National Children's Bureau

Turning the curve on child health indicators:

A rapid review of evidence on proposed 'What Works' ideas to inform action planning for the Jersey Early Childhood Development Programme

April 2017

Contents

Background and purpose of paper

Through the Early Childhood Development Programme (ECDP), NCB is facilitating the implementation of an Outcomes Based Accountability approach to support improvements in outcomes for young children on the island of Jersey. The ECDP Steering Group met on 13th September 2016 to consider the first outcome of focus, 'All children in Jersey are healthy', and agree a prioritised set of indicators. Given the current data available the following indicators were chosen as the best fit:

- Breastfeeding rates (either fully or partially) at 6-8 weeks
- % babies born with a low birth weight
- % reception age children who are overweight or obese

In supporting this decision, and further progressing the work on this outcome, the following activities have taken place:

- An audit of available indicator data for children aged 0-18 in Jersey, to specifically look more closely at indicator data for children aged 0-5 to identify where support is most needed, and to build a picture of children's health and well-being.
- An audit of the early years services (conception to age 4) currently delivered in Jersey
- Initial training in the Outcomes Based Accountability approach for key stakeholders
- Reviews of current evidence and relevant policy to inform the discussions on 'what works to do better'
- Two sets of Turning the Curve workshops with a wide range of stakeholders to examine each of the prioritised indicators and begin to inform what should happen to improve that indicator (December 2016 & January 2017).
- A Turning the Curve report summarising discussions at these workshops and 'What Works' ideas proposed.

The ECDP Steering Group will meet again on 18th April 2017 to discuss these proposed 'What Works' ideas for each indicator, and to agree on which actions will be taken forward. This paper provides a rapid review of available evidence on each proposed 'What Works' idea, to inform discussions and support action planning.

Note on strength of evidence

In reviewing the proposed ‘what works’ ideas below, consideration has been given to the strength of evidence supporting each idea. The following categories have been highlighted:

Strong evidence: These include evidence based interventions or approaches that are supported by a wide body of evidence collected via robust experimental methods (e.g. Randomised Controlled Trials), and those supported by NICE guidelines or World Health Organisation recommendations.

Some supporting evidence: This refers to interventions or approaches where there is 1 or more pieces of evidence, not experimental in nature, but suggest emerging support for an intervention, approach or way of working.

Little evidence: Some anecdotal evidence to support the idea, however little evidence from research.

Indicator 1: Breastfeeding rates (either fully or partially) at 6-8 weeks

Proposed 'What Works' ideas:

1. **Implementation of the Baby Friendly Initiative (planned 2017)**
2. **Roll out of a universal antenatal education programme e.g. a modified version of NSPCC Baby Steps**
3. **Education for healthcare practitioners (all those who have contact with an expectant mother) to ensure consistent messaging**
4. **Change in legislation to support longer paid maternity leave**
5. **Focus on peer support training and provision**
6. **Cultural/attitudinal change through public awareness campaign**
7. **Rebranding of programmes/initiatives already in place to make more inclusive e.g. currently have breastfeeding cafes which could be renamed 'infant feeding group' to include support for weening etc., These should be women only (low cost)**
8. **Education for the wider family, and in particular involving dads**

Summary of available evidence

1. Baby Friendly Initiative (BFI):

Strong evidence: BFI is an evidence based intervention which has had a positive impact on breastfeeding for new mothers globally, in particular the increased initiation and continuation of breastfeeding[1][2]:

Europe:

[1] https://www.unicef.org.uk/babyfriendly/news-and-research/baby-friendly-research/research-on-the-impact-of-the-baby-friendly-initiative/

[2] Being baby friendly: evidence-based Breastfeeding support J Cleminson, S Oddie, M J Renfrew and W McGuire (2014) *Archives of Disease in Childhood. Fetal and Neonatal Edition* Volume: 100 Issue 2 (2015)

- UK mothers- 10% more likely to initiate breastfeeding in BFI hospitals, and 8% increase in breastfeeding at 7 days old.
- Greater impact on mothers from more disadvantaged backgrounds
- No increase in breastfeeding at 1 month old
- Prenatal education and postnatal breastfeeding support were identified as the most important parts of the BFI.
- Positive impact found on cognitive development between 3 & 7 in follow up studies
- Norway- BFI increased likelihood of exclusive breastfeeding until 6 months
- BFI also increases nurses & midwives' knowledge and skills and leads to new mothers perceived better support from practitioners.

Globally:

- BFI has a positive impact on breastfeeding in terms of initiation rate, exclusive breastfeeding at discharge, breastfeeding duration. Long term positive impact found on IQ and academic performance.
- Australia: BFI positively impacts likelihood of initiation of exclusive breastfeeding

2. NSPCC Baby Steps Programme, Jersey

Strong evidence: An evidence informed programme developed by Warwick University & NSPCC. A targeted group work ante-natal education programme, jointly delivered by an NSPCC practitioner and a midwife. The 9-week programme starts before birth and is designed to support parents with the transition to parenthood in a fun, meaningful way and helps them engage positively with their babies.

Impact data:

Evaluation report completed 2015. Findings include:

- Improved preparedness for parenthood due to increased knowledge
- Lower rates of caesarean, lower rate of premature birth or low birth weight.
- Improved parent infant relationship
- Improved parent/partner relationship
- Improved parent emotional well-being
- Improved peer support

3. Education for healthcare practitioners (all those who have contact with an expectant mother) to ensure consistent messaging

Some supporting evidence of the impact of practitioner knowledge on breastfeeding behaviours, but more so on practitioner approach. A systematic review[3] of midwives' experience of supporting breastfeeding mums identified the following key issues:

Midwifery care is seen as either:

- Breast-centred, where the technical process of delivering food to the baby is the central goal, and the midwife is a 'technical expert' and the woman a novice who needs taught what to do. Often very hands on and impersonal, the woman is treated as a 'milk-producing machine' and language used is often patronising e.g. sweetie, ladies, girls.
- Person centred, where the focus is on the attachment relationship and the role that breastfeeding can play- here, the midwife is seen as a 'skilled companion'. The woman is recognised as having the ability to breastfeed autonomously and the midwife is a companion who supports as and when needed.

A range of educational sources influence midwife practice, e.g. formal/informal education, personal experience, cultural/social knowledge, experiential knowledge. On occasion, midwives have been shown to overrule their 'formal' education with personal experience[4].

However, there is also wider evidence that midwives don't have the opportunity to improve their skills due to time constraints & pressures of job. Several reviews have examined the best way to communicate information to practitioners to support continued professional development for breastfeeding. Key lessons include[5]:

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[3] **Swerts, M., Westhof, E., Bogaerts, A., Lemiengre, J.** ***Supporting breast-feeding women from the perspective of the midwife: A systematic review of the literature.*** **Midwifery, 37 (2016), pp32-40**

[4] Battersby, S. (2014) The role of the midwife in breastfeeding: Dichotomies and dissonance. British Journal of Midwifery, vol 22 (8), pp551-556

[5] Bernaix,L.W., Beaman, M.L., Schmidt,C.A., Harris, J.K. & Miller, J.M. (2010) Educational Intervention on Maternal/Newborn Nurses' Breastfeeding Knowledge and Attitudes. Journal of obstetrics, gynaecologic & neonatal nursing, vol 39 (6), pp658-666

- Self-paced study modules allowed practitioners to fit their learning around their current commitments.
- Self-study was also less intimidating than classroom based learning
- Web-based learning combines both benefits above.

4. Change in legislation to support longer maternity leave

Strong evidence: Jersey currently has the highest population of working mothers in the world. Statutory maternity leave in Jersey is currently up to 18 weeks, however the 1001 Days taskforce recognises the need to increase this to 26 weeks (in line with rest of UK), and preferably 52 weeks to give mothers the opportunity to sustain breastfeeding longer term. Given the current low maternity leave in Jersey, employer support for breastfeeding is particularly important.

Employer strategies recommended by the NHS[6] include:

- Support for flexible working hours to be arranged around breastfeeding. Mother may arrange for day care facilities near to the workplace so that they can pop out to breastfeed on breaks.
- Private, comfortable provision in the workplace to allow for expressing of milk during working hours
- Storage provision in the workplace for expressed milk

The ACAS[7] (Advisory, Conciliation and Arbitration Service) recommends the following similar steps for employers:

- Appropriate policy should be in place and made accessible to ensure new mothers wishing to breastfeed are aware of provision in place, as well as the procedures for accessing.
- Provision of appropriate facilities, including a private space to express milk, and fridge and storage facilities

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[6] https://www.nhs.uk/Planners/breastfeeding/Documents/breastfeedingandwork[1].pdf

[7] http://www.acas.org.uk/media/pdf/j/k/Acas_guide_on_accommodating_breastfeeding_in_the_workplace_(JANUARY2014).pdf

- Consideration of requests for flexible working hours and/or additional breaks to facilitate breastfeeding.

A range of studies have considered the impact of length of maternity leave on breastfeeding initiation and duration:

US study[8]:

- Women taking more than 13 weeks maternity leave had higher rates of breastfeeding initiation than those taking less than 13 weeks. Those taking less than 6 weeks had lowest initiation rate.
- Similar findings applied to mothers breastfeeding after 6 months.

Millennium cohort study (UK)[9]:

- Mothers more likely to breastfeeding for at least 4 months if self-employed or working part time
- The longer she delayed returning to work, the more likely she was to breastfeeding at 4 months
- Mothers more likely to breastfeeding at 4 months if employer offered family friendly policies or flexible working arrangements.

Growing up Scotland study[10]:

- Working mothers had a higher risk of early breastfeeding cessation than non-working mothers
- Mothers taking longer maternity leave breastfeeding for longer

[8] Ogbuanu, C., Glover, S., Probst, J., Liu, J. & Hussey, J. (2011) The Effect of Maternity Leave Length and Time of Return to Work on Breastfeeding. Pediatrics, vol 127 (6), pp1414-1427

[9] Hawkins S.S., Griffiths L.J., Dezateux, C. & Law, C. (2007) The impact of maternal employment on breast-feeding duration in the UK Millennium Cohort Study. Journal of Public Health Nutrition, Vol 10(9), pp891-896

[10] Skifida, V. (2012) Juggling work and motherhood: the impact of employment and maternity leave on breastfeeding duration: a survival analysis on Growing Up in Scotland data. Maternal Child Health Journal, vol 16(2), pp519-527.

5. Breastfeeding peer support

Strong evidence: Several systematic reviews have shown some evidence that peer support helps to extend breastfeeding duration across the UK, however there is stronger evidence of positive impact in low income countries. Some examples below:

A Cochrane review[11] of 56,000 mother-infant pairs globally showed that those receiving additional peer of professional support were more likely to breast feed (exclusively or not) for a longer duration.

Universal antenatal peer support doesn't necessarily increase breastfeeding initiation rates alone; however targeted peer support has been shown to be beneficial for some. Peer support has been shown to be particularly beneficial in areas of deprivation or more rural areas[12].

Jolly, Ingram et al (2012) Systematic review of peer support for breastfeeding continuation[13]

- Peer support increases initiation rates and duration in low/middle income countries
- Low intensity support has little impact- peer support must be medium to high intensity and continue after birth.
- No significant impact in high income countries, as universal support already provides breastfeeding support

Trickey, H. (2013) Peer support for breastfeeding continuation: an overview of research[14]

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[11] Renfrew MJ, McCormick FM, Wade A, et al. Support for healthy breastfeeding mothers with healthy term babies. Cochrane Database Systematic Review 2012;(5):CD001141

[12] Ingram, J. (2013) A mixed methods evaluation of peer support in Bristol, UK: mothers', midwives' and peer supporters' views and the effects on breastfeeding. BMC Pregnancy and Childbirth (2013) vol **13**, p192

[13] Jolly, K., Ingram, L., Khan, K., Deeks, J., Freemantle, N. & MacArtuhr, C. (2012) Systematic review of peer support for breastfeeding continuation: metaregression analysis of the effect of setting, intensity, and timing. British Medical Journal, 2012,

[14] Trickey, H. (2013) Peer support for breastfeeding continuation: an overview of research. NCT's journal on preparing parents for birth and early parenthood, issue 21.

Findings as above, however where 'additional support' was provided, over and above universal post-natal support, there were positive outcomes for breastfeeding continuation. Face to face, planned and tailored support was most effective.

A Scottish intervention in deprived area involving peer support groups run by healthcare professionals found the following:

- Improved breastfeeding rates at 6-8 weeks not found, and in some cases, breastfeeding rates declined.
- Reasons thought to include:
    - Failure to attract the target group of mothers
    - Lack of attendance in pregnancy and early weeks after birth

More generally, peer support has been shown to have wider maternal-infant benefits, including increased confidence and self-esteem and reduced isolation, and increased knowledge and change in attitudes to breastfeeding- these may in turn impact positively on initiation and duration of breastfeeding.

6. Public awareness campaign to normalise breastfeeding & change cultural/social opinions

Some supporting evidence: There is evidence that many people are still uncomfortable seeing breastfeeding in public, and this in turn puts many mothers off continuing to breastfeed[15]. To date, the focus of media campaigns has been on the health benefits of breastfeeding, targeted at mothers, immediate family and health practitioners. Recommendations have been made that future focus should be on 'normalise breastfeeding' for the wider public

In general, there is **little evidence** for the impact of media campaigns on health behaviours, and in particular for breastfeeding. Some general lessons from media campaigns include:

[15] Wakefield, M.A., Loken, B. & Hornik, R.C. (2010) Use of mass media campaigns to change health behaviour www.thelancet.com Vol 376.

- Campaigns work best when the behaviour targeted is a one-off (e.g. immunisations) rather than long-term (e.g. smoking)
- The campaign is most effective when it is delivered in conjunction with enhanced service or product provision, so that people can act on the messages if motivated to.
- Effects are usually short-lived, extending little beyond the life of the campaign
- Media campaigns can get a message out to a wide number of people, however it is difficult to isolate the impact of the campaign itself.

The Big Latch On takes place annually across the world during World Breastfeeding Week; the aim is to normalise breastfeeding in public places, as well as to help women to find local peer and community support in their area. The Big Latch hasn't been formally evaluated, however it is increasing in reach globally; in 2016 there were Big Latch events in 28 countries, 758 locations and with 48,628 in attendance.

7. Rebranding of programmes/initiatives already in place to make more inclusive e.g. currently have breastfeeding cafes which could be renamed 'infant feeding group' to include support for weening etc., These should be women only (low cost)

No evidence found to demonstrate that this approach will improve breastfeeding rates. However, **some supporting evidence** that fathers would be more keen to get involved in groups if they were renamed (see below)

8. Education- for parents, practitioners, wider family (in particular dads/partners)

Father

There is **strong evidence** that wider support for new mothers has a significant impact on their likelihood of sustained breastfeeding. While to a lesser extent than previous generations, new mothers still gain much of their knowledge on breastfeeding from their own mothers and close female relatives. Education and support must therefore focus on these key influences in a new mother's life. Partners are also critical, with mothers more likely to initiate and sustain breastfeeding if they have a supportive partner. One study[16] on dad's thoughts on breastfeeding showed that:

[16] **Brown, A. & Davies, R. (2014)** ***Fathers' experiences of supporting breastfeeding: challenges for breastfeeding promotion and education.*** **Maternal and Child Nutrition (2014), 10, pp. 510–526**

- Fathers are generally supportive of their partner breastfeeding, however thought of it as their partner's choice rather than theirs
- Fathers feeling unimportant/left out of antenatal education
- Fathers reported benefits e.g. health of baby, cost and ease of feeding
- Many felt left out of the relationship and like they were missing out on the experience
- Fathers reported receiving little information relating to their role in supporting breastfeeding, other than what their partner told them
- Greater emotional support[17] from father (and other close family members) is associated with higher levels of breastfeeding initiation and duration.
- Greater practical support from father (and other close family members) is associated with lower levels of breastfeeding initiation and duration.

Fathers need educational resources targeted directly at them, as well as dedicated support for themselves.

Grandparents

Grandmothers are a key support for new mothers and can influence feeding choice- particularly if they have strong cultural opinions or personal experiences. Evidence shows that new mothers need encouragement and acknowledgement of the value of breastfeeding from their mother/mother in law[18]. Additionally, as above, practical support from grandparents (and fathers) has been shown to decrease breastfeeding[19] Grandmothers must therefore be included in education and awareness raising activities to support consistent messaging.

[17] Emmott EH, Mace R (2015) Practical Support from Fathers and Grandmothers Is Associated with Lower Levels of Breastfeeding in the UK Millennium Cohort Study. PLoS ONE 10(7): e0133547. doi:10.1371/journal.pone.0133547

[18] Grassley, J. & Eschiti, V. (2008) Grandmother breastfeeding support: what do mothers need and want? Birth, 2008 Vol. 35 (4), pp329-335

Antenatal education

Some supporting evidence: In the period building up to the birth, antenatal education provides an opportunity to improve knowledge and understanding of both parents on the benefits of breastfeeding. Education has been shown to increase openness to breastfeeding, however alone it doesn't necessarily increase uptake. Antenatal education must also focus on develop a mother's confidence and self-esteem, which has been shown to increase likelihood of initiation of breastfeeding[20]. Discussions on antenatal education include:

- Timing of education: antenatal education combined with practical support immediately after birth is most effective.
- Natural process vs a skill to be learned: a combination approach is considered the best approach to be taken in antenatal education. This removes the burden of 'failure' from women who have difficulty in initiating breastfeeding, while recognising the mother's initiative and experience. [21]
- First time mothers were shown to particularly benefit from antenatal education on breastfeeding, however practical guidance must be combined with knowledge on the benefits of breastfeeding to the baby, and a strengths-based model is recommended to build self-confidence and self-esteem in the mother.

There have been very few evaluations on impact of preventative education at school- a systematic review[22] found 6 studies, which demonstrated a positive impact in terms of attitude towards and intention to breastfeed, however no evidence that this was sustained. However, education on breastfeeding in schools is promoted by UNICEF to normalise breastfeeding.

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[20] Avery A., Zimmermann K., Underwood P.W. & Magnus J.H. (2009) Confident commitment is a key factor for sustained breastfeeding. Birth 36 (2), 141–148

[21] Locke, A. (2009) Natural versus taught: competing discourses in antenatal breastfeeding workshops. Journal of Health Psychology, 2016, vol 14 (3), pp 435-446

[22]Glaser,D.B., Roberts, K.J., Grosskopf, N.A., & Basch, C.H. (2015) An Evaluation of the Effectiveness of School-Based Breastfeeding Education. Journal of human lactation, Vol 32(1), pp46-52

A Better Start (Big Lottery)

A Better Start supports the delivery of early intervention programmes in pregnancy and first three years of life across three key areas:

- Social and emotional development- harm prevention and promoting/supporting attachment
- Speech and language development- supporting parents and practitioners to engage with and support speech & language development
- Nutrition- encouraging breastfeeding and good nutritional practices.

Programme focus is on a systems shift to early intervention, needs-led and joined up services.

Evaluation is ongoing (Warwick University): Baseline data collection began in 2016 so no evaluation details available currently.

Summary and implications for Jersey

1. **Implementation of the Baby Friendly Initiative (planned 2017)- Strong evidence**
   - strong evidence that BFI increases breastfeeding rates
   - Plans already in place to roll-out in Jersey

2. **Roll out of a universal antenatal education programme e.g. a modified version of NSPCC Baby Steps- strong evidence**
   - Already in place in Jersey, so mechanisms in place to deliver
   - Initial evaluation has shown decrease in rates of premature birth and low birth weight
   - Evaluation has shown other benefits in terms of attachment and parent relationships, all of which contribute to wider well-being of parent and child.

3. **Education for healthcare practitioners (all those who have contact with an expectant mother) to ensure consistent messaging -some supporting evidence**
   - Evidence shows that practitioners all have a range of approaches to breastfeeding support, informed by formal education, personal experience, informal education. Unclear as to whether further formal education will standardise

approach.

- Practitioners report preference for self-study rather than formal education settings, as fits better with time constraints of job. Online approaches fit well.

4. **Change in legislation to support longer paid maternity leave- strong evidence**

   - Jersey has very high number of working mothers, and very short maternity leave.
   - strong evidence for connection between length of maternity leave and duration of breastfeeding
   - Change in legislation not going to happen easily, focus may better be targeted at mechanisms to support working mothers to breastfeed e.g. flexible working hours, facilities for expressing etc.

5. **Focus on peer support training and provision- strong evidence**

   - Strong evidence that peer support increases breastfeeding initiation and continuation in low income countries, less so for developed countries
   - Evidence suggests peer support offers little over and above universal support in terms of breastfeeding initiation, may positively impact on duration for some, particularly in areas of deprivation (UK)
   - Evidence suggests peer support has more generally positive benefits for new mothers in terms of social support and reduced isolation, which will in turn improve wider health and well-being.
   - May add little over and above Jersey current universal provision

6. **Cultural/attitudinal change through public awareness campaign- some supporting evidence**

   - Evidence shows that public opinion is a strong reason why mothers don't breastfeed in public and therefore are less likely to continue.
   - Media campaigns in general can reach a wide number/range of people, however are costly
   - Previous breastfeeding campaigns have focused on health benefits for mother, however focus should be on normalising breastfeeding.

7. **Rebranding of programmes/initiatives already in place to make more inclusive e.g. currently have breastfeeding cafes which could be renamed 'infant feeding group' to include support for weening etc., These should be**

women only (low cost)- little evidence

- some evidence that fathers may get more involved in breastfeeding if groups were renamed, however no evidence that renaming groups would increase breastfeeding rates in general.

8. **Education for the wider family, and in particular involving dads- strong evidence**

   - strong evidence that wider support for mother, from family and partners, increases duration of breastfeeding
   - Evidence shows fathers largely agreeable and supportive of breastfeeding, however see the decision as the mothers rather than theirs.
   - Antenatal education on benefits of breastfeeding has positive impact on intention to breastfeed.
   - Education in schools on benefits of breastfeeding has positive impact on intention to breastfeed & in normalising breastfeeding for boys & girls, however little evidence of longer term impact- but recommended by UNICEF and part of BFI.

Indicator 2: % babies born at a low birth weight in relation to gestational age

Proposed 'What Works' ideas

1. **Improve uptake of current smoking cessation programme- e.g. opt out rather than opt-in, health needs assessment and referrals made at booking appointment, better sharing of information between healthcare professionals**
2. **Preventative education in schools (for boys and girls)**
3. **Engaging dads during antenatal period to educate and ensure they are equipped to support mum**
4. **Flexible services to support working mums during pregnancy to enable them to make the most of support**

Summary of available evidence

1. Improve uptake of current smoking cessation programme- e.g. opt out rather than opt-in, health needs assessment and referrals made at booking appointment, better sharing of information between healthcare professionals

Strong evidence: The evidence base on the impact of smoking during pregnancy on birth weight is strong, therefore this is a particularly strong intervention. Effective strategies include:

Personalised approach: (RCT of National Health Service Stop Smoking Services -not specifically ante-natal related)
A personalised letter from the GP[23], detailing individual risk and health factors, alongside an invitation to come to a 'taster session' cessation programme session with a specific appointment date made, with follow up letter 3 months later for those who didn't attend, doubled the uptake of the programme compared to those who received a generic info letter and were asked to make contact themselves. Additionally, the personalised group were twice as likely to complete the 6-week course.

[23] Gilbert, H., Sutton, S., Morris, R., Peterson, I., Galton, S., Wu, Q., Parrott, S. & Nazareth, I. (2017) Effectiveness of personalised risk information and taster sessions to increase the uptake of smoking cessation services (Start2quit): a randomised controlled trial. www.thelancet.com, vol 389, February 25, 2017

Financial incentives: A Cochrane Review[24] found financial incentives to be the most effective, however it may be the components of the scheme, rather than the incentive itself, that has the impact e.g. the quality of face to face contact.

Digital interventions: These are reasonably new and while have been shown to be successful in the general population, lack an evidence base when pregnancy related. However, text based and online interventions have shown promise; they remove stigma and potential for judgement, which evidence has shown may hold women back from attending smoking cessation sessions.

In general, effective interventions should:

- Be population wide rather than targeted, but with a personalised approach
- Be theory based
- Include a combination of several Behaviour Change Techniques (BCTs) (e.g. face to face sessions, nicotine patches, financial incentives, group sessions)
- Include personal contact

Uptake can be increased by:

- Improving screening and information sharing to identify those most at risk
- Using a personalised approach
- Taking steps to minimise stigma
- Being adaptive to the individual

2. Preventative education in schools (for boys and girls)

Some supporting evidence: Evidence of impact of education on intention to breastfeed, however little evidence of long term effects of this, or of impact on wider health decisions during pregnancy.

[24] Lumley, J., Chamberlain, C., Dowswell, T., Oliver, S., Oakley, L. & Watson, L. (2009) Interventions for promoting smoking cessation during pregnancy. Cochrane Pregnancy and Childbirth group, Cochrane Database of Systematic Reviews. DOI: 10.1002/14651858.CD001055.pub3

Health education in schools currently focuses more on preventing pregnancy, rather than healthy lifestyles during pregnancy, however as above, UNICEF recommends breastfeeding education in schools.

3. Engaging dads during antenatal period to educate and ensure they are equipped to support mum

Some supporting evidence: Systematic review[25] of current education for fathers suggests that it doesn't prepare fathers for their role as birth partner or parenthood.

- They feel left out of antenatal classes even if they attend
- Many felt disconnected from pregnancy, with 'it's her body' type attitudes
- When father is actively engaged, there are health and well-being benefits for mother and baby
- Limited research on the area altogether, and particularly around fathers' role on health behaviours

4. Flexible services to support working mums during pregnancy to enable them to make the most of support

Little evidence: Workplace studies focus on breastfeeding support and flexibility for childcare, rather than pregnancy support.

Summary and implications for Jersey

1. **Improve uptake of current smoking cessation programme- e.g. opt out rather than opt-in, health needs assessment and referrals made at booking appointment, better sharing of information between healthcare professionals – strong evidence**
   - direct link between smoking in pregnancy and birthweight, so increasing uptake of cessation programmes has potential for strongest impact.
   - Evidence shows that uptake increased by personalised approach to invitation, range of behaviour change mechanisms, financial incentives and use of digital

[25] Smith, S., Spence, D., & Murray, K. (2015) Does antenatal education prepare fathers for their role as birth partners and for parenthood? British Journal of Midwifery, Vol 23, No 5.

information sharing methods (which can reduce stigma & encourage engagement)

2. **Preventative education in schools (for boys and girls)- some supporting evidence**

   - Health education in schools currently focuses more on preventing pregnancy, rather than healthy lifestyles during pregnancy, however as above, UNICEF recommends breastfeeding education for schools.
   - Evidence of impact of education on intention to breastfeed, however little evidence of long term effects of this, or of impact on wider health decisions during pregnancy.

3. **Engaging dads during antenatal period to educate and ensure they are equipped to support mum- some supporting evidence**

   - Evidence that fathers feel unprepared to support their partner through pregnancy & birth
   - Evidence of wider health and well-being benefits for mother if father is engaged
   - little evidence found of father's impact on health behaviours during pregnancy

4. **Flexible services to support working mums during pregnancy to enable them to make the most of support- little evidence**

   - Little evidence; workplace studies focus on breastfeeding support and flexibility for childcare, rather than pregnancy support. No evidence of need in terms of accessing antenatal services.

Indicator 3: % reception age children (typically age 4 or 5) who are overweight or obese

Proposed 'What works' ideas:

1. **Junior Parkrun**
2. **Children's menus in restaurants (mini portions of adult food)- Links to 'Real food for kids' scheme (Caring Cooks & Co-op initiative)**
3. **Cross-departmental forum to share good practice**
4. **Free fruit in supermarkets (Tesco already running this)**
5. **Community mobile outreach re cooking skills, specifically targeted at minority ethnic groups and providing bilingual support to reduce inequalities (Caring Cooks** planned initiative)**

Summary of available evidence

1. Junior Parkrun

Strong evidence (for benefits of exercise): No specific research on impact of a parkrun type scheme, however wide body of general evidence on positive impact of exercise on obesity, as well as on mental and wider physical health. Junior Parkrun is however only 2K per week, and suitable only for age 4-14.

Along the same lines as Parkrun, a 'Daily Mile' scheme in place in many primary schools across UK, where pupils walk or run a mile every day. The scheme was introduced to combat obesity but also has potential impact in terms of concentration and behaviour. No formal evaluation yet.

Recommendations[26] for children under 5 years (who can walk unaided) propose a minimum of 180 minutes of physical activity per day. Junior Parkrun and similar schemes would contribute to these recommendations, and help children to become engaged in exercise.

[26] Department of Health (DoH). Start Active, Stay Active: A Report on Physical Activity from the Four Home Countries' Chief Medical Officers (Report). London: DoH, 2011. Available online at: https://www.gov.uk/government/publications/start-active-stay-active-a-report-on-physical-activity-from-the-four-home-countries-chief-medical-officers

2. Children's menus in restaurants (mini portions of adult food)- Links to 'Real food for kids' scheme (Caring Cooks & Co-op initiative)

Some supporting evidence: Some research on this area. The Soil Association[27] review children's menus at a range of restaurants and tourist attractions via secret shoppers and surveys with parents, and report that much of children's foods served are high in additives, fat and sugar with little fruit or vegetables available.

Children's Food Trust- State of the Nation report 2016[28]: key findings:

- McDonalds, KFC & Pizza Hut most popular for eating out with children
- 26% parents want more fruit and vegetables on children's menus in restaurants- parents with low income were more likely to want this
- 25% would like child sized portions of adult meals

While children's meals in restaurants are undoubtedly often unhealthy, little evidence of how this translates to food choices at home or in daily life.

3. Cross-departmental forum to share good practice

This is a strong principle to guide 'ways of working' rather than a 'what works' idea however would require further detail as to mechanisms of the group and how evidence and best practice would be shared.

4. Free fruit in supermarkets (Tesco already running this)

Some supporting evidence: There are no evaluations of the Tesco scheme at present.

The Scottish Government ran a 'free fruit in schools' scheme, providing all P1 & P2 children with a free piece of fruit 3 times a week. Evaluation[29] showed that:

- Some schools reported improved behaviour because of the fruit
- Some schools reported an increase in pupils bringing in their own fruit, or eating more fruit at lunchtime
- No discussion of decrease in pupil weight

[27] https://www.soilassociation.org/media/7216/out-to-lunch-methodology-2016.pdf

[28] http://media.childrensfoodtrust.org.uk/2016/12/SoN_Report_v4.pdf

[29] MacGregor, A. & Sheehy, C. (2005) Evaluation of free fruit in schools scheme. Scottish Centre for social Research http://www.gov.scot/Publications/2005/12/21110322/03222

5. Community mobile outreach re cooking skills, specifically targeted at minority ethnic groups and providing bilingual support to reduce inequalities (Caring Cooks** planned initiative)

Strong evidence: Evidence of need: A review[30] of parents' preferences in Children's Centres in England showed that less educated parents showed most interest in learning about healthy foods and how to prepare them.

Virudachalam et al[31] (2016) found that preferences for support varied depending on parental background:

- Healthy cooking- preferred by low-income, single, younger parents
- Culinary creativity- preferred by higher-income, older parents with partners
- Convincing toddlers to eat homemade food- preferred by parents who already cook regularly

Evaluations of several parent cooking programmes (e.g. Garcia et al[32], 2013) have demonstrated positive impact in terms of:

- Improved parent self-confidence in cooking ability with basic ingredients
- Improved (self-report) use of healthy ingredients
- Decrease in the consumption of ready-meals
- Some evidence of a positive impact after 6 months

Summary and implications for Jersey

1. **Junior Parkrun – Strong evidence (for benefits of exercise)**
   - Only a minimal amount of exercise (2K per week) and no evidence relating specifically to Parkrun or similar schemes as to wider impact on childhood obesity,

[30] Ohly, H.R., Hayter, A., Pettinger, C., Pikhart, H. , Watt, R.G. and Rees, G.A. (2012) Developing a nutrition intervention in children's centres: exploring views of parents in rural/urban settings in the UK. Public Health Nutrition, Vol 16(8), pp1516-1521

[31] Virudachalama, s., Chungc, P.J., Faerber, J.A., Piang, T.M., Thomas, K. & Feudtnera, C. (2016) Quantifying parental preferences for interventions designed to improve home food preparation and home food environments during early childhood. Appetite, vol 98 (1), pp115-124

[32] Garcia, A.L., Vargas, E., Lam, P.S., Shennan, D.B., Smith, F. and Parrett, A. Evaluation of a cooking skills programme in parents of young children – a longitudinal study. Public Health Nutrition: 17(5), pp1013–1021

however does raise awareness of exercise and encourage participation, and contributes to daily exercise recommendations.

- daily mile scheme in many schools across UK; some evidence that it encourages physical activity and improves behaviour, however no evidence of direct impact on obesity rates. This would be relatively easy to implement and again would contribute to exercise.
- Parkrun already in place in Jersey so mechanisms in place to set up reasonably easily.

2. **Children's menus in restaurants (mini portions of adult food)- Links to 'Real food for kids' scheme (Caring Cooks & Co-op initiative)- some supporting evidence**

-evidence that children's menus in restaurants are generally unhealthy, high in fat and sugar.

- some evidence that majority of parents aren't overly concerned by this
- little evidence of the impact this has on wider health, obesity and food choices

3. **Cross-departmental forum to share good practice**

- cross-cutting 'way of working' for all ideas

4. **Free fruit in supermarkets (Tesco already running this)- some supporting evidence)**

- no evaluation on Tesco scheme or similar
- small evaluation on similar scheme in schools shows increased intake of fruit and healthier food choices for pupils
- no evidence showing direct impact on childhood obesity rates but contributes to raising awareness of healthy eating

5. **Community mobile outreach re cooking skills, specifically targeted at minority ethnic groups and providing bilingual support to reduce inequalities (Caring Cooks** planned initiative)- Strong evidence**

- evidence that parents would like this kind of support, particularly those on low incomes/single parents/higher deprivation areas
- evidence that cooking programmes have positive impact on food choices at home, reducing ready meal intake and increasing fruit and vegetable intake
- may want to consider extending further than minority ethnic groups?

Appendix 1: Further details on 'What Works' initiatives

What is the Baby Friendly Initiative?

BFI was introduced to the UK in 1995 based on the World Health Organisation global initiative. It is designed to support breastfeeding and parent infant relationships by working with public services to improve **standards of care**. It is the first ever national intervention to have a positive effect on breastfeeding rates in the UK.

What are Baby Friendly's strengths?

- A **UNICEF** programme championing the best possible physical and emotional health for all babies in the UK
- **UNIQUE** in recognising the link between responsive parenting and infant feeding, and the impact this has on health, and social and emotional wellbeing
- **UNIVERSAL**, designed to reach all families regardless of who they are or where they come, from through an evidence-based, structured programme that is proven to deliver real change for mothers and babies within: **Maternity**, **Health Visiting**, **Neonatal** and **Early Years services**
- **UNIFYING evidence, policy and practice** by working collaboratively across a large network of organisations involving governments, public services, the voluntary sector and families.

Baby Friendly accreditation is based on a set of interlinking evidence-based standards for maternity, health visiting, neonatal and children's centres services.
These are designed to provide parents with the best possible care to build close and loving relationships with their baby and to feed their baby in ways which will support optimum health and development. Facilities implement the standards in stages over several years. At each stage, they are externally assessed by Unicef UK. When all the stages are passed, they are accredited as Baby Friendly. Award tables are kept to let the public know how facilities are progressing.

Unicef UK also run a Baby Friendly programme for universities. Evidence based learning outcomes support midwifery and health visiting departments to ensure that their courses equip newly qualified midwives and health visitors to implement the Baby Friendly standards in the workplace. Universities implement the standards in stages and it is the course that is accredited as Baby Friendly.

Individual organisations go through the following accreditation process across several years:

Stage:	Assessment	Outcomes
Certificate of commitment	Awarded when the service has an action plan in place and policy that covers all the Baby Friendly standards.	
STAGE 1 ASSESSMENT: Building a firm foundation	Plans and documentation formally assessed; a report is provided outlining guidance to move forward.	Policies and procedures are in place to support the action plan
STAGE 2 ASSESSMENT: An educated workforce	A formal assessment of staff skills and knowledge through interviews; a review of documentation and training records.	All staff have skills and knowledge to implement the Baby Friendly standards in their workplace.
STAGE 3: Full accreditation Parents' experiences of maternity, neonatal and health visiting services and children's centres	A formal assessment of care provision, including listening to mothers about their experiences; a review of documentation.	Mothers and babies (and their families) receive the care outlined in the Baby Friendly standards.

Implementation elsewhere:

In NI, 15 hospitals and community sector organisations have achieved full BFI accreditation- now the highest across the UK.

BFI: The Jersey context:

Plans in place to implement the Initiative across Jersey as part of the 1001 critical days' agenda. Meeting took place on 5th April to share plans.

NSPCC Baby Steps

Summary: Evidence informed programme developed by Warwick University & NSPCC. A targeted group work ante-natal education programme, jointly delivered by an NSPCC practitioner and a midwife. The 9-week programme starts before birth and is designed to

support parents with the transition to parenthood in a fun, meaningful way and helps them engage positively with their babies.

Target audience: Parents (mum and dad) from pre-birth (26 - 28 weeks of pregnancy) to approx. 3 months. Targeted at hard to reach parents, with particular mention for parent/s in prison and those from minority ethnic background.

Programme content:

- Home visit (7th month of pregnancy) – to held engage 'hard to reach' parents
- 6 group weekly group sessions before baby is born
- Home visit when baby is born
- 3 further group sessions

Sessions cover the following themes:

- the development of my unborn baby
- changes for me and us
- our/my health and wellbeing
- giving birth and meeting our baby
- caring for my/our baby
- who is there for us – people and services.

Target outcomes:

- Improved parent-child interaction
- Improved couple relationship
- Improved support network
- Improved parental emotional wellbeing
- Increased knowledge and understanding of child development
- Reduced parent anxiety and/or depression