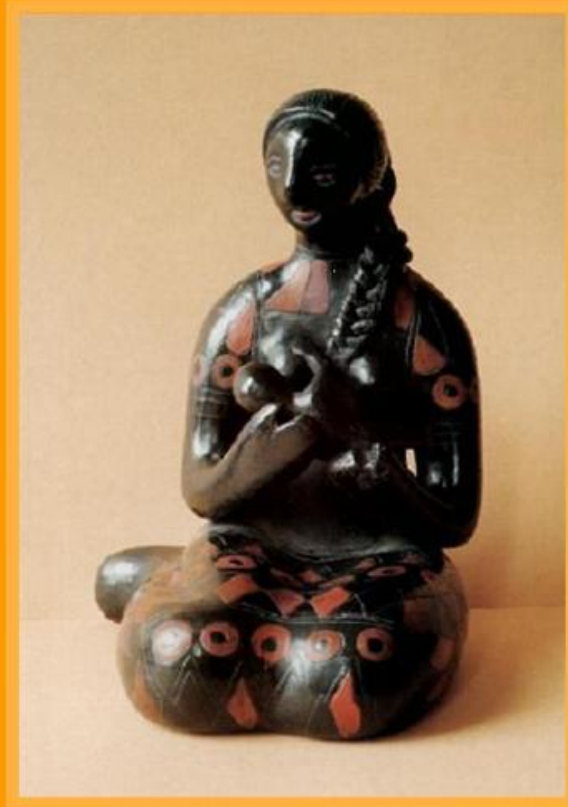




Government Office
for the South West



Standard Evaluation Framework for breastfeeding interventions



EVALUATION OF BREASTFEEDING INTERVENTIONS

Supplement to the

STANDARD EVALUATION FRAMEWORK FOR WEIGHT MANAGEMENT INTERVENTIONS

This guidance is to support PCT's to develop simple but effective evaluation processes to ensure that the *improving performance, monitoring and evaluation* part of the commissioning cycle is fulfilled. It is intended to support those who have little or no experience of evaluation and to be used alongside the Standard Evaluation Framework developed by the National Obesity Observatory (<http://www.noo.org.uk/SEF>).

Why evaluate?

For any intervention it is important to know;

- how effective it has been
- whether the intervention aims have been met
- whether any lessons need to be learnt.

Also, the results from evaluations can also be used to help share experiences between different interventions.

Evaluation of local breastfeeding interventions

PCT's are required to develop local breastfeeding support services which meet local needs (DH/DCSF 2009). Whilst there is evidence about the effectiveness of a variety of support of services which encourage both initiation and continuation of breastfeeding, (Britton 2007 Dyson 2006) local monitoring and evaluation of interventions is essential to ensure that the extent to which interventions achieve what they set out to do is assessed.

Audit and evaluation of breastfeeding interventions is also a requirement of the UNICEF UK Baby Friendly Initiative Seven Point Plan for Sustaining Breastfeeding in the Community which is recommended by DH as a key delivery mechanism for increases in breastfeeding prevalence at 6-8 weeks DH/DCSF 2009 (www.babyfriendly.org.uk)

In evidence based medicine, randomised controlled trials (RCT's) are usually considered to be the 'gold standard' for a scientifically robust assessment of whether an intervention is effective. This process will not be practical or affordable, in most instances, for individual PCT's who are

commissioning breastfeeding support interventions but nevertheless evaluation of the intervention is still essential. The National Obesity Observatory has developed a tool for the evaluation of weight management interventions known as the Standard Evaluation Framework (SEF). This is a straight forward document written by a team of experts which provides a very useful summary of all the key issues to take into consideration when carrying out evaluation and a frame work to use to ensure that the evaluation is robust.

This supplementary document is designed to be used along side the SEF and provides information to enable the SEF to be adapted for use as a frame work for the evaluation of breastfeeding interventions.

The SEF document has six parts:

Parts 1 and 2: *Introduction* and *introduction to evaluation* – this is essential reading for those without a background in evaluating interventions

Parts 3 and 4: *The Standard Evaluation Framework* – and the *explanatory notes* for the frame work – this is reproduced in this supplement with breastfeeding intervention information and examples

Parts 5 and 6: Conclusions and references

Suggested evaluation framework for breastfeeding interventions

This section presents a *breastfeeding intervention* version of the Standard Evaluation Framework.

Essential criteria are presented as the minimum recommended data for evaluating a breastfeeding intervention.

Required by BFI denotes criteria that are required by the UNICEF UK Baby Friendly Initiative for community services accreditation.

Desirable criteria are additional data that would enhance the evaluation.

The explanatory notes (pages 7 –19), describe why particular criteria have been categorised as essential or desirable, and give further information on collecting data.

	ESSENTIAL	Required by BFI	DESIRABLE
Part one: intervention details			
1. Title/name of intervention			
2. Aims and objectives (including primary and secondary outcomes)			
3. Intervention timescale (exposure, quantity and duration)			

4. Intervention delivery dates			
5. Duration of funding (including dates)			
6. Location and setting			
7. Description of intervention: <ul style="list-style-type: none"> • target population; • content; • delivery method; • who will deliver the intervention; • what will be delivered ; • details of quality assurance mechanisms 			
8. Rationale for intervention (including why the target group has been chosen)			
9. Core staff competencies required			
10. Equipment and resources required			
11. Incentives for attendance			
12. Details of training needs (including quality assurance of training)			
13. Methods of recruiting and referral			
14. Participant consent mechanism			
15. Participant admission/exclusion criteria			
16. Cost of intervention per participant			
17. Cost to participant			
18. Detailed breakdown of cost			
19. Type of evaluation and			

evaluation design			
20. Details of equality impact assessment			
21. Relevant policy and performance context			
22. Details of health needs assessments that have been conducted			
23. Contact details			
24. Commissioner(s) of the intervention and sources of funding			
25. Declaration of interest			
26. Details of type and extent of any clinical involvement			
Part two: demographics of individual participants			
27. Age			
28. Sex			
29. Ethnicity			
30. Disability			
31. Measure of socio-economic status			
32. Additional information including marital status, parity, family make-up and details of feeding history			
Part three: baseline data			
33. Breastfeeding initiation rates in local population			
34. Breastfeeding initiation rates in target group			

35. Breastfeeding prevalence rates at 6-8 weeks in local population			
36. Breastfeeding prevalence rate at 6-8 weeks in target group			
37. Exclusive breastfeeding			
38. Data relating to any other outcomes			
39. Progress towards Baby Friendly accreditation in local maternity unit			
40. Progress towards Baby Friendly accreditation in local community (health visiting) services			
41. Baseline support activity			
Part four: follow-up data			
Impact evaluation			
42. Breastfeeding initiation rates in local population			
43. Breastfeeding initiation rates in target group			
44. Breastfeeding prevalence rates at 6-8 weeks in local population.			
45. Breastfeeding prevalence rate at 6-8 weeks in target group.			
46. Exclusive breastfeeding			
47.data relating to any other outcomes			
48. Progress towards Baby Friendly accreditation in local maternity unit			

49. Progress towards Baby Friendly accreditation in local community (health visiting) services			
Process evaluation			
50. Number of potential target population			
51. Number invited			
52. Number recruited			
53. Number attended each session or contact point			
54. Number completed			
55. Number of participants at each follow-up point			
56. Methods of data collection and timings			
57. Reasons for opt-out (where applicable)			
58. Details of any unexpected outcomes and/or deviations from the intended intervention design and the reasons why			
59. Participants' satisfaction with the intervention			
60. Plans for sustainability			
Part five: analysis and interpretation			
61. Summary of results compared to baseline (for primary and secondary outcomes)			
62. Details of any further analyses and statistical methods used			
63. Limitations and generalisability			

Explanatory notes

Part one: intervention details

1. Title/name of intervention ESSENTIAL & Required by BFI

A record of the name or title of the intervention, for example *peer support for breastfeeding in XXX town*.

2. Aims and objectives (including primary and secondary outcomes) ESSENTIAL & Required by BFI

Answer the question: **what does the intervention aim to do?**

The primary outcome will probably be around increasing breastfeeding initiation / prevalence or both. There maybe secondary outcomes (these might be community engagement / development type outcomes). These will be the key outcomes which need to be carefully measured and against which the intervention will be evaluate.

NB aims and objectives do need to be as clear as possible- see section 2.5 of SEF page 11 for details about SMART objectives

Points 3-26 go through the key points that are needed to effectively describe the intervention – not all point are needed for each intervention but enough detail should be provided to thoroughly understand what is proposed.

3. Intervention timescale (exposure, quantity and duration) ESSENTIAL & Required by BFI

Intervention time scale (exposure, quantity and duration) – this information could also be placed in section 7 and describes what the intervention will consist of for example:

- *Each pregnant woman in the target group will have a 1:1 contact with a peer supporter at the antenatal clinic , expected duration of contact 20 minutes*
- *Each mother will have a series of contacts in the postnatal period – up to 6, minimum weekly, lasting 1 hour*

4. Intervention delivery dates ESSENTIAL & Required by BFI

Intervention delivery dates – when will it start, how often will it run etc

5. Duration of funding (including dates) DESIRABLE & Required by BFI

Duration of funding (include dates) – This will provide information about the sustainability of the intervention, if the funding is short term what plans have been made to mainstream the intervention if outcomes are good?

6. Location and setting

ESSENTIAL & Required by BFI

Where is the intervention taking place? It could be in a GP surgery, school or children's centre. It may be that it takes place in several settings and they should all be included here. It may be useful to add any transport that is being provided.

7. Description of intervention

ESSENTIAL & Required by BFI

The headings below are only intended as a guide. It may be that these points are described differently for a particular intervention.

Target population

What is the intervention's target population? From which population are the participants recruited? For example, 'Bangladeshi women from Xtown' or 'mothers under the age of 20 within the PCT area'.

Content

Clearly state what the intervention is going to do, and how it is going to do it. List all of its major intervention activities and outputs. For example:

- All teenage pregnant women will have an invitation to the teenage mothers breastfeeding support group BABES
- the invitation will be designed by the group itself
- the invitation will be given face to face by the midwifery support worker who also attend the BABES group
- the support worker will offer to meet the young pregnant woman outside the venue *and so on*

Delivery method

How will the intervention be delivered? For example, face-to-face meeting, by telephone, text or online.

Deliverer

Who will deliver the intervention? For example, support worker, health trainers or health professionals.

Unit of delivery

Who is the intervention aimed at? For example, individuals, families or particular groups. (This will usually be the mother.)

Details of quality assurance mechanisms

What mechanisms are in place to secure the intervention is being delivered in the way in which it was planned? This is particularly important if the intervention sets out to use a particular delivery method or style such as motivational interviewing.

Examples of quality assurance mechanisms are spot-checks carried out by an external assessor, self-assessment check-lists that can be used by the deliverer of the programme, and participants' satisfaction questionnaires.

Include details of any relevant health and safety checks, risk assessments and Criminal Assessment Checks if applicable.

8. Rationale for intervention ESSENTIAL & Required by BFI
(including why the target group has been chosen)

It is very helpful to state the reasoning behind the design of the intervention and the methods that will be used. State the theories or scientific evidence the intervention is based on. What is the theoretical or scientific basis that suggests the intervention will be successful in its aims and objectives? This could be peer reviewed research studies, NICE guidance on breastfeeding interventions, or theories about health promotion and behaviour change.

9. Core staff competencies required ESSENTIAL

What are the core skills needed by everyone involved in delivering the intervention? E.g. counselling skills, motivational interviewing, breastfeeding knowledge and skills

10. Equipment and resources required DESIRABLE

Equipment and resources required – if a particular type of venue is required, or particular teaching resources needed

11. Incentives for attendance DESIRABLE

Have any incentives been provided for encouraging individuals to take part in the intervention and, if so, what are they? Have incentives been provided for first attendance or completion of the intervention?

12. Details of training needs (including quality assurance of training) DESIRABLE

Are those delivering the intervention to be trained in a certain aspect of the intervention e.g. motivational interviewing, breastfeeding? Do they have to be trained to a specific level?

13. Methods of recruiting and referral ESSENTIAL

How have participants been recruited to the intervention? What percentage of those that are eligible have been recruited? Has there been a referral process or was it self-selection? For example, have participants been referred by a midwife or have leaflets and posters been used to advertise in GP surgeries? Please give brief details here of any sampling process that was undertaken. Was there any targeting of particular groups by, for example, advertising the intervention in certain communities or at specific location? The method by which people have been recruited should be taken into account when carrying out the evaluation. For example, a self-selected group of participants may be more motivated than referred participants.

14. Participant consent mechanism

DESIRABLE

The appropriate mechanism for gaining participants consent must be considered ethics approval may be needed see section 2.12 of SEF (page 16) there will be someone within your PCT who can advise you on this aspect.

15. Participant admission/exclusion criteria

ESSENTIAL

There will probably be none, but if there are they need to be noted. An example would be if you have had to exclude non English speaking mothers as you have not been able to access the funding for an interpreter.

16. Cost of intervention per participant

ESSENTIAL

This describes the cost of running the intervention as either an estimate or true cost in terms of actual expenditure and cost of people's time. This information is important for an economic analysis of whether or not the intervention is good value for money. It enables commissioners to judge whether the resources required to run the intervention are available.

17. Cost to participant

DESIRABLE

It should be noted if participants are charged for any part of the intervention. Any possible hidden costs for participants should also be noted e.g. childcare or bus fares

18. Detailed breakdown of cost

DESIRABLE

A detailed breakdown of an intervention's cost is important for an economic analysis of the entire intervention and judging whether or not it is good value for money. Take into account costs during the planning stages as well as during the delivery and evaluation stages. Some examples of input costs are staff time, transport, venue hire, equipment, publicity and incentives. It is especially important to factor in 'invisible' costs. For example, a room in a local authority leisure centre may be hired free of charge as part of a partnership agreement with the local primary care trust. However, this cost needs to be taken into account so that, if the intervention is repeated, financial resources can be planned accurately.

19. Type of evaluation and evaluation design

ESSENTIAL

The way in which an evaluation is designed to collect data, and the method by which data may be compared with any control population, should be recorded here. For example, does the evaluation use mainly qualitative or quantitative data? See section 2.6 of the SEF for a more detailed explanation of evaluation designs.

20. Details of equality impact assessment

ESSENTIAL

Public bodies have a duty to undertake equality impact assessments (EIA) under race, gender and disability legislation. It is useful to provide an intervention's equality impact assessment as part of its overall evaluation. It can give valuable information if particular outcomes are seen in different groups. An equality impact assessment provides a systematic way of ensuring legal obligations is met. It is also a practical way of examining new and existing policies and practices to determine what effect they may have on equality for those affected by the outcomes. This should begin at the planning stage.

21. Relevant policy and performance context

DESIRABLE

It may be useful to show how an intervention fits into any strategic policies or is a priority service as outlined in, for example, a local area agreement, joint strategic needs assessment, or plans supporting World Class Commissioning.

Information about the drivers behind the commissioning of breastfeeding service is available on UNICEF UK Baby Friendly Initiative developing a Breastfeeding Strategy – Evidence and appendices available at: www.babyfriendly.org.uk

22. Details of health needs assessments that have been conducted

DESIRABLE

Has a health needs assessment been conducted that identifies a gap in this service being provided for the target population? Information may come from a specific needs assessment conducted for the intervention or it may be available from other sources. For example, data relating to health inequalities and gaps in service provision may already be available from policy documents such as Joint strategic needs assessments or Children and Young People's plans.

When using data to identify gaps in service provision and to justify resource allocation, it is important to assess the quality of the data being used. For example, how robust are the data at the geographical level at which you wish to use them? How old are the data? How well validated is the tool used to collect the data? If the data sets are estimates, how have they been modelled and how accurate an estimate are they likely to provide? A more robust approach could be to use findings from a number of different data sources and supporting these by carrying out localised research, for example, by using local health and well-being questionnaires, focus groups or face-to-face interviews with the target population or community.

23. Contact details

ESSENTIAL

Give a list of the key people involved in the interventions planning, delivery and evaluation. This should include all contact details and details of staff positions as staff may change jobs during the course of the intervention.

24. Commissioner(s) of the intervention and sources of funding

DESIRABLE

Where has the funding come from to commission the intervention and who has commissioned it? For example, 'the funding has come from the regional government office and the intervention has been commissioned by the primary care trust'.

25. Declaration of interest

DESIRABLE

This covers any potential conflicts of interest in carrying out the intervention and is particularly important if the evaluation is funded by an agency that could be perceived as wanting to influence the results for commercial reasons. NICE has produced a clear statement covering different categories of potential conflicts of interest that should be declared including pecuniary interest (where someone may have publicly expressed a clear opinion on the intervention in question, and this may influence their impartiality). In general, it is best to declare any potential conflicts even if they do not appear to be important. Perceived conflicts of interest do not necessarily mean the intervention should not go ahead as planned; it may be acceptable to state how potential conflicts are going to be avoided.

26. Details of type and extent of any clinical involvement

DESIRABLE

Will any clinicians be involved at any stage of the intervention? This includes during development, delivery and carrying out quality assurance of the delivery. It would usually be appropriate for the provider to inform GPs, midwives or health visitors that their clients are participating in an intervention.

Part two: demographics of individual participants

27. Age

ESSENTIAL

It is essential to record the age of all participants in the intervention.

Examples of age categories from national population surveillance studies that could be used for comparative purposes are:

- Census 2001 used: 0-4, 5-9, 10-14, 15-19, 16 or 19-24, 25-34, 35-44, 45-54, 55-64, 65-74 and 75+

28. Sex

DESIRABLE

Record the sex of all participants if this seems sensible – for example if the intervention involved working with the mothers' main supporters.

29. Ethnicity

ESSENTIAL

It is standard practice in healthcare interventions to record the ethnic origin of participants. If the intervention is targeted at a specific ethnic group, then a record of ethnic origin is essential for screening participants for eligibility. If the intervention is not targeted in this way, it is still important information for raising understanding about the extent to which response to the intervention may vary between different ethnic groups.

For example, if the intervention is aimed at women aged 45-55 in a local community which has 25 per cent of its population made up of Bangladeshis and, in a rolling programme of intervention, less than two per cent of the participants are Bangladeshi, it is likely that there is something about either the intervention itself or the publicity for the intervention that is not engaging with the Bangladeshi population. In this case, further research and community development work may be needed to engage with these communities and the intervention or publicity amended accordingly.

In addition, there is a legal requirement to carry out ethnic monitoring. The *Race Relations (Amendment) Act 2000* requires public bodies, including local authorities, primary care trusts and their partners to take account of race equality in policy making and service delivery. Ethnic monitoring demonstrates that policies for equality are working in practice. It is a way of identifying potential discrimination and whether policies promoting equality of opportunity and good relations between different racial groups are being implemented. For further information on this, please see the Equalities and Human Rights Commission's website.

The commission recommends public authorities and their partners use the following Census 2001 categories for ethnic monitoring in England and Wales.

White

- British
- Irish
- Any other white background

Mixed

- White and Black Caribbean
- White and Black African
- White and Asian
- Any other mixed background

Asian or Asian British

- Indian
- Pakistani
- Bangladeshi
- Any other Asian background

Black or Black British

- Caribbean
- African
- Any other Black background

Chinese or other ethnic group

- Chinese
- Any other Chinese background

30. Disability

ESSENTIAL

It is standard practice in healthcare interventions to record the disability status of participants. The *Disability Discrimination Act* defines a disabled person as: 'someone who has a physical or mental impairment that has a substantial and long-term adverse effect on his or her ability to carry out normal day-to-day activities.' Detailed guidance on the interpretation of this definition can be found on the archived Disabilities Rights Commission's website.

The Disability Equality Duty came into force in December 2006 and requires all public bodies, including NHS trusts and boards, to actively look at ways of ensuring that people with disabilities have equal access to service provision. It may be particularly important to consider this duty if an intervention has been commissioned by an external provider. More information is on the *Disability Equality Duty* website, the Equality and Human Rights Commission website, and the Office of Public Sector Information website.

31. Measure of socio-economic status

ESSENTIAL

An indicator of socio-economic status should be recorded. There is clear evidence associating lower socio-economic status with the reduced likelihood of breastfeeding. Therefore targeted interventions will usually be aiming to reach a specific socioeconomic group. If this information is not collected how will the effectiveness of the intervention in reaching the target group be assessed?

The standard indicator of socio-economic status, as used in the *Census 2001*, uses the National Statistics Socio-Economic Classifications (NS-SEC). It is a structured, occupationally-based classification that also includes categories for the non-employed. The NS-SEC categories are:

- Employers in large organisations
- Higher managerial occupations
- Higher professional occupations
- Lower professional and higher technical occupations
- Lower managerial occupations
- Higher supervisory occupations
- Intermediate occupations
- Employers in small organisations
- Own account workers
- Lower supervisory occupations
- Lower technical occupations
- Semi-routine occupations
- Routine occupations
- Never worked
- Long term unemployed
- Full time student
- Occupation not stated or inadequately described
- Unclassifiable

Further information on these classifications and how they have been derived is available on the Office for National Statistics (ONS) website.

In many cases it may not be practical to collect the data needed to derive NS-SEC categories (as described on the ONS website, above). In these cases, other proxy indicators of socio-economic status can be used. It is advised that a minimum of two of the following indicators are collected:

1. Postcode for Index of Multiple Deprivation

The Index of Multiple Deprivation combines a number of indicators covering a range of economic, social and housing issues and creates a single deprivation score for each small area in England. This allows areas to be ranked according to their level of deprivation and can be derived from postcodes. These rankings have been produced at Lower Super Output Area level, of which there are 32,482 in the country. Lower Super Output Areas can be mapped against postcode which allows an individual's address to be given a general IMD ranking. Any ranking given is 'modelled' against a number of criteria and related to an overall ranking for an area which may not necessarily be indicative of the characteristics of an individual household.

2. Educational attainment level

The *Census 2001* categorised the population, aged 16-74, in terms of recorded levels of education:

- Level 1: 1+ 'O' level passes; 1+CSE/GCSE any grades; NVQ level 1; Foundation GNVQ
- Level 2: 5+ 'O' level passes; 5+ CSEs (grade 1); 5+ GCSEs (grades A-C); School Certificate; 1+ 'A' levels/AS levels; NVQ level 2; Intermediate GNVQ
- Level 3: 2+ 'A' levels; 4+ AS levels; Higher School Certificate; NVQ level 3; Advanced GNVQ
- Level 4/5: First degree; Higher degree; NVQ levels 4 and 5; HNC; NHD; Qualified Teacher
- Status: Qualified Medical Doctor; Qualified Dentist; Qualified Nurse; Midwife; Health Visitor

3. Housing tenure

Census 2001 housing tenure categories were as follows:

- Owner occupied: owned outright
- Owner occupied: owned with mortgage or loan
- Owner occupied: shared ownership
- Social rented: rented from council
- Social rented: other social rented
- Private rented: private landlord or letting agency
- Private rented: employer or a household member
- Private rented: relative or friend of a household member
- Private rented: relative or friend of a household member
- Private rented: other
- Living rent free

Other relevant indicators might be:

- Household income
- Free school meals status
- Household amenities
- Number of cars per household

Analysis of these data can be a complex issue so it may be necessary to seek specialist help. Local public health analysts or researchers may be able to assist with this type of analysis. Further information about the Index of Multiple Deprivation is available on the Communities and Local Government website.

32. Additional information including marital status, parity, family make-up and details of feeding history

DESIRABLE

Additional information can enhance the evaluation and give an indication of possible confounders when analysing results. You may choose to include: if they have fed previously children, if they know how they were fed themselves, the experiences of close family friends.

Part three – Baseline data

For all breastfeeding support interventions the key long term outcome will be to increase both breastfeeding initiation and prevalence at 6-8 weeks and longer. It is extremely important to collect data before the intervention.

33. Breastfeeding initiation rates in local population

ESSENTIAL & Required by BFI

Breastfeeding rates in local population / area (initiation). Include information on completeness of data. i.e. what % of babies have an unknown feeding status (this figure can be quite high in some areas).

34. Breastfeeding initiation rates in target group

ESSENTIAL & Required by BFI

Breastfeeding rates in target group / area (initiation). Again, include information on completeness of data. The rates identified as baseline need to relate to the aims of the intervention – for example if the intervention is to increase the number of Somali mothers exclusively breastfeeding their babies in the first week of life then this data needs to be captured before the intervention begins to ensure an accurate baseline is available for the evaluation .

35. Breastfeeding prevalence rates at 6-8 weeks in local population

ESSENTIAL & Required by BFI

Breastfeeding rates in local population / area (6-8 weeks). Include information on completeness of data. i.e. what % of babies have an unknown feeding status (this figure can be quite high in some areas).

36. Breastfeeding prevalence rate at 6-8 weeks in target group

ESSENTIAL & Required by BFI

Breastfeeding rates in target group / area (6-8 weeks prevalence initiation) Include information on completeness of data.

37. Exclusive breastfeeding

DESIRABLE

Exclusive breastfeeding – in areas where mixed feeding is common practice the intervention may choose to collect data on the impact of the intervention on rates of exclusive breastfeeding at various points. For example, on discharge from hospital, at 10 days, at 6 weeks.

38. Data relating to any other outcomes

DESIRABLE

Any other outcomes that you need to measure to be able to evaluate whether or not the intervention has met its aims and objectives.

Points 39-41 provide important background information which set the intervention in context and ensure that changes in the other aspects of breastfeeding support provided in the area are acknowledged as they have a potential impact on the intervention

39. Progress towards Baby Friendly accreditation

ESSENTIAL

In local maternity unit

The progress (or lack of progress) towards evidence based care in the universal service has the potential to impact on the outcomes of the intervention and therefore need to be reported as accurately as possible as a baseline.

40. Progress towards Baby Friendly accreditation in local community (health visiting) services

ESSENTIAL

Again the progress (or lack of progress) towards evidence based care in the universal service has the potential to impact on the outcomes of the intervention and therefore need to be reported as accurately as possible as a baseline.

41. Baseline support activity

ESSENTIAL

What other interventions are already running and is there any known impact of these? For example: there may be breastfeeding support groups run in half the children's centres in the city, there may have been no formal evaluation of the groups but there may be data on attendance, client satisfaction etc.

Part four: follow-up data

Outcome evaluation

Points 42- 49 are all repeats from the baseline data. Which will be repeated at agreed points in the intervention (minimum of three points including at one year)

Process evaluation

50. Number of potential target population

ESSENTIAL & Required by BFI

This number is important to establish as it will help identify whether or not there have been any process issues with potential participants getting to the invitation stage.

51. Number invited

ESSENTIAL & Required by BFI

Number of invitees / number of women given information about the intervention. Be careful not to make assumptions that information is passed on automatically.

52. Number recruited

ESSENTIAL & Required by BFI

Number recruited compared to the above figures will establish whether or not the intervention is attractive accessible to women.

53. Number attended each session or contact point

ESSENTIAL & Required by BFI

54. Number completed

ESSENTIAL & Required by BFI

55. Number of participants at each follow-up point

ESSENTIAL & Required by BFI

Amend these categories to fit the intervention. You need information on how many completed the whole of the intended 'programme'.

56. Methods of collecting data and timings

DESIRABLE

This will put the information in context

57. Reasons for opt-out (where applicable)

ESSENTIAL

Reasons for opt out/non engagement can be a very important part of the evaluation and help to identify how it can be strengthened , the women who do not engage/engage for a short time only can tell you a lot about the intervention.

58. Details for any unexpected outcomes and /or deviations from the intended intervention design and the reasons why

DESIRABLE

Again this can be a very valuable source of insight into the intervention and capturing this information will make the evaluation richer.

59. Participants' satisfaction with the intervention

ESSENTIAL & Required by BFI

It is important to collect participants' views on the intervention. If they are not happy with the intervention it is unlikely to be successful. However, it can be difficult to get unbiased views. It is important for the research to be done sensitively, and not by the delivered of the intervention, Semi structures interviews / focus group are recommended by the SEF.

60. Plans for sustainability

DESIRABLE

Plans for sustainability- consideration of the long term impact and costs of continuing the intervention can be very helpful addition to the evaluation

Part five: analysis and interpretation

61. Summary of results compared to baseline
(for primary and secondary outcomes)

ESSENTIAL & Required by BFI

Summary of results compared to baseline for primary and secondary outcomes – the method for analysing the data and presenting the results will depend on the study design – see SEF

62. Details of any further analyses and statistical methods used

DESIRABLE

Details of any further analyses or statistical methods used

63. Limitations and generalisability

DESIRABLE

Limitations and generalisability

References:

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