An investigation of breastfeeding support in Coventry

November 2012

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And Coventry LINk

Your views on Your care
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1. Summary

Coventry LINk undertook this research to:

- Review the effectiveness of current breast feeding support provided in Coventry, in hospital and in the community and variance between the experiences of different communities within Coventry
- Identify good practice and any issues or gaps
- Compare practice in Coventry with elsewhere in the country and with national guidance on breastfeeding support

In recognition of their reach into BME and deprived communities LINk commissioned FWT – a centre for women, (Foleshill Women’s Training) to carry out a survey and focus groups to gather feedback on breastfeeding support on LINk’s behalf.

This project gathered the views of 279 women plus feedback from providers of services and an investigation of good practice. 69% of respondents lived in the most deprived areas of Coventry and 47% of our sample was from Black and Minority Ethnic (BME) communities.

There is significant international and national evidence to support the health outcomes from breastfeeding for both child and mother. The Department of Health expects a 2% increase on breastfeeding rates per year because of its contribution to reducing infant mortality and reducing health inequalities. There is work to be done locally to consistently achieve targets for breastfeeding initiation as University Hospital Coventry and Warwickshire (UHCW) have not yet been able to achieve the new target of 77%.

There is a better picture for breastfeeding continuation locally which exceeded the target of 40% achieving 42.2% in Quarter 1, 2012.¹ This figure is lower than the national average but compared to other Primary Care Trust areas with similar levels of deprivation, Coventry is doing well. However because of the health benefits striving to achieve higher levels of breastfeeding continuation than the government target is very desirable.

LINk has collected independent evidence from local women regarding breastfeeding initiation and continuation including indication of continuation after 6-8 weeks, where there remains room for improvement.

Research has highlighted that the initiation and duration of breastfeeding is influenced by the amount and quality of support provided and that problems with breastfeeding can effectively be addressed by support.²

The birth rate is continuing to rise in Coventry and migration into Coventry is one of the factors generating the city’s rising birth rate. Therefore ensuring service can meet the demand is important along with ensuring that services are delivered in an accessible way.

¹ Department of Health, Integrated Performance Measure Return Crown Copyright © 2011
² Department of Health 2002
The professionals surveyed saw benefits in Coventry’s partnership approach to service delivery for accountability and provision; its commitment to UNICEF Baby Friendly Initiative (BFI) accreditation; and investment in targeted services. The responses for the survey participants have identified positive impacts on user experience of services.

We found from our surveys and focus groups that:

- Professionals and convenience were stated as the most common influences on choice of feeding.
- Women were more positive about the support they received in the community than in hospital.
- Provider support in the community was valued by most participants. The community midwife was also appreciated along with health visiting.
- Positive feedback from service users was also received regarding targeted support from FWT- MAMTA service (which addresses language barriers in the most deprived areas and where ethnic minority women reside) and the Infant Feeding Team.
- Women expressed a preference for one to one and group support.
- There are pockets of women that wanted more encouragement, support and access to information during pregnancy to be able to make an informed choice around feeding.
- There were 45 comments stating that the women wanted more support. Women from more deprived wards more frequently said they would have liked more support and reported concerns such as mixed messages from professionals.
- There were indications that the availability and level of support in hospital varied depending on times of day and days of the week with perceptions that staff were too busy/stretched to provide the necessary support.
- Not all women were given the contact details for the Infant Feeding Team at the point of discharge from hospital.
- Those who stopped breastfeeding may have continued if they had received more support or support in a different way as the reasons given seemed to be things which could have been addressed.
- Mixed feeding in hospital was more prevalent than expected.
- A high proportion of those bottle feeding exclusively or partially were not shown how to make up a bottle by a professional.
- Some babies were not identified as having a tongue tie (which affects breastfeeding) before discharge from hospital.
- Women did not feel there were enough places to breastfeed in the City and reported some adverse reactions to breastfeeding.
• There were issues regarding support for pregnant teenagers and they reported lower rates of breastfeeding than other age groups

As a result of the findings Coventry LINk has made nine recommendations for action directed at commissioners, providers and planners. These can be found on page 50 and page 51.

2. Introduction

Coventry Local Involvement Network (LINk) is one of 151 LINks in England set up by the Government through the Local Government and Public Involvement in Health Act 2007. The role of a LINk is to enable local people to have greater influence on how local NHS and adult social care services are delivered and commissioned. Coventry LINk is an independent network of local people and local voluntary and community groups.

LINk chose to do this piece of work through its annual work planning process. LINk’s Steering Group decided that it was a good time to see if recent investment in developing breastfeeding support in Coventry had addressed previous concerns.

Breastfeeding continues to be a key focus for the NHS and for local partners in tackling health inequalities and the evidence base for the health benefits of breastfeeding is strong. For example government guidance on commissioning breastfeeding support states that: *Breastfeeding saves lives and protects the health of mothers and babies both in the short and long term.*

LINk commissioned FWT - A Centre for Women, an organisation running for 21 years supporting social health and economic aspirations of women in Coventry, to conduct this piece of work. FWT provided: extensive experience of working with cross sections of Coventry communities; establishing health projects; and a track record of engaging with child and maternal health. FWT were therefore well placed to carry out this piece of work for LINk.

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3 Department of Health, (6 October 2009), *Commissioning local breastfeeding support services*
3. Our focus and aims

This project follows up Coventry LINk’s work in 2009, which highlighted concerns about the level of breastfeeding support within the hospital setting to see if more support is now available to new mothers within the hospital. It also extends the research to investigate breastfeeding support within the community.

The aims were to:

- Review the effectiveness of current breast feeding support provided in Coventry and any variance between the experiences of different communities (e.g. BME, deprived wards, teenage parents) within Coventry
- Identify good practice
- Compare practice in Coventry with elsewhere in the country and with national guidance on breastfeeding support

The project looked at the recent investments within the city with regards to breastfeeding delivery and commitment to support the Baby Friendly Status Accreditation. The analysis seeks to identify good practice taking place in Coventry as well as common issues and identifying any gaps surrounding breastfeeding support. This piece of work has also touched on some of the good practice breastfeeding initiatives elsewhere in the country (See Appendix 1: Good Practice Elsewhere in the Country).

4. Context

4.1 Breastfeeding benefits and guidance

Over recent years there has been much guidance regarding the significance and importance of breastfeeding for health outcomes. In 2001 World Health Organisation (WHO) recommended exclusive breastfeeding for the first six months of an infants’ life.\(^4\) Thereafter they recommend infants should receive nutritionally adequate and safe complementary foods whilst breastfeeding continues up to two years or beyond.\(^5\)

WHO has found that initiation of breastfeeding, within one hour of birth, protects the new-born from acquiring infections and reduces new-born mortality. The risk of mortality due to diarrhoea and other infections can increase in infants who are either partially breastfed or not breastfed at all. Formula-fed babies are more likely to develop a number of conditions including gastrointestinal, respiratory and urinary tract infections\(^6\).

\(^4\) Position statement by the Scientific Advisory committee on Nutrition (2001) A commentary on infant feeding practices in the UK, World Health Organisation

\(^5\) UNICEF, (2007), Global strategy for infant and young child feeding

\(^6\) Horta and Ip et al (2007), Evidence of the long-term effects of breastfeeding: systematic review and meta-analyses, World Health Organisation
Babies who are not breastfed are also more likely to be hospitalised as the result of infection\(^7\). In addition, mothers who have not breastfed are at greater risk of some cancers in later life, particularly breast cancer and ovarian cancer. They are also less likely to return to their pre-pregnancy weight.\(^8\)

Adults who were breastfed as babies often have lower blood pressure and lower cholesterol, as well as lower rates of being overweight, obesity and type-2 diabetes.

The UNICEF Baby Friendly Initiative (BFI) is a global campaign by the WHO and UNICEF and it recognises that implementing best practice in the health services is vital to sustain breastfeeding. In the UK the Baby Friendly Initiative is commissioned by various parts of the NHS, to provide advice, support, training, networking, assessment and accreditation. In England only 11% of births are in UNICEF accredited Baby Friendly hospitals and, in 2009, 25 hospitals in England had full Baby Friendly accreditation, with 79 having other stages of accreditation.

UNICEF has created a 7 Point Policy for the Community and Ten Steps to Successful Breastfeeding for Maternity (See Appendix 2 for UNICEF Guidelines).

Government policy in the UK has consistently supported breastfeeding as important in the promotion of maternal and infant health. The Department of Health in the National Service framework for children, young people and maternity services standard 11: maternity services states:

‘Breastfeeding has an important contribution to make towards meeting the national target to reduce infant mortality and health inequalities.

The infant feeding survey showed that 90% of mothers who gave up breastfeeding within six weeks of birth would like to have breastfed for longer. Some of the reasons for stopping breastfeeding were found to include a lack of ante-natal information concerning breastfeeding, delays in the first feed and a lack of post-natal help with breastfeeding problems’.\(^9\)

NICE (National Institute for Health and Clinical Excellence) recommend commissioners and managers of maternity and children’s services should take action to adopt a versatile approach or a co-ordinated programme of interventions across different settings to increase breastfeeding rates. It should include:

- Activities to raise awareness of the benefits of and how to overcome the barriers to breastfeeding
- Training for health professionals
- Breastfeeding peer-support programmes
- Joint working between health professionals and peer supporters

\(^7\) Quigley, M.A, Kelly, Y.J, Sacker, A Pediatrics(2007) Breastfeeding and hospitalization for Diarrheal and respiratory Infection in the United Kingdom Cohort Study

\(^8\) World Cancer Research Fund, 2007 by the American Institute for Cancer Research

\(^9\) Department of Health, (2003), Infant Feeding Recommendations PDF
Education and information for pregnant women on how to breastfeed, followed by proactive support during the postnatal period (the support may be provided by a volunteer).

Implement a structured programme that encourages breastfeeding, using Baby Friendly Initiative (BFI) as a minimum standard.\(^\text{10}\)

Breastfeeding support should be made available regardless of the location of care. Healthcare professionals should have sufficient time to give support to a woman and baby during initiation and continuation of breastfeeding. Where postnatal care is provided in hospital, attention should be paid to facilitating an environment conducive to breastfeeding. This includes making arrangements for:

- 24 hour rooming-in and continuing skin-to-skin contact when possible
- Privacy
- Adequate rest for women without interruption caused by hospital routine
- Access to food and drink on demand.

Commercial packs, for example those given to women when they are discharged from hospital, containing formula milk or advertisements for formula should not be distributed. Written breastfeeding education materials as a stand-alone intervention are not recommended. \(^\text{11}\)

### 4.2 Breastfeeding trends

Breastfeeding has a major role to play in public health. Despite this, the UK has one of the lowest rates of breastfeeding worldwide, especially among families from disadvantaged groups and particularly among disadvantaged white young women.

A target to deliver an increase in breastfeeding initiation rates by 2% per year was set by the *NHS Policies and Planning Framework 2003-2006* and this target has been included in local delivery plans to support the Public Service Agreement (PSA) target on infant mortality focusing especially on women from disadvantaged groups.

In 2000 the breastfeeding initiation rate was 69% for all mothers in the UK at birth and there was continuation rate of 42% at six weeks. There has been an increase in breastfeeding initiation over the years. The breastfeeding rate increased from 76% in 2005 to 81% in 2010 in the UK. The continuation rate has changed very little. \(^\text{12}\)

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\(^{10}\) NICE, *Improving the nutrition of pregnant and breastfeeding mothers and children in low-income households - public health guidance 11*

\(^{11}\) NICE, (July 2006) *Clinical guideline 37 – postnatal care*

\(^{12}\) Coventry University (23rd July 2010) Breastfeeding Best Start Project – Coventry
4.4 Breastfeeding rates in Coventry

Breastfeeding Initiation (all trusts)

The breastfeeding initiation rate in England for 2011/12 was 74.0%. Locally, initiation rates have increased at rates similar to the England average. The Initiation rate for Coventry in 2011/12 was 74.7%

Figure 2 shows the breastfeeding rates for Coventry from the period April 2009 to September 2012. The breakdown of the breastfeeding initiation data for Coventry was reported quarterly in the Integrated Performance Monitoring Returns (Formerly Vital Signs Monitoring Returns). Reporting from South Warwickshire Foundation Trust started from Q4 2010/11. The 2011/12 data was reported at UHCW and South Warwickshire Foundation Trust only. George Eliot Hospital was added from 2012/13. This data is currently collected directly from provider sources.14

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14 Department of Health, (2011/12), Statistical release: breastfeeding initiation and prevalence at 6 to 8 weeks - Quarter 1
Figure 2: Breastfeeding Initiation (all trusts) April 2009- September 2012

Figure 3 summarises the breastfeeding initiation rates in UHCW over the last few years. The initiation rates at UHCW are higher than the Coventry city average particularly within the last year. UHCW delivers the majority of the births of Coventry residents and almost all those surveyed delivered at UHCW.

Figure 3: Breastfeeding Initiation rates in UHCW April 2009- June 2012

The dips in initiation rates in quarter 4 2009/10 and 2011-12 and quarter 3 2010-11 is unexplained and requires further investigation.
Breastfeeding rates 6-8 weeks

The most recent national figures for breastfeeding at 6-8 weeks show that the breastfeeding prevalence at 6-8 weeks in England for 2011/12 was 46.9%. This figure was maintained for Q1 in 2012/13 of infants due a 6-8 week check.

All Coventry data for breastfeeding at 6-8 weeks comes straight from the Child Health System at the Coventry Warwickshire Partnership Trust. The breastfeeding 6-8 weeks rates have increased year on year over the period 2009 to 2012 but are lower than the national average.

Figure 4: Breastfeeding rates 6-8 weeks April 2009- June 2012

Recent statistics: April 2012 March 2013

This year’s target is 77% for initiation and 40% for 6-8 weeks for Coventry. Table 1 shows what has been achieved so far in quarters 1 & 2, 2012/2013.15

Table 1: 2012/2013 Initiation and 6-8 week Targets and Achieved Breastfeeding Rates for Coventry Residents

<table>
<thead>
<tr>
<th></th>
<th>Target: 2012/2013</th>
<th>Quarter 1</th>
<th>Quarter 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Breastfeeding Initiation Rate in Coventry</td>
<td>77%</td>
<td>74.2%</td>
<td>74.5%</td>
</tr>
<tr>
<td>Breastfeeding Initiation Rate for UHCW for Coventry residents*</td>
<td>77%</td>
<td>77.22%</td>
<td>75.13%</td>
</tr>
<tr>
<td>Breastfeeding at 6-8 weeks</td>
<td>40%</td>
<td>42.2%</td>
<td>42.8%</td>
</tr>
</tbody>
</table>

* UHCW 2012

Coventry’s initiation rates are in line with national statistics even though Coventry did not achieve targets for initiation for quarters 1 and 2 in 2012. UHCW initiation rates are higher than the Coventry average and have met the target in quarter 1, but were below target in quarter 2. The accumulative figures for all births at UHCW (78.66%

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Q1 and 76.37% Q2) are slightly higher for its Coventry residents and includes all deliveries that take place at UHCW including Warwickshire and Rugby residents. Breastfeeding continuation rates at 6-8 weeks are above target for both quarters, however lower than the national average so far this year.

5. Methodology

This project investigated breastfeeding support by gathering information on the current provision of support; collating feedback from women on their experiences of breastfeeding support; and desk research.

Multiagency views were gathered from professionals delivering, managing and supporting the breastfeeding agenda, via interviews and electronic correspondence.

Views of women/users were gathered via three methods:

- 1-1 Surveys
- Informal discussions: longer surveys
- Focus Groups

We captured women’s breastfeeding support and experiences within three different stages:

1. Pregnancy
2. Hospital
3. Home & Community

We worked to ensure that the feedback we gathered was recent i.e. within a year or less of the start date of the project and that women from across different social classes and backgrounds were contacted, to reflect the diversity of the city. Language support was offered to BME respondents where needed.

All research was carried out by women in order to encourage engagement. Postnatal women across Coventry were contacted through children centres, breastfeeding groups, clinics and mums and tots groups. A self-completion survey and guided questionnaire were used. (See Appendix 4)

Common themes across all methods of engagement have been grouped together. Evidence that strongly supports the current delivery and approaches or has identified any issues or gaps to be addressed has been captured. Some of the data breakdown within the self-completion survey and guided questionnaire has been calculated from the number of women that answered each question.

The quintiles of deprivation statistics were used as a source in our planning and scoping to ensure we captured a representative sample from the most deprived to most affluent. (See map Appendix 6)

The most deprived wards include Foleshill, St Michaels, Upper and Lower Stoke, Longford, Willenhall, some parts of Henley, Westwood, Wyken, Woodlands and
Whoberly. The most affluent wards are Wainbody, Earlsdon and parts of Whoberly, Sherbourne, Bablake and Woodlands.

The findings from the initial 30% of 1-1 surveys were analysed and to determine the focus group methodology in order to gather more specific information and draw out some common issues and themes.

The focus groups were held in Tile Hill, Bell Green, Tommies and Canley Children centres. Additionally a focus group was held with MAMTA with language support, to capture BME views. Please see (Appendix 5) for the focus group prompts used.

6. Findings

6.1 Sample profile

In total 279 women who had recently given birth formed the sample:

- 225 women participated in completing self-completion surveys.
- 26 women participated in one to one discussions using a longer guided questionnaire.
- 28 women participated in 5 focus groups: 18 (64%) from White British background and 10 (36%) from black and minority ethnic groups

The surveys were completed in 26 venues across the city (See Appendix 7 for a list of venues where the surveys was distributed/carried out).

Of the 251 women completing the surveys, 182 (72%) stated that they were breastfeeding at the time of the survey. Figure 7 shows proportions of babies born within either 3 months or 6 months of the survey date.

Figure 7: Participants with babies born within 3 months and 6 months of the survey date

![Graph showing participants with babies born within 3 months and 6 months of the survey date]
The majority of the women surveyed were aged 21 to 34. Please see Figure 5 for breakdown of age of survey participants.

*Figure 5: Age group of survey participants* 

52% of the women surveyed were from White British background. 47% were from ethnic groups. 1% did not say. 20 (17%) of the ethnic minority women surveyed had been in the UK for less than five years. See Figure 6.

*Figure 6: Ethnicity of survey participants*
6.2 Breastfeeding support in pregnancy

6.2.1 Information and support received in pregnancy
We have found from our survey that of the practitioners that were available to offer support in pregnancy to women, the Community Midwife was rated as offering the best support by 149 (59%) of survey participants. Please see Figure 8.

Figure 8: Support in pregnancy

We asked about the breastfeeding support received in pregnancy: of the 225 who answered, 109 (49%) stated it helped them to decide how to feed their baby. 102 (45%) women said the support they received did not help them to decide how to feed their baby due to already having decided to breastfeed due to personal choice; previous knowledge already having other children or a cultural reason. 14 (6%) did not answer this question.

Comments included:
- “Personal choice”
- “In India Asian women breastfeed because of the culture”
- “Already had the knowledge”
- “This is my 3rd baby so already decided with the other two.”

6.1.2 Gaps in accessing breastfeeding support in pregnancy
In relation to their experience of breastfeeding, 20 out of 251 (8%) advised that they had issues in trying to access general advice and information. Some women also said that they had had a lack of support and advice in pregnancy, with no one to one or group support and getting information from reading leaflets only.

6.1.3 Suggested changes
38 survey participants (15% or the sample) gave comment on changes they would like to see to breastfeeding advice and support in pregnancy.

The most common responses were:

1. More information/advice
2. More assistance during pregnancy including practical advice
3. More support
4. More awareness
5. More groups accessible to working mothers
6. Posters about breastfeeding

50 (20%) stated they would like to see no change and were happy in the way breastfeeding support in pregnancy is currently being offered.

163 (65%) people did not answer this question. Generally in surveys participants that do not answer questions are more likely to be happy with the service than not happy, and in this instance it may also have been because they did not feel they needed support.

6.2 Support in hospital

6.2.1 Initiation

The mother is defined as having initiated breastfeeding if, within the first 48 hours of birth, she either puts the baby to the breast or the baby is given any of the mother’s breast milk.

Initiation of breastfeeding can be interpreted differently and varies from practitioner to practitioner. This is something however which is acceptable for performance monitoring criteria at present.

200 (80%) of survey participants said they had initiated breastfeeding; this is higher than the city and national average. 172 (69%) exclusively breastfeed whilst in hospital, which is lower than the national and local average.

28 (11%) women mixed fed/partially breastfed in hospital. In the first few weeks after birth ten went on to exclusively breastfeed and 15 continued to partially feed, three went on to bottle feed.

In the guided survey and focus groups some women that had C-sections commented that they had no skin to skin contact immediately after birth, there was a delay, or they had to request it. At UHCW the policy is that skin to skin is offered after C-sections but they have stated a majority of women prefer this in the recovery room half an hour after delivery due to the environment and comfort. Consideration however could be given to offering skin to skin contact to all women as soon as possible after birth.

62 (25%) women stated they were not shown how to put the baby to the breast this was mostly due to reasons shown in Figure 9:
6.2.2 Following national good practice

In our guided survey we collected additional information regarding national good practice. 21 (81% of the sample of 25) women were encouraged to breastfeed on demand; some women were separated from their baby and were shown how to maintain breastfeeding even when separated.

11 (42% of 25) stated they were recommended to avoid bottles, dummies and nipple shields whilst in the hospital and were told this by the Breastfeeding Team, Hospital, Midwives, NCT, or Hospital Breastfeeding Peers.

13 (50% of 25) women were told not to offer baby food or drink for the first 6 months; they received this information from the Hospital Midwife, magazines and knowledge from past pregnancies, MAMTA and NCT.

6.2.3 Quality of support

We asked respondents to rate the support provided by the different breastfeeding professionals in the hospital. 151 respondents rated the support from the hospital midwife as good or very good. Please see Figure 10.

Figure 9: Reasons why women were not shown how to put baby on breast

<table>
<thead>
<tr>
<th>Reason</th>
<th>Number of Women</th>
</tr>
</thead>
<tbody>
<tr>
<td>Had previous children</td>
<td>20</td>
</tr>
<tr>
<td>Didn't know why</td>
<td>10</td>
</tr>
<tr>
<td>Instinctively knew</td>
<td>5</td>
</tr>
<tr>
<td>Staff busy/short staffed/not supportive</td>
<td>10</td>
</tr>
<tr>
<td>Medical reasons</td>
<td>5</td>
</tr>
<tr>
<td>Chose to bottle feed</td>
<td>5</td>
</tr>
<tr>
<td>Didn't comment</td>
<td>5</td>
</tr>
</tbody>
</table>

Figure 10: Support in hospital

- **Hospital Midwife**
- **Other staff that support breastfeeding**
- **Infant feeding team**
49 (60% of the 81 women who replied to this question) stated that they had no barriers in accessing breastfeeding support in hospital and were happy with the service received. Of the 32 (40%) women who did have barriers the majority found that they needed more support, or the staff were too busy or short staffed to help them.

6.2.4 Preferred choice

23 women (9%) within the self-completion and guided survey said they did not achieve their preferred choice in breastfeeding their baby after birth, this was mostly because they felt they could not get the baby to latch on to the breast or they felt they were not producing enough milk to feed their baby and therefore gave formula. 201 (80%) women said they did achieve their preferred choice and 27 (11%) didn’t answer this question.

Women did not identify in all cases, exactly who advised them. Phrases like ‘they told me’ or ‘I was told’ were repeatedly used. Comments included:

- “I always wanted to breastfeed but baby wasn’t latching on properly. Midwife suggested to give formula (I was disappointed)”
- “Baby did not latch on so gave up because baby was hungry”
- “Had problems with breastfeeding (really painful) in hospital, because hospital staff didn’t have time to show me how to attach baby properly, only helped me to give baby breast, but I never managed to do it myself in hospital. Very disappointed”

Some women from the focus groups and 32 (13%) out of the 251 women from the surveys said that there were additional barriers and gaps in the support received in hospital including the perception there were not enough staff; when breastfeeding was not successful being advised to switch to formula instantly; and inconsistent advice from different hospital staff. Sometimes support was not immediately after the baby was born but some hours later.

Comments included:

- “Not aware of other teams. Midwife too busy to help a lot of the time”
- “They didn’t help really, it was kind of just help yourself, they said just give her a bottle”
- “Took me a day to ask for help”
- “Language barrier”

6.2.5 Tongue tie

Nine women found that their babies had tongue tie. Some women had to go to Dudley to get this cut. Others found that once they had diagnosis, they were shown how to feed better. Some women chose to use bottles until it was cut.

We found that a tongue tie was not always identified before discharge.
Comments included:

- Baby had tongue tie so had to do mixed feeding until it was cut. Then all breastfeeding.
- Hospital didn’t realise baby was tongue tie at first – I was trying to breastfeed. Once diagnosed with baby fed properly. Hospital could explain how to feed better
- Didn’t treat because baby was putting on weight even though distressed
- ‘My baby lost so much weight due to tongue tie then they told me to give formula milk. This was only picked up in the breastfeeding support group.’

Women from the focus groups who had issues with tongue tie asked for procedures to ensure identification within the hospital and services in Coventry to support treatment rather than having to travel for specialist services.

6.2.6 Suggested changes

The women were asked what changes, if any, they would like to see in the breastfeeding support given to them in hospital. 69 (27%) of women surveyed stated they would like to see changes. The most common responses were:

- More support
- More staff/ time with staff

Changes identified from the focus group:

- Women wanted more assistance on breastfeeding
- More support and to ‘listen to mum’
- More information on expressing
- More staff availability especially for first time mums
- With C-sections allowing to put the baby on the breast/ skin to skin contact

Other comments included:

- ‘I felt really isolated, no one helping you, baby crying it was a bad experience’
- ‘Neonatal care- said give your baby formula milk so this was very discouraging for breastfeeding mum’

48 (19%) of women surveyed stated there should be no change with the services immediately after birth, reporting no issues with the support they received or highlighted good practice. 134 (53%) women did not answer this question.

6.2.7 Professionals’ contact details

UHCW policy is to refer breastfeeding and partially feeding women to the Infant Feeding Team, however 28 (16%) of the women who initiated breastfeeding in hospital stated they were not given contact details of the health professional support available for feeding issues once they had left hospital. Point 10 of the UNICEF guidelines states, services should ensure that mothers know how to access these
prior to discharge from hospital. Just 7 of the 25 women from the guided survey said they were referred to other services.

6.3 Support in the community and at home

6.3.1 Duration of breastfeeding

Figure 11 shows the feeding status of babies at the time surveyed.

*Figure 11: Feeding status of babies at time of survey*

![Feeding status of babies at time of survey](image)

6.3.2 Influence on breastfeeding

Respondents gave the influences on their choice to breastfeed, giving detail of more than one influence if this was relevant to them:

<table>
<thead>
<tr>
<th>Influence</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Convenience</td>
<td>78</td>
</tr>
<tr>
<td>Health Professionals</td>
<td>76</td>
</tr>
<tr>
<td>Families</td>
<td>57</td>
</tr>
<tr>
<td>Cost</td>
<td>42</td>
</tr>
<tr>
<td>Medical</td>
<td>38</td>
</tr>
<tr>
<td>Religious/cultural practice</td>
<td>24</td>
</tr>
</tbody>
</table>

6.3.3 Quality of support

Of the practitioners that were available to offer support in the community the Community Midwife was rated as offering positive support by 89 (35%) of survey respondents.

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16 UNICEF (1992), *Ten steps to successful breastfeeding* www.unicef.org.uk
participants. Participants were able to tick more than one option. In the home setting the Community Midwife was again said to offer positive support by 115 women (46%).

156 (84%) of the 185 women that answered the question, were advised of the benefits of breastfeeding at home after birth. The majority 148 (80%) said this was by their Midwife and/or Health Visitor. Following that the infant feeding team-breastfeeding peers were rated as offering good support. The same response was found within the focus groups. In the areas where FWT - MAMTA operate they were rated as offering a good service within the ethnic groups.

51 (74%) of 69 women who responded to this question stated that they had no barriers in accessing breastfeeding support in the home.

153 (92%) of 167 women who responded to this question felt the support they received was right for them in the community.

*Figure 12: Support in community*

51 (71%) of 72 women who answered stated that they had no barriers in accessing breastfeeding support in the community and the support in Children’s Centre being good in general.

Comments included:
- “Midwife was very good, helpful and supportive”
- “It was right because I managed to breastfeed for a long time”
- “The breastfeeding session with MAMTA was very thorough”

**6.3.4 Gaps in accessing breastfeeding support at home and the community**

69 women answered this question. 18 felt they needed more support at home with feeding. 14 felt the support received was not right for them. Some comments were made on not getting a response from the helpline when called.
Other comments included:

- “As a first time mum I felt I had little support, all I was told was keep going, it’s not easy”
- “Took me ages to get through to helplines, health visitor didn’t return calls”
- “Husband should be educated as well”

Within the focus group analysis, some women felt that they had received mixed messages by some health professionals and received differing professional advice.

6.3.5 Mixed/partially feeding

Some women partially breast fed in the initial stages because their babies were in special care or the mother had had a c-section or they stated the baby was still hungry. Some of these women went on to exclusively breastfeed upon leaving hospital. Of the 130 women who breastfed in the initial stages 18 (14%) stated they went on to mixed feed/partially feed at 2/3 months.

6.3.6 Switching from breastfeeding to bottle

Some women within the surveys said they had had a lack support and hence went onto bottle-feed and others said their baby was not latching.

Comments included –

- “My baby wasn’t getting enough milk so I started to top up with bottle. Midwife and Health visitor suggested that I can top up with bottle. They were supportive”
- “Health professional’s advice to change to bottle-feeding too quickly.”
- “Weight issue for baby I was advised to give 1 bottle a day”

Six women intended to breastfeed but did not get support so said they bottle fed instead.

6.3.7 Breastfeeding facilities

94 (54%) of the 173 women who answered felt there were not enough breastfeeding facilities when they were out in the community. Some women stated they were too embarrassed or shy to feed when out. Comments included:

- “Not seen breastfeeding sign, where ever you go you will see a bottle warming sign”
- “In some cafés people still staring at you while breastfeeding in public, even if it’s officially allowed anywhere.”
- “It would be nice to have more public places just for feeding the baby not mixing nappy changing rooms and feeding rooms, because I wouldn’t mix food and toilets.”

Other Comments:

- “Shy because nowhere to breastfeed.”
- “Did not get information where to feed.”
- “I felt embarrassed to feed in public”
City centre outlets are encouraged to promote breastfeeding via an up to date directory of Baby Friendly premises currently supported through CHIP funding until March 2014. These directories are only given to mums that are seen by the Infant Feeding Team.

Some women commented that issues around finding a place to breastfeed was a reason for them to start to mix feed as they felt shy while breastfeeding outside and the general public would make remarks when women chose to breastfeed.

**Table 2: What did or will influence decisions to stop breastfeeding**

<table>
<thead>
<tr>
<th>Influence</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family issues</td>
<td>4</td>
</tr>
<tr>
<td>Work issues</td>
<td>24</td>
</tr>
<tr>
<td>Professionals advice</td>
<td>8</td>
</tr>
<tr>
<td>Not enough support</td>
<td>13</td>
</tr>
<tr>
<td>Personal choice</td>
<td>76</td>
</tr>
<tr>
<td>Medical reasons</td>
<td>47</td>
</tr>
<tr>
<td>Time management Factor</td>
<td>18</td>
</tr>
<tr>
<td>Tongue tie</td>
<td>14</td>
</tr>
<tr>
<td>Baby not settling</td>
<td>53</td>
</tr>
<tr>
<td>Cultural reasons</td>
<td>1</td>
</tr>
</tbody>
</table>

The main reasons documented for women stopping feeding were personal choice and the baby not settling. Other comments included:

- “*When I or baby is ready*”
- “*Weaning*”
- “*Teeth or biting*”
- “*Baby not gaining weight or lack of milk*”

Women from the focus groups agreed the support received influenced choice of feeding. When women were asked on their influences to stop breastfeeding women advised:

- ‘*Will stop when return to work*’
- ‘*Will breastfeed for as long as possible*’
- ‘*Weaning*’
- ‘*Wasn’t producing enough milk so stopped*’

**6.3.8 Preferred method of support around feeding**

Respondents were asked which had been their preferred method of support and the responses are as follows:

**Table 3: Preferred method of feeding support**

<table>
<thead>
<tr>
<th>Method</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>One to one</td>
<td>114</td>
</tr>
<tr>
<td>Groups</td>
<td>80</td>
</tr>
<tr>
<td>Professional support</td>
<td>57</td>
</tr>
<tr>
<td>Different settings e.g. home visit</td>
<td>50</td>
</tr>
<tr>
<td>Flyers/leaflets</td>
<td>44</td>
</tr>
<tr>
<td>Cultural support</td>
<td>20</td>
</tr>
</tbody>
</table>
103 of the 167 women who answered the question ticked more than 1 box. The most preferred method for breastfeeding support was one to one, followed by group support, which is currently being offered in Coventry. Comments included:

- “One to one/home visit – both are needed; sometimes you don’t want to ask questions in a group but also at other times need support of group”
- “Flyers – read in own time carry around with me”
- “Home visit/cultural Support with language support”
- “One to one – during breastfeeding attempts my babies couldn’t latch on, hospital staff (NNU) excellent but at home would have preferred guidance during breastfeeding attempts”

### 6.3.9 Suggested changes

Some women said there should be more support, reassurance and visits from infant feeding team and professionals. 57 comments were made that stated women would like to see changes in their breastfeeding support in the first few weeks after birth and from eight weeks to six months. 100 comments from the surveys stated there should be ‘no change’ with the services offered in the postnatal period. Suggested improvements were:

- More information on breastfeeding;
- 1-1 support after birth, postnatal classes and weaning advice
- More breastfeeding in public places - more friendly areas
- Advertisement/promotion of antenatal classes and breastfeeding groups
- Consistent advice from health professionals
- Encouraging adverts and images on television

### 6.4 Bottle feeding

75 women stated in the surveys that they had bottle fed or partially fed in hospital. Out of these only 14 (19%) stated they were shown how to make up a bottle feed by a professional:

- 9 by a Hospital Midwife
- 1 by a Health Visitor
- 2 by a Community Midwife
- 1 by a Health Visitor and Hospital Midwife
- 1 By a Health Visitor and Community Midwife

11 (15%) felt supported in their choice of bottle feeding.

### 6.5 Findings by deprivation, ethnicity, age and employment

This section analyses the findings by where women lived (ie how deprived the area is); ethnicity; age; and employment status. This data is drawn mostly from the self-completion survey results and includes common issues drawn from the guided survey and focus groups.
6.5.1 Deprivation

The chart below shows the proportion of survey participants across all five quintiles of deprivation within Coventry. Quintile 1 being the most deprived areas of the city and Quintile 5 the least deprived (according to the government’s multiple indices of deprivation data). Please refer to map in (Appendix 6)

Figure 13: Ward areas where survey participants lived shown by quintile of deprivation

6.5.2 Planning to breastfeed pre- birth

A higher percentage of women in more affluent quintiles planned to breastfeed as shown below:

Table 4: Percentage of women planned to breastfeed from the self-completion survey

<table>
<thead>
<tr>
<th>Quintile</th>
<th>Planned to breastfeed pre birth</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quintiles 1 and 2 (Least Affluent) – sample 174 women</td>
<td>126 (72%)</td>
</tr>
<tr>
<td>Quintiles 4 and 5 (Most Affluent) – sample 57 women</td>
<td>52 (91%)</td>
</tr>
</tbody>
</table>

6.5.3 Breastfeeding status

Table 5 shows how women were feeding their babies immediately after birth within these quintiles.
## Table 5: Feeding status after birth

<table>
<thead>
<tr>
<th></th>
<th>Least affluent (Quintiles 1 and 2)</th>
<th>Most affluent (Quintiles 4 and 5)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Initiated breastfeeding or partial feeding</td>
<td>135 (77%)</td>
<td>49 (86%)</td>
</tr>
<tr>
<td>Bottle-feeding in hospital</td>
<td>36 (21%)</td>
<td>8 (14%)</td>
</tr>
<tr>
<td>Didn’t state</td>
<td>3 (2%)</td>
<td>0</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>174</strong></td>
<td><strong>57</strong></td>
</tr>
</tbody>
</table>

## Figure 14: Breastfeeding status by least and most affluent quintiles

A higher percentage of affluent women initiated breastfeeding; were breastfeeding when babies were a few weeks old and at 2/3 months old. A higher proportion of women from the least affluent areas were bottle feeding. This is similar to the national picture that shows that women from lower socio-economic groups have lower breastfeeding rates than those from higher socio-economic groups.

### 6.5.4 Partial/mixed feeding

In both the least and most affluent areas, for women with babies at 6 months old when surveyed, partial feeding had increased at 2-3 months then went down again at 6 months as more women changed over to bottle feeding.

### 6.5.5 Support offered

High satisfaction ratings were given to Midwives. Similar ratings were recorded for the Health Visiting and Infant Feeding Team – Breastfeeding Peers.

Of the practitioners that were available to offer support in pregnancy, MAMTA were rated as giving good support within the most deprived areas where they operate, and where ethnic minorities reside and NCT within the more affluent areas. More women
from the lower quintiles reported concerns regarding there being a limited amount of staff in the hospital.

Comments included:

- “Breastfeeding is good but hard at first and wasn’t prepared for this, lack of support in my area because it is not considered deprived”
- “All over experience was very good, well supported in hospital, community

In the first few weeks there were similar influences for breastfeeding continuation: professionals, family and convenience across the quintiles. However with some ethnic minority and lower quintile communities, faith influenced some women to breastfeed.

In the affluent areas women were generally happier with the support received. In the lower quintiles women more frequently stated there was a lack of support, and said their baby was not latching and were concerned their baby was not getting sufficient nourishment from breastfeeding. They also reported more mixed messages from practitioners.

Most of these primary reasons for stopping breastfeeding could be resolved the access to trained breastfeeding support consistent with UNICEF and national guidelines.

From the lower quintiles:

- 16 (9%) women felt there were gaps / barriers in breastfeeding support with antenatal classes, and breastfeeding sessions
- 23 (13%) wanted more staff and more support in hospital
- 13 (7%) wanted more home visits
- 21 (12%) wanted more breastfeeding facilities in the community.

6.6 Ethnic Minority Communities

6.6.1 Planning to breastfeed pre birth

From the self-completion survey data more Ethnic Minority women planned to breastfeed pre-birth compared to White British women.

Table 6: Women who planned to breastfeed (taken from the self – completion survey)

<table>
<thead>
<tr>
<th>No of women</th>
<th>Planned to Breastfeed Pre birth</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ethnic minority women</td>
<td>101</td>
</tr>
<tr>
<td>White British women</td>
<td>122</td>
</tr>
<tr>
<td>Didn’t state ethnicity</td>
<td>2</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>225</strong></td>
</tr>
</tbody>
</table>
### 6.6.2 Breastfeeding status

The table below shows how women were feeding their babies immediately after birth within these categories.

**Table 7: Feeding status after birth (taken from both surveys)**

<table>
<thead>
<tr>
<th></th>
<th>Ethnic Minority women</th>
<th>White British women</th>
</tr>
</thead>
<tbody>
<tr>
<td>Initiated breastfeeding or partial feeding</td>
<td>102 (86%)</td>
<td>97 (74%)</td>
</tr>
<tr>
<td>Bottle feeding in hospital</td>
<td>15 (13%)</td>
<td>32 (24%)</td>
</tr>
<tr>
<td>Did not state feeding status</td>
<td>1 (1%)</td>
<td>2 (2%)</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>118</strong></td>
<td><strong>131</strong></td>
</tr>
</tbody>
</table>

**Note: 1% of participants who completed the surveys did not state their ethnicity**

The age of babies at the time of the survey and how they were fed at home is shown in Figure 15.

**Figure 15: Breastfeeding status for ethnic minority and white British women**

Unusually this data shows more White British women breastfeeding at 2/3 months than had been in the first few weeks. This is based on what women told us.

Women from ethnic minority communities initiated and breastfed for longer compared to White British women.
6.6.3 Partial/mixed feeding

For the ethnic minority women with babies over 6 months old partial feeding increased from birth until 3-5 months when it went down slightly as breastfeeding went down and bottle-feeding increased. For the White British women, partial feeding increased over the first 3-5 months but no-one was partial feeding at 6 months. Bottle feeding also increased.

6.6.4 Support offered

Of the practitioners that were available to offer support in pregnancy the Community Midwife was rated highly for the support provided for the ethnic minority women. For White British women in the community and at home they rated their Midwife, Infant Feeding Breastfeeding peers highest for breastfeeding support, followed by their Health Visitor.

Of the women in the focus groups some women had no interpreter booked so had problems understanding hospital staff.

The time women delivered had an impact on the type of breastfeeding support offered. Women that delivered at the weekend and evening commented on lack of interpreters and staffing.

Women said that in some cultures breastfeeding is encouraged. However some women that they were new to the country said they had considered planning to bottle feed after birth having seen women bottle feeding in this country or had done for previous children but decided to breastfeed after attending antenatal classes.

The Millennium Cohort Study\(^{17}\) emphasises the importance of changing the culture of the city into one which supports breastfeeding and reduces the number of women in new communities who think that bottle feeding is the route to follow because it is the “western” way.

The following were the main influences on feeding choices in the first few weeks after birth:

### Table 8: influences on feeding choices

<table>
<thead>
<tr>
<th>Ethnic minority women</th>
<th>White British women</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health Professionals</td>
<td>Health Professionals</td>
</tr>
<tr>
<td>Family</td>
<td>Family</td>
</tr>
<tr>
<td>Convenience</td>
<td>Convenience</td>
</tr>
<tr>
<td>Cost</td>
<td>Cost</td>
</tr>
<tr>
<td>Religion/ Culture</td>
<td>Religion/ Culture</td>
</tr>
<tr>
<td>Medical issues</td>
<td>Medical issues</td>
</tr>
</tbody>
</table>

Influences on feeding choice for women within the focus groups were the advice they received in pregnancy and other experiences after birth. Culture and family also played an important part in choice and influence on how long to feed.

\(^{17}\) Griffiths LJ et al (2005), *The contribution of parental and community ethnicity to breastfeeding practices: evidence from the Millennium Cohort Study*
The majority of ethnic minority women who lived in the most deprived areas felt their cultural needs were met through the culturally sensitive services delivered by FWT MAMTA in partnership with the Maternity and Infant Feeding Team. Focus group respondents had mostly attended women only classes with FWT-MAMTA with language support and said it had influenced them in choosing breastfeeding.

Positive comments were given about health professionals at home and in the community after birth. The Infant Feeding Breastfeeding peers guided and supported some women on the phone and at home and explained how to breastfeed. FWT-MAMTA was also mentioned as offering good postnatal support in the community.

Cultural sensitivity to breastfeeding in public places came up as an issue in this community for example:

“In our culture mothers breastfeed, when I came to England I found limited places to feed”

Some White British women felt embarrassed to feed in public. A woman who attended a baby show got complaints when she breastfed.

Other comments included:
- “Explanation on importance of breastfeeding can help women to decide”
- “Clear information can help you change your mind from intending to bottle to breastfeed. ‘I bottle fed my first child when I came to England as I thought that was best, then I came to MAMTA classes and found it was best for me and my baby so decided in pregnancy to breastfeed”
- “Continue with classes – really helps”

National evidence shows where a person lives and ethnic background influences breastfeeding choice. The Millennium Cohort Study\(^\text{18}\) stated that white disadvantaged mothers are least likely to breastfeed however white lone mothers were more likely to initiate breastfeeding if they lived in areas with a high proportion of ethnic minority communities.

6.7 Age

The age of the survey participants within the quintiles of deprivation in Coventry is shown in figure 16.

\(^{18}\) Griffiths LJ et al (2005), *The contribution of parental and community ethnicity to breastfeeding practices: evidence from the Millennium Cohort Study*
Figure 16: Age versus quintile

6.7.1 Planning to breastfeed
The 21–34 year age group had the highest intention to breastfeed pre-birth. The under 20’s had the lowest intention to breastfeed in pregnancy out of all the age groups surveyed.

Table 9: Percentage of women who planned to breastfeed (from the self completion survey)

<table>
<thead>
<tr>
<th>Number of women per age group</th>
<th>Planned to breastfeed pre birth</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under 20</td>
<td>16</td>
</tr>
<tr>
<td></td>
<td>9 (56%)</td>
</tr>
<tr>
<td>21-34</td>
<td>169</td>
</tr>
<tr>
<td></td>
<td>143 (85%)</td>
</tr>
<tr>
<td>35-44</td>
<td>36</td>
</tr>
<tr>
<td></td>
<td>26 (72%)</td>
</tr>
<tr>
<td>Not stated</td>
<td>9</td>
</tr>
</tbody>
</table>

6.7.2 Breastfeeding status

Table 10 shows how women were feeding their babies immediately after birth within these age groups.

Table 10: Feeding status after birth

<table>
<thead>
<tr>
<th>Initiated breastfeeding or partial feeding</th>
<th>Under 20</th>
<th>21-34 years</th>
<th>35-44 years</th>
</tr>
</thead>
<tbody>
<tr>
<td>8 (50%)</td>
<td>150 (79%)</td>
<td>37 (88%)</td>
<td></td>
</tr>
<tr>
<td>Bottle-feeding in hospital</td>
<td>8 (50%)</td>
<td>35 (19%)</td>
<td>5 (12%)</td>
</tr>
<tr>
<td>Didn’t state</td>
<td>0</td>
<td>4 (2%)</td>
<td>0</td>
</tr>
<tr>
<td>Total</td>
<td>16</td>
<td>189</td>
<td>42</td>
</tr>
</tbody>
</table>
Figure 17 shows the age of babies at the time of the survey and how they were fed at home.

**Figure 17: Duration of breastfeeding within age groups**

A higher percentage of women within the 35-44 age group initiated breastfeeding. At 6 months higher proportions of the 21-34 were breastfeeding.

### 6.7.3 Support offered

From all ages of participants, the Community Midwife was rated as offering the best support in pregnancy and the Infant Feeding /Breastfeeding Peers were mentioned as offering good support after birth.

There were 16 under 20 year olds surveyed and of these 11 were White British; 14 were born in the UK and 15 were from the most deprived areas of the city. More support on feeding and choice was requested by this group of respondents. There were some comments on a lack of support within the hospital. Comments included:

- *Midwife just put baby on the breast and left me, I was very annoyed that she didn’t explain to me.*
- *Doctors, nurses didn’t show me*

Of the women who planned to breastfeed initially from this age group and did not, two bottle-fed. One gave the reason of:

- *“Underestimated me because I am a teenage mum, didn’t support and help me so that I can breastfeed like other mums, I felt discriminated because of my age.”*

Convenience was stated as being the biggest influence on breastfeeding over the first six months. The under 20 group said that they would have benefited from more advice, and sessions specifically for teenage mums.
Teenage mothers are half as likely nationally to breastfeed as older women and our findings are in line with this. Within this survey this group also had the lowest intention to feed pre-birth and initiation rates were very low.

Influences on feeding choice for the 21-34 age groups were convenience, health professional at 58 (34%) and family 47 (28%).

Respondents from the 35-44 age group said their main influence on feeding was family. Of the practitioners offering breastfeeding support, the Community Midwife was rated as offering the best support in the home and the Health Visitor in the community and generally they were very satisfied with the services offered.

This age group seemed to be more informed about choice and had the highest initiation rates within the age groups: higher than local and national averages, however the sample size is small. National surveys have shown that older mothers are more likely to breastfeed. Across the UK as a whole breastfeeding rates were lowest among mothers under the age of 20 and highest among mothers aged 30 and over.

6.8 Employment Status

6.8.1 Planning to breastfeed pre birth

Table 11 shows that the employed women in our sample had the highest intention to breastfeed pre-birth.

<table>
<thead>
<tr>
<th>Number of women by employment status</th>
<th>Planned to breastfeed pre birth</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employed women</td>
<td>79 (31%)</td>
</tr>
<tr>
<td>Unemployed women</td>
<td>90 (36%)</td>
</tr>
</tbody>
</table>

6.8.2 Breastfeeding status

Table 12 shows how women were feeding their babies immediately after birth within these categories.

<table>
<thead>
<tr>
<th>Feeding status after birth</th>
<th>Employed</th>
<th>Unemployed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Initiated breastfeeding or partial feeding</td>
<td>84 (84%)</td>
<td>89 (74%)</td>
</tr>
<tr>
<td>Bottle-feeding in hospital</td>
<td>16 (16%)</td>
<td>29 (24%)</td>
</tr>
<tr>
<td>Didn’t state</td>
<td>0</td>
<td>2 (2%)</td>
</tr>
<tr>
<td>TOTAL</td>
<td>100</td>
<td>120</td>
</tr>
</tbody>
</table>

Figure 18 shows breastfeeding trends in the community for employed and unemployed women. From the women surveyed, higher proportions of employed women initiated breastfeeding and were breastfeeding a few weeks after birth. At 2-3 months this figure drops and slightly higher percentages of unemployed women are breastfeeding up to 6 months.

---

19 Infant feeding survey 2010 (early results)
20 Infant feeding survey 2010 (early results)
6.8.3 Partial/mixed feeding

For survey participants whose baby was over 6 months old there were slightly different patterns of mixed feeding:

For employed women mixed feeding stayed at 16% from the first few weeks to 3-5 months. At 6 months it dropped to 10%.

For unemployed women mixed feeding increased from 10% in the first few weeks to 24% at 3-5 months then back down to 18% as bottle feeding increased from 18% in the first few weeks to 47% at 6 months.

6.9.4 Support and issues

Both the unemployed and employed women rated their Community Midwife as offering the best support in pregnancy.

The main influences on unemployed women to breastfeed in the first few weeks were:

- Convenience 47
- Health Professional 44
- Family 34

The main influences for employed women to give up breastfeeding were given as personal choice (9) and returning to work (5) in the more affluent areas. In the least affluent the main reasons were given as personal choice (12) and medical reasons (8).
In national surveys the highest incidences of breastfeeding were found among mothers from managerial and professional occupations, those who were aged 18 when they left full-time education, those aged 30 or over, and among first time mothers.\textsuperscript{21}

Increasing the uptake and duration of breastfeeding particularly in low income groups is a government inequality target.

### 7. Analysis of local breastfeeding services

Interviews and feedback was taken from the main providers, listed below, within the city on their role in supporting breastfeeding.

- Maternity Services UHCW
- Infant Feeding Team
- FWT-MAMTA- a voluntary health service addressing BME child and maternal health
- Health Visiting Service
- FNP intensive nurse-led home visiting, vulnerable first time young parents from early pregnancy until child is two
- NCT- National Childbirth Trust
- Childrens Centres

The Public Health Department, a commissioner of some breastfeeding services, was also consulted.

#### 7.2 Breastfeeding service providers and good practice

##### 7.2.1 Coventry Positive about Breastfeeding Project 2007-2009

In Coventry the 2006/07 target was 67\% for breastfeeding initiation, and the actual rate was 62.8\% and below target. Following a needs analysis which revealed that Coventry communities had a very low uptake of breastfeeding as well as high infant mortality rates, a strategic approach was developed from September 2007, to bring all the breastfeeding project plans and work together in the form of one strategy. A multi-agency team formed the Breastfeeding Steering Group project which ran to 2009. It worked to raise awareness about the benefits of breastfeeding among new mothers, particularly young women living in deprived areas in Coventry. Find out more in (Appendix 3)

In 2009 this project ceased and the breastfeeding partnership work in the city was channelled through Coventry’s Health Improvement Programme (CHIP).

\textsuperscript{21} Infant feeding survey 2010 (early results)
7.2.3 NHS Coventry, Public Health & Coventry Reducing Infant Mortality Project

Public Health is responsible for improving the health of the population of Coventry. A key public health priority is to improve breastfeeding rates and monitor the breastfeeding initiation and breastfeeding 6-8 weeks rates after birth. Within their current child health remit they commission services to support women to breastfeed and have an influence over service delivery specifications with regards to breastfeeding within Coventry.

Public Health supports the overall breastfeeding strategy implementation in Coventry and has funded the accreditation stages of the UNICEF Baby Friendly Accreditation in community settings.

CHIP is a NHS Coventry and Coventry City Council initiative working together to improve the health of the people in Coventry and reduce health differences in areas of the city. A wide range of projects and initiatives have been supported and funded through CHIP including the Reducing Infant Mortality project, which Public Health project manages. These joint ventures under CHIPS’ Infant Mortality work streams have provided the funding resource since 2009.

Funding investment has been provided for targeted support by commissioning the Infant Feeding Team - Breastfeeding Peers Programme delivering city wide within areas of deprivation and the FWT- MAMTA service delivering to ethnic minority communities.

Additionally a joined up working approach with Childrens Centres, UHCW maternity services, Health Visiting Services, and other practitioners including the Family Nurse Partnership (FNP), Council Teenage Pregnancy Lead, Obesity Leads, Substance Misuse Lead, Smoking in Pregnancy Team, Health Development Unit, Children Centres and Primary Care, has been undertaken.

7.2.3 Current support provision

The table below summarises an analysis of the current breastfeeding service provision within Coventry:
<table>
<thead>
<tr>
<th>Service Provider &amp; Funder</th>
<th>Breastfeeding Service Delivery</th>
<th>Good Practice</th>
<th>Issues &amp; Gaps</th>
</tr>
</thead>
<tbody>
<tr>
<td>UHCW Funded by Primary Care Trust (PCT), Arden Cluster</td>
<td>1. Provide information to all pregnant women in the community at first booking appointments give leaflet and advise on benefits 2. Parent-craft classes city wide with breastfeeding element delivered by Coventry University as a generic parent craft not specific to any target audience other than antenatal women 3. Provide and record first feed support ‘initiation’ in the hospital for all mums that deliveries at UHCW as part of performance indicators and within service specification 4. Postnatal support feeding issues if they arise within clinics and if needed in the home with feeding.</td>
<td>Two part time Infant Feeding Co-ordinators in hospital with the role of clinical audit; training frontline staff; reviewing data collection; development of feeding policies; supporting women and staff with feeding issues; co-ordinating UNICEF BFI accreditation UNICEF Baby Friendly Accreditation to Stage 1 working to Stage 2 again and trying to address issues aiming to achieve more collaborative ways of working across professions. Mandatory UNICEF Training for all frontline staff ensuring consistent messages promoting breastfeeding Initiation rates are higher compared to city average at present</td>
<td>Infant Feeding position does not cover weekends or evenings Difficulty accessing teenage mothers, non-compliance within this group Did not achieve initial attempt of UNICEF Stage 2 Not consistently achieving new initiation target of 77% since March 2011.</td>
</tr>
<tr>
<td>Infant Feeding Service Funded by CHIP and Part funded by Public Health for UNICEF Baby Friendly Accreditation</td>
<td>1. Provide support to all women in Coventry with feeding choices and issues after delivery- in groups across the city, at home and some days in the hospital. Helpline also available 2. Co-ordinate the community UNICEF Baby Friendly Initiative</td>
<td>Role of infant feeding co-ordinator in the community includes annual mandatory training of frontline professionals; development of infant feeding strategy; co-ordinating UNICEF BFI accreditation; managing breastfeeding peers.</td>
<td>Funded only until March 2014</td>
</tr>
<tr>
<td>Service Provider &amp; Funder</td>
<td>Breastfeeding Service Delivery</td>
<td>Good Practice</td>
<td>Issues &amp; Gaps</td>
</tr>
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</tr>
<tr>
<td>Health Visiting</td>
<td>1. Provide support to all women in Coventry with advice on feeding and health conditions. 2. Postnatal visits made at 10-14 days where feeding support given. 3. Breastfeeding in service specification to increase breastfeeding rates 4. Record continuation rates</td>
<td>Benefits of breastfeeding given Improvements in their service delivery around breastfeeding have been seen within the team by working towards the UNICEF baby friendly status</td>
<td>Responding quickly can be a constraint. Capacity issues noted recently. Responding to Call to Action, plans underway to increase staffing within the service and the implementation of Healthy Child Programme specifically</td>
</tr>
</tbody>
</table>

3. Co-ordinate the breastfeeding strategy with partners in the city
4. Dedicated infant feeding co-ordinator

The service offers group and 1-1 support city wide

Baby Friendly UNICEF Stage 2 accreditation achieved.

Working towards UNICEF Stage 3 focusing on antenatal support.

6-8 week breastfeeding duration rates for the service are higher than the city and national average of 60% within its user group.

Peer support similar to other national good practice initiatives.
<table>
<thead>
<tr>
<th>Service Provider &amp; Funder</th>
<th>Breastfeeding Service Delivery</th>
<th>Good Practice</th>
<th>Issues &amp; Gaps</th>
</tr>
</thead>
<tbody>
<tr>
<td>5. Referral and signposting to agencies for further breastfeeding support</td>
<td>MAMTA reaching out to vulnerable communities and supporting communication language barriers</td>
<td>Incorporating indicators for breastfeeding.</td>
<td><strong>Utilisation of the infant feeding team has assisted health visiting with response rates for breastfeeding issues recently.</strong></td>
</tr>
<tr>
<td>MAMTA (funded by NHS Coventry), managed by Public Health, CHIP.</td>
<td>Within Public Health’s Infant Mortality project, MAMTA’s key objective is to promote the importance of breastfeeding in key areas which have historically the highest ethnic communities and seen some of the highest increase in birth rates.</td>
<td>Recognised as a good practice service by DOH and external reports</td>
<td><strong>Funded to deliver in two wards only – when BME health inequalities are citywide</strong></td>
</tr>
<tr>
<td>1. Providing support to BME women during and after pregnancy within Foleshill and Hillfields through groups, 1-1 sessions and women only antenatal classes</td>
<td>Ability to engage hard to reach groups and follow users to encourage breastfeeding using its peer model</td>
<td>Funding potentially ending March 2013.</td>
<td></td>
</tr>
<tr>
<td>2. Language supported and culturally sensitive (bi-lingual peer model)</td>
<td>Initiation rates with users at last quarter 91% and 82% continuation rates at 6-8 weeks after birth.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Peer support model</td>
<td>Breastfeeding rates with its users double city average</td>
<td></td>
<td></td>
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<tr>
<td>4. Multi-agency partnership. Working with health professionals to support</td>
<td>Successful antenatal class for women, running for the last 11 years geared to ethnic mums; including</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

22 Department of Health, (27 October), Healthy Child Programme (HCP) Pregnancy and the first five years of life
<table>
<thead>
<tr>
<th>Service Provider &amp; Funder</th>
<th>Breastfeeding Service Delivery</th>
<th>Good Practice</th>
<th>Issues &amp; Gaps</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family Nurse Partnership (FNP) (funded by DoH via Arden Cluster)</td>
<td>child and maternal health strategies and delivery to users. 5. Breastfeeding integral part of service specification supporting increase in rates with its users</td>
<td>breastfeeding promotion and support</td>
<td>Initiation rates of this group is lower than citywide average  Lower continuation rates in this group  FNP work does not include all vulnerable teenagers within the city</td>
</tr>
<tr>
<td>Coventry was chosen as one of the test sites for the programme and has taken part on a randomised controlled trial to measure the effectiveness of the programme.</td>
<td>1. Intensive, nurse led home visits. for vulnerable first time young parents  2. Involves nurses visiting young parents from early pregnancy until the child is two years old.  3. Specifically supporting young parents  4. All young people have access to the universal midwifery service even those who access FNP.</td>
<td>Supporting teenage parents from early pregnancy -2 years  Weekly visits  Engaging hard to reach group  Close links with Infant Feeding Team &amp; City Council’s Respect Yourself Programme  New procedure starting in December which refers those young mothers who don’t access FNP to Children’s Centres who will then contact the young mother to offer a co-ordinated support plan, including access to the breastfeeding team offer a co-ordinated support plan.</td>
<td></td>
</tr>
<tr>
<td>Service Provider &amp; Funder</td>
<td>Breastfeeding Service Delivery</td>
<td>Good Practice</td>
<td>Issues &amp; Gaps</td>
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<tr>
<td><strong>Childrens Centres (Local authority funded)</strong></td>
<td>1. Support service for families including parenting skills &amp; childcare</td>
<td>Breastfeeding Peer Support groups run in the centres, led by Infant</td>
<td>Partnership led delivery – risk to support if partner funding or programmes cease</td>
</tr>
<tr>
<td></td>
<td>2. Partnership working approach to service delivery</td>
<td>Feeding Teams</td>
<td>Host only – non-delivery</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Local – community based</td>
<td></td>
</tr>
<tr>
<td><strong>National Childbirth Trust</strong> (NCT) - a charity</td>
<td>1. Breastfeeding counsellors offer support including face-to-face, at home, local drop-ins,</td>
<td>Breastfeeding Counsellors trained to provide breastfeeding support</td>
<td>No data gathering on feeding information</td>
</tr>
<tr>
<td>funded mostly from membership, donations and</td>
<td>breastfeeding phone line</td>
<td>Volunteer model with mothers offering Peer Support</td>
<td>NCT breastfeeding counsellors have annual registration requirements which they must fulfil to have their licence renewed</td>
</tr>
<tr>
<td>fundraising.</td>
<td>2. Peer support provided from other mothers.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>3. Antenatal courses, led by NCT-trained antenatal teachers and breastfeeding counsellors</td>
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<td></td>
<td>take place usually around 30-35 weeks of pregnancy.</td>
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<td></td>
<td>4. Following delivery, support is offered when the women wish to use the service and is specific to needs of the mother.</td>
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</table>
The providers we spoke to said that partnership work within the city works well. The funding investment within the community from CHIP over the last few years, through the infant mortality project, has allowed links to be made between hospital and community breastfeeding support.

Local provision of breastfeeding support demonstrates good practice and follows NICE/DH national guidance regarding implementing an outcome focused, partnership approach. This collective approach has contributed to increases in breastfeeding rates recently within the city and service provision is comparable to other national good practice initiatives. See (Appendix 1) for examples of good practice elsewhere in the country.

Breastfeeding support in Coventry is following the UNICEF Baby Friendly Initiative (BFI) as a minimum standard. The investment from Public Health funds into this initiative and achievement of Level 2 accreditation, coordinated by the Infant Feeding Team, has added focus and consistency to breastfeeding support within the community.

A comprehensive training curriculum for all community based staff, that offers breastfeeding support to clients, has been developed in Coventry. This has included mandatory breastfeeding updates and evaluation processes.

UNICEF Baby Friendly accreditation has contributed to positive work at UHCW hospital leading to an increase in recorded initiation rates during the period of 2009-2011. It has led to an investment in breastfeeding co-ordinators to support the consistent training of staff to promote integrated breastfeeding messages and to ensure they are equipped with the skills to manage breastfeeding issues on a practical level. UHCW are 95% compliant with UNICEF and breastfeeding in-house training at present and working towards Stage 2.

Professionals have acknowledged to us, that working towards Baby Friendly UNICEF accreditation has kept the breastfeeding focus and momentum particularly the mandatory breastfeeding updates.

Key performance indicators have helped the hospital focus on the breastfeeding agenda. Key performance indicators are also built into service specifications with health visiting for the community, continuation rates.

National guidelines state that a written, audited and well-publicised breastfeeding policy is needed, that includes training for staff and support for those staff who may be breastfeeding and to identify a health professional responsible for implementing this policy. Coventry has breastfeeding policies, implemented at UHCW and in the community through the Infant Feeding Co-ordinators.

Coventry has invested in targeted services aimed at target groups in the local community. Dennis CL, (2001) noted that service delivery should be targeted directly

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23 I NICE (11 March 2008) Improving the nutrition of pregnant and breastfeeding mothers and children in low-income households - public health guidance
at women in areas recognised as being high in deprivation. Coventry has adopted this good practice as Public Health has invested in targeted services, aimed at certain groups in the local community e.g. MAMTA working with ethnic minority groups and the Infant Feeding Team focusing on areas of deprivation.

The MAMTA service has high levels of breastfeeding at 6-8 weeks for their service users; indicating that the project works well to support BME groups to breastfeed. The Infant Feeding Team has high breastfeeding rates within its users and work well to support women at home and within groups city wide.

7.3 Gaps and issues identified by providers

Some practitioners identified that greater support for women in the antenatal period, informing them about feeding and breastfeeding will ensure women are more psychologically prepared to breastfeed and therefore women will be more likely to breastfeed.

Some practitioners have noted that more support is needed immediately after birth at UHCW to ensure mothers have successfully initiated breastfeeding.

Staff vacancies and changes of personnel can impact on the delivery of the interagency model. It was recognised that there was a gap in a dedicated full-time infant feeding post at UHCW. The referrals from the hospital are supported by two part-time infant feeding coordinators, which have only recently been made into a full time equivalent post. The absence of this role has an impact on consistent referrals going out into services into the community.

Currently there is no ‘regular’ access to data that outlines a clear picture on women’s feeding status and demographics (ethnicity, status, age). Public Health reported that a ready access to the intelligence on a breakdown of women breastfeeding compared to those who are not in the city which could be continuously monitored would be beneficial. Presently, due to capacity issues this data is not collected.

Including fathers in the breastfeeding agenda is not something, which is actively done in Coventry. Evidence suggests that partners play a large part and influence decisions to breastfeed.

Young parents have always been difficult to engage. Recent groups that were set up were discontinued due to poor attendance. Recent progress has included closer links with the Infant Feeding team with FNP and the teenage pregnancy even though there are very limited teenage parent sessions within the city. There is currently a lack of clear cut process to assess the needs of teenage parents and co-ordinate support. A new process is being designed starting in December 2012, which refers those young mothers who don’t access FNP to Childrens Centres who will then contact the young mother to offer a co-ordinated support plan, including access to the breastfeeding team. Teenage parent guidelines and referral pathways have been written, that are supported by multi-agency training, to enable professionals to support young mothers who do not access FNP or Childrens Centres.

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Many professionals in the city feel that breastfeeding should be introduced at school and this is a gap at present. If the ‘benefits of breastfeeding’ education starts early in schools, it will create, a positive ‘normalised’ attitude towards breastfeeding amongst the young.

The Infant Feeding Service has recently conducted some work at a local school around breastfeeding however a city wide strategic led initiative would be more effective for the long term possibly within the PSHE (Personal, Social, Health and Economic Programmes) programmes as recommended by public health and many other professionals.

To make breastfeeding the norm across all ages and social groups’ media and publicity is a valuable way of cascading messages, however this is dependent on budget availability.

8. Conclusions

Breastfeeding has an important contribution to make towards meeting the national target to reduce infant mortality and health inequalities. There is extensive evidence of the value of breastfeeding support for women. The initiation and duration of breastfeeding is influenced by the amount and quality of support provided and problems with breastfeeding effectively can be addressed by support.

The project found that Coventry’s partnership approach to service delivery, commitment to UNICEF Baby Friendly Initiatives and investment in targeted services has had a positive impact on both user experience of services and the statistics for rates of initiation and continuation. Therefore there is good practice in delivery in Coventry.

Whilst the ways in which initiation is recorded for the Department of Health have been criticised as potentially only recording a baby being put to the breast rather than success in breastfeeding, this research supports UHCW’s figures and provides an independent report about initiation and breastfeeding continuation rates.

UHCW initiation rates have improved steadily over the period 2009 to 2011 and were achieving targets. However Coventry and UHCW have not yet been able to achieve the new target of 77% consistently from 2011 to the present. This indicates the challenge of the target and that continued emphasis on support is required.

In Coventry the 6-8 weeks prevalence rates have increased slightly over the last two years for Coventry, reaching 42.2%. Compared to other Primary Care Trust areas with similar levels of deprivation we are doing better, but are lower than the national average. The survey showed a clear drop off rate in breastfeeding after the first few weeks indicating that more work is to be done to ensure that women in Coventry breastfeed to at least 6 months after birth.

25 Department of Health (2007), National Service framework for children, young people and maternity services standard 11: maternity services
Support in hospital by the midwife was generally valued, many women said the support received in hospital was right and appropriate and helped with their feeding choice. However, in general women were more positive about the support they received in the community than that in hospital.

Women expressed a preference for one to one and group support, which is currently being offered by professional providers in Coventry.

There are pockets of women that would like more encouragement, support and access to information during pregnancy, in order to have the information to be able to make an informed choice about feeding.

Effective support in the hospital is important to ensure women are comfortable with breastfeeding after birth and before discharge so they can continue to successfully breastfeed at home. Our research collected reports of variation in support provided at different times of day and at weekends; concerns and perceptions that staff were too busy/stretched to provide the necessary support and a few instances of a lack of support were noted by survey participants.

It is therefore important that the NICE guidance around healthcare professionals having sufficient time to give support to a woman and baby during initiation and continuation of breastfeeding are followed. This includes making arrangements for 24 hour rooming-in and continuing skin-to-skin contact when possible.²⁶

UHCW reports that it has recruited more midwives to address the rising birth rate to improve the ratio of midwives to patients. It has also recruited more Maternity Support Workers. During the period of our research the post of hospital feeding co-ordinator was made ‘full time’, Monday to Friday during the working day.

Not all women said they were given the necessary contact details for the Infant Feeding Team at the point of discharge from hospital indicating a training need or need to tighten procedures in hospital.

In our more in depth conversations with women we found that the reasons given for stopping breastfeeding (other than personal choice) mainly sounded like issues which could have been addressed with appropriate and timely support. Some women were advised to switch to formula and were given inconsistent advice from different professionals.

The number of women who reported they were mixed feeding was surprising. NICE guideline says formula milk should not be given to breastfed babies unless medically indicated.

Issues related to babies with a tongue tie and breastfeeding were also found. Some respondents said that the tongue tie has not been picked up in hospital. Therefore there is a need for work to ensure that it is identified before discharge.

²⁶ NICE, (July 2006), Clinical guideline 37 – postnatal care
Disappointingly women felt there were not enough places in Coventry they could breastfeed. City centre outlets are encouraged to promote breastfeeding via an up to date directory of Baby Friendly premises currently supported through Coventry’s Health Improvement Programme (CHIP) funding until March 2014. These directories are only given to mums that are seen by the Infant Feeding Team.

Analysis of survey findings by, deprivation, age, and ethnicity has highlighted a higher proportion of women from the least affluent areas of Coventry were bottle feeding. This is similar to the national picture that shows that women from lower socio-economic groups have lower breastfeeding rates.

The community midwife; health visitor and infant feeding team we acknowledged as giving good support across different wards (least affluent to most affluent). The charity the National Childbirth Trust (NCT) was highlighted as giving good breastfeeding support within the most affluent areas. Respondents praised the support provided by FWT- MAMTA in the most deprived areas and where ethnic minority women reside. This service reaches out to vulnerable communities and addresses language barriers. Whilst we acknowledge that this research was carried out by FWT workers and that this may lead to a potential for more positive feedback, the statistics showing breastfeeding continuation rates for MAMTA clients also show that this service is achieving.

In the affluent areas women were generally happier with the support received. Once leaving hospital women from the more deprived wards more frequently stated there was a lack of support; their baby was not latching; their baby was hungry; and that they were given mixed messages.

It was found that women from ethnic minority communities had higher initiation rates and breastfed for longer than White British women. This is in line with national studies. However, whilst BME women are more likely to favour breastfeeding we found evidence that there was potential for the perceived dominant culture locally: desire to bottle feed, to shift the behaviour of BME women. Quality advice and information was able to counter this.

Services have been set up in the community for pregnant girls but they have not been taken up well. A clear pathway for all teenagers is being developed. Breastfeeding support for all teenage mothers is vital.

The earlier breastfeeding is discussed, the greater the likelihood of it being normalised. Work in schools is a suggestion that many professionals in the city have supported to mainstream breastfeeding into schools to encourage a positive ‘normalised’ attitude towards breastfeeding.

It is also a time of change within the NHS, with the abolition of the local Primary Care Trust Arden Cluster at the end of March 2013, the transfer of Public Health functions from the Primary Care Trust to the Local Authority along with developments of new bodies and ways of working including, Clinical Commissioning Groups (CCGs) and the set up of local Health and Wellbeing Boards to produce local strategies to address health inequalities and wellbeing issues.
There is a danger that as a result of so much change that positive work maybe lost or priorities shifted. Continuing to build on the local good practice in breastfeeding support is important for health and wellbeing in Coventry. The birth rate is continuing to rise in Coventry and migration into Coventry is one of the factors generating the city’s rising birth rate, with births to non UK born mothers continuing to rise. Therefore ensuring service can meet the demand is important along with ensuring that services are delivered in an accessible way.

9. Recommendations

1. Commissioners ensure adequate provision of antenatal support for women in pregnancy regarding breastfeeding in the context of arising birth rate and increasing population.

2. UHCW ensure that UNICEF trained staff: dedicated infant feeding midwife or maternity support worker, are available over 7 days a week, including evenings and night, to ensure that consistent breastfeeding support is available.

3. UHCW ensures all breastfeeding women have contact details/referral to community breastfeeding services and support immediately after discharge from hospital

4. Commissioners: review the support provided to young parents (including developing a clear package of child and maternal care for teenagers across the city) to ensure more are engaged with. Linking with the breastfeeding strategy, existing young parent’s strategy and developing Healthy Child Programme Plans would help.

5. UHCW/Public Health: Continue with UNICEF implementation, training and performance indicators to keep developing the focus and abilities of professionals/providers in hospital and the community in order to address issues regarding mixed messages and incorrect advice.

6. Commissioners: continue to commission community based services including the Infant Feeding Service and services meeting targeted needs of the local population such as MAMTA and continue to fund services where funding is due to an end in 2013.

7. Commissioners/UHCW: develop a local approach for quicker response times for tongue tie treatment and UHCW puts in place processes to ensure that babies with a tongue tie are identified before discharge and there is early intervention/treatment

8. Commissioners ensure that information about baby friendly locations where women can breastfeed should be given to more women. The current list should continue to be updated and should be given out by Health Visitors when they visit

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27 Coventry City Council, (2011), Corporate research
after taking over care of new mothers at 10-14 days. This information should be available in other languages.

9. Commissioners/ Children Services: mainstream education of 14-16 age groups in schools within the PSHE programme to ‘normalise the agenda’ of breastfeeding to increase breastfeeding rates.

10. Acknowledgements

We would like to thank the professionals and partners that supported and took part in this project and all the women who participated in the survey.

This research project was co-ordinated by Noreen Bukhari Healthcare Manager FWT- A Centre for Women with data analysis by Debra Corrigan from FWT.

Contributions were made by LINk volunteers and the LINk staff team.

11. Glossary

1. **Breastfeeding Initiation**: The mother is defined as having initiated breastfeeding if, within the first 48 hours of birth, either she puts the baby to the breast or the baby is given any of the mothers breast milk Department of Health (2004).

2. **Partially breastfed** is defined as babies who are currently receiving breast milk and who are also receiving formula milk or any other liquids or food.

3. **Not at all breastfed** is defined as babies who are not currently receiving any breast milk at 6 weeks of age.

4. **Breastfeeding Duration**: **Totally breastfed** - is defined as babies who are exclusively receiving breast milk at 6 weeks of age - that is, they are NOT receiving formula milk, any other liquids or food.

5. **Incidence of breastfeeding**: This refers to the percentage of babies who were breastfed initially. This definition includes all babies who were put to the breast at all, even if it was only once. This definition of incidence of breastfeeding has remained unchanged since the first survey in 1975.

6. **Prevalence of breastfeeding**: This is defined as the percentage of all babies who are being breastfed at specific ages, even if they are also receiving infant formula or solid food (prevalence information will be available in the main publication which will be published in 2012).

7. **Tongue tie**: Some babies are born with a tight piece of skin between the underside of their tongue and the floor of their mouth. This is known as tongue-tie. The medical name for tongue-tie is ankyloglossia. It can sometimes affect babies feeding, making it hard for them to attach properly to their mother’s breast or a bottle.
8. **Skin to skin:** There is a growing body of evidence that skin to skin contact after the birth helps babies in many ways – indeed; it would be fair to say that being in skin contact is what nature intended for newborns. Skin to Skin has following benefits:

- Calms and relaxes both mother and baby
- Regulates heart rate and breathing in the baby
- Stimulates digestion
- Regulates temperature
- Enables colonisation of baby’s skin with mothers friendly bacteria, thus providing protection against infection
- Stimulates feeding behaviour
- Stimulates the release of hormones to support breastfeeding and mothering
- Skin to skin contact (or kangaroos care) helps preterm babies to be more stable, maintain their temperature, fight infection, grow and develop better and be discharged from hospital sooner. (link to section about preterm babies)

9. **Quintile** of deprivation is any of five equal groups into which a population can be divided according to a particular variable.

10. **LSOA** (Lower Layer Super Output Area) is a geographical area, LSOA’s are a geographical hierarchy designed to improve the reporting of small area statistics in England and Wales. All Local Neighbourhoods in Coventry fall into national ‘quintiles’ of deprivation according to the Index of Multiple Deprivation 2010. That is they are amongst the most deprived 20% of LSOAs in the country (1), the least deprived 20% of LSOAs in the country (5) or somewhere in between (2, 3 and 4). Coventry has many more areas amongst the most deprived than the least deprived.
Coventry LINk is an independent network supported by the charity Voluntary Action Coventry, which acts as the Host organisation.

Coventry LINk is one of 151 LINks in England.