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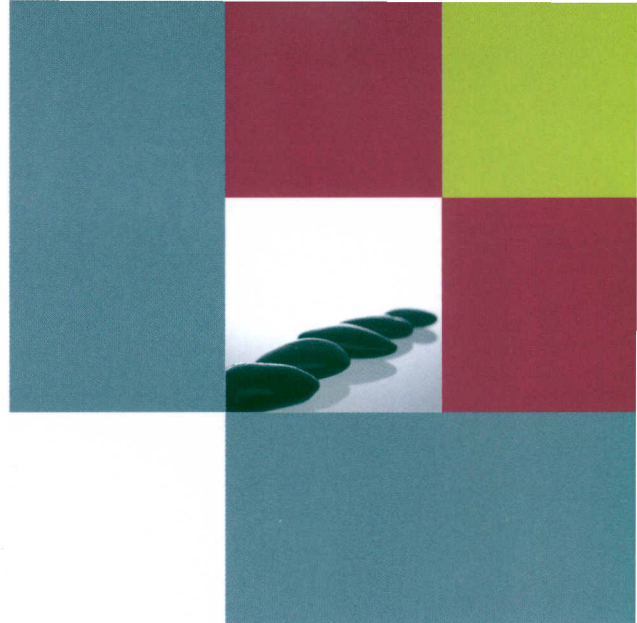
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Setting Standards for Preventative Services to Reduce Child Health Inequalities in Greater Manchester

Final Report



NHS

The Association of Greater Manchester
Primary Care Trusts



University of Salford
A Greater Manchester University

Setting Standards for Preventative Services to Reduce Child Health Inequalities in Greater Manchester

Final Report

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**Centre for Public Health Research (CPHR)
Institute for Health & Social Care Research (IHSCR)**

Institute for Health & Social Care Research

Acknowledgements

The Association of Greater Manchester PCTs was responsible for funding this project. We thank Will Blandamer, Director of Health Improvement, for his collaboration and input into project design and execution.

Thanks are due to Dr Rona Cruickshank, Acting Director of Public Health at Ashton, Leigh and Wigan Primary Care Trust who is committed to the improvement of child health in Greater Manchester and who instigated the project, managed the process and saw the production of service delivery standards through to its final conclusion. We would like to acknowledge the invaluable help of Caroline Smith and Danita Wilmott from Stockport Primary Care Trust for their input into the process of developing the standards, and their support in organising the focus groups and feedback sessions to midwives and health visitors. We are most grateful to all the midwives and health visitors who participated in the focus groups to discuss the proposed standards and for the high quality of their input which was key to the formulation of the final standards.

Su Ellis, Administrator for the Centre for Public Health Research, edited and formatted the final report and we thank her for the coherence she has brought to the presentation of this document.

Contents

Executive Summary	i
Introduction	iii
Child health inequalities in Greater Manchester	iii
Section 1: Initiation and Continuation of Breast Feeding	1
Evidence on patterns of breastfeeding in disadvantaged groups	3
Effective interventions: general	4
Effective interventions: specific to disadvantaged groups.....	4
Standard 1: To reduce inequalities in the initiation and continuation of breastfeeding	6
Example of Good Practice: ROYAL OLDHAM HOSPITAL: promoting breastfeeding	10
Section 2: Identification and Management of Postnatal Depression	13
Evidence on identification and management of PND in disadvantaged groups.....	15
Effective interventions: general	15
Effective identification and management of PND; specific to disadvantaged groups	16
Standard 2: To reduce inequalities in the identification and management of postnatal depression	17
Example of Good Practice: THE PERINATAL SUPPORT TEAM – TRAFFORD PCT	20
Section 3: Smoking Cessation in Pregnancy	21
Evidence on maternal smoking in disadvantaged groups.....	23
Effective Interventions: general.....	24
Effective interventions; specific to disadvantaged groups.....	24
Standard 3: To Reduce Inequalities in Maternal Smoking	26
Example of Good Practice: THE COMMUNITY MIDWIFE TEAM, NORTH MANCHESTER	28
Section 4: Improving Nutrition in Pregnancy	29
Evidence on maternal nutrition in disadvantaged groups	31
Effective Interventions: general.....	31
Effective interventions; specific to disadvantaged groups.....	32
Standard 4: To Reduce Inequalities in Maternal Nutrition.....	33
Example of Good Practice: THE SUNFLOWER COMMUNITY HEALTH PROJECT WIGAN	35
REFERENCES	37

APPENDICES	42
Appendix 1a: Evidence Tables (Breastfeeding).....	42
Appendix 1b: Focus group discussion: breastfeeding.....	49
Appendix 2a: Evidence Tables (PND).....	52
Appendix 2b: Focus group discussion: postnatal depression	55
Appendix 3a: Evidence Tables (Smoking cessation)	59
Appendix 3b: Focus group discussion – smoking cessation in pregnancy	63
Appendix 4a: Evidence Tables (Nutrition in pregnancy)	65
Appendix 4b: Focus group discussion: Nutrition in Pregnancy	69

Executive Summary

Recent policy documents such as *Every Child Matters* and the *National Service Framework for Children, Young People and Maternity Services* have indicated a fundamental shift in ways of thinking about child health, emphasising the crucial role of preventative action as well as treatment for ensuring that children have the best possible chance to reach their full potential. This is paramount in deprived areas, where child poverty translates itself into social disadvantage that affects the life chances of children from birth onwards. In Greater Manchester there is widespread deprivation – 7 of the 10 Local Authorities score in the top quartile of the Index of Multiple Deprivation. Inequities in access to primary health care services arise in relation to both deprivation and ethnicity and half of the Primary Care Trusts in Greater Manchester have minority ethnic group populations that are above the national average.

These socioeconomic and demographic features of Greater Manchester's population present a challenge for preventative services aimed at the improvement of child health. A recent comprehensive audit of the delivery of key preventative interventions to reduce inequalities in child health (*The Greater Manchester Child Health Inequalities Audit*) showed that these interventions were not being delivered equally or consistently across all geographical areas, services or populations and that this was particularly apparent for smoking cessation, the management of postnatal depression and breastfeeding initiation and continuation rates.

As a consequence of widespread child health inequality and evidence of the inconsistent delivery of preventative interventions in Greater Manchester this project aimed to establish evidence based standards for the provision of preventative services that have the potential to reduce child health inequalities and that can be systematically applied to the provision of services across Greater Manchester.

The first stage of this process was to formulate draft standards based on a comprehensive literature review of the most up-to-date UK evidence summarising the known benefits of selected preventative interventions for improving child health. Comprehensive searches for reviews or intervention studies aimed specifically at disadvantaged/ethnic minority groups were carried out.

Service delivery standards derived from this literature review were focused on initiation and continuation of breastfeeding, identification and management of postnatal depression, smoking cessation in pregnancy and the postnatal period and improving nutrition in pregnancy.

The service delivery standards drawn up in this way were then subject to critical review by the health professionals who will be ultimately responsible for their implementation. For this purpose four focus groups were carried out across Greater Manchester, each one focusing on a single standard and in an area where previous good practice had been identified. The areas were: Salford (breastfeeding), Trafford (postnatal depression), Rochdale (smoking cessation) and Ashton, Leigh and Wigan (nutrition).

Participants in the focus groups were asked to consider whether the standards were fit for purpose, what benefits they would they bring in terms of improved service, what were the main barriers to implementation and to cite examples of good practice i.e. where recommended practices have already been implemented and their effectiveness tested. The standards were then reviewed in the light of these comments and modified accordingly.

This report presents the final standards for each of the four topics in the form of five components: a summary of the evidence review; a set of recommendations for service delivery to reduce child health inequality; implementation issues raised in the focus group discussions; routinely collected data required to monitor the effectiveness of standards for improving health

and reducing inequality and an example of good practice locally. More detailed reviews of the literature and material from the focus group discussions are included in the appendices.

We hope that these standards will underpin the equitable delivery of high quality and effective preventative care to improve child health in Greater Manchester.

Introduction

Recent policy documents such as *Every Child Matters* and the *National Service Framework for Children, Young People and Maternity Services* have indicated a fundamental shift in ways of thinking about child health, emphasising the crucial role of preventative action as well as treatment for ensuring that children have the best possible chance to reach their full potential.

This is paramount in deprived areas, where child poverty translates itself into social disadvantage that affects the life chances of children from birth onwards. Whilst the NHS cannot tackle the fundamental drivers of child poverty, it can make a substantial contribution to improving the health and life chances of children living in deprived areas through making sure that parents have access to the services they need and have the information and support to make the best choices about the health and development of their children.

The World Health Organisation (WHO) in its strategy on equity in health states that disparities in health status between different groups in the population should be reduced by improving the health of the disadvantaged. Hence, the *National Service Framework for Children, Young People and Maternity Services* set down 11 standards that define, in general terms, the aims and objectives of services for all children (standards 1-5), services for particular groups of children and young people (standards 6-10) and maternity services (standard 11). These standards underpin a more generic health inequalities target that sets the goal of a reduction of at least 10% in the gap in infant mortality between manual groups and the population as a whole in 2010.

Child health inequalities in Greater Manchester

Such policy issues are particularly pertinent for Greater Manchester. There is widespread deprivation – 7 of the 10 Local Authorities (LA) score in the top quartile of the Index of Multiple Deprivation, Manchester being the 2nd most deprived LA in the country, Salford being the 12th. Inequities in access to primary health care services also arise in relation to ethnicity and half of the Primary Care Trusts (PCTs) in Greater Manchester have minority ethnic group populations that are above the national average. For example in Central Manchester PCT, over 30% of the population belongs to a minority ethnic group.

These socioeconomic and demographic features of Greater Manchester's population present a challenge for preventative services aimed at the improvement of child health, and this is starkly illustrated in a recent comprehensive audit of the delivery of key preventative interventions to reduce inequalities in child health (*The Greater Manchester Child Health Inequalities Audit*). The report showed that these interventions were not being delivered equally or consistently across all geographical areas, services or populations and that this was particularly apparent for smoking cessation, the management of postnatal depression and breastfeeding initiation and continuation rates. It was also clear however, that some PCTs were tackling the problems of health disadvantage in their communities by implementation of procedures indicative of a high standard of care across the majority of the interventions examined.

The aim of the first stage of this project is therefore to establish evidence based standards for the provision of preventative services that have the potential to reduce child health inequalities and that can be systematically applied to the provision of services across Greater Manchester.

These standards have been formulated based on a comprehensive literature review of the most up-to-date UK evidence summarising the known benefits of selected preventative interventions for improving child health. Comprehensive searches for reviews or intervention studies aimed specifically at disadvantaged/ethnic minority groups were carried out using the following electronic databases:

- Cinahl
- Cochrane Library
- Embase
- Medline
- Psycinfo
- Social Science Citation Index
- Social Policy and Practice

Reference checking was also carried out to obtain other relevant papers, and studies were excluded if they were not conducted in the UK.

In this report standards derived from this literature review are presented for:

- Initiation and continuation of breastfeeding
- Identification and management of postnatal depression
- Smoking cessation in pregnancy and the postnatal period
- Improving nutrition in pregnancy

The standards focus on evidence of effective interventions by socioeconomic status and by ethnicity, and the effectiveness of primary preventative action for improving health in deprived and/or ethnically mixed areas. Summaries of the key articles used to derive the standards are presented in Appendices 1-4a.

Stage 2

The aim of the second stage of the project was to gain the opinions of health professionals as to whether the standards are fit for purpose, - the benefits they will they bring in terms of improved service, the barriers to implementation and examples of good practice i.e. where recommended practices have already been implemented and their effectiveness tested.

Four focus groups were carried out across Greater Manchester, each one focusing on each standard and carried out in an area where good practice was identified in the Child Health Inequalities Audit. The areas were:

- Salford (breastfeeding)
- Trafford (postnatal depression)
- Rochdale (smoking cessation)
- Ashton, Leigh and Wigan (nutrition)

A total of 20 midwives and health visitors attended the focus groups to discuss the standards, and to gather information about the current state of service provision for each of the standards and potential barriers to implementation in their areas. The discussions were recorded and transcribed. (see Appendices 1-4b xx for summaries of focus group discussions). The standards were then reviewed in the light of these comments and modified accordingly

Following the completion of both stages of the project, each standard consists of the following components:

1. A summary of the evidence review.
2. A set of recommendations for service delivery to improve child health inequality.
3. Evidence from the focus group discussions incorporated into the recommendations.
4. Routinely collected data required to monitor the effectiveness of standards for improving health and inequality
5. An example of good practice locally.

Section 1

Initiation and Continuation of Breastfeeding

Section 1: Initiation and Continuation of Breast Feeding

It is now well-established that breastfeeding has a major role for the health of mothers and babies ⁽¹⁾. Breast milk not only provides complete nutrition for the development of healthy infants, it also protects from a number of illnesses including gastro-enteritis, respiratory infection, atopic disease and the prevention of otitis media ⁽²⁾; ⁽³⁾. Breastfeeding also benefits maternal health ; women who breastfeed are significantly less likely to develop ovarian cancer and are also more likely to burn up body fat stored in pregnancy for the production of breast milk ⁽⁴⁾; ⁽⁵⁾; ⁽⁶⁾.

The Department of Health (DH) recommendations are:

- exclusive breastfeeding for the first 6 months of life, with breastfeeding continuing after this age, along with other types of solid foods ⁽⁷⁾.
- A national target for the NHS to “deliver an increase of two percentage points per year in breastfeeding initiation rates focusing especially on women from disadvantaged groups” ⁽⁸⁾.

Evidence on patterns of breastfeeding in disadvantaged groups

Initiation and duration rates of breastfeeding are lowest among families from lower socioeconomic groups ⁽⁹⁾.

E.g. It has been reported that in the UK, 85% of mothers classified to higher occupations breastfed initially. This compared with 73% of mothers in intermediate and 59% in lower occupations. The lowest initiation rate was evident among those mothers who had never worked, this figure being 52%. Women from lower occupational groups were also less likely to continue to breastfed long enough to enhance the health of their babies ⁽¹⁰⁾.

Initiation and duration rates of breastfeeding are lower for teenage mothers

E.g. In one study, it was found that 78% of mothers aged 30 and above initiated breastfeeding compared to 46% of mothers aged less than 20 ⁽¹⁰⁾. Among white mothers in England, being younger has been associated with being less likely to breastfeed for at least one month ⁽¹¹⁾.

Initiation and duration of breastfeeding varies by ethnic group.

E.g. The highest rates of breastfeeding initiation have been found for Black women (95%), followed by Asian women (87%), and the lowest rates for white women ⁽¹⁰⁾. An in-depth examination of ethnicity and breastfeeding was carried out in a large-scale study of first-time mothers in the Millennium Cohort Study ⁽¹²⁾. It was found that Indian, Pakistani, black Caribbean, and black African mothers were more likely to continue breastfeeding at 3 months compared with white mothers.

Effective interventions: general

For the general population

- *effective interventions* include peer support, professional support, education, education and professional support, education and peer support, professional training, hospital practices, multisectoral interventions, hospital practices and media programmes ⁽⁹⁾.
- *Harmful Interventions* include routine hospital practices that restrict feeding and mother-baby contact ⁽⁹⁾.
- *Ineffective interventions* include breastfeeding literature used alone and routine separation of mothers and babies for treatment ⁽⁹⁾.

Effective interventions: specific to disadvantaged groups

1. Peer support:

Breastfeeding peer support programs involve mothers who have breastfed their babies supporting other mothers in their local community usually on a voluntary basis. Peer support programmes, delivered in the ante- and postnatal periods, have been shown to be effective at increasing both initiation and duration rates of breastfeeding among women on low incomes, and particularly among women who have expressed a desire to breastfeed ^{(13), (9), (14), (15)}. One study found there was no difference after 6 weeks compared to a group not receiving peer support ⁽¹⁶⁾, but another study found a significant increase in breastfeeding rates after 8 weeks compared to the area average increase ⁽¹⁷⁾.

2. Familial support:

Interventions which include the support of a family member were shown to be helpful, particularly for the different ethnic groups in a South Asian community and adolescent mothers ^{(18), (19), (13)}.

3. BFI status of maternity unit:

Mothers delivering in accredited units were more likely to initiate breastfeeding than those delivering in units with neither award ^{(20), (13), (14)}, but one study found that BFI status was not effective at increasing the duration of breastfeeding ⁽²¹⁾. Programs incorporating BFI principles in the community are recognised as being characteristics of effective programs, particularly for hard-to-reach groups ⁽⁹⁾.

UNICEF Baby Friendly Initiative

The Baby Friendly Initiative (BFI) is a worldwide programme of the World Health Organisation and UNICEF. It was launched in 1992 to encourage maternity hospitals to implement the Ten Steps to Successful Breastfeeding and practice in accordance with the International Code of Marketing of Breastmilk Substitutes. The BFI came to the UK in 1994, and in 1998, its principles were extended to cover the work of community health care services in the Seven Point Plan for the Promotion, Protection and Support of Breastfeeding in Community Health Care Settings. The BFI works with the health care system to ensure a high standard of care for pregnant women and breastfeeding mothers and babies. They provide support for health care facilities which are seeking to implement best practice and offer an assessment and accreditation process which recognises those which have achieved the required standard.

4. Professional support:

Breastfeeding support centres, both Breastfeeding Network (BfN) and the health professional led drop-in models were found to be effective in disadvantaged communities, and in particular with adolescent mothers ⁽²²⁾; ⁽¹³⁾. One study found /that the use of healthcare assistants in the community would offer a practical and encouraging approach in supporting breastfeeding for disadvantaged women ⁽²³⁾.

e.g. The Breastfeeding Network

The Breastfeeding Network (BfN) is a charity which was set up to provide support for breastfeeding women in their local communities throughout the UK. They provide training to voluntary supporters based on a model called 'Breastfeeding Matters'. Breastfeeding Supporters provide a unique service that is complementary to that provided by health visitors, midwives and other relevant health professionals. Breastfeeding Supporters are available at the end of the phone to give information and support to mothers who have challenges with breastfeeding, and will visit new mothers at home where possible. BfN also operate a number of drop-in centres within local communities.

e.g. Sure Start Children's Centres

Sure Start Children's Centres are at the heart of the Government's *Every Child Matters: Change for Children Programme*. They are a key vehicle for providing services that families need and aim to provide a central role in improving outcomes for all young children, and in reducing inequalities in outcomes between the most disadvantaged children and the rest. Their performance management framework identifies the initiation of breastfeeding as a key indicator for health and aims to target hard-to-reach groups including teenage mothers and ethnic minority households.

5. Trained volunteer support:

The support of a NCT voluntary counsellor was valued by breastfeeding women in deprived populations, but a randomised controlled trial found they did not significantly increase breastfeeding rates ⁽²⁴⁾.

The National Childbirth Trust

The National Childbirth Trust (NCT) is the leading charity for pregnancy, birth and parenting in the UK. Volunteers work through a network of branches to provide and support local services, training and evidence-based information for parents, families and health professionals. NCT offer the services of trained breastfeeding counsellors who often work with other groups such as Sure Start Children's Centres.

Standard 1: To reduce inequalities in the initiation and continuation of breastfeeding

NATIONAL TARGETS	<i>To breastfeed exclusively for the first 6 months of life</i>
	<p><u>To reduce health inequalities</u> The current national target is for the NHS to deliver an increase of two percentage points per year in breastfeeding initiation rates focusing especially on women from disadvantaged groups. Identified from the evidence, these groups are: Low income women Adolescent mothers White and Asian women</p>

1a: Evidence based interventions

Interventions shown to be effective	Groups on whom evidence is based	Recommendation for Greater Manchester	Issues for implementation of standards
Peer support	Low income women Adolescent mothers	Recruit and train volunteer peer counsellors for each Greater Manchester PCT area following UNICEF/La Leche/NCT training programmes to offer support in the postnatal period	<ul style="list-style-type: none"> • <i>Peer support should be offered in all areas consistently – at present it is provided on an 'ad hoc' basis. Measures should be put in place to target high risk groups (see monitoring standards)</i> • <i>The voluntary nature of peer support may effect recruitment and sustainability. Local schemes that directly employ peer supporters have had good results (see example of good practice).</i> • <i>A mechanism for referral of women with specific feeding problems should be embedded in any peer support scheme</i> • <i>Regular evaluations of peer support initiatives should be carried out in order to assess whether this kind of service is successful in reaching vulnerable groups.</i>

Interventions shown to be effective	Groups on whom evidence is based	Recommendation for Greater Manchester	Issues for implementation of standards
UNICEF Baby Friendly Initiative (BFI)	Low income women	All Trusts with a maternity unit and all PCTs in Greater Manchester should have gained BFI accredited status within 5 years	<ul style="list-style-type: none"> • <i>It is important to utilise all the preparatory materials and strategies provided by UNICEF to limit the time taken to implement this initiative.</i> • <i>A BFI coordinator and 'champion' are needed to implement and manage the initiative.</i>
Professional support (i.e. breastfeeding clinics)	Low income women Adolescent mothers	Breastfeeding clinics should be available in each Greater Manchester PCT area, and information regarding the nearest breastfeeding clinic should be given to all pregnant women.	<ul style="list-style-type: none"> • <i>These resources need comprehensive planning and appropriate personnel need to be assigned to manage all initiatives. Guidance from DH Infant Feeding Initiative should be utilised</i>
Family support	Asian women Adolescent mothers	Family members/partners should be invited along to any discussions regarding breastfeeding, with interpreter services to be made available.	<ul style="list-style-type: none"> • <i>Invitations to family members need to be made explicit and offered routinely. For Asian women other community based contact points should also be utilised for this purpose e.g. women's groups, mosques etc.</i>

1b: Data recording standard

Effectiveness of recommended interventions, including targeting of disadvantaged groups, should be routinely assessed using data recorded on the Child Health System Database. This should be progressively adopted by all PCTs in Greater Manchester by the end of 2009. A model on which to base such recording procedures is available for Manchester PCTs.

Current Postcode

NHS Number

Current GP

Current PCT

Birth Data

Mother's date of birth

One parent family

Benefits data (as a proxy of low income – collected at the midwives first visit)*

Ethnicity (using 2001 Census classification)

For members of ethnic minority groups – need for an interpreter*

Number of previous live births

Birthweight (grams)

Health district of birth

Born at code (e.g. Hospital)

Birthplace

Birth area code

Breast Feeding

Stages of info collected

1st Feed –

Initiated (in 48 hours)

Discharge – from PCHR

Primary Visit

Effectiveness of recommended interventions, including targeting of disadvantaged groups, should be routinely assessed using data recorded on the Child Health System Database. This should be progressively adopted by all PCTs in Greater Manchester by the end of 2009. A model on which to base such recording procedures is available for Manchester PCTs.

6 – 8 week review

1st Immunisation

2nd Immunisation

3d Immunisation

6 – 8 months

1st MMR (at 13 months)

Result of feeding – Totally/ Partial/Not At All

BFI stage (annually).*

*** Not currently recorded on Manchester Child Health System Database.**



Example of Good Practice: ROYAL OLDHAM HOSPITAL: promoting breastfeeding

Breastfeeding initiation rates in Oldham have reached over 60% because of innovative working practices at the Royal Oldham hospital. The Royal Oldham is one of just 27 hospitals in England with full UNICEF Baby Friendly Initiative (BFI) accreditation. The hospital achieved BFI status in 1999 and has maintained this status over the past seven years. Initiatives at the hospital include the identification of 'champions' to drive forward change, action plans to address poor practice, and an audit of breastfeeding services. Healthcare professionals have also undergone personal training to increase their knowledge of breastfeeding.

The Royal Oldham Hospital has taken a number of steps to support breastfeeding mothers both in and out of hospital. Initiatives include training local women to become peer supporters and improving services through regular user feedback. Peer supporters assist the lactation consultants, health visitors and midwives to run local 'baby bistros'. There are plans to train peer supporters across the whole of the north-east of Manchester served by the Pennine Acute Hospitals NHS Trust and to set up more baby bistros.

Contact: Val Finigan (Val.Finigan@pat.nhs.uk) or Jill Repley, Baby Friendly Initiative (020 7312 7652)

ANECDOTAL FEEDBACK ABOUT THE SCHEME (email from Val Finigan)

1. It took the Royal Oldham from 1994-1999 to become a Baby Friendly unit and I believe that taking this length of time provides the opportunity to change the culture, provide adequate training and to address some of the values and beliefs people have about breastfeeding. Oldham has sustained BFI for 8 years and moved breastfeeding initiation from 29% to 65% during this time-frame. Our second site North Manchester General has recently achieved the standard becoming a BFI unit in July 2006, again breastfeeding initiation has risen from 29% in 1999 to 61% in 2006 as they progressed, provided information and got better at giving appropriate information and support.

However, I feel the culture is not as stable in newly accredited units and this will only settle as staff start to see new practices become the 'norm' and find that BFI is just what they always do and that it works well.

I would therefore say that my experience of leading BFI in four hospitals directs me to suggest that it requires a five year programme if it is to address the cultures of both maternity services and communities. Organisational change is difficult.

2. The statistical evidence for breastfeeding is collected on the Euro-king system and does provide information on areas where inequalities are prevalent. However, the audits of practice required for BFI, involve identifying randomly selected staff and mothers for interview and we use a computer generated programme (UNICEF) in order to achieve as near as possible an unbiased sample. The audit tools are based on the UNICEF ones and a continuous cycle of audit enables one to see any slippage and deal with it early. It also provides positive feedback to increase staff morale and generate a pride within the organisation.

3. Peer support-we have trained women ourselves, paid La Leche League to run courses and UNICEF to train women for us. I was really optimistic at the start and felt they would be able to help us to deliver better and quicker services to breastfeeding women. However, the problem I

find with peer support is that women are expected to provide a service with no financial gain (usually the opposite-loss for child care, parking fees etc). We do have supporters in each area, Rochdale, Oldham, North Manchester and Bury who are active and very valuable; however, the ones that continue are often linked to Sure Start programmes or Children's Centres. We also have trained a large amount of women who have chosen not to be active or got a job shortly after the course. It depends how you view this-the skills are never lost and often the training empowers women to move forward. Some women that I trained myself, have entered midwifery training or become Health Care Assistants, but on the negative side this doesn't help maternity services within the current financial constraints i.e. we train them, taking at least two skilled staff from the workplace for a week and they don't provide any services in return, I don't mean this is an awful way-just want to share the stark reality. A really good example of peer support working is the 'Little Angels', Blackburn-However, they are not voluntary supporters they are paid, perhaps this is why they are successful.

We train 10-15 peers per course and usually we do two or even three courses a year. I'm not sure how many La Leche training sessions are carried out across our areas as the Health Visitors sort these out, and we also have Health Visitors that train some women. The women are nominated or put their selves forward. I'm really not sure how many should be trained per year in order to keep some available with the continuous circle of returning to work etc.

One programme that has helped us tremendously has been the training of Health Care Support Workers that speak the languages of our clients. They are paid but deliver information on parent craft and also infant feeding to our ethnic minorities. This is really important as the Asian Infant Feeding Survey clearly identified women were unable to feed their babies safely.

Management of Postnatal Depression

Section 2

Identification and Management of Postnatal Depression

Section 2: Identification and Management of Postnatal Depression

Postnatal depression (PND) is recognised as a major public health issue with 15% to 25% of childbearing women likely to develop a clinically significant mental health disorder in the interval between conception and the end of the first postpartum year⁽²⁵⁾. Most cases of PND develop within the first three months⁽²⁶⁾, with a peak incidence at four to six weeks⁽²⁷⁾. Depression following childbirth is particularly distressing, interferes with the adjustment to motherhood, leaves lifelong memories of unhappiness and guilt and can profoundly affect relationships, particularly marriages and other children.⁽²⁸⁻³⁰⁾

Evidence on identification and management of PND in disadvantaged groups

There are increased prevalence rates and population-specific risk factors for PND among adolescent mothers⁽³¹⁾.

E.g. A study examining self-exclusion from postpartum care reported that those who refused to participate were younger and had lower educational attainments than women willing taking up services⁽³²⁾.

There are population-specific risk factors for PND among and ethnically diverse mothers⁽³³⁾,⁽³⁴⁾.

E.g. One study has reported that being non-White (particularly Asian) and being born in a non-English speaking country are significantly associated with high scores on the EPDS, suggesting that women from ethnic minorities should be regarded as at high risk for PND⁽³⁵⁾.

Effective interventions: general

For the general population, a number of treatment options are shown to have varying levels of success:

- *Non-directive counselling (listening visits)* - Limited evidence from a randomised controlled trial (RCT) of 193 people suggested that in the short-term, non-directive counselling improved PND outcome on repeat screening⁽³⁶⁾.
- *Cognitive Behavioural Therapy (CBT)* - Limited evidence from one RCT suggests that individual CBT may improve PND in the short-term, compared with routine primary care⁽³⁷⁾. The study found no clear longer term benefits from individual CBT compared with routine primary care or non-directive counselling.
- *Antidepressants* – Fluoxetine is known to be effective in treating depression in the general population and is frequently used in the treatment of PND⁽³⁸⁾. Evidence as to effective interventions has recently been collated in NICE guidelines¹.

¹ NICE (2006). Antenatal and Postnatal Mental Health: Clinical Management and Service Guidelines. National Institute for Clinical Excellence, Draft Consultation.

Effective identification and management of PND; specific to disadvantaged groups

1. Culturally appropriate screening tools:

Studies which translate the EPDS for use in Bangladeshi and Punjabi-speaking populations report positive results ^{(39), (40)}. However, questions are raised specifically about the use of language-based tools to measure postnatal depressed mood in South Asian populations, and generally about the extent to which focused interviews could be used as an alternative for specific sub-sections of population groups ⁽⁴¹⁾.

2. Antenatal intervention:

Recognition that many risk factors and symptoms of PND can be detected during pregnancy has prompted calls for screening to be performed in the antenatal period ⁽²⁵⁾. There was little evidence from RCTs to support the implementation of antenatal group interventions to reduce PND in 'at risk' women ⁽⁴²⁾, but one intervention study showed that meeting with Asian women antenatally successfully helped to identify those vulnerable to PND ⁽⁴³⁾.

3. Postnatal support:

Intensive postpartum support provided by a health professional was found to have a clear preventive effect in 'at risk' women, and that interventions with only a postnatal component were more beneficial than interventions incorporating an antenatal component ⁽⁴⁴⁾.

Standard 2: To reduce inequalities in the identification and management of postnatal depression

<p>NATIONAL GUIDANCE</p>	<p><i>The NSF for Mental Health suggests that trained health visitors should promptly identify PND</i></p> <p><i>NICE recommend that managed clinical networks for the delivery of perinatal mental health services should be established throughout the country, including specialist perinatal services in each locality.</i></p>
	<p><u>To reduce health inequalities</u> Identified from the most recent evidence, vulnerable groups are:</p> <ul style="list-style-type: none"> • Low income women • Adolescent mothers • Ethnic minorities

2a: Evidence based interventions

Interventions shown to be effective	Groups on whom evidence is based	Recommendations for Greater Manchester	Issues for implementation of standards
Routine administration of the EPDS in the postpartum period	Low income women Adolescent mothers	Administer EPDS at midwives first postpartum visit and at 6-8 weeks postpartum to ALL women including those from minority ethnic groups	<ul style="list-style-type: none"> • <i>Instigate procedures to ensure that the EPDS is administered routinely to all members of the population on both occasions</i>
Culturally appropriate screening tools	South Asian women Black British women	Use culturally specific and language-based screening tools where validated measures are available.	<ul style="list-style-type: none"> • <i>A full review of culturally appropriate screening tools for all ethnic minority groups should be conducted to ensure that these are available of health professionals</i>
Culturally appropriate information/resources on PND	Other predominant minority ethnic groups	A central and well-publicised resource of Information about signs and symptoms of PND should be available in all relevant languages to members of minority ethnic	<ul style="list-style-type: none"> • <i>Culturally appropriate information/resources should be collated and made fully available across all areas of Greater Manchester – current provision is</i>

Interventions shown to be effective	Groups on whom evidence is based	Recommendations for Greater Manchester	Issues for implementation of standards
		communities	<i>patchy.</i>
Antenatal assessment	Asian women Black British women Other predominant minority ethnic groups	Special antenatal class organised specifically for ethnic minority women, to discuss the signs and symptoms of PND and how to get help if needed.	<ul style="list-style-type: none"> • <i>Before classes are implemented, an evaluation needs to be carried out to ensure that the content of the classes is appropriate, that family members can also attend and that measures are in place to target 'high risk' groups.</i>
Postnatal support	Low income women Adolescent mothers Ethnic minorities	Provide frequent visits/invitations to clinic/telephone contact in the first 3 months postnatally to those women identified as high risk on the EPDS.	<ul style="list-style-type: none"> • <i>More frequent visits to women identified as 'high risk' should be carried out, and this timeline should be flexible depending on circumstances.</i> • <i>All women should be made aware of the 24-hour helpline number available in the first 28 days postpartum.</i> • <i>Clearer identification of those groups who are most 'at risk' is needed in order to ensure that vulnerable groups are targeted. Consider those in higher- as well as lower socioeconomic groups.</i> • <i>Services of a specialist Perinatal Support Team should be made available in all areas across Greater Manchester (see 'best practice' section).</i>

2b Data recording standard

Effectiveness of recommended interventions, including targeting of disadvantaged groups, should be routinely assessed using data recorded on the Child Health System Database. This should be progressively adopted by all PCTs in Greater Manchester by the end of 2009. A model on which to base such recording procedures system is available for Manchester PCTs.

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Residential status

Residential status date

Current GP

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Birthplace

Birth area code

Ethnicity (using 2001 Census classification)

For members of ethnic minority groups – need for an interpreter*

Mother's date of birth

Born at code (e.g. Hospital)

Number of previous live births

Birthweight

Health district of birth

One parent family

Benefits data (as a proxy of low income – collected at the midwives first visit)*

EPDS Score at first postnatal visit of midwife and at 6-8 weeks postpartum*

If high risk score:

Referral to GP: yes/no*

***Not currently recorded on Manchester Child Health System Database.**



**Example of Good Practice:
THE PERINATAL SUPPORT TEAM – TRAFFORD PCT**

Estimates of the prevalence of postnatal depression in Trafford give rates higher than the national average of 13%. The Perinatal Support Team was set up in 1995 to address the needs of women with perinatal mental health problems. Referrals are taken from midwives, health visitors and GPs who have identified women as suffering from, or at risk of developing depression antenatally or up to one year postnatally (scoring over 12 on the EPDS). The specialist team currently comprises of 4 part-time health visitors with extra training and qualifications in counselling and cognitive behavioural therapy. The team provides a relatively rapid access to a range of multi-theoretical psychological therapies, signposting to support groups and other services, and consultancy to healthcare professionals as well as providing comprehensive training to health visitors and midwives on the identification and management of perinatal depression.

Before the team was launched, women faced a lengthy wait of up to 12 months in some areas for therapy within mainstream services, but women are now offered an initial psychosocial assessment at home within 6 weeks of referral. The ability of health visitors and midwives to refer directly to the team appears to overcome an important hurdle in women accessing help within mainstream services. The flexibility of the team is also an important factor in breaking down barriers in that home visits are arranged along with support around childcare and appointments at convenient times and places. The team also runs postnatal depression support groups in local family centres, and is in the process of producing a valuable resource for South Asian women in the form of DVD/Video on postnatal depression awareness. This resource is unique and the only one of its kind in the UK.

These factors have led to the Perinatal Support Team being nationally recognized and they have been asked to take part in various national campaigns and TV documentaries. The team has recently been awarded the Trust's quality award for Innovative Service Delivery.

Contact: Pattie Marriott (Pattie.Marriott@trafford.nhs.uk)

Section 3

Smoking Cessation in Pregnancy

Section 3: Smoking Cessation in Pregnancy

Smoking during pregnancy is common, with prevalence studies showing that between 1 in 5 and 1 in 3 pregnant women in developed countries report smoking ⁽⁴⁵⁾. During pregnancy, maternal smoking carries an increased risk of placental complications which may result in pre-term labour, uterine infections and low birth weight. Babies born to smokers weigh on average 200g less than those born to non smokers ⁽⁴⁶⁾. A consultation document issued by the World Health Organisation concluded that passive smoking is a cause of bronchitis, pneumonia, coughing and wheezing, asthma attacks, middle ear infection, sudden infant death syndrome, and possibly cardiovascular and neurobiological impairment in children ⁽⁴⁷⁾. Smoking in the postnatal period is also associated with low rates of breastfeeding initiation and reduced duration ⁽⁴⁵⁾.

The Department of Health (DH) targets are:

To reduce the prevalence of women smoking throughout pregnancy from 23% to 15% by 2010 ⁽⁸⁾.

For PCTs to 'deliver a one percentage point reduction per year in the proportion of women continuing to smoke throughout pregnancy, focussing especially on smokers from disadvantaged groups as a contribution to the national target to reduce by at least 10% the gap in mortality between "routine and manual" groups and the population as a whole by 2010, starting with children under one year' ⁽⁴⁸⁾

Evidence on maternal smoking in disadvantaged groups

Maternal smoking has been closely linked to lower social class, low educational attainment, unemployment, being aged below 20 years, lone motherhood, exposure to others smoking at home, high parity, women who are white and the amount smoked at conception ⁽⁴⁹⁾.

Maternal smoking is not generally linked to minority ethnic status:

E.g. It has been found that Asian and African-Caribbean women have a significantly lower maternal smoking prevalence than the majority White population ⁽⁵⁰⁾.

The differences in maternal smoking prevalence rates are at their sharpest among young women.

E.g. Among married women aged 16-24 without children, 36% are smokers. Among those with children, the proportion is 43% (1990 General Household Survey). These differences are thought to reflect the different socioeconomic circumstances of young women with and without children, with young mothers clustered among those in poorer socioeconomic circumstances ⁽⁵⁰⁾.

Effective Interventions: general

For the general population

- *Population-based campaigns* to encourage smoking cessation during pregnancy are widespread and there appears to be some adoption of systematic intervention programs during antenatal care, but there are still widespread problems with the implementation ⁽⁵¹⁾.
- *Brief opportunistic advice* by a healthcare professional has been shown to increase cessation rates in pregnancy by 1-2%, with more intensive counselling-based behavioural support increasing these rates to around 7% ⁽⁵²⁾.
- A Cochrane review of 64 trials from 1975-2003 concluded that “programmes are effective at increasing smoking cessation, and reducing low birthweight, so interventions should become routine antenatal practice” ⁽⁴⁵⁾. However, there was no clear guidance on what should become standard practice as the review contained a mixture of studies which used a variety of methods. These methods include pharmacological intervention, such as nicotine replacement therapy (NRT) or antidepressants, hypnotherapy, and exercise based interventions ⁽⁵³⁾.

Effective interventions: specific to disadvantaged groups

This review found little or no evidence of effective maternal smoking cessation interventions in disadvantaged groups. The evidence on interventions included:

1. Mass media campaigns:

It is thought that mass media campaigns aimed at specific target groups are more likely to be successful in changing smoking behaviour. One evaluation of a mass media campaign aimed at pregnant young women in deprived areas reported no significant changes in smoking prevalence ⁽⁵⁴⁾.

2. Educational advice:

This is usually delivered by GPs or midwives/health visitors and consists of information about the harmful effects that smoking has on the unborn baby and the harmful effects that passive smoking has on children. One randomised controlled trial (RCT) reported that a one-off advice session delivered by midwives to disadvantaged women was not effective at increasing smoking cessation in pregnancy ⁽⁵⁵⁾.

3. One-to-one counselling:

Two RCTs reported that good quality motivational interviewing did not significantly increase smoking cessation in pregnant women from a deprived area ⁽⁵⁶⁾, nor did not result in a significant increase in smoking cessation in disadvantaged pregnant women’s partners or changes in women’s social support ⁽⁵⁷⁾. Another randomised trial of stage-based counselling reported a small significant increase in smoking cessation in disadvantaged pregnant women, but given that the intervention was resource intensive, it was of doubtful benefit ⁽⁵⁸⁾.

Referral to smoking cessation services

There is wide variation in the level of service provision and uptake with regards to antenatal smoking cessation programmes across the UK ^(61; 62). A nationwide survey found that existing smoking and pregnancy interventions were diverse and ad hoc, that data collection was haphazard and inconsistent and that the commissioning of smoking and pregnancy interventions across the UK appears to be inadequately prioritised ⁽⁶³⁾. In addition, routine monitoring data reveals that there is a very low uptake of smoking cessation services among disadvantaged pregnant women, partly due to wariness in discussing smoking behaviour for fear of being judged, and problems with access due to lack of transport and the demands of childcare ⁽⁶⁴⁾.

A study identifying three services in the UK with the highest number of successful 4-week quitters highlighted the problems of inconsistent data reporting and uptake by disadvantaged groups in the population ⁽⁵⁹⁾, but it was found that all three services with the highest success rate shared a number of features. All three services:

1. Receive the bulk of referrals from local midwives, who are identified as the most important source of referrals. All three services achieved midwife collaboration by providing brief training sessions on how to refer pregnant smokers, rather than how to treat them. All services emphasised the importance of having the full support of heads of midwifery.
2. Offer NRT to almost all pregnant smokers, and have an efficient system of providing the prescriptions.
3. Offer flexible home visits.
4. Provide intensive multi-session treatment delivered by a small number of full-time staff.

All three services relied on exceptionally dedicated and key members of staff, and the authors conclude that, in the absence of clear practical guidance, this seems to be the only way a good service can be developed.

Peer Support Programs

A recent study revealed that those in lower socioeconomic groups showed a preference for peer support programmes to help with smoking cessation, and the authors concluded that this may reflect a situation where more deprived women experience a deficit of social support ⁽⁶⁰⁾.

Although there was little or no evidence found which reported on effective smoking cessation strategies specifically targeted at disadvantaged groups, this is likely due to low uptake of smoking cessation services among these groups. However, it is recognised that smokers are more likely to belong to disadvantaged groups, and therefore the standards below will be formulated using evidence on effective maternal smoking cessation strategies in general, and also the anecdotal evidence described above.

Standard 3: To Reduce Inequalities in Maternal Smoking

NATIONAL TARGETS	<i>To reduce the prevalence of women smoking throughout pregnancy from 23% to 15% by 2010</i>
	<p>To reduce health inequalities The 2003-2006 Priorities and Planning Framework requires PCTs to:</p> <p>'deliver a one percentage point reduction per year in the proportion of women continuing to smoke throughout pregnancy, focussing especially on smokers from disadvantaged groups as a contribution to the national target to reduce by at least 10% the gap in mortality between "routine and manual" groups and the population as a whole by 2010, starting with children under one year'</p>

3a: Evidence based interventions

Interventions shown or thought to be effective	Groups on whom evidence is based	Recommendations for Greater Manchester	Issues for implementation of standards
Effective referral procedures to smoking cessation clinics	Low income mothers Teenage mothers	Training on level 1 smoking cessation to be offered to all midwives and midwifery assistants. Key personnel to be provided with level 2 smoking cessation training.	<ul style="list-style-type: none"> • <i>Training may need to incorporate different strategies to suit those women who are serious about quitting compared to those women who don't want to quit.</i> • <i>Information on the 'smoke free homes' initiative to be given routinely.</i>
Nicotine replacement therapy	Low income mothers Teenage mothers	NRT to be routinely offered/prescribed to all pregnant smokers who wish to stop smoking	<ul style="list-style-type: none"> • <i>Stricter monitoring is needed to ensure all pregnant smokers who wish to quit are offered and prescribed NRT. (see data recording standard)</i>
Home visits to offer advice/support, including partner/family members where appropriate	Deprived populations	Women who do not attend clinics must have home visits by midwives/health visitors	<ul style="list-style-type: none"> • <i>Time resource issues need to be addressed, and if necessary clinic cover could be provided by health trainers/peer supporters</i>
Peer support groups	Low income mothers Teenage mothers	Develop an appropriate peer support program for smoking cessation	<ul style="list-style-type: none"> • <i>More resources devoted to the development of a comprehensive peer support service are needed.</i>

3b Data recording standard

Effectiveness of recommended interventions, including targeting of disadvantaged groups, should be routinely assessed using data recorded on the Child Health System Database. This should be progressively adopted by all PCTs in Greater Manchester by the end of 2009. A model on which to base such recording procedures system is available for Manchester PCTs.

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 Birth area code
 Ethnicity (using 2001 Census classification)
 For members of ethnic minority groups – need for an interpreter*

 Mother's date of birth

 Born at code (e.g. Hospital)
 Number of previous live births
 Birthweight
 Health district of birth
 One parent family
 Benefits data (as a proxy of low income – collected at the midwives first visit)*

 Smoking status at each postnatal visit, including no smoked per day*

 Mother wishes to quit smoking yes/no*

 Nicotine replacement therapy offered yes/no*

***Not currently recorded on Manchester Child Health System**



**Example of Good Practice:
THE COMMUNITY MIDWIFE TEAM, NORTH MANCHESTER**

The smoking in pregnancy rate in North Manchester at booking was an average of 32% in 2003-2004 compared with a national figure of 19%. In some of the most deprived wards, the rates were even higher. Despite these challenging figures, the community midwives in North Manchester have embraced the opportunity to make a difference. They have been trained to intermediate level in smoking cessation skills, incorporating these techniques into antenatal care and have been successful in helping mothers to quit smoking. In 2004-2005 the smoking rates in pregnancy were reduced to 26%.

The success of this service has been attributed to several factors. Firstly, there has been a reduction in the time taken from referral to accessing smoking cessation support – the midwife will arrange to provide the intervention either in clinic or in the home within a few days. Secondly, local women have been trained in smoking cessation techniques in order to offer a peer support group in the community. Thirdly, the midwives receive ongoing, valuable support from the Manchester Stop Smoking Service and also refer on to a local family link worker from a nearby Sure Start programme who runs successful self-help groups or clinics. Finally, the midwives have been able to successfully incorporate the smoking cessation service into routine antenatal care. The midwives report satisfaction in helping mothers to achieve their goals, enhancing maternal health and contributing to local and national health targets in reducing the rates of smoking in pregnancy.

Contact: Eileen Stringer (Eileen.stringer@pat.nhs.uk) or
the Manchester Stop Smoking Service (www.stopsmokingmanchester.co.uk)

Section 4

Improving Nutrition in Pregnancy

Section 4: Improving Nutrition in Pregnancy

A healthy maternal diet is essential for normal foetal development and growth. Good nutrition is also important for the pregnant women to maintain her own health and well-being at this time. The nutrition a woman receives before conception, during pregnancy and lactation affect her health and that of her child ⁽⁶⁵⁾. A diet low in folate not only predisposes to neural tube defects but also to lower birth weight and a shorter pregnancy ⁽⁶⁶⁾. Lack of n-3 fatty acids from fish affects brain development, shortens pregnancy, reduces fetal weight gain and limits placental function and fetal growth ⁽⁶⁷⁾.

Folic acid and multivitamins are recommended during preconception and early pregnancy to reduce the incidence of neural tube defects ⁽⁶⁸⁾, ⁽⁶⁹⁾.

Evidence on maternal nutrition in disadvantaged groups

Pregnancy in adolescence is a time of extreme nutritional risk (Wynn et al, 1994).

E.g. It has been suggested that adolescents who become pregnant are likely to have inadequate nutritional status from the outset as these women are still growing and are more likely to have unfavourable socioeconomic backgrounds. There is often a competition for nutrients between the growing pregnant adolescent and her foetus ⁽⁶⁸⁾.

Poor maternal nutrition exists in all social classes but increases from social class I to V, and further still among single mothers.

E.g. A study carried out in Sheffield reported that diets low in important nutrients for pregnancy such as folate were largely found in participants living in the 40% most deprived electoral wards ⁽⁷⁰⁾. Another study showed that being a single mother had stronger negative associations with 'health conscious' diets ⁽⁷¹⁾.

Racial origin has been linked to poor nutrition in pregnancy ⁽⁷²⁾.

E.g. It has been reported that African women had the lowest levels of iron and folate in the first trimester of pregnancy ⁽⁷³⁾, and that the risk of perinatal mortality increases earlier in gestation among South Asian women than among white women, and the most important factor associated with antepartum stillbirth among South Asian and black women was low birth weight ⁽⁷⁴⁾.

Effective Interventions: general

For the general population

- Healthy Start was introduced by the Department of Health in 2006 and will provide people who qualify with vouchers to buy milk and infant formula. The scheme will also allow parents to buy fresh fruit and vegetables. Free vitamin supplements are an important part of the scheme. An evaluation of the scheme showed that many families welcomed this flexibility, and that health professionals understood how the scheme worked and were able to advise their clients appropriately ⁽⁷⁵⁾.

Effective interventions: specific to disadvantaged groups

1. Community based food-skills workshops:

A midwife-led intervention aimed at altering cooking confidence, food preparation methods and dietary choices was found to have a small but positive impact on food choice and confidence in teenage pregnant women in an area of social deprivation ⁽⁷⁶⁾.

2. Nutritional screening:

An evaluation of the performance of a nutritional screening tool for Caucasian pregnant women of differing socioeconomic status was found to be reliable and appears to be a valid tool for categorising pregnant women according to dietary intake ⁽⁷⁷⁾.

This review found no evidence of maternal nutritional interventions for ethnic minorities.

Standard 4: To Reduce Inequalities in Maternal Nutrition

NATIONAL GUIDANCE	<i>Folic acid and multivitamins are recommended during preconception and early pregnancy to reduce the incidence of neural tube defects</i>
	<p>To reduce health inequalities Identified from the most recent evidence, vulnerable groups are:</p> <ul style="list-style-type: none"> • Low income women • Adolescent mothers • Ethnic minorities

4a: Evidence based interventions

Interventions shown to be effective	Groups on whom evidence is based	Recommendations for Greater Manchester	Issues for implementation
Antenatal nutritional programme	Low income women	<p>Nutritional advice should be routinely provided to all women as part of ante natal care.</p> <p>General Practitioners should provide folate to all women on notification of pregnancy</p>	<ul style="list-style-type: none"> • <i>Protocols should be developed to ensure that dietary/nutritional advice is incorporated into routine antenatal care.</i> • <i>Health trainers may be better placed to deliver this information</i>
Community-based food skills workshops	Adolescent mothers	Each PCT to host regular midwife-led nutritional workshops in the community for all women	<ul style="list-style-type: none"> • <i>Dieticians or health visitors could also deliver these workshops.</i> • <i>Strategies need to be developed to attract vulnerable groups to workshops/classes (see data recording standard)</i>
Nutritional screening	Low income women	All women to be nutritionally assessed at booking visit using a food-frequency questionnaire	<ul style="list-style-type: none"> • <i>Implementation strategy should be developed to ensure the routine use of a validated screening tool</i> • <i>A review of culturally appropriate screening tools should be conducted.</i>

3b Data recording standard

Effectiveness of recommended interventions, including targeting of disadvantaged groups, should be routinely assessed using data recorded on the Child Health System Database. This should be progressively adopted by all PCTs in Greater Manchester by the end of 2009. A model on which to base such recording procedures system is available for Manchester PCTs.

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 Birthweight
 Health district of birth
 One parent family
 Benefits data (as a proxy of low income – collected at the midwives first visit)*

Smoking status at each postnatal visit, including no smoked per day*

Mother wishes to quit smoking yes/no*

Nicotine replacement therapy offered yes/no*

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Evidence on maternal nutrition in disadvantaged groups

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E.g. It has been suggested that adolescents who become pregnant are likely to have inadequate nutritional status from the outset as these women are still growing and are more likely to have unfavourable socioeconomic backgrounds. There is often a competition for nutrients between the growing pregnant adolescent and her foetus ⁽⁶⁸⁾.

Poor maternal nutrition exists in all social classes but increases from social class I to V, and further still among single mothers.

E.g. A study carried out in Sheffield reported that diets low in important nutrients for pregnancy such as folate were largely found in participants living in the 40% most deprived electoral wards ⁽⁷⁰⁾. Another study showed that being a single mother had stronger negative associations with 'health conscious' diets ⁽⁷¹⁾.

Racial origin has been linked to poor nutrition in pregnancy ⁽⁷²⁾.

E.g. It has been reported that African women had the lowest levels of iron and folate in the first trimester of pregnancy ⁽⁷³⁾, and that the risk of perinatal mortality increases earlier in gestation among South Asian women than among white women, and the most important factor associated with antepartum stillbirth among South Asian and black women was low birth weight ⁽⁷⁴⁾.

Effective Interventions: general

For the general population

- Healthy Start was introduced by the Department of Health in 2006 and will provide people who qualify with vouchers to buy milk and infant formula. The scheme will also allow parents to buy fresh fruit and vegetables. Free vitamin supplements are an important part of the scheme. An evaluation of the scheme showed that many families welcomed this flexibility, and that health professionals understood how the scheme worked and were able to advise their clients appropriately ⁽⁷⁵⁾.

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4a: Evidence based interventions

Interventions shown to be effective	Groups on whom evidence is based	Recommendations for Greater Manchester	Issues for implementation
Antenatal nutritional programme	Low income women	<p>Nutritional advice should be routinely provided to all women as part of ante natal care.</p> <p>General Practitioners should provide folate to all women on notification of pregnancy</p>	<ul style="list-style-type: none"> • <i>Protocols should be developed to ensure that dietary/nutritional advice is incorporated into routine antenatal care.</i> • <i>Health trainers may be better placed to deliver this information</i>
Community-based food skills workshops	Adolescent mothers	Each PCT to host regular midwife-led nutritional workshops in the community for all women	<ul style="list-style-type: none"> • <i>Dieticians or health visitors could also deliver these workshops.</i> • <i>Strategies need to be developed to attract vulnerable groups to workshops/classes (see data recording standard)</i>
Nutritional screening	Low income women	All women to be nutritionally assessed at booking visit using a food-frequency questionnaire	<ul style="list-style-type: none"> • <i>Implementation strategy should be developed to ensure the routine use of a validated screening tool</i> • <i>A review of culturally appropriate screening tools should be conducted.</i>

4b: Data recording Standard

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 For members of ethnic minority groups – need for an interpreter*

Mother's date of birth

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 Number of previous live births
 Birthweight
 Health district of birth
 One parent family
 Benefits data (as a proxy of low income – collected at the midwives first visit)*

Folate prescribed yes/no*

Food frequency questionnaire administered yes/no*

***Not currently recorded on Manchester Child Health System**



Example of Good Practice: THE SUNFLOWER COMMUNITY HEALTH PROJECT WIGAN

Previous research has shown that only 9.9% of people in the Wigan Borough eat 5+ portions of fruit or vegetables each day, 5.6% eat none and 11.7% eat fried foods 3 or more times a week (Wigan Borough Health Survey, 2001). The Sunflower Community Health Project aims to improve the health of local residents living in three housing estates in Wigan, located in two of the most deprived wards. The project runs several nutrition-based initiatives including 'Cook and Taste', which focuses on healthy eating on a budget and has a published recipe book; providing healthy snacks at local parent and toddler groups; and accredited training courses on healthy eating for community members.

The project is staffed by one full-time and four part-time community health workers and is based in the new Pemberton Primary Care Resource Centre which has access to the clinic's meeting rooms and crèche facilities. The key to the project's success is attributed to the active involvement of local people who promote health activities and support residents in their participation. There are 300 local residents involved in the project's activities who have attended courses accredited through Greater Manchester Open College Network and developed transferable skills that have improved their employment and training prospects.

Contact: Louise Lawlor, Sunflower Community Development Worker
(sunflowerproject@ukonline.co.uk)

References

1. World Health Organisation. Infant and Young Child Nutrition. Global Strategy on Infant and Young Child Feeding. Fifty-Fifth World Health Assembly. Geneva: WHO; 2002.
2. Howie P, Forsyth JS, Ogston SA, Clark A, du V Florey C. Protective effect of breast-feeding against infection. *BMJ*. 1990; 300:11-6.
3. Bick D. The benefits of breastfeeding for the infant. *British Journal of Midwifery*. 1999; 7:312-9.
4. Johnston E. Weight changes during pregnancy and the postpartum period. *Prog Food Nutr Sci*. 1991; 15:117-57.
5. Porter S, Hannum S, McFarlin B, Essex-Sorlie D, Campbell E, Trupin S. Does infant feeding method influence maternal postpartum weight loss? *J Am Diet Assoc*. 1991;91:441-6.
6. Dewey K, Heinig MJ, Nommensen LA. Maternal weight loss patterns during prolonged lactation. *Am J Clin Nutr*. 1993; 58:162-6.
7. Department of Health. National Service Framework for Children, Young People and Maternity Services. 2004 [cited; Available from: http://www.dh.gov.uk/PolicyAndGuidance/HealthAndSocialCareTopics/ChildrenServices/ChildrenServicesInformation/ChildrenServicesInformationArticle/fs/en?CONTENT_ID=4089111&chk=U8Ecln
8. Department of Health. The NHS Plan: Improving health and reducing inequality. London: Department of Health; 2000.
9. Dyson L, Renfrew M, McFadden A, McCormick F, Herbert G, Thomas J. Promotion of breastfeeding initiation and duration. London: NICE; 2005.
10. Hamlyn B, Brooker S, Oleinikova K, Wands S. Infant Feeding 2000. London: TSO; 2002.
11. Griffiths L, Tate AR, Dezateux C. The contribution of parental and community ethnicity to breastfeeding practices: evidence from the Millennium Cohort Study. *International Journal of Epidemiology*. 2005; 34:1378-86.
12. Kelly Y, Watt RG, Nazroo JY. Racial/ethnic differences in breastfeeding initiation and continuation in the United Kingdom and comparison with findings in the United States. *Paediatrics*. 2006; 118:1428-35.
13. Dykes F. Infant Feeding Initiative: a report evaluating the breastfeeding practice projects 1999-2002. London: Department of Health; 2003.
14. Fairbank L, O'Meara S, Renfrew MJ, Woolridge M, Sowden AJ, Lister-Sharp D. A systematic review to evaluate the effectiveness of interventions to promote the initiation of breastfeeding. *Health Technol Assess*. 2000; 4:1-171.
15. Alexander J, Anderson T, Grant M, Sanghera J, Jackson D. An evaluation of a support group for breast-feeding women in Salisbury, UK. *Midwifery*. 2003; 19:215-20.
16. McInnes R, Love JG, Stone DH. Evaluation of a community-based intervention to increase breastfeeding. *Journal of Public Health Medicine*. 2000; 22:138-45.
17. Ingram J, Rosser J, Jackson D. Breastfeeding peer supporters and a community support group: evaluating their effectiveness. *Maternal and Child Nutrition*. 2005; 1:111-8.

References

18. Ingram J, Johnson D, Hamid N. South Asian grandmothers' influence on breast feeding in Bristol. *Midwifery*. 2003; 19:318-27.
19. Ingram J, Johnson D. A feasibility study of an intervention to enhance family support for breast feeding in a deprived area in Bristol, UK. *Midwifery*. 2004; 20:367-79.
20. Renfrew M, Herbert G, Wallace LM, Spiby H, McFadden A. Developing practice in breastfeeding. *Maternal and Child Nutrition*. 2006; 2:245.
21. Bartington S, Griffiths LJ, Tate AR, Dezateux C & the Millennium Cohort Study Child Health Group. Are breastfeeding rates higher among mothers delivering in Baby Friendly accredited maternity units in the UK? *International Journal of Epidemiology*. 2006; 35:1178-86.
22. Hall-Moran V, Edwards J, Dykes F, Downe S. A systematic review of the nature of support for breastfeeding adolescent mothers. *Midwifery*. 2006.
23. Beake S, McCourt C, Rowan C, Taylor J. Evaluation of the use of healthcare assistants to support disadvantaged women breastfeeding in the community. *Maternal and Child Nutrition*. 2005; 1:32-43.
24. Graffy J, Taylor J, Williams A, Eldridge S. Randomised controlled trial of support from volunteer counsellors for mothers considering breastfeeding. *BMJ*. 2004; 328:1-6.
25. Priest S, Austin M, Sullivan E. Antenatal psychosocial screening for prevention of antenatal and postnatal anxiety and depression. *Cochrane Database of Systematic Reviews*. 2005⁽¹⁾.
26. Cooper P, Campbell EA, Day A. et al. Non-psychotic psychiatric disorder after childbirth: a prospective study of prevalence, incidence, course and nature. *Br J Psychiatry*. 1988; 152:799-806.
27. Cox J, Murray D, Chapman G. A controlled study of the onset and duration of postnatal depression. *Br J Psychiatry*. 1993; 163:27-31.
28. Department of Health. National Service Framework for Mental Health. London: The Stationery Office; 1999.
29. Cox J, Holden JM, Sagovsky R. Detection of postnatal depression. Development of the 10-item Edinburgh Postnatal Depression Scale. *Br J Psychiatry*. 1987; 150:782-6.
30. Ferguson S, Jamieson DJ, Lindsay M. Diagnosing postpartum depression: can we do better? *Am J Obstet and Gynaecol*. 2002; 186:899-902.
31. Troutman B, Cutrona CE. Nonpsychotic postpartum depression among adolescent mothers. *J Abnormal Psychol*. 1990; 99:69-78.
32. Murray L, Woolgar M, Murray J, Cooper P. Self-exclusion from health care in women at high risk for postpartum depression. *Journal of Public Health Medicine*. 2003; 25:131-7.
33. Patel V, Rodrigues M, DeSouza N. Gender, poverty, and postnatal depression: a study of mothers in Goa, India. *Am J Psychiatry*. 2002; 159:43-7.
34. Edge D, Baker D, Rogers A. Perinatal depression among black Caribbean women. *Health Soc Care Community*. 2004; 12:430-8.
35. Onozawa K, Kumar RC, Adams D, Dore C, Glover V. High EPDS scores in women from ethnic minorities living in London. *Archives of Women's Mental Health*. 2003; 6:51-5.
36. Cooper P, Murray L, Wilson A, et al. Controlled trial of the short and long-term effect of psychological treatment of postpartum depression. I. Impact on maternal mood. *Br J Psychiatry*. 2005; 182:412-9.

37. Murray L, Cooper PJ, Wilson A, et al. Controlled trial of the short and long-term effect of psychological treatment of postpartum depression. 2: Impact on the mother-child relationship and child outcome. *Br J Psychiatry*. 2005; 182:420-7.
38. Lumley J, Austin MP, Mitchell C. Intervening to reduce depression after birth: a systematic review of randomised trials. *Int J Technol Assess Health Care*. 2004; 20:128-44.
39. Fuggle P, Glover L, Khan F, Haydon K. Screening for postnatal depression in Bengali women: preliminary observations from using a translated version of the Edinburgh Postnatal Depression Scale (EPDS). *Journal of Reproductive and Infant Psychology*. 2002; 20:71-82.
40. Werrett JCC. Validation of the Punjabi version of the Edinburgh postnatal depression scale (EDPS). *International Journal of Nursing Studies*. 2006; 43:227-36.
41. Downe S, Butler E, Hinder S. Screening tools for depressed mood after childbirth in UK-based South Asian women: a systematic review. *Journal of Advanced Nursing*. 2006.
42. Austin M. Targeted group antenatal prevention of postnatal depression: a review. *Acta Psychiatr Scand*. 2003; 107:244-50.
43. Bostock J, Marsen M, Sarwar Z, Stoltz S. Postnatal depression in Asian women. *Community Nurse*. 1996(November/December):34-6.
44. Dennis C-L, Creedy D. Psychosocial and psychological interventions for preventing postpartum depression. *Cochrane Database of Systematic Reviews*; 2004.
45. Lumley J, Oliver SS, Chamberlain C, Oakley L. Interventions for promoting smoking cessation during pregnancy. *Cochrane Database of Systematic Reviews*; 2004.
46. Messecar D. Smoking cessation interventions for pregnant women: what does the evidence show? *Journal of Academy of Nurse Practitioners*. 2001; 3:171-7.
47. World Health Organisation. International Consultation on Environmental Tobacco Smoke (ETS) and Child Health: WHO Tobacco Free Initiative, WHO/NCD/TFI/99.10; 1999.
48. Department of Health. NHS Priorities and Planning Framework. London: Department of Health; 2002.
49. Forrest D, Horsley S, Roberts E, Barrow S. Factors relating to smoking and pregnancy in the North Western Region. *Journal of Public Health Medicine*. 1995; 17:205-10.
50. Graham H. Gender and class as dimensions of smoking behaviour in Britain: insights from a survey of mothers. *Social Science and Medicine*. 1994; 38:691-8.
51. Lumley J, Oliver S, Waters E. Interventions for promoting smoking cessation during pregnancy (Cochrane Review). *The Cochrane Library*, Issue 3; 2002.
52. Silagy C, Lancaster T, Stead L, Mant D, Fowler G. Nicotine replacement therapy for smoking cessation. *Cochrane Database of Systematic Reviews*: 2004.
53. Riemsma R, Pattenden J, Bridle C, Sowden AJ, Mather L, Watt IS, Walker A. Systematic review of the effectiveness of stage based interventions to promote smoking cessation. *BMJ*. 2003; 326:1175-7.
54. Champion P, Owen L, McNeill A, McGuire C. Evaluation of a mass media campaign on smoking and pregnancy. *Addiction*. 1994; 89:1245-54.
55. Hajek P, West R, Lee A, Foulds J, Owen L, Eiser JR, Main N. Randomized controlled trial of a midwife-delivered brief smoking cessation intervention in pregnancy. *Addiction*. 2001; 96:485-94.

References

56. Tappin D, Lumsden MA, Gilmour WH, Crawford F, McIntyre D, Stone DH, Webber R, MacIndoe S, Mohammed E. Randomised controlled trial of home based motivational interviewing by midwives to help pregnant smokers quit or cut down. *BMJ*. 2005; 331:373-7.
57. Aveyard P, Lawrence T, Evans O, Cheng KK. The influence of in-pregnancy smoking cessation programmes on partner quitting and women's social support mobilization: a randomized controlled trial. *BMC Public Health*. 2005; 5.
58. Lawrence T, Aveyard P, Evans O, Cheng KK. A cluster randomised controlled trial of smoking cessation in pregnant women comparing interventions based on the transtheoretical (stages of change) model to standard care. *Tobacco Control*. 2003; 12:168-77.
59. Lee M, Hajek P, McRobbie H, Owen L. Best practice smoking cessation services for pregnant women: results of a survey of three services reporting the highest national returns, and three beacon services. *J R Soc Health*. 2006; 126:233-8.
60. Ussher M, West R, Hibbs N. A survey of pregnant smokers' interest in different types of smoking cessation support. *Patient Education and Counselling*. 2004; 54:67-72.
61. Wakefield M, Gillies P, Graham H, Madeley R, Symonds M. Characteristics associated with smoking cessation during pregnancy among working class women. *Addiction*. 1993; 88:1423-30.
62. Batten L, Graham H, High S, Ruggerio L, Rossi J. Stage of change, low income and benefit status: a profile of women's smoking in early pregnancy. *Health Education Journal*. 1999; 58:378-88.
63. Coppel D, Watts K, White J, Owen L. Contracting for smoking and pregnancy interventions: current practice across England. *Public Health*. 2001; 115:222-8.
64. Tod A. Barriers to smoking cessation in pregnancy: a qualitative study. *British Journal of Community Nursing*. 2003; 8:56-64.
65. Reifsneider EG, Gill S. Nutrition for the Childbearing Years. *Journal of Obstetric, Gynaecologic & Neonatal Nursing*. 2000; 29:43-55.
66. Scholl T, Hediger ML, Schall JI, Khoo G-S, Fischer RL. Dietary and serum folate: their influence on the outcome of pregnancy. *Am J Clin Nutr*. 1996; 63:520-5.
67. Olsen S, Hansen HS, Secher NJ, Jensen B, Sandstrom B. Gestation length and birth weight in relation to intake of marine n-3 fatty acids. *Br J Nutr*. 1995; 73:397-404.
68. Czeizel A. Primary prevention of neural tube defects and some other major congenital abnormalities: recommendations for the appropriate use of folic acid during pregnancy. *Paediatric Drugs*. 2000; 2:437-49.
69. Lumley J, Watson L, Watson M, Bower, C. Periconceptional supplementation with folate and/or multivitamins for preventing neural tube defects. *Cochrane Database of Systematic Reviews*. 2001.
70. Mouratidou T, Ford F, Prountzou F, Fraser RB. Dietary assessment of a population of pregnant women in Sheffield, UK. *Br J Nutr*. 2006; 96:929-35.
71. Northstone K, Emmett P, Rogers I. Dietary patterns in pregnancy and associations with socio-demographic and lifestyle factors. *European Journal of Clinical Nutrition*. 2007:1-9.
72. Newnham J. Improving outcomes in pregnancy: what are the implications of first trimester fetal growth and racial origin? *BMJ*. 2007; 334:807-8.
73. Rees G, Doyle W, Srivastava A, Brooke ZM, Crawford MA, Costeloe KL. The nutrient intakes of mothers of low birth weight babies - a comparison of ethnic groups in East London, UK. *Maternal and Child Nutrition*. 2005; 1:91-9.

74. Balchin I, Whittaker JC, Patel RR, Lamont RF, Steer PJ. Racial variation in the association between gestational age and perinatal mortality: prospective study. *BMJ*. 2007; 334:833-8.
75. Department of Health. Healthy Start Application Leaflet (HS01) Free Milk, Fruit, Vegetables and Vitamins for You and Your Family. 2006. www.healthystart.nhs.uk.
76. Wrieden W, Anderson AS, Longbottom PJ, Valentine K, Stead M, Caraher M, Lang T, Gray B, Dowler E. The impact of a community-based food skills intervention on cooking confidence, food preparation methods and dietary choices - an exploratory trial. *Public Health Nutrition*. 2007; 10:203-11.
77. Mouratidou T, Ford F, Fraser RB. Validation of a food-frequency questionnaire for use in pregnancy. *Public Health Nutrition*. 2006; 9:515-22.

APPENDICES

Appendix 1a: Evidence Tables (Breastfeeding)

Major studies/Reviews – Findings

Authors/Body	Overview	Key findings/recommendations
Dykes (2003)	A synthesis of findings and key challenges identified by 79 Infant Feeding Projects funded between 1999 and 2002 by DH. The projects centred upon the development of innovative practices that aimed to increase the incidence and duration of breastfeeding in groups that have been identified as being least likely to breastfeed.	<p>It was recommended that Acute Trusts, Primary Trusts and Sure Start schemes continue to collaborate and fund projects to include:</p> <ul style="list-style-type: none"> Breastfeeding peer support programmes that are carefully co-ordinated through interagency partnerships; Breastfeeding support centres, both Breastfeeding Network (BfN) and the health professional led 'drop-in' model; Antenatal interactive workshops developed with sensitivity to the local socio-cultural needs; Development of the healthcare assistant role in supporting breastfeeding women across the hospital community interface; Innovative projects primarily involving qualified breastfeeding counsellors/supporters; Education and training for health visitors, midwives, neonatal staff and doctors; Schemes that specifically reach and support women from ethnic minority communities; Projects that specifically support adolescent mothers; Schemes that involve significant others; Expansion of the Breastfeeding Friendly Award project; Prison outreach programmes; Media projects to include National Breastfeeding Awareness week; Health informatics systems that enable robust yet sensitive data collection and analysis using consistent time points and definitions related to infant feeding practices.
Dyson et al (2005)	This NICE report presented a series of evidence-based actions for promoting the initiation and continuation of	<p>Interventions which were shown to be effective were listed as:</p> <ul style="list-style-type: none"> Peer support

Authors/Body	Overview	Key findings/recommendations
	breastfeeding, particularly among population groups where breastfeeding rates are low.	Professional support Education Education and professional support Education and peer support Professional training Hospital practices Multisectoral interventions Media programmes
Fairbank et al (2000)	A systematic review to evaluate the effectiveness of interventions to promote the initiation of breastfeeding	Informal, small group health education, delivered during the antenatal period, appears to be effective at increasing initiation rates among women from different income groups and from some minority ethnic groups. There is also some evidence to show that one-to-one health education can be effective at increasing initiation rates among women on low incomes. Peer support programmes, delivered in the ante- and postnatal periods, have also been shown to be effective at increasing both initiation and duration rates of breastfeeding among women on low incomes, and particularly among women who have expressed a desire to breastfeed.
Hall-Moran et al (2006)	A systematic review of the nature of support for breastfeeding adolescent mothers	Of 209 studies identified, 7 fitted the inclusion criteria. Five types of support were identified: emotional, esteem, instrumental, informational & network. The participants seemed to find the emotional, esteem and network components most helpful Support from the participants' mothers seemed to be particularly powerful The provision of continuity of support from an expert individual who is skilled in both lactation support and working with adolescents was also highly valued Targeted breastfeeding educational programmes specifically designed for the adolescent learner may be successful in improving breastfeeding initiation and continuation rates in this population Further qualitative and feasibility studies are therefore warranted in order to inform future randomised-controlled trials.

Individual studies - Findings

Authors	Sample	Overview	Findings	Recommendations
Alexander et al (2003)	Women from a socio-economically disadvantaged housing estate in Salisbury, UK (n=53)	To evaluate a newly set-up breastfeeding support group (Bosom Buddies)	76% of respondents reported that they were still breastfeeding at 6 weeks. While the greatest value of the group was considered by the women to relate to its function in supporting breastfeeding, 46% of the aspects identified by them as being 'good' related to issues of a predominantly psychosocial nature.	The authors suggest some 'ingredients' for success: the group should be informal with the emphasis on social support; skilled, evidence-based professional help should be readily available; the breastfeeding counsellor introduces women with similar difficulties which assists women in supporting each other.
Bartington et al (2006)	First time mothers (n=17,359) taken from Millennium Cohort Study	Self-reported breastfeeding according to maternity unit BFI status at birth	Mothers delivering in accredited units were more likely to start breastfeeding than those delivering in units with neither award, but were not more likely to breastfeed at 1 month, after adjustment for social, demographic and obstetric factors. Antenatal class attendance, vaginal delivery, a companion at delivery and maternal post-partum hospital stay were also independently associated with breastfeeding initiation.	Policies to increase the proportion of maternity units participating in the BFI are likely to increase breastfeeding initiation but not duration. Other strategies are required in order to support UK mothers to breastfeed for the recommended duration.
Beake et al (2005)	Women living in an area of London identified by the Sure Start scheme as socio-economically disadvantaged (n=84)	To evaluate the implementation of a small-scale pilot project using healthcare assistants in the community to support breastfeeding women.	The findings suggest that the use of healthcare assistants in the community may offer a practical and encouraging approach in supporting breastfeeding which is acceptable to both breastfeeding women and healthcare professionals.	More research is needed to establish whether the intervention significantly increases breastfeeding rates.
Ingram et al (2003)	South Asian families in Bristol where exclusive breastfeeding is low (n=16)	To evaluate an intervention for grandmothers to support exclusive breastfeeding based around a leaflet.	South Asian women are not a homogenous group and differences were seen in cultural and religious practices and in breastfeeding rates between the Pakistani, Bangladeshi and Indian communities. The intervention was appreciated by the families involved and seemed to be influencing behaviour.	Recording details of baby-feeding method at eight weeks systematically by ethnic group will enable local rates to be monitored, particular groups targeted with information and positive reinforcement provided. Link workers with appropriate training should be available to speak the languages relevant to the ethnic groups in the area. Involving influential local interpreters in

Authors	Sample	Overview	Findings	Recommendations
				an educational intervention will help to educate the wider population in practices to support exclusive breastfeeding.
Ingram et al (2004)	Families in an area of relative social and economic deprivation in South Bristol (n=29)	To design a suitable intervention for fathers and grandmothers to support breastfeeding mothers.	Using an antenatal session based around a leaflet, specifically written for grandmothers and fathers, and including a demonstration of good breastfeeding positioning and attachment in addition to the discussion of specific issues around the health benefits and mechanics of breastfeeding was found to be acceptable, useful and enjoyable by all participants, particularly for first time parents. Significantly more intervention mothers were breastfeeding their babies at 8 weeks than in the wider practice population.	This type of intervention could be part of a multi-faceted approach towards improving breastfeeding rates in areas of low prevalence. Health professionals should be opportunistic about involving other family members in discussions about breastfeeding whenever possible, both antenatally and postnatally.
Ingram et al (2005)	Mothers from a disadvantaged community attending a peer support group (n=35)	To evaluate the effectiveness of a peer support initiative in increasing breastfeeding rates.	Breastfeeding rates in the area showed a significant increase at 8 weeks, which was higher than the overall average in the area.	Peer supporters combined with a breastfeeding peer support group are an effective way of increasing breastfeeding prevalence in areas of low continuation.
McInnes et al (2000)	Low-income women in Glasgow (n=919)	To determine whether peer counselling would increase the prevalence and duration of breastfeeding.	Breastfeeding prevalence was significantly higher in the intervention group relative to controls. However, by 6 weeks postnatally, the difference between the two groups was not statistically significant.	As the impact of the intervention was not sustained, even for the modest duration of 6 weeks postnatally, it would be premature to justify widespread use of peer support programmes to increase the prevalence of breastfeeding in disadvantaged communities.

Method and outcome summary table for all studies

Authors/Body	Type of study	Inequality measures	Method	Outcome measures
Alexander et al (2003)	Intervention	<ul style="list-style-type: none"> • Low socioeconomic status 	Eleven peer supporters were trained over a 6-week period and then ran a weekly drop in session in a socio-economically disadvantaged housing estate, also attended by a trained breastfeeding counsellor & a midwife.	Evaluation of sessions, reasons for attending/not attending, and reasons for discontinuing breastfeeding.
Bartington et al (2006)	Intervention	<ul style="list-style-type: none"> • Low socioeconomic status • Ethnicity 	Using a stratified sample of the Millennium Cohort to over-represent families with a high proportion of disadvantaged and ethnic minority families. Mothers and their partners were interviewed at home with analysis of maternally reported breastfeeding initiation and prevalence of breastfeeding at 1 month according to maternity unit BFI status at birth.	Breastfeeding initiation and prevalence of breastfeeding at 1 month.
Beake et al (2005)	Intervention	<ul style="list-style-type: none"> • Low socioeconomic status 	A post of Infant Feeding Support Worker was created and managed within the midwifery service with a community base, funded by Sure Start on the health care assistant scale. Questionnaires (related to before and during implementation) and semi-structured interviews with women in the area 6 weeks postnatally, focus group discussions with midwives, semi-structured interviews with all working group members and support worker and midwife case records were analysed.	Evaluation of role, satisfaction with service.
Dykes (2003)	Review	<ul style="list-style-type: none"> • Ethnicity • Adolescent mothers • Access to services • Low socioeconomic status 	Various	Initiation and duration of breastfeeding

Authors/Body	Type of study	Inequality measures	Method	Outcome measures
Dyson et al (2006)	Review	<ul style="list-style-type: none"> • Adolescent mothers • Low socioeconomic status • Lone parents 	Various	Initiation and duration of breastfeeding
Fairbank et al (2000)	Review	<ul style="list-style-type: none"> • Low socioeconomic status • Ethnicity 	Various	Initiation of breastfeeding
Graffy et al (2004)	Randomised controlled trial	<ul style="list-style-type: none"> • Low socioeconomic status 	28 accredited counsellors for the NCT took part. Women were recruited during antenatal care at one of 32 practices selected on the basis of proximity to counsellors willing to participate, having a mixed or deprived population, providing antenatal and postnatal care, and not undertaking specific initiatives to breastfeed.	Prevalence of breastfeeding at 6 weeks. Also measured was the proportion of women giving any breast feeds, or bottle feeds at four months, duration of any breastfeeding, time to introduction of bottle feeds, and satisfaction with breastfeeding.
Hall Moran et al (2006)	Systematic review	<ul style="list-style-type: none"> • Adolescent mothers 	Various	Initiation and duration of breastfeeding
Ingram et al (2003)	Intervention	<ul style="list-style-type: none"> • Ethnicity 	The intervention was based around an educational leaflet including traditional messages about breastfeeding and was delivered to mother and grandmother pairs at around 36 weeks gestation and translated into three languages. Qualitative focus groups and interviews took place in community health centres and family homes	Assessment of acceptability and feasibility of the intervention.
Ingram et al (2004)	Intervention	<ul style="list-style-type: none"> • Low socioeconomic status 	Same as above, except sample included fathers and grandmothers from a deprived area, not just South Asian families.	Evaluation of the feasibility of an antenatal intervention
Ingram et al (2005)	Intervention	<ul style="list-style-type: none"> • Low socioeconomic status 	6 local women were trained in peer supporter and then set up a support group in a community centre. Focus groups were held with peer supporters, who also completed questionnaires before and after their training. Questionnaires were sent to	The effects of training on the women were explored, the combined effect of peer support and the group on breastfeeding prevalence was assessed, and mother's views on what they had gained from the breastfeeding support group were also reported.

Authors/Body	Type of study	Inequality measures	Method	Outcome measures
McInnes et al (2000)	Intervention	<ul style="list-style-type: none"> • Low socioeconomic status 	<p>all mothers who attended the support group over the first 5 months. Breastfeeding rates were extracted from local data.</p> <p>The intervention comprised peer counselling of pregnant women by 7 local women who underwent a specially devised training program. Women were then offered the support twice antenatally and twice postnatally. The control group were not offered any peer support. Questionnaires were completed at the time of offering the support for both the intervention and control groups.</p>	<p>Antenatally - Feeding intentions, influences on choice of feeding method and previous feeding behaviour. Postnatally – actual feeding behaviour.</p>

Appendix 1b: Focus group discussion: breastfeeding

A focus group discussion took place at the University of Salford and was attended by 4 midwives and health visitors from Salford PCT, and a lecturer in midwifery at the University. The aim of the focus group was to discuss the evidence-based recommendations or standards with relation to: implementation/barriers; information on the general procedures to encourage breastfeeding; to discuss issues relating to data recording; and to provide details of any ongoing programs/initiatives in the area. The structure of the focus group discussion was based around the recommendations in the report, and a questionnaire following the same format/questions was also drawn up to allow individual feedback. The results are documented in the transcription below:

1. Peer support in the antenatal and postnatal periods

Information provided by the group indicated that peer support is offered in both the antenatal and postnatal periods on an 'ad hoc' basis, and not at all in some areas. The group expressed concern about the importance placed on peer support in the evidence, and felt that other factors (such as BFI) were equally, if not more important to encourage breastfeeding. The group also felt that a service which is wholly reliant on volunteers gives rise to problems with implementation, such as recruitment, affordability and sustainability. The group expressed concern that peer supporters have a limited skills base and "cannot replace trained and accountable staff". It was also reported that peer supporters can "support but not help with specific feeding problems". When asked whether peer support roles should be turned into paid positions, the group members felt that this would mean having to provide consistent training for all peer supporters, and that it would raise issues around confidentiality, ethics, and insurance.

As peer support often comprises the services of charities such as the Breastfeeding Network, a concern was raised by one group member who stated that this particular types of support is usually accessed by a marginal proportion of women who are not disadvantaged or hard-to-reach. The group also felt that whilst the development and progress for peer supporters is great, the success of breastfeeding mothers is not as great, and although it is a positive service, the costs appear to outweigh the benefits.

Several times, the group mentioned 'The Breastfeeding Project' which is a collaboration between Sure Start and Salford PCT that consists of two lactation consultants who provide training, support and advice to mothers as well as peer supporters .

The group felt the most successful practice that worked across all social levels was the provision of one-on-one home visits with mothers. This was reported to be the favoured method as the group felt it alleviated pressure on the mothers, but recognised the limitations regarding money and staff shortages.

2. BFI accreditation

Hope Hospital in Salford has achieved BFI accreditation, and it was reported in the group that since the initiative was introduced, breastfeeding rates had increased but there was no evidence to show that duration rates had also increased. One group member stated that there was usually about a 12% drop-off rate from initiation feeding to duration feeding. With reference to the recommendation in the report that all maternity units across Greater Manchester should obtain BFI status within 5 years, it was reported that it took 10 years for the initiative to be implemented and accreditation achieved at Hope Hospital in Salford. Reasons for this were given as poor dissemination of information between staff, resulting in a lack of understanding and appreciation of the initiative. It was felt by the group that BFI put too much emphasis on staff to discuss the benefits of breastfeeding rather than providing support and advice, and that this made staff feel as if they were "preaching or dictating". Another reason given as to the length of time taken to

achieve accredited status was that “hours of executive time is often wasted in breastfeeding strategy meetings” and that this is unnecessary as UNICEF has already prepared a strategy.

It was also felt that this approach was target-driven, and the statistics were not a real reflection of the situation. As a result, the group felt that a lot of the ward staff did not see the point behind the initiative and were sceptical. It was stated that the Trust was putting too much emphasis on meeting targets for breastfeeding, and that this was “overshadowing the legitimate reasons for encouraging it”. It was also reported that the initiative needs a ‘champion’ to drive it on, as clinical staff were already too busy to take on the amount of work needed for its progression. One of the group members thought that BFI was “too little too late” and thought educating women about breastfeeding needed to be done earlier in life, and should be promoted in schools.

3. Involvement of family members in discussions about breastfeeding

One group member thought that the influence of family members plays a big part in encouraging breastfeeding, and “in a lot of cases female relatives put subtle pressures on new mums to bottle feed by playing up its benefits”, i.e. helping the baby to sleep through the night and giving the mum more freedom to socialise. It was reported that “partners and family members are welcome to attend antenatal appointments and parentcraft sessions”, but the group felt that encouragement of family members was perhaps “the remit of Infant Feeding Advisors and the national media”.

4. Availability of breastfeeding clinics

The group mentioned the local breastfeeding support groups run and funded by Sure Start and the PCT, and again The Breastfeeding Project, but also how these services were “battling for funding” and how this causes them to “fall apart”. One example given was BFI in the Community which is supposedly being brought in within 3 of Sure Start’s flagship Children’s Centres. The group felt that Salford PCT had bought into this initiative without much of an idea of how much work it will take to implement, and that there is no-one in charge of running it or overseeing implementation. However, one group member thought that promoting BFI in the Community would help to inform more people of the potential infections and illnesses that can be caused by poor hygiene practices used in the preparation of formula feeds, and that the initiative would produce higher success rates in breastfeeding compared with the hospital-based program.

Other issues

The group mentioned that data on breastfeeding were recorded via the Infant Feeding Advisor at Hope Hospital, the Salford Breastfeeding Project and Salford Public Health (it was not clear whether these were initiation or continuation rates). On the issue of interpreter services, the group documented that these were provided via the Acute Trust and the PCT, but that they were “very expensive to the Trust”.

The group also wanted to make the comment that “none of us were aware of this initiative (the research project) prior to the focus group”. One group member enquired about who had commissioned this research project and whether they had any authority to affect change following the results. She spoke of past experiences of when she had been involved in discussions on how to implement changes in practice and had become frustrated when there was a lack of authority and budget to do so. Another group member stated that she also had experience of this, and though there was “visible evidence to support progression the ideas never made it into practice”.

The group often cited problems within midwifery culture in relation to the promotion of breastfeeding, and felt that practice needed to be changed in order to progress. The group agreed it was a matter of “changing people’s thinking and routine” in order to promote practices that encourage breastfeeding, such as skin-to-skin contact. It was felt that if practitioners were

shown evidence of the effectiveness of such practices, then they would be more likely to promote them. Concerns about practices within postnatal wards were also raised as discouraging the natural bonding between mother and baby, and therefore impeding breastfeeding. An example was given of babies being removed from their mothers and placed in incubators or cosy cots. It was recognised by a few group members that these practices were often adopted by new practitioners and assistants, and they felt that it was probably due to a lack of confidence of these staff members that they tended to over-medicalise childbirth.

The group also felt that not enough money was spent on breastfeeding in the media, and that it should be promoted more to affect a cultural change. The group discussed how the media's portrayal of celebrity mothers had given some women unrealistic expectations of breastfeeding, and felt that changing these ideas was a "big part of the battle". When questioned as to why the group thought it was so difficult to change the culture, one group member felt that formula feeding had been 'normalised' within hospital and society rather than breastfeeding, and said "this idea needs turning around". The group felt that breastfeeding was perceived as an "extra bonus" and that mothers were not being encouraged to persist with it. It was also agreed that hospitals medicalised births and intervened with natural processes too often. They cited a lack of breastfeeding training amongst paediatricians, and said that "many babies who go on to paediatric wards end up being bottle fed".

One group member felt that this report had missed a major factor in not referring to the UK laws on advertising formula. She felt that the laws were not being adequately regulated by the government, and cited the imbalance in the advertising of breastfeeding compared to formula feeding. The group reported that in most clinics and surgeries, the formula adverts far outnumbered breastfeeding adverts. The focus group ended with a discussion on the safety and hygiene implications of formula feeding, and in particular the recent government guidelines on making up formula feeds (not to be made up in advance). One group member reported that some mothers had believed this guidance to be "scaremongering tactics in order to promote breastfeeding".

The session was drawn to a close and all members were thanked for taking part.

Appendix 2a: Evidence Tables (PND)

Reviews

Authors/Body	Overview	Key findings/recommendations
Austin (2003)	To review the efficacy of antenatal group interventions aimed at reducing PND in 'at risk' women.	<ul style="list-style-type: none"> RCTs included (n=5) suffered from substantial limitations, with three of the studies using invalidated interventions. There is currently little evidence from RCTs to support the implementation of antenatal group interventions to reduce PND in 'at risk' women.
Dennis & Creedy (2004)	Systematic review of psychosocial and psychological interventions compared with usual care on the risk of PND.	<ul style="list-style-type: none"> The only intervention to have a clear preventive effect was intensive postpartum support provided by a health professional. Identifying women 'at risk' assisted in the prevention of postnatal depression Interventions with only a postnatal component were more beneficial than interventions that incorporated an antenatal component Individually-based interventions were more effective than group-based interventions.
Downe et al (2006)	Screening tools for depressed mood after childbirth in UK-based South Asian women: a systematic review	<ul style="list-style-type: none"> Seven papers were included in the review. Four of the papers between them reported on translations of two existing tools (EPDS & General Health Questionnaire). Two new tools were reported between the remaining three papers (Punjabi Postnatal Depression Scale and 'Dooop Chaon'©). Dooop Chaon is a visual tool and the other tools used either Bengali or Punjabi, based on written scales. None of the tools are currently sufficiently evaluated for clinical practice. Questions are raised specifically about the use of language-based tools to measure postnatal depressed mood in this population and generally about the extent to which focused interviews could be used as an alternative for specific sub-sections of population groups.

Individual studies

Author	Sample	Overview	Findings	Recommendations
Bostock et al (1996)	Asian women from a deprived area in Nottingham (n=8)	To develop a method of identifying PND in Asian women.	Four out of the 8 women seen antenatally were identified as being 'at risk' of PND and one was referred 6 weeks postnatally as suffering from PND. Two other women were referred at between 3 and 4 months postnatally. All three women had been identified as being 'at risk' during the antenatal interview.	Health visitors should meet all Asian women antenatally and regular planning meetings should take place between the team to ensure that vulnerable women do not miss out on the services.
Fuggle et al (2002)	Bangladeshi postnatal women	The development and use of a	Although one item of the EPDS presented some translation difficulties, the majority of items obtained reasonable semantic equivalence and were	While this is not a screening validation study of the Bengali version of the EPDS, the findings do provide preliminary evidence that postnatal

Author	Sample	Overview	Findings	Recommendations
	(n=48)	Bengali version of EPDS.	successfully rated by the women in the study. Preliminary examination suggested adequate reliability for the scale.	depression screening programmes may be an appropriate and inexpensive method of identifying emotional distress in Bangladeshi women.
Werrett & Clifford (2006)	Bilingual (Punjabi & English speaking) new mothers (n=23)	Validation of a Punjabi version of the EPDS	The tool was acceptable to the majority of mothers and yielded high sensitivity and specificity scores, but further validation is needed on the scale with mothers whose first language is Punjabi.	The small number of Punjabi-speaking health visitors who are in a position to help validate this tool further means that research in this area is slow.

Method and outcome summary table for all studies

Authors/Body	Type of study	Inequality measures	Method	Outcome measures
Austin (2003)	Systematic review	<ul style="list-style-type: none"> Low socioeconomic status 	5 RCTs were included, although all suffered from substantial limitations.	Reducing PND in 'at risk' women
Bostock et al (1996)	Intervention	<ul style="list-style-type: none"> Low socioeconomic status Ethnicity 	Initial discussions and workshops took place with the GP, health visitor, Asian link worker, community midwife and clinical psychologist, also involving the local community development worker. A number of women were interviewed at a baby clinic about their experiences of motherhood. As a result, a protocol was developed for understanding what may contribute to PND in Asian women, and the issues incorporated into a semi-structured interview. Pilot interviews showed that an interview schedule was difficult to use with an interpreter and women were put off by this formal approach. The interviews were translated into a more informal format.	Identifying PND in Asian women
Dennis & Creedy (2005)	Cochrane review	<ul style="list-style-type: none"> Low socioeconomic status 	Various	Preventing PND in 'at risk' women
Downe et al	Systematic	<ul style="list-style-type: none"> Ethnicity 	Seven papers were included. None of	Identifying PND in South Asian women.

Authors/Body	Type of study	Inequality measures	Method	Outcome measures
(2006)	Review		<i>the studies were rigorous enough to demonstrate generalisable sensitivity or specificity.</i>	
Fuggle et al (2002)	Intervention	<ul style="list-style-type: none"> • Ethnicity 	<i>48 Bangladeshi postnatal women were interviewed in both Bangladesh and England by a Syhletti/Bengali-speaking psychologist. The translated version of the EPDS was presented in the usual way, along with a standardised interview about the degree of social support and a translated version of the GHQ.</i>	<i>Identifying PND in Bengali women.</i>
Werrett & Clifford (2006)	Intervention	<ul style="list-style-type: none"> • Ethnicity 	<i>Punjabi and English speaking new mothers completed the English and Punjabi EPDS on two separate occasions and underwent a diagnostic interview.</i>	<i>Identifying PND in Punjabi women.</i>

Appendix 2b: Focus group discussion: postnatal depression

A focus group discussion took place at the University of Salford and was attended by 5 midwives from Trafford PCT (3 were community midwives, and 2 were based at the Maternity Unit at Trafford General Hospital). Although it was intended for health visitors to attend the session also, this was not possible due to staffing resource issues. However, a report was provided from a specialist health visitor team which gave details of perinatal support service provided in Trafford (see 'good practice' above). Information from this report will be included along with the transcription of the focus group discussion.

The aim of the focus group was to discuss the evidence-based recommendations or standards with relation to: implementation/barriers; information on the general procedures for dealing with postnatal depression; to discuss issues relating to data recording; and to provide details of any ongoing programs/initiatives in the area. The structure of the focus group discussion was based around the recommendations in the report, and a questionnaire following the same format/questions was also drawn up to allow individual feedback. The results are documented in the transcription below.

1. Administer the EPDS at primary visit and 6-8 weeks postpartum

It was identified from the discussion that administering the EPDS at 6-8 weeks postpartum was a recognised practice, and the report submitted by The Perinatal Support Team supported this: "All health visitors complete an EPDS at 6-8 weeks post-delivery with all women". However, it was further elicited in the discussion group that the use of the EPDS was not 'routine' and was only used when "there seems to be a reason for concern". The midwives in the group felt that the EPDS was impersonal and preferred to adopt a more informal approach first. It was felt that building up trust with patients was vital to being able to treat them. One of the midwives also felt that the information provided through this sort of screening tool was not always reliable, as some women may try to guard their feelings by answering the questions misleadingly.

It was revealed that the EPDS is not normally administered at the primary visit postpartum. The discussion group felt that this was "too soon", and felt it would be more appropriate to be administered at the discharge stage instead. It was agreed that this particular standard would not be popular. It was reported in one questionnaire completed by a midwife that "several visits are needed to establish the condition". In addition, it was stated in the report from the Perinatal Support Team that "it is hoped eventually all midwives will screen antenatally by completing an EPDS with pregnant women at the wellbeing assessment at 24 weeks gestation". The use of the EPDS antenatally was not raised in the discussion group.

2. Use culturally specific and language-based screening tools validated for use in South Asian women

The discussion group were not aware of any language-specific screening tools. The health visitor team reported in their questionnaire that "at the moment in Trafford we do not have the facility to support women who do not speak English as their first language, therefore it would be unethical to screen them. Where possible, we would work with voluntary groups such as the South Asian Mental Health Project in Manchester and occasionally we have done joint visits with Asian support workers/interpreters".

3. Information about signs and symptoms should be available in all relevant languages to members of ethnic minority communities

The discussion group acknowledged that there were information leaflets printed in different languages, and information from The Perinatal Support Team indicates that they are producing a valuable resource for South Asian women in the form of DVD/Video on postnatal depression awareness, and that "many PCTs with areas of high ethnicity are eagerly anticipating its completion". The discussion group felt that sufficient provisions were made for ethnic minority women in Trafford and confirmed that interpreters were available for home and hospital visits. However, the questionnaire completed by The Perinatal Support Team reported that "we don't always use interpreters when counselling because we know this is not always effective/confidential".

The group felt that there were a lot of barriers in the way of ethnic minority women being able to access information/resources, and that women were "being sheltered by their family and pressured to stick to their cultural ways". The midwives said that they sometimes felt powerless to help. In response to being presented with evidence that suggests that some ethnic minority women (particularly those that do not speak English) were at high risk of postnatal depression, the midwives suggested that in a lot of cases, such women were not given a voice to discuss their concerns due to the control and pressure from the patient's family.

4. Special antenatal classes organised specifically for ethnic minority women to discuss the signs and symptoms of PND and how to get help.

The midwives felt that such classes would be very beneficial and could not see a problem with them being routinely implemented. However, the group spoke of a previous attempt to set up a special antenatal class for ethnic minority women in the Trafford area, but due to lack of attendance it was closed. As no feedback was received, reasons for non-attendance could not be identified but the midwives suggested that it was due to "social disapproval and pressure to conform to cultural norms". One group member discussed an experience of treating a woman who was only allowed to attend the classes with supervision from a family member, and was not allowed to talk to the midwife. The group recognised that more of these classes should be offered, but felt that unless they could get women to attend the classes initially then they would not receive the funding needed. It was asked what the measures were to try and attract these groups to classes, and the group reported that patients are given invitations at antenatal check-ups, and are provided with the dates of the classes. One group member reported that she had seen a rise in the representation of other ethnic minority women at the classes she facilitates, but felt that research has been focussing mainly on Asian groups.

The group also mentioned that some Sure Start schemes in Trafford were offering specialist antenatal classes for ethnic minorities, and that the value of these programmes and other 'drop-in' clinics were acknowledged. However, the group also voiced concerns that the success of such services could lead to the decline in home visits, which would mean "some women who need help could slip through the net". The Perinatal Support team reported in their questionnaire that "all Trafford community midwives are trained by us to ask relevant questions in the antenatal period".

5. Provide frequent visits/invitations to clinic/telephone contact in the first 3 months postnatally to those women identified as 'high risk'.

In order to monitor women who were identified as 'high risk' the discussion group reported that they provided more frequent visits and offered the use of a 24-hour helpline for the first 28 days postpartum. After this period, the service would go back to the normal home visit schedule, but agreed that depending on the circumstances, this time limit was flexible. The group felt that being able to provide a personal service was vital in helping women through experiences of anxiety and depression, and felt that experience in the role was important. With reference to the service the

Perinatal Support Team provide in Trafford, the group felt that this was beneficial in addition to the service that they as community midwives provide, but should not be a replacement service. The midwives said they tend to opt for this service "as a last resort" as they felt like they "would be passing their patients problems on". The group also stated that this service was "stretched" and were concerned that some women may have to wait up to 8 weeks for an appointment, and noted that the service does not generally cater for women who are experiencing problems on the maternity ward, or for women who have previously been diagnosed with mental health problems.

It was reported several times in the questionnaire completed by the midwives that "midwives aim to provide supportive on-going care to meet each woman's needs but staffing and time constraints may sometimes affect length/frequency of visits". One midwife in particular reported in her questionnaire that "too much emphasis is being placed on 'specialist' roles and this fragments care rather than enhances it. More midwives with a full, holistic remit should be considered best practice".

Other issues

When the subject of data recording was broached, the focus group confirmed that they recorded the majority of information in the hand-held record books. However, the group did report that they felt it was "quite difficult to record information as a lot of the time cases are dealt with verbally" and that it would not be easy to record all information on a database. At present, information is not being recorded on the Child Health System database. The report provided by The Perinatal Support Team stated that the health visitors were currently looking at methods of improving post-therapy data collection. The team used to monitor effectiveness of the service by carrying out the EPDS at initial assessment and then again at discharge, but this method has now ceased because "guidelines state that the EPDS should be used as a screening tool only and not as a measure". The report suggests that the team is now looking at the possibility of introducing the Beck Depression Inventory II at assessment and discharge "cost allowing".

Interestingly, the discussion group felt postnatal depression was more common in "advantaged women" rather than disadvantaged groups. One group member said that she in particular had more experience of "dealing with more advantaged women, who tended to be financially stable in responsible jobs". The group felt that such women had more access to information regarding pregnancy, possibly leading to more worry and concern. They also suggested that these women have unrealistic and high expectations of the pre- and postnatal experience, triggering anxiety and possible depression when expectations are not met. One group member reported how she experienced many women from advantaged backgrounds saying they "wanted their life back" and were anxious to return to the lifestyles they had prior to pregnancy. It was cited that loss of control over their lives was a major reason (along with the usual stresses and strains such as sleep deprivation) for anxiety and depression amongst this sector of women. The group also felt that the breakdown of the 'nuclear/extended family model' in more advantaged groups meant that new parents were more likely to be isolated from family, losing out on additional support.

In contrast, the group felt that disadvantaged women were more prepared as they tended to have more experience of caring for children/babies from a younger age in the extended family, and because of the extended family being nearby they had more family support. It was also mentioned that disadvantaged women were less likely to have the pressure to return to work, and they were "more balanced and content". One group member thought that this was because "the baby had given these women a purpose and something to love".

Along the same vein, one group member felt that postnatal depression was being used too easily as a label, and in a lot of cases it was just the need for adjusting to the new way of life. The group also recognised that the pressure on women in relation to images being portrayed in the media were unrealistic and hard for women to live up to.

APPENDICES

The group appeared to view postnatal depression arising from a change in lifestyle and unrealistic expectations rather than being purely a physiological disorder, and as such thought that anti-depressants were being over-prescribed. The group felt that it was a "very close line" between those cases that needed treatment through medication and those that didn't. In support of this, information in the report provided by The Perinatal Support Team in Trafford refers to recent NICE guidance which recommends that psychological treatments be initiated in preference to prescribing medication for generalised anxiety disorder, panic disorder, OCD, and PTSD. Furthermore, the guidelines state that "women should have access to specialist Perinatal teams". The report submitted by The Perinatal Support Team concludes that "by working to improve maternal mental health and making sure staff are trained in the screening and detection of Perinatal Depression, the Perinatal Support Team is ideally placed to achieve the National Service Framework for Children, Young People and Families' vision under Standard 2 to help parents feel confident and able to bring up their children in a way that promotes positive health and development and emotional wellbeing".

The session was drawn to a close and all group members were thanked for taking part.

Appendix 3a: Evidence Tables (Smoking cessation)

Individual studies

Author	Sample	Overview	Findings	Recommendations
Aveyard et al (2005)	Pregnant smokers who were mostly from lower social class groups (n=918)	RCT of three interventions with the outcomes of change in social support and report cessation in woman's partner.	Few pregnant women's partners stopped smoking and the probability of quitting did not differ significantly by trial arm (standard care, self-help manual and enhanced stage-based counselling or self-help manual, enhanced stage-based counselling and use of an interactive computer program). Social support did not differ significantly by trial arm.	Given that women and their partners often stop smoking together, or one influences the others smoking behaviour, future interventions to prevent smoking in pregnant women could encourage both partners to quit.
Campion et al (1994)	Pregnant women who were between 15-24 years and deprived (1,232)	An evaluation of a mass media campaign	There was a significant increase among the sample in those considering smoking to be very dangerous to the unborn child, in those understanding the term passive smoking and in those considering passive smoking to be very dangerous. During the campaign there was a 14% increase in the number of calls to a cessation helpline from pregnant women. Over the campaign there were no significant changes in smoking prevalence and consumption among pregnant women or partners, or in the number of partners offering suggestions to pregnant women about their smoking behaviour.	Smoking cessation programs need to be more individual and tailored to address specific social and economic issues.
Hajek et al (2001)	Pregnant women who recently given up smoking and those still smoking (n=1,120)	RCT of a one-off smoking cessation intervention delivered by midwives	Pregnant women who continued to smoke were significantly more likely to be unemployed, be single/not living with partner, be in manual occupations and have no educational qualifications. At the time of delivery, 54% of recent ex-smokers and 7% of smokers had been abstinent for at least 3 months prior, and 23% and 3% respectively were still abstinent by the child was 6 months old.	A brief one-off smoking cessation intervention by midwives does not seem to be a practicable or effective method of helping pregnant smokers to stop. Other options such as tailored self-help materials and telephone counselling should be examined.
Lawrence et al (2003)	Pregnant smokers who were mostly from lower social class	Cluster randomised trial of two interventions based on the TTM compared to current	There was a small significant increase in quitting at the combined intervention arm compared with controls. Only about 3% of the intervention groups achieved sustained cessation.	Given that the intervention was resource intensive, it is of doubtful benefit.

Author	Sample	Overview	Findings	Recommendations
Tappin et al (2005)	groups (n=918) Pregnant women who were regular smokers in Glasgow, the majority of which were from deprived areas (n=762)	standard care RCT to determine whether motivational interviewing provided at home by specially trained midwives helps pregnant smokers to quit	4.8% of women in the intervention group stopped smoking compared to 4.6% in the control group. 4.2% of women in the intervention group cut down compared with 6.3% in the control group. These differences were not significant. However, significantly fewer women in the intervention group reported smoking more.	Good quality motivational interviewing did not significantly increase smoking cessation among pregnant women.

Method and outcome summary table for all studies

Authors/Body	Type of study	Inequality measures	Method	Outcome measures
Aveyard et al (2005)	RCT	<ul style="list-style-type: none"> Low socioeconomic status 	100 general practices were randomised into three trial arms: A (standard care), B (TTM based self-help manuals), and C (TTM based self help manuals plus sessions with an interactive computer program giving individualised smoking cessation advice).	Changes in women's reported social support and reported cessation in the woman's partner.
Campion et al (1994)	Evaluation	<ul style="list-style-type: none"> Low socioeconomic status Young mothers 	Two surveys were conducted among pregnant women throughout England before and after a mass media campaign on smoking and pregnancy targeted at young women in low social classes. Quota samples were selected and coded questionnaires were administered by trained interviewers in the home.	Measuring awareness of the campaign and changes in knowledge and beliefs relating to smoking and pregnancy, smoking prevalence and consumption, the number of callers to a cessation helpline and in the role played by partners.
Hajek et al (2001)	RCT	<ul style="list-style-type: none"> Low socioeconomic status 	Midwives were randomised to deliver a one-off educational intervention or usual care. The 10-15 minute intervention was based on brief counselling, written materials, arrangements for continuing self-help support and feedback on expired-air carbon monoxide levels. The intervention was tailored to the women's needs: those who did not want to stop smoking received a brief motivational intervention, those who wanted to stop received an intervention designed to assist them and those that had stopped recently received a relapse prevention intervention.	Continuous abstinence for at least 3 months prior to delivery, point prevalence abstinence immediately post-delivery, and continuous abstinence from 3 months prior to delivery to 6 months post-delivery.
Lawrence et al	Cluster	<ul style="list-style-type: none"> Low socioeconomic status 	100 general practices were	Biochemically confirmed smoking

Authors/Body	Type of study	Inequality measures	Method	Outcome measures
(2003)	randomised trial		randomised into three trial arms: A (standard care), B (TTM based self-help manuals), and C (TTM based self help manuals plus sessions with an interactive computer program giving individualised smoking cessation advice).	cessation for 10 weeks previously and point prevalence abstinence, both measured at 30 weeks of pregnancy and 10 days after delivery.
Tappin et al (2005)	RCT	<ul style="list-style-type: none"> • Low socioeconomic status 	All women received standard health promotion information. Women in the intervention group were offered motivational interviewing in the home.	Self-reported smoking cessation.

Appendix 3b: Focus group discussion – smoking cessation in pregnancy

A focus group discussion took place at Heywood, Middleton and Rochdale PCT and was attended by 4 midwives and 1 health visitor. The aim of the focus group was to discuss the evidence-based recommendations or standards with relation to: implementation/barriers; information on the general procedures to encourage smoking cessation in pregnancy; to discuss issues relating to data recording; and to provide details of any ongoing programs/initiatives in the area. The structure of the focus group discussion was based around the recommendations in the report, and a questionnaire following the same format/questions was also drawn up to allow individual feedback. The results are documented in the transcription below:

1. Training midwives on referral to smoking cessation services

It was reported that all community midwives are intermediate trained, which comprises being able to deliver a brief intervention. 'Intermediate trained' was explained as midwives asking their patients if they smoked during all stages of pregnancy, and recording this information whilst offering advice on the benefits of giving up smoking, and referring women to smoking cessation services. These women are then usually followed up on a weekly or fortnightly basis. It was suggested that this training should be given to hospital midwives also, and that the training should be mandatory for all midwives in the Trust. It was also reported that all health visitors/health team members/community nursery nurse support workers are also trained with a yearly update provided.

When asked for feedback about this training, one group member felt that "not all midwives feel confident to support women with this", and time limitations along with the amount of paperwork were also recognised as a reason for action not being taken at the earliest opportunity, i.e. the booking visit. One group member also felt that the current service was not effective because "midwives spend a lot of time chasing up women who don't really want to quit, but just say they do". Two issues highlighted by the group in this respect were: how to target women that were serious about quitting; and what to do to encourage women who don't want to quit. It was reported that because of this problem, the emphasis was now more on the woman approaching the midwife to seek help.

2. Routine prescription of NRT to all pregnant smokers

The group reported that NRT was routinely offered, and that all midwives were able to dispense a prescription for this. However, it was reported on the questionnaire that NRT is only offered with appropriate support/advice and only if "a woman is serious about quitting". One group member said that NRT would not be the first option, and that "other methods of support would also be discussed". One midwife felt that NRT should be available on antenatal and postnatal wards also.

3. Provision of home visits for disadvantaged women/those unable to attend clinic

The group felt that drop-in clinics were more successful than home visits, as most pregnant women say they want to stop smoking but then are not available when the midwife/health visitor arrives at their house. The group felt that if women were serious about stopping smoking then they would attend clinics and drop-in centres, such as those operated by Sure Start. Home visits were provided if the woman really could not attend the clinics, but this was not usually a problem as the services provided are very flexible, i.e. different types of appointments and longer opening hours. The group also mentioned future plans to integrate antenatal services with Children's Centres which would increase accessibility.

4. Provision of peer support groups

It was recognised that involving partners and families in smoking cessation was very effective, especially if the partner could be encouraged to quit with the patient. The group agreed that having peer support was a great motivating factor, but in general, it was reported that there were few peer support groups operating in the area. One midwife reported that “time and staff, and the motivation of staff” was a problem, and another that “the time resources of midwives is a problem”. One group member reported that different authorities were trying to set up peer support groups, but the majority of the group felt that drop-in clinics were currently the most appropriate service and that these were best placed in community locations such as Children’s Centres. It was also raised by one group member that smoking cessation services need to be tailored to the individual, and that peer support may not always be appropriate. She gave an example of women from ethnic minorities not feeling comfortable discussing being a smoker with other people, due to the “stigma placed on pregnant smokers in their culture”, and that many women “would be afraid of being judged”. Although the evidence suggests that smoking during pregnancy is not as common in ethnic minorities, one group member reported increasing numbers of Asian women seeking out smoking cessation support, and that by “providing as many different services as possible then the success of reaching all pregnant smokers and supporting them through the quitting processes would be greater”.

Other issues

It was reported that 4-week quit rates are recorded in the hand-held notes, but one midwife stated that routine data recording was a problem which has not been addressed, and that “it is very difficult to obtain accurate data as it is not seen as a priority to record information on smoking”. It was suggested that the design of the information sheets in the hand-held records needs reorganising “to include space for smoking status and cessation support given”, and that this would help all midwives to routinely record the information. One group member also stressed the need to record information accurately, and how many times a patient was asked about stopping smoking in order to “legally protect the midwife”.

With regard to providing language services to ethnic minorities, it was reported that bilingual support workers were valuable and that the services of an interpreter are available at the antenatal clinics and maternity wards. However, it was also stated that ethnic minority women tended to be “difficult to help due to language and cultural barriers”.

When asked for insight into why some pregnant women did not want to quit smoking, stress and lifestyles (“quitting smoking is not a high priority for those disadvantaged women”), as well as family members being smokers were cited. The group highlighted the importance of the ‘smoke free homes’ initiative, and explained that it meant families would agree to smoking outside the home in order to provide a smoke free environment for the baby. After agreeing to the scheme, women were provided with information packs containing smoke free signs for the house (to discourage visitors from smoking) and exterior ashtrays. The group felt that this approach would benefit women wanting to quit and that it was a positive step to encourage smoking cessation in pregnancy. At the close of the discussion, the group reported that they felt whilst smoking cessation services were having a positive effect, they were limited and that in order to help more pregnant women quit smoking, “more work needed to be carried out in the community”, and that it was important to “make patients aware of smoking cessation services from the antenatal, postnatal and children’s services stages so that women would be able to access help whenever they felt ready”.

Appendix 4a: Evidence Tables (Nutrition in pregnancy)

Reviews

Authors/Body	Overview	Key findings/recommendations
Department of Health (2006)	A qualitative evaluation of Healthy Start communication materials among potential beneficiaries	<p>Most of the respondents were white British, but urban groups included some women of Asian, African & African-Caribbean descent.</p> <p>All the over 18s were from very low income families</p> <p>Those women with other children were confident in their own skills and experience and had little interest in receiving information about parenting.</p> <p>Women pregnant for the first time had a keen interest in parenting information.</p> <p>There was a strong perception across the sample that the Welfare Food Scheme is aimed at children rather than pregnant women.</p> <p>Views of the Welfare Food Scheme were broadly positive.</p> <p>Opinions of the new Healthy Start Scheme were very positive, with the main benefit being a wider choice of where to use the vouchers and what to exchange them for.</p> <p>The inclusion of fruit and vegetables in the scheme was of particular interest to pregnant women and those with more than one qualifying child.</p> <p>It was thought that the NHS branding gave Healthy Start a positive feel as it appeared to have the potential to reduce any stigma attached to using the vouchers.</p>

Individual studies

Author	Sample	Overview	Findings	Recommendations
Anderson et al (1995)	Local population of pregnant women, mostly lower social classes (n=286)	To assess the effect of an antenatal nutrition programme designed specifically for the local population.	The results showed that knowledge about nutrition was significantly higher in the intervention group. However, no significant differences were detected between the two groups for attitude variables or nutrient intake.	It was concluded that the most widely-read form of nutrition advice for pregnant women may have some impact on nutrition knowledge but has little effect on nutrient intake during pregnancy.
Mouratidou et al (2006)	A sample of Caucasian pregnant women of different socio-economic status (n=123)	An evaluation of a semi-quantitative food-frequency questionnaire with the aim of developing a nutritional screening tool	The validity of the FFQ was tested against a series of two 24-hour recalls. The FFQ performed well for most nutrients and had acceptable agreement with the 24-hour recall.	The questionnaire gave useful and valid estimates of nutrient intake and appears to be a tool valid for categorising Caucasian pregnant women according to dietary intake.
Wrieden et al (2007)	Teenage pregnant women from deprived areas of Scotland (n=113)	A community-based food skills intervention led by midwives	A food skills intervention is likely to have a small but positive effect on food choice and confidence in food preparation. However, it was clear that many subjects led fragmented lives and found commitment to intervention classes problematic.	A full-scale RCT in this hard-to-reach group would require a range of flexible approaches rather than a fully defined intervention, and presents challenges for trial design.

Method and outcome summary table for all studies

Authors/Body	Type of study	Inequality measures	Method	Outcome measures
Anderson et al (1995)	Controlled trial	<ul style="list-style-type: none"> • Low socioeconomic status 	The study was designed in three stages: ⁽¹⁾ development of nutrition education material for dietary advice; ⁽²⁾ development of assessment measures for nutrition knowledge, attitudes to healthy eating and nutrient intake; ⁽³⁾ controlled trial of nutrition advice. The education programme was presented at two information packs comprising a self-assessment quiz and information booklet, and a shopping list pad. The second pack comprised a personalised letter promoting healthier eating during pregnancy from a named doctor, and recipe leaflets.	Changes in women's nutrition knowledge, attitudes to healthier eating and improvements in nutrient intake.
Mouratidou et al (2006)	Validation study	<ul style="list-style-type: none"> • Low socioeconomic status 	123 women of different socioeconomic status, aged between 17 and 43 years provided complete dietary data at their first antenatal appointment. The validity of the FFQ was tested against a series of two 24-hour recalls. The first recall was collected at the initial interview with a nutritionist, and the second was administered via telephone after a period of 10-14 days. For a number of participants weekend dietary information was randomly collected. The foods were recalled chronologically from the previous day and household measurements were used to estimate portion sizes. Mean daily intake was estimated from the two 24-hour recalls.	Estimates of nutrient intakes of Caucasian pregnant women.
Wrieden et al (2007)	Intervention study	<ul style="list-style-type: none"> • Adolescent mothers • Low income women 	A standardised 2-hour skills programme delivered over 7 weeks was designed and implemented in community-based settings. Quantitative evaluations using food diaries, shopping diaries and questionnaires were carried out in intervention and comparison groups at baseline, immediately after the	Increased cooking confidence, food preparation methods and improved dietary choices.

Authors/Body	Type of study	Inequality measures	Method	Outcome measures
			<p>intervention and 2 months later and at 6 months follow up. Qualitative interviews were also carried out. The aim of the intervention was to increase cooking confidence and food preparation methods, and promote increases in consumption of fibre-rich starchy carbohydrates, fish, vegetables and fruit, and decreases in consumption of fat.</p>	

Appendix 4b: Focus group discussion: Nutrition in Pregnancy

A focus group discussion took place at Pemberton Primary Care Resource Centre, Wigan and was attended by 3 health visitors. The aim of the focus group was to discuss the evidence-based recommendations or standards with relation to: implementation/barriers; information on the general procedures to improve diet and nutrition in pregnancy; to discuss issues relating to data recording; and to provide details of any ongoing programs/initiatives in the area. The structure of the focus group discussion was based around the recommendations in the report, and the results are documented in the transcription below:

1. Nutritional advice should be provided as part of routine antenatal care

The group agreed that midwives do provide nutritional information at antenatal visits, but it was felt that this could be seen as an “overload of information” in a short space of time without proper follow-up. The group also felt that this was adding to the already stretched workloads of midwives and suggested that health trainers were better placed to deal with this issue.

2. Each PCT to host regular midwife-led nutritional workshops in the community

The group questioned why nutrition classes should be midwife-led, and felt that health visitors and health trainers were just as capable of leading such classes. One group member spoke of a project that had been set up in Preston where a dietician had been appointed to train staff who then facilitated community nutrition classes. Another group member highlighted the fact that Wigan employs health visitors who could deliver nutrition sessions. However, when questioned about the timing of contact that health visitors have with pregnant women, it was confirmed that this was only from 32 weeks onwards. It was therefore acknowledged that midwives may be better placed to deliver this information for women having their first child, and health visitors that already knew women who had children previously would better serve this group.

On the whole, the group thought the concept of community workshops was a good one, but one group member raised the issue of hard-to-reach groups, as it was felt that generally these groups did not want to attend workshops. One group member suggested using vouchers for healthy food items as an incentive, and another group member felt that the promotion of community services needed to be more personalised and suggested giving out personal invitations at booking appointments. It was suggested by one group member that family allowance benefits ought to be linked to attendance at workshops, and that attendance should be a condition of receipt of benefits. This member went on to give an example of such a scheme in the US whereby the government has enforced nonworking parents to take their children to nursery in order to receive their benefits. It was said there was evidence that these children are benefiting from this initiative as they are receiving a nutritionally balanced diet at nursery. The group felt that this type of approach should be adopted in the UK as it was suggested that the UK government “hand out benefits too easily and perpetuate apathetic behaviour”.

The group felt that a community approach using peer supporters would help to encourage attendance and reduce barriers as they recognised that some families were very wary of health visitors and worried about being judged by them. The group agreed that appointing a local resident to be a ‘champion’ of the community workshops would be effective. It was also stated that for any community initiative to be successful the target groups needed to be able to see how they would benefit from participating, and this is the reason why past attempts had failed.

3. All Caucasian women to be nutritionally assessed at booking visit using the food-frequency questionnaire

The group felt that using a nutritional screening tool would be effective as this would lead to extra interventions and enable midwives and health visitors to better liaise with each other around this issue.

Other issues

The group moved on to discuss the influence of fast food on peoples diets and highlighted the fact that poorer areas were being monopolised by fast food outlets. The group also raised the point of how the marketing and advertising of food plays a huge part in influencing peoples dietary decisions, and identified the minor budget the government has to use on promoting healthy eating initiatives in comparison to the advertising of major food corporations. The group felt that in order to change ideas about nutrition they had to re-educate people and one group member felt that diet and nutrition education needed to be re-introduced into the core curriculum within schools, as it has been made into an option-only subject.

The group also mentioned how values and lifestyles can be inherited or learned from older generations. One example given was when schools imposed bans on junk food, and some mums sneaked sweets and crisps to their children during break times. The group reported the struggle they faced promoting healthy eating amongst children when they faced such opposition from the parents.

One group member said that in her experience it was not just socially deprived communities that were uninformed on how to provide nutritionally balanced diets for their families, and cited a faster paced lifestyle as well as lack of skills for reasons why people did not cook from scratch anymore. One woman pointed out the fact that "simple meals such as spaghetti bolognese could be cooked in the same amount of time as a ready meal", but said that when people were busy they did not want to cook.

Finally, the group was asked what they thought about the 'Healthy Start' initiative, implemented by the government in 2006 (see above). The group felt that it was a good idea but mentioned faults in its design which led to claims being returned due to lack of information. They also felt that the initiative is not publicised enough, and that there was very little information available.