

# Baby Friendly News

UNICEF UK Baby Friendly Initiative

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In this issue: Meet the regional Infant Feeding Co-ordinators  
An introduction to the Community Initiative Review

See page 7

See page 9

## “A great year for breastfeeding”

During the opening remarks of the Baby Friendly Initiative Annual Conference last November, 2008 was declared as, "a great year for breastfeeding." There was a vibrant sense of optimism at the Glasgow conference, reflecting on how things have improved in the world of breastfeeding over the last 12 months.

It seemed that every one of the more than 900 delegates at the conference was saying the same

thing – that there was a special buzz about 2008 and a strong sense that the same would be true of 2009.

And there was good reason for such positivity, thanks to a number of significant developments which have taken place during the past year. The £4 million from the DoH for PCTs to implement best practice is set to alter the breastfeeding landscape and much of the discussion between talks

was about how individual Trusts might make use of this. Equally, with the Infant Feeding Coordinators from all four countries having been appointed, and with each one chairing one of the conference sessions, it really felt as though we are really building mutual support and learning from each other.

Adding to the excitement, the line-up of speakers included brand-new research on bed sharing and neonatal care, and presentations from the country's leading experts in all aspects of breastfeeding and infant care.

UNICEF UK Baby Friendly Initiative Director Sue Ashmore opened the conference with a warm welcome to everyone attending the SECC and a brief overview of the exciting changes that have taken place this year – including the Community Initiative Review (covered further on page 9) and the new Strategic Package to support trusts to achieve Baby Friendly status (see page 11).



Delegates from Northern Ireland at the 2008 conference © UNICEF UK 2008



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# Breastfeeding and diarrhoeal disease

Dr Maria Quigley from Oxford University gave everyone a good reminder of just why breastfeeding is so important. Presenting findings from the Millennium Cohort Study (MCS), she told delegates that this research clarified and backed up earlier studies which have shown that exclusive breastfeeding protects against diarrhoeal disease and respiratory infections. Data from the MCS showed a 63% reduction in the risk of

hospitalisation for diarrhoeal disease associated with exclusive breastfeeding (EBF) compared with not breastfeeding. The protective effect of partial breastfeeding was not as strong, and not statistically significant. For lower respiratory tract infections EBF was associated with a 34% reduction in the risk of hospitalisation compared with not breastfeeding. In this case there was a smaller protective effect for partial

breastfeeding. Dr Quigley illustrated these figures in a dramatic way: "We can estimate that for diarrhoeal disease 53% of hospital admissions could be prevented by EBF. And one-quarter of respiratory infections could be prevented by EBF or partial breastfeeding. So it is clear that breastfeeding could substantially reduce the risk of hospitalisation in the UK."

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## A new view on bed sharing

A highlight of the conference was one of the country's leading experts in bed sharing practices – Dr Peter Blair from the University of Bristol, whose latest work with Professor Peter Fleming is due to be published shortly.

Giving some context for the new research, Dr Blair explained that there has been a backlash against co-sleeping in recent times, not least due to a number of studies which have shown an increase in the proportion of co-sleeping deaths taking place in the parental bed. "I don't think we can dispute that SIDS (Sudden Infant Death Syndrome) is occurring more often in the co-sleeping situation than one would expect," he told the conference. However, Dr Blair stressed the importance of looking underneath the headline findings, in order to determine what was really being seen, especially when the evidence was being used to develop public health policy.

To examine this outcome, Fleming and Blair developed the SWISS (South West Infant Sleep Study) to look more closely at the sleeping environment. They collected data from all SIDS infants aged 0-2 years in the South West over a four-year period from 2003-2006. There were 90 cases of SIDS, and 86 were analysed and allocated randomised controls, weighted for age and day or night sleep.

The initial outcome was that half (43) of the SIDS infants were found dead while

they were co-sleeping with an adult. Rather than jump to the conclusion that co-sleeping was inherently dangerous to babies, Fleming and Blair asked more questions. And their findings demonstrate the importance of looking carefully at all the data.

They found that 13 of those 43 infants were co-sleeping on a sofa – a known risk factor for co-sleeping.

Furthermore, more than half of all the co-sleeping victims (24/43) had co-slept with a parent who had consumed more than two units of alcohol or taken cannabis or opiates. "It may be somewhat surprising," said Dr Blair, "that no other studies have asked about alcohol and drugs. We should be shouting loud and clear that such sleeping environments are unacceptable for a vulnerable infant."

"However, if we demonise co-sleeping we have tired mothers who need to feed their babies sometimes several times during the night. We cannot use simplistic labels saying bed sharing is safe or unsafe," advised Dr Blair. "We should be in the business of explaining to parents the specific circumstances where co-sleeping should be avoided."

The SWISS study also looked at dummy use and, once again, threw doubt over recent claims that using a dummy reduces the risk of SIDS. The data showed that most dummies fell out shortly after

**Dr Blair's conclusion was that recommended advice on dummy use was to say nothing – a comment that drew spontaneous applause from delegates**

the baby fell asleep, while SIDS usually takes place several hours into the sleep.

Dr Blair suggested that what the data actually showed was that SIDS infants were not given a dummy before the particular sleep in which they were found dead, indicating that perhaps this was a proxy marker for something else such as a disrupted routine.

Dr Blair's conclusion was that recommended advice on dummy use was to say nothing – a comment that drew spontaneous applause from delegates.

### GOOD NEWS!

Paul Martin, Chief Nursing Officer for Scotland, announced a change in government policy on the age at which solids should be introduced, from between 4-6 months, to around six months – in line with guidance from the World Health Organisation and the recommendations of the Departments of Health in England, Wales and Northern Ireland, as well as many other organisations, including UNICEF.

## Breastfeeding continuation rates

The afternoon session, chaired by Northern Ireland's Breastfeeding Coordinator Janet Calvert, focused on community interventions to promote and support breastfeeding. The first speaker, Professor Mary Renfrew, from the University of York, gave an overview of work she has carried out in the past few years looking at continuation rates of breastfeeding and how they might be improved.

Professor Renfrew began with a graph illustrating the dramatic decrease in breastfeeding rates during the two weeks after birth, reminding everybody of the huge challenge that community support for breastfeeding poses in all sections of society. "These women are starting to breastfeed with a heart full of optimism and hope about feeding their baby, and then what happens to them in the first two weeks is often devastating for them. We know they are not stopping because they want to." She went on to say that some of the problems that have led to this dramatic fall-off in breastfeeding rates are starting to be addressed: the lack of appropriate training within the NHS, and breastfeeding not being a priority issue, are beginning to change. But breastfeeding mothers still face huge obstacles within a society which

sexualises breasts, from a lack of both formal and informal support once they leave the maternity unit, to the continued misleading promotion of formula milk – which has successfully established itself as "good enough" (with breastfeeding as the luxury option for those who can cope with it). Having illuminated the problem, Prof Renfrew explained the conclusions that her team had reached after examining all the studies of community initiatives to support and promote breastfeeding, and carrying out a wide-ranging external consultation of plausible interventions.

Firstly, experts have consistently reported that any community package needs to be determined locally, depending on the population cross-section and current breastfeeding services.

Secondly, considered by far the most effective specific intervention was the UNICEF UK Baby Friendly Initiative, said Prof Renfrew, as it comprehensively addresses many of the single issues that can help women continue breastfeeding – such as training for NHS staff, policies and procedures, professional and peer support, and mainstreaming breastfeeding. Other community interventions which were found to be important included an appropriate mix of



Professor Mary Renfrew © UNICEF UK 2008

peer and professional support, appropriate basic hospital and community practices to support breastfeeding, such as teaching positioning and attachment effectively, promoting ongoing mother-baby contact, a complementary telephone support line, and local media programmes to target young people in order to shift views on breastfeeding.

Prof Renfrew concluded that the problem of improving continuation rates was complex, and that any solutions needed to be integrated and incorporate a multi-sectoral approach. "It has been said that it is not women who breastfeed," she concluded, "but society. If you are going to fix it for women you need to fix it further out."

## Biological nurturing – a new approach

There was certainly no shortage of thought-provoking material from Dr Suzanne Colson, from Canterbury Christ Church University.

Her work, known as "biological nurturing"



Dr Suzanne Colson © UNICEF UK 2008

has grown out of many years as a practising midwife, during which time she has observed in great detail the instinctive behaviours of mothers and babies and their early breastfeeding practices.

Dr Colson explained that biological nurturing was a new approach to initiating breastfeeding, which introduced new and varied positions for the mother and baby to adopt, primarily by encouraging the mother to lie back and to put the baby on top of her body, tummy down, so as to maximise the baby's body touching the mother's skin. Adopting this leaning back position releases innate behaviour interactions between the mother and baby which enable the baby to latch on.

She then proceeded to show some video footage of newborn babies which had formed part of her research. It was fascinating to see how one aspect of a baby's innate behaviour such as head-bobbing was seen as a stimulant to breastfeeding when the mother was lying back, but could be interpreted as the baby "playing with the breast" and not wanting to breastfeed when the mother was more upright.

Dr Colson finished with a suggestion that biological nurturing might be a helpful additional tool for health professionals working with new mothers and babies, in order to encourage maternal behaviours that aid successful latching on.

## Breastfeeding in the community - Two different approaches

On Day Two, Catherine Pardoe (right) and Michelle Atkins (below right) from the Baby Café and Little Angels (respectively) spoke about their work to support breastfeeding beyond the maternity unit. Though they take different approaches, both interventions are growing in numbers and being taken up by Primary Care Trusts wanting to make progress towards Public Service Agreement (PSA) target 12 and improve the prevalence of breastfeeding at 6-8 weeks.

Founded in 2000, there are now 126 Baby Cafés across the country, which offer a “bridge between clinic and café, with a focus on the provision of clinical support and peer support in a non-clinical professional setting” for 11,000 women per year. Catherine explained that Baby Cafés aim to be places of excellence – from the quality of the coffee and surroundings, to the level of training and support offered to mothers. “Everything matters at the Baby Café, because what the mums are doing matters. We must show them we respect and value what they are doing. And it does work. Mothers tell us that attending a Baby Café enabled them to carry on breastfeeding for longer.”

Little Angels operates through teams of trained individuals offering group care and one-to-one support for every mother who passes through a participating maternity

unit, as well as a 24-hour telephone helpline. They too have grown rapidly over the past four years, and now employ 52 paid staff. “Our unique selling point is that we employ women from the local community to become Little Angels,” said Michelle. “All staff are trained in accordance with Baby Friendly, and every mother can expect support in her mother tongue. And all breastfeeding mothers are seen – none are missed. We work very closely with midwives and health visitors. We carry out two home visits in the first 10 days (after discharge) and then all mothers get continued care – as much or as little as they want.”

“Everything matters at the Baby Café, because what the mums are doing matters”



Catherine Pardoe (top), Michelle Atkins (above) © UNICEF UK 2008

## Do you remember the first time? – Jim Paterson does...

Watching the crowds entering the hall of the Scottish Exhibition and Conference Centre, I felt a little uneasy. Was it the hurriedly-eaten breakfast from earlier? Or could it be that I was about to spend two days with 800 women who were passionate about breastfeeding, a subject about which I had known next-to-nothing a month earlier? Oh yes, that was it.

Before joining UNICEF UK as the Web and Resources Editor for the Baby Friendly Initiative I had done a variety of editorial jobs but had little knowledge of the breastfeeding world itself, not an insurmountable problem – I’m here to

look after the web pages and documents, not lean over a midwife’s shoulder and unhelpfully say, “I’m no expert, right...”

From day one though, I’ve been on a learning curve approaching the vertical about every aspect of breastfeeding. I certainly know of no other single man of my age who will begin a conversation in a pub with, “You won’t believe what I found out about inducing lactation today.”

The conference was both a great learning experience and a spur to find out even more. There’s something really exciting about being in an environment where

everyone has a shared passion and is eager to talk about it. A selection of excellent speakers helped by communicating strong feeling with the rigorous research-based approach that has helped underpin our work. My purpose in being there was to find out how people were using the website – and it was very revealing in terms of what people thought about the website and the way in which they navigate it. Over the coming months we’ll be acting on some of the points raised to make the website as useful a resource as possible for you. If you have any questions or suggestions, please email me at [jimp@unicef.org.uk](mailto:jimp@unicef.org.uk)

## Breastmilk and low-birthweight babies

Following hot on the heels of Professor Mary Renfrew's research was a very moving and practical talk by Liz Jones, from North Staffordshire Hospital, who has developed a set of standards for helping women to express breastmilk for their very preterm and low-birthweight babies.

She explained how her extensive real-life experience of working with preterm and low-birthweight babies has demonstrated to her the vital importance of getting at least some breastmilk into these babies and, intrinsically linked to that, the importance of understanding and supporting the mothers – who are often in shock or are suffering tremendous trauma – to express their milk.

"In a crisis, the most important thing is to turn a victim into a powerful team member," said Liz. "Even just some breastmilk is very important for the development of these infants. We need these mothers to make a commitment to these babies and so we must enhance the maternal attachment."

Liz emphasised that the principles of lactation for mothers of preterm babies are often very different from those of



Liz Jones © UNICEF UK 2008

mothers whose babies are born at term – largely because of the changes that take place in the mother's body over the final trimester - and that an understanding of this is crucial if staff on neonatal units are going to be able to help mothers express milk for their babies.

For example, without intervention, the mother of a baby born at 28 weeks will typically start with a poor milk supply, then it will dwindle further and soon she will lose it altogether. In order to counteract this, a programme of frequent expression is needed to encourage and then establish milk production. "Don't wait until the woman has recovered to introduce this," said Liz, "intervene when she is partially recovered. This will help to grow breast tissue and increase the

milk supply. You have a window of approximately two weeks in which to increase the volume of milk to the amount a term baby would need at discharge. After two weeks it is very hard to up-regulate the volume."

Liz suggested that early and frequent expression of at least 8-10 times in 24 hours was required, and that aiding milk removal in any way possible was crucial – such as by double pumping, teaching hand expression, skin-to-skin contact, and massage. She concluded with a call echoing Prof Mary Renfrew's – for all staff caring for preterm mothers and babies to be fully trained and have the skills and knowledge needed to deal with this specific and vulnerable group.

## Teaching hand expression – A UNICEF Response

In response to some concerns expressed by infant feeding advisors on what is required when teaching hand expression – following research which suggests that lactiferous sinuses are not a discrete anatomical structure of the breast – the UNICEF Baby Friendly Initiative would like to offer the following information to help clarify the issue.

The key messages for teaching hand expression have not changed – only the terminology used to describe it. Mothers still need to know where to place their fingers and thumb on the breast to and

how to compress and release to ensure success. The only difference is that the term 'lactiferous sinus' is no longer used to describe what is being compressed.

We recommend that a mother be encouraged to find the right 'spot' by 'walking' her thumb down the breast (or backwards from the nipple) until she feels a change in texture within the breast. This will probably be about an inch (2 - 3 cm) from the base of the nipple. There is no need to give this area a name. The mother should then place her fingers and thumb opposite each other over this area

and compress and release.

An outline of the suggested technique is included in the sample clinical practice feedback form for hand expression, part of the Baby Friendly Initiative's guidance on writing a training curriculum and is accessible via our website: [www.babyfriendly.org.uk/curriculumguidance](http://www.babyfriendly.org.uk/curriculumguidance).



## Neonatal hypoglycaemia – Looking at the evidence

After lunch, just as delegates' blood sugar levels were peaking, Dr Martin Ward Platt gave a down-to-earth talk about neonatal hypoglycaemia. He focused on normal, healthy, full-term breastfed babies, explaining simply and clearly the physiology that ensures that these infants are not at risk from low blood glucose levels.

Firstly, the stress of birth causes the breakdown of protein, releasing lactate, which is the brain's preferred energy source. Secondly, the healthy baby has enough glucose stored in his liver to last for 24 hours anyway. Thirdly, the baby breaks down stored fat to provide ketones, the levels of which peak on days two and three – whether or not the baby is feeding well. All of this means that a healthy, term baby is not going to suffer if feeding takes a while to get going. The

baby's blood glucose level may fall but he will automatically call on his reserve fuels to keep himself safe and well.

Dr Ward Platt explained that babies who fall into an 'at risk' category may not have these fallback fuel sources, so their blood glucose levels have to be maintained. Measuring the level is therefore appropriate: 2.6mmol/l is generally considered a safe level for these babies.

The most important message from this upbeat and reassuring presentation was that if we are in any doubt about a baby's wellbeing, we should pick him up and talk to him: "To know how well a baby's brain is being fuelled, you have to ask for a response from the baby. If the baby has a good level of consciousness you don't need to measure his blood glucose."

## Library of experiences online

The final speaker, Dr Kath Ryan, told the audience about an award-winning web-based information resource for breastfeeding (and other health issues), compiled jointly by Oxford and Bournemouth Universities.

**Healthtalkonline.com** is a series of modules, each one backed by a stand-alone qualitative study, for users to access information and hear other people's experiences. The site features recordings of women talking about their own experiences combined with a Q&A, glossary and links to up-to-date information to help both health professionals and mothers receive support and learn more about breastfeeding.



And then that was it – all that remained was for taxis to be called, stands dismantled and hotel bills settled. It was two days that reflected on progress achieved and the promise of more to come. Between the talks from the podium and the talks over coffee, it was very clear that Glasgow appreciated the growing momentum of the breastfeeding movement – and shared the enthusiasm that will take us to new and exciting places in 2009. Roll on Bournemouth and this year's conference...

Delegates from Wales at the 2008 conference © UNICEF UK 2008

## UK Infant Feeding Co-ordinators: who are they?

It is great to start 2009 with infant feeding co-ordinator positions in place in all four UK countries – another important step in the trend of improving breastfeeding services and ensuring that every child gets the best start in life.

But do you know anything about your infant feeding lead? Did you know there are in fact five people rather than four? Here we give you a brief biography about each of these people, who come from very different backgrounds but who are all united in their goal of providing better support for breastfeeding mothers and babies.

In **Scotland**, Ruth Campbell took up her post in May 2008, with the purpose of developing a nationwide infant feeding strategy. A registered dietician and public health nutritionist, she is seconded from NHS Lanarkshire, where she has been the public health nutritionist for the past nine years. Her role includes work to improve maternal nutrition, breastfeeding and the feeding of children up to the age of two years. A mother of two, Ruth is passionate about improving women's experience of breastfeeding.

In **England**, Phyll Buchanan and Lorna Hartwell share the position of Infant Feeding Best Practice Advisor. The job share partners were seconded from the Breastfeeding Network (BfN) back in April 2008 to the Department of Health with the aim of reducing health inequalities by promoting breastfeeding.

The two met in the mid 1990s when they were both working in the voluntary sector supporting breastfeeding women and their families, and their paths remained closely aligned as they joined the Breastfeeding Network at its inception in 1997.

Phyll has three daughters and has worked in the voluntary sector supporting breastfeeding women for nearly two decades. She was a founder member and trustee of BfN. As a tutor she trained and supervised peer supporters in various communities in England and



Julie Smee, Carmel Duffy, Janet Calvert, Mary Renfrew © UNICEF UK 2008

Wales. She represented BfN on the Baby Feeding Law Group and the Breastfeeding Manifesto Coalition and has co-chaired her local Maternity Services Liaison Committee.

Lorna started her professional life as a primary school teacher but has been involved in training mothers and health professionals in breastfeeding and communication skills since the late 1980s. When she breastfed her own two children she realised that breastfeeding was not just about nutrition, and that presenting it as a simple choice was not acceptable.

Lorna said: "I have become aware of, and am constantly refreshed by the many voices and influences, past and present, who promote and protect breastfeeding, and I believe that the message is being heard and understood by more and more people. Phyll and I are committed to maintaining this gathering momentum and rediscovering a breastfeeding society."

Janet Calvert (above) has been in place in **Northern Ireland** since 2002. She has extensive experience in promoting and supporting breastfeeding, and providing breastfeeding education to health professionals. Janet was previously employed as Breastfeeding Coordinator at the Ulster Hospital and was instrumental in the Hospital's success in becoming the first Baby Friendly Hospital in Ireland. She has also been employed as a Professional Officer by the Baby Friendly Initiative for the last four years. Her role as Regional

Breastfeeding Coordinator is based at the Health Promotion Agency in Belfast. Janet has two children, a husband, and a dog.

Sue Sky was appointed as the Welsh Assembly Government's first Breastfeeding Co-ordinator for **Wales** in May 2003.

Sue has lived in Cardiff for 30 years and her background is in community work and social work, mostly in the voluntary sector, ranging from Women's Aid to community development and community theatre. She was an NCT Breastfeeding Counsellor for five years and joined the Welsh Assembly Government 10 years ago to work in child health policy development. Sue is responsible for supporting the implementation of the Welsh Assembly Government's Breastfeeding Strategy "Investing in a Better Start: promoting breastfeeding in Wales". She works closely with health professionals and with a growing number of very knowledgeable and enthusiastic volunteers.

Sue said, "The greatest opportunity for advancement lies amongst the growing number of mothers who are supporting new families in their area, as well as the training of health professionals. I believe that we are about to see a long-awaited increase in breastfeeding rates in the UK."

## Bristol's a Baby Friendly town

St Michael's Hospital in Bristol has become the first maternity unit in the country to become Baby Friendly accredited under the new Staged Approach. This means that Bristol is one of the most Baby Friendly cities in the UK, as both city hospitals are fully accredited, and the PCT has passed its Stage 1 assessment.

The Staged Approach, launched two years ago, was designed to make progress towards accreditation more logical and structured, and give more support to those responsible for implementation.

Sally Tedstone, Infant Feeding Coordinator for University Hospitals Bristol NHS Foundation Trust, said: "The Staged Approach gave a step-by-step structure for to what we had to do next, which clarified the process – meaning all our energy could be spent on implementing the Baby Friendly Standards.

"It was still a great deal of hard work for all those involved, and I would to thank my whole team for their commitment and



Staff of St Michael's Hospital, Bristol and Sue Ashmore © UNICEF UK 2008

dedication in improving breastfeeding care for mothers and babies at St Michael's."

"We are now looking at getting the Trust up to the same standard, so that Bristol mothers get the best levels of support for breastfeeding both in and out of hospital."

Sally has been working as a professional officer for the Baby Friendly Initiative for six year and divides her time between the two roles, "I have to be very compartmentalised. Otherwise I'd be

barmy. But mostly it's a plus because the roles feed into one another, so something I'm doing in one place can help in another."

Sue Ashmore, UNICEF UK Baby Friendly Director, said: "The speed at which St Michael's implemented the Ten Steps under the Staged Approach is most impressive. It shows what can be done, and we look forward to further exciting progress in Bristol."

## Course Dates for 2009

### Breastfeeding Management

20–22 May – UNICEF House, Central London  
15–17 July – UNICEF House, Central London  
7–9 October – UNICEF House, Central London  
11–13 November – UNICEF House, Central London

17–19 June – Derby  
16–18 September – Derby  
20–22 May – Scotland

For further information on the Breastfeeding Management course please go to [www.babyfriendly.org.uk/breastfeedingmanagement](http://www.babyfriendly.org.uk/breastfeedingmanagement) or phone our Helpdesk on 0870 801 2414

### Workshops

12 March – Auditing Practices to Support Breastfeeding  
– UNICEF House, Central London

Please note: the Education Workshop is to be replaced by an enhanced 'Training-for-Trainers' course which it is planned will be run over three days and include teaching materials. This course will be piloted in April, after which dates will be available to book.

For further information on the workshops please go to [www.babyfriendly.org.uk/workshops](http://www.babyfriendly.org.uk/workshops) or phone our Helpdesk on 0844 801 2414



# The Community Initiative Review

## – What is it, what's in it and what does it mean for you?

The revised and renamed Seven Point Plan for Sustaining Breastfeeding in the Community was officially launched at the Baby Friendly Initiative's 2008 conference.

Since the Seven Point Plan for the Protection, Promotion and Support of Breastfeeding in Community Health Care Settings was originally introduced in the UK in 1998, the UK has seen significant increases in breastfeeding initiation rates. But many mothers still give up earlier than they want to – and well before the recommended minimum age (six months for exclusive breastfeeding and at least one year of partial breastfeeding).

The last 10 years have also seen many changes in the structures and staffing of community health care, as well as the publication of several studies of what helps mothers to sustain breastfeeding.

In light of these developments, the time had come to review the criteria for accreditation as a Baby Friendly community health-care facility to take account of these changes and the new evidence.

The result is a set of standards which are not too different from the original criteria but which are more strongly grounded in what actually works for mothers.

The key changes are:

### **Point 1 – Have a written breastfeeding policy that is routinely communicated to all health-care staff.**

It is no longer a requirement that the policy must be displayed in all health-care premises. Instead, the health-care facility must ensure that the policy is communicated effectively to pregnant women and parents. This may be, for example, by distributing a leaflet or adding a page to the 'red book'.

### **Point 2 – Train all staff in the skills necessary to implement the breastfeeding policy.**

The Stage 2 assessment interview for all staff who have responsibility for caring for breastfeeding mothers now includes questions about how to recognise effective breastfeeding, how to support a mother in coping with night-time feeds, the nature of early feeding cues, and the importance of encouraging mothers to keep their babies close so that they can recognise these.

Other changes mean that it will no longer be possible for facilities to apply to become Baby Friendly without including General Practitioner (GP) colleagues. In recognition of the important role of GPs in supporting breastfeeding, the facility or trust must provide them with information and/or training to enable them to provide effective support. Each individual facility will decide how best to provide this training, which may be classroom based or consist of information packs or computer-based packages. Evidence that the training has been provided for will be required at Stage 2 assessment but GPs will not be formally interviewed.

The criteria for providing training and information for all other staff (receptionists, clerical staff) remain the same, although receptionists will no longer be formally interviewed as part of a Stage 2 assessment.

### **Point 3 – Inform all pregnant women about the benefits and management of breastfeeding.**

The criteria for Point 3 have been expanded to encourage community facilities to target areas of the local population that have the lowest breastfeeding prevalence rates. These groups are less likely to access mainstream interventions and evidence suggests that specific interventions aimed at meeting their needs are more effective than routine care alone at increasing the numbers who choose to breastfeed. The intervention(s) to be implemented will be decided according to local knowledge and identified need, but must be broad enough to have the potential to increase overall breastfeeding rates in the locality. Interventions may consist of, for example, peer support, telephone contact, informal groups or additional one-to-one support, or a combination of any of these. Evidence that the intervention will be effectively audited and evaluated will also be required.

### **Point 4 – Support mothers to initiate and maintain breastfeeding.**

The criteria for this Point have been strengthened substantially to ensure that optimum support and information is provided for each breastfeeding mother as soon as care is taken over by community-based staff. As the lead professional, it will most often fall upon the health visitor



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to make the primary 'new birth' visit and it is now a requirement that a full breastfeeding assessment be carried out during this visit. This replaces the need for a formal handover of care from the midwife. The assessment should include an evaluation and discussion of the signs in the both the mother and baby which would indicate effective feeding and sufficient milk intake.

A further discussion should take place to ensure that the mother is confident in the practical skills of breastfeeding and understands the importance of effective positioning and attachment and that she has the confidence to know when her baby is getting enough milk and what to do if she has concerns. It is important that staff ensure mothers are confident with hand expressing breastmilk and are aware of the importance of this skill to prevent and manage breastfeeding challenges such as engorgement and mastitis.

Other discussions (which can take place during future visits or at clinic attendance) should include:

- The importance of demand feeding and how to recognise feeding cues
- The appropriate use of teats and dummies
- Strategies for coping with night time feeds
- Breastfeeding and returning to work

The Baby Friendly Initiative has developed a sample breastfeeding assessment tool and postnatal checklist which can be downloaded from our website on [www.babyfriendly.org.uk/point4](http://www.babyfriendly.org.uk/point4)

### Point 5 – Encourage exclusive breastfeeding and continued breastfeeding, with appropriately timed introduction of complimentary foods.

There are no changes to the criteria for this Point.

### Point 6 – Provide a welcoming atmosphere for breastfeeding families.

Expansion of the criteria will now include a requirement for staff to help mothers develop strategies for breastfeeding in public places.

It is still important to ensure that breastfeeding is welcome in all health premises and signs announce this but evidence suggests that many mothers feel anxious about breastfeeding outside the home which can result in them giving up earlier than they would have wanted to. The additional criteria now require staff to have a discussion with mothers on strategies to help them feel confident about breastfeeding outside the home. This may include a discussion on appropriate clothing to help build confidence in the mother. Although it is not a requirement, many places have begun to collect information on local businesses that welcome breastfeeding. Being able to provide a mother with information on where she can confidently breastfeed her baby will help ease her anxiety when going out with her new baby in the first few weeks.

### Point 7 – Promote co-operation between health-care staff, breastfeeding support groups and local community.

The criteria for this Point have been expanded to strengthen the breastfeeding support offered to mothers within the community. In addition to providing mothers with contact details of both professional and voluntary agencies facilities will be required to provide additional support within her locality which is specially designed to meet her needs and that of her community. As with the antenatal intervention this might take the form of peer support, telephone contact, informal groups, long term one-to-one support or a combination of measures. Evidence will be required at Stage 1 assessment of the criteria used to identify the intervention and the audit and evaluation mechanism used to ensure its effectiveness.

There will be a six month transition period to allow health-care facilities to begin to put these changes into practice. It is recognised that the introduction of some criteria (specific interventions for Points 3 and 7 and completion of GP training) may take longer and assessment of individual needs will be made. The Baby Friendly Initiative will provide support and guidance to help facilities integrate the changes into their workplace. Some guidance documents are already available on our website and this is regularly updated. An amended audit tool will be available shortly. For community facilities who are already accredited as Baby Friendly and are due for assessment in the next year staff at the Baby Friendly office will discuss this on an individual basis.

Finally, it is recognised that changes to the Community Initiative may cause some concern within community facilities who may have been working towards accreditation for some years. It is hoped that this article will provide some reassurance that the majority of current standards remain unchanged and the strengthening or expansion of some standards linking them to the current evidence base will help to achieve the desired increase in breastfeeding continuation rates locally and nationally.



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# Strategic package initiative - an overview

Anne Woods, Deputy Programme Director of the Baby Friendly Initiative, goes through these new plans

## Background

The last 12-18 months have seen increasing numbers of organisations, particularly large organisations, becoming engaged in the process of working towards achievement of Baby Friendly accreditation. This will clearly have an impact both for Baby Friendly and those charged with implementing the standards in their area. Large organisations can mean increased challenges in gaining buy in from senior staff, will employ large numbers of staff, with greater and more varied training needs and overall, can present greater difficulty in achieving effective and sustainable change management. It is clear that the task faced by the key individuals in these large organisations is on a different level and therefore in addition to providing services such as breastfeeding management courses, Baby Friendly needs to address services offered in order to support capacity building within these organisations with the result that more could be achieved in-house.

## Government support

Endorsement of the Baby Friendly Initiative by a number of government documents and the introduction of the PSA targets in 2008 has been the driver for this increased requirement for support and service provision by Baby Friendly with a view to achievement of accreditation. To begin the process of aiding achievement of the PSA targets, the government has made £4 million available and this will be shared by 40 Primary Care Trusts (PCTs) who submit successful bids.

A separate tender was invited from Baby Friendly to enable the development of additional services and support that will be needed by the Infant Feeding Co-ordinators in the successful PCTs. Our vision is to be able to deliver an enhanced package of technical assistance, services and materials, in order to build capacity in PCTs and also in hospitals and other

organisations wishing to achieve Baby Friendly status

## Planning the route

As part of the initial planning of this new package, we found it helpful to imagine the journey undertaken by the Trusts and individuals involved. We considered what would be needed for a PCT (or hospital) travelling from a position of having done nothing to implementing Baby Friendly to achieving full accreditation.

We considered what would be needed in a package of services aimed at supporting and enabling those in the Trust with the job of implementing Baby Friendly to be able to work at a higher level and facilitate full implementation of all of the best practice standards. Firstly, a project lead would be needed. Our vision is that each area would have a project lead with sufficient skill, time and resources to undertake the role effectively. In the largest areas, this may be more than one person, or a lead person with additional dedicated trainers for example. In order to support Trusts to employ staff who are suitable for the role, guidance on recruitment will be provided, including ideas about drawing up an accurate and relevant job description.

## Developing a strategy

Next on the journey, we anticipate that Trusts will need to develop a Breastfeeding Strategy. Our vision here is to provide a guidance document about the development of a clear and comprehensive strategy which will bring together all the key elements required to improve breastfeeding outcomes in the locality, including Baby Friendly and peer support, and will be based on local needs. The document will include guidance on what to include in such a strategy, for example the rationale, aims, objectives and an action plan which will be needed to improve breastfeeding rates in the locality. To supplement this we intend to develop guidance for Commissioners so that they

can best understand how effective provision of breastfeeding services will contribute to the outcome measures they have to demonstrate.

Both job description and strategy documents will be available to download from the website. In addition, to supplement this information, a strategic level planning visit aimed at senior staff and policy makers will be available for anyone wishing to enlist this level of support. Consisting of a half-day visit from a senior member of the Baby Friendly team, the aim will be to explain how breastfeeding rates can be improved and assist in development of the local strategy.

## Project management and new courses

One of the things that many infant feeding co-ordinators have told us is that moving from a clinical background into a project management post has been a major challenge. Working with external consultants, a project management workshop has been developed which will take Infant Feeding Co-ordinators through the process of managing a major change management project with a focus on Baby Friendly implementation. The workshop will be aimed specifically at those with responsibility for co-ordinating the implementation of the Baby Friendly Initiative covering issues such as setting aims and objectives, change management, influencing, finance, managing risk and action planning.

From all of our conversations with Infant Feeding Co-ordinators over the years, education of staff would appear to pose one of the biggest challenges, hence the popularity of Baby Friendly breastfeeding management courses. Therefore, the training for trainers course will be further developed taking it from one day to three days and will include greater emphasis on what and how to teach, with time allowed for lesson preparation, presentation in groups and feedback from the facilitators. To complement this training, a package of

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materials including suggested learning outcomes, lesson plans, and slides will be provided.

### Effective auditing

Those of you who have worked with us on your own journeys will know how much emphasis is placed by Baby Friendly on audit, without which it is not possible to know whether action plans are being effectively implemented. Lots of us however, are frightened by the prospect of audit. The current one day workshop together with the audit tool have done lots to reduce that fear, however, we still hear from some of you that you would like to expand on what is available with more practical experience during the training. What we plan to offer is an enhanced audit workshop which will include coaching and supervision from a Baby Friendly assessor in the workplace in order to enhance interviewing skills and confidence.

And finally, we will offer individual supervisory days for any facility which has difficulties in one or more areas, be it with how to reduce supplementation levels, or how to gain buy-in and commitment from staff, for example. We can facilitate a day based on your individual needs and led by one of the Baby Friendly team with particular expertise in that area, who can offer guidance and education for key staff.

### Action planning visits

Another area where change is proposed is that of the need for Trusts to host an action planning visit. This has always been a pre-requisite for hospitals and community facilities to help them begin the process of Baby Friendly implementation and the agreement of a written action plan is part of the requirement for a Certificate of Commitment. Some of you have been telling us that this is not always helpful for you – maybe if you have previously worked in a Baby Friendly facility and have significant experience of the process and confidence to complete your own action plan. After action planning visits, many infant feeding co-ordinators take their plans and use them very effectively to guide them through the changes needed, however we are also aware that they can seem very daunting and may languish in a drawer!

We would like to be able to respond to all of your individual planning needs – maybe you would still like to have a meeting which results in a detailed action plan, or perhaps you would prefer a broader meeting which could include guidance on how to develop your own action plan, with the extra time available spent discussing key areas of difficulty in your area. Or if you are that experienced Infant Feeding Co-ordinator, you may not need to have any visit at all. We aim to try to fit in with all your needs and therefore will plan



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individually with you what you need in your Trust. The requirement for a clear and effective action plan to be submitted as part of the application form for a Certificate of Commitment will remain. All of the above proposals were launched at the 2008 Baby Friendly conference held in November in Glasgow, with delegates being given the opportunity to comment.

# Research round-up

## Does early introduction of solids increase risk of hospitalization for diarrhoea and LRTI?

The Millennium Cohort Study has prospectively followed a large cohort of babies (n=15,980) to assess whether the timing of the introduction of solids was related to the risk of hospitalisation for diarrhoea and lower respiratory tract infection (LRTI). It has previously been reported that for both diarrhoea and LRTI, the monthly risk of hospitalisation was significantly lower in those receiving breast milk compared with those receiving infant formula. It has been suggested that early introduction of solids increases the vulnerability of the gut to infection, and that the risk of infection is increased by the potential use of contaminated foods or equipment. In addition, it is thought that the high permeability of the immature gut may permit large foreign proteins to penetrate and provoke immune sensitization. However evidence from developed countries is scarce. In this study, infants were followed up monthly to assess whether they had received solids during that month. The mean age for the introduction of solids was 3.8 months with breastfed babies on average starting one week later than formula fed babies. The monthly risk of hospitalisation was not significantly higher in those who had received solids compared with those not on solids and the risk did not vary significantly according to the age of starting solids. The authors comment that the study only followed babies until eight months of age and therefore was unable to detect any effects of early or delayed weaning later in childhood. The study did not look at other implications of early introduction of solids.

Quigley MA, Kelly YJ, Sacker A (2008) *Infant feeding, solid foods and hospitalisation in the first 8 months after birth*. Arch. Dis. Child;10.1136/adc.2008.146126

## Does gestation at birth have an impact on breastfeeding success in term/near term infants?

A longitudinal study carried out in Australia, using a sample of 3600 babies, investigated the effect of gestation on initiation and duration of breastfeeding. The impact of being born between 35 and 40 weeks was assessed. Breastfeeding initiation was lower for infants of 35–36 weeks gestation (88.2%) than 37–39 weeks gestation (92.0%) and >40 weeks gestation (93.9%). In addition,

infants born at earlier gestations were less likely to be breastfeeding at 6 months than infants born at 40 weeks or later. Of infants born at 35–36 weeks, 41.2% were breastfeeding at six months, compared with 54.5% of infants born at 37–39 weeks and 60.5% of infants born >40 weeks. This difference was maintained even after adjusting for confounding variables such as maternal smoking, age, education, socioeconomic status and caesarean birth. The authors state that the reason for this difference was not apparent, however they recommend that health care staff should anticipate that there may be unexpected adverse consequences when infants are born before 40 weeks, particularly in the babies born at 37–39 weeks when it may be anticipated that behaviour will be comparable with a term baby. In addition, they recommend awareness in settings where artificial feeding is the norm as it may be easier for mothers of these infants to turn to infant formula rather than to persevere with breastfeeding.

Donath SM, Amir LH. (2008) *Effect of gestation on initiation and duration of breastfeeding*. Arch. Dis. Child. Fetal Neonatal Ed; 93: F448-F450

## Breastfeeding reduces pain scores in term infants undergoing neonatal screening

A study has been conducted in Italy with the aim of comparing breastfeeding with orally administered sucrose solution in reducing pain response during blood sampling using the heel prick technique. The researchers conducted a randomized, controlled trial in a neonatal unit on term babies (n=101) undergoing testing with an automated piercing device for routine neonatal screening. Infants were randomly assigned to breastfeeding or to the oral administration of 1 ml of 25% sucrose solution. A validated multidimensional acute pain rating scale (Premature Infant Pain Profile) was used which assessed heart rate increase, oxygen saturation decrease, crying behavior, duration of sampling, and the number of performed heel lances. The researchers found that median pain scores were lower in the breastfeeding group (3.0) than in the sucrose-solution group (8.5). The median heart rate increase, oxygen saturation decrease, and duration of first cry for the breastfeeding group were, respectively, 13.0, -1, and 3 and for sucrose group were 22, -3, and 21. These were significantly different between the groups. There were no significant differences in the sampling duration and numbers of heel lances. The researchers conclude that the study

suggests that breastfeeding provides superior analgesia for heel pricks compared with oral sucrose in term neonates.

Codpietro L, Ceccarelli M, Ponzone A. (2008) *Breastfeeding or oral sucrose solution in term neonates receiving heel lance: a randomized, controlled trial.* *Pediatrics*; 122: e716-21.

## Is there a 'normal' pattern for breastfeeding?

Babies tend to vary greatly in the frequency and duration of feeds and this can be of great concern to mothers. If the range of normality and changes with stage of lactation could be better identified this information could be used to reassure mothers that the breastfeeding behaviour of their babies is normal. A study was therefore devised in Australia with the aim of defining normal breastfeeding behaviour. Forty-two mothers of exclusively breastfed babies test-weighed their babies before and after every breastfeed for a 24 hour period at 1, 2, 4 and 6 months after birth. A breastfeed consisted of a feed from one or both breasts depending on the baby's appetite. The study demonstrated a wide variety of feeding patterns. There were an average of 7 breastfeeds per day (range 4–14), with fewest (6.4) at 2 months. Each breastfeed lasted 41 minutes on average (range 21–101 min) at 1 month decreasing to an average of 28 minutes (range 11–54 min) at 6 months. The longest interval between breastfeeding sessions increased from an average 4 hours 54 minutes (range 2 h 24 min–8 h 55 min) at 1 month to 6 hours 52 minutes (range 3 h 29 min–10 h 30 min) at 6 months. The babies consumed 112 g on average at each breastfeed (range 58–227g) with a maximum average amount (136 g) consumed at 2 months. The total average milk production of the mothers was 821g/24 hours (range 464–1370g/24 h) and did not change during the period of exclusive breastfeeding. The researchers conclude that there was at least a three-fold variation between infants in breastfeeding frequency, duration of breastfeeding sessions, longest interval between breastfeeding sessions, and milk intake. Mothers can be reassured that all babies do not need to show the same breastfeeding behaviour. During the lactation period babies can be expected to become more efficient, but will not increase their milk intake.

Kent JC, Sherriff JL, Cox DB, Hartmann PE (2008) *Defining Normal Breastmilk Intake During Exclusive Breastfeeding.* *Arch. Dis. Child.* 2008; 93(2\_MeetingAbstracts): pw27

## Does breastfeeding protect against substantiated child abuse and neglect?

A large prospective study in Australia was carried out with the aim of establishing whether there was a protective effect of breastfeeding on maternally perpetrated child maltreatment. A total of 7223 Australian mother-infant pairs were monitored over 15 years and maltreatment was confirmed on the basis of substantiated reports by the child protection agency. In 6621 (91.7%) cases, the duration of breastfeeding was analysed with respect to child maltreatment (including neglect, physical abuse, and emotional abuse) whilst factors which may confound results were taken into account (e.g. sociodemographic factors, whether the pregnancy was wanted, substance abuse during pregnancy, postpartum employment, attitudes regarding infant care giving, and symptoms of anxiety or depression). Of 512 children with substantiated maltreatment reports, the odds ratio for maternal maltreatment increased as breastfeeding duration decreased. After adjustment for the above confounding variables, the odds for maltreatment for non-breastfed infants remained 2.6 times higher. Maternal neglect was the only type of maltreatment associated independently with breastfeeding duration. The authors conclude that breastfeeding, among other factors, may help to protect children against maltreatment by their mother, particularly child neglect.

Strathearn L, Mamun AA, Najman JM et al (2009) *Does breastfeeding protect against substantiated child abuse and neglect? A 15-year cohort study.* *Pediatrics* Vol. 123; 483-493

## Does breastfeeding help mothers to lose weight gained during pregnancy?

Weight gained during pregnancy and not lost postpartum may contribute to obesity in women of childbearing age. A large study was carried out in Denmark where the population traditionally breastfeeds exclusively and for a lengthy duration. Women were interviewed initially at six months (n = 36,030) and 18 months (n = 26,846) postpartum. Statistical analyses were used to investigate whether breastfeeding duration and intensity reduced postpartum weight retention (PPWR) at both times.

Adjustment was made for maternal pre-pregnancy body mass index (BMI) and weight gain during pregnancy. The researchers found that weight gain during pregnancy was significantly associated with PPWR at both six and 18 months postpartum ( $P < 0.0001$ ). Breastfeeding reduced PPWR in all but the mothers with the greatest pre-pregnancy BMI at both 6 months ( $P < 0.0001$ ) and 18 months ( $P < 0.05$ ) postpartum. They estimated that if women exclusively breastfed for 6 months as is recommended, PPWR could be eliminated by that time in women with pregnancy weight gain of approximately 12 kg, and that the possibility of major weight gain (5 kg) could be reduced in all but the heaviest women.

[Baker JL, Gamborg M, Heitmann BL et al \(2008\) \*Breastfeeding reduces postpartum weight retention. American Journal of Clinical Nutrition: 88; 1543-1551.\*](#)

## Prolonged and exclusive breastfeeding improves children's cognitive development

The evidence that breastfeeding improves cognitive development is based generally on observational studies and therefore may be affected by differences in the breastfeeding mother's behavior or her interaction with the infant. The PROBIT study followed up children from the original cohort at 6.5 years of age to assess whether prolonged and exclusive breastfeeding improves children's cognitive ability. A total of 17,046 healthy breastfeeding infants were enrolled, of whom 13,889 (81.5%) were followed up at age 6.5 years. The researchers measured IQ scores on the Wechsler Abbreviated Scales of Intelligence and teacher evaluations of academic performance in reading, writing, mathematics, and other subjects. The experimental intervention led to a large increase in exclusive breastfeeding at age three months and a significantly higher prevalence of any breastfeeding at all ages up to and including 12 months. The experimental group had higher mean scores on all of the Wechsler Abbreviated Scales of Intelligence measures for IQ. Teachers' academic ratings were significantly higher in the experimental group for both reading and writing. The researchers conclude that their results demonstrate that prolonged and exclusive breastfeeding improves children's cognitive development.

[Kramer MS, Aboud F, Mironova E. \(2008\) \*Breastfeeding and child cognitive development: New evidence from a large randomized trial. Arch Gen Psychiatry 2008; 65; 578-584.\*](#)

## Breastfeeding for at least four months increases lung volume in children

The protective effects of breastfeeding on early life respiratory infections are well documented but there have been conflicting reports on protection from asthma in late childhood.

Two recent studies have looked at lung function in children who were breastfed. A study in the Isle of Wight (1) ( $n=1,456$ ) assessed breastfeeding practices and duration prospectively from birth and at subsequent follow-up visits (one and two years). Breastfeeding duration was categorised as not breastfed ( $n=196$ );  $<2$  months ( $n=243$ );  $2$  to  $<4$  months ( $n=142$ ) and  $\geq 4$  months ( $n=374$ ). Lung function was measured at age 10 ( $n=1,033$ ) using differing measures: forced vital capacity (FVC) and forced expiratory volume in one second (FEV1); FEV1/FVC ratio; and peak expiratory flow (PEF). Maternal history of asthma and allergy were noted at birth. The effect of breastfeeding on all these measures was analyzed adjusting for birthweight, sex, current height and weight, family social status and maternal education. The researchers found that compared to those who were not breastfed, statistically significant increases in FVC, FEV1 and PEF were noted in children who were breastfed for at least four months.

A second study in Arizona (2) recruited babies at birth ( $n=1246$ ) and analysed data from the group on whom lung-function testing was performed at ages 11 and/or 16 years and who had provided data regarding infant-feeding practices ( $n=679$ ). Early formula milk introduction resulted in reduced FVC and lower FEV1/FVC ratio. The researchers concluded that longer duration of breastfeeding favorably influences lung growth in children. However, they noted that in the presence of maternal asthma, longer breastfeeding is associated with decreased airflows. The clinical significance of this is unknown and further research is indicated.

[1. Ogbuana IU, Karmaus W, Arshad SH et al \(2008\) \*The effect of breastfeeding duration on lung function at age 10 years: A prospective birth cohort study. Thorax: 10.1136/thx.2008.101543\*](#)

[2. Mahr T \(2008\) \*Effect of breastfeeding on lung function in childhood and modulation by maternal asthma and atopy. Pediatrics: 122\(Supplement\\_4\); S176-S177\*](#)