UNICEF UK BABY FRIENDLY INITIATIVE

Annual Conference 2026 - Posters booklet

This booklet contains all 21 posters displayed at this year's conference:

1. Improving Access to Infant Feeding Support Through a Seven-Day Tiered Community Model
2. Right Call, Right Time: Proactive Support for Infant Feeding in Leeds
3. Mum 2 Mum breastfeeding peer support project: Supporting white working-class women from pregnancy through birth and beyond
4. Delivering early breastfeeding support
5. Wakefield's infant feeding journey – A step-by-step guide
6. Beyond Gold: Building on excellence in infant feeding and relationship building at RGU
7. A qualitative scoping review on familial experiences of neonatal infant feeding support
8. First-time fathers' experiences of supporting infant decisions and the factors that influence this activity
9. Bringing in UNICEF hospital-based children's services BFI
10. Infant feeding and beyond
11. Increasing breastfeeding rates in Tameside through the integrated infant feeding team
12. How prepared are UK healthcare professionals to support the emotional dimensions of infant feeding? Findings from the BREATHE Approach study
13. Improving completion of the UNICEF BFI data on Badger – A quality improvement project
14. Standardised parent education and resources to improve skin-to-skin rates in the neonatal unit
15. The breastfeeding experiences of women living with a disability and/or long-term health condition in Scotland – Results of a survey
16. Views and experiences of postpartum women regarding alcohol, alcohol-free and low-alcohol drinks, and breastfeeding – A mixed methods study
17. Building a Baby Friendly university
18. The Case for Child Death Overview Panels (CDOPs) to recommend UNICEF's Baby Friendly Initiative (BFI) accreditation progression
19. Integrating sustainability and virtual reality into breastfeeding education with midwifery, child nursing and health visiting students – Evaluation of a pilot study
20. From learning gap to curriculum development – Using formative simulation to make breastfeeding visible in paramedic education:
21. An all-Wales approach to breastfeeding in the workplace

Improving Access to Infant Feeding Support Through a Seven-Day Community Infant Feeding Service Model

A flexible, tiered and integrated approach to supporting families in St Helens

Amanda Brooks, IBCLC and Infant Feeding Coordinator | St Helens Community Infant Feeding Team

Every feed matters, every family counts

1 WHY CHANGE WAS NEEDED

High levels of deprivation
High proportion of residents living in areas within IMD 1-2 areas

Lower breastfeeding prevalence and continuation rates
Local breastfeeding prevalence at 6-8 weeks reached its lowest point in 2019

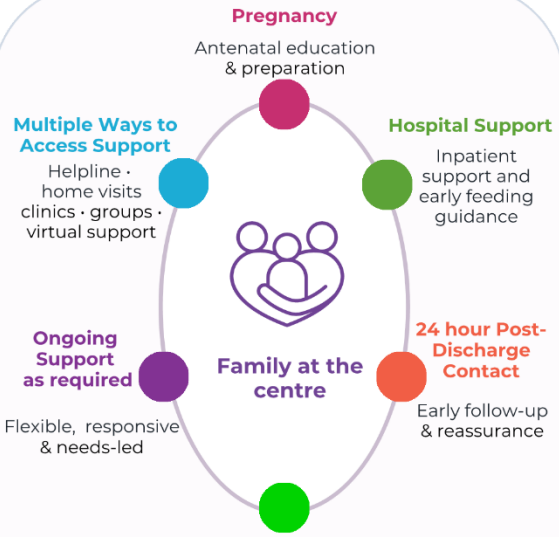
Accessibility barriers
Weekday only support did not always meet family needs

Increasing complexity of infant feeding needs
Responsive support required across different levels of need

Low uptake of antenatal education
Engagement with traditional models was inconsistent

A different approach was needed to ensure timely, equitable and family centred support.

2 THE SEVEN-DAY COMMUNITY INFANT FEEDING SERVICE MODEL



Inclusive support for every family, responsive to feeding method, individual need and parental choice

3 TIERED WORKFORCE MODEL & ESCALATION

IBCLC & Infant Feeding Coordinator
- Specialist assessment and complex feeding support
- Clinical advice and escalation
- Workforce supervision and competency development
- Service coordination and leadership

Infant Feeding Practitioners
- Feeding assessment and support for more complex needs within scope of practice
- Planned follow-up and continuity for families requiring ongoing support
- Receiving escalations from Support Workers
- Escalation to the IBCLC when specialist assessment is required

Infant Feeding Support Workers
- First-line infant feeding support
- Planned routine contacts
- Parent support and reassurance
- Signposting and escalation within the tiered team

Families receive the right support at the right time, with clear escalation pathways and specialist oversight

4 IMPROVING ACCESSIBILITY & REDUCING BARRIERS

Extended Access
Seven-day service and helpline
Weekdays: 8am-8pm
Weekends/bank holidays: 10am-4pm

Flexible Delivery Methods
Home visits, clinics, groups, telephone, video and text support. The Anya app provides access to digital support 24 hours a day.

Integrated pathway
Integrated hospital/community pathway with early post-discharge contact

Reducing Barriers to Support
Professional interpreting and targeted support within communities experiencing greater health inequalities

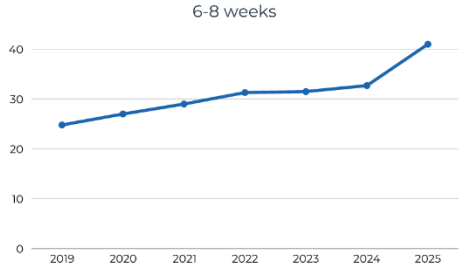
Support for All Feeding Journeys
Inclusive support regardless of feeding method

5 IMPACT & OUTCOMES

Improving breastfeeding continuation and reducing inequalities in St Helens

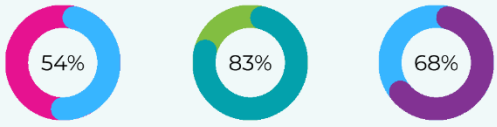
chcp ST HELENS WELLBEING

Local breastfeeding continuation trends (population outcome)



Sustained improvement in breastfeeding continuation at 6-8 weeks since 2019

Breastfeeding retention within the community pathway (service cohort outcome)



At discharge
Reported breastfeeding on entering the service

Day 10
Retained breastfeeding at Day 10

6-8 weeks
Retained breastfeeding at 6-8 weeks

Retention calculated from babies breastfeeding at discharge.

EQUITABLE ACCESS & RESPONSIVENESS 2025-2026

(service reach and performance)

42.1%	of families supported live within IMD 1-2 areas
35.3%	of babies in IMD 1-2 areas breastfeeding at 6-8 weeks
95%	of families contacted within 24 hours of discharge
17.8%	of breastfeeding families requiring language support

CONTINUITY OF CARE FOLLOWING DISCHARGE

Hospital discharge · 24 hour contact · Day 6 contact · Day 12 contact · 4 Week contact · 6 Week contact

Multiple planned contacts support feeding journeys and early identification of concerns

6 LEARNING FROM IMPLEMENTATION

What Worked Well
- Improved access outside traditional hours
- Multiple routes to improve equitable access
- Strong continuity following discharge
- Tiered model enabled timely escalation
- Integrated hospital and community working

Operational Challenges
- Maintaining seven-day cover during workforce pressures
- Balancing responsive and planned support
- Consistency across delivery methods
- Meeting demand in areas of high deprivation
- Maintaining training and competency across tiers

Sustainability Considerations
- Clear escalation pathways and defined scopes of practice
- An appropriately trained skill-mix workforce
- Protected clinical leadership and IBCLC oversight
- Flexible delivery shaped by local population need
- Ongoing review of capacity, demand and equitable access

7 CONCLUSION

A seven-day, tiered community infant feeding model enables timely, accessible and individualised support, connecting families with the right level of care when they need it.

By integrating hospital and community services, the model supports continuity, reduces barriers to care and makes effective use of workforce skills.

The key learning: effective infant feeding support must be flexible, equitable and built around families, not service hours.

HERE FOR EVERY FAMILY · EVERY FEEDING JOURNEY · EVERY DAY OF THE WEEK

Contact: amanda.brooks16@nhs.net

Empowering families. Supporting feeding. Strengthening communities.

Right Call, Right Time

Proactive Support for Infant Feeding in Leeds

Why It Matters, What we Did

Breastfeeding is a key public health priority and plays a significant role in reducing health inequalities. Partnership approaches such as this undertaken in Leeds are integral to increasing breastfeeding rates. This project introduced a simple, proactive telephone call from a 0-19 practitioner at 4-7 days postnatally, which aims to:

- Address early challenges and signpost to support
- Improve feeding confidence and outcomes
- Strengthen early relationships with families

New parents welcome the call and report that the early contact makes a meaningful difference not only to feeding, but to how supported they feel in the first days of their baby's life.

What We Found

Feedback from both parents/carers and staff has been consistently positive.

Parents/carers reported:

- *Feeling reassured, listened to and supported*
- *The call came at the "right time", when questions began to arise*
- *For some, it directly influenced continuation of breastfeeding*
- *Increased awareness of local support following signposting*

> ***"It was brilliant just to have space to talk about the feeding. It made such a difference" (mum)***
>
> ***"They was wonderful. Answered our questions reassured us as parents. They was very helpful. These two women was amazing and wonderful" (mum)***

Practitioners reported:

- *Increased confidence and peer support in delivering feeding guidance*
- *Greater engagement with families early on*
- *Ability to remind and rearrange New Birth Visits where needed*
- *Enhanced continuity—Health Visitors could build on advice already given*
- *Increased attendance at breastfeeding groups, particularly among families with younger babies*

> ***"I was anxious, but enjoyed it more than I thought I would, I find it really enjoyable" (practitioner)***

The calls also supported early identification of wider needs, including maternal wellbeing and safeguarding concerns.

Outcomes

- Increase in breastfeeding rates at 10 days, following previously static performance
- Improved uptake of community breastfeeding support
- Strengthened continuity of care between early contact and the New Birth Visit
- Earlier and stronger relationship-building with families

Leeds City Council
NHS Leeds Community Healthcare NHS Trust
Contacts: Sally.goodwinmills@leeds.gov.uk
sophie.ames@nhs.net

Mum2Mum Breastfeeding Peer Support Project

Supporting White British Working Class Women from Pregnancy Through Birth and Beyond

Rationale

- Breastfeeding initiation and continuation rates remain significantly lower among women from poorer White British communities, particularly in areas where breastfeeding is not a cultural norm and where women may lack family or social role models *(Oakley et al, BMJ, 2013)*
- Leicester Mammas had long been asked by partners in Public Health for our reflections on the disparity, and ideas of how change may be effected in our city
- Studies suggest that peer support from women from a similar cultural background can be effective in increasing breastfeeding rates in underserved communities *(Waseem Aslam et al, 2025, NIHR)*

Proposed support:

- One antenatal meeting to explore hopes, fears, and expectations
- Information/support re antenatal colostrum collecting and a pack of collectors delivered by their supporter
- Ongoing antenatal, birth, and postnatal contact as agreed
- Text and WhatsApp support alongside face-to-face meetings
- Encouragement to attend local Bumps to Babies classes and Mammas Baby Cafés
- Incentives provided at key points, to include vouchers, hampers and gifts for mother and baby

Having formula fed my first child and then breastfed my second, I knew how important having the right people around me, to help support me, is.
I was grateful to be able to be that support for someone who had a similar situation to me.



Key info

- 10 women recruited from target areas
- Included 2 teen parents
- Matched with 9 Mammas Peer Supporters

2 Focus groups –

- 5 Women from target demographic who had breastfed
- 4 women from target demographic who had not breastfed

Interviews with 13 women

- 8 Teen parents from a city support group
- 5 from Mammas network of mothers

Project proposal

To see if one to one peer support, with women being linked with a named trained Peer Supporter from a similar background, at key stages throughout the antenatal, birth, and postnatal period, enables women who come from a community and family where breastfeeding is not practiced, to establish and continue breastfeeding up to 4 months.

Mammas Peer Support

- 9 peer supporters from similar backgrounds to the aims of the project – White British women who did not know anyone who had breastfed before having their own baby
- All had been part of Mammas Peer Support network for several months
- 2 had formula fed previous babies and had gone on to breastfeed, with support from Mammas
- All were strongly invested in a desire to support others like themselves, and understood the need for sensitive, timely, responsive support, in a way that met the participant's individual needs.

Outcomes

- All but one engaged well with their Peer Supporter, by texts, WhatsApp and calls
- All but one initiated breastfeeding
- 6 had interventions during the birth, and faced challenges establishing breastfeeding as a result
- 2 were still breastfeeding at 4 months

The project helped me so much, there were so many different people who contacted me from Mammas to help and advise and just to reassure me. I could contact people at all hours pretty much. It feels like part of a community and I definitely felt less alone in it

Observations

Breastfeeding often ended at the point where early problems (pain, latch, weight loss) were met with no escalation to skilled support
Early one-to-one help, reassurance, and latch checks were repeatedly described as pivotal turning points
Confidence collapsed quickly when early difficulties were not resolved and mothers were left unsupported in the first hours/days
Breastfeeding intention was undermined when specialist help was unavailable or delayed
Emotional validation and confidence-building - Being told "you're doing a good job"- had a disproportionate impact on persistence
Exposure to breastfeeding role models made continuation feel possible and acceptable
Partners were rarely barriers and often key facilitators when actively involved

Recommendations

1. Breastfeeding Peer Support from a named peer supporter, as proposed in this project, is a valued and valuable element in supporting mothers from communities where few role models exist, and initiation rates are low
2. However, to achieve the hoped-for outcomes, it needs to be part of a whole-system approach that ensures that all those involved in their care have the time, understanding, and skills to overcome longstanding barriers, as soon as they arise – a joined-up approach, with everyone on the same page
3. Having a named professional for each mother as part of the project would be highly effective in increasing successful outcomes

Project Leads – Dr Lyndsay Poore, IBCLC; Sally Etheridge, IBCLC – Leicester Mammas - Thank you to all our Mum2Mum Peer Supporters
office@mammas.org.uk www.mammas.org.uk

DEBS

Delivering Early Breastfeeding Support

J Millar, K McIntyre, C Buchan

WHAT IF BREASTFEEDING SUPPORT STARTED BEFORE FAMILIES NEEDED TO ASK?

A QI project providing proactive breastfeeding support to women and their famiies in West Lothian

WHY: in 2018-19 breast milk drop-off at 10-14 days was 21% in West Lothian compared to 13% across NHS Lothian

AIM:
To reduce breast milk drop-off at 1st HV Visit by 2% and increase exclusive breastfeeding rates



Sign up to project at 28 week community midwife appointment



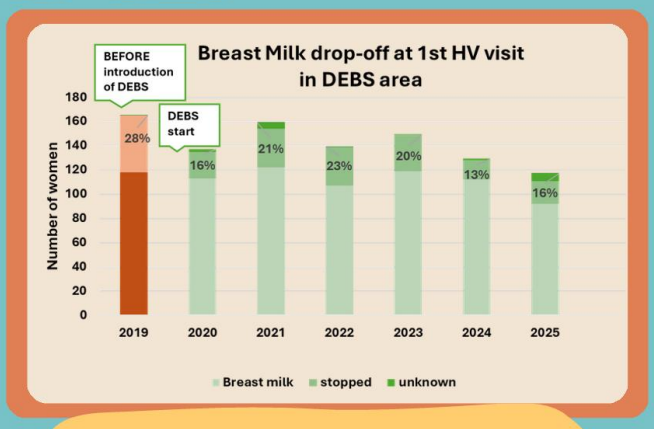


Antenatal conversation, virtual or in person between 34-36 weeks

Day 1
postnatal visit to Mum & baby



Proactive telephone support for 28 days



Sustained improvement in breast milk drop-off following introduction of DEBS



National and local exclusive breastfeeding rates from 2024/25 [1] and DEBS 2024/25

Early, structured breastfeeding support can reduce breast milk drop-off and improve exclusive breastfeeding rates

NHS Lothian

Loth.debs@nhs.scot

NHS LOTHIAN MATERNITY & INFANT NUTRITION SERVICE

[1]Infant feeding statistics - Financial year 2024 to 2025 - Infant feeding statistics - Publications - Public Health Scotland

Wakefield's
Infant Feeding Journey

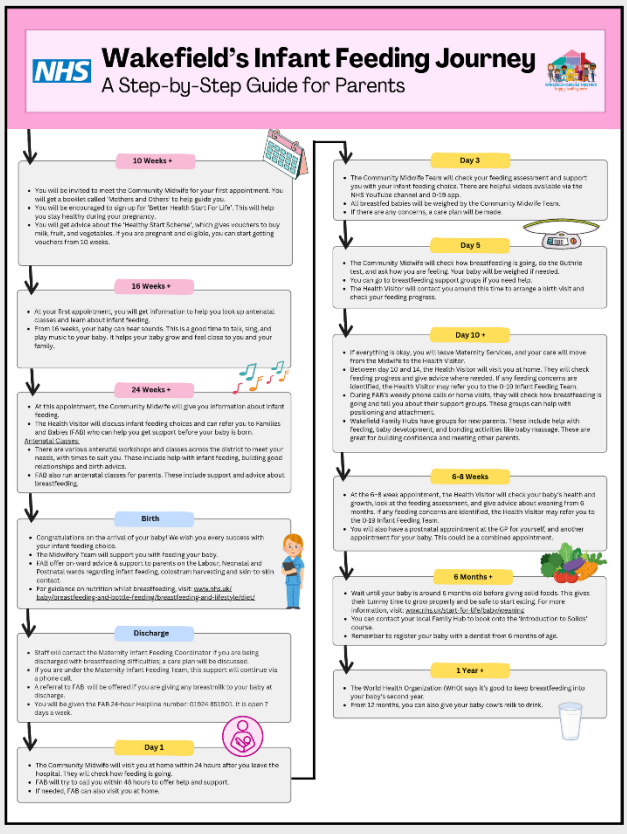
The **Best Start in Life agenda** highlights the critical importance of the **first 1001 days**, emphasising how responsive early years systems can reduce inequalities, improve long-term health and social outcomes, and relieve pressure on public services.

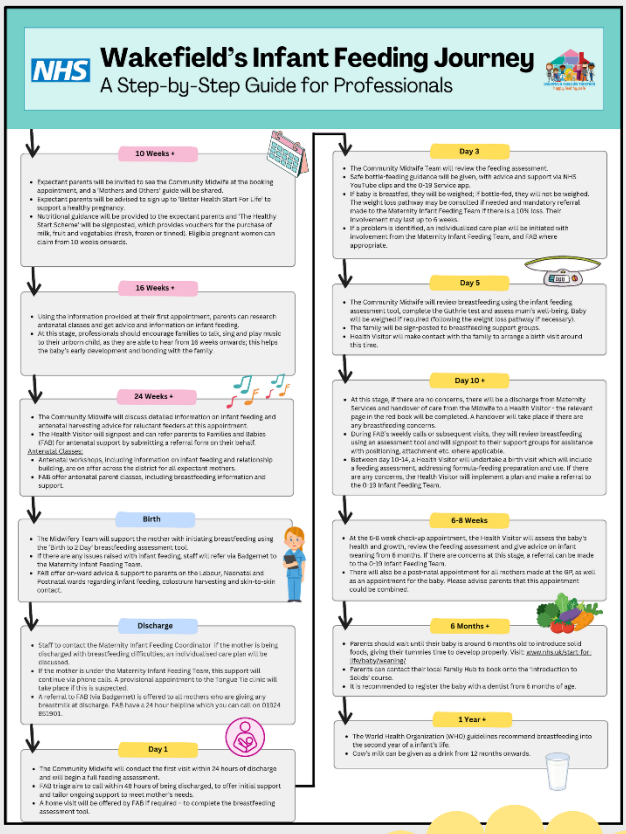
Embedding integrated **infant feeding support** from **pregnancy through to the postnatal period,** works to **improve parent-infant relationships, enhance parental confidence and resilience, and reduce avoidable demand on acute and specialist services.**

The development and implementation of Wakefield's Infant Feeding Journey directly supports key public health outcomes by strengthening prevention in the earliest stages of life and reducing health inequalities across the district.

The Infant Feeding Journey has two guides, one for **Parents**, and one for **Professionals**. It was published in January 2026.
Both present the **same core information**, but have been **tailored** to meet the needs of each audience.

- For parents, the guide provides a clear overview of what to expect at each stage of pregnancy and the postnatal period, alongside signposting to support when needed.
- For professionals, it functions as a practical framework, outlining what information, support and interventions should be offered at each stage to ensure consistent, high-quality care.





The reverse side of the resource provides additional information, including:

- Descriptions of partner organisations, alongside links to further support services and useful contacts.
- Key information highlighting the importance of communication in the early years, supported by a QR code directing users to relevant resources.
- A maternity ward "Who's who" visual guide, illustrating the uniform colours worn by different staff members to aid identification.

Thanks to the
Infant Feeding Steering Group
for their contributions to development and implementation of the Wakefield Infant Feeding Journey.

For further Information, contact
Janet Wilson via email on
janetwilson@wakefield.gov.uk

Growing Healthy Wakefield 0-19 Service
FAB FAMILIES AND BABIES
WAKEFIELD FAMILIES TOGETHER happy, healthy, safe
NHS Mid Yorkshire Teaching NHS Trust
BEST START IN LIFE
Funded by UK Government
wakefieldcouncil

Beyond Gold: Building on Excellence in Infant Feeding and Relationship Building at RGU

Emma Hay-Higgins, Sally Macdonald and Stacey Paterson | School of Health, Robert Gordon University, Aberdeen

Background

RGU was the first university in Scotland to achieve UNICEF Baby Friendly Initiative Gold accreditation in 2021. Following successful Gold reaccreditation in October 2025, RGU continues to build on this achievement through a collaborative approach to education, practice and partnership working.



Partnership & Sustainability

Collaboration
Practice Partners across multiple Health and Social Care Settings, Peer Supporters, Public Health and Community Groups work collectively to improve outcomes for all.

Sustainable Leadership
RGU-led UNICEF BFI steering group brings together academics, infant feeding leads, students and peer supporters.

Sustainability
RGU has a strategic commitment to the UN Sustainable Development Goals and helping future generations thrive.



Community Engagement

Breastfeeding Scotland Early Years Award
Achieved by our campus nursery demonstrating commitment to strengthening support for families.

Breastfeeding-Friendly Campus
Enhancing supportive environment for all students, staff and visitors.

Community Contribution
Knitted breast models provided by the community to facilitate student learning and provide practical support to families.



Education and Innovation

Embedded Learning
UNICEF BFI principles integrated across Midwifery, Health Visiting, Nursing, Paramedic, Physiotherapy and Occupational Therapy programmes to extend Baby Friendly values and embed consistent evidence-based practice.

Interdisciplinary Learning
Annual Infant Feeding Conference hosted by RGU that promotes shared learning and innovation.

Peer Learning
Senior students contribute to audit and support development of earlier-stage learners promoting leadership and preparation for practice.

Conclusion

RGU are building beyond Gold through a commitment to continuous collaboration, innovation and improvement to enhance outcomes for infants, families, students, staff and the wider community.

Contact

s.macdonald49@rgu.ac.uk
e.hay-higgins@rgu.ac.uk

Accredited as Baby Friendly Gold
unicef UNITED KINGDOM

Familial Experiences of Neonatal Infant Feeding Support: A Qualitative Scoping Review

Shilanne Giles[1], Moriam Mustapha[2], Louise Wells[2], Dr Erin Stella Sullivan[1]

[1] Department of Nutrition & Dietetics, King's College London, [2] London Neonatal Operational Delivery Network, NHS

Contact details: shilannegiles@outlook.com

Background

1 in 7 Infants in the UK are admitted to a neonatal unit annually[1], where admission may disrupt lactation initiation through stress-related hormonal delays or infant complexity, compounded by structural and service-level barriers to feeding support[2].

Family-centred approaches, including the Baby Friendly Hospital Initiative and Family Integrated Care have show improved feeding outcomes, reinforcing the importance of accessible support & parental involvement in the neonatal unit[3].

It is currently unknown how different forms of feeding support interact in practise, with existing research largely focused on predefined feeding methods or infant groups studied in isolation.

Aim

To map and examine existing evidence on family experiences of infant feeding support in neonatal inpatient settings, to describe the feeding methods and types of support provided and to explore the factors shaping family experiences.

Methods

Studies from Databases (n=9341)
(Web of Science, CINAHL, Embase, MEDLINE, MIDIRS)

Duplicates Removed (n=2269)

Title & Abstract Screening (n=7072)

Studies Excluded (n=5867)

Full-text assessed for for eligibility (n=1205)

Studies included in review (n=48)

Eligibility: English-language studies of caregiver-reported feeding experiences during current or previous neonatal admission, using qualitative or mixed methods design in high income settings, with no date restriction.

Data analysis: Thomas and Harden's 3-stage thematic synthesis for qualitative research methodology [4].

Narrative Appraisal: 4 pillars of trustworthiness: Credibility, Transferability, Dependability, Confirmability assessed study quality [5].

Figure 1. *Flow diagram for the scoping review process, adapted from PRISMA-ScR guidelines.*

Results

41 Qualitative & 7-mixed methods studies, over 32 years, >75% in past decade. Conducted mainly in USA (n=18), Sweden (n=10) and UK(n=8).

Qualitative Samples: 8 - 178 participants. 35 mother-only, no-father only, 4 included single mothers & no diverse or same-sex family units represented in studies.

Preterm infants most studied (n=32), Preterm only (n=24), Preterm & Very Low Birth Weight (n=8), Donor Human Milk related (n=6), Surgical requirements (n=4).

Credibility, dependability & confirmability well demonstrated through data saturation, thematic analysis, verbatim quotations, appropriate qualitative study designs & use of reporting frameworks.

Transferability limited by context-specific findings and variation in feeding practices. Reflexivity & researcher positionality were underreported and retrospective designs introduced potential recall bias.

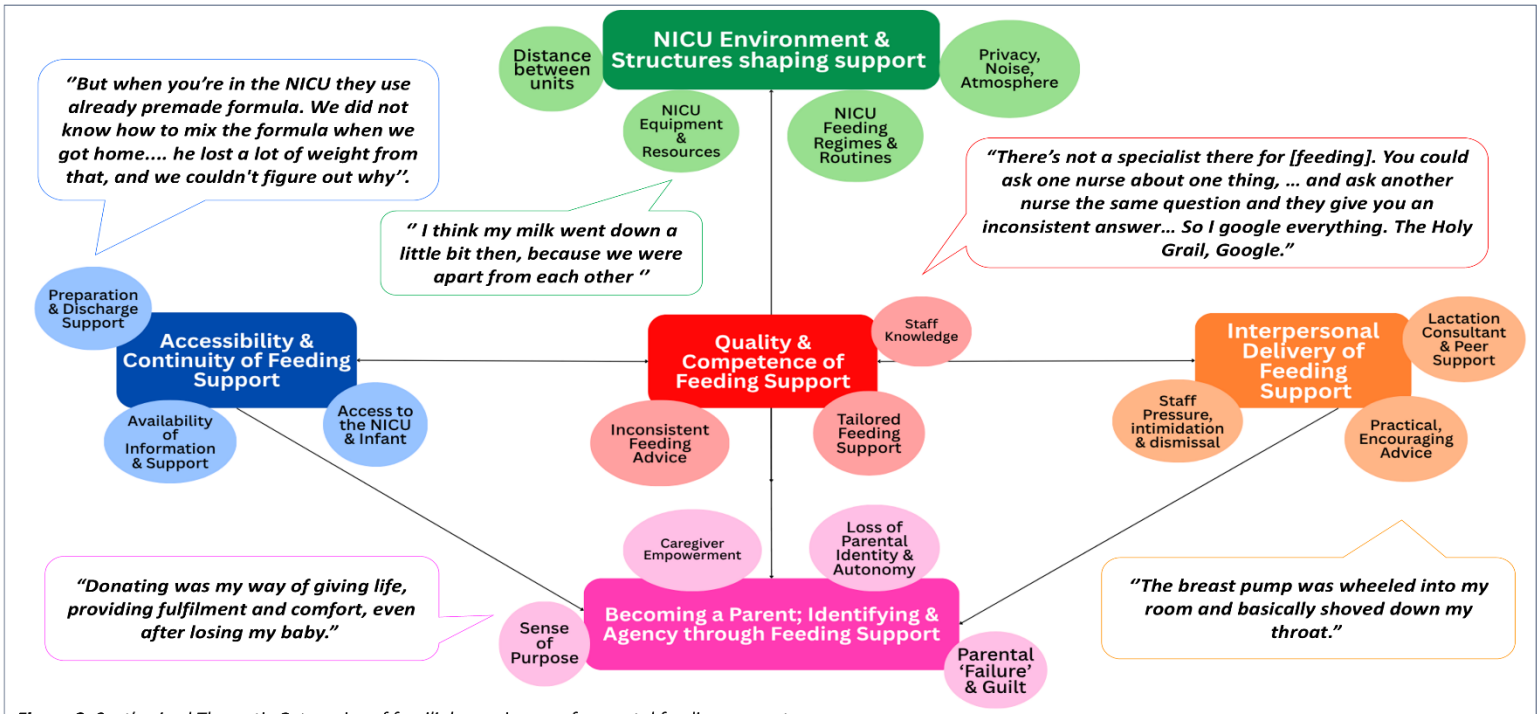


Figure 2. *Synthesised Thematic Categories of familial experiences of neonatal feeding support.*

Discussion & Conclusion

This study extends the literature by conceptualising feeding support as multidimensional, shaped by feeding pathway, neonatal context & infant complexity, requiring accessible, individualised & family-centered support approaches.

Families valued breastfeeding peer counsellors & lactation consultants, while Allied Health Professional support was comparatively less visible and external support, including online resources and peers, was frequently sought.

Feeding support reflected tensions between medicalised care and parental involvement, where relational, structural and environmental factors influenced the development of parental identity and feeding outcomes.

Further UK-specific synthesis independent of international variations is required and longitudinal research is needed to capture how support needs evolve across the neonatal admission and discharge, with the inclusion of fathers and more diverse family units.

Reference List

References: *[1] Ougham K, N. The Neonatal Data Analysis Unit Report 2016. 2017, [2]Lau C. Breastfeeding Challenges and the Preterm Mother-Infant Dyad: A Conceptual Model. Breastfeed Med. 2018;13(1):8–17,* [3] Fallon VM, Harrold JA, Chisholm A. The impact of the UK Baby Friendly Initiative on maternal and infant health outcomes: A mixed-methods systematic review. Maternal & Child Nutrition. 2019;15(3):N.PAG–N.PAG *[4]Thomas J, Harden A. Methods for the thematic synthesis of qualitative research in systematic reviews. BMC Medical Research Methodology. 2008;8(1):45. [5]Ahmed SK. The pillars of trustworthiness in qualitative research. Journal of Medicine, Surgery, and Public Health. 2024;2:100051.*

Present, but invisible

Fathers, gender inequity and infant feeding

Findings from interviews with first-time fathers in north-east England

Dr Jen Menzies | Northumbria University
Supervisors: Dr Catherine Ellis, Dr Vicky Smith

Scan for the full article



1 Who we asked

9 first-time fathers, names changed · 2 interviews each: before birth and around 6 weeks after
One of England's most deprived areas, ranked 23rd · Interpretative Phenomenological Analysis

i Aim · Background · Questions · How

Aim

Explore fathers' experiences of supporting infant feeding decisions and the support they receive.

Background

Fathers can influence feeding decisions, yet services are built around mothers.

Questions

How do fathers experience supporting infant feeding? What support do they need?

Who

9 first-time fathers in north-east England, interviewed before birth and at 6 weeks.

How

Interpretative Phenomenological Analysis of two in-depth interviews per father.

Why

To inform practice, guidance and policy that include fathers as equal partners.

2 What we found

A They wanted to be involved

Fathers were not disengaged. They wanted to co-parent but were caught between traditional father roles and the involved fatherhood they wanted.

B Services built around mothers

"Behind a glass wall"

"A cup of cold tea left on the mantelpiece"

"The visible-invisible person in the room"



Appointments, leaflets, eye contact and questions were directed mainly to mothers. No family record for fathers. Fewer antenatal feeding conversations.

C Formula felt like the only option

Breastfeeding guidance did not reach fathers. Online searches made formula brands most visible. At 2am with a distressed baby and an exhausted partner, formula was the only thing fathers knew how to do.

Hegemonic: crisis, the "fixer."

D Stepping back from decisions

Fathers respected their partners' autonomy and worried that speaking up would seem coercive. This led to passivity rather than partnership.

Caring: holds back, defers

3 Why it matters

Breastfeeding

Paternal support is linked to mothers starting and continuing breastfeeding.

Men's health

Men in the UK live about 4 years less than women; fatherhood is a rare opportunity to reach them.

Family wellbeing

Feeling redundant or sidelined affects fathers' mental health and the whole family.

4 What could help

Practice and systems

Speak directly to fathers, give them their own leaflets, record both parents in a family record.

Guidance

Clarify that antenatal feeding guidance welcomes fathers in feeding education.

Policy

Consider extending paid paternity leave towards European levels.

Fathers are half the parenting unit.
Together, we can design services that include them.

jennifer.menzies@northumbria.ac.uk
Ethical approval: Northumbria University · Based on the published article

Baby Friendly Initiative

Hospital Based Children's Services

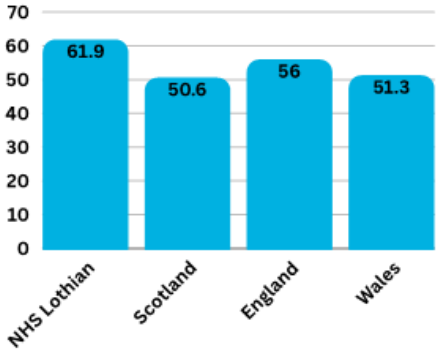
Supporting families and babies through skilled, compassionate and consistent infant feeding care

NHS Lothian

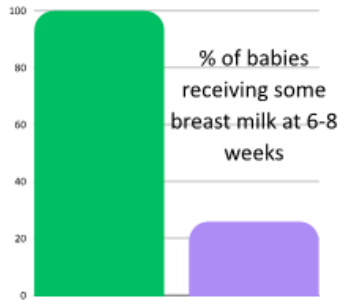
NHS Lothian at a glance

Population	800,000
Births per year	7,500
Hospitals	16
Teaching hospitals	4
Emergency dept	3
Neonatal units	2

Breastfeeding at 6 weeks %



Inequalities callout



HBCS in NHS Lothian

Royal Hospital for Children and Young People, Edinburgh

- 242 beds
- 10 wards
- 10 theatres
- Ronald McDonald Hotel - 25 rooms

St John's Hospital children's ward, Livingston

- 14 beds within a general hospital

Infant feeding statistics - Financial year 2024 to 2025, published 11/11/25, Available from Public Health Scotland 2025

2015-16 first conversations → **2021** draft standards available → **June 2023** awarded pilot site → **Nov 2023** HBCS IFA appointed → **May 2024** Certificate of commitment → **Feb 2026** stage 1 accreditation → **Target 2028** stage 2 accreditation



Level 1 (L1) training

- for every staff member
- watch vimeo
- read policy document
- completed during induction
- completion recorded by IFA

Level 2 (L2) training

- mainly working with <2s
- in addition to L1 training
- approx 4 hrs online modules
- in person training day
- competency (practical skills review) 1:1



Helen Anderson
Infant Feeding Advisor
Hospital Based Children's Services
(IFA HBCS)



Tracy McGillivray
Strategic Prog Manager
Maternal & Infant Nutrition Services



Nicola Tait
Prog Manager & BFI Lead

challenges

- data collection - digital systems constraints
- engagement with training
- sustainable funding
- building staff ownership

early indicators of programme success

2022 - before pilot started

- 1x infant feeding advisor intervention
- 2x resident doctor interventions

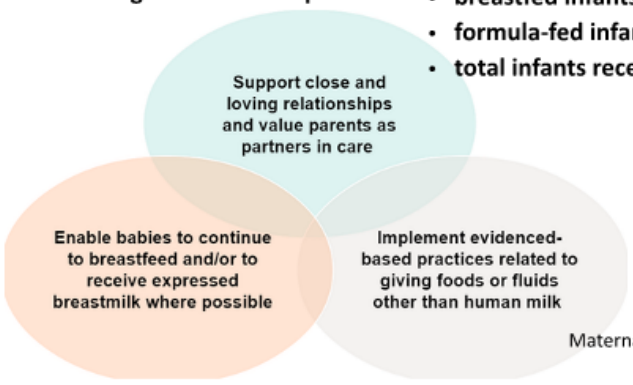
2025 - 15 months after pilot began (47 staff L2 trained)

- breastfed infants receiving support 30% (16/53)
- formula-fed infants receiving support 15% (7/46)
- total infants receiving support 23% (23/99)

Overall, infants receiving some breast milk increased from 48% in June 2022 to 54% in June 2025

What we're hearing

- 100% positive feedback from parents (anonymous JISC survey)
- lower incidence of negative feedback around feeding in hospital
- staff feel empowered and involved
- more families giving more breast milk for longer
- elevated value of breast milk by staff
- HV/FN teams see progression of personal feeding goals following hospital admission



Maternal & Infant Nutrition Service, Public Health and Health Policy, NHS Lothian, Edinburgh, Scotland

Acknowledgement and thanks to Drs Maya Lamoudi & Lucy Craig for programme success data

September 2026

Infant Feeding and Beyond Initiative (IFAB)

Authors:
Emma Williams | *Advanced Public Health Practitioner*
Fiona Murray | *Public Health Researcher*
Emily Ross | *Senior Analyst, Public Health*
Gillian Swinscoe | *Quality Improvement Midwife*
Leah Will, Tyler Hepburn and Amy Stubbs
| *Infant Feeding Health Care Support Workers*

Background/Context

Breastfeeding provides significant health benefits for infants and mothers. In Grampian marked inequalities in breastfeeding initiation and continuation persist in more socio-economically deprived communities. Infant Feeding and Beyond (IFAB) was developed as a targeted public health initiative to address this inequality by providing enhanced infant feeding support to families living in Priority Areas in Aberdeen City. Neighbourhoods were identified from annual infant feeding data where initiation and continuation was lower and drop off high. IFAB complements universal infant feeding services by offering proactive, relationship-based support beginning in pregnancy and continuing in the postnatal period. Wrap-around support is included for income maximisation and other health indicators.

Aim

To reduce inequalities by providing targeted, enhanced infant feeding support to families living in Priority Areas of Aberdeen City.

Objectives

- Improve maternal confidence and self-efficacy in infant feeding
- Support families to achieve their individual infant feeding goals
- Increase breastfeeding initiation rates
- Improve breastfeeding continuation at 10-14 days and 6-8 weeks onwards
- Reduce early breastfeeding drop-off
- Support paced bottle feeding to reduce risk of overfeeding when mixed or formula feeding is chosen
- Provide community-based infant feeding support

Method and approach

- Using a whole-family, relationship-based approach, IFAB aims to build confidence, address infant feeding challenges early, reduce social isolation and improve infant feeding inequalities. The pathway provides personalised antenatal support, one-to-one and group infant feeding education, early postnatal contact, home visiting and community and peer support groups.
- **Booking ⟩ Preparation ⟩ Early Support ⟩ Ongoing Support ⟩ Community Connection**

Pregnancy

- Identified at booking
- IFAB Information sheet posted by 25 weeks
- Recruitment conversation at 27-28 weeks
- Antenatal infant feeding education session
- Referral to wider support services where required

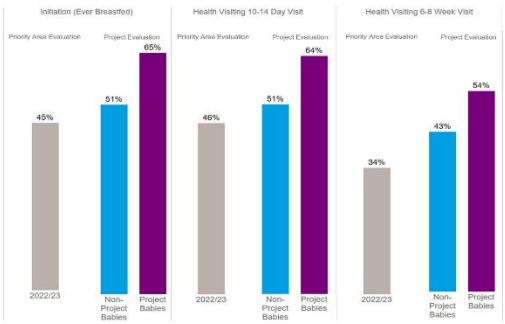
Birth to 14 Days

- Proactive infant feeding support delivered via, postnatal ward, clinic, home, telephone or NearMe

Beyond 14 Days

- Ongoing support as requested
- IFAB groups delivering support in the local community

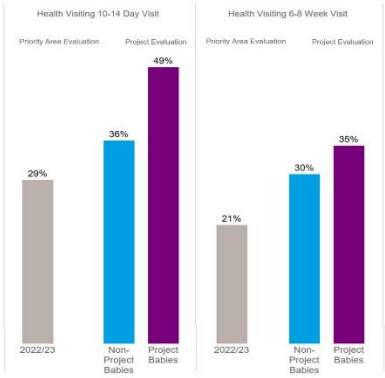
Results



Overall Breastfeeding in IFAB January 2025-June 2026

January 2025-June 2026 data shows an increase in breastfeeding initiation in the IFAB area (52% compared to 45% in 2022-23). Babies of enrolled mothers were more likely to have been breastfed (65%) compared to those not enrolled in the initiative (51%) .

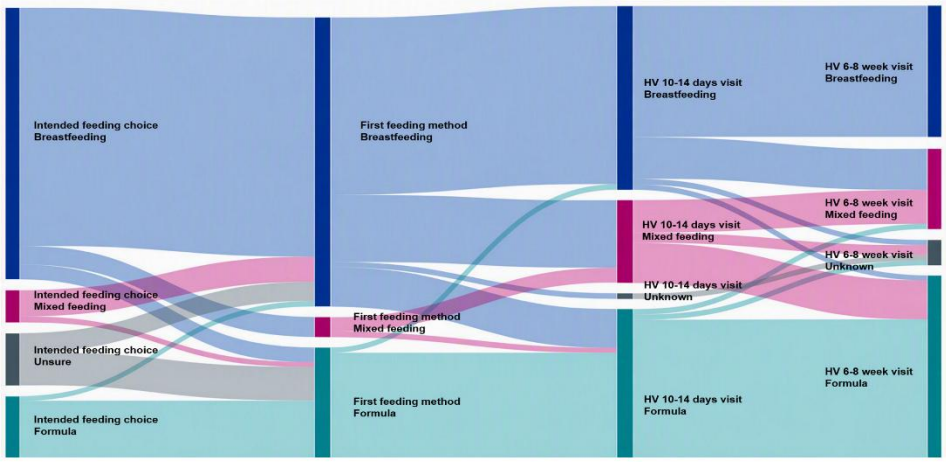
Drop-off in breastfeeding from initiation to 6–8 week assessment was lowered (19 % compared to 27% in 2022-23) in the IFAB area, with 16% drop-off among babies of enrolled mothers and 19% among those not in the initiative.



Exclusive breastfeeding in IFAB January 2025-June 2026

Babies of enrolled mothers were more likely to be exclusively breastfed at first visit (49%), and 6-8 week assessment (35%), than those not enrolled (36% at first visit and 30% at 6-8 week assessment).

IFAB project: infant feeding journey from antenatal feeding intention to the 6-8 week assessment.



Feedback from participating mothers highlighted the importance of personalised support, timely intervention and continuity of care in helping families to overcome feeding challenges. The initiative has strengthened links between maternity, health visiting, and peer support, creating a more integrated support pathway for families.

...the advice they have given me and reassurance that what I'm doing is working. It has boosted my confidence so much so that I was able to carry on feeding. I know I would have given up at the start if I didn't have them all. **[project mum 2]**

...I can't explain what it means to me to be able to breastfeed my son. I hope to feed him for a long time yet and knowing the team are with me all the way means the world. **[project mum 3]**

The families I meet stay with me long after our visits end. Getting to know them, hearing their stories, and supporting them through the ups and downs of infant feeding is one of the best parts of my job. **[Infant Feeding HCSW]**



This project has been invaluable to myself my husband and my baby. We honestly don't know what people do without the support of the team...so dedicated to putting us as a family first-something we really appreciated at a time when we felt very medicalised... **[project mum 1]**

Conclusion

Findings suggest that IFAB is an effective targeted public health intervention, helping to reduce infant feeding inequalities in disadvantaged communities.

Families receiving enhanced support achieved higher breastfeeding initiation and continuation rates than non-participating families in the same areas. Continued evaluation will support future scaling and sustainability of the model, contributing to improved outcomes and giving every child the best start in life.

TRANSFORMING INFANT FEEDING OUTCOMES THROUGH AN INTEGRATED MULTI-DISCIPLINARY APPROACH

The Integrated Infant Feeding Team, Tameside & Glossop Integrated Care NHS Foundation Trust
Fiona Munro-Muotune, Rebecca Astley, Helen Haley, Sian Holden, Kat Corker & Karla Brooks

Background & Challenge

Why change was needed
Breastfeeding is one of the most effective public-health interventions for improving maternal and infant health outcomes. Despite this, breastfeeding continuation rates in Tameside remained below national averages and were strongly associated with deprivation and health inequalities.

Before service implementation
- ❑ Lower than expected breastfeeding continuation rates
- ❑ Variation in infant feeding advice across services
- ❑ Inconsistent access to specialist support
- ❑ High levels of feeding-related neonatal readmissions
- ❑ Risk to achieving UNICEF Baby Friendly standards

Principal Drivers for Change

Principal drivers for change
- ➢ Patient safety and quality improvement
- ➢ Delivery of UNICEF Baby Friendly Initiative standards
- ➢ Reduction in neonatal admissions and readmissions
- ➢ NHS Best Start for Life priorities
- ➢ Saving Babies' Lives programme
- ➢ Reduction of health inequalities
- ➢ Long-term public-health improvement

Aim of the Integrated Model

Aim
To improve breastfeeding initiation and continuation rates, reduce health inequalities, improve family experience and reduce neonatal re-admissions through an integrated, evidence-based infant feeding model.

Integrated infant feeding model
Band 8a Clinical & Strategic Lead
Band 7 Infant Feeding Coordinator Maternity
Band 7 Infant Feeding Coordinator Community
Band 6 Infant Feeding Lead NICU
Band 6 Infant feeding Nurse
Band 3 Infant Feeding Support Worker x2

Interventions – Integrated Infant Feeding Team approach to Staff Education

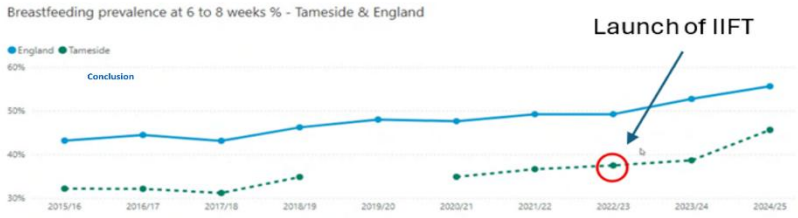
- **Integrated Infant Feeding Team** - UNICEF training courses for all staff trainers. - Mentoring and Study days to support IBCLC exam. - -QI Project work to develop skills
- **Integrated UNICEF BFI staff 2 day training for Maternity / NICU / Health visiting Teams**
- **UNICEF BFI staff online training for Paediatricians, Obstetricians & GP's**
- **UNICEF BFI training for Family HUBS staff**
- **UNICEF BFI training for commissioned Peer Support service**
- **UNICEF BFI Audits and yearly 1 day update training**
- **Incident Feedback Round table sessions for staff/ Quality & Safety forums**
- **Staff feedback provided from compliments and complaints**

Interventions - Family journey and supporting a seamless pathway from pregnancy through infancy, for infant feeding information

Antenatal education	High-risk clinics	Specialist team	Postnatal support	Community pathway	Better outcomes
Build knowledge and confidence early	Diabetes, pre-term birth and young parents	Early assessment and tailored support	Responsive support after birth	Health visiting, Family Hubs and peers	For babies, families and communities

MEASURED OUTCOMES

KPI	Qtr 4 23/24	Qtr 1 26/27
Skin to skin contact	83.1%	83%
Breastfeeding initiation	67.4%	69.1%
Breastfeeding at 10-14 days	56.3%	60.5%
%age infants with breastfeeding status recorded at 6-8 weeks	39.7%	53.4%



Neonatal readmissions

- Readmissions initially increased as feeding concerns were identified earlier
- Referral pathways improved after implementation
- Readmissions fell as the service became embedded
- A 15.3% reduction was achieved within eight weeks versus the previous year

15.3% Reduction in feeding-related readmissions

UNICEF Baby Friendly Stage 1 & 2 Accreditation October 2026



Reducing inequalities and creating value

Health inequalities
- Use population intelligence to identify need
- Target specialist support equitably
- Narrow the gap with England prevalence rates

Value and efficiency
- Reduce avoidable neonatal admissions
- Reduce urgent and acute care activity
- Invest in prevention and early intervention
- Create system-wide efficiency benefits

Better outcomes for babies, families and communities

A coordinated multidisciplinary model can improve breastfeeding outcomes, reduce inequalities and decrease neonatal readmissions

Collaboration + Early Intervention + Specialist Support

What next?
- ➢ Business case to secure future funding
- ➢ Stage 3 Accreditation in 2027 & Prepare for GOLD Accreditation
- ➢ Embed the UNICEF BFI Standards across Tameside Children's Unit and Children's A&E

Contact details – Fiona Munro-Muotune, Clinical & Strategic Lead for Infant Feeding and BFI Accreditation, Fiona.munro@tgh.nhs.uk

How prepared are UK healthcare professionals to support the emotional dimensions of infant feeding?

Findings from the BREATHE Approach study: a UK-wide cross-sectional online survey

Rachael Gardner, Research Midwife, NIHR Pre-doctoral Fellow, MRes student at King's College London
Yan-Shing Chang, Lecturer in Child and Family Health, King's College London
Amy Brown, Professor of Maternal and Child Public Health, Swansea University
Contact: rachael.gardner6@nhs.net



Funded by NIHR | National Institute for Health and Care Research

1 BACKGROUND

72% of mothers who had stopped breastfeeding would have liked to breastfeed for longer.

When infant feeding does not go as hoped, women may experience disappointment, guilt, grief and trauma. Although these experiences are increasingly recognised, little is known about how healthcare professionals understand, recognise and respond to the emotional dimensions of infant feeding, or whether they feel equipped to provide appropriate support.

2 STUDY OVERVIEW

Method: Study-specific questionnaire informed by literature, expert review and patient and public involvement and engagement.

Measures: Awareness of breastfeeding grief and trauma; conceptual understanding of key terms; confidence in practice; current support and referral practices; training and personal feeding experiences.

Aim: To explore healthcare professionals' awareness, perceptions and practices relating to the emotional dimensions of infant feeding when feeding does not go as hoped.

Participants (*n* = 263)

Midwives	21.7%
Peer supporters / counsellors	21.7%
Infant feeding leads	20.9%
Health visitors	9.9%
IBCLCs	6.1%
Other (Nurses • GPs • AHPs • support workers • educators • other)	19.7%

3 FINDINGS

78.3% encountered emotional distress related to infant feeding **daily or weekly**

57.7% knew of **no specific service** for breastfeeding grief or trauma

39.9% had **no specific training** but would like it

Terms encountered by healthcare professionals

76.4% had heard the term 'breastfeeding trauma'

71.5% had heard the term 'breastfeeding grief'

Conceptual understanding

94.7% **understood breastfeeding grief** as emotional pain or loss when breastfeeding did not go as hoped

96.9% **understood breastfeeding trauma** to include an emotional / psychological dimension

- 68.8% physical + emotional
- 28.1% emotional only

Confidence in practice

59.6% **were very or completely confident** supporting women experiencing emotional distress related to infant feeding

- 34.2% moderately confident
- 6.1% slightly or not at all confident

Median 4/5 (IQR 3–4)

Practices

What do professionals currently do?

Listen & give emotional support	99.2%
Reassure	96.6%
Practical feeding advice	94.7%
Signpost to peer support	70.0%
Refer to infant feeding specialist	57.0%
Refer to mental health service	41.8%

Personal experience shapes care

223 participants answered optional questions about their own feeding experiences

92.4% said their **own feeding experiences** influenced how they supported families.

See adapted I-poem →

- 56.5% described positive experiences
- 48.0% described challenging experiences
- 28.7% reported guilt
- 17.9% reported grief
- 15.7% reported trauma
- 7.2% reported shame

Participants could select more than one response.

4 NEXT STEPS

Preparedness needs to move beyond recognition alone.

- Co-design woman-led ways to recognise and discuss emotional distress
- Strengthen training and clarify referral and signposting pathways
- Explore how healthcare professionals' own feeding experiences may shape care

Scan for reference list

IN THEIR OWN WORDS

An adapted aggregate I-poem bringing together first-person reflections from 13 participants about emotionally difficult feeding experiences.

Knowing Was Not Enough

I expected that deep knowledge about feeding would mean,
I could do it easily, but this was not the case.

I remember being told "You're a midwife,
you know babies feed a lot".

I was dismissed,
I was told, "some babies are like this".

I didn't get offered support post birth, as it's assumed
I knew what I was doing.

I encountered breastfeeding grief with my second child,
I just needed to hear
"I'm so sorry you couldn't feed her the way you wanted to".

I felt my body had failed and if,
I could breastfeed successfully
I would have regained some pride. But sadly,
I stopped breastfeeding, and this impacted my own mental health.

I would like to have experienced breastfeeding, when
I reflect back now.

I didn't necessarily feel it as much in the early days,
but as time went on, and then
I breastfed my second, it grew more intense.
I just needed reassurance.

I felt that my professional career hugely increased my own distress,
I had been force-fed the idea of how wonderful breastfeeding was, and
my experience was not wonderful.

I think that it is important to know, that even though
I very much ended up meeting my feeding goals,
I still experienced grief and trauma in order to get there.

I wish I knew then what I know now.

I have received support to reframe my experience,
I now direct my emotional energy into supporting others.

I regret not doing more, but
I just didn't have the support.
This work I do now is amazing.

Funded by an NIHR Pre-doctoral Fellowship (NIHR500426); the funder had no role in the study. KCL ethics ref HR-25/26-53388.

Improving completion of the Unicef BFI data on Badger

Dr Jade Crist, ST7 Neonatal GRID Trainee
Dr Nicola Crowley, Consultant Neonatologist
Neonatal Intensive Care Unit, St George's Hospital NHS Trust

Background

Unicef Baby Friendly Initiative (BFI) feeding data is recorded in six fields on Badger. Accurate recording underpins infant feeding outcome measurement. Baseline audit showed only **40.9 - 59.6%** completion across all fields. Pre-intervention staff survey identified barriers to completion including challenges finding data, form not being prominently located, no option for formula fed infants meaning data for these babies always appeared incomplete.

Aim

Improve accurate completion of all BFI fields on Badger for **at least 80%** of discharged babies on a teritary NICU (100% not realistic as some babies bottlefed).

Interventions

- **Reminder emails** to discharging clinician requesting data completion
- Outstanding **data completion** by project team & discussion with Badger team for improvement suggestions
- **Infographic poster** in the team office and shared via WhatsApp and email
- **Reminder prompts** on computers

Teaching & reminding collegues throughout

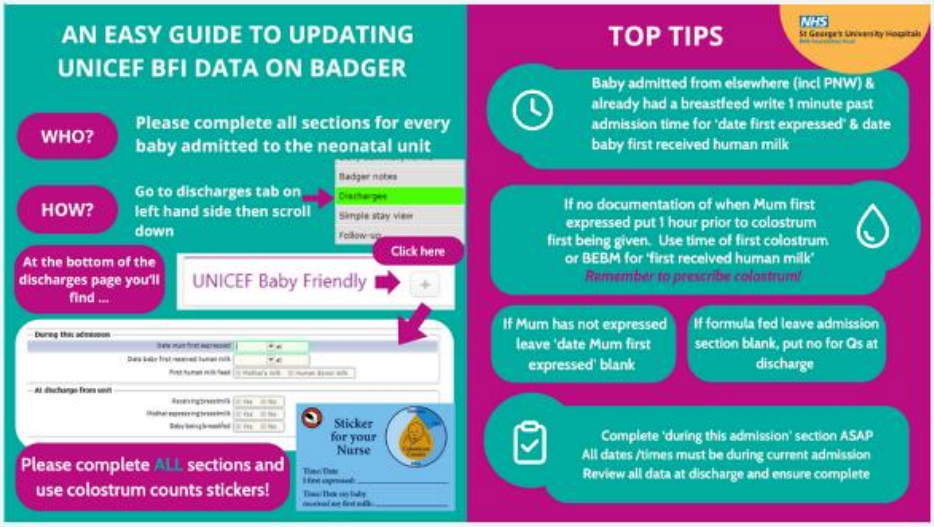


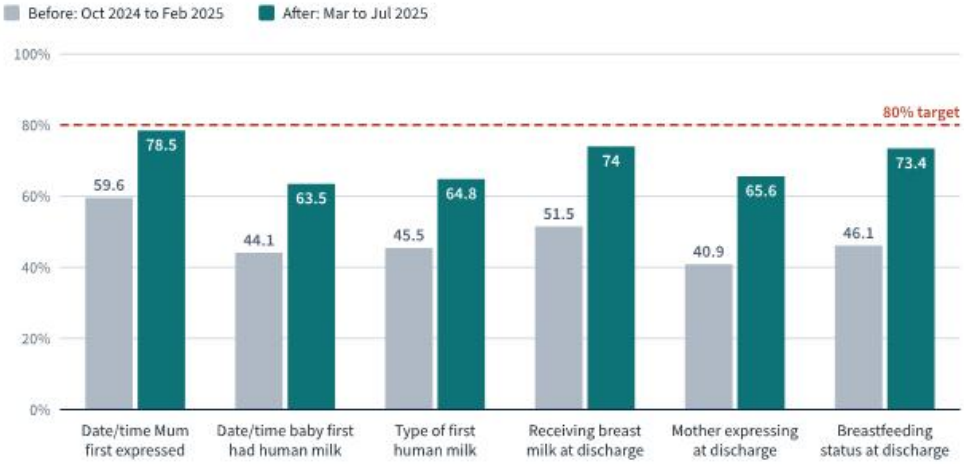
Figure 1: Infographic guide with step-by-step instructions and top tips for tricky cases



Figure 2: Reminder prompt for computer

Results

Figure 3: Percentage of discharged babies with each BFI field completed, before and after intervention



Post intervention audit showed significantly improved data acquisition by **18.9 - 27.3%** across all 6 fields (Fig 3). Declined to breastfeed option pending approval - will reduce apparent missed data.

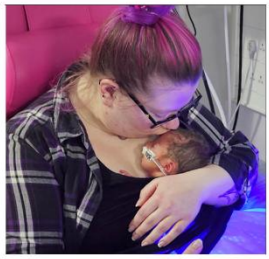
Conclusion

Meaningful improvement of 20% in one PDSA cycle. Simple, low-cost reminders, visual guides and teaching offer a transferable approach for other units working towards reliable BFI data.

Questions welcome jade.crist@nhs.net

PRINCESS ALEXANDRA HOSPITAL NEONATAL QUALITY IMPROVEMENT PROJECT

STANDARDISED PARENT EDUCATION AND RESOURCES TO IMPROVE SKIN TO SKIN RATES IN THE NEONATAL UNIT



CLARE ABELA – NEONATAL INFANT FEEDING LEAD NIKKI SARGEANT – OCCUPATIONAL THERAPIST RUTH CHAMPION – NEONATAL PHYSIOTHERAPIST REMYA ANITHA – NURSING REPRESENTATIVE

INTRODUCTION

Skin to skin or kangaroo care is a well documented practice that provides many benefits to both infant and the parent whilst on the neonatal unit and in the months following discharge. It supports greater autonomic stability, growth, sleep, reduction in pain, breastmilk production and improved feeding outcomes. It also provides important opportunities for the parent and infant to bond and connect, mitigating stress and promoting co-regulation.

OBJECTIVE

To provide standardised parent education and resources, to improve the percentage rate of daily skin to skin occurrences in infants admitted to the neonatal unit from June 2025 to January 2026.

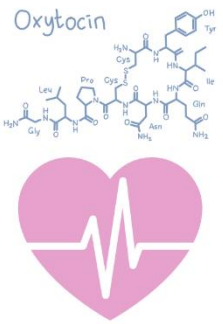
METHODOLOGY

Research was gathered
Examined current practices
Audits taken from badgernet - national database, and notes
Parent feedback was gained through questionnaire

RESULTS

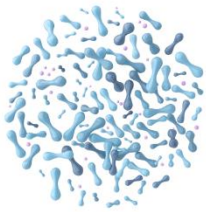
- The data showed low rates of skin to skin throughout the babies' stay, regardless of gestation.
- First neonatal skin to skin was often delayed - the more complex the infant, the longer the delay (up to 6 days).
- It was observed that babies didn't cope well with staff or parent-led transfers for skin to skin.
- There was a lack of parental confidence reported in babies requiring more support and in early days of admission. Additionally, provision of parental education was not standardised, leading to skin to skin rates dropping off in older gestations and those in special care.
- Skin to skin reporting and documentation was not standardised.

TIMELINE



1	2	3	4	5
AUDIT	SMART GOAL	RESEARCH	RESOURCES	TRAINING
Informal verbal feedback- parents and staff Badgernet data Randomised notes Parent questionnaire	Inital ideas PDSA Developing ideas SMART goal developed	Trust library literature search Professional journals Collaboration	Develop parent education leaflets, staff training Trust guideline and PSR	Launch resources Deliver staff training

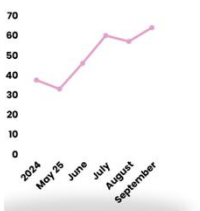




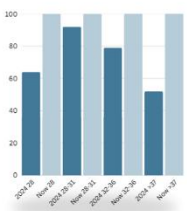
REFLECTIONS AND DATA

- Clinical pressures led to a delay in staff training.
- The initial stages of the project highlighted the importance of reporting and accountability of staff.
- Rates improved significantly after the launch of the resources in May.
- The data so far shows almost all babies now receive skin to skin during their stay - 25 percent increase over last year.
- Reporting showed an increased quantity of skin to skin has been attained, however current documentation doesn't take into account the quality of transfer.

Percentage of days baby had skin to skin



Number of baby's receiving Skin to Skin



NEXT STEPS

- Finish practical staff training
- Continue to audit the skin to skin rates monthly
- Gather feedback from parents
- Embed utilisation of comfort wraps for transfers
- Peer review
- Compile stage 1 reflections and repeat PDSA cycle
- Start of phase 2 - Improving quality of skin to skin

Introducing wraps/sling use and improve depth of documentation and auditing



modern • integrated • outstanding

patient at heart • everyday excellence • creative collaboration

The Breastfeeding experiences of women in Scotland living with a disability and/or long-term health condition

Scottish Breastfeeding Collaborative

Aim and method

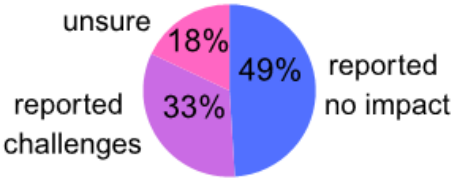
Evidence on how disability and long-term health conditions (LTHCs) affect breastfeeding is limited. Previous research indicates barriers, care disparities and lower initiation and continuation rates.

The online survey was shared through NHS Boards and third-sector organisations with women in Scotland with disabilities and/or LTHCs who had given birth in the previous five years.

126 women from 11 of 14 NHS Boards responded. LTHC **37%**; disability affecting mobility, sensory function, mental health or stamina **37%**; both **25%.**
68% of respondents exclusively breastfed, **29%** mixed fed and **3%** formula fed.

Impact and barriers

Impact of disability or LTHC on feeding



Barriers were grouped into three main categories -

Physiological: pain, fatigue, positioning, low milk supply and blood-glucose management.

Psychological: anxiety, depression, sensory overload and reduced confidence after poor support.

Pharmaceutical: inconsistent or inaccurate medication-safety advice risking unnecessary cessation or harm.

Support and information

33% of respondents received conflicting advice, often about medication.

Only 25% received professional information on how their condition might affect breastfeeding.
Sources: specialists 61%, midwives 39%, and health visitors/family nurses 30%. Of those who received support, most received information during pregnancy (73%), but early tailored support was often missed.

Other sources of support
Peer support 60%, Social media 44%, internet 37%

Few respondents used disability or LTHC specific organisations.



94% of alternative support was accessed postnatally, showing the need for proactive antenatal engagement.

What would have helped

- Better-informed professionals, particularly on disability and medication safety.
- More antenatal information on challenges, expressing and normal feeding behaviour.
- Consistent, coordinated care.
- Greater mental-health awareness and emotional support.

Conclusions

Women with disabilities or LTHCs want to breastfeed and many succeed with appropriate support, but substantial avoidable barriers and inequalities remain.

RECOMMENDATIONS

1. Enhance professional training.
2. Integrate person-centred care planning.
3. Strengthen NHS–third-sector collaboration.
4. Improve medication-safety information pathways.
5. Promote peer and community support.

For more information contact mairi.mclachlan@NHS.scot

Read the full report

Staff resource

Views and experiences of postpartum women regarding alcohol, alcohol-free and low-alcohol drinks, and breastfeeding: a mixed methods study

Kate Maslin[1,2] (RD, PhD) Katie Edwards[1] (PhD), Heather Hopper[1,2,3] (RM, PhD), Jill Shawe[1,2,4] (RN, RM, PhD)

1: School of Nursing and Midwifery, University of Plymouth 2: KU Leuven, Belgium 3: University Hospitals Plymouth NHS Trust 4: Royal Cornwall Hospitals NHS Trust

Background

Alcohol is a known teratogen, with the WHO advising there is no safe level of intake during pregnancy (1). Advice surrounding alcohol consumption and breastfeeding is less consistent, with some, but not all, countries suggesting moderate consumption is acceptable (2).

Concerns about alcohol consumption during breastfeeding relates to both direct and indirect effects. These include:

- Alcohol inhibiting oxytocin release leading to reduced milk ejection, transfer, and subsequent decline in supply (3).
- Alcohol altering infant sleep patterns resulting in shorter duration and fragmented sleep (4)
- Impaired parental judgement with excessive alcohol consumption (5)
- Data around alcohol consumption patterns in breastfeeding mothers is lacking, with most studies investigating maternal consumption of alcohol focusing on pregnancy (2).

Alcohol-free drinks are increasingly available. Their use in relation to breastfeeding practices is unknown.

Aim

To understand the awareness, views and use of alcohol-free and low-alcohol drinks in relation to breastfeeding practices in postpartum women.

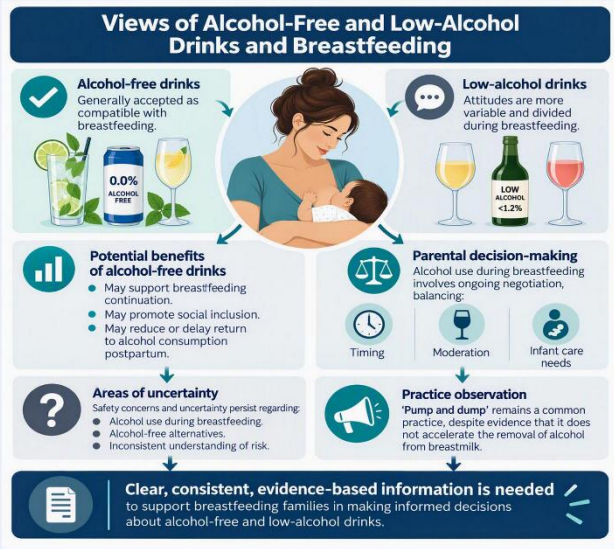
Methods

This analysis forms part of a larger mixed method study of pregnant and postpartum women (6).

These findings are from an online survey (undertaken in Spring 2025) of postpartum women living in the UK, aged ≥18 years, who had given birth in the last year. Quantitative data were analysed using descriptive statistics. Free-text responses were analysed using inductive content analysis.

Ethical approval was granted by the UoP FREIC (ref: 5946).





Results

- Of the 1103 respondents, most lived in England (69.9%, n=700) and were of White ethnicity (91.0%, n=1003).
- 56.7% (n=625) were breastfeeding exclusively and 21.2% (234) reported mixed feeding.
- 57.4% (633) were multiparous (had 2 or more children).
- Most (81.8%, n=902) thought consuming alcohol-free drinks if breastfeeding was very acceptable, decreasing to 45.9% (n=506) for low-alcohol drinks and to 15.6% (n=172) for alcoholic drinks.
- Those who were feeding their infant human milk only were more likely to think it acceptable to consume alcoholic drinks than those who were not (chi square, p<0.001).
- Seven key themes were identified from analysis of 170 free-text comments that specifically referred to breastfeeding.

Selected Quotes

"There is a stigma around drinking alcohol whilst breastfeeding. I do occasionally but have had comments." (56)

"If I drink alcohol or low alcohol I have to pump and dump my breast milk." (91)

"I also don't have caffeine for example while breastfeeding so would be really careful about what other ingredients are in drinks" (149)

"Timing is important- I feel more comfortable now my baby is older and there is longer between feeds for alcohol to metabolise (4 + hours)." (133)

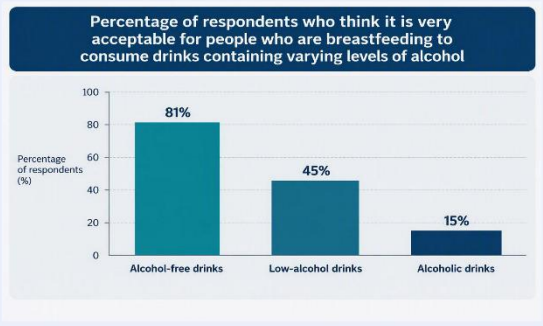
"In my opinion alcohol-free drinks are fine during pregnancy and breastfeeding. However, I don't know if low alcohol drinks are safe enough during that time". (78)

Strengths and Limitations

A large, ethnically diverse UK sample enhanced the study's reach, although potential bias from digital exclusion and a predominantly highly educated sample should be considered. Findings may be transferable to other settings, but further research is needed to confirm this..

"I regularly enjoy drinking alcohol-free drinks which means I haven't missed alcohol at all. I'm in no rush to start drinking alcohol again and hope that means I can continue breastfeeding for many months" (115)

"The information on alcohol and breastfeeding is quite confusing/conflicting. It would be helpful if this was more consistent." (94)





Conclusion

This study provides novel insights into perceptions of alcohol, alcohol-free and low-alcohol drinks during breastfeeding, highlighting the complex decision-making involved for parents. The findings support the need for clear, evidence-based guidance to help families make informed choices and promote health and wellbeing.

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3. Anderson PO. Alcohol Use During Breastfeeding. Breastfeed Med. 2018;13(5):315-7.
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Contact kate.maslin@plymouth.ac.uk or heather.hopper@plymouth.ac.uk

BIRMINGHAM CITY University

Building a Baby Friendly University

A student-led approach to promoting breastfeeding culture, inclusion and health equity through the Infant Feeding Room Project

♡ Student voices Inclusive spaces Health equity Lasting cultural change

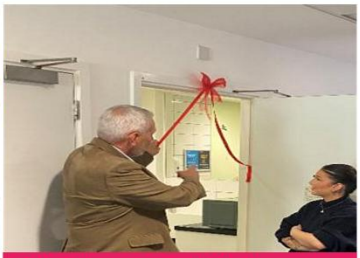
STUDENT-LED INITIATIVE: PLANNING, DESIGNING AND DELIVERING CHANGE



Students and staff celebrating the project



Celebrating the launch



Official opening – 14th November 2024



A welcoming and comfortable space

FROM STUDENT VOICE TO LASTING CHANGE

1 → STUDENT VOICES
Identified a need and shared ideas.

2 → CO-DESIGN
Chose décor, resources and layout.

3 → PARTNERSHIP
Worked with staff, leadership and BFI champions.

4 → ROOM DEVELOPMENT
Created a calm and welcoming environment.

5 → OFFICIAL OPENING
Launched and celebrated across the school.

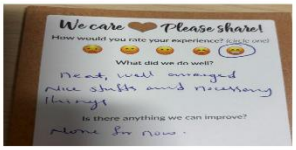
6 → ONGOING OWNERSHIP
Students continue to champion the room.



EVENTS, CELEBRATION AND COMMUNITY ENGAGEMENT







PROJECT IMPACT

- Dedicated Infant Feeding Room established and promoted.
- Strengthens Baby Friendly culture across the university.
- Student partnership and belonging embedded in the initiative.
- Senior leadership and BFI champions actively involved.
- Accessible resources support staff, students and visitors.

WHY WE CREATED THE INFANT FEEDING ROOM

We recognised the need for a welcoming, inclusive space where students, staff and visitors can breastfeed, express and access support.

By creating a dedicated Infant Feeding Room, we are promoting and protecting optimal infant feeding, while supporting student retention, wellbeing and progression.

The project aligns with UNICEF Baby Friendly Initiative principles and wider recommendations for infant feeding.

PROJECT OBJECTIVES

1. Fully equip and promote the University Infant Feeding Room.
2. Encourage student midwife involvement in planning and design.
3. Support positive choices and embed a Baby Friendly culture.

STUDENT REFLECTIONS

"The idea that as a cohort we can make a difference has pulled us together as a team."

"It is great to know that even once we have left and qualified, there will still be a memory of our time together."

"It is important for people to feel safe and supported when feeding their baby."

PROMOTING HEALTH EQUITY ACROSS OUR UNIVERSITY



SUPPORTING FAMILIES: RESOURCES AVAILABLE

The Infant Feeding Room is supported by evidence-based resources for:

- Breastfeeding and responsive feeding
- Skin-to-skin and relationship building
- Positioning and attachment
- Hand expression and breastmilk storage
- Commercial formula feeding
- Local Birmingham support services



UNICEF BABY FRIENDLY PRINCIPLES

1	PROTECT	Promotes and protects optimal infant feeding.
2	INCLUDE	Creates a welcoming and inclusive environment.
3	EDUCATE	Supports infant feeding education.
4	ENGAGE	Strengthens student engagement and belonging.
5	EMPOWER	Empowers students to lead change.

UNICEF BABY FRIENDLY INITIATIVE PRINCIPLES

SUSTAINABILITY & FUTURE DEVELOPMENT

- ✓ Maintain student ownership and feedback
- ✓ Promote the room to future cohorts & other university campuses
- ✓ Strengthen collaboration with leadership
- ✓ Review resources and accessibility
- ✓ Share learning across the university

SUSTAINABILITY & FUTURE DEVELOPMENT

CONTACT

Kimberley Jones
Midwifery Lecturer
School of Nursing and Midwifery
Birmingham City University
kimberley.jones@bcu.ac.uk

Creating inclusive spaces is only the beginning. Student partnership, education and accessible resources can embed lasting Baby Friendly cultural change.

LEARN MORE

Scan to request the Infant Feeding Room Information Booklet

The Case for Child Death Overview Panels (CDOPs) to recommend UNICEF's Baby Friendly Initiative (BFI) accreditation progression

CONTEXT

- Child Death Overview Panels (CDOPs) in England have been responsible for reviewing child deaths since 2006. In 2018, responsibility for Child Death Reviews (CDRs) became a joint statutory duty shared between local authorities and the NHS.
- The establishment of the National Child Mortality Database (NCMD) in 2019 strengthened national oversight, with all child deaths required to be notified to the database within 48 hours.
- Current guidance for reviewing child deaths is set out in Working Together to Safeguard Children (Department for Education) and the Child death review: statutory and operational guidance (England) - GOV.UK

AIMS OF CDRS

- To ensure that families are supported throughout and their voice is central
- To have a better understanding of contributory factors to child deaths
- To identify modifiable factors through analysis and discussion
- To learn lessons from discussions and make recommendations
- To share information locally and nationally to reduce future child deaths
- To improve multidisciplinary collaboration to reduce child deaths

CDR DATA IN LONDON

- Data from CDOPs indicates that the gap in infant mortality between the most and least deprived is widening, and there are stark inequities in infant mortality rates by ethnicity.
- Of all the reviews completed by London CDOPs in 2020-2024, 28% identified modifiable factors- the most common are shown in the table below. Sleep-related factors remain among the most frequently identified modifiable factors in infant deaths.

Category	Number of reviews
Guideline/pathway available but not followed	23
Co-sleeping	21
Tobacco/e-cigarettes smoked in household	15
Unsafe sleeping arrangements	14
Poor communication/information sharing within an agency	13

KEY CHALLENGE

Across the system there are difficulties in translating CDOP learning into measurable, sustainable actions with clear accountability.

WHY RECOMMEND BABY FRIENDLY ACCREDITATION?

- To address key prevention priorities highlighted by CDR data by improving both infant feeding and safer sleep practices through a recognised, evidence-based quality improvement programme.
- To deliver population-level impact, creating sustainable improvements in staff training, policies, parent education, governance and service quality across maternity and early years services.
- To support prevention of Sudden Unexpected Death in Infancy (SUDI) and infection-related infant deaths by strengthening breastfeeding support, aligning with NCMD findings that infants are vulnerable to infection-related mortality.
- To provide a measurable and auditable improvement framework, enabling CDOPs to recommend an action with clear milestones, accountability and monitoring.
- To transform review findings into system-wide action, helping services address recurring modifiable factors.

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Walsh et al. (2023) Improving breastfeeding support through the implementation of the Baby-Friendly Hospital and Community Initiatives: a scoping review. X
NCMD (2025) Child mortality during winter periods
UNICEF The benefits of breastfeeding - Baby Friendly Initiative & Baby Friendly Standards - Baby Friendly Initiative
OHID (2025) Reducing Infant Mortality in London – Strategic Action Plan

KIANA BOWDEN | PUBLIC HEALTH STRATEGIST, LONDON BOROUGH OF NEWHAM

Integrating sustainability and virtual reality into breastfeeding education with midwifery, child nursing and health visiting students: Evaluation of a pilot study

Yan-Shing Chang*, Kate Frith, Charlotte Martins; Emma Jefferson, Holly Brackenboro, Alison Meinel, Kerstin Lelubre, Behnam Jafari Salim, Kaabah Asif; Alexandra Oladimeji, Megan Rajan, and Sylvester Odame-Amoabeng
*Corresponding Author Email: yan-shing.chang@kcl.ac.uk

KING'S College LONDON

BACKGROUND

Midwives, child nurses and health visitors are important in women's breastfeeding journey.

A core element in education for sustainability is experiential learning

Virtual reality (VR) provides safe learning enviroment for students

This pilot study used immersive VR scenarios for students to experience breastfeeding in the shoes of a breastfeeding person.

3

Three- part learning experience
- Introduction, VR scenario and guided debrief



3 disciplines
- Child nursing, health visiting & Midwifery



39 Students
Total number in education sessions

Survey
- 19 consented for research

Semi-structured interviews
- 9 students
- 5 Facilitators

THE PARTICIPANT JOURNEY







1 **INTRODUCTION**
Breastfeeding, health and safety, VR technology

2 **STEP IN**
Put on the VR headset, or observe on the monitor

3 **EXPERIENCE**
Immersive breastfeeding scenario in a home, park or office

4 **DEBRIEF**
Trained educator led discussion & shared peer experiences



WHAT DID THE SURVEY SHOW?

19/19 Were satisfied with the overall learning experience	100%
89.5%	17/19 Felt a sense of being there during the headset VR experience
18/19 Reported an increase in knowledge on sustainability	94.7%
89.5%	17/19 Would recommend the breastfeeding VR session to classmates

WHAT DID PARTICIPANTS TELL US?

Key findings from interviews

Empathy
- VR enabled students' empathy towards breastfeeding parents.
- *"It makes you sympathise and empathise with the parents a lot more when they get frustrated with baby crying."*

Immersion
- Participants described scenarios as believable and engaging
- *"I was trying to get my baby to latch on me, it was realistic, and I felt it was good."*

Reflection
- Debriefing was needed as part of the learning experience
- *"I think the debrief is key to the experience. I think without it, it's almost just like playful."*

VR provided experiential learning opportunities

Debriefing was essential to contextualise learning

->Encouraged sustainable thinking
-> Developed deeper understanding of breastfeeding challenges
->Informed better practice

MAKING BREASTFEEDING VISIBLE IN PARAMEDIC EDUCATION

Using formative diagnostic simulation to inform curriculum development

Lisa Clarke • Jamie Scott • Niall Carty

Ulster University
Faculty of Life and Health Sciences
School of Nursing & Paramedic Science

What happens when undergraduate paramedic students encounter breastfeeding distress before receiving formal infant feeding education?

01 WHY THIS MATTERS

Breastfeeding education is relevant across the healthcare workforce. Parents report receiving conflicting professional advice, highlighting the need for consistent, evidence based support (Hauck, Graham-Smith, McInerney and Kay, 2011). This project used formative simulation to identify learning needs and inform targeted paramedic education..

02 FORMATIVE SIMULATION

8 groups • Third year paramedic students • Breastfeeding Scenario





The scenario included barriers beyond feeding technique:

- £ Socioeconomic disadvantage
- ↗ Limited access to support
- ◌ Family pressure to use formula
- Rx Medication concerns

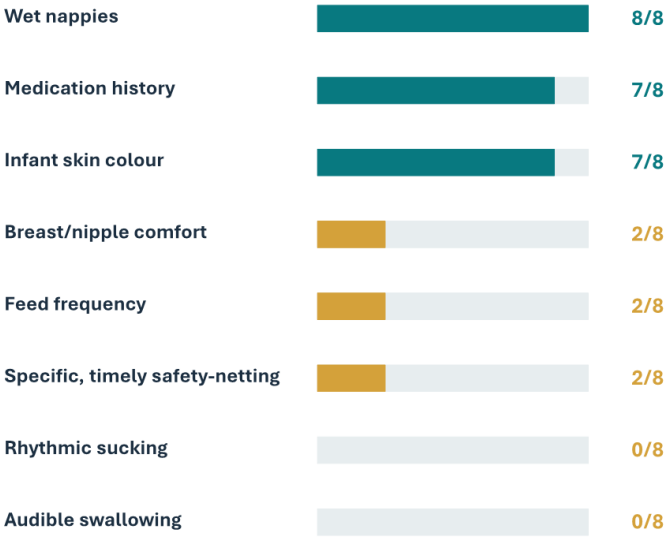
03 FROM OBSERVATION TO EDUCATION

1	SIMULATE	Observe group responses
2	IDENTIFY	Recognise learning needs
3	TEACH	Target curriculum content
4	EVALUATE	Test impact in future

04 WHAT THE SIMULATION REVEALED

Group-level educator observations | n = 8 groups

More commonly observed



Some students offered advice that was not evidence based or protective of parental breastfeeding goals.

05 THE EDUCATIONAL RESPONSE

A targeted teaching session followed the simulation

ASSESS	PROTECT	SUPPORT	REFER
Mother, infant and feeding	Goals, milk supply and autonomy	Compassionate, within-scope care	Right help, right urgency

06 UNICEF BABY FRIENDLY INIATIVE

Baby Friendly principles extend beyond maternity and health visiting. All healthcare professionals contribute to the wider system surrounding families and have a role in providing safe, consistent, person centred and breastfeeding protective care. Integrating relevant Baby Friendly learning outcomes across health professional education can support this shared responsibility.

SAFE • CONSISTENT • PERSON CENTRED • BREASTFEEDING PROTECTIVE

Scan the QR code for the supporting article and references

Developing the All Wales Breastfeeding in the Workplace Toolkit
A Partnership Project

Rachel Evans, Lead Midwife for Breastfeeding, Public Health Wales

Background

Policy- All Wales Breastfeeding Action Plan (2019)[1]
Strategic aim 2- enabling mothers who have opted to breastfeed to do so successfully for as long as they would like to.
Approach 2, Aim 2- Creating settings and environments which reflect a positive and inclusive ethos towards breastfeeding- including workplaces.

Context

1. Research including by the Royal College of Midwives (RCM)[2,3] highlighted lack of consistency. Appetite for improvement through "Caring for You" campaign.
2. National focus on retention.
3. Tribunal decision highlighting need for health boards to support breastfeeding employees appropriately.

Public Health Wales working group reviewed existing evidence and conducted survey of employees in Wales. Key findings:

- A lack of consistent support- evidence of excellent practice and very poor practice.
- Line managers did not feel well informed.

"The request was instantly shut down and I was advised to use a toilet."

"My colleagues and manager have always been very supportive."

1. Partnership working

- Collaborative working with RCM and Royal College of Nursing (RCN) partners enabled presentation of the work to senior workforce leads and the Unions Partnership Forum.
- Agreement to take forward the work on an All Wales basis to maximise the impact for employees. Working group formed with representatives from a range of organisations.
- Powys Teaching Health Board joined as partners and generously shared their own work on supporting breastfeeding employees.
- Healthy Working Wales, a team within Public Health Wales, had expertise in developing interactive documents for employers in Wales and agreed to create the resource in collaboration with the Early Years and Child Health team.

2. Activity of the group

- Practical focus- members agreed that policy was in place but not applied. Line managers needed practical information, therefore "toolkit" approach agreed.
- Membership included RCM, Royal College of Nursing, British Medical Association, senior workforce representatives and the Breastfeeding Network.
- Strict timescale- at first meeting in February 2026 group agreed to launch resource in August 2026 to coincide with World Breastfeeding Week.
- Collaboration and consultation- All members worked to circulate drafts and gather feedback.

3. Approval and launch

- Unions Partnership Forum approved the resource in July 2026.
- Public Health Wales hosted a well attended webinar showcasing the resources.
- Health Working Wales provided communications pack for group members to highlight the resource.
- Review planned in 6-12 months.



What's in the toolkit?

- Checklist for organisations
- Flexible, individualised approach
- Practical information and training presentation for managers
- FAQs and conversation starters for managers and employees
- "Breastfeeding Passport" to record and review individual plans



[1] Welsh Government (2019). *All Wales Breastfeeding Five Year Action Plan*. [online] Available at: https://www.gov.wales/sites/default/files/publications/2019-06/all-wales-breastfeeding-five-year-action-plan-july-2019_0.pdf [Accessed: 7th September 2026].
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GIG CYMRU NHS WALES
Iechyd Cyhoeddus Cymru
Public Health Wales