

# Why Baby Clinics?

A systematic review of the effectiveness of universal Health Visitor led Child Health Clinics in promoting the healthy development of pre-school children and reducing health inequalities.

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### Key points

- Health Visitor led baby clinics are prevalent across the UK however there is a lack of research about their structure, process or anticipated outcomes
- The lack of evaluative research makes it impossible to draw any conclusions about the effectiveness of the service offer
- Clinics appear to be an historical tradition with a ritualistic focus on weighing babies, which is an embedded cultural expectation of the service
- The lingering pre-occupation with weighing at clinics may be preventing this service element from evolving in line with the rest of the Health Visiting Service offer
- The theoretical processes through which positive outcomes are promoted at baby clinics need to be established, followed by good evaluative studies with clear outcome measures

## **Abstract**

This paper presents the findings of a systematic review undertaken to assess how effectively health visitor led child health clinics ('baby clinics') contribute to the promotion of pre-school child health and the reduction of health inequalities.

Despite the widespread presence of baby clinics across the UK, there is little published research about the service model, its purpose or effectiveness.

The initial search produced 559 articles, after removing duplicates, 175 abstracts were assessed against the inclusion criteria and 24 qualitative studies were identified as relevant to the review. No studies were excluded based on quality issues, however the quality of studies was variable. Thematic analysis was used to organise and interpret the data.

Although the review presents a synthesis of research over the last 30 years, there is a lack of evaluative research about the structure, process and outcomes of baby clinics, which makes it impossible to draw any conclusions about the effectiveness of the service offer.

Findings suggest research on the value and purpose of baby clinics is now needed and whilst good evaluation studies with clear outcome measures are sought, it is clear that the theoretical processes through which positive outcomes are promoted need to be established first.

## **Introduction**

The first child health clinics were set up in the UK in the late 1800's, primarily to supply uncontaminated modified cow's milk and support mothers with infant feeding and nutrition. With the advent of the NHS in the mid-20th century, clinics became part of mandatory local authority provision and developed an educational outlook aimed at providing advice around childcare, development and health (Plews 2001).

Whilst the value of Health Visitors in providing this service was acknowledged in the Sheldon Committee report into the function of the child health clinic in 1967, their contribution was subsumed by the emerging wider medical remit of the clinics which focussed on immunisations, screening and growth monitoring. Research primarily focussed on the uptake of secondary preventative programmes leaving the advisory role of the health visitor within clinics largely unexplored (Plews 2001).

The move from a national programme of child health surveillance to an approach based on primary prevention through health promotion engendered significant professional reflection and development of the health visiting service, which in turn led to a reduction in the level of screening and physical growth monitoring by health visitors (Healthy Child Programme 2009, updated 2015).

A continued focus on weighing at clinics (Barlow & Coe 2011, Burgess-Allen 2010, Russell 2008, Sparrow 2005, Sachs 2005, Plews and Bryar 2002), against a backdrop of professional progress towards more holistic approaches to health promotion raises the question of

whether a focus on weight monitoring at clinics is preventing this service element from evolving in line with the rest of the Health Visiting Service offer.

A national survey of health visiting activities and service organisation published in 2007 (Cowley et al) reveals that, at that time, baby clinics were a core service being delivered by 98% of the 968 caseload holders included. The only other service having such a high prevalence of delivery being the 'new birth' home visit by health visitors.

It is clear therefore that historically, a significant number of health visiting hours have been used in the delivery of baby clinics. However Cowley et al (2013), in the literature review 'Why Health Visiting?' found insufficient research on this topic to demonstrate whether clinic work should be deemed as a 'core practice'. Given the lack of a theoretical basis, it is unsurprising therefore that they were not mentioned in the review of health-led parenting interventions in pregnancy and early years (Barlow et al 2008) conducted to inform the structure of the Healthy Child Programme (2009).

In fact, when Health Visiting was commissioned nationally during the Health Visiting Implementation Plan phase (2011-2015), there did not appear to be an explicit expectation that clinics were delivered as part of the Health Visiting Core service offer (National Health Visitor Service specification 2014 /15). Despite this, baby clinics continue to be routinely offered by many service providers, raising the important question of how effective they are in promoting the healthy development of pre-school children and reducing health inequalities.

In order to address this gap, this paper presents the findings of a systematic review undertaken to assess the impact and effectiveness, in terms of either process or outcome of health visitor led baby clinics.

## **Methodology**

### Systematic search

A comprehensive search of 13 electronic databases was undertaken during June – July 2015. Databases searched included: BNI, CINAHL, Medline, ASSIA, Psychinfo, HMIC, Psycharticles, AMED, Science Direct, Web of Science, Cochrane Library, Embase, Maternity and Infant Care.

The following broad search terms were used to ensure a wide spectrum of literature was included:

("health visit\*" OR "specialist public health nurs\*" OR "specialist community public health nurs\*") AND ("baby clinic\*" OR "child health clinic\*")

The literature search extended from 1985 to June 2015.

## Search selection / Inclusion Criteria

Citations and abstracts were filtered based on the following inclusion criteria:

*Publication date: Since 1985*

*Study focus: Health Visitor service provision in child health clinics (baby clinics) and / or lay or professional views on the purpose or value of baby clinics*

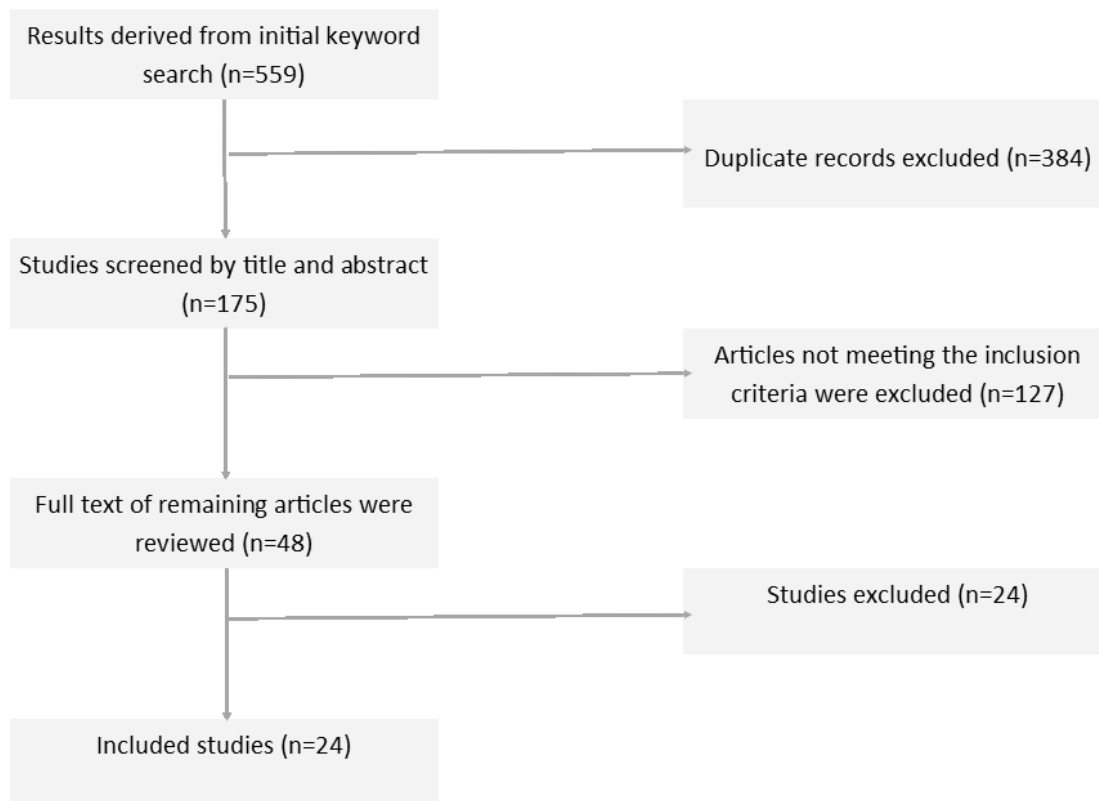
*Type of studies: Qualitative and quantitative studies, including survey of views, observational data, commentaries from clinicians, parents and others, audit results, reviews of research, small scale studies and recommendations of practice*

*Country: Studies of UK child health clinics*

The initial search produced 559 articles. Duplicate studies were removed and 175 abstracts assessed against the inclusion criteria, 24 were identified as potentially relevant to the review and full papers were obtained (*Figure 1.*)

Studies were included based on relevance to the review question rather than study type or quality. No studies were excluded based on quality issues, however the quality of included studies was variable.

The 24 studies meeting the inclusion criteria are detailed in *Table 1.*



**Figure 1: Flow chart showing the retrieval process of studies included in the systematic review**

### Data collection and analysis

Data was extracted systematically using a specifically designed data extraction form.

All included studies were qualitative and the appraisal criteria was based on Mays and Pope Quality Guidelines (2000). Each study was scored and assigned a quality range:

Low quality 0 - 10

Medium quality 11 – 20

High quality 21 - 30

The quality of the studies was variable; nine studies in the lower range, six studies in the medium range and nine studies in the high range. Table one includes the quality score of each study.

A 'sensitivity analysis' was performed after the thematic analysis of data to establish if the included papers were aligned with the themes identified. Whilst all papers contributed to the themes, a number of the earlier descriptive surveys contributed little more than an historic snap shot of clinic structure and attendance. However, this contributes a valuable insight into the conventions of the clinic setting and sets the context for the process of change discussed in the more recent, evaluative research included.

### Thematic analysis

The review used thematic analysis (Attride-Sterling 2001) an approach which has been successfully used in other systematic reviews of qualitative studies (Tomas & Harden 2008).

The aim was to identify patterned meaning across the data. It was felt that thematic analysis, above other methods of qualitative synthesis, provided sufficient flexibility to examine, organise and interpret the eclectic range of qualitative data. An inductive approach was taken whereby the 'coding' of data using 'gerunds' (Charmaz 2006) informed the construction of basic themes. A clear progression was evident between the themes of the earlier included studies ( $\leq 1999$ ) and the later research included ( $\geq 2000$ ). This led to a thematic comparison being conducted of older, descriptive evidence with newer more critical and interpretive research.

The thematic progression identified suggest that the potential value of community based family support within universal clinic settings is now being recognised in research literature. The theoretical processes by which this support might be delivered and received appears to be relationally and socially constructed and the review provides formative themes on which theories of change or models of delivery may be focussed and tested in the future.

### **Results / Findings**

24 studies were included in the review (table 1).

Thematic analysis was conducted comparing studies  $\leq 1999$  with  $\geq 2000$  studies. This approach was adopted because of a clearly emerging thematic progression across the research papers linked to the time period in which the studies were published.

A diagrammatic representation of the themes is shown in Figure 2.

Two main themes were identified:

1. The pre 2000 studies revealed a thematic focus on secondary ‘**health surveillance**’
2. The post 2000 studies revealed a thematic focus on primary ‘**health promotion**’ within the clinic environments

Twelve sub themes were constructed (six  $\leq 1999$  studies; six  $\geq 2000$  studies) and are organised as a progression across the two main themes.

The sub themes have no hierarchy or weighting in terms of importance and are shown in the diagram as a flat structure in no significant order (*Figure 2*).

Table 1. Table of included studies

Authors (year)	Title	Journal	Volume, Issue, Page	Quality Score
Donetto & Maben (2014)	‘These places are like a godsend’: a qualitative analysis of parents’ experiences of health visiting outside the home and of children’s centre services	Health Expectations	18 (6) pp. 2559 - 2569	High
Donetto <i>et al</i> (2013)	Health Visiting: the voice of service users Learning from service users’ experiences to inform the development of UK Health Visiting practice and services	National Nursing Research Unit, King’s College London		High
Bidmead (2013)	Health Visitor / Parent Relationships: a qualitative analysis	This study is part of a larger doctoral thesis in progress and was published as an Appendix to the report		High

		entitled 'Why Health Visiting?' (2013, Cowley et al, Department of health Policy Research Programme)		
Barlow & Coe (2011)	Integrating Partner Professionals. The Early Explorers Project: Peers Early Education Partnership and the Health Visiting Service	Child: care, health and development	39(1) pp.36-43	High
Burgess-Allen <i>et al</i> (2010)	A qualitative exploration of the role of baby clinics in supporting infant feeding in Stockport	NHS Stockport / Sheffield Hallam University		High
Russell (2008)	Left Fending for Ourselves – A report on the Health Visiting Service as experienced by mums	Netmums (online social networking site)		Medium
Sparrow <i>et al</i> (2005)	Provision in Child Health Clinics	Journal of Community Nursing	19(5) pp.26-30	Medium
Sachs (2005)	'Following the line': An ethnographic study of the influence of routine baby weighing on breastfeeding women in a town in the Northwest of England	University of Lancashire, Department of Midwifery Studies		High
Plews & Bryer (2002)	Do we need health visitors in the child health clinic?	Clinical Effectiveness in Nursing	6. pp. 27-35	High
Knott & Latter (1999)	Help or Hindrance? Single, unsupported mothers' perceptions of health visiting	Journal of Advanced Nursing	30(3) pp.580-588	High
Finch & Whitefield (1997)	Setting up a Saturday morning Child Health Clinic	Care of Mother and Child	7(3) pp.61-62	Low
Sefi & Grice (1993)	Parents' view of clinics	Health Visitor	66(10) p.62	Low
Sharpe & Loewenthal (1992)	Reasons for attending GP or health authority clinics	Health Visitor	65(10) pp.349-353	Low
Gillespie & Hanny (1992)	Health Visiting in a well-baby clinic	British Journal of Nursing	1(6) pp.289-291	Low
McIntosh (1992)	The perception and use of child health clinics in a sample of working class families	Child: care, health and development	18 pp.133-150	High
While (1990)	Child Health Clinic Attendance During the First Two Years of Life	Public Health	104 pp. 141-146	Low
Betts & Betts (1990)	Establishing a child health clinic in a deprived area	Health Visitor	64(4) pp.122-	Low

			124	
Morgan (1989)	Who uses child health clinics and why: a study of a deprived inner city district	Health Visitor	62 pp. 244-247	Medium
Sefi & Macfarlane (1987)	Increasing Health Visitor Involvement in Child Health Surveillance	Health Visitor	60	Low
Cubbon (1987)	Consumer Attitudes to Child Health Clinics	Health Visitor	60 pp,185-186	Medium
Kilpatrick & Mooney (1987)	Tea and Sympathy: A campaign to improve mothers' involvement in a local baby clinic	Community Development Journal	22(21) pp.141-146	Low
Karmali & Madeley (1986)	Mothers' attitudes to a child health clinic in a deprived area of Nottingham	The Society of Community Medicine	100 pp.156-165	Medium
Turya & Webster (1986)	Acceptability of and need for evening	Child: care health and development	12 pp.93-98	Low
Sefi & Macfarlane (1985)	Child Health Clinics: Why Mothers Attend	Health Visitor	58 pp.129-130	Medium



Figure 2: Diagrammatic representation of themes

Older descriptive studies (≤ 1999)

Newer research (≥ 2000)

Health surveillance

Health promotion

Surveillance & social control

Building social capital & adding social value

- Clinic environment precludes socialising
- Fixated on weighing measuring & tracking
- Monitoring of maternal competence
- Conforming to perceived social norms of infant behaviour

- Clinic environment facilitates social interaction
- Prioritising opportunities for parents to share experiences & offer mutual support
- Valuing lay & peer support
- Health Visitors to have facilitation skills relevant to group & social setting

Physical health of baby

Health & psycho-social wellbeing of mother-infant dyad & family unit

- Medical model of care
- Progress measured through weighing
- Baby's health disembodied from wellbeing of mother-infant dyad

- Bio-psycho-social model of support
- Focus of parent - infant interaction
- Focus on parenting support

Older descriptive studies (≤ 1999)

Newer research (≥ 2000)

Health surveillance

Health promotion

Advisory role

Facilitative, guiding role

- Health Visitors believe their role is to impart advice
- Mothers seek reassurance & advice
- Authoritarian approach by clinic staff
- Mothers doubt their own mothering abilities

- Facilitating discussions between parents
- Guiding parents to the evidence base
- Supporting parents to understand & consider their options

Parents passive in clinic process

Promotion of parental autonomy

- Parents wait in line to be called to the Health Visitor
- Babies weighed by Health Visitor
- Health Visitor's agenda
- Receiving 'advice'
- Clinic layout formal & segregates parents

- Clinic layout informal & encourages parents to socialise
- Parents involved in any process of developmental assessment
- Discussing parent's agenda
- Discriminating between information sources and choosing your support network
- Purpose, function and process of clinic clear

Older descriptive studies (≤ 1999)

Newer research (≥ 2000)

Health surveillance

Health promotion

Outcome / problem oriented

Process / relationship centred

- Screening problems for GP's
- Focus on tracking / plotting weight
- Focus on measuring clinic attendance
- Perceived pressure to conform to weight norms

- Focus on parents' experiences of support at clinics
- Focus on identifying theoretical processes of community based family support
- Continuity of staff builds relationships
- Partnership working at clinics with all staff embodying shared aims, values & philosophies

Focus on weighing

Focus on supporting infant feeding & sensitive, responsive parenting

- Weighing an admission ticket to the clinic
- Weighing prioritised
- Weighing a progress check

- Needing an alternative to the ritual of weighing at clinics
- Needing social spaces to support all forms of infant feeding without dividing parents
- Replace following the weight chart with understanding infant behaviour

## **An exploration of the sub themes**

The sub themes are discussed in an order which provides the best descriptive flow.

### **Moving from physical health of baby to the health and psycho-social wellbeing of mother - infant dyad & family unit**

Early research ( $\leq 1999$ ) describes a clinic environment focussed on assessing and monitoring the health of babies through screening and weighing (Sefi and Macfarlane 1985, Turya and Webster 1986, Karmali & Madeley 1986, Kilpatrick and Mooney 1987, Cubbon 1987, Sefi and Macfarlane 1987, Morgan et al 1989, Betts and Betts 1990, While 1990, McIntosh 1992, Gillespie et al 1992, Sharpe and Lowenthal 1992, Finch and Whitefield 1997, Knott and Latter 1999)

Across the research, weighing is given as the reason for clinic attendance and is conceptualised by parents as an indication of an infant's progress (Sefi and Macfarlane 1985, Turya and Webster 1986, Cubbon 1987, Sharpe and Lowenthal 1992, McIntosh 1992, Sachs 2005).

A study by Sachs (2005), suggests that weighing has become privileged in our understanding of how to evaluate the health and wellbeing of babies and may prevent other important means of assessment from being discussed with parents.

A shift in emphasis away from weighing towards mother-infant interaction is suggested by Barlow and Coe 2011 and a focus on parenting support at clinics is identified as a need across many of the later papers (Donetto and Maben 2014, Barlow and Coe 2011, Burgess-Allen et al 2010, Sparrow et al 2005, Plews and Bryar 2002).

In fact, a paper looking at service provision in clinics concludes that '*traditional child health clinics addressing the physical needs of pre-school children are at odds with the expressed psycho-social needs of parents and carers*' (Sparrow et al 2005, p.299).

The thematic movement identified suggests that perhaps community based family support at clinics should focus on promoting a positive psychosocial adjustment into parenting.

### **Moving from surveillance and social control to building social capital and adding social value**

The perceived focus on surveillance at clinics extends beyond the physical health of babies to the monitoring of maternal competence with parents feeling a sense of social control underlying the clinic encounter:

*'I've noticed when you take her to the clinic you need to strip her.... they look under their arms and in between their legs and things like that. They're looking for marks'* (MacIntosh 1992, p. 139)

The sense of social control is also implied through formal clinic environments, with chairs organised in a regimented way, precluding parents and children from socialising (Gillespie et al 1992, Betts and Betts 1990, Kilpatrick and Mooney 1987).

An understanding of the importance of the social function of clinics is evident throughout all the research and a number of the papers describe successful attempts to revitalise clinic attendance by making changes which encourage a more social environment (Gillespie and Hanny 1992, Betts and Betts 1990, Kilpatrick and Mooney 1987).

*'The biggest benefit is talking over little worries with other mothers'*  
(Sefi and Macfarlane 1985, p.129)

The need for contact with other mothers is echoed in a quote from a 2008 paper (Russell) demonstrating how a mother attempts to balance her undisclosed need for contact with other mothers within the framework of a clinic structured on weighing:

*'I started going to get my baby weighed weekly (just to get out of the house and to meet other mums) I was told that I didn't need to keep going, so I started going fortnightly and then she told me in no uncertain terms that I really, really didn't need to keep coming just to get my baby weighed.'* (Russell 2008 p.68).

The importance of prioritising opportunities for parents to share experiences and offer mutual support is a prevalent theme in ≥2000 research (Donetto & Maben 2014, Donetto et al 2013, Barlow and Coe 2011, Burgess Allen 2010, Russell 2008, Sparrow et al 2005).

### **Moving from parents' passive in clinic process to the promotion of parental autonomy**

The early descriptive research suggests that clinics structured around surveillance and perceived social control place parents in a passive position. Recommendations of later research acknowledge the importance of creating a less formal environment in order to promote parental autonomy.

The research suggests that the manner in which babies are weighed is also a potentially disempowering activity for mothers.

*'They weighed him but that's all they really did. Anyone can weigh a baby'* (Knott, 1999 p.584).

Sachs (2005) suggests that when health professionals weigh babies, if it is not accompanied with an appropriate, knowledgeable conversation which supports parents to understand and contextualise the information, it can undermine the confidence of parents. A number of studies recognise that parents should also be given the opportunity to weigh their own babies (Sparrow et al 2005, Plew & Bryer 2002, Burgess-Allen 2010)

An 'expert' led approach where health visitors bestow 'advice' to parents is criticised in a number of the papers with the patronising or authoritarian approach of staff undermining parents' confidence (McIntosh 1992, Knott 1999). A lack of clarity about the purpose and function of clinics was also found to place parents in a passive position, making them more reliant on professionals (Burgess-Allen et al 2010).

More recent research begins to 'unpick' the process of promoting parental autonomy at clinics. Donetto and Maben (2014) suggest that relational readings of the concept of autonomy may provide a more appropriate conceptualisation of this construct for families and urge more research into the theoretical processes underlying community based family support.

The importance of building relationships with parents and providing safe and supportive community spaces where parents can 'rehearse agency and judgement' is thought to support autonomy (Donetto and Maben 2014 p. 2566, Donetto *et al* 2013).

*'Hearing other people asking questions....it builds confidence in me as well because I can see how they (health visitors) respond to other people's questions and it makes me feel confident in asking my own silly questions' (Bidmead 2013 p. 21).*

Whilst continuity of staff at clinics was found to build relationships (Bidmead 2013), other studies also highlight the important role that clinics with multiple staff play in enabling parents to choose their own support networks and distance themselves from styles of support they find unhelpful (Donetto et al 2013, Donetto and Maben 2014).

*'If you find you don't "click" with your health visitor, so long as you have the option to speak to someone else it's fine.'* (Russell 2008 p.35)

### **Moving from an advisory role to a facilitative guiding role**

A common theme throughout the early research is that staff, believing their role to be 'advice giving' (Sefi and Macfarlane 1987), had a tendency to be patronising and authoritarian in their approach (McIntosh 1991).

A paper by Plews and Bryer (2002) which evaluated the advisory role of Health Visitors within clinics, suggest a partnership approach where health visitors elicit and respond to the mother's agenda rather than giving opportunistic advice, which is often unsolicited and unwelcome.

Later research reframes the concept of advice giving at clinics with offering opportunities for families to access a wide range of information (Barlow and Coe 2011). Data generated from parents' discussions at focus groups in 2005 suggest that health visitor facilitated drop ins, where parents could be guided to the evidence base when topics were raised, would be preferable to groups which were led by health visitors (Sparrow 2005).

Linked in with the theme of mothers seeking professional advice at clinics is an additional theme which suggests that mothers often seek reassurance at this transitional stage in their life and need safe social spaces where they can build positive perceptions of their '*new or renewed parent identities*' (Donetto and Maben 2014 p.2563).

Later research papers focus on the objective of creating the conditions at health visitor drop ins which increase parental confidence and foster self-trust. Supporting parents to seek and evaluate both information and sources of information and to understand and consider their options, through building informal support networks with peers and professionals (Donetto & Maben 2014, *Donetto et al 2013*, Bidmead 2013, Barlow & Coe 2011, Burgess-Allen *et al* 2010, Sparrow *et al* 2005).

### **Moving from outcome / problem oriented to process / relationship centred**

The studies included show a clear progression from early descriptive papers focussed on measuring outcomes such as clinic attendance, screening or immunisation uptakes, to more recent research focussing on identifying and understanding the processes of community based family support and parent's experiences of support at clinics.

A problem oriented approach to clinics is described in many of the earlier studies ( $\leq 1999$ ), with health visitors effectively filtering 'problems' for GP's.

A number of studies (particularly later papers) are critical of the primacy of weight monitoring at clinics (Barlow & Coe 2011, Burgess-Allen 2010, Sachs 2005, Knott & Latter 1999) and a shift in focus towards understanding the relational processes through which parents' access community based support is evident (Donetto and Maben 2014, *Donetto et al 2013*, Bidmead 2013).

Bidmead (2013) suggests that continuity of staff can enhance relationships between parents and health visitors, whilst busy clinics with no staff continuity are a barrier to relationship building. Donetto et al (2013) also highlight that repeated one to one contact with the same professional is an important element of satisfaction, whilst noting the value in parents being able to meet different health visiting team members in a clinic or group setting to '*identify and access the professional with whom they felt most comfortable and in tune*' (p.42)

The importance of a relationally focussed approach to community based support also extends to the relationships between staff at clinics. Barlow and Coe (2011) suggest that an important distinction exists between the co-location of services and true partnership working where staff embody shared aims, values and philosophies.

## **Moving from a focus on weighing to focussing on infant feeding and sensitive, responsive parenting**

The emphasis on weighing at clinics is a theme that pervades the entire research included in this review.

The older, descriptive research ( $\leq 1999$ ) depicts a service where weighing is ritualistically prioritised and regarded as a progress check by staff and parents.

Even in 2005, Sachs laments:

*'The measure of success is weight gain which conforms to expectations, not the quality of the breastfeeding relationship or the emotional relationship between baby and mother, or wider family.'* (Sachs 2005 P.169)

The thematic movement across the studies suggest that an alternative to the ritual of weighing at clinics is needed and the purpose and potential value of clinic attendance needs to be made explicitly clear to parents.

A number of suggestions are made, including: re-focussing clinics on mother-infant interaction (Barlow and Coe 2011); prioritising relationally based support to encourage parental autonomy, esteem and self-trust (Donetto and Maben 2014, Donetto et al 2013, Bidmead 2013); and building social capital through facilitating parent to parent support (Donetto and Maben 2014, Donetto et al 2013, Bidmead 2013, Barlow and Coe 2011, Burgess-Allen et al 2010, Sparrow 2005).

A number of papers suggest that social spaces are needed to support all forms of infant feeding without dividing parents (Burgess-Allen et al 2010, Russell, 2008 Sparrow et al 2005).

In fact over ten years ago Sachs (2005) advocates rearranging clinics to include, but not impose weighing and replacing following the weight chart with focussing encounters at clinics on *'relational aspects and holistic infant development'* Sachs 2005 p. 208.

## **Discussion**

The broad search criteria combined with searching of reference lists of included papers and consulting with five academics in the field of health visiting research supports the conclusion that all relevant research was included and the conclusions are therefore based on a synthesis of all available evidence.

The review found no evidence papers with robust evaluations of process or outcome measures, potential models or any wider evidence for baby clinics, which makes it impossible to draw any conclusions about the effectiveness of this service offer.

The value of conducting the search for evidence across a 30 year period became apparent in the analysis of the papers obtained which provided a valuable temporal view of the

structural context of services and historical culture of practice in clinics, which still influence current practice.

The results of this review are in line with the conclusions of a recent narrative review of literature examining the potential public health benefits from health visiting practice (Cowley et al 2014) which suggests that in general, there is a lack of evaluative research about the mechanisms by which the service promotes health and reduces health inequalities.

The persistence of clinics, without national guidance or a theoretical evidence base is reflected in the findings of this review; clinics appear to be an historical tradition with a ritualistic focus on weighing babies, which is an embedded cultural expectation of the service.

The emergent themes of the post 2000 research included in the review; that of clinics moving towards being relationally centred, facilitated social spaces which promote parental autonomy and build social capital, fit with the emphasis on parenting support and integrated services within the Healthy Child Programme (2009, updated 2015).

Moving on from the advisory role of health visitors in clinics, depicted in the early descriptive research reviewed, the guiding approach that emerged as a style preferred by parents is consistent with models of anticipatory guidance suggested by Barlow's review on health led parenting interventions (2009). Facilitating discussions between parents and supporting parents to understand and explore the context of their infant's behaviour offers the potential to address all six of the early year's high impact areas within the clinic setting (Watts 2014) in a guiding and participative, rather than didactic style, which would enable parents to explore their own agenda for information and support.

The progressive thematic movement identified in this review suggests that community based family support at clinics should be focussed on promoting a positive psycho-social adjustment into parenting. This is a common goal of all services supporting children and families in the early years and supports the physical and emotional wellbeing of infants and children.

Typical measures of psycho-social wellbeing from a strengths based approach which focusses on individual and community resilience (UNICEF 2009) include some measurement of:

- the acquisition of knowledge and skills
- improved emotional adjustment
- improved social well being

Such measures could include:

**Knowledge and skills:** Understanding infant behaviour and development; infant feeding; normal infant sleep; play and interaction; where to access information and how to discriminate between sources of information



**Emotional adjustment:** Building resilience, confidence and self-efficacy, supporting an attuned style of parent-infant interaction, promoting sensitive and responsive parenting, adjusting expectations and improving coping mechanisms through this life course transition

**Social well-being:** building support networks, promoting relational autonomy, adding social value, building social capital and navigating perceived social norms around parenting and infant behaviour

The mechanisms by which such change could occur within a health visiting led, community based offer, appears to be socially and relationally based however the theoretical process by which such support might be delivered needs to be explored and examined.

## **Conclusion**

The lack of evaluative research into the structure, function and process of baby clinics means that a conclusion about their effectiveness as a universal service offer cannot be reached. It seems clear however, that the lingering pre-occupation with weighing at clinics is preventing this service element from evolving in line with the rest of the Health Visiting Service offer.

The primacy of the weighing scales at clinics advocates a continued underlying emphasis on surveillance and monitoring and a problem-oriented approach, which is at odds with the expressed psychosocial support needs of parents attending (Burgess –Allen 2010, Russell 2008, Sachs 2005, Sparrow 2005, Knott and Latter 1999, McIntosh 1992).

Lack of evidence of effectiveness does not necessarily mean evidence of ineffectiveness and Donetto et al (2013) highlight *'the importance of consolidating a health visiting service that combines home visiting with opportunities for support and advice outside the home'* (p.91).

This review suggests that professional reflection and research into the focus, structure and function of clinic models and the theoretical process of community based family support within the health visiting service is now needed in order to progress this element of universal service provision to an evidence base. The review provides formative themes on which potential theories of change or models of delivery may be focussed and tested in the future.

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