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Increasing support for breastfeeding: What can Children's Centres do?

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Background.

Breastfeeding is an area of high health inequality and several UK Department of Health strategies recognise the importance of supporting breastfeeding, including Choosing Health (2004a), the National Service Framework (NSF) for Children and Maternity Services (2004b), and Public Service Agreement indicators to monitor breastfeeding prevalence levels at 8 weeks (2008).

Raising breastfeeding initiation and continuation rates is a target for both NHS Bristol (Primary Care Trust - PCT) and Bristol City Council. In Bristol the 6-8 week continuation rates vary between wards from over 80% to under 20% according to socio-economic status. Sure Start Children's Centres are based in areas of greatest deprivation and they are also required to put interventions in place to improve breastfeeding continuation rates (DH (PSA) 2008). Sure Start Children's Centres are part of the UK Government's ten-year childcare strategy to enable all families with children under 5 to have access to affordable, flexible, high-quality childcare. The aim is to provide every community with a Sure Start Children's Centre by 2010. They provide a range of high quality, family support, early learning and childcare services to local families (surestart.gov.uk).

It is known that a variety of interventions work to increase breastfeeding initiation and continuation rates (Dyson 2006). Evidence-based interventions include the WHO/UNICEF Baby Friendly Initiative (BFI) programme, ante-natal and post-natal support from health professionals and peer support. The UNICEF BFI is a worldwide programme to encourage both maternity hospitals and community settings to promote, protect and support breastfeeding. The BFI works with the health-care system to ensure a high standard of care for pregnant women and breastfeeding mothers and babies (www.babyfriendly.org.uk). Consistent advice about breastfeeding between health professionals (midwives, health visitors and GPs) and additional support has been shown to enable women to breastfeed for longer (Dyson 2006, Britton 2009). Also training mothers who have breastfed to be peer supporters, not breastfeeding counsellors or to give advice, but just to encourage and support new mothers who are breastfeeding, has been shown to help women to continue to breastfeed (Dyson 2006, Shribman 2008, Britton 2009).

There is little research from a parents' perspective on how to raise breastfeeding rates, and no research on how Children's Centres can best support breastfeeding mothers. Children's Centre staff are encouraged to monitor prevalence levels and identify barriers to women accessing services (DH best practice guidance 2009).

Action research is a cyclical process in which researchers and participants work together to identify problems and take forward developments to effect change (Lingard et al 2008). NHS Bristol commissioned the current research project to support the implementation of the community BFI programme in Children's Centres. Using action research the project aimed to work in

partnership with parents and staff in three Children's Centres to develop a model of effective breastfeeding support.

Parahoo (1997) A number of models of action research bit in essence involves ac collaboration between researcher and practitioner in:

- Identifying a practice problem
- Using research methods to assess this problem
- Planning and implementing the change
- Evaluating the outcome

Conventionally research is carried out by outside researchers on practitioners to advance the researchers cause. In action research there is more 'give and take' (Parahoo 1997). Researchers and practitioners can enter into a dialogue, discuss their different interpretations and produce more valid findings by drawing form each other's special knowledge and experience (Parahoo 1997, p171). However action research resembles conventional search in taking a rigorous and systematic approach (Denscombe).

Figure 1: The cyclical process and key stages of action research

(adapted from Denscombe 2007)

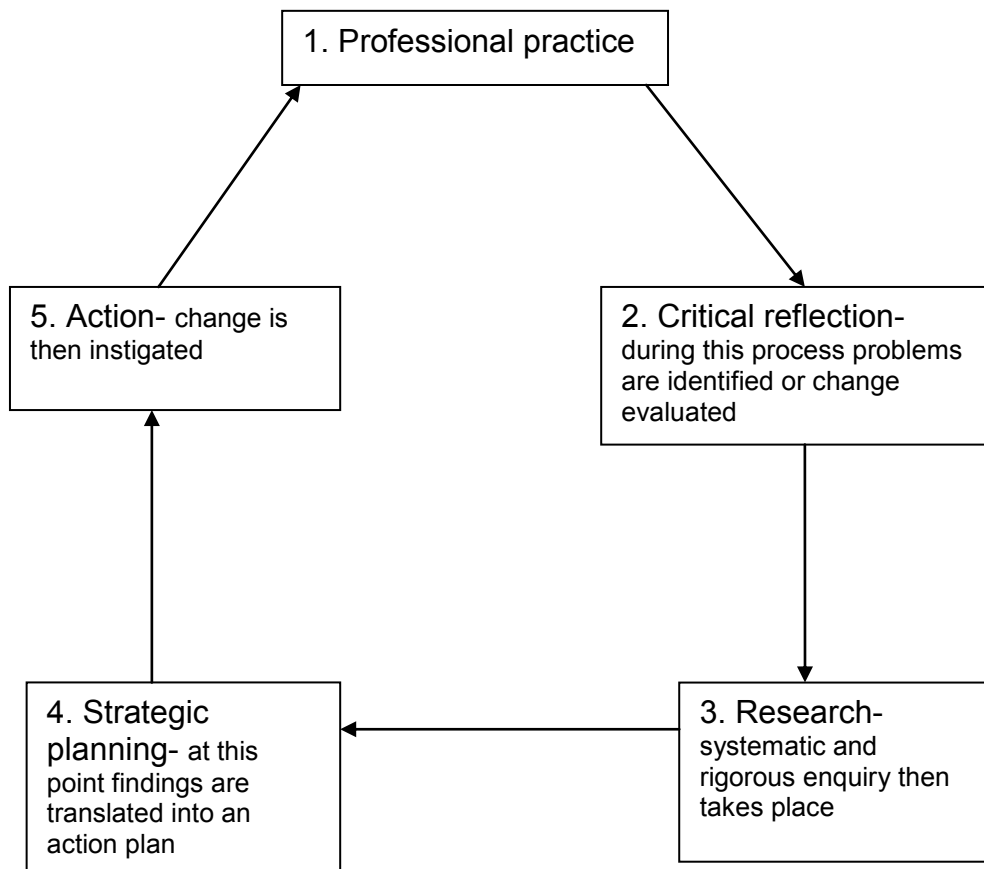


Figure 1 demonstrates the cyclical nature of the action research process. At stage 1 existing professional practice is already in place, in this case the breastfeeding promotion work of the three Children's Centres. This varied between one Children's Centre which was already running a breastfeeding support group to another which as yet had made no specific efforts to address breastfeeding promotion (see table 1). All Children's Centre managers were aware of work that was being done in Bristol by health services, such as the health visiting teams working towards Unicef Baby Friendly Initiative standards. As part of this initiative basic training in breastfeeding support and promotion had been offered to Children's Centre workers, and a deputy manager from one of the study Children's Centre had attended this half day training.

At stage 2 critical reflection is undertaken by practitioners in order to assess what is already being done and to consider possible future action which might better meet the aim of the research study. In this study this occurred at the early stages of the study when Children's Centre managers and workers considered their current breastfeeding promotion and decided whether to engage in a study to develop their future health promotion activities in this area. This was followed by focus groups attended by both Children's Centre workers and local parents which facilitated rigorous and systematic enquiry into views on current provision, ways in which stakeholders thought provision could be improved and how change could be implemented (stage 3).

Strategic planning (stage 4) took place both at the level of the focus group, and in a more focused way with the managers of the Children's Centre. In one Children's Centre the manager passed the management of change onto the Children's Centre deputy, though she remained informed about the project. At this point Children's Centres varied greatly in how they took forward this process. At the end of the first cycle change was implemented, but then the cycle began again with reflection on what had occurred, and systematic enquiry into the process by means of focus groups. Ideally this process would continue as an ongoing action research process, but as with many projects at this point the researchers withdrew from the process, and the Children's Centres were left with their future practice to manage as they would.

Methodology

The study incorporated a three stage iterative process:

1) Explore the views of staff and parents about breastfeeding support in Children's Centres.

Three Children's Centres were chosen across Bristol, one in each locality, North, South and East Central. In each Children's Centre, a focus group was held with parents and another group with staff to share views and explore the type of support for breastfeeding that Children's Centres could provide, in order to increase the numbers of mothers choosing to initiate and continue breastfeeding. The focus groups were facilitated by a researcher from the University of Bristol and suggestions made written down on large flip charts by an assistant, so that participants could agree what had been suggested. The group discussion was also digitally recorded to add detail to these notes later. The suggestions were analysed thematically and summarised for each Children's Centre and a short report sent to the manager soon after the groups had taken place.

2) Develop interventions suggested by staff and parents

From suggestions made during the groups and the themes developed, interventions were implemented in each Centre. It was agreed that a core steering group of the manager, key staff and parents would be set up in each Centre to monitor and maintain the progress of the interventions, with some input from the research team during the process.

3) Explore the views of parents and staff on what had been achieved.

The final stage of the action research project was to carry out further focus groups with parents and staff meeting together to explore their views on the changes made to providing support for breastfeeding by each Children's Centre. A report, compiled from the focus groups and interim meeting notes, would identify which interventions had been successful in promoting and encouraging a breastfeeding-friendly environment within the Children's Centres. Recommendations for future practice would be based on these outcomes.

Results.

1) Focus groups with parents and staff.

The Children's Centres were based in an old Victorian school building, a converted post-war built nursery and a new purpose built centre next to a Primary School. They were based in different areas of the city and had been established for different lengths of time (two opened in 2006 and one in 2008).

Seven focus groups were held at three venues with 51 people involved in the discussions: 17 mothers and 34 Children's Centre staff. The groups were held between July and September 2008.

Breastfeeding settings.

All three Centres had managed to establish a health visitor-led baby clinic to take place at the Children's Centre once a week. Two had small breastfeeding support groups that were linked to these clinics and one centre hosted some midwife-led antenatal classes.

Breastfeeding in the community

Staff acknowledging that breastfeeding was not well supported in the wider community in two of the areas, with no local cafes or places to feed and no breastfeeding welcome signs. They reported that it was unusual to see women breastfeeding locally and some expressed worries about media horror stories of being thrown out of cafes. The third area was felt to have a community which was more supportive to breastfeeding and that more confident women in the area would breastfeed readily, whereas others may not be so confident.

In two areas, mothers reported that they had received negative comments from older women when they had tried to breastfeed in cafes and ridicule from men. Some shops and cafes had asked them to leave. They felt vulnerable, self-conscious and self-aware about breastfeeding in some places; anxious about others watching and felt that they were waiting for someone to say something. They suggested that signs to say that breastfeeding was welcome would be helpful, so that they would know that the owner/manager is supportive, which might make others without children more aware. In the third area mothers felt fairly comfortable feeding in the area as it was more 'breastfeeding friendly'. Some still expressed a worry about whether they were 'allowed' to breastfeed, so needed to ask if it was ok, and worried about being told to stop. They felt that signs or stickers (indicating that breastfeeding was welcome) would be a good idea.

Breastfeeding in the Children's Centres

In all three Centres, staff felt that breastfeeding was welcomed and supported, and many mothers had breastfed there. It was possible to find a private space for a mother to feed in if requested, either in a parents' room or a quiet area with comfy chairs. Women mainly breastfed in the PEEPS groups (Peers Early Education Partnership (www.peep.org.uk)) - parenting groups for those

with babies under 1 year and 1-2 years old) and seemed to feel relaxed and encouraged.

Mothers confirmed that they felt comfortable breastfeeding at all the Centres and that they were happy to feed there. The staff were supportive and positive, the environment relaxing and they enjoyed attending those with breastfeeding support groups. They felt that a breastfeeding group was a good way of meeting other mothers, as the existing postnatal sessions were sometimes not very good.

Suggested breastfeeding actions for the Children's Centres. (*this could go in a box instead?*)

i) Practical points:

Develop and display a breastfeeding policy; display breastfeeding welcome stickers in visible places; provide more comfortable chairs and offer a private place to feed (especially in the early days). All staff needed to be aware what a breastfeeding mother needs, including a comfy chair and a drink.

ii) Links with health professionals:

Good links with both health visitors and midwives should be established or maintained. Midwives should be encouraged to run antenatal classes at the Centres to encourage women to come along when pregnant.

Breastfeeding support groups should be rejuvenated or established to give one-to-one advice; somewhere to come to have a drink and breastfeed, with privacy for new mothers. Parents would like good advice from knowledgeable health visitors to support breastfeeding.

iii) Involving fathers:

A range of suggestions for encouraging fathers to get involved in Children's Centres and breastfeeding support including : starting a discussion group for fathers – run by a father; invite them to existing groups and on trips; maybe run sessions and events in the evenings or at weekends. The possibility of involving male members of staff in breastfeeding discussions and support for fathers was discussed. Having leaflets for fathers on breastfeeding available to show how they can help and support when problems arise. Informed men can become advocates for breastfeeding.

Encouraging fathers to attend antenatal classes and make sure that they are invited and actively involved. This may mean that larger rooms are needed to hold antenatal classes so that they can all attend.

iv) Further support:

Suggestions about other ways that Children's Centres could support breastfeeding included having a stock of breast pumps to loan out to mothers and information about pump hire. Training local mothers as peer supporters was also discussed at the groups.

v) Outreach into the community and neighbouring Children's Centres (managed by the same staff):

It was felt that more publicity was needed for the Centres to increase community awareness of services, and that perhaps health professionals could distribute leaflets. Also more promotion of Centres was needed in shops and the wider community to raise their profile.

Actions for newly established Children's Centres nearby included: starting a breastfeeding support group, which involved mothers with a range of experiences and baby ages; having reference books available to borrow; leaflets for Dads; personal contact from supporters in the group; breastfeeding welcome stickers and posters.

2) Core working groups to develop interventions.

Working groups were set up in two of the three Centres, with a manager or the breastfeeding lead, one or two other staff members with community or nursery roles, a mother and a health professional. Three months after the focus groups had taken place, the staff were struggling to move on with the work, so they were offered a few hours of a community development worker's time by the PCT to help them and to attend their meetings. The two centres, with working groups established, welcomed this offer and the worker assisted with phone calls, taking notes at meetings and general liaison with health professionals, PCT staff and the researchers. They found this useful as it helped them to achieve something between meetings. The third centre did not set up a group, but the manager worked through the list of suggestions with different staff members and used the list extensively in setting up breastfeeding support in a new Children's Centre.

3) Final focus groups.

Three final focus groups were held in May 2009. Overall 15 people attended the groups: 11 Children's Centre staff and 4 mothers, most of whom had been actively involved in the regular meetings since the previous group discussions.

Those with working breastfeeding groups had met every 6 to 8 weeks during the 9 months since the initial groups and felt that they had achieved quite a lot with this structure. They also felt that having the research project taking place had pushed things along faster than would have happened otherwise. Both centres hoped to continue the impetus with a regular breastfeeding slot at their community meetings. The community development worker had been helpful in various ways as another pair of hands to focus on the tasks to be achieved. In the third Centre there had been some wider liaison meetings with a range of stakeholders to discuss how breastfeeding and other activities linked together.

Breastfeeding support outcomes for the Children's Centres.

i) Practical points:

All three Centres had produced breastfeeding policies and breastfeeding welcome stickers and posters were clearly displayed in the entrance areas and on doors. Staff were aware of what to offer a breastfeeding mother in terms of a comfortable place to sit and a drink. This would usually be in a parents' room and one centre had bought some breastfeeding pillows for their quiet area. Mothers rarely asked for a private place to feed, which may be because it is quite a difficult thing to ask for, however a place could be found in all Centres if requested. Mothers seemed to be quite relaxed about breastfeeding during the PEEPS sessions and at the breastfeeding groups.

ii) Links with health professionals:

Health visitors: Since the initial focus groups health visitor numbers had decreased across the city and the time available for breastfeeding support was often squeezed to a minimum. All health visitors continued to run weekly baby weighing clinics at the Centres, and two health visitor teams were now based in one of the Centres, which was felt to be a great strength. However very few are able to attend breastfeeding support groups. Elsewhere health visitors attended a network meeting to exchange information, so relationships were being maintained.

Midwives: Liaison through one of the core breastfeeding groups facilitated the start of midwife-led antenatal classes being held at the Children's Centre, which would provide a more comfortable and spacious environment, and staff hoped that this would encourage more fathers to attend. Another Centre continued to hold regular midwife antenatal classes and the midwives had started to use a room for some antenatal appointments and postnatal checks. Having breastfeeding core group meetings had enabled staff to involve the maternity support workers which they hope would encourage more contact with women antenatally.

Similarly a few midwives had agreed to give consent forms to antenatal women to ask if their details could be passed to the Children's Centre, to enable the Centre to invite them to local activities. Other Centres would like to use this way of publicising their activities by contacting all new parents in the area, once they have had their baby, to say 'hello' and to send them a welcome leaflet and some information about the Centre. However some local health professionals were not keen to do this and responded that they had no time to do it.

Breastfeeding groups: Breastfeeding support groups continued to run each week in two Centres, one facilitated by peer supporters immediately after the health visitor baby clinic, and the other by a maternity support worker (supported by the midwives).

iii) Involving fathers:

Having a male member of staff (preferably also a father) in post was seen as the best way of starting to involve fathers in Centre activities. In one Centre the male member of staff had been given this role and he had offered to pop

into the antenatal classes and talk about being a father, if there was an opportunity. A few fathers had attended the breastfeeding group and had been on some Centre outings. All Centres were keen to have a leaflet for fathers on breastfeeding, including suggestions about how they can help and support their breastfeeding partners.

iv) Further support:

All of the Children's Centres were becoming established as places where parents could ring or call in for information about who to contact for breastfeeding advice, where to hire breast pumps and which community activities and groups were based at the Centre, such as NetMums and parent-led play groups. One Centre had started a drop-in antenatal group (Bump to Babe) once a week, held after the breastfeeding group, and encouraged pregnant women to come to the breastfeeding group too.

Peer support training.

Two Centres had mothers keen to train as peer supporters to encourage and support other breastfeeding mothers in their area and this was the main area of further support that the core groups identified. The initial courses will be funded by the PCT and facilitated by Association of Breastfeeding Mothers or La Leche League breastfeeding counsellors. Ongoing training and meetings after the taught course will be arranged by the Centres where the peer supporters will be based. The Centre managers will guide the role of these new peer supporters, which will include supporting mothers in more deprived areas, as well as linking into the health visitor baby clinics.

v) Outreach:

Most of the outreach activity had been focussed on setting up breastfeeding support groups in satellite Centres, either linked to a baby clinic or facilitated by a maternity support worker. The breastfeeding leads have had some breastfeeding training and run breastfeeding awareness sessions for the staff.

Discussion.

The action research project set out to explore ways of improving breastfeeding support in three Children's Centres across Bristol, which were at different stages of development. The focus groups suggested a range of interventions for Children's Centres to implement, and setting up core working groups and input from a community development worker and the research team helped them to achieve some of their goals.

Action research methods enabled Children's Centre staff, parents and health professionals to explore solutions collaboratively based on the needs and priorities for each Centre. Having regular meetings with dedicated staff in two Centres helped them to focus their activities and moved things along faster than might have happened without them. Staff felt that they probably would

have got there eventually, however, the research process enabled them to make better links with the midwives and get the antenatal classes moved to the Centre, which was a huge step. The Centre that did not form a core working group found that the list of suggestions was a useful way of focussing things and including staff and parents' views for keeping on track with breastfeeding awareness and support.

Other studies have shown that peer supporters combined with a breastfeeding support group are an effective way of increasing breastfeeding prevalence in areas of low continuation (Ingram 2005), but that women may prefer to attend group based peer support as groups may increase their confidence with breastfeeding (Hoddinott 2006). The Children's Centres all ran breastfeeding support groups, some facilitated by peer supporters, and two were keen to train more peer supporters to provide further outreach and other help for breastfeeding mothers in their areas.

Fathers' attitudes influence breastfeeding initiation and continuation. Since they have been described as key supporters or deterrents to breastfeeding, they should be better prepared for their breastfeeding support role (Giugliani et al. 1994; Arora et al 2000; Scott et al 2001; Pollock CA et al. 2002). Involving fathers in antenatal groups and postnatal activities held in Children's Centres should help to facilitate this role and provide support for breastfeeding women.

Children's Centres are ideally placed venues where parents can come to obtain information about breastfeeding and where to get help; attend antenatal classes and postnatal groups; find support and encouragement at breastfeeding groups; and feel accepted and supported as a family. If all these activities are available then Children's Centres will play a crucial role in supporting breastfeeding women and improving breastfeeding rates.

Conclusions

Successful interventions to promote and encourage a breastfeeding-friendly environment within the Children's Centres include:

- i) strengthening links with health professionals, enabling them to run antenatal classes at Children's Centres and having a health visitor team based in the Centre, were seen as enormously beneficial;
- ii) employing a male worker with a specific remit for involving fathers and with some experience of fatherhood was felt to be the next big step towards involving more fathers in Centre activities;
- iii) facilitating peer supporter training to provide some additional support for breastfeeding support groups, at health visitor baby clinics and with outreach work in the wider community was felt to be important in underpinning breastfeeding support for more mothers in the community;
- iv) identifying what was needed to establish breastfeeding support in a new Children's Centre including a welcoming environment, a breastfeeding support group linked to health professional activity and availability, and input from mother peer supporters.

Implications for practice

- Health professionals should be encouraged to become embedded in Children's Centres by running clinical sessions and classes, and facilitating breastfeeding support groups at Children's Centres.
- Midwives and health visitors are key to getting new parents involved in Children's Centre activities and should be encouraged to give out consent forms to allow Children's Centre staff to contact them.
- Employing male workers with a remit for involving fathers will encourage parents to feel supported as a family. Information specifically for fathers about breastfeeding would also be helpful.

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