Infant feeding: changing the conversation

In light of new research about the benefits of breastfeeding, the National Childbirth Trust's Senior Research Manager Heather Trickey, and Unicef UK Baby Friendly Initiative's Director Sue Ashmore discuss why we need to change the way we talk about breastfeeding.

Education alone will not help vulnerable babies receive breast milk

Heather Trickey Research Associate, DECIPHer Cardiff University, and Senior Research Manager, the National Childbirth Trusts (NCT)
trickeyhj@cardiff.ac.uk

Babies born in the UK are less likely to be breastfed than babies born in almost anywhere else in the world.[1] At six months around a third of babies born in the UK receive some breast milk compared to just over half in the US and more than 70% in Norway.[2] From a public health perspective this represents a problem because artificial feeding is associated with poorer health outcomes for babies and mothers; in a UK context, studies indicate that 'low breastfeeding rates in the UK lead to increased incidence of illness that has significant cost to the health service'. Improved rates would lead to fewer gastrointestinal and respiratory tract infection-related consultations and admissions, fewer cases of otitis media and fewer cases of necrotising enterocolitis (NEC), as well as fewer cases of breast cancer among mothers.[3] Low breastfeeding rates also matter from a parent experience perspective, as UK mothers who do initiate breastfeeding often struggle to continue and go on to experience feelings of guilt and shame.[4]

For more vulnerable, premature babies the relationship between artificial feeding and poorer health outcomes is particularly acute. Breast milk is protective against infection, and improving the rates of breastfeeding at discharge from neonatal care from 34% to 75% could lead to 361 fewer cases of NEC annually and savings in treatment costs to the NHS of around £6 million.[3] Furthermore, mothers often value being able to provide milk for their babies in neonatal care as this helps them to overcome feelings of helplessness.[5]

Why do UK-born babies receive so little breast milk?

Why do so many UK mothers formula feed despite evidence and education that breast milk is best for babies? Are parents simply making a personal choice?

Often not. Breastfeeding is a complex bio-psycho-social health behaviour; one which needs to be valued and supported if it is to be sustained. The experience of key members of a mother's immediate social network matter. Younger, less well-educated mothers are least likely to breastfeed[6] and geographically low breastfeeding rates correlate with higher indices of deprivation.[7] It is simply more challenging, less socially normal, to breastfeed in some contexts than others and choices are constrained by these challenges. In addition, many UK mothers struggle to maintain breastfeeding to an extent that mothers in other countries do not experience. Successive infant feeding surveys have shown that, while the proportion of mothers who initiate breastfeeding has gradually climbed (from 76% in 2005 to 81% in 2010), the proportion of mothers who stop before they plan – often in the early weeks, before breastfeeding is established – has scarcely altered. In 2010, only 55% of mothers were still breastfeeding at six weeks after the birth; eight out of 10 mothers who stopped during this period stopped before they had planned to do so.[6] If we add to this a very large measure of unplanned mixed feeding we begin to get a handle on the UK's exceptionally high breastfeeding disappointment rate.[8] Strong social and geographical patterning and the marked mismatch between parents' feeding intentions and feeding outcomes, suggest that the notion that parents' feeding decisions are generally a matter of 'choice' is deeply flawed.[9]

Mothers of babies born prematurely are additionally constrained in their access to a 'choice' to breastfeed. Premature babies may be unwell and can be separated from their mothers after birth. Babies at different stages of prematurity may not have developed co-ordinated sucking, swallowing and respiration reflexes.[10] Health professionals need knowledge and skills to facilitate a transition to breastfeeding as well as a healthcare environment that promotes parent-infant closeness and family-centred care.[11] The evidence base to support practices that enable breastfeeding in a neonatal setting has been steadily building.[12]

Unicef UK call to action

The Unicef Baby Friendly call to action on breastfeeding (see the accompanying article opposite) addresses the structural and social causes of low breastfeeding rates. The call highlights the mistake of imagining that our internationally low breastfeeding rates can be improved simply by educating about the benefits of breastfeeding more vigorously. It stresses the need for an ecological and strategic approach to policy development and implementation – to change the context for mothers' decisions. The call fits well with NCT policy to promote and protect the conditions that make a decision to breastfeed more straightforward.[13]

Ecological approaches to intervention emphasise structural, social and cultural influences on health behaviours that interact

with the individual's own decision-making. These influences are not one-off; they interact with a mother's experiences of feeding throughout her life-course and along her own feeding journey.

Structural causes of low breastfeeding rates include health service policies and practices that work against breastfeeding, restricted access to maternity leave, limited facilities to enable breastfeeding in the paid work environment, as well as weak implementation of the World Health Organization code[14] with respect to formula milk marketing. Social causes include a lack of knowledge, skills and experience among family and friends as well as limited access to professional and voluntary help for feeding at community level. Cultural influences include notions of privacy and propriety, the sexualisation of breasts and the media portraying bottle feeding as a social norm.

In November 2016, the World Breastfeeding Trends Initiative report compared countries in terms of policies and practices to support breastfeeding.[15] This highlighted key policy gaps, including the lack of a national strategy in England.

Baby Friendly neonatal care

Since 2013 neonatal units have been able to work towards Baby Friendly accreditation. This involves meeting standards to:

- support parents to have a close and loving relationship with their baby
- enable babies to receive breast milk and to breastfeed when possible
- value parents as partners in care.[12]

Units that have achieved accreditation have seen improvements in:

- support and facilities to express and store breast milk, including improved availability of breast pumps
- measures to lift restrictions on parents spending time with their babies and holding them skin-to-skin, including facilities to allow parents to sleep in and to rest while holding their babies
- changes in practice at ward rounds to create a culture that involves parents in their babies' care and is more welcoming to parents and siblings.

The call to action recognises that the work of encouraging and supporting mothers to breastfeed cannot be achieved through changes to the health service alone. However, health service regimes can provide a firm basis for wider change and implementing Baby Friendly standards across maternity care is one powerful way to ensure that a key cog is turning effectively, particularly for babies in neonatal care.

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Breastfeeding: a public health issue

Sue Ashmore Director, Unicef UK Baby Friendly Initiative
bfi@unicef.org.uk

It's a brave person who dares speak in public about infant feeding these days. I know of one highly experienced research press officer, who had worked on controversial issues like human animal hybrids, GM crops, animal research, minimum alcohol pricing and climate change, who admitted: "Nothing had prepared me for the most polarising, knee-jerking subject of all: breastfeeding."

Whether you are Jamie Oliver trying to show support for breastfeeding and rightly recognising a genuine problem – that women who want to breastfeed in this country often face barriers that mean they can't – or a new mother just blogging or tweeting about her personal experiences, speaking out puts you in the direct path of the opinion juggernaut which careers headlong into anyone who dares to take a stand on either side of the polarised infant feeding debate.

In some ways, Oliver was an easy target for criticism: a public figure not afraid of being outspoken, resilient, successful. Those attacking him would not have been concerned about his personal wellbeing. It is a different story for the mothers, midwives and health professionals whose daily work is supporting mothers who want to breastfeed, who often find themselves on the receiving end of similar criticism for putting pressure on women to breastfeed. Any chance of having an inclusive, factual and non-judgemental conversation about infant feeding is shut down.

So it is time to change. First, we need to be upfront and admit that yes, sometimes, well-meaning efforts to promote breastfeeding may have been insensitive and over-zealous. No mother should feel pressurised, or manhandled, around feeding her baby; we must do better than that and provide non-judgemental information and support so that a woman can genuinely choose how she wants to feed her baby, and is able to follow through on that choice.

Second, we must also be upfront with the evidence around

Images courtesy of Unicef UK/Mead.

breastfeeding. Recently three new major studies have been published, including a series in *The Lancet*,[1-4] which delivered resounding and extensive evidence that breastfeeding saves lives, improves health and cuts health service costs in every country, rich or poor.

This is powerful information that mothers will want to know when making a decision about how to feed their child. But even writing it down here presents a dilemma as it will be upsetting for many families who have not breastfed, or who have experienced the trauma of trying very hard to breastfeed and not succeeded.

So thirdly, we need to change the conversation. We can stop laying the blame for a major public health issue in the laps of individual women and acknowledge the collective responsibility of us all to remove the barriers to breastfeeding which lead to eight out of 10 women reporting they had to stop breastfeeding before they had wanted to.

On the back of the recent new evidence around breastfeeding, Unicef UK is calling on all UK governments to implement four key actions that will kick-start a supportive, enabling environment for women who want to breastfeed:

1. Develop a National Infant Feeding Strategy Board that includes members from all relevant government departments, and task the board with developing a comprehensive infant feeding strategy and implementation plan.
2. Include actions to promote, protect and support breastfeeding in all policy areas where breastfeeding has an impact. This includes obesity, diabetes and cancer reduction; emotional attachment and subsequent school readiness; improved maternal and child mental health; wellbeing in the workplace; and environmental sustainability.
3. Implement evidence-based initiatives that support breastfeeding, including the Baby Friendly Initiative (BFI), across all maternity, health visiting, neonatal and children's centre services.
4. Protect the public from harmful commercial interests by adopting, in full, the International Code of Marketing of Breast Milk Substitutes and subsequent resolutions.

For further information visit www.unicef.org.uk/babyfriendly/baby-friendly-resources/ advocacy/call-to-action

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Baby Friendly neonatal conference 2017

The BFI's second neonatal conference will be held on Tuesday 9 May 2017 at Senate House, London. The event offers an opportunity to hear the latest ideas and discussions around caring for the most vulnerable babies and their families to help give these babies the best possible chance to thrive. More details coming soon at: **babyfriendly.org.uk**