EARLY YEARS SERIES:
REPORT 2

The Food Foundation

Breaking down the barriers to breastfeeding to support healthy weight in childhood

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This report builds on the work undertaken in this area by many other organisations and professionals, with particular credit to Bremner & Co, who undertook a comprehensive landscape review of breastfeeding barriers, support and portrayal for Impact on Urban Health, which has been referenced throughout this report. In addition, we credit First Steps Nutrition Trust for their report, *Enabling Children To Be A Healthy Weight: What We Need To Do Better In The First 1,000 Days*, and also the Obesity Health Alliance report, *Turning The Tide: A 10-Year Healthy Weight Strategy*, along with Maternity Action and Institute of Health Visiting (iHV) surveys.

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Foreword

By the first year of school, more than a fifth of children in England are living with overweight or obesity.[4] It is too late to wait until children start school before considering effective interventions to tackle this - preventative measures are needed much earlier. This report explores how infant feeding can influence the development of childhood obesity. It examines current breastfeeding practices in the UK and looks in particular at barriers to breastfeeding for those who would like to breastfeed more or for longer and at factors which shape intention to breastfeed. We explore the factors that can act as facilitators or barriers to breastfeeding, particularly in the first six months, and present a range of recommendations as to what needs to be done to make improvements in this area. This report is the second in a series that will progress, stage-by-stage, through a child's early years.

The first report focused on pre-conception and pregnancy. Throughout the series we will be investigating the gaps and issues in policy, business practice, local authority provision and formal and informal support that need addressing. We will present a set of recommendations for policies that can enable the consumption of a healthy diet during pre-conception and pregnancy, infancy and early childhood. By the end of the series we hope to have built a picture of the underlying systemic failures in the food system that lead to the high numbers of children living with overweight or obesity by the start of primary school.

44% of women who breastfeed would have liked to do so for longer
You Gov, 2024[32]

The evidence brought together in this series of reports will inform a final report that will also take into account the feedback and views of stakeholders across the sector including frontline professionals and parents. For more information on our ongoing early years work please visit ***foodfoundation.org.uk/initiatives/early-years***

Glossary

Exclusive breastfeeding
Exclusive breastfeeding is defined as giving no other food or drink – not even water – except breast milk. It does, however, allow the infant to receive oral rehydration salts (ORS), drops and syrups (vitamins, minerals and medicines).[1]

Overweight and obesity
Overweight and obesity are defined by the World Health Organisation (WHO) as abnormal or excessive fat accumulation that presents a risk to health.[2]

Baby Friendly UK
UNICEF's UK Baby Friendly accreditation programme supports maternity, neonatal, health visiting and children's services by setting standards, providing training and assessing progress. It is recognised and recommended in government and policy documents across all four UK nations, including NICE guidance.

WHO Code of Marketing of Breastmilk Substitutes
The WHO's International Code of Marketing of Breastmilk Substitutes ('the Code') places limitations on all forms of marketing of breastmilk substitutes to the public and to healthcare professionals, defined as all "product promotion, distribution, selling, advertising, product public relations, and information services." This includes infant formula, follow-on formulas and any other food or drink, together with feeding bottles and teats intended for babies and young children.

Maternity Leave
Anyone who is employed and pregnant in the UK is entitled to Statutory Maternity Leave: 52 weeks of time off work, no matter how long they have worked for their employer.

Maternity Pay
Statutory Maternity Pay (SMP) is a regular payment made by employers to their employees who have a baby and are on maternity leave. SMP is paid for up to 39 weeks and provides 90% of average weekly earnings (before tax) for the first six weeks, and £172.48 or 90% of average weekly earnings (whichever is lower) for the next 33 weeks (in 2022-23).

Breastmilk substitutes
Breastmilk substitutes are defined by the WHO as "any food being marketed or otherwise presented as a partial or total replacement for breast milk, whether or not suitable for that purpose."

UN Convention on the Rights of Child
The United Nations Convention on the Rights of the Child (UNCRC) is a legally binding international agreement setting out the civil, political, economic, social and cultural rights of every child, regardless of their race, religion or abilities.

Note: When referring to breastfeeding in this report, the words 'women', 'mothers' and 'breastfeeding' are used because most people who feed their babies this way identify as women. However, we recognise that not all people who breastfeed or chestfeed identify as women.[3]

Abbreviations and definitions

BBF	Becoming Breastfeeding Friendly	**IFS**	Infant Feeding Survey	**OHID**	Office for Health Improvement and Disparities
BFI	Baby Friendly Initiative	**ILO**	The International Law Organisation	**PHE**	Public Health England
BMI	Body Mass Index	**NCT**	National Childbirth Trust	**SACN**	Scientific Advisory Committee on Nutrition
CQC	Care Quality Commission	**NHS**	National Health Service	**SMP**	Statutory Maternity Pay
COSI	The WHO Childhood Obesity Surveillance Initiative	**NICE**	National Institute for Health and Care Excellence	**UNICEF**	United Nations Children's Fund
DHSC	Department of Health and Social Care	**OECD**	The Organisation for Economic Co-operation and Development	**WHA**	World Health Assembly
HCP	Healthcare professionals			**WHO**	World Health Organisation

Scope of research

This report draws on a **literature review** of existing data and insights of breastfeeding in the UK, qualitative interviews with mothers and a **YouGov survey commissioned by The Food Foundation** to capture mothers' experiences. It also draws on a range of **qualitative research** carried out by Bremner & Co (commissioned by Impact on Urban Health) which examines the perspectives of stakeholders across the breastfeeding space, including NGOs, charities, local government, health visitors and midwives, on the barriers to breastfeeding initiation and longevity, as well as the implications for infant food security. Quotes included in this report have been anonymised, referencing the sector only. The research also analysed how the media portrays infant feeding.

BREAKING DOWN THE BARRIERS TO BREASTFEEDING TO SUPPORT HEALTHY WEIGHT IN CHILDHOOD

Executive summary

Breastfeeding reduces the risk of childhood overweight and obesity and therefore can play an important role in supporting healthy weight in childhood. The UK has some of the lowest rates of exclusive breastfeeding in the world, with less than half of infants breastfed exclusively at one week old, and just 1% of infants being exclusively breastfed for six months, with rates lower in deprived communities.[26] Many report that they would have liked to breastfeed for longer, thus highlighting the importance of addressing some of the barriers faced by women who want to breastfeed.

We have identified a range of factors that could support mothers to breastfeed for longer, including more support from healthcare professionals, better maternity pay and leave, and more support from families and friends.

Key areas where policy intervention could help to address these barriers include inadequate support and advice from the health system and from the workplace; financial considerations; and social attitudes and commercial pressures. Specifically, the government needs to do more to recognise infant feeding as a critical issue, and as a tool to reduce childhood obesity in the UK. It must take steps to better support women to breastfeed by:

- **Providing financial support for local authorities to deliver breastfeeding support services** for all, ensuring family hubs/children's centres are available in areas of high deprivation in line with the government's pledge, and providing adequate training for healthcare workers who work with mothers and have opportunities to support breastfeeding.
- **Increasing the number of health visitors**, allowing for an increase in the number of mandatory face-to-face contacts with health visitors to eight contacts, along with tailored follow up.
- **Introducing statutory recommendations for workplaces** regarding the support they need to provide for women.
- **Increasing the number of Baby Friendly Initiative (BFI) accredited facilities**, particularly those achieving full/gold accreditation.
- **Strengthening protections for women breastfeeding in public**.
- **Increasing statutory maternity pay** to align with the living wage and extend the Sure Start Maternity Grant to second and subsequent children.
- **Increasing eligibility for Healthy Start/Best Start**, introducing auto-enrolment, increasing value in line with inflation, and ensuring Healthy Start provides a nutritional safety net for breastfeeding as well as formula feeding mothers.
- **Strengthening the UK law on the marketing of breastmilk substitutes**, in line with WHO's *International Code of Marketing of Breastmilk Substitutes*, including by closing loopholes, extending restrictions to include follow-on formula and toddler/growing up milks, introducing mandatory independent monitoring and enforcement and providing clarification on what falls within UK law.
- **Dedicate a specific government team to breastfeeding** and integrate breastfeeding within the childhood obesity strategy.

The link between infant feeding and later overweight and obesity

Around one in five children (21.4%) in England are starting school affected by overweight or obesity, increasing to one in four children by the time they leave primary school.[4] Children from the most deprived households are more than twice as likely to live with obesity, compared to those from the least deprived households.[4]

A similar pattern is true in Wales, with 27% of four- to five-year-olds living with overweight or obesity, and in Scotland where 33% of all children aged two to 15 have overweight or obesity in England.[5, 6] While not directly comparable due to using a different definition, a similar pattern is also seen in Northern Ireland, where 25.4% of all children are affected.[7]

There have been a wide range of efforts by government to address childhood obesity, with 14 government strategies and 600 policies developed and implemented over the last 30 years.[8] Infant feeding and the early years have been a particularly neglected area of national policy to prevent childhood obesity, despite evidence consistently demonstrating that breastfeeding can help to reduce the risk of overweight and obesity.

There is a huge body of evidence, most recently captured in a meta analysis commissioned by the WHO which shows that breastfeeding reduces the risk of childhood obesity and that effects remain even after adjusting for a wide range of potential confounding factors.[9]

Exclusive breastfeeding for six months can decrease the likelihood of a child developing obesity by up to 25%
WHO COSI, 2022[10]

The degree of reduction in obesity varies between studies, and often depends on the quantity of breastfeeding ('dose response') – i.e. some breastfeeding delivers some impact, more breastfeeding delivers greater impact. This was demonstrated by the WHO Childhood Obesity Surveillance Initiative (COSI), a study of 16 countries across Europe monitoring nearly 30,000 children, which found that exclusive breastfeeding for six months with no formula or weaning foods can decrease the likelihood of a child developing obesity by up to 25% when compared to children who were never breastfed.[10] Specifically, the study found that 16.8% of the children who were never breastfed developed obesity, compared with 13.2% of those who received some breastmilk and 9.3% of those who were breastfed for six months or more.[10] Meanwhile, a UK study found that, after adjustments for socioeconomic status, breastfeeding for at least the first four months of infancy resulted in a lower chance of living with overweight at three years old compared with those who had never been breastfed.[11]

By contrast, bottle feeding may promote weight gain and formula fed babies are likely to gain weight more rapidly than infants who are breastfed.[12-15]

To put this in perspective, we can look at these benefits of breastfeeding in the context of other obesity-related interventions that have been implemented in the UK. The UK Sugary Drinks Industry Levy, for instance, is estimated to have reduced obesity among 10-11 year old girls by 8%; the Transport for London ban on advertising of high fat, salt and sugar foods (HFSS) is estimated to have resulted in a 4.8% reduction in obesity in adults and children; while Universal Free School Meals (UFSM) are estimated to reduce prevalence of obesity by 9.3% in Reception and 5.6% among Year Six children on average.[16-18] While recognising the different natures and timescales of these exposures, this demonstrates how significant the impacts of increasing breastfeeding rates could be.

The specific mechanisms that explain the reduction in childhood overweight and obesity as a result of breastfeeding are less well understood. A number of potential mechanisms have been identified. These include factors related to the gut microbiome, hormones, appetite regulation and gene moderation.

- Human breast milk is high in bifidobacteria, which positively influence the development of the baby's **gut microbiome**. Bifidobacteria have been shown to be present to a lesser extent in the gut of children with obesity.[10]
- Breastfeeding supports **appetite regulation** as babies are better able to judge when they are full, compared to bottle feeding where the carer is more in control.[20,21]
- Breastfeeding may play a role in **moderating the genes** associated with fat mass and obesity.[22]
- Breastfeeding can result in a different **hormonal response** when compared with formula, with the latter causing greater insulin release which in turn leads to fat deposition.[10]
- Breastfeeding is associated with a **healthier diet during childhood**, in that children who are breastfed seem to have more favourable food preferences, consuming more fruit and vegetables compared with those who are formula fed.[10]

Infant feeding in Britain

Both the WHO and UNICEF recommend that breastfeeding is initiated within the first hour of birth and that children are exclusively breastfed for the first six months of life, meaning no other food or liquid is provided, including water. From the age of six months, children should begin eating complementary foods while continuing to breastfeed for up to two years of age or beyond.[23] The NHS makes the same recommendation for those who choose to breastfeed, and a recent Scientific Advisory Committee on Nutrition (SACN) report recommended more support for breastfeeding into the second year of life.[24,25]

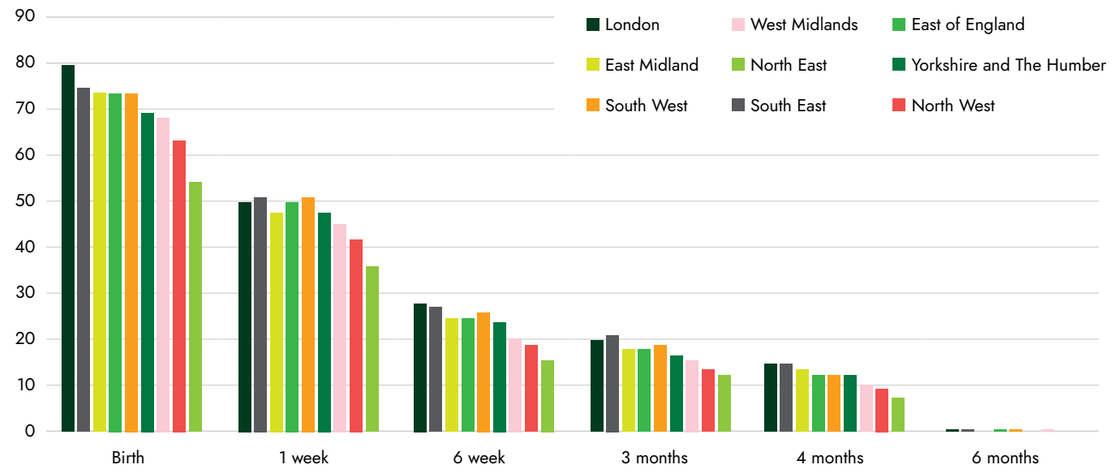
The last-conducted UK wide Infant Feeding Survey (IFS) (see box) in 2010 showed that, while rates of breastfeeding initiated at birth are relatively high in the UK (around three quarters of babies are breastfed from birth), levels of exclusive breastfeeding dropped rapidly thereafter, falling to less than half by one week, a quarter by six weeks and around 1% at six-months.[26] Data for England indicates that there were substantial disparities in breastfeeding rates between English regions.[27] London and the South East had a higher prevalence of exclusive breastfeeding at birth and up to six months, while the North East and North West showed the lowest exclusive breastfeeding prevalence across the same age range.

UK Infant Feeding Survey

The Infant Feeding Survey (IFS) is the best standardised measurement survey for infant feeding across the UK. However it has not been conducted since 2010 which makes it hard to get an accurate picture of breastfeeding rates in the UK as a whole, and in each of the devolved nations. In turn, this makes it challenging to target interventions where most needed. Up until 2010, the IFS was conducted every five years from 1975, and provided national estimates of the incidence, prevalence and duration of breastfeeding (including exclusive breastfeeding) and other feeding practices adopted by mothers in the first eight to ten months after their infant was born.[26] The Department of Health and Social Care commissioned the ninth series of the survey in 2023.[24]

FIGURE 1

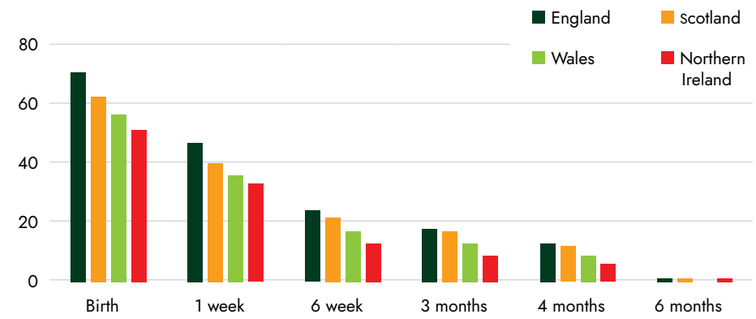
Regions of England: mothers reporting exclusive breastfeeding up to six months, 2010



Source: Mcandrew et al, Infant Feeding Survey, 2010[26, 66]

FIGURE 2

UK nations: percentage of mothers reporting exclusive breastfeeding up to six months, 2010



Source: Infant Feeding Survey, 2010[26, 66]

The pattern of a rapid decline within a week of birth, and further decline by the time infants were aged three months old is seen across each of the four UK nations. Exclusive breastfeeding was highest in England compared to the other nations of the UK, starting at over 70% at birth and falling below 20% at three months, with the lowest exclusive breastfeeding in Northern Ireland, starting at just over 50% at birth and falling below 10% by three months.[26]

More recent surveys have been conducted in each of the devolved nations and, while not directly comparable to the IFS or to each other, they indicate that breastfeeding rates may have changed, though improved in some places. For instance, the latest data from Wales suggests improvement, with exclusive breastfeeding at six months rising to 19.3% in 2022.[28] Similarly, data on breastfeeding is captured at multiple data points in Scotland (more than the other regions) and rates of breastfeeding appear to have improved, with 2022/23 data suggesting that 66% were breastfed a few days after birth. At six to eight weeks, 47% were breastfed and 28% were exclusively breastfed (compared to 32% and 18% in England, respectively).[29]

POLICY ON BREASTFEEDING IN BRITAIN

There are a number of overarching policies and pieces of guidance designed to support breastfeeding across the UK, covering healthcare, workplaces and formula marketing. However none of these is comprehensive.

Each of the devolved nations have their own initiatives on breastfeeding. Scotland has a particularly comprehensive approach to breastfeeding, having invested a lot in their breastfeeding programme and in their infant feeding data collection.[30] The *Becoming Breastfeeding Friendly (BBF)* research project, an evidence-informed global initiative designed to identify strengths and develop recommendations for scaling up policies and programmes, scored Scotland much higher than Wales and in Scotland (2.4/3 compared to 1.1/3 in both Wales and England). Scotland was recognised for its "strong political commitment to breastfeeding evidenced by effective leadership, strong policies and significant investment."[19, 49-51]

Since this analysis was carried out, Wales has introduced a five-year action plan (2019-2024) for breastfeeding, covering both the healthcare system and a wider whole system approach which touches on social norms, marketing and inclusive settings.[52] This covers a range of actions focused on better monitoring, the development of local action plans, better education standards for NHS staff and communications to help normalise breastfeeding.

> *"What we see in Scotland is a clear vision for breastfeeding and a government playing a role in really leading and shaping delivery according to that vision. There's a clear plan in place."* CHARITY[30]

Barriers to breastfeeding for mothers who want to

42% of mothers who exclusively breastfed said that more support from HCPs would have helped then to breastfeed for longer
YouGov, 2024[32]

The general pattern of low breastfeeding rates across the UK along with weak, disjointed policy suggests more action is needed to support breastfeeding for those who want to.

Data provided by YouGov shows that, in a Food Foundation-commissioned survey of 500 mothers with children under 18 months, 44% of mothers who reported to have breastfed at some point and were no longer doing so would have liked to *exclusively* breastfeed for longer.[32]

Every mother must be free to choose the feeding option which best suits her and her baby. No mother should be in a situation where she wants to breastfeed but does not have the support to do so, but many are.

A vast range of barriers to breastfeeding have been previously identified, many of which are experienced by women who want to breastfeed for longer than they do.[30] The barriers range from insufficient support from healthcare professionals to financial challenges while breastfeeding, as well as wider social issues and the marginalisation of breastfeeding, at least in part as the result of formula marketing. Such barriers likely provide the greatest challenges for minority ethnicities and the most deprived. The presence of these barriers also varies between locations, suggesting disparities across the country.[31]

Data provided by YouGov shows that the top five factors that would have most helped mothers to exclusively breastfeed for longer were: more support from healthcare professionals (42%), higher maternity pay/more financial support (28%), longer maternity leave (22%), more support from family and friends (22%) and more places to feed baby in public (21%).[32]

Furthermore, a series of interviews commissioned by The Food Foundation and carried out by ActivMob highlighted that, while the intention to breastfeed was there for many, the reality was quite different.

A lack of consistent information, lack of timely support, feelings of judgement about feeding choices, and personal and baby health in the first few days all contributed to additional challenges and factors that contributed to feeding choices.[46]

These barriers, in many cases, stem from insufficient government action and political will to create supportive environments. For instance, there is no national breastfeeding strategy; maternity provisions (such as maternity pay and leave) are inadequate; limited data is available on breastfeeding to support targeted intervention and funding is insufficient to enable local authorities, health visitors and midwives to deliver enough support to mothers and families (see Figure 3).

Here we focus on three of these key categories of barriers:

- Support and advice from the health system and the workplace
- Financial considerations
- Social attitudes and commerical pressures.

FIGURE 3
Barriers to breastfeeding – a complexity map

Source: Bremner & Co and Impact on Urban Health[30]

1 SUPPORT AND ADVICE

Support from healthcare professionals

WHAT SHOULD BE IN PLACE: NICE GUIDANCE ON INFANT FEEDING SUPPORT

NICE makes clear recommendations around the importance of face-to-face support in the first eight weeks of a baby's life. The guidance stipulates that regardless of their feeding choices, face-to-face support is valuable for parents and should form an integral part of routine postnatal contacts. Individualised support, including assessment and observation of feeding, is highlighted as giving parents the knowledge and understanding they need. This helps them establish good feeding practice and make informed decisions about feeding their baby. If there are ongoing concerns, healthcare professionals can arrange additional contacts to observe feeds until feeding is established and any problems have been addressed. The guidance focuses on feeding observations during the first 24 hours and at least once in the first week, as well as the need for ongoing assessments at postnatal follow up appointments with midwives and health visitors.[100, 101] Support beyond the first 8 weeks is also critical, and additional NICE guidance is available for this.[108]

Consistent, reliable and face-to-face support to families is a key aspect of improving breastfeeding rates, and the absence of accessible, effective support a critical barrier.[33] Data provided by YouGov showed that support from healthcare professionals was the main factor that could have supported mothers to breastfeed for longer.

Across the UK, there is considerable variation in the number of health checks or visits that mothers and babies should receive in the first days, weeks and months. Mothers in England get the least help in the first six months.

- **IN ENGLAND** there are five checks determined by the Healthy Child Programme as part of the Health and Social Act 2012: one during the antenatal period, followed by three further health visitor checks in the first year at one to two weeks, six to eight weeks, 9-12 months. There is also an additional follow up at 2-2.5 years.[34]
- **IN SCOTLAND** there are eight home visits from health visitors and three child health reviews, as defined by the Universal Healthy Visiting Pathway in Scotland. The home visiting programme includes an antenatal appointment at 32-34 weeks, followed by seven appointments in the first year at 11-14 days, two between three to five weeks, six to eight weeks, three months, four months and eight months. Additional health reviews are at 13-15 months, 27-30 months and four to five years.[35,36]
- **IN NORTHERN IRELAND** there are eight health visitor appointments as part of the Healthy Child Future Programme. This includes a first contact with Health Visitors as an antenatal visit, followed by five visits in the first year at 10-14 days, 6-8 weeks, 14-18 weeks, 6-9 months and 12 months. Additional reviews take place at two years and a final one at around three years.[37]
- **IN WALES** there are 11 surveillance contacts as part of the Healthy Child Wales Programme, seven of which are in the first 6 months: a midwife follow up, then health visitor service at 10-14 days, six weeks, eight weeks, 12 weeks, 16 weeks, six months. Additional checks happen at 15 months, 27 months, 3.5 years, and then school nurse checks at four and seven years.[38]

Health checks or visits in first six months

	MONTH 1	MONTH 2	MONTH 3	MONTH 4	MONTH 5	MONTH 6
	1-2 weeks	6-8 weeks				
	11-14 days Two between 3-5 weeks	6-8 weeks	3 months	4 months		
	10-14 days	6-8 weeks	14-18 weeks			
	10-14 days	6 weeks 8 weeks	12 weeks 16 weeks			6 months

In addition, levels of support in England seem to be declining. An NHS maternity survey published in 2022 showed that a significant percentage of mothers in England did not feel they were receiving sufficient support with feeding their babies, and that this has worsened since pre-pandemic.[45] Less than half of respondents (45%) felt they received support during the evening, at night or over the weekend when they needed it (compared to 53% in 2019), and 56% received feeding advice from a midwife or health visitor in the six weeks following their baby's birth (a drop from 61% in 2019).[45] Interviews carried out for this report indicate that a lack of, and inconsistent, information from different parts of the health system was also a barrier to breastfeeding in some cases.[46]

> *"I really want help to latch her on, but they were just too busy and by the time I got home he was so hungry we gave him a bottle"* [46]

The need for breastfeeding support starts during the antenatal period when mothers require information to make informed decisions about feeding choices, as part of both regular midwife appointments and also antenatal health visitor appointments. However, just 13% of health visitors in England report to be delivering an antenatal contact with all families and the Royal College of Midwives (RCM) have highlighted a shortage of midwives and lack of specialist infant feeding midwives which are necessary to provide sufficient infant feeding support.[42,43]

Support is also critical in hospital during the first few hours and days and midwives need to be adequately trained to support women with breastfeeding initiation. However, with breastfeeding initiation rates relatively high (about three quarters of newborn babies are exclusively breastfed), the support provided for mothers once they have returned home is likely a more critical area where improvement is needed.

While support systems are officially in place for the first few weeks and months, the reality is that many women are not receiving sufficient support, with England faring particularly poorly.

> *"We've got an absence of a health visitor workforce to be able to attend to breastfeeding and that's a real concern because new parents do need to know that there is a secure place to turn and seek advice and, you know, many families are barely visited now. After the baby's born, mother has just been neglected and, as a result, we'll see that coming through in the nutrition of their babies."* MP[30]

Across the UK, only 7% of health visitors report feeling confident that all families would be able to access the support they need when a problem was identified.[42] In England, around 80% of parents receive a home visit within 14 days of birth and a second by eight weeks old, meaning around one in five families are missing out.[44] A survey of health visitors suggests the situation is even more concerning with just 54% reporting to deliver a six to eight week review to all families.[42] In Wales, the figures are slightly better where 93% of mothers receive contact at

> *"In England, around 80% of parents receive a home visit within 14 days of birth and a second by eight weeks old, meaning around one in five families are missing out."* [44]

the 10-14 day point and 80% at six months, but only 78% received contact at six weeks and 51% at 12 weeks.[38]

There can also be considerable variation in the levels of support and the number receiving the recommended checks in a timely fashion depending on where you live, indicating a degree of 'postcode lottery' in the support available to new mothers.[44]

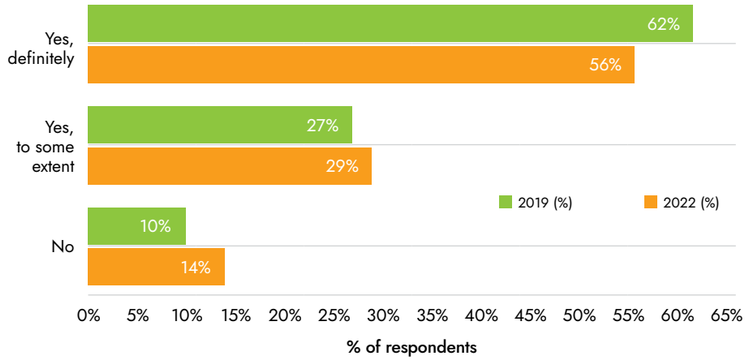
Studies show that breastfeeding practices could be substantially improved with the use of interventions to support women in their homes and communities and through health services.[39] Various local initiatives exist, such as schemes like Better Start Bradford and Small Steps Big Change in Nottingham, which undertake a range of actions to support breastfeeding in the local area.[40,41] However, while such initiatives provide opportunities to support breastfeeding they are often not sustainable (due to the absence of sufficient funding) or an adequate replacement for health service provision.

In addition, mothers often have to rely on informal support networks to help them breastfeed, particularly in the early days. This includes support, for instance from family members.[46]

Furthermore, third sector and voluntary organisations often provide support. While these have become an essential resource, they are often not universally accessible and should be considered supplementary to universal provision.

FIGURE 4

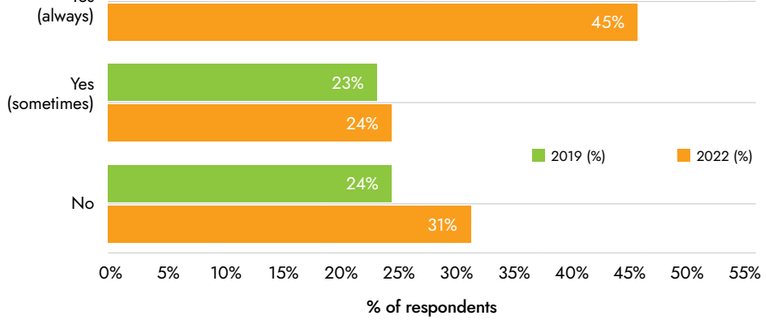
In the 6 weeks after the birth of your baby did you receive help and advice from a midwife or health visitor about feeding your baby?



Source: Maternity Survey, Care Quality Commission, 2022.[45] Note, data is for England only.

FIGURE 5

If, during evenings, nights or weekends, you needed support or advice about feeding your baby, were you able to get this?



Source: Maternity Survey, Care Quality Commission, 2022.[45] Note, data is for England only.

This lack of support for mothers may be, at least in part, the result of inadequate investment in maternity and health visitor services, with large gaps in capacity and resource, particularly in England.[30] A survey by the iHV found that the number of health visitors in England has decreased by over a third (37%) between 2015 and 2022, with a shortfall of around 5000 health visitors reported.[42,47] Furthermore, while the other nations were able to deliver a relatively high continuity of care with consistent health visitors (88% in Scotland, 80% in Wales and 87% in Northern Ireland), in England just 3% of families had that continuity.[42]

31% of respondents reported to not have breastfeeding support during nights and weekends
Maternity Survey
CQC, 2022

A 2017 UNICEF survey of Infant Feeding Leads in England found that reduced capacity and resourcing was leaving health visiting services struggling to deliver visits, with 58% of respondents reporting cuts to the service.[48] 48% reported closures of children's centre services and 47% reported cuts to infant feeding support groups.[48] Across all nations the extent to which important breastfeeding support programmes reach mothers and babies living in poverty is often limited or unknown.

Sure Start Children's Centres and Family Hubs in England

In England, Sure Start Children's Centres used to provide a place for families to go to on a range of issues related to family health, parenting, money, training and employment, but these have been gradually closed over the last decade. This is despite evidence that they served as a vital 'one stop shop' for families with children under five, with benefits to child health.[55] In some locations, they have been replaced with a new Family Hubs programme which includes a £302 million three-year fund for 75 local authorities (with 14 local authorities acting as trailblazers), which would include, amongst other support, one-to-one support post-birth, and a virtual and face-to-face breastfeeding service, including peer support and lactation consultants.[56]

UNICEF'S BABY FRIENDLY INITIATIVE (BFI)

UNICEF's Baby Friendly Initiative (BFI) is a scheme which accredits various settings based on having staff that are trained to support infant breastfeeding, providing support to help mothers make informed decisions about breastfeeding, helping all parents develop close and loving relationships with their baby and ensuring all staff work within the International Code of Marketing of Breastmilk Substitutes. Eligible health service settings include hospitals, neonatal and community services and health visitor services, while there is also a separate accreditation for universities to help boost training. Accreditation is achieved in a tiered system, starting with basic accreditation and working up towards 'full' and then 'gold' accreditation. The goal across the UK is to achieve at least basic Baby Friendly accreditation across all maternity services. In England, the NHS Long Term Plan has recommended BFI accreditation for all maternity services, in Northern Ireland all babies are born in a Baby Friendly environment, in Scotland there is a requirement for all maternity services and 80% of community health partnerships to be Baby Friendly accredited, and similar targets have been set in Wales.[57,58] Across the UK, 41% of maternity services, 64% of health visiting services, 38% of university midwifery courses and 17% of university health visiting courses have gold or full Baby Friendly accreditation.[41] Distinct differences exist across the regions in the number of hospitals with full or gold accreditation, with England having the lowest at 27% and Scotland the highest at 94% (though England has a significantly higher number of overall facilities). More information available at: ***www.unicef.org.uk/babyfriendly***

	Number of facilities	Gold and full accreditation
England	620	27%
Wales	39	36%
Scotland	77	94%
N Ireland	29	69%
All UK	**765**	**36%**

Source: based on UNICEF accreditation data.[41]

LOCAL INITIATIVE: Breastfeeding support in Bradford

The Breastfeeding Support project was a universal intervention developed within the Better Start Bradford programme and delivered by Health for All. The primary offer of the project was a timely and personalised support service for breastfeeding mothers, with the goal of helping them to reach their breastfeeding goals. Women were offered the service in hospital or shortly after discharge to ensure access to feeding support as early as possible. Support was provided by qualified breastfeeding support workers, and was offered both in women's homes and via the telephone. Women could receive support from the project for the first six months of their baby's life, after which they were discharged.

Over the course of five years of delivery, the project supported over 1500 women in their breastfeeding journeys by providing practical support (such as advice on positioning, latching, and dealing with challenges like engorgement and pain), emotional support, and support materials including breast pumps. Of the women who were available for follow up, 53% were still breastfeeding. Women received the support offer early, often before they left hospital, and 98% of women were contacted with the support offer within 48 hours of referral. The in-depth qualitative evaluation showed key strengths of the project were that it was easily and quickly accessible for women, women had strong relationships with their support workers, both staff and women found home visits an important asset of the service, and there was great value in having a protected space for breastfeeding support (outside of statutory services like midwifery and health visiting). Recommendations from the evaluation included that the service be offered as early as possible, ideally in person; home visits should remain a part of the delivery despite the resource implications; and more antenatal work should be done to provide a better foundation for breastfeeding initiation rates.

Source: Based on an evaluation, carried out by Nielsen, D et al (2023)[82]

BREAKING DOWN THE BARRIERS TO BREASTFEEDING TO SUPPORT HEALTHY WEIGHT IN CHILDHOOD
BARRIERS TO BREASTFEEDING FOR MOTHERS WHO WANT TO

Support in the workplace

WHAT SHOULD BE IN PLACE: INTERNATIONAL AND UK STANDARDS ON INFANT FEEDING AT WORK

The International Labour Organisation (ILO) recommends entitlement to one or more breastfeeding breaks or the reduction of hours to breastfeed without loss of pay.

Guidance from Acas states that employers in the UK must provide somewhere for a breastfeeding employee to rest and women can ask their employer for a safe and healthy place to breastfeed or express milk, but there is no legal requirement for breaks at work for breastfeeding or expressing milk.[102]

Mothers returning to work or study in the UK should be able to continue breastfeeding if they want to, and while many do, sufficient support is not always available. Data from the IFS shows that the availability of breastfeeding facilities at work is associated with longer breastfeeding durations for women, and that babies born to mothers whose employer offers breastfeeding facilities experience significantly fewer sickness days in the first six months of life.[59]

Employers are legally required to provide a space for mothers who are breastfeeding to rest or lie down if they need to, and must meet obligations to breastfeeding employees under health and safety law, flexible working law and discrimination law. Mothers in the UK do not, however, have any legal entitlement to breastfeeding breaks at work despite the ILO's recommendations. Further guidance for employers is given by Acas, however this is not statutory and falls short of the support needed. Support for breastfeeding mothers who want or need to return to work is largely agreed to be inadequate, with the onus often being on the mother to initiate conversations about the support needed.[30] With any mothers returning to work earlier than intended and not taking the full year of entitlement as a result of the economic pressures (see more under 'Financial Considerations'), this is of particular concern.

Challenges faced by women on return to work include finding sufficient space to express, lack of paid time to express, and lack of appropriate storage space for expressed milk, amongst others.[30] For instance, a study of breastfeeding NHS doctors returning to work highlighted a number of challenges, with 55% being interrupted whilst expressing, 52% reporting embarrassment, and many reporting having inadequate facilities for breastfeeding resulting in using changing rooms (23%), toilets (32%), cars (25%) and cupboards (15%).[30,60]

This can all contribute to anxiety and humiliation and in turn contribute to mothers' decisions to depart from breastfeeding, either entirely or moving towards combination feeding.

> *"I had to stop breastfeeding. If I was to take an hour's lunch time instead of half an hour, they wanted me to make up the time at the end of the day. But then I had to pay an extended day's childcare fee. We couldn't afford to do that. I had no choice. It still makes me angry."*
>
> LIVED EXPERIENCE PANELLIST[30,61]

2 FINANCIAL CONSIDERATIONS

Breastfeeding and deprivation

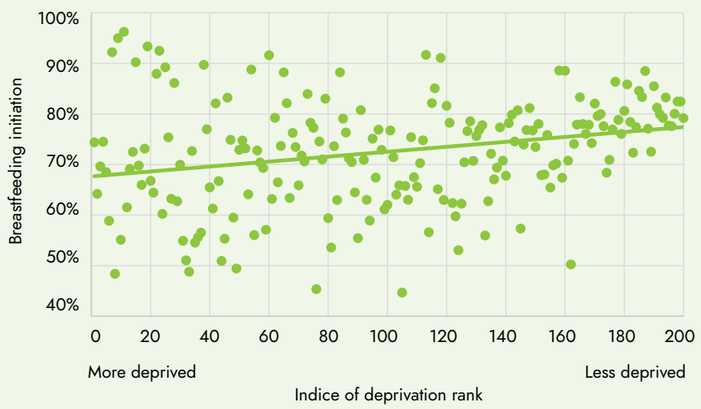
A number of socio-economic factors have been found to influence breastfeeding initiation and duration. For instance, the 2010 IFS found that breastfeeding was highest in mothers aged 30 and older, those who completed further education and those in managerial or professional roles. Mothers in routine or manual roles or those who have never worked are least likely to initiate breastfeeding and have a higher probability of stopping breastfeeding after a week.[26]

Deprivation is shown to have a significant impact on average breastfeeding initiation rates, with substantial differences in levels of exclusive breastfeeding in NHS Trusts between the most and least deprived areas of England. Mothers from NHS trusts in the most deprived quintile had breastfeeding initiation rates of 70.7%, compared to 80.1% in the NHS Trusts in the highest quintile areas (Figure 6).[62]

Breastfeeding patterns associated with deprivation are monitored in Scotland. As in England, the data show a sustained social gradient, with mothers from most deprived neighbourhoods significantly less likely to initiate breastfeeding and to be maintaining exclusive breastfeeding at six weeks compared with mothers from the least deprived neighbourhoods.[64] Very similar social gradients are also found in Northern Ireland for data that combine exclusive and partial breastfeeding rates.[65]

FIGURE 6

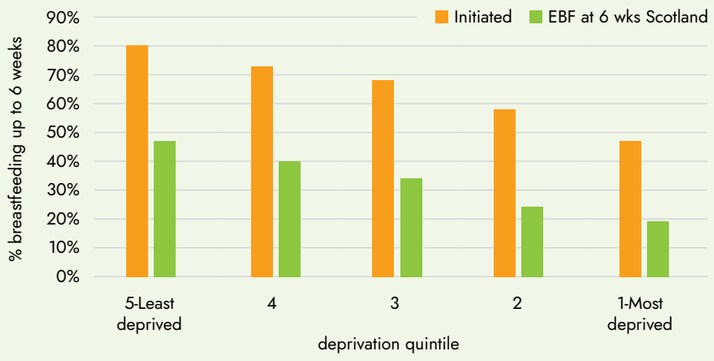
Breastfeeding initiation rates plotted against ranked index of deprivation for 205 NHS Trusts in England



Source: Based on analysis of NHS England, Statistical Release Breastfeeding Initiation, 2017; Department for Communities and Local Government, English Indices of Deprivation, 2015 [62,63]

FIGURE 7

Scotland: Exclusive breastfeeding up to six weeks according to deprivation quintile of the mother, 2021-2022



Source: Public Health Scotland, Infant Feeding Statistics, 2022[64]

Financial support during maternity leave

WHAT SHOULD BE IN PLACE: INTERNATIONAL STANDARDS ON MATERNITY PAY

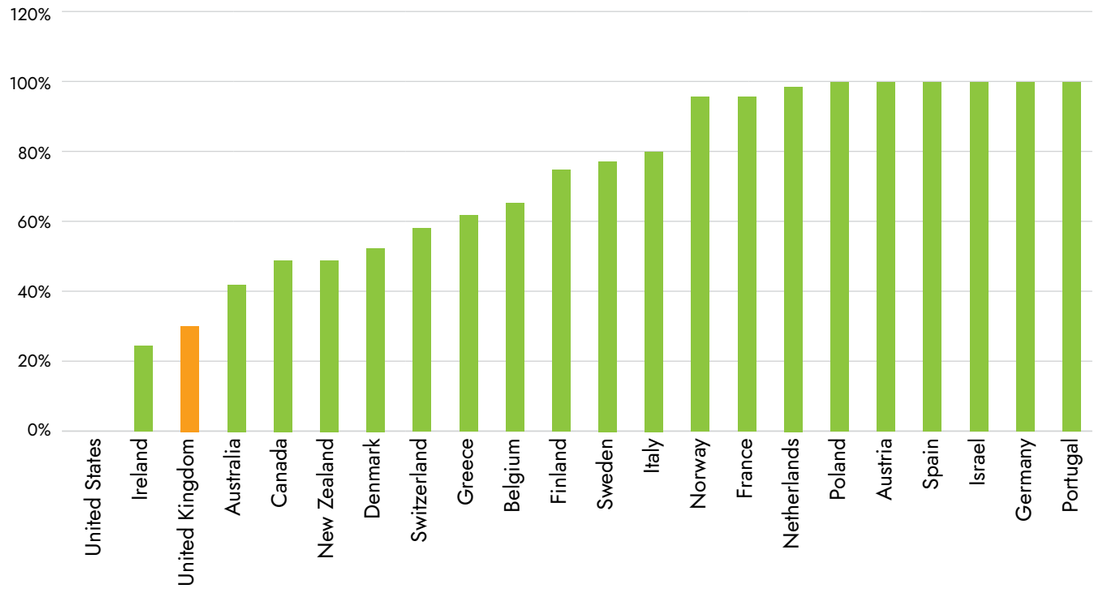
The International ILO standards for protecting and supporting breastfeeding among working mothers recommend:

- **A minimum of 14 weeks of paid maternity leave.**
- **Entitlement to one or more breastfeeding breaks or the reduction of hours to breastfeed without loss of pay.**
- **Job protection and non-discrimination for breastfeeding workers.**[11,106]

While UK employment rules require mothers to be given 52 weeks of maternity leave, statutory maternity pay falls short of the ILO standards, with 90% of a mother's average earnings provided for the first six weeks only followed by a *maximum* of £172.48 per week (in 2023) for the next 33 weeks, and nothing thereafter. The weekly maternity payment of £172.48 works out as approximately 47% of the national living wage, based on a 35 hour working week, and 37% of average weekly earnings for women.[67] Similar figures have also been reported by the OECD who have compared maternity provisions as a proportion of national average income, and number of weeks at full pay. In both cases the UK came out as one of the worst performing countries, with only Ireland and the USA performing worse in relation to national average earnings.[68] Many employers in the UK do provide additional maternity support, however this is not available to all mothers and disparities may exacerbate inequalities.

FIGURE 8

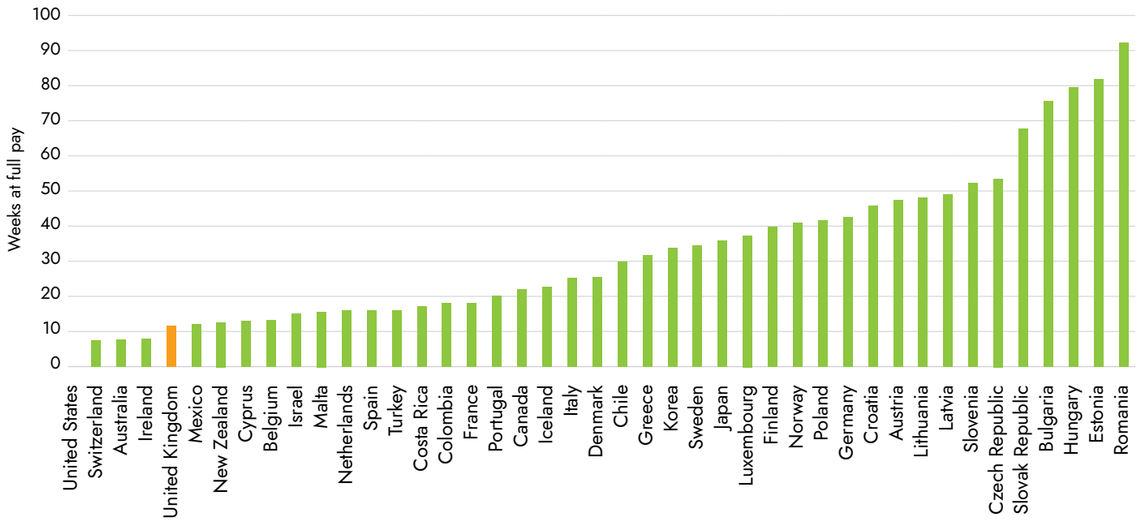
Average payment rate available to mothers during maternity leave, 2022



Source: OECD, Parental Leave Systems, 2022[68]

FIGURE 9

Equivalent number of weeks at full pay (national average wage) available in maternity leave, 2022



Source: OECD, Parental Leave Systems, 2022[68]

In addition to statutory maternity pay, low-income mothers and families are also provided with additional support through Healthy Start (Best Start in Scotland), maternity grants and baby boxes which vary across the four UK nations (see graphic). These are vital lifelines for low income families, however are still falling short of meeting the financial needs of many families.

ENGLAND

MATERNITY PAY

- 90% of the mother's average weekly earnings (before tax) for the first six weeks following birth[69]
- £172.48 or 90% of average weekly earnings (whichever is lower) for the following 33 weeks[69]

HEALTHY START at £8.50 per week or £34 per month for those with children aged under one, with 73% of eligible parents and carers on average accessing the scheme in December 2023[70]

SURE START MATERNITY GRANT – a one-off payment of £500 for parents on low incomes (to be claimed within 11 weeks of the baby's due date or within six months of the baby's birth)[71]

BABY BOX – Some local authorities in England offer baby box schemes but these can be externally funded and may have limited contents.[72]

Healthy Start and Best Start Scotland
Healthy Start (England, Wales and Northern Ireland) and Best Start (Scotland) are means-tested entitlements for pregnant women and children under the age of four (three for Best Start) designed to support feeding and family diets. They are also available to mothers under 18 years, regardless of income. These are delivered as a smartcard which can be used to purchase infant formula, cow's milk, pulses, eggs or fruit and vegetables.

NORTHERN IRELAND

MATERNITY PAY

- Statutory Maternity Pay (SMP) – 90% of mother's average weekly earnings (before tax); £156.66 or 90% of average weekly earnings (whichever is lower) for the following 33 weeks[73]
- Maternity Allowance (paid by the government rather than an employer):
  - £172.48 or 90% of the mother's weekly earnings (whichever is lower) or £172.48 for up to 39 weeks OR
  - between £27 and £172.48 a week for 39 weeks - how much you get increases with each Class 2 National Insurance contribution made or
  - £27 a week for up to 14 weeks[74]

HEALTHY START at £8.50 per week or £34 per month for those with children aged under one, with 59.7% of eligible parents and carers on average accessing the scheme in December 2023[70]

SURE START MATERNITY GRANT – means-tested entitlement for a one-off payment of £500 for parents on low incomes (to be claimed within 11 weeks of the baby's due date or within 6 months of the baby's birth)

BABY BOX – no information identified

SCOTLAND

MATERNITY PAY

- 90% of the mother's average weekly earnings (before tax) for the first six weeks following birth[69]
- £172.48 or 90% of average weekly earnings (whichever is lower) for the following 33 weeks[69]

BEST START FOODS SCHEME

Uptake of this scheme was 88% in 2021-22.[76] The amounts available on the prepaid card are as follows:

- £4.95 a week during pregnancy
- £9.90 for the first year of the child's life
- £4.95 a week when the child is between the ages of one and three years old[77]

BEST START GRANT – available any time following the end of the 24th week of pregnancy until the baby is six months old. The payment for the mother's first child is £707.25, which drops to £353.65 for any child that comes after the first[77]

BABY BOX – universal entitlement including a fitted mattress, sheet, bedding, towel, changing mat, nappies, baby clothes and other essentials including breastfeeding information[78]

WALES

MATERNITY PAY

- 90% of the mother's average weekly earnings (before tax) for the first six weeks following birth[69]
- £172.48 or 90% of average weekly earnings (whichever is lower) for the following 33 weeks[69]

HEALTHY START at £8.50 per week or £34 per month for those with children aged under one, with 77% of eligible parents and carers on average accessing the scheme in December 2023[70]

SURE START MATERNITY GRANT – means-tested entitlement for a one-off payment of £500 for parents on low incomes (to be claimed within 11 weeks of the baby's due date or within six months of the baby's birth)

BABY BOX – a universal entitlement providing essential items and guidance to help families in the first weeks and months of their new baby's life.[79] First deliveries are expected to go out in February and March 2024[80]

Impact of inadequate financial support during the maternity period

Research published by Maternity Action in 2023 showed an increase in the number of women experiencing financial challenges during maternity leave since 2022. 58% of survey respondents cut their maternity leave short for financial reasons (up from 42% in 2022), 71% worried 'a lot' about money (up from 64%). 49% were buying less healthy food and 71% said their partner had taken no leave, or less leave than they would have wanted to, for financial reasons. Respondents also said they had to go back to work and leave their baby well before they felt emotionally or physically ready to return because they could not afford to spend any length of time on the lower rate of statutory maternity pay or maternity allowance. Similarly, a survey of over 5,000 women carried out by 'Pregnant then Screwed' found that many mothers were cutting maternity leave short due to financial pressures with one in ten returning at four months and just one in four able to take full maternity leave.[81]

The weekly maternity payment of £172[48] works out as approximately 47% of the national living wage, based on a 35 hour working week, and 37% of average weekly earnings for women

This can in turn have an impact on mothers' ability and/or desire to breastfeed, even when they would ideally like to for longer. Mothers who returned to or started work for financial reasons were shown to be 14% less likely to breastfeed for at least four months.[62] They were more likely to breastfeed for at least four if they received Statutory Maternity Pay (SMP) plus additional pay during their maternity leave (rather than SMP alone). These findings were independent of confounding factors, such as socio-economic status and maternal education.[62]

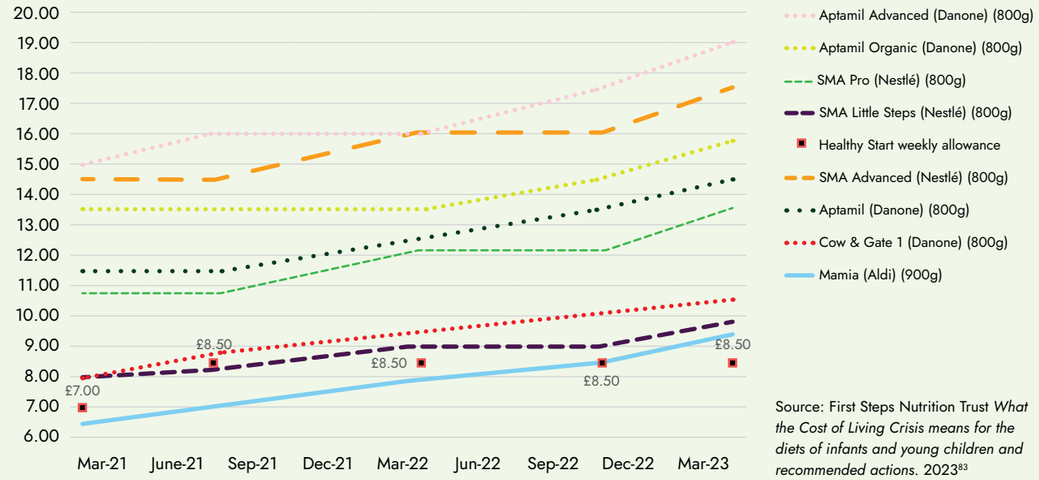
When financial pressures mean mothers have to return to work sooner than they would like to, especially if it is difficult to express while they're at work, they will often switch to formula feeding. This means that they then face the additional financial challenge of meeting formula costs, which can be significant – see box on 'Formula costs'. Furthermore, returning to work comes with additional financial pressure with the cost of childcare. A Maternity Action survey showed that 55% of mothers were very concerned about the impact of the cost of childcare on household finances.[67]

Ensuring families have sufficient financial support when they have a baby is crucial for them to safely pursue their infant feeding choices.

Formula costs

FIGURE 10

Unit cost of infant formula compared with Healthy Start Allowance



Source: First Steps Nutrition Trust *What the Cost of Living Crisis means for the diets of infants and young children and recommended actions.* 2023[83]

Formula prices have increased and created additional financial burdens for families. This is not only of concern for those families that have always used formula for feeding their infants, but for those who are forced to switch to formula on return to work due to insufficient support.

"The breastfeeding rates in the most deprived communities are at the lowest and therefore you've got this almost double disadvantage. I've had parents come to me saying, 'I can't get access to baby milk' and the local authority saying, 'we have no access to baby milk, we need it because they can't afford it'." MP.[30]

"I couldn't breastfeed, and after four weeks I had to go onto formula. Now we had an extra cost and formula is so expensive. Our budget just doesn't cover what we need. We know our baby needs this and we have no choice! She has to be fed. We are struggling and having to adjust what we need; we are not a priority anymore." Mum from Cornwall living with partner and their one child.[46]

Formula prices have risen steeply from an already high base during the cost of living crisis, with First Steps Nutrition Trust reporting that the seven formulas by leading suppliers Danone and Nestlé rose 24.6% between March 2021 and April 2023. One own-brand product, Mamia, rose by 45%.[83] The Competitions and Market Authority reported concerns about the pricing of branded infant formula increasing more than input costs, suggesting profiteering. Furthermore, First Steps Nutrition Trust has found that the feeding guideline volumes recommended by formula manufacturers is significantly higher than SACN recommendations.[107]

> *"I have weaned both the younger ones earlier just so we didn't have to afford all the milk."* [46]

Healthy Start value (£8.50 for a baby under 12 months) is significantly less than the cost of exclusively formula feeding a baby, with up to two tins a week needed to meet the requirements of exclusively formula fed infants.[30,75]

The cost of formula increases the risk that parents are forced to make difficult decisions about how they feed their child with some reports of mothers diluting powder too much or using products other than formula (e.g. cows milk).

Data provided by YouGov shows that 26% of mothers who used formula (exclusively or in combination with breastmilk) reported to have struggled to afford formula. To help feed their child, mothers reported to shop around for the cheapest product (23%), switch brands (12%), borrow money (10%), wean earlier than 6 months (10%) and skip meals for themselves (10%).[32]

3 SOCIAL ATTITUDES AND COMMERCIAL PRESSURES

Social attitudes and commercial pressures can contribute to decisions around breastfeeding and are likely to be contributing to the low breastfeeding rates. Data provided by YouGov showed that more support from friends and family (22%), more places to breastfeed (21%) and more positive social attitudes (19%) were all identified as important factors that would have helped them to exclusively breastfeed for longer.[32]

Social attitudes to breastfeeding

In the UK, breastfeeding is often viewed as being 'unusual' or even 'weird'.[30] This is not unique to the UK and is seen across OECD countries. For instance, mothers in OECD countries are often afraid of other people's reaction to them breastfeeding and members of the general public who witnessed breastfeeding in public have been found to have a poor understanding of normal infant feeding behaviour and the associated need to breastfeed in public spaces.[84]

> *"We're fighting against a culture in our society where breastfeeding is seen as non-desirable and weird by some groups. Other cultures within our multicultural society have much higher breastfeeding rates."* HEALTH [30]

Breastfeeding in public is protected in the UK by the Equality Act 2010, but these legal protections are often unknown to the people they are designed to support and are often under-enforced.[30,84,85] Scotland has stronger protections for breastfeeding mothers than the other UK nations through the Breastfeeding (Scotland) Act 2005, which makes it a criminal offence to prevent or stop someone breastfeeding a child under two years.[86] The absence of clean and safe breastfeeding spaces that mothers can use without having to pay can further contribute to the challenges of breastfeeding in public.

> *"It can be challenging in terms of cost of living, if you've got to go into a cafe to feed your baby, you've got to buy something. In the winter you can't breastfeed outside. I think that that can be a challenge."* LOCAL GOVERNMENT [30]

Mothers have been reported to often adhere to the breastfeeding practices of their family and base their decision of whether to breastfeed on what their own mother and grandmother did.[30] Similarly, negative messages from close family or partners can undermine breastfeeding decisions. According to the NCT a mother is more likely to choose to breastfeed if she's sure her partner is positive about it and if she does decide to breastfeed, she's much more likely to maintain breastfeeding, have a good experience and manage any difficulties if her partner supports her decision.[87]

> *"The culture about families is such a big issue. It's not unusual in the early days for women to say, 'I feel embarrassed breastfeeding in front of so and so' and then they move into their bedroom. That can be hard because they feel excluded."* HEALTH [30]

Infant feeding in the media

A media analysis of 65 articles in the UK media presented a complex and divisive picture of breastfeeding. On the one hand, breastfeeding was idealised and presented as magical and best for mother and baby, magnified by showing celebrities breastfeeding in a deified fashion. Conversely, it contributed to the narrative of shame around breastfeeding, referring to the country's low breastfeeding rates and mothers' experiences of feeling like a failure, being shamed in public and being stigmatised for using formula. Extensive celebrity coverage also portrayed the negative impacts on the physical body, sex drive and mental health. Predominantly, breastfeeding was covered in a negative light, with only 7% of the articles analysed presenting a positive picture of breastfeeding.

The media also rarely highlighted systemic barriers to breastfeeding, and the predominant narrative around formula feeding focused on the shame and guilt that mothers felt. Many articles reported that women felt like they needed permission from those around them to formula feed. In summer 2023, the articles began to refer to food insecurity and formula-feeding mothers. This included articles relating rising formula costs and parents stealing formula.[30]

Analysis undertaken by Bremner & Co and Impact on Urban Health[30]

Formula marketing in the UK

International Standards

In 1981 The International Code of Marketing of Breastmilk Substitutes[88] ('the Code') was adopted by the World Health Assembly (WHA), and has been subsequently refined and updated through numerous WHA resolutions which seek to clarify, refine and close loopholes. The Code places limitations on all forms of marketing of breastmilk substitutes to the public and to healthcare professionals, defined as all "product promotion, distribution, selling, advertising, product public relations, and information services." It also covers the provision of free samples, all forms of direct contact between company staff and pregnant women/parents, sponsorship of scientific meetings, and a wide range of other activities. It is expected that all governments introduce regulations to implement the Code in their domestic legislation in order to prevent commercial interests from damaging breastfeeding rates.[88] The Code has also been endorsed by the UN Committee on the Rights of the Child, who have confirmed that implementing the Code is required in order for states to fulfil their international human rights obligations under the UN Convention on the Rights of the Child, to which the UK is a signatory.[103]

WHAT SHOULD BE IN PLACE: CURRENT LAWS AND REGULATIONS IN THE UK

The UK's current legislation – The Infant Formula and Follow On Formula Regulations 2007 – dates from when the UK was a member of the EU, and was introduced to implement the European Commission Directive 2006/141/EC, which was intended to 'give effect to the principles and aims of the WHO Code'. For many years, the UK government claimed that it was not able to pursue full Code implementation in the UK because the requirements in this EU Directive were narrower than those of the Code.[104,105] Since leaving the EU, however, the UK Government has not acted to bring the UK's regulations fully in line with the Code.

'The Code' restricts the marketing of all foods for infants and young children and products that could replace breastfeeding – as well as bottles/teats and related equipment. The UK regulations, however, restrict the marketing of first infant formula to the public, but do not restrict marketing of follow-on formula (labelled for use 6-12 months) and growing up or toddler milks (labelled for 12 months+). Infant formula can be advertised to HCPs, providing the information is 'scientific and factual'. This allows them to legitimately carry out a wide range of marketing activities, including advertising to the general public, as long as these activities are restricted to the promotion of those breastmilk substitutes in their range which are not infant formula.[88]

89% of mothers with a 6-week-old infant reported seeing advertising for baby milk[26]

Formula companies can and do utilise gaps in the regulations to ensure that parents receive advertisements, promotions and recommendations for breastmilk substitutes through a wide range of routes.[89] Alongside traditional advertising on television, in print and on the radio, growing numbers of women are now also reporting seeing promotional content for breastmilk substitutes on social media, including through content from influencers (such as photos of formula products in influencer's 'hospital bags').[90] 17% of women have received a free sample of formula in hospital, and online baby clubs and advice helplines aimed at pregnant women which are directly operated by formula companies are also now widespread. Around a third to a half of women hear about formula products directly from a healthcare professional.[90,91] When a particular brand of formula is given to a baby in hospital at birth, brand loyalty is known to be strong, with parents often choosing to utilise the same products at home.[91]

Common marketing messages used in the UK include stating that particular products have advanced or scientific formulations, that they are convenient, and that they will support

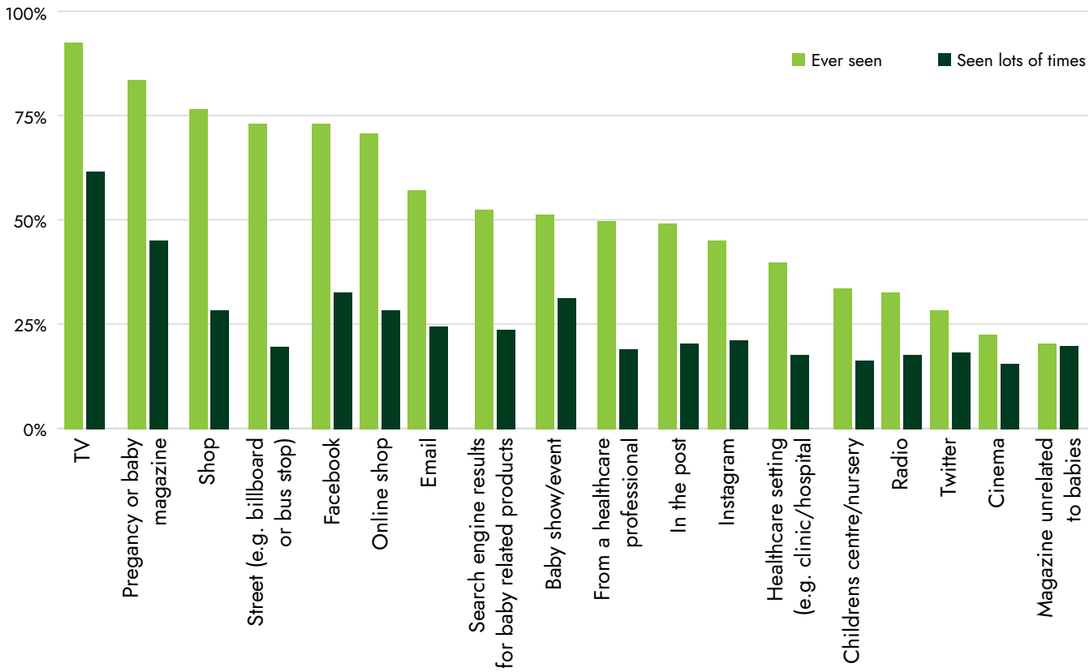
development and help with common infant problems such as unsettled behaviour, crying, constipation, reflex and colic.[90,91] Particularly impactful tactics used to push these messages include unifying branding across whole product ranges, maximising the use of new forms of digital marketing, and targeting healthcare professionals.

As a result, the vast majority of pregnant women and parents of young children will see or hear marketing for breastmilk substitutes. Figures from the Infant Feeding Survey in 2010 highlight that 89% of mothers with a six-week-old infant reported seeing advertising for baby milks on television, radio or in a magazine or newspaper.[66]

A more recent survey commissioned in 2022 by WHO and UNICEF found that 85% of pregnant women in the UK had reported seeing or hearing formula milk marketing in the preceding year.[90]

FIGURE 11

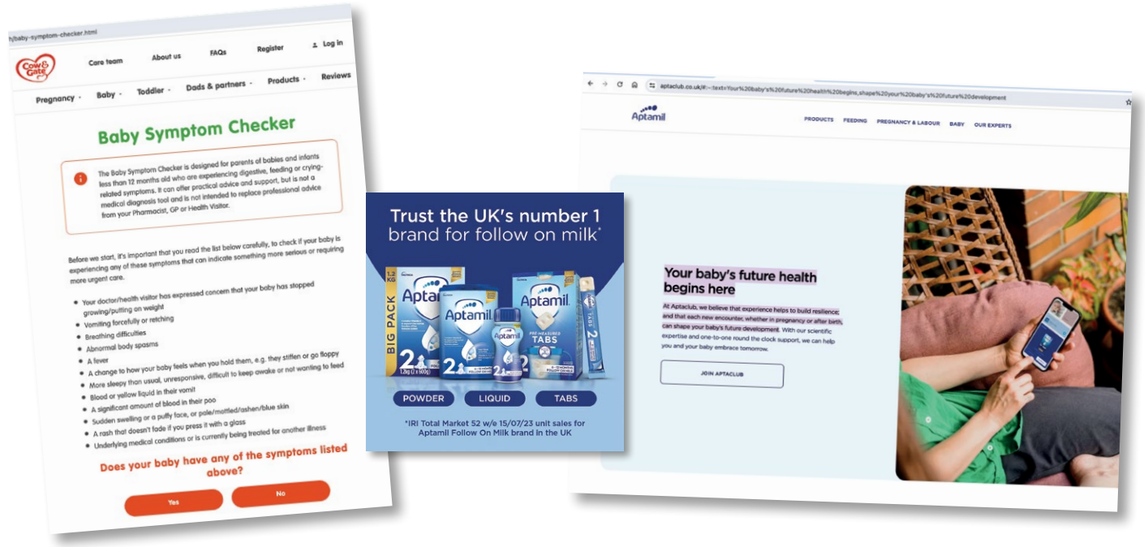
Proportion of mothers report seeing infant milk advertised across different media



Source: Brown A., Jones SW, Evans E. Marketing of infant milk in the UK: what do parents see and believe? London: First Steps Nutrition Trust. 2020[91]

> *"I think at the hospital, I got vouchers for [X brand] milk... and I have been given free [Y brand] bottles, the 200 ml sizes they do. I will try and breastfeed, do whatever I can to do that and if I can't, then I'll try some of these other samples...I think I [got them from] a baby show."* MOTHER FROM LONDON, UK[92]

Furthermore, there is no adequate or independent monitoring of compliance or enforcement mechanisms related to the regulations in the UK and there have been no prosecutions for practices that break the law in the last 13 years, even when both the responsible enforcement authorities (e.g. Trading Standards) and the companies involved acknowledge that the law has been broken.[93] This means women and families are insufficiently protected from the marketing which could in turn impact on the decisions made around infant feeding and breastfeeding.



Impact of formula marketing

Parents have a right to be able to access unbiased information about the benefits and risks of infant feeding options. However, marketing from formula companies risks undermining this by influencing social norms and presenting formula feeding in a positive light, creating a sense of equivalence between breastmilk and formula, and introducing negative ideas about breastfeeding.

The marketing of formula can influence breastfeeding in a number of ways:

1 **It normalises and encourages bottle feeding**. A substantial challenge presented by breastmilk substitute marketing is the gradual effect it has in normalising bottle feeding and in making breastfeeding seem a less attractive choice to mothers, as evidenced by the steady rise in global bottle-feeding rates – globally, just 48% of infants are now breastfed as recommended by the WHO.[94] Regular, ongoing exposure to positive imagery and messaging relating to bottle feeding can incrementally change cultural norms.[94] Marketing has been found to create an expectation amongst mothers that they will find breastfeeding challenging, whereas formula feeding is seen as straightforward and convenient.[95,96]

2 **It disrupts parents' ability to make informed decisions about infant feeding**. Formula companies have an inherent conflict of interest which prevents them from being able to impartially provide information to parents to inform infant feeding decisions. By sharing marketing materials with parents, companies undermine the right of parents to access unbiased, accurate information – through biases in the materials themselves and sheer volume. This can create confusion about the risks of formula feeding, undermining public health messaging about the benefits of breastfeeding. In addition, claims of extra nutritional benefits of certain formula products gives the impression that neither breast milk nor competing products are nutritionally adequate, despite the fact that all formulas are required to meet the nutritional needs of an infant.[95]

3 **It raises levels of concern about common infant behaviours in order to sell products**. Marketing encourages parents to self-diagnose unsettled behaviour, crying and common feeding behaviours such as constipation, reflex and colic, framing these issues as symptoms or problems. This sort of marketing increases parents' awareness and concern, and subtly spreads the unevidenced message that particular products can help mitigate these issues.[95,97–99]

Sales across the whole UK formula milk market grew by 9.1% between 2021 and 2022, despite the birth rate in the UK growing only by 1.7% in that time.[50]

Recommendations: What more needs to be done?

Women and families are subject to a range of barriers to breastfeeding, including insufficient support from the health system and from the workplace, financial challenges and social attitudes and commerical pressures. This has resulted in the UK having some of the lowest rates of exclusive breastfeeding globally, which in turn contributes to the high rates of childhood obesity faced by children. Addressing these barriers to enable women who want to breastfeed to do so could help increase breastfeeding rates and subsequently help achieve healthy weight in childhood. In order to address these barriers, there are a number of critical steps that the Government should take. These recommendations draw on the research presented in this report, including insights from citizens based on their own experiences of infant feeding.[46]

1 INVEST IN BREASTFEEDING SERVICES AND SUPPORT

We know that most women want to breastfeed, and investing in better services could make a real difference in enabling them to do so.

THE GOVERNMENT SHOULD:

- Dedicate a specific team in government to breastfeeding and integrate breastfeeding within the childhood obesity strategy, while also recognising that infant feeding is more than a health issue requiring cross-government support
- Increase financial support for local authorities to provide breastfeeding support services for all parents

- Increase investment in the training of health visitors and midwives to deliver effective breastfeeding support, and invest in more practitioners across the country
- Increase mandatory face-to-face contact between mothers and health visitors to eight appointments, with tailored follow up
- Introduce statutory guidance and requirements for workplaces to support breastfeeding mothers and families on their return to work
- Increase the number of gold BFI accredited facilities, including hospitals, health visitor and community services, as well as universities
- Strengthen laws on breastfeeding in public to protect women.

2 PROVIDE MORE FINANCIAL SUPPORT FOR NEW PARENTS

Ensuring that women and families can afford to take maternity leave and meet the extra costs of having a baby.

THE GOVERNMENT SHOULD:

- Increase maternity pay to align with the national minimum/living wage, to reduce financial pressures during maternity leave and ensure all mothers are able to afford a healthy diet for themselves and for their child (including formula where needed)
- Extend the Sure Start maternity grant to second and subsequent children, mirroring Scotland's Best Start Grant
- Extend the eligibility of Healthy Start to all families in receipt of Universal Credit, introduce auto-enrolment to ensure all those eligible benefit and increase the value of the vouchers in line with inflation. In the short term, families with a baby under six months should receive a further increase in value, increasing from £8.50 to £12.75, to bridge the gap between formula prices and the voucher value, and support breastfeeding mothers to access a healthy diet during the cost of living crisis.

3 ENHANCE PROTECTIONS AGAINST INAPPROPRIATE MARKETING OF BREASTMILK SUBSTITUTES

All parents have the right to decide how they feed their child, but this choice can be unduly influenced by inappropriate marketing of formula and misinformation about feeding practices which often undermine breastfeeding. This is particularly notable for follow-on, growing up and toddler milks which currently fall outside of the existing legislation. It is critical that parents are protected from misinformation about feeding.

THE GOVERNMENT SHOULD:

- Extend restrictions in law regarding the marketing of formula to follow-on, growing up and toddler milks to ensure that cross-product marketing does not mislead parents
- Implement stringent independent monitoring and enforcement of the law and give penalties where companies have been found to break the regulations.

Conclusion

This report has presented evidence about some of the factors undermining breastfeeding and the barriers preventing women to breastfeed as much or for as long as they would like. Breastfeeding is a critical intervention for supporting healthy weight during childhood. We are calling for the Government to ensure that policies related to promoting healthy weight in childhood take a life course approach, which includes supporting and protecting breastfeeding. This report outlines how better support and advice from the health system and from workplaces; more financial support for new parents, particularly those on a low income; shifts in social attitudes and better protection against commercial pressures could make a real difference in enabling women who want to breastfeed to do so. The Government has acknowledged the need to reduce "levels of childhood obesity. But unless the barriers to breastfeeding are tackled, the childhood obesity targets will remain out of reach.

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APPENDIX

OVERARCHING UK POLICES AND GUIDANCE DESIGNED TO SUPPORT BREASTFEEDING

Healthcare

- Health and Care Act 2022: provides the structure for joined-up working by making Integrated Care Systems (ICS) statutory bodies. Sets out legal duties for collaboration between local authorities/NHS.
- The Start for Life Programme: £50m funding for breastfeeding support in 75 local authorities between 2022 and 2025.
- Maternity Transformation Programme: aims to achieve the vision outlined in Better Births of a safer, more personal and kinder maternity service through local leadership and joined-up action across organisations, delivered by Local Maternity Systems (LMSs).
- Commissioning Guidance for Infant Feeding, 2016: co-produced by UNICEF and PHE, advises local commissioners on infant feeding services.
- Health matters: giving every child the best start in life, 2016: advises healthcare professionals and local authorities on services from pregnancy to two years.
- Best start in life: cost-effective commissioning, 2018: advises local commissioners on delivering cost-effective interventions from pregnancy to five years.
- NICE Postnatal Care guidelines, 2021: advises healthcare professionals on the postnatal care of mothers and infants in the first eight weeks after birth.
- Scientific Advisory Committee on Nutrition (SACN) report: feeding young children aged one to five years. SACN is the government's advisory panel and advises that breastfeeding should continue into the second year of life.

Spaces and workplaces

- The Equality Act 2010: prohibits discrimination against a breastfeeding woman.
- Workplace Regulations 1992: employers must offer rest facilities for breastfeeding mothers.
- Management of Health and Safety at Work Regulations 1999: employers must manage risks for women of childbearing age and breastfeeding women.
- Acas Accommodating breastfeeding employees in the workplace: signposted to by government.

Formula

- Infant formula and follow-on formula regulations (2007), updated in 2020 to reflect EU directive (EU delegated regulation 2016/127): prohibits advertising of infant formula (not follow-on formula) – no point-of- sale advertising or use of promotions (coupons/vouchers), no health or nutrition claims allowed on infant formula, labelling restrictions that distinguish between infant and follow-on formula.

Source: Bremner & Co and Impact on Urban Health, 2023[30]

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