CEL 36: Maternal and Infant Nutrition*: scoping exercise and needs assessment*
A **level** research REPORT
Prepared for: NHS Borders Health Improvement Department
November 2010

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1. BACKGROUND AND PROJECT OBJECTIVES

1.1 BACKGROUND

Healthy Eating, Active Living – An action plan to improve diet, increase physical activity and tackle obesity (2008-2011) was committed to make £19 million available over the 3 year period to improve the nutrition of women of childbearing age, pregnant women and children under 5 in disadvantaged areas (CEL 36).

There are 5 key areas for the funding to:

- Increase the uptake of Healthy Start
- Support delivery of the HEAT target on breastfeeding
- Invest in specialist nutritional services
- Support delivery of existing programmes where they meet the general criteria set out
- Enable existing training for anyone involved in interventions with the target group to be taken up

There was a need for research to gain an insight into needs of individuals relating to engagement with, delivery, barriers and access to specific aspects within CEL 36. A scoping or mapping exercise using existing secondary data to determine current baseline information relating to Healthy Start, Breastfeeding and training opportunities is also required.

The research findings will shape the design of the maternal and infant nutrition work undertaken by the CEL 36 team but also, potentially, by other professionals within both Health and external agencies. They will help ensure that NHS Borders Health Promotion Team provides maternal and infant nutrition related health improvement programmes which fit the identified needs of the target group, in order to maximise uptake and build the capacity for sustainable health improvement.

1.2 PROJECT AIM AND OBJECTIVES

This research project had five key elements:

- To gather more baseline information on the following:
  - Current breastfeeding activities and rates within the Scottish Borders
  - Eligibility, uptake and redemption information for Healthy Start
  - Borders' Retailers participation in Healthy Start Scheme

- To undertake research with professionals working within the CEL 36 remit; Midwives- BGH & Community, Health Visitors, Maternity Care Assistants, Community Nursery Nurses and other staff working with Pregnant women/Mothers:
  - To investigate the current training opportunities within maternal and infant nutrition related topics such as, but not limited to, Vitamin D, breastfeeding and weaning
  - To discover resources currently used to promote maternal and infant nutrition topics such as, but not limited to, Vitamin D, breastfeeding, weaning, Healthy Start and formula feeding
  - To investigate the knowledge, skills, awareness, attitudes and beliefs of breastfeeding
  - To investigate the knowledge, skills, awareness, attitudes and beliefs of Healthy Start

- To undertake research to investigate the knowledge, skills, awareness, attitudes and beliefs of pregnant women and their significant others (parents, grandparents and peers) on:
  - Current knowledge of the benefits of breastfeeding,
  - Skills associated with supporting and encouraging breastfeeding
  - Attitudes and barriers towards breastfeeding
  - Why women choose to breastfeed or not

- To undertake research with women who are eligible for Healthy Start to find out:
  - Awareness of the scheme by the target group
  - If they have signed up for the scheme
  - What are the barriers to signing up
  - How easy have they found using the vouchers/obtaining the vitamins
  - Their knowledge of the benefits of vitamins for both pregnant women and children under 4

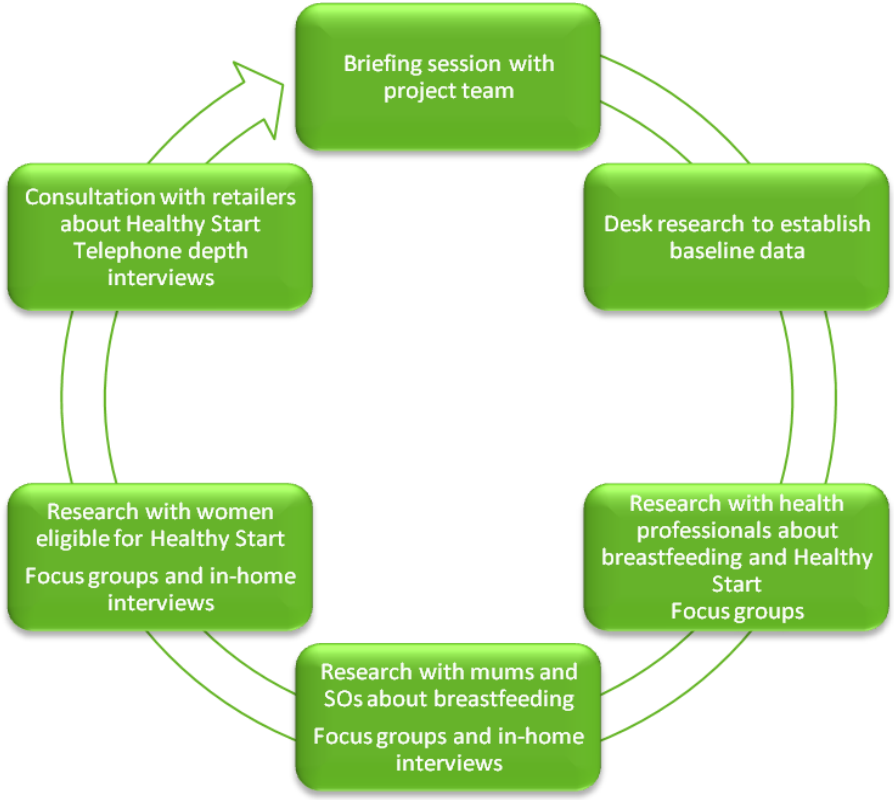
- To undertake research with retailers to investigate if:
  - They know about the Health Start Scheme
  - They do or do not accept Healthy Start vouchers
  - They have experienced any problems with the vouchers
  - They have any protocols or systems are in place for the use of the vouchers
  - There are there any barriers to the joining the scheme?

The research findings have already been presented to the Maternal and Infant Nutrition Team (MINT) and NHS Borders representatives, and they are formalised in the following report.

2. METHODOLGIES AND PROJECT SAMPLE

2.1 METHODOLOGIES

Our research programme had 5 components, included in the following diagram and discussed further below:



NB: SOs = Significant others (mothers or partners)

2.2 SAMPLE

- 6 short telephone depths with (non-Pharmacy) retailers:
  - Mix of business size, all decision-makers

- 2 focus groups with Health Professionals:
  - 1 at Borders General Hospital, 1 at the HLN community flat in Burnfoot, Hawick. Comprised of a mix of remits: Midwives-BGH & Community, Health Visitors, Maternity Care Assistants, Community Nursery Nurses
- 4 x mini-groups of women and 8 x in-home depth interviews with women. The sample structure is set out in the table below:

	MAIN TOPIC	LOCATION/S	SAMPLE COMPOSITION	ATTITUDE TO BREASTFEEDING	AGE BAND
GROUP 1	BREAST-FEEDING	Langlee	Pregnant women	Not intending	25-34
2	HEALTHY START	Langlee	Pregnant women & mums	N/A	16-24
3	BREAST-FEEDING	Eyemouth / Chirnside	Pregnant women	Maybe or definitely intending	18-24
4	HEALTHY START	Burnfoot	Pregnant women & mums	N/A	25-34
DEPTHS 1-4	BREAST-FEEDING	Chirnside, Walkerburn, Hawick	Mums (2 of the 4 paired with significant others)	Currently breastfeeding	18-34
DEPTHS 5-8	HEALTHY START	Langlee, Walkerburn, Melrose	Mix pregnant women & mums	N/A	16-34

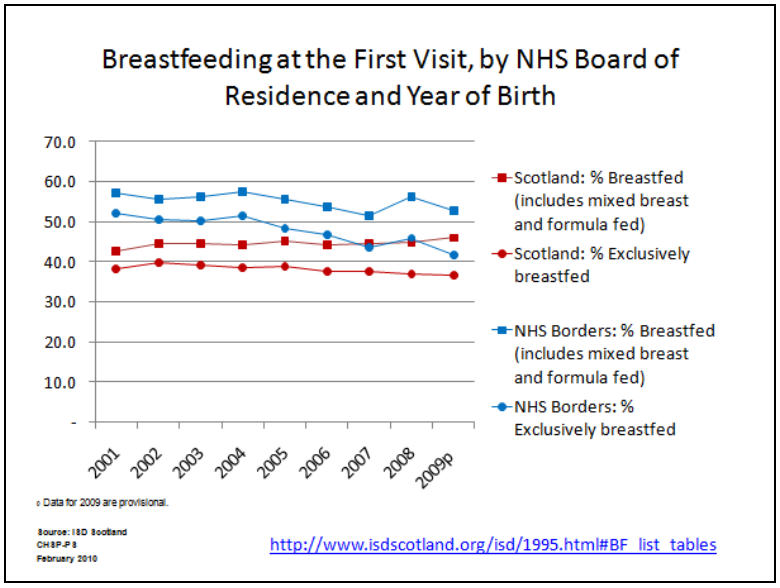
•All respondents were SEG C2DE

•All fieldwork was conducted from 17 August to 20 September 2010

3. FINDINGS: CONTEXT AND SAMPLE

3.1 PRIMARY RESEARCH

We conducted a brief internet / desk research exercise, focussed primarily on benchmarking current rates of breastfeeding in the Scottish Borders and assessing eligibility for Healthy Start across the region. A report on this has already been submitted and we summarise the key learnings in this overall project report.

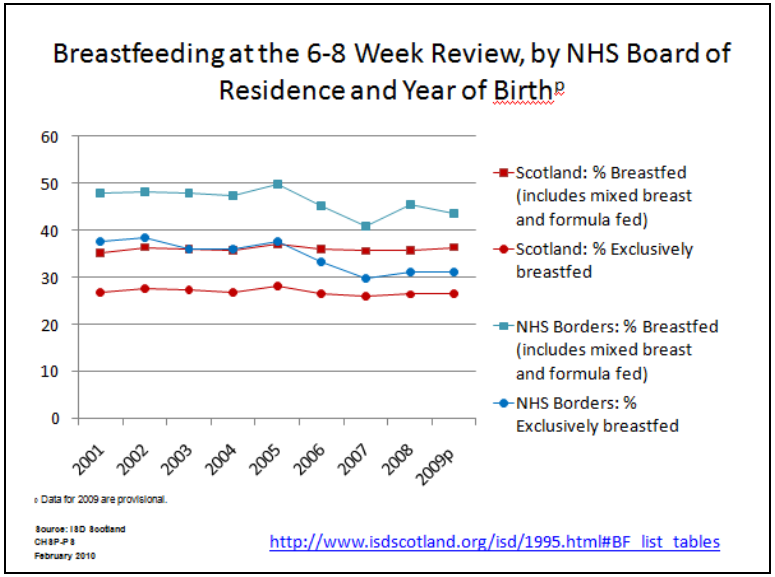


In summary, and as evidenced in the table above, we have found:

- Borders rates are much higher than the overall Scottish picture
- Total % breastfed dropped from 58% in 2001 to 52% in 2009
- There has been a steady decline in breastfeeding rates in the Scottish Borders since 2004
- Overall Scottish rates have remained steady in that time

In the next table, we can see statistics on breastfeeding rates at the 6-8 week review and, in summary, we discovered:

- Borders rates are higher than Scottish rates for total breastfed and for exclusively breastfed
- Total % breastfed dropped from 49% in 2001 to 42% in 2009
- There has been a decline in breastfeeding rates in Scottish Borders since 2005 but some pick-up is observed more recently
- Both sets of statistics together signify a 10% drop in rates over the first 6-8 weeks



We attempted to gauge eligibility for Healthy Start across the Scottish Borders region. There are various statistics available and means of estimating eligibility. The factors we focussed on were: benefits claimants (income support and JSA); Child tax Credit claimants; income level; age of child/ren; and teenage pregnancy. As highlighted in the table below, many of these counts are estimates for Borders region. However, overall, the data we studied (detailed further in the supplementary report) signifies an overall target of 600-700 families across the region. Working Tax Credits are just one example of how eligibility can 'shift' over short periods of time – this makes it hard to provide a conclusive figure and it also makes it challenging for potential recipients of healthy Start vouchers to be certain of their own eligibility.

Element	Count	Notes
Income Support	384	Estimated no. of claimants
Job Seeker's Allowance	104	Estimated no. of claimants
Employment and Support Allowance	Up to 4440	No 'youngest child' info available
Child Tax Credit	643	This is expected to be a high-end estimate
Income	Between 25% and 50% of households receiving CTC	Actual % will be lower than 50%
Pregnant at <18 years	64	If no other benefits claimed

3.2 CHARACTERISTICS OF THE SAMPLE

In terms of the sample of pregnant women and mums, we found two distinct attitudinal groupings, labelled 'Resisters' and 'Intenders'. These labels apply to both breastfeeding and infant nutrition.

Those we refer to as 'RESISTERS' tend to be town-based and have:

- Less confidence
- Weaker family networks
- Less settled relationships, some absent fathers
- Strong reliance on friends
- Challenging day to day finances, somewhat hand-to-mouth
- A distrust of authority

And 'INTENDERS' tend to be more rurally-located and have:

- More focus, with some appetite for knowledge
- Strong extended family networks
- More planned pregnancies, settled
- Reliance on friends and other mums
- More financial confidence and control
- An openness to specialist support

3.3 HEALTH PROFESSIONALS: SOME CONTEXT

In terms of the Health Professionals, some of the characteristics of the sample and of their roles and practise are summarised below:

Time Management

- There are lots of targets to meet, for a variety of health initiatives
- Rurality of caseload and increasing paperwork impacts on time pressures and prioritisation
- Community nursery nurses and maternity care assistants can help to ease the burden in some cases
- Some professionals expressed concerns about 'mixed skillsets', as more empty roles are filled by more junior / less specialist personnel

Support

- Those in less-qualified roles need support in terms of managing different 'bosses' and styles
- Many of the health professionals are looking for support in terms of the 'correct' way to address resistance and attitudinal barriers

Training

- Some concern was expressed about not being fully up-to-date with latest guidelines
- This is a specialist, demanding and time-pressured group: "tell me something I don't know"
- The 'train-the-trainer' style appeals, passing on knowledge to other personnel in their team or setting

Resources

- Some more reliant on printed resources than others
- The health professionals were more critical of the (Borders) weaning booklet than the mums were
- The health professionals tended to perceive the breastfeeding materials we introduced (such as posters) as being more targeted at the 'middle-classes'
- There was a clear interest in being able to access more PEER influencing materials - to help them coach and influence more than the mum if necessary

Some of the key topics, areas of comment and discussion from the Health Professionals which indicate challenges and support needs were:

Time pressures	Various HEAT targets and the sheer number of women on the caseload contribute to this. Increasing levels of administration are also a challenge in this regard, and it is hard for many of the professionals to incorporate 'extras' such as group-work into their schedules.
Less time in hospital	There is now less time and opportunity for direct intervention and encouragement of breastfeeding with new mothers as they are perceived to be in the maternity ward for an average of 1 day now, compared with up to 3 days a relatively short time ago. One to one support and coaching is not always possible, and it is felt many younger mums in particular, return home still feeling overwhelmed.
Hard to 'join up' / be seamless	This was discussed in the context of shorter times in the maternity ward. It is challenging for the health visitor to be available as soon as the mum arrives home, and it also a challenge for those in a community setting, juggling caseloads, to exercise any sort of formal 'handover'.
Budgets = less training	This was an issue across the board. The professionals are aware that there is always new research and theory on best practice, and there is some concern that they are not able to access this due to workload or a lack of structured training. An example of this is weaning, where official guidelines have shifted form 4 months to 6 months, and they are not always certain about the rationale for that or how to present it to the mums in their caseload.
Very mixed caseloads	Another characteristic, and sometimes challenge, is the breadth of audience they cover, from rural to town-based, and across all social grades and age bands.
Lots of travel time	Due to the geography of the area and the resourcing of clinics and baby groups, travel time can be fairly significant for those working in a community setting.

Some language barriers	A more recent trend was noted regarding migrant workers entering the region, particularly from Poland and other eastern European countries. This represent a communications challenge for the health professionals, especially if there is a lack of printed materials in a range of languages.

4. FINDINGS: BREASTFEEDING

4.1 BARRIERS

There was a range of barriers identified, categorised and summarised below:

CORE BARRIERS

1. PAIN: This was by far the strongest barrier we found, and seems stronger than it may have appeared in similar research in the past. There was a perception that no-one tells you this (apart from your friends)
2. Not everyone can do it (backed up by previous experience for some)
3. There was perceived to be little focussed coaching in maternity wards (this mirrors a challenge mentioned by health professionals)
4. Losing out on social life – an issue particularly for the younger, teenage mums in the sample
5. The perception that formula milk might be just as good, and some mentioned that this is an advertising claim

SECONDARY BARRIERS

1. A barrier to ongoing breastfeeding, even beyond the maternity ward, was the belief that it is acceptable and OK to try once, to "do your best"
2. There was also a perception that it is not allowed to combination feed, and a sense of breastfeeding being 'all or nothing'
3. Hard to deal with hungry babies – this barrier is about not recognising signs or having ongoing advice from a reliable source
4. Impact on body / body image was a barrier for the (relatively) more settled women in the sample, and generated a degree of insecurity
5. An assumption was also made that breastfeeding is not possible after a C-section, and many of the younger mums had experienced complicated births which led to a C-section

The cumulative effect of these core and secondary barriers (often expressed as excuses) can vary, but here are examples of how it can impact on each of our attitudinal groups:

- **INTENDERS:** Lack of confidence plus limited training in technique = ongoing pain plus isolation = stopping pre-8 weeks
- **RESISTERS**: The 'good intention' of trying once plus squeamishness / pain = stopping before leaving hospital

There are a number of other factors which are less emotive, but also contribute to barriers / reasons not to breastfeed, or consideration of breastfeeding. They are broadly categorised and summarised below:

PRACTICAL

- Lack of understanding of benefits, and particularly the more 'complex' iteration of these, for example referencing antibodies etc.
- Perception that the father cannot be involved
- Finding it hard to seek or access support at particular stress points (e.g. immediately upon return from hospital, weekend, late night, after 6-8 week visit)

CULTURAL

- No role models, or previous exposure within immediate family or wider local community
- Fear of feeding in public, and in particular fear of distaste and criticism from others (strangers)
- More important to keep the house clean, a factor that the health visitors had observed and also commented on

EXTERNAL

- Lack of support from partners or mums could represent a strong barrier. Once a woman is open to the idea of breastfeeding she needs emotional support from someone she trusts in order to keep the intention
- Need to ask permission of partners. Some women (in the 'Intenders' group)had asked their partner's permission to breastfeed because they felt it might make them less sexy and experienced some insecurity about this

It is important to remember that some positive factors and influences encouraging the uptake of breastfeeding were also identified. These tended to be mentioned by either health professionals or the women who were recruited as being 'maybe' or 'definitely' likely to breastfeed.

- An established tradition among rural families
- The greater bonding between mum and baby
- Strengthens and builds baby's general health (immunity)
- A cheap and portable way of feeding, and less complicated than bottle preparation
- A natural activity (although this was a minority perception)
- Migrant women breastfeed openly and set an example to local young women
- In a general sense, it was felt that more young women are open to considering breastfeeding (however, this can be a very low-committal form of consideration, if they are prepared to 'try once' in the maternity ward

These are positive factors, but it must be noted that for the majority of our sample of women (especially the 'Resisters') strong short-term barriers (pain and try my best) compete with all of these.

4.2 THE HEALTH PROFESSIONALS' VIEWS

We discussed some of the findings from the earlier stages of the project with the Health Professionals, and their own perceptions of triggers and barriers to breastfeeding. This is summarised below:

BARRIERS

- There was the observation here that a large challenge is faced if cultural, peer and family influences dominate, and that this indicates a need for peer education
- Information and printed materials can help to tackle some barriers e.g. when competing with formula
- Hands-on / direct support was perceived to be needed at a crucial 3-week stage when women can really begin to have to operate on their own

- It was apparent that the health professionals were keen to tackle the PAIN barrier but were unsure how to. The answer seems to relate to coaching about 'how to' breastfeed, something that requires a lot of resource and / or high turnout at breastfeeding support groups. It also involves access to up-to-date training and guidance for the health professionals
- It was recognised that a 'coaching' approach can help to deal with the fundamental issues of low confidence and self-esteem, particularly among the 'Resisters'

POSITIVE FACTORS

- The health professionals cited and agreed with these and perceive scope to work with many of them. However, they also observed that these factors tend to be more biassed to rural / settled women ('Intenders')
- They observed that positive influences are much more rare among urban types (the 'Resisters')
- They are keen to encourage other women to share experiences, as a form of peer-to-peer education, removing the fear of 'authority' that some women have and introducing a relevance via endorsement
- There was agreement that a positive trigger to emphasise about breastfeeding is 'bonding' / skin-to-skin contact, and this might have more appeal to lone, younger mothers

5. FINDINGS: WEANING AND INFANT NUTRITION

5.1 KNOWLEDGE, ATTITUDES AND INTENTIONS

There is a spectrum of attitudes and intentions in relation to infant nutrition from ages 0-5. As context, we have observed how firmly-embedded the healthy eating message of 5 fruit and vegetables a day is. It is almost a barrier to further consideration of additional nutrition factors, and can be interpreted as a message and / or benefit for all ages.

There is one set of attitudes (we could attribute to 'Intenders') defined as being determined / trying hard to do best for baby. In this case, the baby's / toddler's nutrition comes first and the whole family eats differently. These mums are more likely to actively seek out advice, to read recipes and booklets and to attempt to become aware of and to follow healthy eating 'rules' and guidelines.

Another set of attitudes which emerged (and could be attributed to the 'Resister' end of the scale) results in a more relaxed approach, defined as keeping to guidelines if possible. The target here is more aligned to working towards baby eating the same as the rest of the family. Sometimes this is clearly-linked to the diet of the mum and significant others. Mums here are more likely to adopt a 'ying and yang' approach, perceiving that a healthy snack, or some fruit and vegetables allows / counterbalances the inclusion of processed or sweet foods. We would tend to see more resistance here towards health promotion messages, but where the women had attended weaning classes, and become actively involved, this resistance had been converted to an interest.

What was apparent across the board was that time, convenience, knowledge & finances all contribute to the mums' intentions and efforts with regards to infant nutrition.

There were several issues and areas which emerged and build a picture of information needs in this area, which are summarised below:

ADVICE

- Their own mums and other mums have a very strong influence. Particularly in the case of low-income households, a lot of time is spent at other mums' homes, and this is the environment in which parent and infant eating behaviours are observed
- Mums (grandmothers) can be a core part of childcare, even just to give the mum a break or some 'me-time' if they are unemployed. This generation appears less ready to investigate or acknowledge healthy eating guidelines, weaning information etc. There is a strong sense of them "knowing what worked for them"
- Friends per se exert an influence and give and share advice. In the case of 'Resisters' this can be focussed on how to 'bend the rules' (this is a group that have a tendency to feel 'policed' by health visitors, for example). And in the case of 'Intenders' the information, tips and advice being shared are not always accurate, if they have not understood it, or it has been challenged, by their own mums, for example.

AREAS OF CONFUSION: WEANING

- When to wean? There appears to be a deal of confusion here – 4 months or 6 months? This is attributed to official guidelines changing and the mums not understanding the rationale for this
- Aside from being an issue of timing however, there is confusion about how to read signs, and understand when the baby is actually 'ready' for weaning. This is assumed to be when they get 'too hungry', for example aligned to (still) needing night feeds and it seems that these signs are also hard to read. This is an example of when a mum will 'bend the rules' and feed the baby a commercial formula milk specifically for 'bedtime', or add some baby rice to the last feed

MILK TO SOLIDS

- Some solids are not perceived to be 'real solids', for example rusks, or baby rice
- There is some additional confusion about whether purees (commercial baby food, or home-prepared fruit and vegetables) are solids or not
- The key switch to solid food and therefore 'total' weaning is often perceived to be when the baby / toddler can eat the same as the rest of the family (and this is perceived to be a sign of development)

SUPPORT GROUPS

- For those who had heard of or experienced them, there was a very positive reaction to Surestart and MINT weaning groups, and they had really enthused some of the mums with the hands on approach, and apparently non-intimidating coaching style
- They were praised for showing the convenience and the benefits (including financial) via practical demonstration
- They also seem to offer a forum and allow discussion and debate of guidelines. This is an ideal situation to deal with the "my mum did this with me" style of objections
- It was also clear that the mums who had received them, like the booklets and recipes too, although any text-heavy black and white content can be off-putting and prevent them from accessing headline 'dos and don'ts'

5.2 THE HEALTH PROFESSIONALS' VIEWS

We discussed some of the findings from the earlier stages of the project with the Health Professionals, and their own perceptions of triggers and barriers to breastfeeding. This is summarised below:

BARRIERS

- Again, it was observed that a challenge is faced if cultural, peer and family influences dominate, and that this indicates a need for peer education
- Clear, visual information was perceived to help them to communicate key issues to women: e.g. food preparation hints and tips, or timelines for child development
- A simple, straightforward presentation is required to allow clear interpretation and intent. Within this context, the health professionals appreciated the role and contribution of existing weaning classes in conveying overall nutritional information and guidance. There was an additional role perceived too, in terms of clarifying the balance of diet, and addressing the 'ying and yang' approach taken by some
- It was also felt that a key vitamin message is being overlooked, and it is a gap in the information filtering out to mums currently

POSITIVE FACTORS

- Many of the health professionals observed that some mums really enjoy the focus and nurturing aspects of learning about 'real baby food'. Although this might tend to be more biassed to rural / settled women (our 'Intenders') it also echoes the praise for the weaning classes that we heard from the mums themselves, in all areas and situations
- The health professionals are keen themselves to understand the rationale for new / shifting guidelines, as this is what they need to convey and clarify to the mums they work with
- They also observed that it would help to focus on and communicate developmental stages: real SIGNS of a baby ready for solids, not just a certain number of months

6. FINDINGS: HEALTHY START AND RETAILER VIEWS

6.1 HEALTHY START: TRIGGERS AND USAGE

Friends and families' knowledge and experience of the vouchers often triggered awareness among the mums. However, a key driver in take-up was when a midwife had assisted with the application, and this was sometimes done as part of broader financial support (especially in the case of those with Surestart midwives). If the application had been made as part of a 'financial review', along with an application for a Maternity Grant for example, it seemed less daunting, and less of a 'big deal' in itself.

In practical terms, having a convenient participating retailer also encouraged take-up, and there was some confusion about which retailers accept the vouchers and not. For instance, most of the mums in the sample did not think Tesco accepted Healthy Start vouchers, and some claimed to have been told this by staff in the store. This suggests that perhaps there is confusion within the stores themselves, and posters or stickers might help raise staff awareness of participation, as well as that of the general public.

The vouchers are used for milk predominantly, and we did not meet any mums who were using or had used them for vitamins. They tended to be referred to as 'milk vouchers'.

When used, the vouchers were seen to make a positive difference (particularly in the first year) and to help with competing household expenses. Some of the women tended to 'double-up' the vouchers, and occasionally to use them when retailers were running special offers on formula milk.

6.2 HEALTHY START BARRIERS TO USAGE

All of the women in the sample were recruited to be (theoretically) eligible for Healthy Start, yet we found a significant lack of awareness, which represented a key barrier to application and take-up. There was an amount of uncertainty about eligibility, and this may have been

compounded by having a previous application refused. It was felt that the eligibility guidelines are hard to follow and can families can 'shift' in and out of eligibility. A good example of this is if they are in (temporary) receipt of working Tax Credit.

A barrier to usage was if it was perceived to be hard to access retailers, or if participation was not promoted by local retailers. In this case a lot of women would not like to ask, they would prefer to see a sign, a poster in the store or a sticker in the window.

For a minority, there was some social embarrassment associated with using vouchers and being obviously in receipt of state support.

Additionally, and again for a minority, the vouchers were seen to offer an insignificant amount of savings or contribution to their expenses.

There was almost no awareness of the inclusion of vitamins, and where it had been noticed, it was perceived to be more complicated to access these. This is possibly related to the way these used to be issued, as a separate 'token' to be claimed.

6.3 RETAILERS' VIEWS

This was a very small sample and small part of the project overall, and we have some topline observations from our telephone interviews.

There was an apparently high awareness of the scheme, among both participants and non-participants.

Those whom we interviewed who were currently participating were very supportive. Their main observations were that the vouchers are used predominantly for milk, not fruit and vegetables. In some cases, there is a corporate policy to participate, for example, the Co-operative.

Non-participants appeared to have some concerns and barriers. It was felt that they might find it difficult to anticipate the supply and demand, and they also perceived and expected difficulties in dealing with paperwork when accepting any sort of redemption scheme. A minority of these non-participants had concerns that the Healthy Start scheme might attract the 'wrong sort' to their outlets.

There were some overall barriers, across the sample, to do with the administrative side of processing Healthy Start vouchers, and there was some interest in the idea of online redemption, in order to reduce paperwork and time.

The scheme participants were interested in receiving some or more point of sale materials, for example to show in the shop window, to raise awareness generally, about eligibility and voucher coverage.

7. SUMMARY: TARGET AUDIENCES' INFORMATION NEEDS

In the following section of the report, we have summarised our interpretation of the core information needs of each target audience, based on our fieldwork and observations above.

7.1 PREGNANT WOMEN

BREASTFEEDING	INFANT NUTRITION
• Benefits to baby, specifically in comparison to formula milk • Bonding and closeness to baby: a benefit for both • Techniques that can address / reduce pain • That early support is needed and available • The ongoing / later life benefits of breast milk • Convenience and practicalities of breastfeeding • How to access other mums who have made the decision and endorse it	• Importance and role of vitamins in child development • Understanding food expenses and budgetting • Identifying the fit or influence of the rest of the family's eating habits • Understanding how things may have changed since they were babies

7.2 MUMS OF 0-4 YEAR-OLDS

BREASTFEEDING	INFANT NUTRITION
• Awareness that support is available • Acknowledgement that it can be difficult but coaching / techniques can help • Advice on how to deal with partner / peer objections • Dressing for breastfeeding in public • Having access to an experienced support network: For example, a Phoneline in addition to scheduled groups • Access to people with time to listen	• Timings for weaning and the rationale for this • How to gauge when and why baby needs solids • Incorporating fresh foods for babies / toddlers into budget • How to incorporate healthy choices into mum's / family meals • Which foods to avoid, and which to introduce gradually • Importance of vitamin intake • Accessible, straightforward 'dos and dont's', for example the table in the existing Borders NHS weaning booklet, but in a lighter format: less verbal content, more colour

7.3 SIGNIFICANT OTHERS / PEERS

BREASTFEEDING	INFANT NUTRITION
• The overall health benefits for mum and baby • The benefits and practicalities of expressed milk compared to bottled • The 'natural' benefits • How others in the family can still have involvement in feeding and nurturing	• The convenience and ease of progressing to purees before rice or rusks • Techniques for comforting mum and (hungry) baby • Foods and additives to avoid • Scenarios and dealing with crisis points • Rewarding without bribery

7.4 HEALTH PROFESSIONALS

BREASTFEEDING	INFANT NUTRITION
• How to incorporate the 'pain' barrier into early discussions • Communicating core 'techniques' ante-natal and early at home • Providing seamless support for new mums • How to identify and encourage peer support routes • Running a breastfeeding group that is not just about (or labelled) breastfeeding • Dealing with squeamishness / sexuality issues • How to endorse mixed feeding without encouraging it	• A simple resource to advocate benefits of vitamin supplements • A simple resource to share 'baby development' theory, and signs • How to explain changes in guidelines and recommendations (for example, timings for weaning) • Reference and access to ongoing baby / weaning groups across the region

8. CONCLUSIONS AND RECOMMENDATIONS

We present each key concluding insight below, with a fuller explanation and suggested activities and reinforcement in terms of information and support provision which might be possible from MINT.

BREASTFEEDING RATES ARE REDUCING AT 6-8 WEEK STAGE

- Shorter-time in hospital means less hands-on support
- **Other mums' coaching** could play a strong role here
- Need for seamless transition from hospital to home
- Crucial times cannot always be covered in person
- **A telephone helpline or support access point** could be a strong backup

IT IS HARD TO IDENTIFY NUMBER OF FAMILIES ELIGIBLE FOR HEALTHY START

- This is a challenge for advisors and potential sign-ups
- Signposting participating retailers
- **Emphasising (or enabling) ease of application** and processing

MORE EMOTIONAL INFORMATION NEEDS FOR BREASTFEEDING

- **Continue and bolster Surestart approach to breastfeeding 'coaching'** / trying this together in harder to reach communities (confidence building, especially for Resisters)
- Demonstrate minimal impact on social life, ability to overcome / avoid pain
- Recruitment of 'mums like me' show that it can work

- **Peer training** or how to deal with resistant peers needed by some

INFORMATION NEEDS FOCUSSED ON PRACTICAL ISSUES FOR NUTRITION

- Shopping, cooking, preparing: making life easier
- How to identify signs of readiness
- **Keep developing the weaning classes**
- Scope to **extend to cover broader nutritional issues**: vitamins, dental health, 'children's food'
- Still an emotional requirement too e.g. Coaching to deal with pressure points, kids' demands

HEALTH PROFESSIONALS ARE WARY OF A 'TEMPORARY' RESOURCE

- Really welcome the MINT resource but little evidence of 'action' so far
- Health professionals need **solid, ongoing and consistent support**
- Strong interest in **updating / refreshing knowledge on breastfeeding**
- Nutrition is harder to address: appreciate the input from MINT but should be direct to mums

MUMS IN MORE URBAN AREAS ESPECIALLY PRAISE THE SURESTART APPROACH

- **Holistic and helpful approach**
- Could this address the 'trying' barrier?
- **Financial advisory role** generates greater confidence
- Can 'substitute' difficult family relationships
- Consider striving for this **friendly, non-judgmental tone in all materials**

A RANGE OF BARRIERS TO HEALTHY START UPTAKE IDENTIFIED

- **Encouraging early application** by all
- Greater clarity on eligibility needed
- **Consider 'pre-screening'** if possible
- Consider 'pen portraits' of eligible mums / families
- **Have a separate, more focussed message for vitamins**

RETAILERS COULD BE MORE SUPPORTIVE OF HEALTHY START

- Address their barriers regarding paperwork
- Encouraging them to **signify involvement (e.g. Sticker / poster in window)** useful for mums too
- **POS materials to explain scheme**, even recipes, simple meal planning