfeeding specific and non-specific courses (eg management, communication) among health professionals providing breastfeeding promotion and support.

Action point 6: Supporting special needs infants and their mothers

- Some training has been available on breastfeeding of special needs babies through in-service training, the Beeches and the HPA. However, with only some of the BSIG members, commissioners and the Beeches (the only training provider) responding, it is difficult to judge whether the training in supporting the needs of ill and preterm babies is sufficient.
- There appear to be gaps in either the collection and/or provision of data on breastfeeding of special needs infants. The number of babies being fed breast milk in neonatal units is collected within Trusts. A leaflet on breastfeeding ill and premature babies was developed and has been updated by the HPA. Overall, health professionals' knowledge of data relating to breastfeeding ill and premature babies, and awareness of information materials, could be improved.
- The human milk bank has been successfully established and provides human milk for infants throughout Ireland. It has been very successful in terms of implementation of best practice for milk banking. Issues around sustainability and meeting future challenges need to be taken into account in a new strategy.

Suggestions for way forward

- For the future of the human milk bank, it is envisaged that more donor milk will be needed in Ireland as well as more research on the use of donor milk. The human milk bank will have to be flexible and adaptable in relation to new policy and guidance (eg new advice from the Department of Health, Social Services and Public Safety (DHSSPS), NICE guidelines for the operation of human milk banks, 2010). In addition, the milk bank will have to adapt to a potential broadening remit of tasks, including the feeding of older babies and the use of donor milk in cancer and immunoglobin A deficient patients. The additional work demands have big implications for the sustainability of the milk bank, particularly for staffing levels and laboratory time.

Action point 7: Raising public awareness

- There was substantial activity on public information campaigns (general population, specifically targeting men) which helped to improve awareness of health benefits and attitudes towards breastfeeding in Northern Ireland. However, some mothers felt that the portrayal of breastfeeding women needs improved (too old-fashioned and drab).
- A variety of regional materials supporting breastfeeding have been produced for use in both the ante- and postnatal period. Health professionals acknowledged that supply issues exist for some of the resources. The mothers' suggestion of using appealing images of breastfeeding women applies also to materials/resources.

- The National Breastfeeding Awareness Week (NBAW) each May has achieved considerable involvement from both the statutory and voluntary sector. Some issues were raised around the preparation period (eg time frames, development of materials, supply).
- Breastfeeding coordinators have had some involvement in breastfeeding education and promotion in schools. A compact disc (CD) to raise breastfeeding awareness in post-primary schools was developed in partnership with the Council for the Curriculum, Examinations and Assessment (CCEA) and has been evaluated. Various concerns remain over breastfeeding education (eg lack of materials, impact of materials, who delivers this, training) and particularly how bottlefeeding is still, though possibly inadvertently, promoted in schools.
- In terms of community support for breastfeeding, feedback provided a varied picture. Breastfeeding outside the home, despite some improvement in society's attitude towards it, was still viewed as difficult in NI. The Breastfeeding Welcome Here scheme has proven successful in providing support to breastfeeding mothers, although it needs further support for wider implementation throughout NI. Volunteer peer supporters are a valued source of community support. However, they face issues in terms of recruitment, training, recognition and retention, financial resources, access to and uptake from mothers. Breastfeeding support (eg groups) provided by the statutory sector was in some areas deemed insufficient regarding geographical spread and the availability of enthusiastic health professionals, with key concerns being accessibility of support and the provision of inconsistent advice across health professionals.

Suggestions for way forward

- From a commissioner's perspective, community action in the form of peer support in areas of deprivation is needed. Moreover, increased partnership working/involvement between community groups with professionals from the public and voluntary sectors is needed to promote breastfeeding on an ongoing basis.
- There is need for further materials, in particular for other family members (eg grandmothers, children in the family), to be more tailored to specific situations (eg single mothers, young mothers, culturally relevant for ethnic groups), downloadable UNICEF leaflets and their translations, leaflets and teaching resources for hand expression and milk storage, and a website listing all available resources. Mothers specifically wanted advice in relation to drinking alcohol and intimacy with their partners and for materials to be visually appealing, ie 'catchy'.
- To alleviate negative attitudes to breastfeeding outside the home:
    - Raise more public awareness through campaigns, advertising, and media exposure, thus promoting the normality of breastfeeding in public.
    - Simultaneously encourage mothers to feed in public and businesses to become involved with supportive schemes such as Breastfeeding Welcome Here.
    - Make more social support available by providing support groups/peer support, improving support provided by family and friends, in the workplace, and at societal level (public attitudes, councils).
    - Introduce specific legislation to protect a mother's right to breastfeed in public.
    - Establish a mother's confidence in her ability to breastfeed.
    - Focus efforts in breastfeeding education on young people, older people, and mothers' partners.

Action point 8: Limiting promotion of artificial milks

- Many healthcare professionals state that compliance with the World Health Organization (WHO) code is monitored through Trust or Board monitoring or BFI. Contact with formula company representatives and provision of promotional materials still appear to be a challenge and are at the heart of many breaches of compliance. Contact with representatives is being filtered to an extent, although unsolicited visits and offers of hospitality at meetings outside the health service have been reported. The provision of reduced-cost products to healthcare facilities is prohibited in Trust policies. Provision of promotional materials is restricted, yet their use is still the main issue of non-compliance with the code among staff. Diary covers for health professionals have been made available to prevent use of those sponsored by formula companies.
- Parent information leaflets on breastfeeding and formula feeding have been made available by the HPA to Trusts. Formula company representatives continue to offer free educational resources to a range of healthcare professionals, including breastfeeding coordinators and health visitors.
- The recommendation on the discontinuation of the sale of artificial milk in healthcare premises is now adhered to. Thus, this positive practice needs to be maintained.

Suggestions for way forward

- All health professionals need education on the WHO *Code of marketing of breast milk substitutes*. Compliance with the WHO code requires ongoing monitoring and audit.
- Health professionals reported the need for providing further educational materials, particularly for specialist feeding needs (eg reflux, anti-allergen), and stationery items (calculators for gestational age/baby age, Post-it notes, pens) devoid of trade names and logos which could replace those provided by the formula industry.

Action point 9: Legislative change

- It is difficult to determine the extent to which employers facilitate flexible work arrangements for women returning to work while still breastfeeding, as only one HSC Trust responded to the review. This Trust has a variety of arrangements in place. In general, good practice guidance information was developed for mothers and employers. However, it appears that continuity of flexible working arrangements is not observed across HSC, let alone in the wider employment sector.
- Consultation feedback suggests that the discontinuation of the exchange of milk tokens in HSC premises has been well adhered to, mostly as a result of the introduction of the Healthy Start programme. However, low awareness of the Healthy Start programme by those in need was considered a problem.
- The 2007 *UK infant formula and follow-on milk regulations* have been strengthened in relation to health claims and differences between infant formula and follow-on milk. However, the regulations are still not as stringent as the WHO code. Those responsible for monitoring regulations on the promotion and sale of infant formula stated that only one incident has been reported within the past 10 years.

Suggestions for way forward

- Further effort needs to be made to establish flexible working arrangements for mothers returning to work while still breastfeeding. This affects HSC and other employers. It might be useful to monitor the implementation of such policies and arrangements and their impact on employers.
- The low awareness of the Healthy Start programme by those in need needs to be addressed.
- Ongoing support for staff to continue to comply with the WHO *Code of marketing of breast milk substitutes* is required through infant feeding policies and best practice guidelines (eg Food Standards Agency – FSA – guidelines).

Introduction

The Breastfeeding Strategy Group was established by the DHSS in 1997 to develop a regional breastfeeding strategy for NI. The aim of the breastfeeding strategy was to provide a framework for evidence-based approaches for breastfeeding promotion and support in a variety of settings.

The multi-disciplinary group comprised wide representation from the health service, commissioning, voluntary organisations and the Department. In 1999 the Northern Ireland breastfeeding strategy was published and disseminated for implementation.[1] Subsequently, BSIG took on the task of overseeing implementation of the strategy. This work was then supported by the appointment of the regional breastfeeding coordinator in 2002.

DHSS/DHSSPS has provided ongoing support for regional breastfeeding initiatives and has led the work of BSIG. Commitment to supporting implementation of the breastfeeding strategy since 1999 has been significant, with involvement at all levels from regional to local, and within a variety of settings.

Since the breastfeeding strategy was introduced, several other key policy documents and recommendations on infant feeding have been published. These include:

- WHO (2003) *Global strategy for infant and young child feeding*;[2]
- EC (2008) *Protection, promotion and support of breastfeeding in Europe: a blueprint for action (revised edition)*;[3]
- DHSSPS (2002) *Investing for health*;[4]
- DHSSPS (2005) *A healthier future: a twenty year vision for health and wellbeing in Northern Ireland 2005-2025*;[5]
- NICE (2006) *Routine post-natal care of women and their babies: NICE clinical care guideline 37*;[6]
- NICE (2008) *Improving the nutrition of pregnant and breastfeeding mothers and children in low-income households: NICE public health guidance 11*;[7]
- Scientific Advisory Committee on Nutrition (2008) *Infant feeding survey 2005: a commentary on infant feeding practices in the UK*;[8]
- British Medical Association (2009) *Early life nutrition and lifelong health*.[9]

In 2008–09, work was undertaken to review the *Northern Ireland breastfeeding strategy*. By consulting widely with key stakeholders, the review aimed to examine progress on the recommendations of the breastfeeding strategy and identify potential barriers to implementation. Subsequently, future actions required can be based on the findings of the review and will incorporate key evidence and guidance that have emerged since the strategy was introduced.

Method

The Breastfeeding Strategy Review Group developed a list of potential stakeholders involved in the delivery or implementation of any of the nine action points within the *Northern Ireland breastfeeding strategy* ('Agents for action'). Based on this list, a series of consultation questionnaires was developed for individual stakeholder groups.

A few respondents received several questionnaires owing to multiple memberships of stakeholder groups (eg a breastfeeding coordinator or commissioner also being a BSIG member). However, due to the anonymity granted to several stakeholder groups, individuals' responses on more than one questionnaire could not be linked and, thus, were treated independently. Each questionnaire gathered information on stakeholders' knowledge of what progress had been achieved in implementing the action points. This was explored in terms of specific successes and barriers in the process.

Several stakeholder groups were consulted on the achievement of all/almost all action points of the strategy, whereas other stakeholders were consulted on the achievement of action points that only fell into their remit. The country breastfeeding coordinators for RoI, England, Scotland and Wales were also included as an additional stakeholder group, as collaboration and communication with them is embedded in the strategy.

While the views and attitudes of a wide range of stakeholders were sought, a representative sample of larger groups such as midwives and health visitors was not sought. Rather, an attempt was made to scope the views of several representatives across all five HSC Trusts. A summary of all stakeholder groups involved in the review, the action points each group responded to, and the response rates are provided in Appendix 1.

Consultation process

Country breastfeeding coordinators were sent their questionnaires via email in September 2008. The stakeholders were mailed their questionnaires during November and December 2008, with repeated follow-up of responses via reminder letters, emails and phone calls until February 2009. Midwives and health visitors were contacted indirectly via midwifery/breastfeeding coordinators/managers and health visitor coordinators/managers (one per HSC Trust) who were asked to distribute the questionnaires.

Qualitative research with mothers

In addition to the consultation questionnaires, qualitative research was conducted with mothers of babies aged under one year, as a key group to have benefited from the strategy. Eight focus groups (including three mini focus groups) and one interview were conducted during November 2008 by Perceptive Insight Market Research.[10] The qualitative research included both mothers who still breastfed their babies (n=46; babies aged five weeks to nine months) and those mothers who ceased breastfeeding sooner then they originally intended or wanted to (n=11; babies aged seven weeks to six months). Groups were held across all four HSS Board areas, taking account of rural and urban locations, with two focus groups drawing on Sure Start-based

breastfeeding groups. Participating mothers were from less affluent backgrounds (C1C2DE) and varied in age from 16 to 44. One focus group included young expectant women/mothers from the School Aged Mothers (SAM) project to provide insight into the issues faced by young mothers.

Synthesis of responses

This review follows the nine action points of the breastfeeding strategy. Each section starts with a brief summary of who was contacted in relation to the specific recommendations outlined in the strategy. Due to the generally open-ended nature of the questions, main themes were identified while considering agreement and differences in views from different stakeholders. Quotes are used to illustrate key points. For some of the stakeholder groups, individuals are identifiable to explore local differences (eg CHS information managers, commissioners); in other groups, respondents remained anonymous to encourage critical engagement (eg breastfeeding and Sure Start coordinators, members of BSIG, midwives). The four stakeholder groups – breastfeeding coordinators, Sure Start coordinators, midwives, and health visitors – are generally referred to as health professionals throughout the review.

Where response rates were very low, caution should be applied in interpreting the findings as these may only reflect the experiences and views of few individuals.

Mothers' views were integrated where appropriate, and quotes are used to exemplify. For further detail on the findings from the research with mothers, please refer to the research report available from the PHA.[10]

1. Coordinating activities

Although a wide range of breastfeeding promotional activities is being undertaken across the province, there is little coordination or communication between the various players. There is a need to address this issue, both within Northern Ireland and beyond, to ensure more efficient and effective working.

Recommendations

- Within all HPSS Boards and Trusts there should be an identified individual with the responsibility of coordinating breastfeeding activities within their organisation and with local voluntary and community groups.

  These individuals should meet 2–3 times yearly to share information and models of good practice, and for the purpose of update.
  Agents for action: Commissioners and providers

- Communication and collaboration in the dissemination of good breastfeeding practice between agencies in Northern Ireland, Great Britain and the Republic of Ireland should be facilitated.
  Agents for action: Northern Ireland Breastfeeding Strategy Group, DHSS

Responses to the recommendations within Action point 1 have been sought from BSIG members, commissioners, regional country breastfeeding coordinators, breastfeeding coordinators, Sure Start coordinators, midwives, and health visitors. The response by each stakeholder group to the individual recommendations alongside the response rates are highlighted below.

	Response rate	Recommendation
• BSIG members	4/12	1.1-3
• Commissioners (EHSSB, SHSSB)	3/10	1.1-3
• Country breastfeeding coordinators	3/5	1.3
• Breastfeeding coordinators*	12/18	1.1-3
• Sure Start coordinators	10/25	1.1-3
• Midwives	6/25	1.1-3
• Health visitors	8/25	1.1-3

[*NOTE: At time of consultation there were 18 breastfeeding coordinators on the database. One coordinator post is jobshare, thus two individuals were contacted (17 individuals for 16 posts). The 18th forum member is the regional breastfeeding coordinator.]

The views of mothers explored in focus groups (mothers who were breastfeeding and those who stopped breastfeeding before they intended) are included in the synthesis of findings. However, it must be noted that these views may not represent the views of mothers who never breastfed.

1.1 An individual within all HPSS Boards and Trusts with the responsibility of coordinating breastfeeding activities within their organisation and with local voluntary and community groups

Different individuals have been given the responsibility of coordinating breastfeeding activity at the various levels. Within the Eastern HSS Board (EHSSB) the health promotion commissioner had dedicated responsibility. The EHSSB Investing for Health (IfH) commissioner noted that breastfeeding monitoring was the responsibility of the Board and it received quarterly returns for HSC Trusts on breastfeeding levels.

In the Southern HSS Board (SHSSB) area, one commissioner had lead responsibility for three areas (health promotion, IfH, and maternal and child health), and confirmed Board representation on local and regional breastfeeding coordinating groups. BSIG members confirmed the establishment of breastfeeding steering groups in the HSS Boards whose members also include peer supporters and volunteers from National Childbirth Trust (NCT) and La Leche League (LLL). The groups' remit is to plan activity and initiatives.

In addition to the post of regional breastfeeding coordinator, 16 breastfeeding coordinator posts were developed at HSC Trust level. However, some of these posts are temporary positions with individuals expected to fulfil a dual role as a breastfeeding coordinator and midwife or health visitor.

Breastfeeding activity in areas of deprivation is focused within Sure Start areas and Sure Start coordinators have taken on this responsibility. At each of these levels, the successes and challenges faced by these leads on breastfeeding are examined separately below.

Breastfeeding leads at HSC Trust level

The establishment of breastfeeding coordinator posts, particularly within maternity units, has increased since 1999 when the breastfeeding strategy was introduced. BSIG members and commissioners reported that breastfeeding coordinators had been appointed (see overview in Appendix 2). Breastfeeding coordinator posts are in place in 7 of 10 maternity units, three of them working in a dual role and two of them without protected time. [Overall, there are 11 maternity units in NI but one, Downpatrick, is so small that it does not warrant having its own breastfeeding coordinator.]

There are eight appointed community breastfeeding coordinators and one unique post of breastfeeding advocate within NHSCT, generally held in a dual role. Please note, the role of some community breastfeeding coordinators is less clearly described than for those based in hospitals (mainly dual roles, less protected time, main criteria is leading on implementation of UK BFI).

BSIG members noted some shortfalls such as erratic funding, which meant posts not being permanent or always filled. Twelve breastfeeding coordinators (across the hospital and community setting) responded to the consultation and eight reported having a job description available for their post (three do not). Nine coordinators are employed on permanent contracts, with three reporting temporary contracts (eg five year term). In addition, breastfeeding coordinators also cover other duties such as midwifery or health visiting workloads, so the time given to the coordinating role may not be adequate.

Half of the breastfeeding coordinators (n=6) confirmed holding posts in a single role, with five reporting holding their post in a dual role. Protected time was reported by five coordinators but three did not have their post safeguarded this way. Independent of a dual or single role, the insufficient funding to provide cover for midwifery care and staff shortages impacts negatively on the breastfeeding coordinators' role.

The EHSSB IfH commissioner highlighted that much of the coordination of activities remained with hospital and community midwives – in the EHSSB area, four posts were not filled. Midwives and health visitors who commented in the consultation also reported that not all Trusts had hospital and community coordinators in post. The EHSSB health promotion commissioner stated that in the Trusts where an appointment of breastfeeding coordinator had not been made, there was an identified individual who took the lead on breastfeeding activity and attended the Eastern breastfeeding coordination group. In the SHSSB area, the Southern HSCT has lead responsibility for coordinating breastfeeding activities in the area. It is also noted that areas of responsibility for breastfeeding coordinators may have changed since RPA, with areas of work potentially having expanded.

Where the post of breastfeeding coordinator is established, these individuals are clearly seen as the Trust lead for breastfeeding and are therefore involved in Board breastfeeding coordination groups and breastfeeding steering groups at both Board and Trust level. Some individuals undertake the role of chairperson in Trust breastfeeding steering groups.

Despite RPA, over half of the breastfeeding coordinators said that their role had not changed. Although one coordinator was freed from a health visiting caseload, several coordinators were cautious of workload increases due to changes in policy or the role of coordinators and general workload increases throughout the Trust (to achieve UK BFI accreditation). For further information on UNICEF UK BFI, see the chapter on Action point 2. The regional breastfeeding coordinator identified changes in the way they communicated with Trusts to promote best practice, arising from a new joint approach to hospital and community settings.

> *"The way I communicate with those working in the Trusts has changed. With the reorganisation there are now new opportunities to promote best practice throughout Trusts, for example through the development and implementation of combined hospital and community breastfeeding policies for each Trust. Some of the Trusts are further ahead with this but, as yet, not all Trusts have adopted a fully joined-up approach to breastfeeding initiatives in hospital and community settings."* (Breastfeeding coordinator 12)

Breastfeeding coordinators are highly specialised, with most holding the Certified Lactation Consultant qualification (International Board Certified Lactation Consultant) and having completed the UNICEF UK BFI three day breastfeeding management course. A few had also completed a breastfeeding module as part of a diploma or degree course at QUB. Most coordinators provide clinical support for breastfeeding problems and half stated their role was promoted to new mothers.

Mothers with breastfeeding problems are generally referred to breastfeeding coordinators by health visitors, midwives, paediatric nurses, paediatricians, GPs, and breastfeeding support

groups, with self-referral rarely occurring. Breastfeeding coordinators receive between two to six referrals per day. The regional breastfeeding coordinator stressed that she did not receive direct referrals but advised on more complex cases brought forward by Trust-based coordinators. One of the biggest challenges for most of the breastfeeding coordinators is time constraints to marry responsibilities inherent to their role and competing responsibilities. Their role includes a multitude of responsibilities which prove challenging in the available time:

- implementing best practice standards (eg achieving and maintaining UK BFI accreditation);
- breastfeeding support – providing specialist care for referrals, establishing support for mothers (both ante- and postnatally);
- communicating with staff – changing attitudes to breastfeeding, maintaining motivation, providing training and support to health professionals to build knowledge and support for mothers (eg making informed decision, consistent advice);
- attending coordinator meetings.

These main responsibilities are compromised primarily by clinical caseloads and covering for staff due to sick leave or inadequate staffing, and, to a lesser extent, by other activities such as auditing aspects of work outside BFI. Other challenges include lack of financial resources (impacting on implementing best practice standards), lack of breastfeeding knowledge among health professionals and mothers, emotive and political aspects of breastfeeding undermining implementation of best practice and exclusive breastfeeding (within health service and society), and uptake of breastfeeding support.

> *"Time to do everything. Keeping on top of our BFI commitments. Auditing other aspects of our job that don't fall within the BFI programme, eg re-admissions to paeds with breastfeeding related problems… effectiveness of our peer support programme."* (Breastfeeding coordinator 2)

> *"Getting time to do it. Caseload has to take priority and if people are off sick or on leave, the primary visits and 'vulnerables' have to be priority."* (Breastfeeding coordinator 7)

> *"Working across sectors is a very innovative approach but I find statutory support a continuing challenge."* (Breastfeeding coordinator 6)

Research with new mothers reflects some of the key challenges raised by breastfeeding coordinators. Mothers felt that support from health professionals depended on the attitudes and experiences of the individuals, with a lack of continuity of care foremost. Antenatally, mothers perceived midwives as pushing the breastfeeding message and that there was little opportunity for exploring breastfeeding as an active choice (eg no contact with breastfeeding mothers).

Postnatally, they also felt that midwives' attitudes and time pressure and inconsistent advice undermined what support they could give; however, some women had positive accounts of their care (community midwives, specialist advisors). In addition, there was some reluctance among mothers to request help early when faced with breastfeeding challenges.

"There is not enough information on breastfeeding during pregnancy. At antenatal classes we only got a demo with a doll and watched a video – it would have been so much better if someone came in and showed us." (Current breastfeeder, group 4)

"There's not enough support. Staff didn't have the time and, unless you are 120% sure to breastfeed, they would rather give you a bottle." (Ceased breastfeeder, group 1)

"A good community midwife can make all the difference between feeding and not feeding … I could not have done it without them." (Ceased breastfeeder, group 1)

"My midwife gave me her number and told me to contact her whenever I needed her. I didn't use it though – even when I was having problems." (Current breastfeeder, group 4)

Overall, breastfeeding coordinators noted a variety of experiences that they perceived as the most rewarding aspects of their job:

- supporting and helping mothers to succeed at breastfeeding by building skills, confidence and overcoming difficulties;
- changing staff attitudes towards breastfeeding and working within a motivated and skilful team;
- sharing useful and practical information with colleagues and opportunities for professional development;
- receiving positive feedback (eg at audits, informally);
- establishing best practice (eg BFI – see Action point 2 for further detail).

"When breastfeeding works. When you see the mothers empowered. When babies at the breastfeeding support group turn corners and thrive on breast milk." (Breastfeeding coordinator 9)

"I find my job extremely rewarding, particularly when I am able to empower others to implement best practice for breastfeeding. Helping others to find solutions and overcome barriers is very satisfying." (Breastfeeding coordinator 12)

Midwives' experiences show that they value the breastfeeding coordinators as a great resource of breastfeeding knowledge and updates, support and advice for dealing with breastfeeding challenges, and for driving BFI implementation. This experience was shared by over half of the responding health visitors, with only two reporting either not having a breastfeeding coordinator in place or not in their Trust locality.

"Enormously, she [breastfeeding coordinator] supports learning and development, practice audits, advises on use of and maintenance of breast pumps. She drives the Baby Friendly Initiative programme." (Midwife 1)

"Training is easily facilitated. Audit carried out to ensure our practice is up to date and effective." (Health visitor 8)

Most breastfeeding coordinators said they felt either somewhat or a little supported by management, while two acknowledged being very well supported and one reported not having any management support. Actual support in carrying out their post more effectively has been received from colleagues including midwives, health visitors, medics, ward clerks and information technology (IT) staff.

The regional breastfeeding coordinator, other coordinators and their forum were also given credit for their support, with few mentioning Sure Start, Health Action Zone (HAZ), the breastfeeding steering group, the Beeches, and mothers. The regional breastfeeding coordinator praised the DHSSPS IfH team, BSIG, HPA health intelligence unit and communications team, UK BFI team, coordinators' forum, and the other country coordinators as crucial for effectively meeting the remit of her post.

A number of sources for funding educational materials, breast pumps, and attending or holding a course/event were accessed to allow breastfeeding coordinators to fulfil their role. When funding was received, it was most consistently provided by HSC Trusts, HSS Boards, health promotion departments, and DHSSPS. Sporadically, funding was provided by Sure Starts, IfH, HPA, HAZ, manager, or via donations from companies that supply breast pumps to the health service.

Sure Starts as breastfeeding leads in areas of deprivation

One of the Sure Start objectives is to improve the health and wellbeing of infants and children through promoting and supporting breastfeeding.[11] Low breastfeeding rates are recognised as an accurate marker for deprivation, and increasing breastfeeding rates in areas of deprivation is an important mechanism for reducing health inequalities. The EHSSB IfH commissioner stressed that some of the Sure Start programmes in north and west Belfast were beginning to take a community lead.

It is also noted that, although not reported in the questionnaires of this consultation, several Sure Starts have taken a proactive approach to promoting and supporting breastfeeding through implementation of recognised best practice for breastfeeding. Two Sure Starts have achieved UNICEF UK BFI accreditation and other Sure Starts are involved in this process.

The responding leads on breastfeeding in Sure Start centres (generally referred to as Sure Start coordinators, n=10) hold different job titles such as coordinator (3), health visitor (3), midwife (2), and support worker (2). Similar to breastfeeding coordinators, most Sure Start coordinators hold their post in a single role (7) and/or have permanent contracts (8), with few having dual roles (3) and/or temporary contracts (2).

Sure Starts are involved in various breastfeeding initiatives, with all responding coordinators reporting to have breastfeeding support groups. Most of them are also involved in peer support projects, postnatal (breastfeeding) support groups, and UK BFI; these initiatives were reported to be their most successful projects. Furthermore, there has been high involvement in the Breastfeeding Welcome Here scheme. Further information on this scheme is discussed in the chapter on Action point 7 (section 7.5).

Other successful projects include the annual breastfeeding awareness event, staff awareness training, and practical support for mothers. Such support varies widely to meet the needs of mothers: immediate post-hospital contact, home visits, milk pump/support cushion distribution, and providing a bilingual family social worker translating to ethnic minorities.

Nearly all Sure Starts had a midwife or health visitor working as part of their team and someone within these Sure Start teams had been able to provide support with breastfeeding problems. Only one respondent reported she had been unable to provide support for breastfeeding problems due to the lack of a midwife and health visitor in their Sure Start team.

Mothers experiencing breastfeeding problems were mainly referred to Sure Start midwives and health visitors, with half reporting referrals to breastfeeding support groups. Less common were referrals to hospital staff (breastfeeding coordinator, midwife), peer support mothers, breastfeeding counsellors, mother's own health visitor or doctor, and phone helpline (eg Uplift).

Sure Start respondents encountered a number of challenges in promoting and supporting breastfeeding in their area, notably that family/peer pressure and cultural attitudes was not conducive to breastfeeding. Sure Start coordinators regretted the lack of antenatal contact with expectant mothers, called for more antenatal breastfeeding promotion and for mothers to attend antenatal groups. Mothers need to be motivated and encouraged to begin and maintain breastfeeding as well as not to delay seeking help when experiencing breastfeeding problems. The low breastfeeding (initiation) rates and varying level of support in hospital were also seen as challenges.

> *"Not having contact with pregnant women who have not considered breastfeeding before giving birth."* (Sure Start coordinator 8)

Most Sure Start coordinators stated they were very well supported by management in their role as coordinator/leaders, with only three reporting some or little management support. For example, the Sure Start coordinator without midwife and health visitor support felt little supported by management. With regard to continually developing and sustaining breastfeeding projects, the coordinators also acknowledged the support from colleagues (midwives, health visitors, social workers, other coordinators) and management within own and other Sure Starts and wider HSC Trusts, forums and steering groups, IfH partnership, local and regional breastfeeding coordinators, local peer support programmes, access to HPA courses/literature. Few identified joint working with the Trust to identify pregnant women and new mothers as a challenge.

> *"My coordinator is supportive. Trust management continually use 'data protection' to avoid giving me details of antenatal/postnatal mothers."* (Sure Start coordinator 1)

> *"I have just recently taken up post with this Sure Start. Receive excellent support from manager with HSC Trust and Sure Start coordinator, community breastfeeding steering group, Sure Start health visitors' forum."* (Sure Start coordinator 6)

Funding for resources or activities that will allow them to provide breastfeeding support is vital. Most funding for educational materials, breast pumps, attending or holding a course/

event, providing a breastfeeding support group comes from the Sure Starts themselves, with occasional funding from the HPA, IfH partnership, HSC Trusts, core project funds, and the health promotion unit.

1.2 These individuals should meet two to three times yearly to share information and models of good practice, and for the purpose of update

According to two commissioners (EHSSB health promotion and SHSSB health promotion, maternal and child health, IfH), meetings of breastfeeding leads have occurred at the set frequency of two to three times yearly. BSIG members also confirmed that the breastfeeding coordinators' forum met four times per year and that each Trust was represented. Almost all responding breastfeeding coordinators attended three to four meetings per year, with one not achieving the recommended frequency of attendances. At Board level, breastfeeding steering groups had been in place for several years and met *"regularly to plan breastfeeding activity and develop new initiatives"* (BSIG member 1).

The breastfeeding coordinators' forum provides a valued opportunity to share experiences with other coordinators. Such exchanges with colleagues are facilitated by staff/team meetings, training and awareness courses, other professional forums (eg health visitor professional issue forum, BSIG, breastfeeding education interest group) and less formal means (email, day-to-day contact).

The breastfeeding coordinators' forum also has Sure Start representation involving midwives, health visitors, and Sure Start coordinators who lead on breastfeeding. Bar one respondent, these meet bi-monthly or quarterly to network and share work related to breastfeeding with other Sure Starts. Within one Sure Start, other means such as newsletters and leaflets and feedback through the Sure Start health visitor were used.

Most of the responding health visitors and midwives attended a Trust breastfeeding steering group, with midwives attending between 6 to 12 times per year and health visitors attending two to six meetings yearly. All midwives and health visitors were aware of breastfeeding initiatives within NI. While midwives generally heard of initiatives through the breastfeeding coordinator and publications (journals, *Keeping abreast*), health visitors learned about them in their work place (eg management, colleagues, circulars), the breastfeeding steering groups and coordinators, and conferences/training. Experiences in supporting breastfeeding families were shared with colleagues at meetings (team/staff, steering/consultation/action group), discussion with colleagues, training, and through clinical supervision and support (health visitors only).

Conferences, study days, and training workshops provide important opportunities for sharing information and practice. Responding breastfeeding and Sure Start coordinators, midwives and health visitors availed of a wide variety of such opportunities and often attended repeatedly. The most popular were:

- UNICEF BFI conferences and training (breastfeeding awareness, management, audit).
- HPA organised conferences, seminars and training (eg maternal and child nutrition, peer support), with best uptake of all island breastfeeding conferences (except for midwives).

- Trust level training and workshops (eg by Sure Starts, breastfeeding coordinators).
- Lactation consultant training (Association of Lactation Consultants Ireland – ALCI; International Lactation Consultants Association – ILCA; International Board Lactation Consultants Examiners – IBLCE).
- Voluntary sector conferences/study days (LLL, NCT, Home Birth Association, UK Association for Milk Banking – UKAMB).
- Other (The Beeches breastfeeding training; UK breastfeeding conferences).

The annual breastfeeding coordinators' training achieves high uptake and BSIG members praised this training session.

1.3 Communication and collaboration in the dissemination of good breastfeeding practice between agencies in NI, GB and RoI should be facilitated

The roles of, and relations between, regional country coordinators

The remit of the country coordinator posts varies quite substantially (see overview in Appendix 2). While the NI coordinator has a main focus on breastfeeding, the Welsh coordinator's remit focuses on infant feeding, and the Scottish coordinator has also maternal nutrition and feeding of children up to the age of two years included in her remit. This difference in remit is also reflected in the composition of the national committee/strategy group on breastfeeding. Moreover, the Wales coordinator is the lead person for infant feeding policy in her department of health. The Scotland coordinator, although no lead, has significant direct involvement in policy, while the NI coordinator has an advisory role. In terms of practitioner support, the NI coordinator has the most significant direct involvement. All three country coordinators have central roles in developing national information campaigns.

The NI and Wales coordinators have been longer serving (seven and five years respectively) which is reflected in the excellent liaison between these two coordinators. Based on this reliable and supportive cooperative relationship, Wales has had permission to use and adapt NI resources (see below for further detail). The Scottish infant nutrition coordinator is in post since May 2008 and has been in contact with the NI breastfeeding coordinator through meetings (eg UK country coordinators meeting, UNICEF BFI steering committee) and conferences (BFI, all-island conference 2008) but also via email or telephone (eg communication on the materials and launch of the DVD *From bump to breastfeeding*).

Both BSIG members and commissioners confirmed that communication and collaboration in the dissemination of breastfeeding practice between the countries had been positive. This process has been mainly facilitated through meetings between local and regional coordinators at, for example, UK stakeholder meetings.

Legislative and policy context

In terms of legislative change, only Scotland introduced a law to protect women's right to breastfeed in public. In Wales there have been several enquiries in this area but this has not

yet been formalised. Both the NI and Wales coordinators expect the improved maternity leave provision to have been positive for breastfeeding mothers. In NI, the changes to the food welfare scheme should also have helped to ensure equivalent support for breastfeeding families (see also Action point 9).

In England and Scotland, according to the NI coordinator, government departments appear to be making important linkages between breastfeeding and maternal and infant health and, particularly, obesity and breastfeeding. The Scottish Executive (SE) produced a number of key policy documents since 2008 that demonstrated the SE's commitment to improving child health and ensuring that every child gets the best possible start in life. Improving maternal and infant nutrition, particularly breastfeeding, is a key component of the government's *Early years framework*.[12] This framework, published jointly with Convention of Scottish Local Authorities (COSLA), identifies the earliest years of life as crucial to a child's development and describes joint action to be taken to reduce inequalities in education, health and employment to ensure better outcomes for children.

Equally well, a report of the ministerial task group on health inequalities, also highlights the marked inequalities in breastfeeding rates and, therefore, emphasises the need for action to target the most vulnerable women, including young mothers.[13] Nonetheless, despite the raised profile of the importance of early bonding between mothers and babies and the specific mention of breastfeeding, concerns remain as to what extent local politicians appreciate the significance of breastfeeding. Strategic, ie performance management, targets have been set for National Health Service (NHS) Boards in Scotland on breastfeeding this year: the proportion of babies who are exclusively breastfed at six to eight weeks has to increase from 26.6% in 2006/07 to 33.3% in 2010–11. This is expected to raise the profile of breastfeeding at chief executive level within Boards.

Such major policy developments in linking breastfeeding with obesity and health inequalities or setting of Public Service Agreement (PSA) targets has not happened as yet in NI. However, the NI coordinator acknowledged that, in contrast to Wales and RoI, breastfeeding has been better funded in NI. Moreover, there has been significant commitment within the DHSSPS policy unit for ongoing resourcing of the breastfeeding programme and public information campaigns for breastfeeding through the HPA.

Public information campaigns (PICs) seem to have increased the profile of breastfeeding among the public as indicated by campaign evaluations in NI, with Scotland also having undertaken breastfeeding PICs in the past and revisiting this in light of increased resources now available to target obesity. Since completing the questionnaire, Scotland has undertaken a new PIC and has developed significant materials to support NBAW.

Successful cross-country initiatives

A number of successful initiatives of an all-UK or all-Ireland context occurred. These all reflect the good communication and collaboration between the five countries. The feedback from the three responding country coordinators on the various activities is summarised below. One BSIG member highlighted the all-island breastfeeding conferences, sharing of resources produced in

NI (eg parent leaflets), input into UK infant feeding surveys (2000, 2005), and linking of NBAW activity with England themes as examples of good collaboration.

NBAW is held in May each year and involves links between NI and the rest of the UK. The Scotland coordinator noted that some initial discussion took place at the country coordinators' meeting around NBAW and sharing ideas etc. However, as the Wales coordinator pointed out, NBAW had been implemented differently in all four countries. NI generally has its own theme because the materials produced by the Department of Health (DH) are not always accessible here and may lack relevance. Difficulties in getting information about DH plans for NBAW in sufficient time prevent producing NI materials on a similar focus or to complement the campaign in England.

DH national network of breastfeeding coordinators meetings are held in London and the NI coordinator attends at least once a year. This group is primarily a forum for regional breastfeeding coordinators for England and the voluntary organisations; Scotland, Wales, and NI are invited to it as observers rather than on a reporting level. However, these meetings prove very useful for learning about breastfeeding activity in GB and also for informing members about what initiatives are being undertaken in NI.

The UNICEF UK BFI has been promoted and supported in NI since its launch in 1994. Significant work has been undertaken to encourage maternity units and community health care facilities to implement recognised best practice standards in the care of breastfeeding mothers and babies. NI was the first UK country to recognise the need for a BFI professional officer. This part-time post has been supported by the HPA through a service level agreement with UNICEF and allows Trusts ready access to information and support for adopting best practice through the regional breastfeeding coordinator. This role of a country BFI professional officer with its valuable opportunity for consistent training support and access to guidance for mothers and health professionals alike has been replicated by Wales and in Scotland.

All three coordinators mentioned the *Bump to breastfeeding* DVD which is a UK-wide initiative and therefore *"seemed to carry additional 'weight' with health professionals"*. The evaluation of this intervention is conducted in collaboration with the University of Bournemouth, with NI data feeding into a UK-wide analysis and permitting a localised exploration. The *Infant feeding survey* 2005, according to the Wales coordinator, enables useful comparisons between the four countries.[14]

The NI coordinator has been a member of the national breastfeeding committee for RoI and has worked jointly with the RoI breastfeeding advisor on a number of initiatives. One such successful collaboration is the all-island conferences which were credited by the Scotland coordinator as very successful in attracting large numbers of delegates and in the quality of the presenters, content of presentations, etc. In addition, a further result of the collaboration is the ongoing provision of support for the development of training resources and publications for parents by the HPA which were then adapted for use in RoI. This joint activity received acknowledgement from the previous RoI health minister.

The sharing of resources and initiatives that were developed by the HPA and adapted for use elsewhere is another indicator for the successful collaboration (eg materials for fathers on breastfeeding). Wales has adopted the Breastfeeding Welcome Here scheme and guidance on bottle feeding procedures, while Scotland was interested in the schools' CD teaching pack (*Breastfeeding awareness in schools*).

> *"While it is rewarding to have affirmation of the usefulness of such resources and initiatives, it can be very time consuming following up requests and seeking permissions"* (NI coordinator).

In terms of the most significant initiatives in breastfeeding promotion and support, all three country coordinators declared that BFI had dramatically changed practices on maternity wards despite resistance and unhelpful routine care practices (night-time nurseries, supplementary formula feeds). Both the Wales and Scotland coordinators highlighted the increased coverage of the peer support programme and supporting breastfeeding in public places (eg particularly the Scottish legislation). The Scotland coordinator also stressed research evidence (on benefits, what works in breastfeeding support) and more infant feeding advisors in boards. The support by Charlotte Church to NBAW in Wales generated large and positive press coverage.

> *"Northern Ireland always produces interesting materials and we look forward to continuing to work together using a national perspective."* (Breastfeeding coordinator, Wales)

Reaching the grassroots

One BSIG member was concerned about the limited success of communication and suggested that *"more effort needs to be made to communicate and raise awareness of issues and statistics"* with staff 'on the ground'. This perception seems to be confirmed by the limited awareness among health visitors and, particularly, midwives regarding initiatives that promote and support breastfeeding outside of NI. Health visitors had heard of peer support initiatives (eg baby cafes) and LLL, while midwives were only aware of BFI.

Staff on the ground keep informed of breastfeeding issues, such as guidelines and research affecting UK and RoI, by a variety of means; they suggest that filtering down from the regional breastfeeding coordinator to the next levels only partially works. Breastfeeding and Sure Start coordinators kept informed primarily through UNICEF email updates (BFI, research), the regional breastfeeding coordinator for NI, and attending conferences/forums. Other information sources were publications (eg professional journals, newsletters), websites (eg BFI, DH, HPA, NCT), through membership of associations such as NCT, Association of Breastfeeding Mothers (ABM), ALCI, UKAMB (midwives), and professional leads and partner organisations (eg IfH, their Sure Start projects, Eastern Childcare Partnership).

> *"Tend not to enquire re RoI focus on UK developments. Breastfeeding coordinators forum useful for updates but mostly self directed research."* (Breastfeeding coordinator 6)

In contrast, midwives and health visitors kept informed primarily via publications (eg professional journals, training updates, newsletters), websites (eg BFI), and breastfeeding steering group meetings/forums (health visitors only) but less so through breastfeeding coordinators, colleagues and conferences.

The future of cross-country collaboration

A vision of breastfeeding

All three country coordinators offered a vision of breastfeeding for the future. Joining up the individually raised aspects, this vision maps out what standards need to be achieved to make breastfeeding the cultural norm, the given infant feeding practice. The public, professionals, and politicians need to be aware of short- and long-term consequences of not breastfeeding (within a period of 10 years). More specifically, the vision lists all the links in the chain that are needed to ensure a mother has a successful breastfeeding experience:

Table 1. Regional country coordinators views of breastfeeding for the future

A supportive culture and environment	• Breastfeeding in public places • Maternity leave • Workplace facilities • Every NHS Trust to have breastfeeding coordinator in maternity services and in primary community health care services
Provision of consistent information	• Mandatory updates in health professionals knowledge, including doctors • Improvements in information given in schools
Provision of skilled support	• Baby Friendly 100% hospitals • Breastfeeding support groups funded in every area • Support of partners/family and friends, etc
Recognition as a significant public health issue	• Breastfeeding integrated into obesity action plans • Mothers supported to achieve optimum nutrition for infants • Six months exclusive breastfeeding and continued breastfeeding into the second year of life • Breastfeeding recognised in reducing health inequalities

Opportunities for joint working

The country coordinators listed a wide variety of opportunities for joint working, with the ongoing communication through the UK stakeholder breastfeeding meetings providing the setting that allows sharing on information and resources. The Wales coordinator noted that similarities in the country coordinators' ways of working would help such joint working but that differences provide challenges (eg the Welsh requirement for bilingual version of all materials produced).

- Sharing ideas, plans etc for a range of activities at national (country specific) level to promote and support breastfeeding:
  - NBAW: opportunity to link and use media opportunities to the benefit of UK and RoI.
  - An inclusive UK and Ireland conference looking at successful interventions and the evidence about antenatal and postnatal interventions.
  - Sharing approaches, ideas and evaluation of social marketing/national public information campaigns in order to change public perceptions/attitudes to breastfeeding.
- Potential collaboration on research and evaluation of interventions across all countries.
  - Similar socioeconomic issues in relation to breastfeeding in NI and Scotland.

- Collaboration on/sharing of resources
  - Development of training resources such as e-learning packages – can be adapted for use in each country.
  - The HPA work on breastfeeding awareness in schools has been requested by practitioners throughout UK. This could be adopted for use in England, Wales and Scotland and that the country coordinators take this forward.
- Tackling issues on the regulations around advertising and promotion of breast milk substitutes, eg is there potential to work with the DH and FSA to strengthen/change the regulations at European Union (EU) level

To facilitate the successful joint working between country coordinators further, a minimum of two meetings per year would be needed and three to four meetings would be ideal (according to the Wales coordinator). These meetings would not need to be convened separately but could be attached to other existing opportunities (eg other forums/meetings). Differences in financial resources might limit the extent of such regular meetings. However, regular meetings will result in better working relations between the country coordinators and a more coordinated UK approach. Links with the NI coordinator will be strengthened through work on a national strategy (Scotland) and the continued sharing of resources (Wales).

Outlook

- There is a need to ensure that all 10 maternity units have access to a breastfeeding coordinator with protected time in line with NICE guidance published in 2008.[7] Furthermore, the roles of community breastfeeding coordinators need to be implemented in all five Trusts. RPA and ongoing restructuring may provide the opportunity to increase access to a lead professional for breastfeeding within each Trust.
- There are further opportunities for expanding the collaboration with GB and RoI in relation to research and evaluation, resource development, activities to promote and support breastfeeding, as well as tackling issues around the regulations for advertising and promotion of breast milk substitutes.

Summary

- Breastfeeding coordinator posts are now in place within 7 of 10 maternity units, with less than half (3) working in a dual role and without protected time (2). There are eight appointed community breastfeeding coordinators plus one unique post of breastfeeding advocate within NHSCT. While each Trust has at least one breastfeeding coordinator in a hospital or community setting, on-site access to expertise and leadership in breastfeeding is not available in all facilities. The breastfeeding coordinators, in particular, have proven valuable in terms of improving practice standards, training and support; however, post insecurity adversely affects their functioning.
- Commissioners met two to three times a year, while the breastfeeding coordinators' forum met four times a year, with most coordinators being able to attend all meetings.
- Cross-country communication and collaboration has been established successfully and provides opportunities for further joint working. The sharing of information and practice proved successful at the level of coordinators, but the cascading down of this information to staff on the ground needs improved.

2. Commissioning services

Given Northern Ireland's low breastfeeding rate and the targets set within the Regional Strategy, HPSS commissioners of services should give priority to breastfeeding promotion, support and management issues within their commissioning intent documents.

Recommendations

- Breastfeeding-specific services should be included in the commissioning intent documents of Board and primary care commissioning groups.
- Commissioners should promote the achievement of the UK Baby Friendly Initiative's award in hospital and community settings.
- The commissioners responsible for breastfeeding services should meet on an annual basis to share information and experience.

  Agents for action: Commissioners and providers

Responses to the recommendations within Action point 2 have been sought from BSIG members, commissioners, breastfeeding coordinators, Sure Start coordinators, midwives, and health visitors. The individual recommendations responded to by each stakeholder alongside the response rates are highlighted below.

	Response rate	Recommendation
• BSIG members	4/12	2.1-3
• Commissioners (EHSSB, SHSSB)	3/10	2.1-3
• Breastfeeding coordinators	12/18	2.2
• Sure Start coordinators	10/25	2.2
• Midwives	6/25	2.2
• Health visitors	8/25	2.2

2.1 Breastfeeding-specific services should be included in the commissioning intent documents of Board and primary care commissioning groups

Feedback from the Eastern and Southern Health and Social Services Board (HSSB) areas indicated that this recommendation is currently met. The EHSSB health promotion commissioner stated that *"breastfeeding promotion and support is included in the health improvement planning process and health and wellbeing improvement plan. Funding is now taken from* Fit Futures *to implement the work"*.

The commissioner in SHSSB with responsibility for three areas – health promotion, maternal and child health, and IfH – stated that breastfeeding services were included in a number of documents which included:

- Board contract with Trusts specified adherence to breastfeeding policy and strategy.
- Child and maternal health programme commissioning group specifications.
- Health promotion specifications.
- Southern Area integrated action plan to tackle obesity and overweight in children.
- IfH Healthy start healthy weight healthy life action plan.

Feedback from some BSIG members mentioned breastfeeding coordinator posts and increases in the number of support groups as a fundamental outcome of these commissioning arrangements.

> *"Commissioning of breastfeeding education and peer support initiatives has been detailed by commissioners. Various temporary support roles for community breastfeeding posts have involved commissioning with [local health and social care groups] LHSCGs in the past."* (BSIG member 1)

> *"On the ground the only breastfeeding specific services are breastfeeding coordinators. Although there are more breastfeeding support groups than nine years ago."* (BSIG member 3)

2.2 Commissioners should promote the achievement of the UK BFI award in hospital and community settings

NICE has now recognised the need to implement a structured programme for breastfeeding within the health care system and has recommended UNICEF UK BFI as a minimum standard within the NICE postnatal care guidelines and the NICE maternal and child nutrition guidelines.[6, 7]

The WHO/UNICEF internationally recognised best practice standards for breastfeeding include the *Ten steps to successful breastfeeding* (applicable to hospital setting) and the UK UNICEF's *Seven point plan for community settings*.[15]

Ten steps to successful breastfeeding

1. Have a written breastfeeding policy that is routinely communicated to all staff.
2. Train all staff in the skills necessary to implement the policy.
3. Inform all pregnant women about the benefits and management of breastfeeding.
4. Support mothers to initiate breastfeeding soon after birth.
5. Show mothers how to breastfeed and how to maintain lactation if separated from baby.
6. Give no other food or drink to breastfed babies unless medically indicated.
7. Avoid separation of mothers and babies and encourage rooming-in.
8. Practice baby-led feeding.
9. Avoid teats and dummies during the establishment of breastfeeding.
10. Refer all breastfeeding mothers to local and national breastfeeding support contacts.

Seven-point plan for community settings

1. Have a written breastfeeding policy that is routinely communicated to all staff.
2. Train all staff in the skills necessary to implement the policy.
3. Inform all pregnant women about the benefits and management of breastfeeding.
4. Support mothers to initiate and maintain breastfeeding.
5. Encourage exclusive and continued breastfeeding with appropriately timed introduction of solid foods.
6. Provide a welcoming atmosphere in healthcare facilities for breastfeeding families.
7. Promote cooperation between healthcare staff, breastfeeding support groups and the local community.

Funding and promotion of the UNICEF UK BFI

All three responding commissioners confirmed activity in relation to achieving the BFI award. According to the EHSSB health promotion commissioner, this has been written into their communicating intent and Key Quality Indicator (KQI) over the years, while the EHSSB IfH commissioner reported that this is happening in north and west Belfast.

In contrast to the commissioners, members of the BSIG presented more varied views on promotional support for UK BFI accreditation. Two respondents acknowledged that promotion has been varied depending on Board area, with one of them commenting:

> *"EHSSB has actively commissioned breastfeeding courses and support through* Fit Futures *for Trusts to achieve BFI accreditations."* (BSIG member 1)

Breastfeeding coordinators confirmed progress with more facilities seeking BFI accreditation, although commissioning of this process is variable. The necessary resources required to achieve and maintain accreditation have not been made available in all of the Boards. In addition, some Trusts have not appointed breastfeeding coordinators, making it difficult to maintain high standards of care unless protected time is given to auditing and providing update training (see Action point 1 for more detail). The resource issues involved in the assessment process is also a concern, with some Trusts finding it difficult to access the funding needed to participate in BFI, particularly if follow-up visits and reassessments are required.

According to most breastfeeding and Sure Start coordinators, the majority of the Trusts and Sure Starts they work in have been implementing recognised best practice standards for breastfeeding. The involvement varied between 3–11 years and 1–7 years as reported by breastfeeding and Sure Start coordinators, respectively. This high involvement in UK BFI is further supported by the responses from midwives and health visitors. Five midwives (between 2000 and 2007) and health visitors (between 2003 and 2007) each stated that their Trust achieved UK BFI accreditation. One said that their Trust was working towards it, with one health visitor stating that their Trust was not working towards it.

All 11 breastfeeding coordinators reported that funding for seeking and maintaining UNICEF UK BFI accreditation was received from the Trusts. Sure Start coordinators involved in implementing UK BFI stated that their Sure Starts received funding from local commissioning groups (LCGs) and IfH partnerships, with four saying their Sure Start funded the involvement, while Boards (n=3) and Trusts (n=2) also provided funding.

The cost of external assessments required to achieve BFI accreditation is £8,000 in an average four year period. NICE has published a resource analysis and found the process of BFI accreditation to be a cost effective mechanism for increasing breastfeeding initiation rates.[16]

Difficulties in implementing standards

All four professional groups also reported on the most difficult aspects of implementing BFI best practice standards. Breastfeeding coordinators provided rich detail on the challenges they face, while Sure Start coordinators, midwives and health visitors made fewer comments. The key

challenges faced are outlined below: some are inherent to maintaining BFI standards, others relate to staff, resources, community working, and educating mothers. It needs to be noted that these challenges are also interlinked and not independent from each other. Within each key area, the following more specific challenges have been identified:

Maintaining standards

Nine breastfeeding coordinators and five Sure Start coordinators were the lead persons for implementing best practice standards for breastfeeding in their Trust or Sure Start. Active involvement in carrying out audit was reported by 10 breastfeeding coordinators and half of the Sure Start coordinators and health visitors. Specific challenges in maintaining standards include:

- audit with difficulties in accessing mothers and their ability to recall the required information;
- maintaining best practice standards against competing pressures and continuously updating policies and guidelines;
- coordination of BFI activity with communication problems in joint projects;
- competing factors such as formula companies that push their interests.

> *"My biggest problem is doing audits – getting access to women at clinics and getting them to recall who has told them what. I find that they confuse the hospital info, community midwife info and HV [health visitor] info."* (Breastfeeding coordinator 7)

> *"Keeping the international code of milk marketing. Trying to stop the rep with lunch. Now the latest problem is "cases" on milk allergy which the health visitors have been attending in droves and bringing back all the formula pens, tissues, etc."* (Breastfeeding coordinator 10)

Staff factors

- Motivation issues in terms of understanding the usefulness of BFI, commitment to BFI and its repeated award process and attending training.
- Changing staff attitude toward breastfeeding practice.
- Completing training, training of new staff members and providing consistent messages to new mothers.
- Providing support during critical incidences (eg readmission of dehydrated babies).

> *"From a senior management perspective – lack of understanding of commitment required to obtain Baby Friendly accreditation."* (Breastfeeding coordinator 11)

> *"Still arguing the corner for BFI with diehard staff hankering for old practices!"* (Breastfeeding coordinator 2)

Resources

- Time constraints with no allocated time for post (breastfeeding coordinators) and insufficient time to spend with new mothers (midwives).
- Staffing issues due to high workloads and low staff ratios.
- Financial constraints.

In relation to funding, BSIG members reported that some of the Boards had funded breastfeeding coordinator posts (see Action point 1 for further detail) which aim to support implementation of best practice. In contrast, *"other Boards have not funded the role of achievement of BFI"*, with a reluctance to fund Baby Friendly assessments. One respondent was uncertain about the commissioners' input but had noticed an increase in activity towards achieving BFI:

> *"I do not know how much commissioners have promoted Baby Friendly but there are certainly many more BFI awards and certificates of commitment than nine years ago."* (BSIG member 3)

Breastfeeding and Sure Start coordinators differed in their assessment of sufficiency of resources. Breastfeeding coordinators were split on the issue of resources for assessments, action planning visits and courses. They also acknowledged that finances, while once sufficient, were now getting scarcer. Sure Start coordinators generally felt that sufficient resources were available for assessments and action planning visits. However, the availability of resources for courses was equally confirmed and complained about.

> *"Allowed to stay in post – asked to work on wards/clinic over two years."* (Breastfeeding coordinator 8)

> *"Financial constraints – dilution of services to facilitate the whole Trust – limited hours for BFI."* (Breastfeeding coordinator 11)

Community working

- Lack of antenatal contact with pregnant women to promote breastfeeding (Sure Start).
- Working in areas with low breastfeeding rates.

> *"Working across a large multicultural area with a history of very low breastfeeding rates."* (Sure Start coordinator 5)

Educating mothers

- Change mothers' attitudes to infant feeding and support them to make informed choices (eg alternatives of mixed feeding, breast milk feeding).
- Provision of consistent advice to mothers from various health professionals.
- Issues around the non-use of available materials.

> *"Change mothers' perspectives on things like 'topping up' and using soothers."* (Midwife 6)

> *"Ensuring continuity of advice and getting away from professionals giving 'their take on advice' therefore conflicting opinion."* (Health visitor 8)

Although there was overlap in the issues raised, some challenges seemed more salient to particular stakeholder groups. Breastfeeding coordinators focused primarily on maintaining standards, audit, and formula company representatives, while Sure Start coordinators stressed lack of antenatal contact with women and working in area with low breastfeeding rate. Midwives' concerns were time, education of/messages to mothers and maintaining standards

despite competing interests. Health visitors felt challenges around staff training in terms of time and resources and education of mothers.

From a more strategic, assessor perspective, the regional breastfeeding coordinator highlighted the following standards that hospitals and community settings particularly struggle with:

Hospital:	*Step 3 – effective antenatal information.* *Step 5 – support with positioning and attachment.* *Step 5 – teaching all breastfeeding mothers hand expression.* *Step 6 – supplementation of breastfed babies except for fully informed maternal choice or clinical indication.* *Step 7 – rooming-in (Northern Ireland seems to struggle with this).*
Community setting:	*Point 3 – effective antenatal information.* *Point 4 – support with positioning and attachment by the health visitor.* *Point 4 – checking all breastfeeding mothers now how to hand express.* *Point 7 – providing support contacts: professional, voluntary and out of hours.*

Rewarding aspects of improving care

The health professionals also reported on what they consider the most rewarding aspects of improving care. The responses reflected a deep sense of achievement and reward from implementing BFI. Improved outcomes, in terms of breastfeeding rates, mothers' awareness and confidence and achieving BFI milestones, are seen as the result of competent advice and support, changed breastfeeding practices, improved staff attitude and commitment, and training.

Improved outcomes

- Positive feedback received generally and at audit.
- Increased breastfeeding rates (initiation rate, duration).
- Increased awareness of breastfeeding benefits and positive feedback regarding its promotion.
- Increased confidence and satisfaction in mothers.
- Reduction in breastfeeding problems.
- Achieving assessment.

> *"It's very rewarding mum and baby thriving through breastfeeding with your support. Our community is more aware of the benefits of breastfeeding."* (Sure Start coordinator 9)

> *"Outcomes – more women initiating breastfeeding and breastfeeding for longer."* (Midwife 5)

Competent advice and support

- Increased staff knowledge and confidence (eg regarding potential problems when breastfeeding).
- Improved and consistent advice for mothers/parents.
- Establishment of better breastfeeding support (in hospital, support groups, peer support) and better uptake.

"Achieving 100% in care of breastfeeding mother in postnatal and neonatal unit." (Breastfeeding coordinator 5)

"Increase health professionals encouraging mother to breastfeed. Support offered to those who breastfeed." (Health visitor 5)

Changed breastfeeding practice

- Establishment of key practices: skin to skin, first feed, positioning, fewer compensatory feeds.
- More promotion of breastfeeding and improved information ante- and postnatally, including better facilities.
- Midwives and health visitors working together.

"Experience from carrying out assessments within NI would suggest that changes to breastfeeding practice such as early skin to skin contact and improved information giving both antenatal and postnatal has made a significant difference." (Breastfeeding coordinator 12)

Improved staff attitude and commitment

- Staff well motivated and committed to improving breastfeeding outcomes for mothers.
- Changed attitudes to breastfeeding among staff at various levels.

"Commitment from health professionals to improve breastfeeding outcomes for mothers." (Breastfeeding coordinator 11)

"Attitude changes within Sure Start support staff." (Sure Start coordinator 1)

Training

- Regular staff training ensured and expected by staff.
- Opportunity to explore experienced barriers to improving care.

"Training of staff through the UNICEF UK BFI breastfeeding management course provides important opportunities to meet with practitioners and explore what the main barriers are to improving standards of care." (Breastfeeding coordinator 12)

"I think the main positive aspect of BFI – that it sets the expectation for regular staff training." (Midwife 3)

Breastfeeding coordinators stressed particularly the giving of competent advice and support for mothers, changed practice and training, whereas Sure Start coordinators focused more on explicit outcome factors such as increased breastfeeding rates and duration. Both coordinators valued improved staff attitude and commitment. Midwives and health visitors considered competent and consistent advice and support, changed practice, and the increases in breastfeeding as particularly rewarding.

2.3 The commissioners responsible for breastfeeding services should meet on an annual basis to share information and experience

The IfH commissioner responses to this part of the questionnaire were varied. The EHSSB health promotion commissioner stated that information was shared at health promotion commissioner meetings which occured every six to eight weeks. However, in terms of success of these meetings, she noted that *"the information exchanged is at a superficial level because this is not a priority area of work for all health promotion commissioners"*.

The IfH commissioner pointed out that IfH managers are not included at these meetings, which contributed to a less coordinated approach in the area of health promotion:

> *"Investing for Health managers have not been included in EHSSB area. More coordination needed here to strengthen the outworking of the inequalities agenda and the health issues and health promotion agencies. IfH commissioners and health promotion commissioners should be commissioning regularly to ensure that the local health improvement planning priorities of IfH strategy are reinforced through the development and implementation of health promotion programmes."*

In contrast in the SHSSB, the commissioner (for health promotion, maternal and child health, IfH) noted that no meetings had taken place because other health improvement strategies had been prioritised as a DHSSPS requirement and such meetings had not been a Priorities for Action (PfA) target since 2001–02.

Outlook

- Integrate breastfeeding into all health-related policies and strategies and further support and expand UK BFI accreditation by making it compulsory for both community and hospital based Trusts. Participate in UNICEF BFI university standards.

In contrast, two critical voices cautioned that BFI was interfering with breastfeeding research in NI because it monopolised the promotion and support of breastfeeding, thus preventing the investigation of new and innovative approaches of promotion and support (Breastfeeding coordinator 6, health visitor 3).

> *"BFI should not be interfering in breastfeeding research – BFI should accept there are many other issues needing to be addressed and not penalise/threaten Trusts for being courageous in looking at new ways of working."* (Breastfeeding coordinator 6)

Summary

- According to commissioners, breastfeeding-specific services have been included in strategic planning documents but awareness of this was low among members of BSIG.
- BSIG reported that breastfeeding coordinator posts and breastfeeding education and support (eg peer support, groups) are among the key achievements of the commissioning process.

- Good progress in achieving UK BFI accreditation has been made, with widespread implementation. This has resulted in positive changes in breastfeeding rates through improved practices. Those leading implementation of BFI have been provided with advice and support to develop training and audit health care practice. However, commissioning of the process and provision of sufficient resources (funding, protected time) was varied.
- Annual meetings of commissioners responsible for breastfeeding services did not occur regularly, with a further lack of information-sharing due to the precedence of other health promotion strategies.

3. Collecting regional information

Procedures are needed for capturing regional information on breastfeeding incidence and prevalence across the province. This information should be collected in a standardised format to allow comparisons and calculation of trends over time.

Recommendations

- The Child Health System (currently used in all HSS Trust should be developed to capture the information required.
  Agents for action: DHSS, commissioners and providers

- Northern Ireland should continue to participate in the UK-wide five-yearly *Survey of infant feeding*.
  Agent for action: DHSS

Responses to the recommendations within Action point 3 have been sought from the BSIG members, commissioners, Child Health System information managers (CHS IMs), breastfeeding coordinators, Sure Start coordinators, midwives, and health visitors. The individual recommendations responded to by each stakeholder alongside the responses rates are highlighted below.

	Response rate	Recommendation
• BSIG members	4/12	3.1-2
• Commissioners	3/10	3.1
• Director for Research and Analysis (DHSSPS)	1/1	3.2
• CHS IM	4/4	3.1
• Breastfeeding coordinators	12/18	3.1
• Sure Start coordinators	10/25	3.1
• Midwives	6/25	3.1
• Health visitors	8/25	3.1

3.1 CHS (currently used in all HSS Trusts) should be developed to capture the information required

CHS is the primary vehicle that is used to record surveillance or routine data on infant feeding in NI. Both commissioners who responded to the strategy review (SHSSB and EHSSB) were aware of this system, with the SHSSB commissioner reporting a representative from their area sits on and chairs the regional CHS user group.

Over the lifetime of the breastfeeding strategy (since 1999), changes have been made to the CHS in the way data are captured. These changes came into effect from April 2007 with the CHS3b neonatal discharge form and HALL 4 Personal Child Health Record (PCHR, 'red book') and affected terminology and recording times. The terminology of recording feeds was changed from *1 Breast, 2 Bottle, 3 Breast and Complimentary* and *8 Other* to *Breastfeeding 1 Total, 2 Partial, 3 Not at all*.

Information is gathered on children's feeding behaviour at various stages in their first year of life: at hospital discharge, health visitor first visit, 6 weeks, 3 months, 6 months, 12 months. However, the 6 weeks, 6 and 12 months feeding information that is required does not coincide

with a children's health assessment. Information on feeding behaviour at these time points is therefore gathered at the next available assessment, ie the 6 week information is gathered at the 8 week assessment, and that required for 6 and 12 months is gathered at a child's 15 month assessment. Both the PCHR (red book) and the CHS3 and 3b forms were updated to hold this new data format. There was some local variation in recording infant feeding information on the CHS prior to the changes introduced in 2007, with the CHS in the Northern HSSB (NHSSB) area only having routinely collected information on breastfeeding at discharge.

Training issues for health professionals since the implementation of Hall 4

Although training was provided to midwives and health visitors for the implementation of Hall 4, there seems to be uncertainty that this has been fully sufficient. A particular concern among three of the CHS information managers (Western Health and Social Care Trust (WHSCT), Southern Health and Social Care Trust (SHSCT), NHSCT) is the correct recording of breastfeeding status at the various contact times. This requires further reinforcement for health visitors on its importance, particularly when the mother did not commence breastfeeding. The CHS information manager for NHSCT reiterated the concern over adequate knowledge of health professionals and definitions of expressing breast milk as the training was not provided by the CHS information manager throughout all the NHSCT area.

Awareness of data collection periods

CHS information managers showed good awareness of the changes and new working practices but some inconsistencies appeared. While the Belfast and SHSCT CHS information manager stated a recording time at eight weeks, the managers from the Western and Northern Trusts stated six weeks. Given the differences stated above between when the information is collected, and the time period the information corresponds to, may account for the different answers given by the information managers. One manager (SHSCT) also noted that although breastfeeding at newborn assessment and discharge from community midwife are reported, they are not recorded on the CHS.

Among the midwifery and health visiting staff that responded, half of the midwives (three out of six) and three quarters of health visitors (six out of eight) were involved in recording infant feeding method. Four midwives recorded on the Northern Ireland Maternity System (NIMATS), with two of them also using CHS, and two further midwives reported that the BF coordinator collects breastfeeding data. All responding health visitors had the CHS system in place for recording infant feeding statistics. However, they reported some variation in the frequency that infant feeding data was recorded:

- four health visitors said data on infant feeding was recorded at 8, 12, 16 weeks contacts;
- two health visitors collected additional data on feeding at a 15 month review;
- one health visitor commented data was recorded on all returns to CHS;
- one health visitor said data was only recorded at discharge.

It should be noted that a recording at 16 weeks was not mentioned by CHS information managers who stated that infant feeding data are recorded at 6, 9 and 12 months after the 12 week recording.

Recording of data

Among breastfeeding coordinators, breastfeeding information was most commonly recorded on the CHS system, with few recording on NIMATS, stating the IT department and the midwifery register. Sure Start coordinators said infant feeding statistics were recorded on "paper or hard copy", on the CHS, through the Trust, and via questionnaires issued by either the midwife or health visitor. One respondent cited a number of ways statistics were recorded in their Sure Start including *"attendance at breastfeeding groups, references from midwives, home visits, and questionnaires"* (Sure Start coordinator 3). Another coordinator replied that infant feeding statistics were *"not recorded but can be accessed as I would remember those who feed"* (Sure Start coordinator 10). Generally, breastfeeding coordinators report, collate and disseminate breastfeeding information more frequently than Sure Start coordinators.

With reference to the CHS, BSIG members and CHS information managers agreed that the collection of data at discharge was good and that some progress had been made with the new PCHR (red book) on the definitions and recording times. However, the CHS is not considered to fully meet its function and a number of key problems were identified by the consulted stakeholders.

> *"Presently, the CHS is not able to collate information on breastfeeding duration. Discussion with CHS managers has confirmed that changes needed to the system have significant resource implications which cannot be met. However, progress has been made in making changes to the PCHR (red book) with new definitions and recording times clarified."* (BSIG member 1)

> *"To my knowledge, the CHS information recorded at discharge would be reliable, but not at eight weeks."* (Belfast/Eastern CHS information manager)

Across the responding CHS information managers, breastfeeding and Sure Start coordinators, midwives, and health visitors there was agreement on the key problems in collecting and recording data (see Table 2). These key issues relate to the definition and coding of breastfeeding information; significant problems exist due to poor and inaccurate recording of data by health professionals, exacerbated by a lack of sufficient CHS software and limitations due to geographical area coded by postcode.

These key problems then impact on collating and reporting infant feeding information. In particular, it is difficult to provide accurate and complete infant feeding statistics for specific timeframes. Time lags between occurrence and recording of the feeding method delay the provision of statistics and limitations posed by the software in causing problems for data manipulation and extraction.

> *"A recent audit on the implementation of Hall 4 in the SHSCT identified poor reporting from professionals and poor recording from the CHS staff. From the CHS perspective, this is possibly as a result of not having appropriate software to link the [breastfeeding] BF data to the individual contact. Further reinforcement to health visitors is also required on the importance of recording BF at the contacts. Analysing the data in the free text field as the free text field is subject to varying methods of recording. … Timing for producing the stats for, for example, BF [breastfeeding] at 6 and 12 months cannot be produced until the 15 month contact has been carried out and inputted to the CHS. …"* (Southern CHS information manager)

"Information on breastfeeding has been known to contain inaccuracies, for example, definition of breast milk in a bottle, one breast milk feed after birth but not on discharge, yet recorded as breastfeeding on discharge. Unsure of reliability of information currently. There is also a big issue around the fact that CHS software has not yet been developed to properly record this information. Information from first visit until 12 months is held in a single text field in an abbreviated format, eg TFV T6W T3M P6M N1, which means total at first visit, total at 6 weeks, total at 3 months, partial at 6 months and not at all at 1 year. The codes for breastfeeding at discharge were changed on the documentation but have not yet been changed on the system, so this means that CHS staff are having to manually map the new codes and new information to the existing codes relating to the old definitions which are held on CHS. The new codes are 1 – total, 2 – partial and 3 – not at all. The old codes on CHS are 1 – breast, 2 – bottle and 3 – breast and comp. Obviously, both 1s match but 2 and 3 are the wrong way round. As CHS staff are having to manually map this new information to the old codes, there is an increased risk of error." (Northern CHS IM)

Table 2. Issues identified in the collection, recording, collating and reporting of information

Collecting and recording information	Collation and reporting of information
1. **Defining and coding of breastfeeding information** • Time of discharge varies between 6 hours to 6 days • Time lag between occurrence and recording of feeding information (feeding at 6 weeks recorded at 8 weeks and at 6 and 12 months recorded at 15 months) • No code for breast milk feeding	• Delay in accessing 6 and 12 months feeding information due to recording at 15 months – statistics not readily available
2. **Poor and inaccurate recording of data by health professionals** • Incomplete forms/PCHR • Incomplete and inaccurate recording on CHS	• Impacting on data quality – produced statistics may be inaccurate or incomplete
3. **Lack of appropriate CHS software** • Mismatch between codes used when collecting feeding information and codes for recording this information onto CHS - potential human error in mapping • Different recording times need entered into the same free text field	• Impacting on data quality • Problems in data manipulation and extraction: problems in producing statistics for particular time frames
4. **Geographical coverage** • Information recorded by postcode	• Information by geographical area is difficult to access and only partially covered because HSCT and Sure Start boundaries do not coincide with postcode areas

"BF at discharge from hospital recorded on NIMATS. However, discharge from hospital can be from six hours to six days." (Breastfeeding coordinator 4)

"Getting health professionals to tick the boxes. CHS has to send forms back to get them completed properly." (Breastfeeding coordinator 7)

"The lack of coordination between midwife held notes and CSP [Children's Services Planning] data. Statistics have to be manually counted." (Sure Start coordinator 4)

"The statistics are recorded in postcode areas. Since Sure Start does not cover all of these postcodes – only partial cover of BT15 and 14." (Sure Start coordinator 7)

Accessing breastfeeding information

Breastfeeding and Sure Start coordinators accessed breastfeeding data for audit and reports either manually or via CHS, NIMATS, or locally held Sure Start data (Sure Start coordinators only).

Breastfeeding coordinators obtained regional statistics on breastfeeding primarily from the regional breastfeeding coordinator at the HPA and the IFS, with the CHS accessed in fewer cases. In contrast, Sure Start coordinators relied primarily on the CHS and IFS, with some accessing information via the regional breastfeeding coordinator at the HPA, while CSP and Eastern Childcare Partnership were only used in single cases.

There appears to be a lot of variation in the frequency of feedback on infant feeding methods that midwives and health visitors receive from their HSC Trust. When occurring regularly, feedback varies between once per year to every six weeks, with some health visitors never or only sporadically receiving such information.

Suggestions to improve CHS function in gathering breastfeeding information

The most vital improvement listed by CHS information managers (SHSCT, NHSCT, Belfast Health and Social Care Trust [BHSCT]) is to get the appropriate software installed so that infant feeding information can be accurately recorded at the core times. More training for professionals to ensure use of the same codes to record information was suggested by the CHS information manager for Belfast.

"More training for professionals for all to use the same codes. Software amendment on CHS to capture the information when the department required." (Belfast/Eastern CHS IM)

"Software development is needed for CHS to be able to record breastfeeding status at each of the core times and to also be able to link this record to the health visitor contacts at which the information should be collected. This software development has been listed as a requirement under the specification for all developments arising out of the implementation of Hall 4. However, timescales for the development and implementation of this are as yet unknown because there had been a long delay securing funding from the DHSSPS and now there are other emerging pressures impacting on the CHS, such as changes to blood spot screening and HPV programme, which are having to take priority." (Northern CHS IM)

In addition to the resource implication of having the appropriate software, members of the BSIG and health visitors were also concerned at the depth of the collected data as a means of improving the CHS' data collection function:

- Collecting detailed information on breastfeeding duration.
- Detail on the first two weeks (when there is the highest rate of abandoning breastfeeding).
- *"Detail at 'the other end' of a lactation, when the focus is less likely to be on feeding and information may not be sought or recorded"* (BSIG member 2).
- More detail on partial feeding (eg number of feeds).

Individual health visitors also pointed to the difficult retrieval of information on the CHS computer system and suggested that information should be recorded by their department to enable retrieval of data when required. A further suggestion concerned the long gap of no contact between 16 weeks to 1 year to accurately collate figures and collecting breastfeeding information beyond at birth and at discharge.

3.2 NI should continue to participate in the UK-wide five yearly IFS

Given the DHSSPS was the main agent for action to be tasked with this recommendation, only BSIG members and the acting director for research and analysis were consulted.

Most members of the BSIG that responded judged participation in the IFS to be very important. It is seen as the most reliable source of data on infant feeding methods in Northern Ireland, with the following reasons given for its importance:

- allowing comparisons of breastfeeding rates with the rest of the UK;
- tracking trends in breastfeeding rates (also by demographic groups);
- tracking progress and areas for action as part of implementation of the strategy
- making presentations;
- informing the media about infant feeding trends.

The director for information and analysis (DHSSPS) provided the following information on IFS:

> *"Detailed Northern Ireland specific information from the 2005 infant feeding survey is reported in the UK-wide report that was published in May 2007. Early results from the 2005 survey were published in May 2006."*

The reports are accessible on the Information Centre for Health and Social Care website.[17]

Outlook

- Improve the functioning of CHS by appropriate software, further training in recording breastfeeding information, review of depth of data collected, and timing of data recording. Emphasis should be placed on agreed definitions for collating breastfeeding statistics.
- With the introduction of the new centile charts, more training will be required. Breastfeeding coordinators should be involved in training delivery to ensure a strong focus on breastfeeding.

Summary

- CHS is not meeting its data-capturing function fully, with the lack of appropriate software the key problem. Further training for health professionals is required to eliminate inaccurate or incomplete recording of feeding behaviour.
- Participation in the UK-wide *Infant feeding survey* (IFS) was considered invaluable for providing reliable data for comparison and tracking trends.

4. Focusing research

Most breastfeeding research in NI consists of unpublished studies submitted as part of undergraduate or postgraduate work. The findings of these studies are characterised by several themes, which are consistent with the ONS *Survey on Infant Feeding* 1995 and with several published studies conducted in the Republic of Ireland and in Britain.[18]

These findings are as follows:
- Breastfeeding in the presence of family members or in public places, even when carried out discreetly, tends to be embarrassing and unacceptable to the mother and others.
- There is confusion, associated with embarrassment, between the sexual and nurturing functions of the breast. This is relevant to the choice of educational and publicity materials.
- Male partners' attitudes significantly affect the choice and success of breastfeeding. Teenagers do not identify with breastfeeding.
- Artificial feeding is perceived as the norm; there is a concomitant lack of confidence in breastfeeding as a method of feeding.
- Health care systems do not always give optimal support to breastfeeding.

Recommendations

- Further research is needed to obtain information in the following areas:
  - most effective methods of promoting and supporting breastfeeding;
  - reasons for breastfeeding variations in different areas of Northern Ireland;
  - effective approaches for low uptake areas and social groups;
  - reasons for early cessation;
  - effects of women's working patterns and maternity leave;
  - effective breastfeeding education in schools.

  Agents for action: Northern Ireland Breastfeeding Strategy Group will provide and facilitate research through liaison with DHSS, Queen's University Belfast, University of Ulster and the voluntary sector.

Responses to the recommendations within Action point 4 were sought from academic departments within QUB and UU as well as from the statutory sector, BSIG members, the Research & Development (R&D) office (now PHA R&D), the director for information and analysis (DHSSPS), breastfeeding coordinators, Sure Start representatives, health visitors and midwives. [QUB: Schools of Medicine, Dentistry and Biomedical Sciences; Nursing and Midwifery; Psychology; Sociology, Social Work and Social Policy. UU: Schools of Nursing; Psychology; Sociology and Applied Social Studies; Biomedical Sciences; NI Centre for Food and Health; Institute for Postgraduate Medicine.]

	Response rate	Recommendation
• BSIG members	4/12	4
• Academic departments at QUB and UU	5/10	4
• DHSSPS: director for research and analysis; R&D Office	2/2	4
• Breastfeeding coordinators	12/18	4
• Sure Start coordinators	10/25	4
• Midwives	6/25	4
• Health visitors	8/25	4

Breastfeeding research conducted by academic departments

Academic departments were asked to provide details of any studies carried out to date, either by staff or students, which were applicable to the areas identified in Action point 4 of the strategy. These studies could be published or unpublished, and including those underway. The information provided is summarised below under each of the areas recommended for further research in the strategy. Where reference is made to published papers, these references can be found in Appendix 3.

From the information received from academic departments, it can be seen that the majority of academic work to date (eight studies) has investigated 'the most effective methods of promoting and supporting breastfeeding'. This involved studies investigating, for example, factors involved in mothers' decisions and different interventions (including online support, training programme). In contrast, only one study was identified which incorporated the investigation of the 'effects of women's working patterns and maternity leave'. Please note that several research projects span a number of the identified research topics.

Funding was primarily provided by the NI R&D office, with few projects supported by the Department for Employment and Learning (DEL) and the UK Department of Higher and Further Education Training and Employment (DHFETE).

Table 3. Overview of research projects by topic

Project title	Department	Lead researcher
a) The most effective methods of promoting and supporting breastfeeding (n=8)		
Research as part of the CHIP (Centre for Health, Intervention and Prevention) programme Found increased rates of breastfeeding in mothers with chronically ill infants who received no CHIP intervention [c]	QUB School of Psychology	McCusker C
Increased breastfeeding rate and ease of establishing breastfeeding following prenatal intervention [c]	QUB School of Psychology	Hepper P
Women's perceptions of support for breastfeeding in the postnatal period (MSc midwifery dissertation)	QUB Nursing & Research	Cooke P
Successful breastfeeding promotion: a motivational model of instructional design applied and tested 2002–2007 (PhD study) See Appendix 3 for published papers	UU Institute of Nursing Research	Stockdale J
Testing an online support system for breastfeeding[a]	UU Institute of Nursing Research	Principal Investigator: Sinclair M Student: Heron M
Paper IV – 'Factors influencing infant feeding choices in Northern Ireland' in 'The psycho-social aspects of infant feeding – PhD 2008' [b]	UU Institute of Nursing Research	Sittlington J
Identifying factors determining infant feeding decisions in new mothers (qualitative enquiry followed by attitude survey using the IOWA Infant Feeding Attitude Scale and an observational study)[a] See Appendix 3 for published papers	UU NICHE (NI Centre for Food and Health)	Sittlington J, Wright M, Stewart-Knox BJ
Factors determining infant feeding decisions in mothers undergoing antenatal care within the County Antrim area[a] See Appendix 3 for published papers	UU NICHE	Stewart-Knox, BJ, Gardiner K & Wright M

Project title	Department	Lead researcher
b) The reasons for breastfeeding variations in different areas of Northern Ireland (n=2)		
'Paper IV – Factors influencing infant feeding choices in Northern Ireland' in 'The psycho-social aspects of infant feeding – PhD 2008' [b]	UU Institute of Nursing Research	Sittlington J
'Paper II – Infant feeding attitudes of expectant mothers in Northern Ireland' in 'The psycho-social aspects of infant feeding – PhD 2008' [b] See Appendix 3 for published paper	UU Institute of Nursing Research	Sittlington J

Project title	Department	Lead researcher
c) Effective approaches for low uptake areas and social groups (n=4)		
Research as part of the CHIP programme Found increased rates of breastfeeding in mothers with chronically ill infants who received no CHIP intervention [c]	QUB School of Psychology	McCusker C
Increased breastfeeding rate and ease of establishing breastfeeding following prenatal intervention [c]	QUB School of Psychology	Hepper P
Improving the outcome of pregnancy and early infancy with an intervention study in women from socially deprived areas of Belfast – the MOMENTS study 01/08/03 – 31/12/06	Feedback from R&D office	Halliday H, Stewart M, Percy A, Hepper P, Cupples M
Can peer mentoring in first time mothers from socially deprived areas, during pregnancy and the first year of the infant's life, have sustained effects on child growth, health and development and maternal health and well-being? 01/10/06 – 31/03/09	Feedback from R&D office	Halliday H, Stewart M, Percy A, Hepper P, Cupples M

Project title	Department	Lead researcher
d) Reasons for early cessation (n=2)		
Development of a Breastfeeding Motivational Instructional Measurement Scale (BMIMS) 2004-2005	UU Institute of Nursing Research	Stockdale J, Sinclair M, Kernohan G, Keller J
'Paper IV – Factors influencing infant feeding choices in Northern Ireland' in 'The psycho-social aspects of infant feeding – PhD 2008' [b]	UU Institute of Nursing Research	Sittlington J

Project title	Department	Lead researcher
e) Effects of women's working patterns and maternity leave (n=1)		
'Paper IV – Factors influencing infant feeding choices in Northern Ireland' in 'The psycho-social aspects of infant feeding – PhD 2008' [b]	UU Institute of Nursing Research	Sittlington J

Project title	Department	Lead researcher
f) Effective breastfeeding education in schools (n=3)		
Attitudes to breastfeeding: a health educational initiative with adolescents 01/08/04 – 01/08/06 See Appendix 3 for published paper	UU School of Psychology	Giles M, Stewart-Knox B, Wright M
Changing attitudes to breastfeeding: the evaluation of an evidence based intervention with adolescents in Northern Ireland 01/02/07 – 04/07/10	UU School of Biomedical Sciences. NICHE.	Giles M, Mallett J, McClenaghan C, Stewart-Knox B, Wright M
Attitudes to breastfeeding and breastfeeding promotion among teenagers in Northern Ireland [a]	UU School of Biomedical Sciences.	Greene J, Stewart-Knox B, Wright M

[Note: [a] funding received from DEL; [b] funding received from DHFETE; all other research projects funded by R&D office; [c] funder not known]

The director for information and analysis (DHSSPS) provided information on breastfeeding-related questions asked within the *Health and social wellbeing survey* (HSWBS) 2005/2006.[19]

The survey included questions on breastfeeding which asked parents if any of their children were breastfed, and for each child (up to the age of two years old) who was breastfed and how long this was sustained for (their first feed, at two weeks, at four weeks, at six weeks, at four months and at six months).

Parents were asked to indicate at each of these time periods whether the feeding was exclusively breast/bottle or mixed. This information has not been published anywhere but it can be accessed from the Public Health Information and Research Branch in DHSSPS. Currently, this survey takes place only every four years, but a proposal to replace it from April 2010 with a continuous NI health survey is being considered.

The involvement of BSIG in research activity

Members of BSIG indicated that they received information on research at conferences and seminars. They also reported having a widely varying involvement in promoting research into breastfeeding. This ranged from no involvement to considerable involvement through advising on research proposals, leading audits, and supporting a student through their PhD. This research involving BSIG members were:

- public information campaign evaluations;
- research into attitudes, knowledge and beliefs about breastfeeding in NI;
- an audit on the effects of teaching sessions on GP practice, and on new mothers' experience;
- research on motivational breastfeeding.

Health professionals' awareness of research and evaluation activity on breastfeeding in NI

Most breastfeeding coordinators who responded were able to name at least one breastfeeding study undertaken in NI in the past five years (9 out of 12), with over half of Sure Start coordinators (6 out of 10) being aware of such research. Only a small number of health visitors (2 out of 8) and midwives (2 out of 6) were aware of breastfeeding research undertaken in NI in the past five years.

One research group at UU had disseminated their research findings on 'Successful breastfeeding promotion: a motivational model of instructional design applied and tested' (more commonly known as 'designer breastfeeding') at a breastfeeding coordinators meeting. Therefore, this particular study was known to all breastfeeding coordinators but only two Sure Start coordinators and one health visitor.

A list of the various other research studies, which were generally just mentioned in single cases, is provided in Appendix 3. From this feedback it seems that some of the research being carried out in academic departments was identified by those in the statutory sector. Feedback from health professionals highlighted also other work not stated by academic departments. This work may be carried out within other settings, eg hospitals and schools. Some of the areas of

research identified fall outside the areas recommended in the action point. Only breastfeeding coordinators seemed to be aware of the work carried out in schools, most likely because this setting may not be as relevant for other statutory respondents.

Health professionals were also asked to specify if they were aware of any evaluations of breastfeeding interventions. There was less awareness of evaluation reports (in comparison to research) among breastfeeding coordinators, Sure Start coordinators, and health visitors, with some of these individuals misclassifying surveys as evaluations. The better known evaluations/ studies were the evaluation of peer support within NI (HPA; n=4), IFS (n=3), the summary report on knowledge, attitudes and behaviour 1999–2004 (HPA; n=2), HPA *Breastfeeding awareness in schools* evaluation (n=2), and the ongoing evaluation of the breastfeeding DVD (n=2).

Other evaluations were mentioned and these are listed below; however, in some cases not enough information was given to identify the specific source of work:

- breastfeeding in Northern Ireland;
- designer breastfeeding research;
- teenage pregnancy and parenthood;
- obesity strategy for Northern Ireland;
- HPA campaign evaluation;
- group looking at breastfeeding in Northern Ireland as part of breastfeeding strategy at the beginning;
- annual report of local statistics from lactation midwife.

Outlook

BSIG members and the four health professional groups suggested further research into breastfeeding promotion and support in NI is required in six main areas (a detailed overview of the suggested projects provided in Appendix 3):

A. **Attitudinal and motivational issues** (promotion of benefits, focusing on health professionals and mothers)
B. **Service approaches to support** (ante- and postnatal interventions, limitations of UK BFI)
C. **Support for breastfeeding** (support in the community, family and workplace)
D. **Breastfeeding difficulties** (care of physical problems, help-seeking behaviour, slow weight gain)
E. **Breastfeeding uptake and duration of breastfeeding** (demographic variation of breastfeeding uptake, specific subgroups, cessation reasons, breastfeeding older babies)
F. **Breastfeeding and young people** (attitudes, evaluation of school education programmes, young mothers)

Stronger research focus is needed on reasons for early cessation and how to reach those least likely to breastfeed.

There was some variation among responding BSIG members and health professionals over the areas for future research. Breastfeeding and Sure Start coordinators identified issues for

research across all the topic areas (A–F). BSIG members focused specifically on issues of breastfeeding cessation (vs factors for continued breastfeeding; E), UK BFI (B), and evaluating school education programmes (F). While midwives were interested in breastfeeding promotion (A), breastfeeding difficulties (D) and young people's attitudes (F), health visitors focused on interventions (A), breastfeeding support (C), long-term breastfeeding (E), and young people (F).

Some areas that health professionals recommended for further research have already had academic research undertaken (see main overview above). Thus, it can be assumed that either the statutory sector has limited awareness of work which is carried out by university departments or that members of the statutory sector believe that more could be done in addition to what is currently available.

In general, reasons for early cessation and how to reach those least likely to breastfeed are two of the key areas where more research is needed.

Summary

- Some research has been carried out to address all areas outlined in Action point 4. However, the majority has focused on 'the most effective methods of promoting and supporting breastfeeding'. Less research was undertaken on the 'effects of women's working patterns and maternity leave', 'reasons for early cessation', and 'reasons for breastfeeding variations in different areas of Northern Ireland'.
- Several studies have examined attitudes of young people and the development of breastfeeding education in schools. Yet, BSIG members and health professionals suggested this area for future research on outcome and process evaluations – indicating a potential lack of awareness of this work carried out by academic departments.
- Two respondents were critical of UK BFI interference with breastfeeding research due to its monopoly in promoting and supporting breastfeeding, thus preventing the investigation of new and innovative approaches of breastfeeding promotion and support.
- This provided an overview of the extent to which research had been carried out in a number of areas. Further investigation is needed to assess how the studies may have influenced practice and lead to interventions. This level of enquiry requires an in-depth appraisal of the research, which is beyond the scope of this consultation.

5. Training health professionals

The training and updating of health service workers in the promotion, support and management of breastfeeding is essential if consistent, scientifically sound and supportive information is to be provided to mothers.

Doctors

Medical undergraduates at QUB receive formal teaching on infant nutrition. However, across NI there is little regular systematic training in breastfeeding management for junior hospital doctors in the specialties of obstetrics and paediatrics, or for GP registrars. Three maternity units provide one hour of tuition six-monthly in lactation management; one GP training scheme provides one hour of training in the practical management of infant feeding including breastfeeding.

Recommendations

- Medical undergraduates should receive teaching in the promotion and management of breastfeeding within the contexts of preventative medicine, nutrition and child health.

  Agents for action: The Northern Ireland BSIG will liaise with the School of Medicine, QUB, to take this forward

- Each hospital, community paediatric department and GP training scheme should include appropriate teaching on practical breastfeeding management for all doctors in training. Because of staff turnover, this needs to be provided twice yearly for junior hospital doctors and annually for GP registrars.

  Agents for action: The Northern Ireland BSIG will liaise with the Northern Ireland Council for Postgraduate Medicine and Dental Education and local facilitators of post-graduate education

Midwives, health visitors, paediatric nurses and dietitians

All pre-registration diplomats and undergraduates receive formal education and training in relation to infant feeding including breastfeeding. The pre-registration midwifery programme also includes formal education and training on these subjects.

As part of the continuing education process, paediatric nurses, midwives and health visitors additionally have clinical supervision which supports good practice.

Multidisciplinary or undisciplinary training in depth in breastfeeding management for midwives, health visitors, paediatric nurses and dieticians has been provided in most Boards and Trusts in Northern Ireland To date, however, there are still few Trusts where no in-depth breastfeeding training has been provided.

Recommendations

- All Trusts in Northern Ireland should ensure that newly appointed midwives, health visitors, paediatric nurses and relevant dieticians receive an initial two-day update on breastfeeding promotion and management. A refresher programme should also be mandatory for these staff at maximum of three-yearly intervals.

  Agents for action: The Northern Ireland BSIG will liaise with the National Board for Nursing, Midwifery and Health Visiting for Northern Ireland; Queen's University Belfast; University of Ulster; consortia for in-service training; commissioners and providers

Responses to the recommendations within Action point 5 were sought from training providers, BSIG members; commissioners; breastfeeding coordinators; Sure Start representatives; health visitors and midwives.

	Response rate	Recommendation
• BSIG members	4/12	5.1-4
• Commissioners	3/10	5.2-4
• Breastfeeding coordinators	12/18	5.2-4
• Sure Start coordinators	10/25	5.3-4
• Midwives	6/25	5.3-4
• Health visitors	8/25	5.3-4
• Training providers:		
- QUB School of Medicine and Dentistry		5.1
- NIMDTA		5.2
- Dr Carol Campbell		5.2
- QUB School of Nursing and Midwifery		5.3
- UU School of Nursing		5.3
- The Beeches Management Centre		5.4

Doctors

Feedback on the training of doctors was provided by Northern Ireland Medical and Dental Training Agency (NIMDTA), BSIG members, commissioners, and breastfeeding coordinators.

5.1 Medical undergraduates should receive teaching in the promotion and management of breastfeeding within the contexts of preventative medicine, nutrition and child health.

Responses from BSIG members on training for medical staff were varied. It was considered that training for medical students at Trust level may be insufficient, and adequate coverage was dependant on provision by breastfeeding coordinators but this was not used throughout NI. One respondent stated there were "some materials which have been developed by coordinators at Trust level and these seem adequate for medical students. This curriculum isn't used throughout Northern Ireland".

Without information from QUB (the sole provider of undergraduate medical training in NI), it has not been possible to judge the depth of teaching on breastfeeding-related issues and which changes have been implemented following the breastfeeding strategy.

5.2 Each hospital, community paediatric department and general practice training scheme should include appropriate teaching on practical breastfeeding management for all doctors in training. Because of staff turnover, this needs to be six-monthly for junior hospital doctors and annually for GP registrars.

According to three BSIG members, some progress on the provision of such training regime for doctors in training has been made with a significant contribution from Dr Carol Campbell. Nonetheless, this training is still variable across the regions. In the Western Trust, provision for

junior doctors happens at the appropriate intervals but uptake issues due to work demands remain, while the GP registrar's programme does not include infant feeding. In contrast, the EHSSB health promotion commissioner reported that work in their area was more successful with GP registrars, with less work undertaken with hospital doctors.

Regional provision of breastfeeding education for GPs is currently delivered through the Child Health Surveillance training programme. This is primarily a 30 minute session on prescribing for the breastfeeding mother, usually delivered by Dr Carol Campbell or Dr Mary Donnelly. The challenge is ensuring that training is attended by all GPs and that it covers medications and common breastfeeding problems, such as mastitis, cracked nipples, thrush, insufficient milk supply. Lack of training among doctors (hospital, GP) was seen as a reason for mothers being inappropriately advised to cease breastfeeding. Clinical constraints and medical opinions on paediatric needs were seen as obstacles to training.

NIMDTA provided the following information on the context of the postgraduate training of doctors:

- obstetrics and gynaecology placements;
- case analysis in practice;
- attachments/discussions with health visitor;
- antenatal clinics;
- baby clinics;
- ST2 tutorials;
- child health core training day.

Breastfeeding is also part of the GP curriculum under the headings: care of children and young people, healthy people, and women's health.

As part of their roles and responsibilities, breastfeeding coordinators provide breastfeeding training to medical staff. Of the six hospital-based breastfeeding coordinators, five provide training in implementation of the breastfeeding policy to medical staff. One cautioned that this does not always happen and that staff are issued with an orientation pack that includes the unit's hypoglycaemia policy.

The length of training is about one hour every six months, with one coordinator reporting a three-hour session jointly conducted with the dietitian and consultants.

> *"Myself and my job share colleague… we usually get 1–1½ hours every six months for paediatricians and approximately 1 hour for obstetricians."* (Breastfeeding coordinator 2)

Midwives, health visitors, paediatric nurses and dietitians

Feedback on the training of non-medical staff was provided by UU School of Nursing, BSIG members, commissioners, breastfeeding and Sure Start coordinators, midwives and health visitors.

Student midwives (QUB) and health visitors (UU) are provided with breastfeeding education as part of their training programme. The UU School of Nursing provides breastfeeding education

for health visiting students on the Specialist Community Public Health PGDip BSC Hons Nursing Programme in Jordanstown. The 52 week programme (prior to 2008–09: 45 week programme) contains a three day breastfeeding workshop which covers the following topics:

- anatomy and physiology of the breast;
- cultural and social issues in breastfeeding;
- breastfeeding – good practice, 10 steps;
- attachment and positioning;
- hand expression;
- problem solving (mastitis/thrush/insufficient milk; damaged nipples, medications when breastfeeding);
- supporting mothers when separated from baby;
- alternative methods of feeding;
- nutritional aspects of breastfeeding/weaning/slow weight gain.

5.3-4 All Trusts in Northern Ireland should ensure that newly appointed midwives, health visitors, paediatric nurses and relevant dieticians receive an initial two-day update on breastfeeding promotion and management. A refresher programme should also be mandatory for these staff at maximum of three yearly intervals.

The responses from the four BSIG members varied on breastfeeding training for midwives, health visitors and paediatric nurses and its effectiveness. Training participation differs by area, with the challenge of training new staff within six months and staff shortages hampering release for training. Since 1999, the appointment of breastfeeding coordinators to some of the maternity units has enabled Trusts to develop their own in-service training programmes. One BSIG member (2) reported that in the Western Trust (Northern sector) training is *"part of Trust and Board policies and is being effectively implemented – with many resulting changes in practices and improvement in BF rates"*. However, this member stressed that pharmacists, as one source where mothers seek advice, are currently excluded from the training recommendation which needs to be changed.

> *"Almost all staff need more training. Only staff with a keen interest in breastfeeding obtain enough training. Women are still being given wrong information on breastfeeding that leads to breastfeeding cessation. Some staff are very good. Others don't know how to help if there is a problem and some are just awful."* (BSIG member 3)

Several UNICEF training courses have been funded by the EHSSB, Trusts, and the HPA. The Beeches also provide a two day breastfeeding management course based on the UNICEF course; this is delivered predominantly to Southern Trust staff. It was stressed that, despite these significant contributions to improving practice, there is still work to be done.

Breastfeeding training is devised and provided by most breastfeeding coordinators (n=10) and half of the responding Sure Start coordinators (n=5) for their organisation. One breastfeeding coordinator reported that there had been no breastfeeding training delivered in-house by their

Trust for the past five years; instead, a select few midwives and health visitors had attended UNICEF or Beeches courses.

One breastfeeding coordinator had attended a postgraduate course at UU (course not named), while seven breastfeeding coordinators and one health visitor reported that they had completed the QUB postgraduate breastfeeding module.

In general, in-service breastfeeding training has been devised and provided by breastfeeding and Sure Start coordinators and the Beeches. The QUB School of Nursing and Midwifery has developed and provided a postgraduate module.

Training for midwives and health visitors

The majority of breastfeeding coordinators had concerns about the effectiveness of undergraduate training for midwives and health visitors in breastfeeding education and skills. The regional coordinator reported that those coordinators who undertake Trust in-house audits have identified gaps in the knowledge and skills of newly qualified staff.

All midwives and most health visitors who responded attended one or more study days, courses, and conferences in the past five years as part of their training, with the majority of training being conducted by the breastfeeding coordinators. Also popular were UNICEF courses and HPA events. Training programmes for those providing practical support for breastfeeding families generally varied in length between 2–3 days (12–18 hours), with health visitors reporting slightly shorter courses (one half day mentioned) than midwives. Both midwives and health visitors received training that included a practical element on breastfeeding skills with positioning and attachment and hand expression of breast milk.

Training for paediatric nurses and dieticians

Seven and six breastfeeding coordinators reported to provide training for paediatric nurses and dietitians, respectively, with one stating that this initial training is only followed up when requested. No uptake by dietitians was mentioned by two coordinators. A few breastfeeding coordinators were uncertain who provided such training, while one coordinator reported no training being offered.

Breastfeeding awareness training for support staff

Half of the breastfeeding coordinators reported that health care assistants, family support workers, and reception and clerical staff receive breastfeeding awareness training as breastfeeding support staff. Such training is often provided by the breastfeeding coordinator but also by the Trust, the BFI coordinator, or the Beeches. There is great variation in hours of training with between 1 to 18 hours/3 days for health care assistants and family support workers, while reception and clerical staff generally receive about one hour or less of training. Seven breastfeeding coordinators have also been involved in training peer support mothers.

Training in the Sure Start setting

Half of the 10 responding Sure Start coordinators indicated that they provide the training in their organisation, with just four saying that all of their team had received breastfeeding training. Most

likely to have received training were family support workers, the coordinator, health visitors, and crèche/childcare workers, with some also stating clerical staff, midwives, peer group educators/ supporters, and outreach workers. All respondents said LLL had provided breastfeeding training and many also mentioning UNICEF UK BFI (8) and the Trust breastfeeding coordinator (7). In fewer cases, the Beeches, the health visitor and 'Sure Start – awareness' had provided training. Training ranged from 3–6 hours to 18 hours/3 day courses. Many Sure Starts had been involved in training peer support mothers.

Professional development
One key area to maintain and improve breastfeeding promotion and support are opportunities for professional development. The different health professionals specified different needs appropriate to their work remit; yet, issues of time for release (versus spending this time to support mothers) and financial constraints remain.

- Training in achieving and maintaining BFI accreditation (eg audit, visits of successful units).[a, c]
- Breastfeeding specific courses and refresher courses (training for trainers,[a] peers support training for mothers using Sure Start,[b] lactation consultant training,[c, d] local informal training sessions for health visitors).
    - o Third level education (MA level module on breastfeeding care/pharmaceutical issues;[a] breastfeeding module at QUB;[d] accruing modules towards a MA degree – no breastfeeding-specific provision in NI [d]).
- Continued updating (eg on treatment of mastitis, relevant research and initiatives in NI/ UK/RoI) not only exclusively for those giving breastfeeding management advice and more time available.[b, d]
- Breastfeeding unspecific courses/training (IT, project management,[a] health service management,[a] communication skills within multidisciplinary settings [b]).

[Note: [a] Breastfeeding coordinators; [b] Sure Start coordinators; [c] midwives; d health visitors]

Outlook

- A mandatory training programme, including communication skills, is needed to explore attitudes to breastfeeding among staff who have primary responsibility in caring for breastfeeding mothers. Following the implementation of NICE guidance and BFI standards, a mandatory training programme (eg e-learning, training pack) for all doctors is required. In addition, pharmacists need to receive continued training as mothers often seek their advice.
- In terms of professional development, there is further need for breastfeeding specific and non-specific courses (eg management, communication) among health professionals providing breastfeeding promotion and support.

Two BSIG members made the following suggestions for training:

> *"If NICE requirements and BFI standards are fully implemented, a training package which is mandatory for all [doctors] is needed; this would be e-learning or a training pack"* (BSIG member 1).

Summary

- According to BSIG members, teaching about promotion and management of breastfeeding to medical undergraduates can be improved. However, it is difficult to validate this without feedback from QUB School of Medicine, Dentistry and Biomedical Sciences (as the sole provider of undergraduate training in NI).
- Regional provision of breastfeeding education for GPs is delivered through the Child Health Surveillance training programme. Breastfeeding coordinators also provide breastfeeding training to medical staff. Despite progress, not all hospital doctors or GP registrars receive breastfeeding training as had been recommended.
- For non-medical staff, in-service breastfeeding training has been devised and provided by breastfeeding and Sure Start coordinators and the Beeches. A postgraduate module has been developed and provided by QUB. Student midwives (QUB) and health visitors (UU) are provided with breastfeeding education as part of their training programme. Although improvements have been noted, gaps in the provision and uptake of training of midwives and health visitors were reported, with midwives more likely to receive training than health visitors, paediatric nurses and dietitians.
- Time for release and financial constraints remain as barriers in professional development for health professionals.

6. Supporting special needs infants and their mothers

Evidence continues to accumulate on the particular benefits of breast milk feeding for special needs infants. Health professionals require training in the area of lactation management. Parents also require adequate education, both ante-natally and in the event of the birth of a special needs infant, in order that they may make informed choices on the feeding of their child.

Recommendations

- The management of breast milk feeding of special needs infants should be part of the training of health professionals, at a level appropriate to their area of work.
  Agents for action: see Action Point 5 (Training health professionals)

- Information on breast milk feeding of special needs infants should be collected on a regional basis, and made readily accessible to both health professionals and parents.
  Agent for action: The Northern Ireland BSIG

- Human milk banking should be developed within Northern Ireland, to support breast milk feeding of special needs infants.
  Agents for action: The Northern Ireland Breastfeeding Strategy Group will liaise with consultant paediatricians; consultants in communicable disease control; senior midwifery and paediatric nursing managers; commissioners and providers

Responses to the recommendations within Action point 6 have been sought from BSIG members, commissioners, training providers and the director of the human milk bank in NI. The individual recommendations responded to by each stakeholder alongside the responses rates are highlighted below.

	Response rate	Recommendation
• BSIG members	4/12	6.1-3
• Commissioners (EHSSB, SHSSB)	3/10	6.1-3
• Training providers:	2/6	
- QUB School of Medicine and Dentistry		6.1
- NIMDTA		6.1
- Dr Carol Campbell		6.1
- QUB School of Nursing and Midwifery		6.1
- UU School of Nursing		6.1
- The Beeches Management Centre		6.1
• Director of the human milk bank in Northern Ireland	1/1	6.3

The views of mothers explored in focus groups (mothers who were breastfeeding and those who stopped breastfeeding before they intended) are included in the synthesis of findings. Yet, it needs to be cautioned that these views may not represent the views of mothers who never breastfed.

6.1 The management of breast milk feeding of special needs infants should be part of the training of health professionals, at a level appropriate to their area of work

In relation to what specific training on breastfeeding special needs infants (ill and preterm babies) has been provided, very few responses were made by commissioners and BSIG members. It was reported that in-service courses included a section on breastfeeding ill and preterm babies; this focused on initiating and maintaining lactation, alternative methods of feeding, and safe storage of breast milk. It was also noted that the HPA had provided a training seminar on breastfeeding in special circumstances.

One of the BSIG members highlighted the current gaps in training and information and the impact of this.

> *"… resources and paediatric policies on fluid intake requirements and medical training did not highlight the importance of breastfeeding."* (BSIG member 4)

The only training provider to respond to the review was the nursing and midwifery education section at the Beeches. The centre provides training on breast milk feeding of vulnerable infants for all health professionals as part of their two day breastfeeding course 'Successful breastfeeding: evidence and practice' (see detail under Action point 5). This course includes a lesson (30 minutes) on 'Breastfeeding the preterm infant' which has the following aim, learning outcomes, and content:

Aim: To enable participants to provide the information and support to mothers who are breastfeeding their sick or preterm babies

Learning outcomes: Able to:

- Explain why breast milk is the food of choice for sick and preterm babies
- Describe ways in supporting a mother to feed her sick or preterm babies
- Describe alternative methods of feeding a sick or preterm babies
- Explain the procedure for handling and storage of expressed breast milk

Content:

- The difference between preterm and full term milk
- The natural sequence of feeding and the preterm baby
- What do mothers of babies who are ill need to know in regard to breastfeeding
- Alternative methods of feeding
- Handling and storage of expressed milk

NIMDTA indicated that issues of breast milk feeding of vulnerable infants are addressed in the training outline provided in relation to Action point 5. Given that no other training providers responded to the strategy review, it cannot be determined if other courses within this area were available.

6.2 Information on breast milk feeding of special needs infants should be collected on a regional basis, and made readily accessible to both health professionals and parents

Limited knowledge was apparent on the collection of such data from both the commissioners and the BSIG members who responded. Only one responding BSIG member stated that the number of babies being fed breast milk in neonatal units is collected within Trusts.

In relation to information that is available to parents, one BSIG member noted a HPA leaflet on breastfeeding ill and premature babies which was developed and updated recently. This leaflet is provided to all neonatal units on an annual basis to be distributed to all mothers whose babies need special care.

6.3 Human milk banking should be developed within Northern Ireland to support breast milk feeding of special needs infants

When asked about the human milk bank, the EHSSB health promotion commissioner and the three BSIG members agreed that the establishment of the human milk bank has been an immense success, which benefits parents, their babies, and health professionals. Moreover, according to the director of the human milk bank, one of the great successes of the milk bank is that it issues more milk than any other bank in the UK, attributed to providing a centralised service. Furthermore, *"the bank is unique in the UK in that we provide milk to babies with gut and absorption problems, in the hospital and home setting, as well as babies undergoing cardiac surgery and those born prematurely. The local research has shown that the bank is helping to reduce in-patient cot time."* (Milk bank director)

However, a number of challenges to running and sustaining the milk bank were highlighted by the health promotion commissioner (EHSSB) and the three BSIG members. These include:

- getting medical staff to use donor milk;
- transportation;
- funding (to be secured from all Boards);
- payment by Trusts for donor milk;
- infection control issues;
- storage;
- a concern of the milk bank's future when the director retires.

> *"I hear reports of staff not wanting to use banked milk as they are disgusted at the thought of handling it. However, many more women are aware of it and more babies are being helped by banked milk."* (BSIG member 3)

The director of the human milk bank highlighted the primary challenge in running the milk bank was to maintain the volumes of milk that have been needed to sustain the service. The director commented further on how this endeavour has been supported by *"help from all the voluntary*

sector organisations, giving us slots and stands at conferences. Additional help has also been sourced from journalists, the radio and TV services on both sides of the border. We regularly receive donations from hospitals all over Ireland, giving an excellent example of cross border cooperation."

In addition, the director suggested ways to potentially address milk storage issues. The milk bank could *"improve the service by being able to freeze dry the milk to use as human milk fortifier or so that units could have milk in storage, with a two year shelf life"*.

The milk bank arose in the discussions of a number of the focus groups with mothers who were breastfeeding or had previously breastfed. Indeed, one mother who was breastfeeding twins donated any extra expressed milk to the bank. However, the vast majority of mothers were unaware of this service, especially those who had stopped breastfeeding.

> *"If I was given information about it, I would have used it."* (Current breastfeeder, group 3)

Some of those who were aware of the milk bank service felt it was something they would be reluctant to use, finding it strange using milk from another mother. Others said that previously they had been reticent about using the milk bank but, on hearing more about it, were open to using it in the future.

> *"I was offered it but didn't use it…I wouldn't make the same decision again"* (Current breastfeeder, group 4)

Outlook

- For the future of the human milk bank, it is envisaged that more donor milk will be needed in Ireland as well as more research on the use of donor milk. The human milk bank will have to be flexible and adaptable in relation to new policy and guidance (eg new advice from the DHSSPS, NICE guidelines for the operation of human milk banks, 2010).[20] In addition, the milk bank will have to adapt to a potential broadening remit of tasks, including the feeding of older babies and the use of donor milk in cancer and immunoglobin A (IgA) deficient patients.

  > *"The bank is supporting more and older babies to have donor milk at home, giving these children the possibility of an earlier hospital discharge. ...Many requests are being received for cancer patients. These we have not provided any milk for, as the milk is only issued on the request of the physician. IgA deficiencies would be another possible use, as donor milk would be a reliable source."* (Director, human milk bank)

The additional work demands have big implications for the sustainability of the milk bank, particularly in terms of staffing levels and laboratory time.

> *"Staffing levels in the bank are stretched to the limit at present; any longterm staff sickness would result in the service being unsustainable. Increased secretarial support is desperately needed at present to cope with the increased workload."* (Director, human milk bank)

Summary

- Some training has been available on breastfeeding of special needs babies through in-service training, the Beeches and the HPA. However, with only some of the BSIG members, commissioners and the Beeches (the only training provider) responding, it is difficult to judge whether the training in supporting the needs of ill and preterm babies is sufficient.
- There appear to be gaps in either the collection and/or provision of data on breastfeeding of special needs infants. The number of babies being fed breast milk in neonatal units is collected within Trusts. A leaflet on breastfeeding ill and premature babies was developed and has been updated by the HPA. Overall, health professionals' knowledge of data relating to breastfeeding ill and premature babies, and awareness of information materials, could be improved.
- The human milk bank has been successfully established and provides human milk for infants throughout Ireland. It has been very successful in terms of implementation of best practice for milk banking. Issues around sustainability and meeting future challenges need to be taken into account in a new strategy.

7. Raising public awareness

Once further information has been reviewed on the factors influencing breastfeeding rates in NI, a public information campaign needs to be undertaken to promote breastfeeding. Promotion methods should take into account Northern Irish culture, perceptions and attitudes.Community development approaches for the promotion of breastfeeding should be encouraged.

Recommendations

- A public information campaign to promote breastfeeding, using all available media, should be undertaken.
  Agents for action: The Northern Ireland BSIG; DHSS; Health Promotion Agency for Northern Ireland (HPA), commissioners and providers; La Leche League; National Childbirth Trust

- Materials to support breastfeeding should be produced for regional use.
  Agents for action: DHSS; HPA/; The Northern Ireland BSIG

- A theme for the annual Breastfeeding Awareness Week in May should be selected by the Northern Ireland Breastfeeding Strategy Group, and should be communicated to all interested parties by December of each year.
  Agent for action: The Northern Ireland BSIG

- Breastfeeding education and promotion should be undertaken in primary and second-level education.
  Agent for action: The Northern Ireland BSIG and DHSS will liaise with the Department of Education for Northern Ireland on taking this forward

- Community support for breastfeeding outside the home should be developed.
  Agent for action: The Northern Ireland BSIG will liaise with public and private sector organisations as appropriate.

Responses to the recommendations within Action point 6 have been sought from BSIG members, commissioners, breastfeeding and Sure Start coordinators, midwives, health visitors, and voluntary breastfeeding support counsellors and peer work leaders. The individual recommendations responded to by each stakeholder alongside the response rates are highlighted below.

	Response rate	Recommendation
• BSIG members	4/15	7.1-5
• Commissioners (EHSSB, SHSSB)	3/10	7.1
• Breastfeeding coordinators	12/16	7.2-5
• Sure Start coordinators	10/25	7.2-3; 7.5
• Midwives	6/25	7.2, 7.5
• Health visitors	8/25	7.2, 7.5
• Voluntary breastfeeding support counsellors and peer work leaders	8/15	7.1, 7.3, 7.5

The views of mothers explored in focus groups (mothers who were breastfeeding and those who stopped breastfeeding before they intended) are included in the synthesis of findings. Yet, it needs to be cautioned that these views may not represent the views of mothers who never breastfed.

Breastfeeding rates and influencing factors

Breastfeeding rates in NI are among the lowest in the UK and much work has yet to be carried out to enable breastfeeding to become the social norm in this country. Research has shown that among women who experience breastfeeding as more of a social norm, eg those who are more likely to know more people who breastfeed and who have family and friends who are supportive of breastfeeding, are more likely to continue breastfeeding in comparison to those who have less knowledge or support. Mothers recognised that there were a number of factors that made them reconsider whether or not to breastfeed, including:

- the attitudes of family (eg partners generally seen as supportive but the baby's grandmothers being potential barriers) and society in general;
- lack of knowledge about how to breastfeed;
- misunderstanding of information/lack of education/awareness.

> *"My husband's from Australia and when I was breastfeeding out there it was just so natural and accepted."* (Current breastfeeder, group 6)

> *"It's very isolating. It's like being an alcoholic. Your mother-in-law or your parents are telling you to just feed it a bottle. There isn't enough support in the community."* (Ceased breastfeeder, group 2)

Mothers also acknowledged a variety of factors that made them reconsider whether to continue breastfeeding. These included:

- lack of support in early stages after birth;
- lack of practical knowledge of how to breastfeed;
- societal attitudes;
- personal preferences for other activities, eg drinking alcohol;
- problems experienced included sore/cracked nipples, etc (primarily in first few weeks).

> *"You need both moral support and advice on technique."* (Current breastfeeder, group 4)

> *"I would have planned my pregnancy better. I had a wedding coming up and wanted a drink."* (Ceased breastfeeder, group 2)

Health visitors and midwives adequately identified many of the problems that mothers experienced with continuing breastfeeding.

7.1 A public information campaign to promote breastfeeding using all available media should be undertaken

In 2003, 2004 and 2005 a PIC was conducted to raise public awareness of the health benefits of breastfeeding, promote breastfeeding as socially acceptable, and encourage wider uptake among mothers in NI. The campaign was administered through a variety of media including TV, radio, and bus advertising, with an evaluation undertaken by the HPA in 2006. These campaigns were followed by a convenience advertising campaign for men in 2007 highlighting the benefits of breastfeeding. The PIC was also rerun in early 2009 in the form of TV advertising.

Overall, responding BSIG members and commissioners were positive about the PICs, indicating that the campaigns helped to raise public awareness of breastfeeding. However, one BSIG member considered the *"Breastfeeding Welcome Here policies/posters/pictures in public places are more likely to be helpful (than campaigns) and supportive to mothers"* (BSIG member 2). Another BSIG member noted that the coverage achieved by formula manufacturers is still much greater than the media coverage on breastfeeding.

In contrast, findings from the focus groups indicated that mothers (who had breastfed, or were still breastfeeding) considered advertising for breastfeeding was more heavily promoted than formula, with some mothers specifically mentioning the breastfeeding advertising on buses. Nevertheless, despite this positive response from mothers, it was highlighted that more could be done to make breastfeeding trendier. Some mothers commented that text books and advertising portrayed breastfeeding women in dull clothes and grumpy-looking whereas other advertising related to babies featured women looking full of life.

> *"Anything you see on bottle feeding, the mum is young, well dressed and hot ... the breastfeeders, to me they just look grumpy and older."* (Current breastfeeder, group 5)

The SHSSB commissioner also stressed that the regional campaigns supported the work of all local agencies involved in breastfeeding. In terms of local activity, the EHSSB health promotion commissioner reported having *"produced local poster messages across EHSSB ie breast milk for the best start"*. The SHSSB commissioner for health promotion, maternal and child health, and IfH provided a detailed list (see Appendix 4) of their activity dating back to 1989 which includes information on their first survey, establishment of breastfeeding steering group, local campaigns, strategies and policies.

Only three of the eight responding voluntary breastfeeding support counsellors and peer work leaders (ie volunteer counsellors) reported involvement in PICs. One volunteer was present during filming of the regional campaign and considered the campaign "excellent". Another volunteer promoted breastfeeding using local media and radio stations and the third respondent runs a local support helpline.

> *"I have been involved in organising events for breastfeeding mothers, which are widely publicised in the Armagh and Dungannon area. I run a freephone helpline for mothers which is also widely advertised."* (Volunteer supporter 8)

7.2 Materials to support breastfeeding should be produced for regional use

According to BSIG members, a number of regional materials supporting breastfeeding have been produced; a full list of resources and promotional materials can be found at the HPA legacy website (www.healthpromotionagency.org.uk). These include:

- antenatal leaflet *Feeding your baby*;
- postnatal booklet *Off to a good start*;
- fathers' leaflet *What dads should know about breastfeeding*;
- leaflet *Breastfeeding and returning to work*;
- leaflet *Feeding out and about*;
- *Breastfeeding Welcome Here* scheme and materials;
- posters to support NBAW.

Since autumn 2008, a new DVD called *From bump to breastfeeding*, used UK-wide, is also available to expectant mothers in Northern Ireland. In addition, voluntary groups also provide information leaflets for specific circumstances but it was cautioned that this information may not be accessed by all women.

The responding health professionals (breastfeeding and Sure Start coordinators, health visitors and midwives) reported using a wide variety of resources to support decision making antenatally and with breastfeeding mothers, with the following resources being most commonly used:

During the antenatal period:	With breastfeeding mothers:
Off to a good start	*Off to a good start*
Feeding your baby	*Feeding your baby*
What dads should know about breastfeeding	*Breastfeeding and returning to work*
Bump to breastfeeding DVD	*Bump to breastfeeding* DVD

Among midwives, the fathers' leaflet was less frequently used antenatally, while they used the new DVD more frequently with breastfeeding mothers. In general, the DVD *From bump to breastfeeding* received very positive views from some midwives and anecdotally from postnatal mothers according to midwives.

Supply issues (ie running out of resources) were primarily reported by breastfeeding coordinators and to a lesser extent by Sure Start coordinators, midwives, and health visitors. Insufficient supplies were primarily reported for the *Off to a good start* booklet but also for the *Pregnancy book*, *Birth to five* book and weaning leaflets. Sure Start coordinators were keen on having more supplies of the *Bump to breastfeeding* DVD.

Research with mothers depicted a sense of insufficient education and advice being given to young mothers on breastfeeding during their pregnancy. Some thought that more could be done to introduce pregnant women to other mothers who were breastfeeding so that they could have

more insight into how it is done, the problems they encounter as well as the positive benefits of breastfeeding. However, it was acknowledged that if mothers were aware of all the issues with breastfeeding they might not try it.

> *"I would have wanted to hear the different problems that people could have. You only hear the benefits of breastfeeding but you don't hear the negative things. It might put people off but they should be told."* (Current breastfeeder, group 4)

There also appears to be some misunderstanding among women about how long they need to breastfeed. (This was noted at one of the Derry groups in particular.) One individual thought that unless you were going to breastfeed exclusively for six months, you could not breastfeed at all.

> *"There should not be a perception that you must breastfeed for six months, take it day by day and if it doesn't work out look at other options."* (Current breastfeeder, group 7)

7.3 A theme for the annual NBAW in May should be selected by the Northern Ireland Breastfeeding Strategy Group and should be communicated to all interested parties by December of each year

BSIG has been involved in developing a theme for NBAW and this information has been communicated through the publication *Keeping abreast* published by the HPA. This newsletter has been produced on behalf of BSIG since August 2002 and is the responsibility of the regional breastfeeding coordinator. Suggestions for and critique of NBAW centred around more discussion and planning in the future as materials developed have been produced in response to requests, gaps in available resources, and themes to be better advertised and more inclusive.

There was some variation between breastfeeding and Sure Start coordinators as to how and when they were informed about the NI theme for NBAW. Most breastfeeding coordinators heard about the theme through the regional breastfeeding coordinator at the breastfeeding coordinators forum held in March/April, with two respondents acknowledging they received information about four months before the event. Most Sure Start coordinators learned about the theme from the HPA, either via the website or from the regional breastfeeding coordinator. Other sources included breastfeeding coordinators meetings, the NCT website, breastfeeding steering groups, and Trust coordinators.

In general, breastfeeding and Sure Start coordinators received materials related to supporting NBAW from the HPA, with a few breastfeeding coordinators receiving the materials from the breastfeeding coordinators forum. Some coordinators had accessed a few sample materials from the DH (England) campaign. Sure Start coordinators stated that materials were also accessed through the Trust, midwives, and managers. While overall, breastfeeding and Sure Start coordinators appeared satisfied with how NI materials for NBAW were sourced, a few suggestions were made, with some coordinators suggesting a high profile event which catches media attention should be organised, whereas others wished to simply receive materials produced from elsewhere (eg the Be a Star campaign in England). Other differences in opinion arose in how individuals wished to order supplies, with some suggesting the need for Sure Starts to be able to make direct orders instead of using regional suppliers.

Volunteer counsellors are important contributors to NBAW and reported a wide range of involvement – from making suggestions for the NBAW theme to disseminating themes to community groups and organising events and activities.
These events and activities primarily focused on social events like coffee mornings/lunches or pampering sessions for mothers, and fun days for mums and toddlers (eg teddy bear picnic), with other activities including a helpline launch and stalls at local shopping centres.

> *"I have been involved in disseminating themes from the strategy group to community groups. We have held successful 'fun days' for mums, toddlers etc and very successful coffee mornings in local coffee shop with 'goodie bags' for mums full of donations from local chemists. These have been covered by local papers."* (Volunteer counsellor 3)

> *"Our Uplift breastfeeding counsellors group organises two very successful pampering days in breastfeeding awareness. May 2008 – increased breastfeeding awareness in area and donors to milk bank."* (Volunteer counsellor 6)

The success of NBAW in the community and its impact on a mother's decision to breastfeed was evident from the focus groups with mothers, with a small number of women reporting they had seen other mothers breastfeed either through an organised event, such as NBAW, or at a support group. The mothers reported they found this experience to be particularly beneficial in providing them with practical advice and information. It was these mothers who tended to be more successful in their own breastfeeding.

7.4 Breastfeeding education and promotion should be undertaken in primary and second-level education.

Half of the breastfeeding coordinators have provided breastfeeding awareness in post-primary schools. Sure Start coordinators were less involved in school-based breastfeeding education. Two BSIG members mentioned the CD *Breastfeeding awareness for schools* was used as a teaching resource for breastfeeding education and promotion in post-primary schools. The CD (launched in 2008) was developed in cooperation with CCEA. It aims to raise breastfeeding awareness in post-primary schools, with the specific aims of the CD being:

- to improve availability of breastfeeding awareness education for schools;
- to increase knowledge of breastfeeding and challenge misconceptions about breastfeeding among teenagers;
- to signpost teachers to reliable resources for provision of infant feeding education.

The CD has previously been evaluated and found to be successful in achieving its key goals, yet a larger evaluation is still in progress.[21]

Despite these efforts, a number of concerns regarding the current provision of breastfeeding education were identified by BSIG members and breastfeeding coordinators:

- a lack of materials for primary school children;
- access to materials for teachers and packs being available when needed by teachers;

- a lack of knowledge how available materials are being used, including
    - o who decides if, when, how they are used?
    - o who trains the teachers?
    - o which children receive programmes – boys/girls, at what age, in what subject areas?
    - o who misses out?
    - o do children need more than one teaching session during their school career and how many and when?
- what had been the impact of materials currently available?

Concerns were raised regarding the primary school sector where pupils seem to receive teaching on bottle feeding or are exposed to environments displaying formula feeding paraphernalia which is undermining the breastfeeding message.

> *"The new DVD aimed at secondary schools is very good – it would be good to know how much it is being used and its impact. There is a gap at primary level with teachers promoting what they believe is right – some are embarrassed or disgusted by breastfeeding. Also, formula cans are seen in schools used to hold pens etc."*
> (Breastfeeding coordinator 3)

Agreeing with the recommendation, some mothers involved in the focus groups expressed the view that education on breastfeeding needed to start much earlier than pregnancy and that the issue should be addressed in school with both boys and girls.

> *"It's not even the mothers that need to change. It's the boys in school so that it's an open thing… they see it as a sexual thing rather than a natural bonding thing with a baby."*
> (Ceased breastfeeder, group 1)

7.5 Community support for breastfeeding outside the home should be developed

Breastfeeding outside the home

Research carried out with mothers (who had or were still breastfeeding) found that the key issue for many mothers in relation to breastfeeding outside the home was confidence. Mothers who attended support groups tended to be much more confident about breastfeeding outside the home, viewing it as the right of their baby. These mothers seemed to draw much of their confidence from talking with and seeing other members of the support group breastfeeding in public. In contrast, mothers who were much less confident about feeding in public reported trying to schedule their outings to fit around the feeding times of their baby or expressed milk so they could feed using a bottle. Mothers reported that breastfeeding was a social issue and that it was generally not accepted in public places in NI.

> *"It's not seen as normal here. In other European countries it's fine, but here you have to go and hide. It's a social issue here in Northern Ireland."* (Current breastfeeder, group 5)

Some mothers believed that there was some movement towards breastfeeding in public

being more acceptable within society. Although, given this research did not gather the views of mothers who bottle fed, these findings may not reflect the views of the wider population. Yet, previous research would support the notion of improved attitudes and knowledge of health benefits of breastfeeding in NI.[22] Mothers, in particular, noted such progress in men's attitudes and behaviour towards breastfeeding and reported men to be more comfortable with breastfeeding and aware of its benefits.

> *"Men are OK with it. It's women that are the problem."* (Current breastfeeder, group 3)

> *"I thought fellas would have been more embarrassed with the way society is but they are actually very open to it."* (Current breastfeeder, group 4)

Many mothers felt that facilities for breastfeeding outside the home are not adequate (eg toilets seen as unhygienic and unsuitable) and some recounted negative experiences of facilities and of comments received. Mothers also stressed the importance of facilities that are comfortable, relaxing and provide privacy.

> *"I had to breastfeed in public and a child asked me was I poor because I didn't have a bottle."* (Current breastfeeder, group 7)

> *"I had to ask for a chair. It's terrible bringing your baby into the toilet to feed them."* (Current breastfeeder, group 7)

Although mothers did not report being asked to stop breastfeeding, anecdotal evidence from three breastfeeding coordinators said they had contact with mothers who had been asked to stop breastfeeding in a café/restaurant whilst out with their baby. Another breastfeeding coordinator added that some mothers received critical comments when feeding in public. None of the Sure Start coordinators but one health visitor and half of the midwives reported that they had been in contact with mothers who were asked to stop breastfeeding while out with their baby.

According to the BSIG, three main areas of support have been developed which primarily aim to help women overcome the obstacles to breastfeeding by offering a support mechanism within the community setting. These include the Breastfeeding Welcome Here scheme and volunteer peer supporters. The HSC Trusts also provide community-based breastfeeding support through breastfeeding support groups. All three areas of community support are explored in more detail below. In EHSSB, according to the health promotion commissioner, Sure Starts are now becoming fully engaged. There have been some very good models of action including peer support, joint application for Baby Friendly, Breastfeeding Welcome Here, but more still needed to be done.

Breastfeeding Welcome Here

This scheme, launched in July 2005, aimed to make it easier for mothers to recognise places where they could breastfeed their baby when they were out and about, and to help normalise breastfeeding in the community.[23] The scheme provides certification of the premises' support for breastfeeding (eg businesses, councils) and currently has 210 members (at 22 March 2010).

Two of the BSIG members noted several issues which needed to be addressed to maintain the success of this scheme:

- low participation in some areas;
- lack of council involvement in Belfast;
- resource implications for maintaining scheme and carrying out assessments.

The majority of responding breastfeeding coordinators, Sure Start coordinators, and health visitors had sought business participation in the Breastfeeding Welcome Here scheme in their area. Some respondents had not done so because their organisations already grant such support to breastfeeding (eg midwives – as it is a right on NHS premises).

The popularity and awareness of this scheme was high with all breastfeeding mothers involved in the qualitative research mentioning the Breastfeeding Welcome Here scheme and awareness of the stickers in shops and cafes. A number of mothers felt that they would actively look for stickers on entering a café/restaurant before they decided to breastfeed inside, and most were in agreement that this should be more readily available.

Volunteer peer supporters

Peer supporters are trained mothers who provide informal advice and practical help with breastfeeding at community level, either individually or in group settings. This advice is often delivered over the telephone after an initial face to face visit. These peer support workers have been recommended as an invaluable form of breastfeeding support in the community by NICE, with guidelines suggesting women should have contact with peer supporters within 48 hours of a home birth or hospital discharge.[7] Yet, one BSIG member stressed that many new mothers are not aware or rarely have contact with local peer supporters, particularly in *"the first week or two – the time when they are most likely to abandon breastfeeding"*.

The responding volunteer supporters reported receiving queries from mothers on a range of problems including low milk supply, slow weight gain or even weight loss, breastfeeding problems (sore/cracked nipples, thrush, pain, engorgement, mastitis), babies who are unsettled, do not latch on, or seem to feed all the time. Volunteer supporters also reported receiving queries on medication and breastfeeding. According to volunteer supporters, mothers receive inadequate support and inconsistent advice from health professionals (eg confusion over hypoglycaemia), a situation which arises from lack of time and training and staff shortages, thus failing mothers to establish proper breastfeeding technique and skills.

In relation to reaching those least likely to breastfeed, half of the responding volunteer supporters declared being unsuccessful. Reasons undermining their efforts were women's motivation of not wanting to breastfeed, lack of sufficient time and resources to educate women (*"to make an informed choice"*), their partners and grandparents.

Volunteer supporters and BSIG members outlined a number of difficulties faced by those providing voluntary peer support which can threaten its sustainability:

- **Recruitment:** Over half of the volunteer supporters reported proactively approaching

mothers to become peer supporters, identified either by themselves or through midwives or community groups. Other volunteer counsellors expected mothers to show initiative to come forward to volunteer as peer supporters and responded to mothers with encouragement. Mothers who take up such a role had breastfed their own babies, some overcame breastfeeding problems but they all were keen to help other mothers.

- **Training issues:** A few volunteer supporters mentioned their ongoing training and the various courses completed, yet requested regular updates as necessary to maintain their expertise. Lack of time impacts on organising peer support training and support (eg agreeing dates and venues).
- **Financial resources:** Lack of funds restricts training opportunities and even recruitment because training cannot be afforded. Moreover, with no funds volunteer supporters receive no expenses for hospital or home visits while incurring travel and childcare costs. The support offered depends on what they can afford themselves.
- **Recognition:** It was also stressed that volunteers need to be recognised for their training and qualifications and to be accepted by health professionals, ie to be considered *"experts in the field of breastfeeding"*, to be able to continue their efforts.
- **Retention of trained supporters:** Loss of trained peer supporters is difficult due to the long training they require. Yet, half of responding volunteer supporters stated that they will continue their roles in the future.

Community support from the statutory sector

The majority of breastfeeding and Sure Start coordinators were involved in facilitating breastfeeding support groups, while this was less common among health visitors and midwives. Those involved in facilitating breastfeeding groups provided information on what they perceive are the main challenges for breastfeeding mothers. The key challenge that was reported most often by Breastfeeding and Sure Start coordinators, midwives and health visitors was the availability of support from health professionals, family, and friends, and its accessibility.

Breastfeeding in public and receiving conflicting advice from health professionals and family and friends still remain problems. Many mothers are concerned about adequate milk supply and experience breastfeeding challenges and problems. Other challenges include mothers' poor motivations and attitudes to breastfeeding, the lack of role models and achieving uptake of antenatal education. While breastfeeding coordinators were more likely to mention challenges around breastfeeding problems and milk supply, it was only Sure Start coordinators who raised concern over mothers' attitudes, motivations and lack of role models.

Table 4. The perceived main challenges for breastfeeding mothers as detailed by those who facilitate breastfeeding support groups.

Challenge	Details
Availability of support	• Lack of support from health professionals, family and friends (poor staffing in hospital, undermining comments, need for encouragement and practical information) • Accessibility of support (timing and location of support groups; out-of-hours support and advice) • In specific circumstances (returning to work)
Breastfeeding in public	• Lack of social acceptance and negative cultural attitude toward breastfeeding • Adequacy of facilities
Conflicting advice from health professionals, family and friends	• Conflicting information regarding positioning and attachment, number of feeds, dummies, etc.) • Lack of knowledge among family and friends, challenging mothers
Mothers' attitudes, motivations and role models	• Perceived ease of bottle feeding and breastfeeding as time consuming and tying down • Few breastfeeding mums – lack of role models • Difficult to motivate to use peer support (eg attend groups)
Breastfeeding challenges and problems	• Managing oversupply • Confidence in ability to produce adequate milk • Sustaining breastfeeding • Breastfeeding problems: sore nipples, (recurrent) thrush, mastitis, blocked ducts • Defining and reassuring 'normal': night-time feeders, noisy feeders, small amounts when expressing milk • Moving to breast milk feeding
Antenatal education	• Education workshops • Impact of missing antenatal education

In SHSSB, community groups have been supported through the Southern IfH small grant programme on an annual basis. Also there has been ongoing support for BFI.

Volunteer supporters provided some more specific detail on what support mothers need to enable them to breastfeed and commented on the provision by the statutory sector. Except for one volunteer supporter who acknowledged that mothers receive an excellent service from midwives in her area, all others stated a number of deficits and suggestions for their improvement which broadly fall into the following areas:

- **Knowledge among health professionals:** Volunteer supporters were concerned about accuracy of information provided to mothers, particularly among midwives, health visitors, GPs and the benefits of longer-term feeding. They reiterated the importance of accurate information being provided which is consistent across health professionals who are knowledgeable and provide simple and practical strategies for dealing with breastfeeding challenges.
- **Level of support:** Available support, despite being well intentioned, was considered as insufficient, varying by area and depending on few enthusiastic health professionals. This is the result of overstretched resources (staff shortages, lack of essential books/training aids). Bottle feeding and formula prescriptions at postnatal wards need to be tackled with improved support immediately from birth. Volunteer supporters argued for breastfeeding support to be provided in support groups or individually, be in an accessible locality, held regularly (eg weekly), and well advertised to mothers. Emphasis was put on specialist health professionals and particularly having access to breastfeeding counsellors and peer supporters (trained and supported). Other modes of support could include a helpline, a baby café, a breastfeeding clinic in hospital or community setting as well as more acceptance of breastfeeding in public.
- **Mode of breastfeeding instruction:** The current model of breastfeeding instruction is seen to limit the knowledge and skills of health professionals, resulting in breastfeeding mothers' needs not being met. BFI is considered a minimum standard and further models of instruction should be explored to increase motivation and sustainability of breastfeeding among mothers.

Outlook

- From a commissioner's perspective, community action in the form of peer support in areas of deprivation is needed. Moreover, increased partnership working/involvement between community groups with professionals from the public and voluntary sectors is needed to promote breastfeeding on an ongoing basis.
- There is need for further materials, in particular for other family members (eg grandmothers, children in the family), to be more tailored to specific situations (eg single mothers, young mothers, culturally relevant for ethnic groups), downloadable UNICEF leaflets and their translations, leaflets and teaching resources for hand expression and milk storage, and a website listing all available resources. Mothers specifically wanted advice in relation to drinking alcohol and intimacy with their partners and for materials to be visually appealing ("catchy").
- To alleviate negative attitudes to breastfeeding outside the home:
    - Raise more public awareness through campaigns, advertising, and media exposure, thus promoting the normality of breastfeeding in public.
    - Simultaneously encourage mothers to feed in public and businesses to become involved with supportive schemes such as Breastfeeding Welcome Here.
    - Make more social support available by providing support groups/peer support, improving support provided by family and friends, in the work place, and at societal level (public attitudes, councils).
    - Introduce specific legislation to protect a mother's right to breastfeed in public.
    - Establish mothers' confidence in their ability to breastfeed.
    - Efforts in breastfeeding education should particularly focus on young people, older people, and mothers' partners.

In contrast, the only response from a health visitor stated that enough materials are provided but that hands on *"evidence-based information is still lacking"*.

There was some variation by health professionals and the issues they had raised around protecting mothers from negative attitudes to breastfeeding outside the home:

- Sure Start coordinators and health visitors particularly advocated raising more public awareness through campaigns, advertising, and media exposure (eg in soaps), and hence promoting the normality of breastfeeding in public.
- Addressing available social support needs was primarily reported by Sure Start coordinators.
- Breastfeeding coordinators favoured the introduction of specific legislation to protect a mother's right to breastfeed in public.

"More public campaigns highlighting the normality of breastfeeding in public and 'legal' 'ethical' right to." (Breastfeeding coordinator 2).

"More women breastfeeding in public. Perhaps the breastfeeding support groups are in the wrong place – should they be in cafes. Only problem is that women would have to pay for their coffee and biscuits and, since they are on maternity leave, most are short of money." (Breastfeeding coordinator 7).

Summary

- There was substantial activity on public information campaigns (general population, specifically targeting men) which helped to improve awareness of health benefits and attitudes towards breastfeeding in NI. However, some mothers felt that the portrayal of breastfeeding women needs improved (too old-fashioned and drab).
- A variety of regional materials supporting breastfeeding have been produced for use in both the ante- and postnatal period. Health professionals acknowledged that supply issues exist for some of the resources. The mothers' suggestion of using appealing images of breastfeeding women applies also to materials/resources.
- NBAW each May has achieved considerable involvement from both the statutory and voluntary sector. Some issues were raised around the preparation period (eg time frames, development of materials, supply).
- Breastfeeding coordinators have had some involvement in breastfeeding education and promotion in schools. A CD to raise breastfeeding awareness in post-primary schools was developed in partnership with CCEA and has been evaluated. Various concerns remain over breastfeeding education (eg lack of materials, impact of materials, who delivers this, training) and particularly how bottle feeding is still, though possibly inadvertently, promoted in schools.
- In terms of community support for breastfeeding, feedback provided a varied picture. Breastfeeding outside the home, despite some improvement in society's attitude towards it, was still viewed as difficult in NI. The Breastfeeding Welcome Here scheme has proven successful in providing support to breastfeeding mothers, although needs further support for wider implementation throughout NI. Volunteer peer supporters are a valued source of community support. However, they face issues in terms of recruitment, training, recognition and retention, financial resources, access to and uptake from mothers. Breastfeeding

support (eg groups) provided by the statutory sector was in some areas deemed insufficient regarding geographical spread and the availability of enthusiastic health professionals, with key concerns being accessibility of support and the provision of inconsistent advice across health professionals.

8. Limiting promotion of artificial milks

The use of artificial infant milks is depriving women and children of the health benefits of breastfeeding. Artificial milks should not be promoted within the healthcare system.

Recommendations

- All HPSS Boards and Trusts should comply with the International Code of Marketing of Breast Milk Substitutes.[24]
  Agents for action: Boards and Trusts

- Educational materials, such as leaflets, produced by or carrying the trade names or logos of infant formula companies should not be distributed by health professionals. Suitable educational materials on infant feeding (including artificial feeding) should be developed where these do not yet exist.
  Agents for action: The Northern Ireland Breastfeeding Strategy Group; HPA

- Consideration should be given to the discontinuation of the sale of artificial baby milks on HPSS premises.
  Agent for action: DHSS

Responses to the recommendations within Action point 8 have been sought from BSIG members, commissioners, breastfeeding and sure start coordinators, midwives and health visitors. The individual recommendations responded to by each stakeholder alongside the responses rates are highlighted below.

	Response rate	Recommendation
• BSIG	4/12	8.1-3
• Commissioners (EHSSB, SHSSB)	3/10	8.1-3
• Breastfeeding coordinators	12/18	8.1-2
• Sure Start coordinators	10/25	8.1-2
• Midwives	6/25	8.1-2
• Health visitors	8/25	8.1-2

8.1 All HPSS Boards and Trusts should comply with the International Code of Marketing of Breast Milk Substitutes

The International Code of Marketing of Breast Milk Substitutes requires the following:

- no advertising of breast milk substitutes, feeding bottles, dummies and teats;
- no free samples to mothers, families and health workers;
- no promotion of products within the scope of the code within the health care system;
- no free gifts or samples to health workers, product information must be scientific and factual;
- no free or low cost supplies of breast milk substitutes within the health care system;
- all information on infant feeding must explain the health benefits of breastfeeding and the health hazards associated with bottle-feeding and the costs of using infant formula;
- product labels must state the superiority of breastfeeding and not idealise the use of infant formula.[24]

All stakeholders within this section were asked about compliance with the code but specifically dealing with company representatives and promotional items. According to two responding commissioners, compliance with the WHO code has been monitored but the process of monitoring has changed over time. In the EHSSB, it was reported that a study had been undertaken to check compliance and, in the past, monitoring visits were carried out. This has now stopped as compliance with WHO code is required as part of UK BFI.

In the SHSSB it was noted that Trusts were required to comply with the WHO code following the breastfeeding strategy which has been overseen through ongoing Board/Trust monitoring. Feedback from breastfeeding and Sure Start coordinators, midwives and health visitors also confirms that their organisations' breastfeeding policy requires compliance with the WHO code.

Dealing with WHO code violations still seems a common experience among breastfeeding coordinators, yet rare among Sure Start coordinators. BSIG members were evenly split in reporting such incidents, with two BSIG members stating that violations arose from:

- formula milk company representatives seeking contact with health care staff outside Trust premises, concerns about access to evidence based rather than promotional company funded information, managers not always being aware of WHO code issues;
- use of a formula company representative providing information to parents on the introduction of solid foods (in at least one Sure Start).

Dealing with company representatives

Dealing with representatives from infant formula companies forms part of breastfeeding coordinators' post. It seems uncommon for Sure Start coordinators to have contact with company representatives.

According to the breastfeeding coordinators, it varies among HSC Trusts how contact with formula company representatives is dealt with including:

- **Contact handled by management team or coordinators:** This allows that information on artificial feeding can be screened before dissemination to staff.
- **Direct contact in staff meetings:** This does not permit prior screening of information and contact with staff is limited to providing product information. Free gifts (resources with logos) or free lunches are generally not accepted, yet free lunches have still been provided according to two breastfeeding coordinators.
- **Appearing uninvited:** Unsolicited visits remain an issue despite a policy of 'appointments only'. There were still (attempted) visits to postnatal wards and paediatric consultants without breastfeeding coordinators' knowledge.

Overall, 5 out of 11 breastfeeding coordinators explicitly stated they have had problems when dealing with formula company representatives. Particular issues are representatives' claims of the need for updated product information for staff and parents, discrimination of bottle fed babies, and that they are welcome in BFI accredited hospitals, with other challenges including unsolicited visits and hospitality.

"My manager invites the reps to our staff meetings where they give a talk and provide sandwiches, tea and coffee for all HVs. I have argued against this to no avail. I have organised training on all formula drinks given by the paediatric dietitian which was arranged by huge numbers of HVs as it was obviously needed but still the reps come to our meetings." (Breastfeeding coordinator 7)

"Generally they contact myself or ward sister. No free gifts are given. Info is kept on file for staff to see. Occasionally speak to staff in my presence." (Breastfeeding coordinator 9)

"Their need to call six monthly to update us. I wasn't aware their products changed so much! No wonder parents are confused. Their claims that parents aren't being fully informed about the benefits of their products over other firms." (Breastfeeding coordinator 2)

"Paying for meals at audit evenings – they have approached medical staff. They will always say they have been into other Baby Friendly hospitals and play one off against other." (Breastfeeding coordinator 8)

"Representatives just walking into health centres uninvited." (Breastfeeding coordinator 10)

Confirming breastfeeding coordinators' feedback, some of the responding midwives and health visitors reported no contact with a representative in the past two years. Representatives generally contact management and ask to attend staff meetings or speak with managers who then disseminate the information to staff at staff meetings. However, in some cases health visitor reported that formula representatives had tried to make direct contact.

"Breastfeeding lead person meets with rep. Information disseminated to staff and placed on formula feeding book to access as necessary." (Midwife 5)

"She invited herself to speak to me on one-to-one basis. Asked her as a nutritionist how she rationalised promoting 'bovine based formula' over 'breastfeeding'! Reps approach line managers and ask to come to meetings. They are continuing to provide catering which is endorsed by Trust." (Health visitor 3)

"I believe the breastfeeding coordinator and/or our managers meet with them and pass on relevant information." (Health visitor 6)

Reduced cost products and free promotional items

According to the feedback from health professionals, the provision of reduced cost products by company representatives seems almost eliminated as compared to the provision of free promotional items. Free promotional items still appear to be a challenge for breastfeeding coordinators and health visitors, while Sure Start coordinators seem to be unaffected. Yet, it needs to be noted that a number of breastfeeding coordinators, midwives and health visitors were uncertain about such provisions.

To prevent use of formula company-sponsored diary covers, the HPA developed a diary cover

free of trade names or logos. Nonetheless, despite policies, use of promotional materials has not been eliminated among all midwives and health visitors, with sponsorship and use of promotional materials being particularly pronounced among student midwives and health visitors.

Six breastfeeding coordinators and two Sure Start coordinators reported they had to challenge a member of their team about code compliance on the use of promotional items (eg diary covers, pens, Post-its) provided by formula companies. Nonetheless, of the few responding midwives and health visitors, almost all reported they never saw colleagues use promotional items, with one health visitor saying sometimes and another being uncertain.

8.2. Educational materials, such as leaflets, produced by or carrying the trade names or logos of infant formula companies should not be distributed by health professionals. Suitable educational materials on infant feeding (including artificial feeding) should be developed where these do not yet exist.

Over the course of the breastfeeding strategy, the HPA developed parent information leaflets on breastfeeding and one on formula feeding (bottle feeding) free of company branding for use by health professionals. BSIG members were aware of these educational resources. One BSIG member noted that formula companies were still providing sponsorship items and *"patients 'education' materials to doctors and others in venues outside Trusts"*. This enforces the need for education on the WHO code for all health professionals. Another BSIG member mentioned regular audits by the breastfeeding coordinator to monitor the use of materials.

The EHSSB health promotion commissioner reported that, by and large, these materials were not being used but stressed that this has been a difficult battle, particularly regarding diary covers. The SHSSB commissioner only reiterated the Trust's requirement to adhere to the WHO code.

8.3 Consideration should be given to the discontinuation of the sale of artificial baby milks on HPSS premises

All four responding BSIG members stated that the sale of formula milk on HPSS premises discontinued, with two saying that this happened several years ago. This discontinuation was confirmed by the EHSSB health promotion commissioner who stated that this happened at least five years ago. The SHSSB commissioner again just stated that Trusts are required to adhere to the WHO code.

Outlook

- Focus efforts in breastfeeding education on young people, older people, and mothers' partners. All health professionals need education on the WHO *Code of marketing of breast milk substitutes*. Compliance with the WHO code requires ongoing monitoring and audit.
- Health professionals reported the need for providing further educational materials, particularly for specialist feeding needs (eg reflux, anti-allergen), and stationery items (calculators for gestational age/baby age, Post-it notes, pens) devoid of trade names and logos which could replace those provided by the formula industry.

Summary

- Many healthcare professionals state that compliance with the WHO code is monitored through Trust or Board monitoring or BFI. Contact with formula company representatives and provision of promotional materials still appear to be a challenge and are at the heart of many breaches of compliance. Contact with representatives is being filtered to an extent, although unsolicited visits and offers of hospitality at meetings outside the health service have been reported. The provision of reduced cost products to healthcare facilities is prohibited in Trust policies. Provision of promotional materials is restricted, yet their use is still the main issue of non-compliance with the code among staff. Diary covers for health professionals have been made available to prevent use of those sponsored by formula companies.
- Parent information leaflets on breastfeeding and formula feeding have been made available by the HPA to Trusts. Formula company representatives continue to offer free educational resources to a range of healthcare professionals, including breastfeeding coordinators and health visitors.
- The recommendation on the discontinuation of the sale of artificial milk in healthcare premises is now adhered to. Thus, this positive practice needs to be maintained.

9. Legislative change

A number of factors which have a significant effect on breastfeeding may require the creation of alteration of legislation to effect change. The achievement of these changes is part of the longer term vision of the Northern Ireland BSIG. The BSIG will act as an advocate for change in the following areas:

- Maternity leave
- Free artificial milks
- Marketing of breastmilk substitutes

Recommendations

- Employers should facilitate flexible work arrangements for women returning to work while still breastfeeding: these might include lactation breaks during the day, nursing mothers' rooms and part-time work. The HPSS, as a major employer, should take the lead in this area.
  Agents for action: The Northern Ireland BSIG, Trusts

- Recommendations emanating from this review [English document] should be implemented as appropriate in Northern Ireland. Consideration should be given to the discontinuation of the exchange of milk tokens in HPSS premises where this has not already been achieved.
  Agent for action: DHSS

- The marketing of breast milk substitutes and feeding products in Northern Ireland should be brought into line with the International Code of Marketing of Breast Milk Substitutes.
  Agents for action: The Northern Ireland BSIG, DHSS

Responses to the recommendations within Action point 9 have been sought from BSIG members, commissioners, human resources, environmental health officers and a food standards agency representative. The individual recommendations responded to by each stakeholder alongside the responses rates are highlighted below.

	Response rate	Recommendation
• BSIG	4/12	9.1-3
• Commissioners (EHSSB, SHSSB)	2/10	9.1-3
• Human resources (HR) offices of HSC Trusts (WHSCT)	1/5	9.1
• Principal Environmental Health Officers (PEHOs) - Southern Group Environmental Health Committee (SGEHC), Northern Group System, Belfast City Council	3/5	9.3
• Food Standards Agency (FSA) representative	1/1	9.3

The views of mothers explored in focus groups (mothers who were breastfeeding and those who stopped breastfeeding before they intended) are included in the synthesis of findings. Yet, it needs to be cautioned that these views may not represent the views of mothers who never breastfed.

9.1 Employers should facilitate flexible work arrangements for women returning to work while still breastfeeding: these might include lactation breaks during the day, nursing mothers' room and part-time work. The HPSS, as a major employer, should take the lead in this area.

As an example, the implementation of this recommendation within the HPSS in NI was examined. It should be noted that this may not be representative of the wider employment sector.

Three BSIG members reported that some Trusts had developed HR policies supportive of mothers who returned to work and continued to breastfeed, or that their employer was very supportive. However, two of these respondents added that not all health professionals and other employed women had been able to obtain such flexibility to continue breastfeeding, even within government departments.

> *"Don't know what the HPSS is doing. Some women find their employers very helpful while others find their employer very unhelpful. There is a gap in research here on how much good practice is occurring."* (BSIG member 3)

The EHSSB health promotion commissioner stated there was a policy of support for EHSSB staff as was the case in the SHSSB, where HR family friendly policies have also been implemented.

To get an insight on how this recommendation impacted on HSC Trusts, HR offices of all five Trusts were invited to contribute to this review, with feedback received only from the Western HSC Trust. According to the HR director, the Western Trust offers an extensive range of flexible working arrangements to support employees including breastfeeding mothers. These include part-time work and (in some legacy arrangements) phased return to work following maternity leave on full pay. Both administrative and clerical staff has access to a flexi time scheme, thus enabling mothers to organise work and home demands. The Trust's commitment to flexible working is demonstrated by 29% of staff working part-time. Access to reduced hours and flexible working is supported and recent policy changes have ensured that mothers state explicitly when they wish to return to flexible work arrangements and require support for breastfeeding.

Some areas have access to breastfeeding rooms which provide a secure fridge to store breast milk. Without monitoring of access to breastfeeding rooms being undertaken, it is not known how big the demand is.

Overall, as no formal research or audit has been conducted, it is difficult to judge how such policies have impacted on service delivery. Anecdotal evidence suggests that managers find it challenging to meet requests while maintaining service delivery demands.

9.2 Recommendations emanating from the review should be implemented as appropriate in NI. Consideration should be given to the discontinuation of the exchange of milk tokens in HPSS premises where this has not already been achieved.

Two BSIG members, the EHSSB health promotion commissioner and the SHSSB commissioner confirmed that milk tokens were no longer exchanged in Trust premises since Healthy Start was introduced.[25] However, one of the BSIG members noted that not all breastfeeding women eligible for Healthy Start vouchers seemed to know they were eligible. It was suggested that more promotion of the help available to lower income breastfeeding women was needed.

This issue of lacking awareness of the help available to low income breastfeeding mothers, as compared to those who bottle feed, emerged also in the focus groups with mothers. Participating mothers complained about the apparent lack of incentives for mothers to breastfeed. None was aware of any schemes aimed to help breastfeeding mothers on low incomes even though some exist. A few mothers commented on others receiving formula for free. They viewed this as a disincentive to breastfeed.

> *"There should be incentives for people who try but can't breastfeed."* (Current breastfeeder, group 9)

> *"My friend got formula on prescription."* (Current breastfeeder, group 7)

In terms of incentives, some mothers suggested financial support for those who breastfeed and for support groups. Others wanted to see more breastfeeding friendly places throughout NI. A third group thought there should be more information on the negative aspects of using formula.

> *"Need more breastfeeding friendly places when you are out and about. Somewhere with a sofa where you are comfortable and don't feel embarrassed to breastfeed."* (Current breastfeeder, group 7)

> *"Need to show people what is actually in formula. The general public think it's the same as breast milk and it's not!"* (Current breastfeeder, group 3)

9.3 The marketing of breast milk substitutes and feeding products in NI should be brought into line with the International Code of Marketing of Breast Milk Substitutes.

The 2007 UK Infant Formula and Follow-on Milk Regulations have been strengthened in relation to health claims and differences between infant formulas and follow-on milk.[26] However, according to BSIG members, these regulations still do not go as far as the WHO Code of Marketing of Breast Milk Substitutes and therefore raises issues of compliance with the WHO code.[24] While one member stated that her organisation complies with the WHO code, the other three members drew attention to current deficits and loopholes in policies and legislation.

One member stated that breastfeeding policies were not sufficient to prevent code violations (as discussed under Action point 8: contact with company representatives, offered training), while another called for UK-wide legislation to close gaps on *"active marketing of follow-on milks, teats, bottles"* (BSIG member 2). The third respondent refuted any compliance with the code and stressed that follow-on milk advertising undermines breastfeeding promotion. Support from MLAs to support legislation that protects breastfeeding was called for.

Commissioners reiterated the responses already given in relation to Action point 8: In the EHSSB, a study and monitoring visits were undertaken to check compliance until such monitoring recently became part of the applications for BFI, while the SHSSB commissioner simply stated the Trust's requirement to comply.

PEHOs and the FSA

PEHOs and the FSA monitor violations against the WHO code, particularly in relation to the marketing of breast milk substitutes. Both the PEHOs from the SGEHC and Belfast City Council reported that no incidents of non-compliance with legislation relating to the marketing of infant formula and follow-on formula had been reported to FSA since 1999. Neither of them reported being aware of any reports of non-compliance with the infant formula and follow-on regulations to trading standards of environmental health departments.

In contrast, the Northern Group System PEHO reported one incident had occurred in June 2008 and was referred to the FSA and to trading standards/environmental health departments. This incident related to placing a 'cheaper' sign on infant formula.

Suggestions were made for what information health professionals needed to be able to assist with compliance and monitoring of the 2007 Infant Formula and Follow-on Regulations.[26] The PEHO from the Southern Group suggested a *"coordinated survey of infant formula"* for this purpose. The respondents from FSA, Belfast City Council, and Northern Group Systems suggested a copy of the FSA guidance would be useful information for health professionals.[27] Moreover, the FSA representative suggested the following in relation to compliance and monitoring:

> *"Health professionals could report instances of observed sales in contravention of the legislation to their local environmental health department of the district council that have a duty to investigate complaints and take appropriate action... Environmental health departments should be able to provide details of instances where infant food has been sampled, analysed and checked for compliance with labelling."*

Outlook

- Further effort needs to be made to establish flexible working arrangements for mothers returning to work while still breastfeeding. This affects the HSC and other employers. It might be useful to monitor the implementation of such policies and arrangements and their impact on employers.
- The low awareness of the Healthy Start programme by those in need needs to be addressed.

- Ongoing support for staff to continue to comply with the WHO *Code of marketing of breast milk substitutes* is required through infant feeding policies and best practice guidelines (eg Food Standards Agency guidelines).[24]

Summary

- It is difficult to determine the extent to which employers facilitate flexible work arrangements for women returning to work while still breastfeeding, as only one HSC Trust responded to the review. This Trust has a variety of arrangements in place. In general, good practice guidance information was developed for mothers and employers. However, it appears that continuity of flexible working arrangements is not observed across HSC, let alone in the wider employment sector.
- Consultation feedback suggests that the discontinuation of the exchange of milk tokens in HSC premises has been well adhered to, mostly as a result of the introduction of the Healthy Start programme. However, low awareness of the Healthy Start programme by those in need was considered a problem.
- The 2007 *UK infant formula and follow-on milk regulations* have been strengthened in relation to health claims and differences between infant formula and follow-on milk. However, the regulations are still not as stringent as the WHO code. Those responsible for monitoring regulations on the promotion and sale of infant formula stated that only one incident has been reported within the past 10 years.

Health professionals' overview and future vision

Perceived implementation of the action points

Breastfeeding and Sure Start coordinators, midwives and health visitors were consulted in relation to how they overall judged the achievement of the recommendations based on the nine Action points (AP). According to their responses:

Most significantly implemented were:

- limiting the promotion of artificial milk (AP8)
- commissioning services (AP2)
- coordinating activity (AP1)
- raising public awareness (AP7)
- legislative change (AP9)
- training of health professionals (AP5)

Least implemented were:

- focusing research (AP4)
- supporting special needs infants and their mothers (AP6)
- collecting regional information (AP3)

Some disagreement emerged on how well individual action points were implemented. While midwives and health visitors felt that collecting regional information (AP3) was most significantly implemented, both breastfeeding and Sure Start coordinators mainly disagreed. Midwives were (evenly) split regarding how well raising awareness (AP7) and legislative change (AP9) were implemented. Midwives and some Sure Start coordinators believed progress was made regarding supporting special needs infants and their mothers (AP6), however, this was judged differently by breastfeeding coordinators and health visitors. Breastfeeding coordinators were split on the implementation standard of training health professionals (AP5).

Suggestions for a new breastfeeding strategy

The four groups of health professionals involved in this review provided further ideas in relation to:

- What would they like to see given more emphasis in the next breastfeeding strategy for NI?
- What issues/areas did the current strategy not address?

Responses can be categorised into the seven following broad areas: strategic, information sharing and resources, research and information, training, support, public information and education, protecting breastfeeding.

Table 5. Professionsals' suggestions for a new breastfeeding startegy

Strategic	
Regional level	• Set out targets for breastfeeding • Integration of breastfeeding into all related health policies and strategies • Addressing the cultural diversity within NI • Baby Friendly accreditation for both universities in NI
HSCT level	• The need for at least one full-time breastfeeding coordinator in each of the five HSC Trusts and either a permanent part-time or full-time breastfeeding coordinator with protected time in all maternity units • Support for breastfeeding coordinators • Promoting BFI accreditation for all Trusts, both community and hospital based, to become UNICEF Baby Friendly accredited
Community level	• Adopt a community development approach • Look at encouraging breastfeeding coordinators at working in a more community development framework and being less 'hospitalised'
Inter-sectoral	• More emphasis on collaborative working across sectors • Focus on the power/possibilities of statutory sector collaborating/ working in partnership with local Sure Starts to achieve supportive/informative breastfeeding practices
Information sharing and resources	
Staff	• Increase in numbers of health professionals to support mothers breastfeeding (particularly numbers of midwives) • A breastfeeding counsellor paid to work in the maternity units and antenatal parent class classes • Focus more on the use of multi-skilled input, particularly the use of peer support workers
Other resources	• A collection of up to date reference books in each Sure Start • Support for Regional Women and Children's Hospital at the Royal Victoria Hospital Group
Information sharing	• Improve access to information • Improve collaboration of midwives and health visitors to share information with their peers in Sure Starts (particularly Belfast HSCT)

Research and information	
Breastfeeding information	• Accurate collection of regional information and agreed definitions for collating breastfeeding statistics • Developing skills in interpreting breastfeeding statistics
Research	• Increased funding and effort for breastfeeding research • More research on effective approaches for low uptake areas and social groups • Concern was raised that BFI might limit innovative research efforts
Training	
General	• More education and training for all employees working in health care areas (health professionals, ancillary staff) to positively support breastfeeding
Medical and non-medical health professionals	• Encourage health professionals (health visitors, midwives, paediatricians) to develop specialist roles in breastfeeding • Curriculum guidance for under-graduate and in-service training • More training on breastfeeding during degree course for nurses as well as midwives and student health visitors • GPs and medical staff training
Specific	• Training for all staff on centile charts by breastfeeding coordinators • The development of e-learning packages and e-networking among breastfeeding coordinators

Support	
Antenatal	• Encouragement and support of mothers to start breastfeeding and to continue
Statutory support	• Support to breastfeeding mothers and those wishing to breastfeed whilst in the hospital • Firm integration of breastfeeding into Sure Start programmes
Voluntary/peer support	• Increase peer support for mothers/breast buddies/Mother to Mother support programmes in hospital and the community • Improve provision by breastfeeding support groups (eg run weekly in different towns) • Increase in government funding to support voluntary groups • More emphasis on Peer Support training and continued service to mothers • Support and develop voluntary breastfeeding networks and new breastfeeding counsellors (eg through LLL and NCT) • Accreditation of peer support
Specific circumstances	• Tailored provision of support on discharge for mothers with special needs babies and emphasis on people with a physical or mental disability
Public information and education	
Public awareness raising	• Continue public education campaigns to 'normalise' breastfeeding in society and to highlight its importance using various types of media coverage (eg TV ads/buses etc.) • Research based information on benefits of breastfeeding made more known (ie TV/press etc., especially topics discussed at major conferences)
Information needs	• A regional breastfeeding centre for mothers and health professionals • More information on drugs and breast milk • Address the information needs of grandmothers • Emphasis on the problems associated with bottlefeeding
School setting	• Increased breastfeeding education programmes for schools (both primary and post-primary) and youth groups

Protecting breastfeeding	
Legislation	• Influence development of a breastfeeding bill/legislation similar to that in Scotland to support breastfeeding in public
Marketing of infant formula	• Encourage Trusts to comply with WHO code • Encouragement/stronger emphasis to report to FSA and environmental health officers any concerns relating to statutory regulations in relation to the marketing of infant formula • Audit and abolish the availability of formula milk on maternity wards. Concerns were raised that such availability has caused confusion with some mothers who do not speak English and think the milk is free when returning home.
Standards for safe-guarding practice	• Encourage all hospitals and community Trusts to participate in BFI • Participation in UNICEF BFI university standards

The health professionals also considered what initiatives or organisations they would like to see in the proposed new strategy. Responses included the following initiatives and organisations:

Initiatives

- UNICEF BFI for HSCT (hospital, community) and universities
- More research initiatives in partnership with regional R&D office and in Trust-based research teams
- Breastfeeding counsellors
- Peer support programmes
- A shift in emphasis from medical based input to input from mothers.
- Breastfeeding Welcome Here scheme
- Focus on fathers to become more proactive

Organisations

- More recognition of district councils, community associations and voluntary agencies
- Sure Starts at a regional level and cooperation from the Department of Education to maintain support and funding for breastfeeding
- Doctors and GPs
- Stronger involvement of QUB and UU
- Wider promotion of the benefits of the human milk bank
- Stronger involvement of both primary and post-primary schools in breastfeeding education
- Media
- Social networking sites

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Appendix 1: Methods

Overview: Country breastfeeding coordinators and strategy stakeholders contacted for the review of the breastfeeding strategy

Stakeholder group		Action points consulted on	Response rate
Country breastfeeding coordinators	• England: Phyll Buchannon and Lorna Hartwell • Northern Ireland: Janet Calvert • Scotland: Ruth Campbell • Wales: Sue Sky • RoI: Maureen Fallon	1	3/6
Breastfeeding Strategy Implementation Group	DHSSPS, HPA/PHA, HSCT (breastfeeding coordinator, midwifery manager and community paediatrician), HSSB (commissioner and public health doctor), HSCB, GP, NCT, LLL	1-9	4/12
Commissioners (HSSB)	• Health promotion • Maternal and child health • Investing for Health (IfH)	1-3, 5-9	3/10
Breastfeeding coordinators	• 9 Trust-based[1] • 8 Community-based • Regional breastfeeding coordinator	1-5, 7-8	12/18
Sure Start coordinators/ project leads		1-5, 7-8	10/25
CHS information managers	• NHSCT (Ruth Johnston) • WHSCT (Theresa Conaghan) • SHSCT (Valery Doyle) • EHSSB (Maria Monaghan; Belfast and SEHSCT)	3	4/4
DHSSPS	• HSC R&D Office • Director of Information and Analysis (DHSSPS)	4 3-4	2/2

1. Two of the trust-based coordinators are job sharing, thus they reflect one post overall.

Stakeholder group		Action points consulted on	Response rate
Academics[2]	• QUB: Schools of Medicine, Dentistry and Biomedical Sciences; Nursing and Midwifery; Psychology; Sociology, Social Work and Social Policy • UU: Schools of Nursing; Psychology; Sociology and Applied Social Studies; Biomedical Sciences; NI Centre for Food and Health; Institute for Postgraduate Medicine	4	5/10
Training providers	• QUB: Schools of Medicine (medical undergraduates), Nursing and Midwifery (under- and postgraduate midwives, paediatric nursing) • UU: Schools of Nursing and Midwifery (under- and postgraduate health visitors, community paediatric nursing) • The Beeches Management Centre • In-service training within each Trust (Dr C Campbell: staff doctors) • NIMDTA	5-6	3/8
Director of the Human Milk Bank		6	1/1
Voluntary breastfeeding support counsellors and peer work leaders	• LLL • NCT • Uplift programme Dungannon, support group leaders of HSC support groups (at least one from each HSCT)	7	8/15

2. In university departments, the head of the school, school manager (where available) and known researchers were contacted. Thus, 10 different academic departments were contacted by mailing out to more than 10 individuals.

Stakeholder group		Action Points consulted on	Response rate
Infant formula regulations	• FSA (Mervin Briggs): • PEHOs in: - Eastern Group Environmental Health Committee (EGEHC) - Southern Group Environmental Health Committee (SGEHC) - Western Group Environmental Health Committee - Northern Group Systems (Environmental Health) - Belfast City Council	9	4/6
HR offices at HSCTs	• BHSCT (Marie Mallon) • NHSCT (Jacintha Melaugh) • WHSCT (Nuala Sheerin) • SHSCT (Kieran Donaghy) • SEHSCT (Eamon Molloy)	9	1/5
Midwives	• In each HSCT, midwifery/ breastfeeding coordinators/ managers distributed five questionnaires	1-5, 7-8	6/25
Health visitors	• In each HSCT, health visitor coordinators/managers distributed five questionnaires	1-5, 7-8	8/25

Appendix 2: Action point 1

Breastfeeding coordinator posts in the hospital and community setting

Hospital setting

Trust	Maternity facility	Breastfeeding coordinator	Hours allocated to breastfeeding	Permanent post
Belfast	Royal Jubilee Mater	Yes Yes	Full–time Part–time	Yes Yes
South Eastern	Ulster Lagan Valley Downpatrick	Yes No No	Full–time n/a n/a	Yes n/a n/a
Southern	Craigavon Daisy Hill	Yes (dual role) No	Part-time n/a	No n/a
Northern	Antrim Causeway	Yes No	Part-time n/a	Yes n/a
Western	Altnagelvin Erne	Yes (job-share) Yes (dual role)	Full-time Part-time	Yes No

Community setting

Trust/ Sure Start	Area covered	Breastfeeding coordinator	Hours allocated to breastfeeding	Funding
Belfast		No No	n/a n/aN/A	n/a
South Eastern	Down Lisburn locality North Down and Ards locality	Yes Yes	Part-time Part-time	PHA Trust
Southern	Armagh Dungannon	Yes	Part-time	Trust
Northern GOLD Sure Start	Mid-Ulster Causeway Homefirst locality Cookstown & Ardboe	Yes Yes Yes Yes	Part-time Part-time Part-time Part-time	PHA (IfH) PHA (IfH) Trust GOLD Sure Start
Western	Northern Sector Southern Sector	Yes Yes	Part-time Part-time	Trust Trust

Overview of remit of the country coordinators for Northern Ireland, Scotland, and Wales			
	Northern Ireland	**Scotland**	**Wales**
Title	Breastfeeding coordinator within PHA	Infant nutrition coordinator	Infant feeding coordinator within the Welsh Assembly Government (full-time permanent civil servant)
National breastfeeding committee	Breastfeeding Strategy Implementation Group Chaired by DHSSPS, senior medical officer Representation from: DHSSPS Policy Unit, Trusts, Midwifery, PHA, Commissioning, GPs, Breastfeeding coordinators, La Leche League, NCT, Paediatricians, CEMACH, Regional breastfeeding coordinator	Strategy group with broad remit of breastfeeding, maternal nutrition, feeding of children up to age 2 Chaired by a director of public health from one of the health boards Representation from: Royal College of Paediatrics and Child Health, Royal College of GPs, RCM, CPHVA, Scottish Infant Feeding Advisers Network, Care Commission (regulatory body that inspects childcare providers), NHS Health Scotland, NHS Public Health Nutrition Group, NHS Quality Improvement Scotland, NHS Education for Scotland, Food Standards Agency Scotland, researchers x 2, Breastfeeding Network, Community Food & Health Scotland, Health Promotion Managers Group, local authority, representatives from various departments in Scottish Government – nursing, medical, health improvement and early years	Strategy group is chaired by Chief Nursing Officer for Wales Representation from: Policy leads with Welsh Assembly Government relating to statistics, nutrition, medical, midwifery, health visiting; RCM, RCN, CPHVA, RCGP Wales, local health boards, Sure Start, NCT, ABM, LLL, BfN, BFI Wales, All Wales Breastfeeding Forum, NHS Direct Wales, dietitians

	Northern Ireland	Scotland	Wales
Involvement in policy development at national level	- Providing policy advice as requested by DHSSPS and the Breastfeeding Strategy Implementation Group - Informing DHSSPS of changes to policy relating to infant feeding within England, Wales and Scotland	- Direct involvement in change to Scottish Government policy on exclusive breastfeeding and age of introduction of solids - Advice on changes to recommendations on caffeine consumption during pregnancy, consumption of peanuts during pregnancy, while breastfeeding and in early childhood	- Policy lead within the context of Ministerial approval for strategic developments
Lead person for infant feeding policy at department of health	DHSSPS Policy Unit	John Froggatt, Deputy Director Child and Maternal Health Division (line manager; overall responsibility) john.froggatt@scotland.gsi.gov.uk Mike Watson, Head of Maternal and Infant Health Branch (lead for breastfeeding and infant nutrition policy) mike.watson@scotland.gsi.gov.uk	Susan.sky@wales.gsi.gov.uk

	Northern Ireland	Scotland	Wales
Provision of practitioner support at national level	- NI breastfeeding coordinators forum which meets four times a year: ongoing support for practitioners working at Trust level - Assess, develop and provide training for all who support breastfeeding families in NI - Produce the NI newsletter *Keeping abreast*: (Information on changes to policy, research, and training) - Ongoing support with practice and development issues and challenging breastfeeding problems through telephone contact and at meetings	- Scottish Infant Feeding Advisers Network, comprising the leads for infant feeding/breastfeeding from each of the health boards (meeting twice/year with aim for more often) - potential forum for two-way communication: practitioners to discuss issues affecting them within their respective boards and coordinator to update colleagues on progress on work at national level	- Through the All Wales Breastfeeding Forum and the Welsh Network of Infant Feeding Coordinators - On practical level: financial support for attendance at BFI conference and courses/ workshops provided by WAG - Infant Feeding Guidelines have been produced and distributed to all relevant health professionals in Wales who have contact with new mothers and babies - Responding to requests and proposals for additional resources

	Northern Ireland	Scotland	Wales
Input in informing and developing national information campaigns	- Responsible for examining available evidence from research and evaluation and the infant feeding survey and highlight areas of concern with the marketing manager in PHA - Providing access to individuals and groups who will provide input during testing to ensure the campaign is targeted appropriately - Advice on approaches to be used and technical expertise in relation to breastfeeding images and footage of breastfeeding	- NHS Health Scotland is the lead agency for all aspects of social marketing on breastfeeding on behalf of the Scottish Government - Plays central role in the development of a social marketing strategy for breastfeeding along with colleagues in the Maternal and Infant Health Branch and Health Improvement Strategy Division at Scottish Government - Plans have been developed for short, medium and long-term phases of a campaign, with the first phase to be launched for NBAW May 09	- Lead on the work to support the National Breastfeeding Programme

Appendix 3: Action point 4

Publications from research projects in relation to the research topics set out in the strategy

Giles M, Connor S, McClenahan C, Mallett J, Stewart-Knox BJ, Wright M (2007). Measuring young people's attitudes to breastfeeding using the Theory of Planned Behaviour. Journal of Public Health, 29, 17-26.

Giles M, Connor S, McClenahan C, Mallett J, Stewart-Knox B, Wright M (2005). Young people's attitudes to breastfeeding: a pilot study using the theory of planned behaviour. Psychology & Health, 20, S94-S95.

Greene J, Stewart-Knox BJ, Wright M (2003). Attitudes to breastfeeding and breastfeeding promotion among teenagers in Northern Ireland. Journal of Human Lactation, 19, (1), 57-65.

Sinclair MK, Gardner J, Gillen P, Boreland Z, Hood R (2002). Exploring the issues in midwife-led care. Down Lisburn Trust.

Sinclair MK, Gardner J, Gillen P, Boreland Z, Hood R (2001). Analysis of the records of maternity patients deemed as low-risk on admission and of former patients' perceptions of maternity care. Down Lisburn Trust.

Sittlington J, Wright M, Stewart-Knox BJ (in press). Infant feeding method, subjective mood and salivary cortisol in primiparous postpartum mothers. Biological Psychology.

Sittlington J, Stewart-Knox BJ, Wright M, Scott J (2007). Infant feeding attitudes of expectant mothers in Northern Ireland. Health Education Research, 22, 561-570.

Sittlington J, Millar E, Stewart-Knox BJ (2003). Infant feeding attitudes in Northern Ireland. Annals of Nutrition & Metabolism, 47, 571.

Sittlington J, Stewart-Knox BJ (2003). Breast and bottle feeding in Northern Ireland: what are the influencing factors in the uptake and duration of breastfeeding? Annals of Nutrition & Metabolism, 47, 574.

Sittlington J, Stewart-Knox BJ, Wright M (2004). Breast is best... according to whom? Journal of Human Lactation 20(4): 450.

Sittlington J, Stewart-Knox BJ, Wright M (2004). Lowest global breastfeeding rates in Northern Ireland: exploring misconceptions? Journal of Human Lactation 20(4): 450-451.

Stewart-Knox BJ, Gardiner K, Wright M (2003). What is the problem with breastfeeding? A qualitative analysis of infant feeding perceptions. Journal of Human Nutrition and Dietetics, 16, 265-273.

Stockdale J, Sinclair MK, Kernohan WG, Keller JM, Dunwoody L, Cunninghan JB, Lawther L, Weir P (2008). Feasibility study to test Designer Breastfeeding: a randomised controlled trial. Evidence Based Midwifery 6(3): 76-82.

Stockdale DJ (2005). Observation of breastfeeding demotivation In: Conference Proceeding – 27th Congress of the International Confederation of Midwives Brisbane Australia pp 350-353.
Stockdale J, Sinclair M, Kernohan WG, Keller JM (2007). Exploring the potential of the internet to motivate breastfeeding. Evidence Based Midwifery 5(1): 10-5.

Stockdale J, Sinclair M, Kernohan WG, Dunwoody L, Cunningham JB, Lawther L, Weir P (2008). Assessing the impact of midwives' instruction: the breastfeeding motivational instructional measurement scale. Evidence Based Midwifery 6(1): 27-34.

Stockdale J, Sinclair M, Kernohan WG (2008). Designer breastfeeding – successful, personal and powerful. University of Ulster. ISBN:978-1-85923-227-9.

Research projects mentioned by health professionals

(other than 'Designer Breastfeeding'):

- Baby Friendly versus motivational interviewing
- QUB survey on infant and young child nutrition
- UU research on breastfeeding education in schools
- Infant Feeding Survey 2005
- NICE guidelines
- Attitudes to breastfeeding in NI
- Audits and development of material within the HPA for NI
- Group looking at BF in NI as part of BF strategy at the beginning
- Cleanliness of collected breast milk

Obesity
SIDS*
Use of dummies*
Intelligence of baby*
Altnagelvin Hospital – how to improve growth velocity of neonates
Prevention of cancer
NNICU
Infant feeding of less than 1500g
Local research by network mothers on the effect of support groups
CD to promote breastfeeding

*non Northern Ireland based studies.

BSIG members and health professionals' suggestions for further breastfeeding research*

Area of research		Proposer group
Attitudinal and motivational issues		
General	Advantages of breastfeeding	Sure Start coordinators
	Ongoing public information campaigns/ promotion of breastfeeding in society	Breastfeeding coordinators, midwives
Focus on health professional	Promotion during training of health professionals	Sure Start coordinators
	Attitudes of professional staff	Sure Start coordinators
Focus on mothers	Research into the motivational factors associated with breastfeeding	Breastfeeding coordinators
	Communicating with mothers	Breastfeeding coordinators
	Empowering informed decision making	Breastfeeding coordinators, Sure Start coordinators
Service approaches to support		
	Antenatal needs and interventions	Breastfeeding coordinators, health visitors, Sure start coordinators
	Postnatal interventions	Breastfeeding coordinators, health visitors
	Limitations of BFI and how to move to next levels	BSIG members

Area of research		Proposer group
Support for breastfeeding		
	Developing supportive environments for breastfeeding	Breastfeeding coordinators
Community context	Support for mothers – peer support, multi-agency support	Breastfeeding coordinators, health visitors, Sure Start coordinators
Family context	Other family members – fathers/partners, grandmothers	Breastfeeding coordinators, health visitors
Work context	Breastfeeding and women working	BSIG members, Breastfeeding coordinators
Breastfeeding difficulties		
	Physical issues – treatment and care of cracked nipples, jaundice, mastitis, thrush.	Sure Start coordinators , health visitors, midwives,
	Mothers approaches to breastfeeding problems – avoidance of help-seeking	Breastfeeding coordinators
	Why some breastfeeders are slow to gain weight	Midwives
Breastfeeding uptake and duration of breastfeeding		
	Low uptake areas/ breastfeeding variation in NI (eg specific groups: young women in deprived areas, Travellers)	BSIG members, Sure Start coordinators
	Reasons for cessation/ early cessation vs factors enabling further breastfeeding	BSIG members, Breastfeeding coordinators
	Sustaining breastfeeding in older babies – 1 year plus	Health visitors

	Area of research	Proposer group
Breastfeeding and young people		
	Breastfeeding education in schools (outcome and process evaluation)	BSIG members, Sure Start coordinators, health visitors
	Attitudes of young people towards breastfeeding	Midwives
	Breastfeeding and young mothers	Breastfeeding coordinators, health visitors
Other		
	Breastfeeding nutrition – poor rates	Sure Start coordinators

*Health professionals included breastfeeding coordinators, Sure Start coordinators, midwives and health visitors.

Appendix 4: Action point 7

SHSSB Health Promotion, Maternal and Child Health, IfH commissioner: Developments in the area of breastfeeding in the SHSSB

1989: The first breastfeeding survey was carried out within SHSSB, prior to CHS data being available. One Trust area had a 16% breastfeeding initiation rate, reducing to less than 10% after six weeks.

1991: The first Southern area breastfeeding steering group was established by SHSSB, comprising representation from four legacy Trusts, community, voluntary sector and interest groups. An initial awareness raising campaign was developed, breastfeeding rooms were identified in all Trust facilities and promotion of breastfeeding outside the home was delivered.

1992-95: Annual awareness raising campaigns throughout Southern area facilitated to coincide with National Breastfeeding Awareness Week.
Raising awareness of WHO International Code of Marketing of Breast Milk Substitutes began in earnest.

SHSSB breastfeeding strategy developed, launched and written into Trusts contracts.
Monitoring of breastfeeding through Elderly and Health Promotion Programme Commissioning Group.

1995: SHSSB commissioned and launched its first Infant Feeding Guidelines and required Trusts to comply with them.

1999: Regional breastfeeding strategy launched. Area breastfeeding steering group disbanded in favour of Trusts having own local groups to coordinate all breastfeeding services and initiatives. SHSSB annually commissioned Trust to promote breastfeeding.

2003: In response to Priorities for Action target 2001/02, SHSSB commissioned Trust to update the Infant feeding guidelines and these were launched in 2003.

2004-08: Adherence to strategy and guidelines monitored by SHSSB through contracting processes.

2008: Southern Trust re-established Southern area-wide breastfeeding steering group and SHSSB has representation on this.

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01/11