Infant feeding impact review

Summary report

Methods, findings and recommendations
Acknowledgements

The methodology for this impact review has been highly participative. The authors would like to thank the NCT volunteers, members, practitioners, and paid staff – literally hundreds of individuals from across the UK – who over a period of 18 months took part in focused discussions, workshops and conference sessions that sought to identify NCT’s strengths for this area of work, and to develop priorities for future action.

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Executive summary

Aims

NCT’s Impact Committee, a Board of Trustees sub-committee, commissioned an impact review of NCT activity related to baby feeding in the period 2000–10. The aims were to:

1. Identify strengths and areas of achievement in relation to impact
2. Identify any long-running unresolved issues relating to impact
3. Make recommendations to guide future deployment of resources towards NCT’s goals in relation to supporting parents with feeding their babies.

The review coincided with the development of NCT’s 2020 Strategy. Findings of the impact review fed into the 2020 Strategy and informed the strategic priority to:

Enhance our baby feeding information and services, providing information focused on parents’ needs, and continue to lobby for better support for feeding, in partnership with other organisations.

NCT strengths

The following perceived key strengths were identified from the impact research:

1. NCT breastfeeding counsellors take a skilled person-centred approach to breastfeeding support
2. NCT provides a range of peer and mutual support opportunities (formal and informal)
3. NCT takes an evidence-based approach
4. NCT learns from the lived experiences of the parents it supports
5. NCT is an organisation for all mothers and fathers, and not just mothers who are breastfeeding
6. NCT is often influential in policy terms
7. NCT is reaching more parents through training peer supporters, increasing co-working with the NHS and other service providers, offering couples’ courses and discounts for parents on low incomes, having a helpline available for all concerns and parenting issues.

Unresolved issues addressed

The following key issues were identified and addressed through the impact research:

1. Some mothers who use formula milk feel under-supported and judged
2. Mothers who run into breastfeeding problems sometimes feel that they have been given unrealistic expectations in antenatal classes
3. Many mothers who might benefit from it do not access the available breastfeeding support.
Strategic priorities for action

The review identified three strategic priorities for action to improve feeding support for UK mothers:

1. There is a need to shift the focus from seeking to influence initial feeding decisions towards supporting mothers and fathers over many months throughout what we call their ‘feeding journeys’, enabling and protecting decisions to breastfeed as one aspect of ongoing support.

2. As it usually takes time and focused attention to get breastfeeding established, NCT should promote the idea that there is a necessary ‘adjustment and investment period’ during the early weeks after birth in order for breastfeeding to be established.

3. Models of support that are proactive and mother-centred should be developed. Proactive support must be genuinely mother-centred if it is to be acceptable.

Recommendations

NCT stakeholders made 11 recommendations to support implementation of the strategic priorities:

1. Review the language, tone and content of infant feeding information, and promote a discourse shift away from the idea of one-off, unconstrained ‘choices’ towards more of a focus on real, continuing experiences and perceived obstacles and pressures.

2. Structure services with minimal initial categorisation of mothers according to feeding behaviour, emphasising the need for mother-centred approaches.

3. Within a framework of integrated infant feeding support, provide expert breastfeeding support services and implement policies that make breastfeeding easier for mothers and more culturally acceptable. Ensure that the rationale for investing in protecting breastfeeding, in a context where most mothers stop breastfeeding before they plan to, is widely understood.

4. Within a framework of integrated feeding support, improve access to individualised support for formula use as and when mothers need it, minimising the need to rely on commercial sources of information.

5. Identify, appraise and develop the evidence to understand any impact of antenatal and perinatal breastfeeding education on maternal confidence and on preventing problems.

6. Improve signposting to high-quality information and skilled problem-solving support, especially in the early postnatal period.

7. Develop broad cultural awareness that, during the early weeks, new mothers who decide to breastfeed benefit from informal support from family and friends that enables them to focus on establishing feeding.

8. Increase capacity for infant feeding support in the community by developing well-integrated systems of supervised peer support and breastfeeding counselling, alongside access to health professional services. Use settings that are comfortable and convenient for new mothers and fathers. Enhance support from family and friends. Develop the evidence about how best to enhance support from family and friends.

9. Incorporate evidence for the importance of relationship-building into intervention design.

10. Re-affirm maternal experience and psychological well-being as key outcomes for feeding support interventions.

11. Develop the evidence base to support the effectiveness and acceptability of a range of proactive support models.

These were accepted by the Board of Trustees in December 2010 and taken forward as part of the NCT 2020 Strategy development.
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**Priority 2**  Promote the concept of an investment or adjustment period

**Priority 3**  Develop models of support that are mother-centred and proactive
Section 1: Aims and methods

1.1 Aims of the impact review

At its inception in 2010, NCT's Impact Committee, a sub-committee of NCT's Board of Trustees, commissioned an impact review of NCT activity related to baby feeding in the previous decade, 2000-10.

NCT is the UK’s largest charity for expectant and new parents, and has an advocacy role as well as providing support and information services. NCT's Baby Feeding Policy states:

NCT believes it is important for parents to have every opportunity for positive feeding experiences.

At the time of the review, NCT’s primary focus was on improving opportunities for positive experiences of feeding regardless of feeding method. However, NCT also recognised that there was good evidence that most UK mothers would like the opportunity to breastfeed for longer, and was aware that for some mothers breastfeeding was not currently a realistic option, mainly for cultural reasons and lack of adequate services. As a charity for parents, NCT focused primarily on supporting parents, rather than on experiences for babies. Philosophically, this was based on a normative assumption that overwhelmingly parents are motivated to do the best for their children, sometimes in difficult circumstances, and therefore, wherever possible, they seek to parent in a way that they feel is right for themselves and their families.

NCT’s Baby Feeding Policy set out its aim for parents to have positive feeding experiences. The policy stated that NCT’s work was underpinned by three core principles:

- support for all parents
- informed decision-making
- promotion of breastfeeding.
Support for all parents: The charity had a universal aspiration to work with all expectant parents and parents of a new baby, and to improve parents’ experiences of feeding regardless of geography, socio-economic background, family structure, pattern of service use or method of feeding.

Informed decision-making: NCT intended to provide independent, evidence-based, non-judgemental information to support decision-making.

Promotion of breastfeeding: NCT's advocacy role included working for services and a wider culture that are more supportive of breastfeeding, through better support for breastfeeding in hospitals, in community-based health services, in the workplace and in public places.

The aims of the impact review were to:

1. Identify strengths and areas of achievement in relation to impact
2. Identify any long-running unresolved issues relating to impact
3. Make recommendations to guide future deployment of resources towards NCT's goals in relation to supporting parents with feeding their babies.

1.2 Review methods and processes

The review incorporated a mix of methods in order to gather relevant data. The stages of the review process are set out in Figure 1.

Context mapping and identification of key issues: The authors mapped the wider context for NCT’s work via a non-systematic review of published literature on infant feeding in the UK over the decade 2000–10, in which important patterns and experiences relevant to NCT's infant feeding work were identified. The NCT activity context over the same time period was mapped via interviews with key internal stakeholders, collation of published and unpublished NCT materials and evidence (research reports, client feedback surveys, policy documents, monitoring data, research and evaluation evidence and lobbying materials, and findings of prior consultations with internal and external stakeholders). Unresolved problems in relation to NCT’s infant feeding goal were identified from the context mapping stage.

Scoping the issues: Key issues, identified through context mapping, were explored in detail through a focus group and a workshop at the 2010 annual NCT conference, and through an e-group consultation with NCT breastfeeding counsellors. The purpose of this stage was to scope and refine the research team's understanding of key long-running unresolved obstacles to NCT achieving its stated goals, to
gather a broad range of perceptions about the causes and consequences of obstacles, and for stakeholders to begin to identify and explore a wide range of possible solutions.

- **Workshop with members and volunteers at 2010 annual conference:** Thirty-five NCT members and volunteers participated in this conference workshop, which explored aspects of NCT’s role in providing infant feeding support. The group activities were prefaced by a short presentation setting out the aims of the impact review and highlighting long-running issues identified from the literature review, from the mapping of NCT activity and from NCT feedback survey responses (see Appendix A).

- **Focus group with mothers at 2010 annual conference:** Attendees at NCT’s 2010 annual conference who had had a baby in the last three years were invited to sign up for the focus group. Participants were informed that the purpose of the focus group was to better understand some of the issues that had begun to emerge from the review. Drawing on their own experiences as mothers and as NCT members and volunteers, participants were invited to explore what NCT does well, to identify any unmet needs, and to consider what NCT might do better or differently in future. Sixteen mothers participated. The group included women from England and Scotland. All participants were, or had been in the past, NCT volunteers as well as members. The focus group was held over a lunch-time session and lasted 45 minutes (see Appendix B).

- **E-discussion group with breastfeeding counsellors following 2010 annual conference:** A three-week facilitated focused e-discussion, open to NCT’s breastfeeding counsellors and breastfeeding counsellor students, was used to explore themes from the overview of the literature on parents’ experiences of feeding in the UK, feedback surveys, and the annual conference events described above. Breastfeeding counsellors and breastfeeding counsellor students were invited to join the research e-discussion group via two existing active Yahoo! discussion group forums (one for qualified counsellors and one for students) and also via an electronic newsletter. The group was joined by 111 participants, of whom 55 actively contributed to the discussion (i.e. posted responses). The final dataset comprised a total of eight conversation threads containing a total of 135 posts to the discussion group (see Appendix C).
Figure 1: Schematic representation of the research process

Mapping the context

Overview of literature on key issues

Overview of NCT goals, principles and services, and feedback on services

Scoping the issues

Three key issues identified

Focus group at 2010 NCT conference with 16 NCT mothers of children < 3 yrs.

Workshop at 2010 NCT conference with 35 members and volunteers

Resolving dilemmas

Identifying priorities

E-discussion joined by 111 breastfeeding counsellors and students

Preliminary work by the research team

Workshop with 40 stakeholders at NCT’s Strategy Development Forum

Follow-up work by the research team

Dissemination and implementation

Priorities identified and described by research team

Dissemination to internal stakeholders

Integration with strategy and implementation actions

Publication of findings
Resolving dilemmas and identifying priorities: A business management theory, theory of constraints (TOC) developed by Goldratt and Cox, was used for analysis of three key issues that were identified. This methodology has been developed as part of a framework for improving business systems, by identifying root causes of long-running unresolved problems. TOC makes a key assumption that negative effects will persist where there are unexplored competing points of view that continually undermine the system as a whole. Goldratt’s contention was that problems could be resolved by undertaking a specific series of analytic steps. These include refocusing on the system’s ‘goal’, identifying constraints to achieving that goal, and applying logical thinking tools to resolve system constraints. A detailed description of the analytical steps undertaken using TOC as part of this review process has been published elsewhere. The brief description of the steps included here is taken from that publication.

Stages of the analysis include refocusing on the system’s ‘goal’ (in this case ‘positive experiences of feeding’), identifying constraints to achieving that goal (these were identified by the authors from the context mapping and scoping stages), and applying logical thinking tools to resolve system constraints.

The authors used competing perspectives to construct draft conflict resolution diagrams (CRDs). A CRD template is presented in Figure 2. On the far left of the diagram is the ‘objective’ or ‘common purpose’. The objective describes a situation that eliminates the core problem being addressed, while avoiding creating a different set of problems, and is worded to describe the best possible end result. Achieving the objective usually means satisfying more than one ‘underlying requirement’ (middle boxes), each of which is necessary but not sufficient alone to achieve the objective. (Thus, in this case, on the one hand mothers using formula milk are not pressured or judged (requirement #1) and on the other neither are mothers who are breastfeeding (requirement #2).

Figure 2: Conflict resolution diagram

Source: Dettmer
In reality there will be many requirements underlying any given objective, but the purpose of the CRD is to identify those that are impacted by an identified underlying conflict. Requirements (middle boxes) do not themselves tend to be in conflict with one another; however, they are assumed to be driven by ‘prerequisites’ – actions or conditions that are assumed to be necessary to meet the requirements (right-hand boxes) – and this is the level at which conflict is usually expressed (as in Figure 3, with a conflict between prerequisite #1 ‘promoting choice’ and prerequisite #2 ‘promoting breastfeeding’). The model requires that the most opposed versions of possible prerequisites be included in the CRD, so that conflicts are immediately apparent. The zigzag arrow between the prerequisite boxes represents the underlying conflict itself.

The CRD diagram is verbalised by reading from left to right. In order for the **objective** to be achieved **requirement #1** must be satisfied, and in order for that to be achieved **prerequisite #1** is necessary. However, in order for the **objective** to be achieved **requirement #2** must also be satisfied, and in order for that to be achieved **prerequisite #2**, which **conflicts** with **prerequisite #1**, is necessary.

Conflict resolution is then achieved through identifying and challenging the validity of assumptions (represented by the arrows between the boxes), with the aim of invalidating one or more opposing or competing positions. Dettmer suggests that invalid assumptions are most likely to be found between ‘prerequisites’ and ‘requirements’, though insight can also come from challenging assumptions underlying other parts of the CRD. The intended outcome of the CRD thinking tool is deeper understanding of conflicts and assumptions that exist in the system, so that this understanding can be used to develop new possible actions – or ‘injections’ in TOC terminology – to help resolve the dilemmas.

Draft CRDs were initially constructed by the authors and were presented at a workshop for 40 participants attending NCT’s Strategy Development Forum in January 2011. Participants included key representatives from the charity’s trustees, staff, breastfeeding counsellors, antenatal teachers, postnatal leaders and volunteers. TOC conflict resolution methodology was explained to participants, who worked in groups to explore the conflicts illustrated. Participants verbalised the dilemmas and recorded the underlying assumptions that they identified in different areas of the diagrams. Participants then intuitively evaluated these assumptions using their own expert or lay understanding of feeding support, and began to generate possible actions or ‘injections’.

Using the outputs from the Strategy Development Forum workshop, the authors refined, rejected or combined draft versions of the CRDs. This process resulted in three final CRD diagrams. The authors then drew on the work of Strategy Development Forum participants to create an ‘assumptions table’ for each CRD, in which they categorised the identified assumptions relating to different parts of the diagrams as ‘valid’, ‘invalid’, ‘some validity’ or ‘lacking evidence’.
This step-by-step process of appraising the identified assumptions enabled logical thinking and the further development of options for action (‘injections’) which incorporated ‘valid’ assumptions and rejected ‘invalid’ assumptions. Competing positions, assumptions and injections were also considered by the authors with respect to the wider research literature. The process did not include a systematic review of the evidence in relation to any of the problems as a formal part of the methodology. Such a review is not a standard step in this method, which, instead, prioritises practice-based knowledge and the experience of participants engaged directly in the system under consideration.

As a final step, the authors identified a ‘priority for action’ for each problem, which incorporated and summarised the ‘injections’ that had been identified by participants during the assumptions analysis for that problem. Priorities were then formally integrated into the charity’s broader strategy development work.

**Dissemination and implementation:** A cross-departmental implementation group was set up and tasked with taking forward initial priorities and ensuring integration with wider NCT strategy developments. Findings were disseminated to NCT members, volunteers and practitioners via a series of workshops and conference presentations in the UK in 2012. The research process and identified priorities were also published in a journal article. The review coincided with the development of NCT’s 2020 Strategy. Findings of the impact review fed into the 2020 Strategy and informed the strategic priority to:

Enhance our baby feeding information and services, providing information focused on parents’ needs, and continue to lobby for better support for feeding, in partnership with other organisations.
Section 2: Infant feeding in a UK context

This section provides a summary of key issues relating to the context in which women and their partners fed their babies in the period 2000-2010.

2.1 Infant feeding policy

At the start of the 21st century, growing evidence of poorer health outcomes associated with formula feeding compared to breastfeeding\(^8,9,10\) led the World Health Organization (WHO) to develop a Global Strategy for Infant and Young Child Feeding with the aim of refocusing attention on the impact that feeding practices have on infant nutrition and health.\(^11\) This strategy was underpinned by a recommendation that babies be exclusively breastfed until they are aged around six months, with continued breastfeeding recommended until children are aged ‘two years and beyond’.\(^12\) In developing countries, water contamination, low immunisation rates and malnutrition mean that the consequences of not breastfeeding are often fatal. In the developed world, where children are better protected against disease, and money and facilities more often available to enable mothers to make up artificial feeds according to manufacturers’ instructions, the central public health concern is about short and longer term morbidity for babies and their mothers.\(^8,13\) The global strategy was intended to galvanise governments to develop and implement comprehensive policies on infant and young child feeding, and to consider how progressive infant feeding policies might be integrated with their policies on nutrition, child and reproductive health, and poverty reduction.

By the year 2000, breastfeeding rates in the UK were low by international standards.\(^14\) Furthermore, feeding with formula milk from birth had become the norm in many low-income communities, with poorer parents who had been themselves formula-fed least likely to decide to breastfeed their own babies; a pattern that has been described as contributing to a ‘cycle of nutritional deprivation’.\(^15,16\) In the early 2000s international evidence suggested that a goal of increased breastfeeding prevalence in countries such as the UK was a realistic ambition; the experience of Scandinavia and Hungary\(^17\) and of New Zealand\(^18\) demonstrated that in the right circumstances an increasing number of mothers can be encouraged and enabled to breastfeed, even in countries where formula milk is affordable, available and can be made up relatively safely.

In response to the WHO Global Strategy, national strategies were developed in Northern Ireland,\(^19\) Scotland\(^20\) and Wales,\(^21\) and in most English regions. Policy co-ordinators were appointed in each of the four countries. Over the next 10 years, key policy developments implemented across the UK included promotion of the UNICEF Baby Friendly Hospital and Baby Friendly Community awards which are designed to improve standards through protocols, training and information in health facilities,\(^22\) adoption of standards in NICE guidance consistent with the Baby Friendly minimum standards.
standards,\textsuperscript{23} funding for community-based breastfeeding peer support\textsuperscript{24} and strengthened legislation around women’s right to breastfeed in public places through the Scottish Parliament’s Breastfeeding (Scotland) Act\textsuperscript{25} and the Equality Act\textsuperscript{26} in England and Wales. However, neither the EU nor the UK governments of the day adopted the WHO International Code of Marketing of Breast Milk Substitutes in its entirety when it was revised during the late 2000s,\textsuperscript{27,28} and, although promotion of formula milk through the UK NHS is prohibited and advertising formula milk intended for babies under six months to mothers is illegal, advertising to health professionals – for example in professional magazines – is permitted and mass marketing of formula milk designed for babies over six months old is legal.

At the same time, there was an increase in available evidence about interventions to improve maternal and infant nutrition,\textsuperscript{29,30,31,32,33} about supporting breastfeeding as part of routine postnatal care\textsuperscript{23} and about improving the nutrition of pregnant and breastfeeding mothers and children in low-income households.\textsuperscript{34}

2.2 Infant feeding patterns

Since 1975, UK governments have commissioned an Infant Feeding Survey (IFS) conducted every five years. Recent surveys have been longitudinal, gathering data from a sample of mothers in separate waves of data collection over the first 8–10 months of their baby’s life. The surveys gather data on the incidence of breastfeeding, formula feeding and feeding with solid foods, as well as a range of information relating to mothers’ experiences of feeding their babies. The data enable cross-sectional comparison between groups of babies according to age, geography and socio-economic characteristics; allow follow-up of cohorts of babies over time, with mothers reporting information relating to intermediate time-points in between the three waves of collection; and permit comparisons between standardised samples of parents at five-year intervals. In 2007 a full analysis of the 2005 infant feeding data was published\textsuperscript{35,2} and data relating to initiation of breastfeeding in 2010 (from the first wave of data collection) was published in 2011.\textsuperscript{36} Routine data collated in the UK by health authorities and health boards provide more frequently reported and geographically specific information relating to incidence and the early weeks, but these data may be collected at different times or to use varying definitions of breastfeeding (any or exclusive) that make direct comparisons difficult.

Formula feeding, either exclusively or in combination with breastfeeding, continued to be the way that most UK mothers fed their babies beyond the early days. Underlying this broad picture, feeding patterns were highly polarised with respect to age, education and employment status, as well as by geographical location. Nevertheless, increases in breastfeeding initiation rates were seen for all social groups.

- **More mothers were initiating breastfeeding:** Breastfeeding initiation rates had increased since 2000. In 2010 average UK initiation rates were at 80%, compared with 76% in 2005 and 69% in 2000.
By international standards these rates are still low; for example, in Norway breastfeeding initiation rates have been at 99% for some years.

- **Mothers who breastfed tended to do so for a short time:** Although breastfeeding prevalence rates increased at all ages for which data were collected, a very steep downward curve in breastfeeding continuation rates in the early weeks persists. In 2005, by two weeks just over half (52%) of UK mothers were still breastfeeding, 28% were breastfeeding at four months and only a quarter (25%) at six months. International comparison indicates that these very steeply declining continuation rate curves are not a universal feature of data collected in the developed world. In the review period, substantially higher continuation rates are found in Scandinavia, where around 80% of Norwegian mothers and 68% of Swedish mothers are breastfeeding at six months. Continuation rates in Canada, Australia and Hungary were lower than this, but nonetheless survey data indicated that ‘any breastfeeding’ rates at six months in these countries were more than double those of the UK over the review period.

- **Most mothers breastfed and used formula milk:** Categorising UK mothers as either ‘breastfeeding mothers’ or ‘formula feeding mothers’ is problematic as most babies receive breast milk and formula milk, and mothers do not feed each of their babies in the same way. In 2005, 92% of babies received some formula milk by the time they were six months old. Mixed feeding was common over the review period: in 2005 one in four babies aged between 4–10 weeks were given formula milk at a time when they were still getting some breast milk, about a third of women who were mixed feeding in the early weeks had introduced just one or two formula feeds a day. Mixed feeding is associated with breastfeeding problems, though the direction of causality is unclear and may be two-way; mixed feeding is often unplanned.

- **Long-term exclusive breastfeeding had not become usual:** The WHO recommendations relate to exclusive breastfeeding (i.e. no supplementary formula milk or solid foods). In 2005, only one in five mothers exclusively breastfed their babies beyond six weeks, and only a tiny proportion of UK mothers breastfed their babies exclusively for six months (about 2%); the proportion who could be said to do this and then continue to breastfeed alongside introduction of solids for ‘up to two years and beyond’, in line with WHO advice, is vanishingly small. In 2005, the rates of exclusive breastfeeding were lower for Welsh mothers than for English mothers.

- **Overwhelmingly mothers stopped breastfeeding before they had intended:** Women’s experience of breastfeeding is not always straightforward; in 2005 around a third reported problems. In 2005, nine out of 10 mothers who stopped in the first two weeks after their baby was born (the period when drop-off is steepest) stopped before they had planned – equivalent to around 200,000 women. This percentage had improved slightly by the 2010 survey, but even so eight out of 10 mothers who stopped breastfeeding in the first six weeks stopped before they planned. In 2005, the most common
reasons given by mothers for stopping breastfeeding were ‘insufficient milk’, ‘baby rejected breast’, ‘painful breasts/nipples’, and ‘took too long/ tiring’. These reasons are particularly important in the first week – the period during which decline in the breastfeeding rate is steepest – and suggest that many mothers are unsuccessful in ever establishing a breastfeeding relationship with their babies. The 2005 survey indicated that returning to work or college became increasingly important as a reason for stopping breastfeeding among mothers who stopped after their babies were six weeks old. In all, more than three-quarters of all mothers who stopped breastfeeding in the first nine months stopped before they had planned.

- **Mothers using formula milk also experienced feeding problems:** In 2005, a third of mothers who formula-fed initially reported experiencing problems with their baby not feeding enough or not being ‘interested’ in feeding. Compared to mothers who continued to breastfeed (exclusively or within the context of mixed feeding) these mothers were more likely to report problems with colic, with vomiting or reflux, and also with their baby being unwell.

- **Parents were introducing their babies to solid foods later:** Between 2000 and 2005, the advice about introducing solids changed. Previously the guidance had been to wait until at least four months, but parents were now advised to delay until around six months. The change was based on WHO work to determine an optimum duration for exclusive breastfeeding, but in the UK these findings were translated into guidance for ‘milk feeding’. UK Department of Health (DH) information, developed with support from the Health Promotion Agency for Northern Ireland, and promoted by the Welsh Government, states that ‘until six months, your baby needs only breast milk or infant formula milk. Around six months your baby needs more than milk alone and is able to eat solid foods in addition to breast or formula milk’. Similarly NHS Scotland advises that: ‘Until six months, breast or formula milk provides all the nourishment that babies need.’ In 2005 an overwhelming majority of mothers were still introducing solid foods before six months, since then the change in guidance has had a discernible impact on the way mothers feed their babies before six months. In 2000, 85% of mothers had introduced solid foods by four months; by 2005 this figure had reduced to 51%. However, the low breastfeeding rates at six months in 2005 indicated that this aggregate delay had been largely achieved by mothers continuing to formula feed without introducing solids. In fact, no health benefits of exclusive formula feeding compared to introduction of solid foods have been identified by epidemiological studies, so the health gains from this shift in behaviour are unconfirmed.

- **There was a persistent social gradient on feeding behaviours:** Mothers who were older, from higher socio-economic groups or with more education had higher breastfeeding initiation rates, longer durations of breastfeeding and were more likely to delay introduction of formula milk and/or solid foods. In 2005 the prevalence of breastfeeding at six weeks was 65% for mothers from managerial and professional occupations, compared to 32% among mothers from routine and manual
occupations. Young mothers (under 20) were much more likely to stop breastfeeding early than other mothers, with only 34% per cent breastfeeding at all at one week compared to a 52% initiation rate.

- **Infant feeding behaviours were geographically patterned:** breastfeeding is less common in Northern Ireland, Wales and Scotland compared to England. In 2005 initiation rates were 63% in Northern Ireland, 67% in Wales, 70% in Scotland and 78% in England. Solid foods tended to be introduced to babies at a younger age by parents in Wales and Scotland. The Infant Feeding Survey is limited in the level of geographical resolution to which results can be applied. At an increased level of resolution, research based on routine initiation data indicated that breastfeeding rates were strongly negatively associated with area-based indices of deprivation.47

### 2.3 Infant feeding experiences

An overview of the literature on parents’ experiences of feeding in the UK revealed recurrent themes, including feeling pressured over feeding decisions, problems associated with the experience of using formula milk, factors contributing to positive and negative experiences of support and the impact of a dominant public health discourse.

**Pressure over decisions:** It is common for British mothers to feel pressured by others over their feeding decisions. This is true whether they breastfeed48,49,50 or use formula milk.51 Despite the fact that most babies receive breast milk and formula milk,2 qualitative research into women’s experiences of feeding suggests that mothers frequently feel the need to carry out significant ‘identity work’ via a process of justifying their feeding decisions to others. This seems to be especially true when a mother takes a feeding path which is divergent either from a path prescribed by health professionals – for example when using formula milk52 – or divergent from community social norms – for example, when ‘long-term’ breastfeeding.53 The relationship between feeding decisions and maternal self-concept appears to become more important as time passes, so that whereas decisions to initiate breastfeeding may be based on an understanding of health benefits, qualitative research suggests that decisions about how long to continue are often linked to mothers’ sense of maternal identity.54

**Using formula milk:** NICE routine postnatal care guidance recommends that women who are giving their babies formula feeds are shown ‘how to make feeds using correct, measured quantities of formula, as based on the manufacturer’s instructions, and how to clean and sterilise feeding bottles and teats and store formula milk’;23 however, there is evidence that mothers using formula milk have been vulnerable to having their needs sidelined in a policy context in which the focus has been on interventions intended to enable more mothers to breastfeed. A systematic review of studies that included mothers who were using formula milk51 found that they often reported receiving little information to help them carry out their feeding decisions in practice. The findings raised concerns that many parents might not have been getting the
support they needed to make up feeds safely or have had a good understanding of how frequently or how much their babies should be fed. Given that mothers who formula feed tend to be younger and poorer it can be argued that a focus on supporting decisions to breastfeed is inequitable.

**Positive and negative experiences of support:** Insight into what constitutes a positive experience of support is provided by a metasynthesis of women’s perceptions of help from ‘created’ peers (breastfeeding counsellors, breastfeeding peer supporters) and from professional health workers. This work sought to identify the aspects of care that mothers deemed supportive. The review of the literature indicated that experiences of direct support for breastfeeding occur along a continuum from ‘authentic presence’ at one end (perceived as effective support) to ‘disconnected encounters’ at the other (ineffective). An authentic presence ‘reflects a trusting relationship or connectedness and rapport between the woman and her caregiver, supporter, or both’ whereas a ‘disconnected encounter’ is ‘characterised by limited or no relationship and a lack of rapport’. The authors distinguish between different styles of support, with a ‘facilitative style’ (one that enables people to draw on a range of information and experience and learn for themselves) perceived as effective, and a ‘reductionist approach’ (‘oversimplifying’ and providing information and advice in a ‘dogmatic or didactic style’) perceived as ineffective. Findings suggest that taking a ‘person-centred’ approach to support means that the support is likely to be experienced as positive. The importance of a trusting personal relationship between mother and supporter is highlighted. The authors believe that their findings are relevant both to the skills and training of professionals and others providing support, and also to the design of systems and services. For example, they argue that continuity of care is likely to be more effective in delivering authentic and facilitative support than a series of poorly integrated encounters with professionals and other supporters.

**The dominance and impact of a public health discourse:** Highly polarised debate, in the print and social media, centres on the extent to which public health policy, and the framing of breastfeeding as a public health issue, is, itself, the primary cause of mothers’ feelings of pressure and guilt. Lee argues that parents’ experiences and interpretations of their feeding journeys and decisions are strongly framed within a ‘paradigm of health and health care’, underpinned by health policy and practice, and that one consequence of the professional validation of the health advantages of breastfeeding over formula feeding has been to leave mothers who use formula milk increasingly open to internal and external moral judgements, so that they may ‘struggle hard to maintain a positive sense of themselves as mothers.’ UK parents do have high levels of awareness of the health benefits associated with breastfeeding. The 2005 Infant Feeding Survey data indicated that 84% of women were aware of health advantages, and of these 80% were able to name a specific health benefit; while 88% recalled receiving advice about health benefits in pregnancy. Mothers who breastfeed sometimes use this understanding of health benefits to justify their decisions to others who view breastfeeding negatively; furthermore, they may ‘lack the language’ to describe other, perhaps personal and emotional, rewards of their decisions. In contrast,
research with women who breastfeed despite social norms indicates that their rationales tend to go beyond a narrow focus on ‘health’; in a research context these women may talk about *enjoying* breastfeeding for its own sake, and about the importance of breastfeeding to the developing relationship between themselves and their babies.\textsuperscript{59} These mothers also related a sense of pride and achievement at having breastfed.

### 2.4 Summary

During the period 2000–10, when NCT’s objectives for baby feeding included ‘support for all parents’, ‘informed decision-making’ and ‘promotion of breastfeeding’, infant feeding data show some notable changes. In particular more mothers were initiating breastfeeding and more were delaying introduction of solid foods. On the other hand, the persistent social gradient on feeding behaviours remained. Mothers who breastfed tended to do so for a short period of time, overwhelmingly stopping breastfeeding before they had intended, frequently in the early days and weeks. Women commonly experienced pressures over their feeding decisions whether they were bottle-feeding or breastfeeding; in particular, mothers who bottle-fed commonly felt judged and guilty for doing so. The evidence from the UK and elsewhere indicated that mothers preferred models of support that were person-centred and emphasised continuity of care.
Section 3: NCT and infant feeding support

This section provides an overview of NCT’s work on infant feeding during the impact review period, 2000–10. NCT practitioners work with individual mothers, couples and groups of parents to help them to develop the confidence and skills to breastfeed and to find solutions to any feeding problems that they experience. Through reflective practice, NCT practitioners continuously seek to resolve an apparent conflict between simultaneously supporting and respecting the decisions of parents who are not breastfeeding on the one hand and ‘promoting’ breastfeeding on the other. In line with NCT philosophy, NCT practitioners aim to take a person-centred approach to providing support for parents.60

NCT has a long history of working with UK national governments, UNICEF and WHO, as well as with other UK third-sector organisations – including La Leche League (LLL), Association of Breastfeeding Mothers (ABM) and Breastfeeding Network (BfN) – which aim to enable breastfeeding, in order to secure the conditions for more supported and informed experiences of feeding.

3.1 Breastfeeding counsellors

Breastfeeding counsellors facilitate most of the breastfeeding sessions offered as part of NCT antenatal courses and provide one-to-one support to parents, often by telephone and at drop-in sessions in the local community. In addition, breastfeeding counsellors also train health professionals and peer supporters, contribute to the development of local and national breastfeeding policies, and develop working relationships with health professionals locally. An NCT breastfeeding counsellor is a mother with experience of breastfeeding a baby who has undergone extensive (currently university diploma level) training to provide accurate information about feeding, and person-centred support, to other women. The role of a breastfeeding counsellor is not to increase rates of breastfeeding, but rather to ‘provide a service in which she offers information and support to enable parents to make informed decisions about feeding their baby and help them in carrying out those decisions’.61 NCT breastfeeding counsellors do not provide advice, but use the skills and knowledge that they develop through training to listen to mothers, to explore their concerns and to help them develop solutions to problems that are right for themselves and their families. They are specialised in providing information and support to enable mothers to breastfeed and they also assist parents in making broader decisions around mixed feeding and weaning from breastmilk to formula milk or solid foods. Breastfeeding counsellors are not medically qualified, but are trained to encourage parents to seek medical help as appropriate.

Over the period of the review the number of practising NCT breastfeeding counsellors remained stable at around 300 trained counsellors (319 in summer 2010). However, annual returns data collated between 2001
and 2009 indicated that work undertaken by breastfeeding counsellors (measured by number of contacts) increased by more than 50% over the decade covered by this impact review. The number of parents and professionals reached increased from 48,000 per year to 75,000 per year (Table 1). Allowing for annual fluctuations, the number of health professionals reached remained stable over this period at around 2,000 per year, while the number of direct contacts with parents went up. Annual returns figures are likely to underestimate the number of contacts due to recording and reporting issues.

### Table 1: Parents reached by breastfeeding counsellors, according to method of contact (2001–09)

<table>
<thead>
<tr>
<th>Type of support</th>
<th>2001</th>
<th>2002</th>
<th>2003</th>
<th>2004</th>
<th>2005</th>
<th>2006</th>
<th>2007</th>
<th>2008</th>
<th>2009</th>
</tr>
</thead>
<tbody>
<tr>
<td>NCT course</td>
<td>25,277</td>
<td>23,640</td>
<td>20,639</td>
<td>23,282</td>
<td>25,791</td>
<td>31,868</td>
<td>31,055</td>
<td>41,578</td>
<td></td>
</tr>
<tr>
<td>NCT drop-in</td>
<td>4,000</td>
<td>-</td>
<td>5,716</td>
<td>4,501</td>
<td>5,236</td>
<td>4,882</td>
<td>4,973</td>
<td>6,502</td>
<td></td>
</tr>
<tr>
<td>NHS Telephone calls</td>
<td>3,100</td>
<td>7,319</td>
<td>6,794</td>
<td>22,743</td>
<td>19,658</td>
<td>14,190</td>
<td>20,455</td>
<td>19,633</td>
<td>21,668</td>
</tr>
<tr>
<td>Breastfeeding Helpline</td>
<td>13,910</td>
<td>13,610</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>11,012</td>
<td>12,557</td>
<td>14,051</td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td>9,443</td>
<td>7,082</td>
<td>7,617</td>
<td>237</td>
<td>453</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td>Website panel</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>226</td>
<td>453</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td>Email</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td>6,627</td>
<td>6,501</td>
<td>8,025</td>
<td>8,905</td>
<td>9,053</td>
<td>6,880</td>
<td>6,398</td>
<td>5,404</td>
<td>5,919</td>
</tr>
<tr>
<td>Total</td>
<td>48,300</td>
<td>53,079</td>
<td>52,063</td>
<td>52,097</td>
<td>63,829</td>
<td>61,524</td>
<td>75,904</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Source: Annual Returns Reports 2001–09. Blank spaces indicate data is missing or not applicable. Proportions (of the total sample of parents reached through direct means) are in parentheses.

### 3.2 Antenatal education

Many parents have not experienced breastfeeding as a normal part of everyday life, so the prospect of breastfeeding may feel daunting and unfamiliar, and they may have absorbed myths and misconceptions. Breastfeeding counsellors run antenatal breastfeeding sessions that aim to make the decision to breastfeed a realistic possibility for more families – socially, culturally and physiologically – and to increase parents’ confidence, understanding and skills so that they are better prepared to start and maintain breastfeeding. The traditional model for NCT antenatal breastfeeding education is a single session as part of the NCT’s paid-for courses. However, over recent decades NCT has increasingly contracted with the NHS and children’s centres to offer courses and drop-in classes free at the point of delivery. Annual returns data indicate that the number of breastfeeding counsellor contacts made through antenatal classes increased from about 25,000 expectant parents in 2002 to around 41,500 in 2009. NCT has also brought in a reduced fee rate for parents on low incomes attending NCT’s paid-for courses.
By the end of the review period, NCT antenatal education was reaching about 10% of all UK first-time mothers. In 2009 antenatal classes accounted for 55% of all breastfeeding counsellor contacts with parents. Feedback from breastfeeding counsellors to this review suggests that there is variation in local arrangements, with some breastfeeding counsellors providing longer single sessions (from 2-3 hours upwards) as part of NCT antenatal courses, and others providing multiple sessions.

An NCT longitudinal study of parents who attended NCT paid-for antenatal classes, conducted during the review period, found that a very large majority of women who attended intended to exclusively breastfeed for the first three months (92%), whereas about 7% intended to mixed feed and only 1% intended to formula-feed, indicating that this self-selecting group of women were highly oriented towards breastfeeding. To be more oriented to breastfeeding than parents in the general population would be expected, as the women tended to be in the socio-demographic group most likely to breastfeed: i.e. aged over 30 and highly educated. In addition, they had booked a course with NCT, an organisation known for providing breastfeeding support. Follow-up at three months post birth indicated that two-thirds (67%) of those who had intended to breastfeed exclusively had done so for the first three months (with most of the remainder mixed feeding). The difference between feeding intentions and outcomes for this group suggests that these women experienced social, emotional and physical barriers, which may be less pronounced because of their motivation or sources of support, but are in some respects similar to those faced by other UK mothers. The nearest comparable general population figures for 2005 indicate that in the general population only 63% of all those who initiated breastfeeding at birth were breastfeeding at all (i.e. including mixed feeding) at six weeks, and that only 44% of these women were breastfeeding at all at four months.

### 3.3 Postnatal support

Postnatal breastfeeding counselling support has traditionally been reactive, in that the parent makes first contact with the breastfeeding counsellor. This reactive model is intended to protect the non-directive, ‘parent-centred’ aspect of the helping relationship between breastfeeding counsellors and those who seek help. However, over the review period, NCT increasingly worked with the NHS and children’s centres to provide more routine and visible community-based support, with the intention of improving accessibility to parents who had not previously had contact with NCT and reducing barriers to support-seeking. This change of approach was driven in part by NICE evidence which recommends proactive support for preventing and resolving breastfeeding problems, as well as by research findings which indicated that reactive breastfeeding counselling support is valued by those who use it but does not improve breastfeeding rates and durations in the general population. Recent annual returns data suggest that in 2009 about 16% of counsellors worked with the NHS or children’s centres in training peer supporters, either in a voluntary capacity or as paid workers. The corresponding proportions in 2008, 2007 and 2006 were 15%, 13% and 20%, respectively.
Many breastfeeding counsellors are well integrated into their local service environments. Examples of this kind of integration include involvement in developing local policies, building relationships with key NHS staff, attending hospital meetings, attending baby show events, being involved in local research, providing study days and providing undergraduate training.

“What is needed is to build trusting relationships with key staff, where problems can be fed back and discussed without blame and solutions can be found that lead to change. This can work both ways on, from NHS to NCT and vice versa.’

NCT breastfeeding counsellor

**Helpline:** During the review period telephone help with feeding was provided via the NCT Breastfeeding Line (now incorporated into the general NCT Helpline) as well as via direct calls to individual counsellors. The Breastfeeding Line was established in 2000 and operates throughout the UK, involving more than 150 breastfeeding counsellors who take calls about feeding on the line, with opening hours from 8am to 10pm, 365 days a year. An evaluation was carried out in May 2009 which found that the helpline was used and valued by women from a range of ethnic groups, but was less successful in reaching younger parents with less formal education. However, as demand exceeded the supply of available counsellors, increased capacity was needed before further promotion of the line.

**Face-to-face counselling support:** Face-to-face support from NCT breastfeeding counsellors is free at the point of access, and may be initiated either when a mother takes up an invitation to contact a counsellor she has met at an NCT class, or when she follows up a recommendation from friends, NCT branch volunteers, a counsellor on the breastfeeding line or a local health professional. Over the review period, face-to-face support was increasingly provided on a regular basis in community and in hospital-based drop-in settings.

**NCT peer support:** NCT breastfeeding counsellors have trained breastfeeding peer supporters since the mid-1990s. During the review period, NICE guidance on the importance of proactive and routine support for feeding soon after birth, plus an increased focus on ensuring that services are widely available and acceptable to parents from a range of backgrounds, prompted NCT to increase its focus on developing peer support training. In the period 2006–9 NCT set up 19 DH-funded local peer support projects, mostly in partnership with the NHS or a children’s centre. By September 2010 NCT had about 40 contracts to provide peer support training, commissioned by children’s centres, community health partnerships, primary care trusts (PCTs), and local and regional NHS units. Peer support training was also offered internally to mothers to NCT branches. During the review period Open College Network (OCN) accreditation was developed for peer support training.
**Baby Cafés:** In summer 2010 NCT announced its merger with the Baby Café Charitable Trust. The Baby Café is a network of drop-in centres that support breastfeeding mothers, run by paid facilitators and freely accessible to all mothers needing support with breastfeeding. Currently there are over 100 Baby Cafés throughout the UK supporting some 10,000 mothers each year.

### 3.4 Geographical reach

Over the review period, NCT was not in a position to provide face-to-face breastfeeding counselling support to UK parents in every part of the UK. For many parents the only way of accessing a fully qualified NCT breastfeeding counsellor was via the NCT Breastfeeding Line. Despite this, NCT had some face-to-face presence across much of the UK, particularly in England (Table 2). In summer 2010, around 10% (32) of the 319 NCT breastfeeding counsellors lived outside England. Within England there is limited presence of NCT breastfeeding support in the North and North East, Devon, Cornwall, and East Anglia. In Scotland, there is limited NCT breastfeeding support presence in rural areas. In Northern Ireland and Wales, NCT coverage looks likely to improve as students qualify, but some areas are likely to remain without an NCT breastfeeding presence for the foreseeable future. By summer 2010 around four-fifths of women of childbearing age lived within half an hour’s drive of ‘potential’ NCT face-to-face support (Table 3).

### Table 2: NCT capacity to provide postnatal feeding support across the UK (summer 2010)

<table>
<thead>
<tr>
<th></th>
<th>UK</th>
<th>England</th>
<th>Scotland</th>
<th>Wales</th>
<th>NI</th>
</tr>
</thead>
<tbody>
<tr>
<td><em>Breastfeeding counsellors registered to practise</em></td>
<td>319</td>
<td>287</td>
<td>20</td>
<td>4</td>
<td>8</td>
</tr>
<tr>
<td><em>Student counsellors in training</em></td>
<td>322</td>
<td>280</td>
<td>22</td>
<td>14</td>
<td>6</td>
</tr>
<tr>
<td><em>Baby Café local facilities</em></td>
<td>83</td>
<td>78</td>
<td>2</td>
<td>3</td>
<td></td>
</tr>
</tbody>
</table>
Table 3: Percentage of women of childbearing age within 30-minute travel time of NCT face-to-face support (summer 2010)

<table>
<thead>
<tr>
<th>Service</th>
<th>UK</th>
<th>England</th>
<th>Scotland</th>
<th>Wales</th>
<th>NI</th>
</tr>
</thead>
<tbody>
<tr>
<td>Breastfeeding counsellors</td>
<td>74%</td>
<td>80%</td>
<td>53%</td>
<td>35%</td>
<td>22%</td>
</tr>
<tr>
<td>Student counsellors</td>
<td>75%</td>
<td>78%</td>
<td>58%</td>
<td>65%</td>
<td>46%</td>
</tr>
<tr>
<td>Counsellors or students</td>
<td>87%</td>
<td>90%</td>
<td>71%</td>
<td>73%</td>
<td>53%</td>
</tr>
<tr>
<td>Baby Café</td>
<td>36%</td>
<td>41%</td>
<td>6%</td>
<td>19%</td>
<td>-</td>
</tr>
<tr>
<td>Peer supporter trainers</td>
<td>27%</td>
<td>31%</td>
<td>2%</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>NCT contracts</td>
<td>26%</td>
<td>29%</td>
<td>-</td>
<td>1%</td>
<td>-</td>
</tr>
<tr>
<td>Any NCT support</td>
<td>81%</td>
<td>86%</td>
<td>55%</td>
<td>46%</td>
<td>22%</td>
</tr>
<tr>
<td>Plus students</td>
<td>90%</td>
<td>93%</td>
<td>72%</td>
<td>76%</td>
<td>53%</td>
</tr>
</tbody>
</table>

3.5 Parent information

Between 2000 and 2010 NCT produced web-based information and hard-copy information sheets for parents. Topics covered included getting a good start to breastfeeding, a step-by-step guide to positioning and attachment, a guide to interpreting the contents of the baby’s nappy, a guide to supporting breastfeeding for family members, expressing and storing milk, bottle-feeding for breastfed babies, cup-feeding, information about mixed feeding, weaning to solids, avoiding nipple trauma, how long to breastfeed for, the role of fathers, the benefits of breastfeeding for different lengths of time and information on using infant formula.

3.6 Lobbying

Between 2000 and 2010 NCT worked with other organisations to campaign for support for improvements to services and changes to the wider cultural environment (see Table 4). NCT work in the period included contributing to NHS policy and policy guidance, influencing national health promotion initiatives, lobbying for legislative changes and tackling commercial pressures. NCT was successful in influencing several aspects of public policy, including influencing developments in NHS policy and guidance, influencing the design of national health promotion initiatives, and – with others – bringing about legislative changes to confirm the right to breastfeed in public places. However NCT was unsuccessful in achieving all of its objectives with regard to restricting formula milk promotion.
In addition, much NCT campaigning is ‘bottom-up’ and prompted by specific local issues or experiences, rather than led by NCT’s wider strategic agenda. This low-level activity is poorly recorded. In feedback collected for this review, breastfeeding counsellors and trainees gave examples of local campaigning and influencing activity they had undertaken. Counsellors who participated in the e-discussion highlighted local work which including influencing local health and community services, questioning unethical advertising and influencing work in schools.
## Table 4: Case study examples: NCT campaigning, lobbying and influencing activity 2000–10

<table>
<thead>
<tr>
<th>Example of lobbying action</th>
<th>Working in coalition</th>
<th>Contributing to NHS policy and policy guidance</th>
<th>Influencing national health promotion initiatives</th>
<th>Lobbying for legislative changes</th>
<th>Tackling commercial pressures</th>
</tr>
</thead>
<tbody>
<tr>
<td>NCT works as part of the Breastfeeding Manifesto Coalition (BMC).</td>
<td>Baby Friendly Initiative (BFI) becomes established as the good practice standard for the NHS.</td>
<td>Introduction of Healthy Start is achieved.</td>
<td>Legislation is passed to protect the right to feed in public places.</td>
<td>There is lobbying for full implementation of WHO Code and resolutions.</td>
<td></td>
</tr>
</tbody>
</table>

### Issues that these actions addressed

- Previously, support for breastfeeding from organisations and individuals was not coordinated and collaborative.
- Support for breastfeeding mothers via NHS and community-based services remained variable and often poor.
- The system of ‘Milk Tokens’ saw families on lowest incomes receive around twice the monetary value per token compared to mothers who were breastfeeding.
- Many mothers felt inhibited to feed their babies in public places. Mothers and others were unclear about legal right to breastfeed in public places.
- The WHO Code and resolutions, specifically preventing the promotion of formula, follow-on milk and other breast milk substitutes, had not been implemented in the UK.

### NCT’s contribution

- NCT contributed to the development of the manifesto, encouraged relevant organisations to join, promoted the manifesto to political and professional signatories, and financed the secretariat from 2008.
- NCT drove the development of the ‘Breastfeeding Access All Areas’ scheme and worked with breastfeeding network to pilot. Alison Baum, who developed the BMC, was an NCT breastfeeding counsellor trainee. The manifesto drew on NICE evidence to which NCT had contributed.
- An NCT tutor was on the BFI designation committee.
- The first BFI hospital facility (Bournemouth Midwifery Unit) had an NCT breastfeeding counsellor as Head of Midwifery. NCT breastfeeding counsellors were involved in local developments across the UK.
- NCT championed BFI as minimum standard in policy documents.
- NCT raised awareness of BFI through articles for NCT publications.
- NCT organised and supported lobbying of local facilities by NCT members, both individually and via maternity service liaison committees.
- NCT breastfeeding counsellors and volunteers raised issue of inherent inequality in ‘Milk Tokens’ benefit.
- When DH and SCAN ran a public consultation on the nutritional aspects of the scheme, NCT responded. NCT supported the principle that vouchers should contribute to the cost of formula milk for babies who are not breastfed and recommended equivalent value for all mothers to be spent on variety of ‘healthy’ products. NCT attended meetings and acted as a lead voice in piloting the Healthy Start vouchers scheme.
- NCT supported the new scheme in the media.
- NCT contributed to evidence about mothers’ inhibitions and compiled directories of welcoming venues, publicised findings that 85% of UK adults had no objection to mothers breastfeeding in public.
- NCT sat on the drafting group for a Scottish Bill to make it a crime to stop a child under two from being fed milk in a public place. NCT provided evidence. NCT lobbied for similar legislation in the rest of the UK. Via BMC, NCT lobbied in support of the UK Equality Bill, which would strengthen the Sex Discrimination Act. NCT raised awareness of strengthened breastfeeding rights when the Bill was passed.
- NCT contributed evidence to the Food Standards Agency during negotiations on the revised European Directive on formula milk and follow-on milk. NCT gathered evidence and sponsored a MORI poll demonstrating the extent of influence of formula milk companies.
- Unfortunately, the Directive (2006) was passed without the strengthened protection from advertising that NCT had lobbied for.
- NCT continued to work with the Baby Feeding Law Group, one of 26 organisations to encourage the UK Government to go further than the Directive, with a particular emphasis on restricting advertising of follow-on milk. Unfortunately, this aim was not achieved.
- NCT continued to feed into consultations from, and guidance produced by, the Food Standards Agency.

### What happened

- BMC, which comprised over 30 organisational members, was supported by politicians from all major parties across the UK.
- BFI standards were incorporated into NICE guidance.
- Healthy Start provided improved benefits over ‘Milk Tokens’ for mothers who are breastfeeding (and not purchasing formula).
- The Scottish Bill was successful and became law in 2005. The UK Equality Bill was successful and passed in 2010.
- NCT was unsuccessful in having talks with ministers, however, they felt that they could not go further than the EU Directive.
3.7 Summary

Over the review period the number of NCT breastfeeding counsellors remained stable while the number of contacts with parents increased by more than 50%. NCT antenatal classes reach around 10% of first-time parents in the UK, and the overwhelming majority of parents attending these classes intend to breastfeed. Postnatal support from breastfeeding counsellors has traditionally been reactive – that is, responding to women who make contact with a breastfeeding counsellor. Over the review period a number of factors led to an expansion in the reach of postnatal support. These included the introduction of the NCT Helpline, an expansion of peer support, and most recently the merger with Baby Café. NCT continued to provide web-based information and a range of information sheets as resources to support parents in their decision-making. NCT was successful in influencing NHS policy and guidance and, alongside others, successfully campaigned for legislation to confirm mothers’ rights to breastfeed in public places. However NCT was unsuccessful in campaigning for full implementation of the WHO Code and subsequent World health Assembly resolutions relating to the marketing of formula milks.
Section 4: Strengths and unresolved issues

4.1 Strengths

The following perceived key strengths were identified from the research:

1. NCT breastfeeding counsellors take a skilled *person-centred* approach to breastfeeding support
2. NCT provides a range of mutual support opportunities (formal and informal)
3. NCT takes an evidence-based approach
4. NCT learns from the lived experiences of the parents it supports
5. NCT is an organisation for all mothers, and not just mothers who are breastfeeding
6. NCT is influential in policy terms
7. NCT is reaching more parents through training peer supporters, increasing co-working with the NHS and other service providers, offering couples’ courses and discounts for parents on low incomes, having a helpline available for all concerns and parenting issues.

4.2 Unresolved issues

Three long-running unresolved issues relating to feeding support in the UK were identified and explored in detail.

1. Some mothers who use formula milk feel under-supported and judged.
2. Mothers who run into breastfeeding problems sometimes feel that they have been given unrealistic expectations in antenatal classes
3. Many mothers do not access the breastfeeding support available.

The remainder of this report is concerned with the analysis of these unresolved issues and recommendations arising.
4.3 Promote breastfeeding or promote feeding choice?

The dilemma can be verbalised as follows: in order for all mothers to feel supported, parents who use formula milk must be supported, and must not feel pressured to breastfeed or judged, which means ‘choice’ must be promoted and there must be a balance of information and services for breastfeeding and formula feeding. On the other hand, in order for all parents to be supported, mothers who decide to breastfeed must be supported; they must not feel pressured to formula feed or judged and must have their potentially fragile decisions to breastfeed protected; so breastfeeding must be promoted, breastfeeding support prioritised and information on formula restricted.

**Figure 3: Some mothers who use formula milk feel under-supported and judged**

- Mothers who use formula milk are well supported, and not pressured to breastfeed or judged for formula feeding.
- Mothers who breastfeed are well supported, and are not pressured to formula feed or judged for breastfeeding. Potentially fragile decisions are supported and protected.
- Promote choice and provide a balance of information on breastfeeding and formula feeding.
- Promote breastfeeding, prioritise breastfeeding support. Restrict information on formula.

**Key insights and challenges**

- Mothers cannot be divided into ‘breastfeeding mothers’ and ‘formula feeding’ mothers. Most mothers do both, so framing in terms of two groups may impede the identification of common issues and exacerbate the need for mothers to justify their decisions to others.
• Decisions to breastfeed are more fragile than decisions to formula feed (this assumption is valid), and in some cases dedicated time, knowledge and skills may be required to enable breastfeeding.
• The concept of ‘choice’ is flawed. Feeding decisions are frequently not experienced as choices – particularly by the many women who decide to formula feed having run into problems with breastfeeding.
• The notion of ‘balance’ is also problematic as it implies decisions are logical and can be weighed equally by information providers – whereas balancing is an individual and internalised process, which external agencies can facilitate but not carry out for the mother.
• There is a tension between the idea that information on formula milk should be restricted and the goal of ensuring all mothers are well supported. However, the assumptions underpinning the dilemma were considered to have partial validity due to the tendency to use formula milk as a quick fix when mothers would prefer to be enabled to breastfeed. An environment which is free from commercial and temporal pressure, and in which carers are both skilled in enabling breastfeeding and accepting of mothers’ preferences and decisions, will lessen the danger of formula milk being used as a quick fix.

A full validity assessment of assumptions underlying the dilemma over whether to promote breastfeeding or to promote feeding choice, leading to options for action (‘injections’), is presented in Table 5.

4.4 ‘Be prepared for problems’ or ‘breastfeeding is straightforward and rewarding’?

The dilemma can be verbalised as follows: in order for breastfeeding problems to be avoided or resolved, mothers need to be prepared for how physically and emotionally demanding feeding a baby can be in the early weeks and to know where to get support for problems. Therefore antenatal classes should focus on identifying and managing problems, and should encourage withdrawal from usual domestic, social and work commitments. On the other hand, in order for breastfeeding problems to be avoided or resolved, mothers need to feel confident and not view breastfeeding as inherently difficult or unrealistic in the light of other commitments, so antenatal classes should avoid emphasising problems and present breastfeeding as part of everyday life.
Figure 4: Mothers who run into breastfeeding problems sometimes feel that they have been given unrealistic expectations in antenatal classes

Key insights and challenges

- The evidence base to determine which aspects of antenatal education can either help prevent problems or build maternal confidence is under-developed.
- The conflict between encouraging withdrawal and presenting breastfeeding as part of everyday life may be alleviated if parents are encouraged to think in terms of a period of adjustment in the weeks after the birth: a period of emotional and physical investment during which the ‘work’ of breastfeeding may be initially hard, but which is likely to ease as the baby grows and breastfeeding becomes more practised and established.

A full validity assessment of assumptions underlying the dilemma over whether to focus on preparing expectant parents for problems or to focus on presenting breastfeeding as straightforward and rewarding, leading to options for action (‘injections’), is presented in Table 6.

4.5 ‘Support proactively or ‘protect the mother’s sense of agency’?"

The dilemma can be verbalised as follows: in order for mothers to be able to access support when they need and want it, mothers need to be in control of the helping relationship and the limited support capacity available is targeted at those who seek help. In order for this to be achieved mothers should themselves initiate requests for support. On the other hand, in order for mothers to be in control and able to access support when they need and want it, mothers must
not need to make difficult approaches at a distressing time, and capacity for support should be shared equitably; therefore organisations should proactively offer help.

**Figure 5: Many mothers do not access the breastfeeding support available**

- **Key insights and challenges**
  - The link between ‘initiating support’ and ‘being in control’ is not straightforward; mothers who are not approached proactively may be left feeling unsupported rather than in control.
  - Waiting for mothers to access support is an inequitable way of meeting need as poorer, younger mothers will be less likely to access available help.
  - Proactive support may actually increase problems if this disrupts mothers’ own problem-solving strategies or if help is associated with pressure over feeding decisions.
  - Service models that are more proactive need to emphasise a respectful, mother-centred approach in order to be acceptable.
  - Capacity challenges may be better met with service models that ensure fuller integration of various types of support (professional, counselling, peer and lay); and also by seeking ways to enhance assets within mothers’ existing social networks.
A full validity assessment of assumptions underlying the dilemma over whether to proactively support mothers or to focus on protecting mothers’ sense of agency, leading to options for action (‘injections’), is presented in Table 7.
<table>
<thead>
<tr>
<th>Aspect challenged</th>
<th>Assumption</th>
<th>Validity assessment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Common objective</td>
<td>All mothers are well supported, practically and emotionally</td>
<td></td>
</tr>
<tr>
<td>Req. #1, #2</td>
<td>Separate requirements imply that mothers using formula milk and mothers who breastfeed are different groups.</td>
<td>Largely invalid</td>
</tr>
<tr>
<td>Req. #1, #2</td>
<td>Separate requirements imply that services and information need to be different and separate according to feeding behaviour.</td>
<td>Some validity</td>
</tr>
<tr>
<td>Req. #2</td>
<td>Decisions to breastfeed are more fragile than decisions to formula feed.</td>
<td>Valid</td>
</tr>
<tr>
<td>Prereq. #1</td>
<td>With 'balanced' information mothers can have a free 'choice'.</td>
<td>Not valid</td>
</tr>
<tr>
<td>Prereq. #1</td>
<td>It is possible to 'provide balance' and there is no existing 'imbalance' in the decision-making context to be addressed.</td>
<td>Largely invalid</td>
</tr>
<tr>
<td>Prereq. #2</td>
<td>In order to promote breastfeeding, information about formula milk must be restricted.</td>
<td>Some validity</td>
</tr>
<tr>
<td>Prereq. #2</td>
<td>Limiting services and information on formula milk can satisfy a common objective for all parents to feel supported.</td>
<td>Not valid</td>
</tr>
<tr>
<td>Conflict</td>
<td>There is a conflict between promoting choice and promoting breastfeeding.</td>
<td>Valid</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Injections</th>
</tr>
</thead>
<tbody>
<tr>
<td>Review the language, tone and content of infant feeding information, and promote a discourse shift away from the idea of one-off, unconstrained 'choices' towards more of a focus on real, continuing experiences and perceived obstacles and pressures.</td>
</tr>
<tr>
<td>Structure services with minimal initial categorisation of mothers according to feeding behaviour, emphasising the need for mother-centred approaches.</td>
</tr>
<tr>
<td>Within a framework of integrated infant feeding support, provide expert breastfeeding support services and implement policies that make breastfeeding decisions easier to realise and culturally acceptable. Ensure that the rationale for investing in protecting breastfeeding decisions, in a context where most mothers stop breastfeeding before they plan to, is widely understood.</td>
</tr>
<tr>
<td>Within a framework of integrated feeding support, improve access to individualised support for formula use as and when mothers need it, minimising the need to rely on commercial information sources.</td>
</tr>
</tbody>
</table>

| Priority for action | Support on-going decision-making, including protecting decisions to breastfeed |
Table 6: Injections – ‘Be prepared for problems’ or ‘breastfeeding is straightforward and rewarding’?

<table>
<thead>
<tr>
<th>Aspect challenged</th>
<th>Assumption</th>
<th>Validity assessment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Common objective</td>
<td>Breastfeeding problems substantially avoided or resolved quickly</td>
<td>Feeding problems are common. Feedback suggests parents feel unprepared for the experience of breastfeeding during the early weeks.</td>
</tr>
<tr>
<td>Req. #1</td>
<td>Feeding in the early days will be physically and emotionally demanding and problems are likely.</td>
<td>Valid</td>
</tr>
<tr>
<td>Req. #1</td>
<td>Knowing about problems and sources of support will help mothers to overcome any problems.</td>
<td>Some validity</td>
</tr>
<tr>
<td>Req. #2</td>
<td>Feeling confident about breastfeeding is important in overcoming problems.</td>
<td>Valid</td>
</tr>
<tr>
<td>Req. #2</td>
<td>Managing wider commitments is associated with positive perceptions of breastfeeding.</td>
<td>Some validity</td>
</tr>
<tr>
<td>Prereq #1</td>
<td>Raising awareness among expectant parents of emotional challenges, potential problems and intensive nature of feeding will help them to address difficulties when they occur.</td>
<td>Some validity/evidence lacking</td>
</tr>
<tr>
<td>Prereq #2</td>
<td>Discussion of problems will undermine confidence.</td>
<td>Evidence lacking</td>
</tr>
<tr>
<td>Prereq #2</td>
<td>It is possible to improve maternal confidence in the antenatal period, for example by reinforcing positive aspects of breastfeeding.</td>
<td>Evidence lacking</td>
</tr>
<tr>
<td>Conflict</td>
<td>Temporary withdrawal from wider commitments may be seen as in conflict with a mother-centred approach and may be viewed negatively.</td>
<td>Evidence lacking</td>
</tr>
<tr>
<td>Conflict</td>
<td>Withdrawal is incompatible with presenting breastfeeding as a manageable part of everyday life</td>
<td>Some validity</td>
</tr>
</tbody>
</table>

**Injections**

- Identify, appraise and develop the evidence to understand any impact of antenatal and perinatal breastfeeding education on maternal confidence and on preventing problems.
- Improve signposting to high-quality information and skilled problem-solving support, especially in the early postnatal period.
- Develop broad cultural awareness that, during the early weeks, new mothers who decide to breastfeed benefit from informal support from family and friends that enables them to focus on establishing feeding.

**Priority for action** | Develop concept of an investment or adjustment period
Table 7: Injections – ‘Support proactively’ or ‘ensure support initiated by mother’?

<table>
<thead>
<tr>
<th>Aspect challenged</th>
<th>Assumption</th>
<th>Validity assessment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Common objective</td>
<td>Mothers get feeding support when they need and want it</td>
<td></td>
</tr>
<tr>
<td>Req #1a</td>
<td>It is important for mothers to be in control</td>
<td>Valid</td>
</tr>
<tr>
<td></td>
<td>There is evidence to suggest mother-centred approach is valued. Relationship-building known to be important. Pressure over feeding is an issue whether breastfeeding or using formula milk.</td>
<td></td>
</tr>
<tr>
<td>Req #1b</td>
<td>Capacity is stretched</td>
<td>Valid</td>
</tr>
<tr>
<td></td>
<td>Given the extent of need and limits of funding, there are capacity issues. However, capacity may be improved by more creative and integrated use of possible support options.</td>
<td></td>
</tr>
<tr>
<td>Req #2a</td>
<td>There are barriers to seeking help</td>
<td>Valid</td>
</tr>
<tr>
<td></td>
<td>Experience of supporters suggests that mothers who need help frequently do not seek it.</td>
<td></td>
</tr>
<tr>
<td>Req #2b</td>
<td>Resources are not provided equitably owing to a non-proactive approach</td>
<td>Valid</td>
</tr>
<tr>
<td></td>
<td>Experience of supporters and independent evidence suggests that support interventions are not accessed equitably.</td>
<td></td>
</tr>
<tr>
<td>Prereq #1</td>
<td>If services wait to be approached this puts mothers in control</td>
<td>Evidence for validity is lacking</td>
</tr>
<tr>
<td></td>
<td>Experience of supporters suggests that mothers are likely to feel abandoned and alone when experiencing problems. Help-seeking may present an additional challenge, particularly if help is felt to be restricted to breastfeeding, or exclusive breastfeeding, rather than feeding more broadly.</td>
<td></td>
</tr>
<tr>
<td>Prereq #1</td>
<td>If services wait to be approached this keeps demand manageable</td>
<td>Some validity</td>
</tr>
<tr>
<td></td>
<td>Limits number of help-seekers, but may result in those who require help seeking it later, when problems are at a more advanced stage, or not at all, or. It may also lead to resources not being directed to greatest need.</td>
<td></td>
</tr>
<tr>
<td>Prereq #2</td>
<td>Receiving proactive offers of help will not be ‘difficult’ for mothers</td>
<td>Likely to vary</td>
</tr>
<tr>
<td></td>
<td>In a health promotion context, offers of help may be interpreted as pressure to breastfeed. Less likely to be the case if delivered in walk-in community-based services and offered as ‘help with feeding’ to all mothers regardless of feeding decisions.</td>
<td></td>
</tr>
<tr>
<td>Conflict</td>
<td>There is a clear distinction between letting women know antenatally about sources of available feeding support and proactively contacting them in the postnatal period and offering them help.</td>
<td>Not valid</td>
</tr>
<tr>
<td></td>
<td>Likely to be a continuum of approaches that are more or less acceptable.</td>
<td></td>
</tr>
</tbody>
</table>

Priority for action | Develop models of support that are mother-centred and proactive

Injections

- Increase capacity for infant feeding support in the community by developing well-integrated systems of supervised peer support and breastfeeding counselling, alongside access to health professional services. Use settings that are comfortable and convenient for new mothers and fathers. Enhance support from family and friends. Develop the evidence about how best to enhance support from family and friends.
- Incorporate evidence for the importance of relationship-building into intervention design.
- Re-affirm maternal experience and psychological well-being as key outcomes for feeding support interventions.
- Develop an evidence base to support the effectiveness and acceptability of a range of proactive support models.
Section 5: Summary of priority recommendations from the impact review

The following strategic priorities and recommendations were identified.

Priority 1: Support on-going decision-making, including protecting decisions to breastfeed (Table 8)

- Review the language, tone and content of infant feeding information, and promote a discourse shift away from the idea of one-off, unconstrained ‘choices’ towards more of a focus on real, continuing experiences and perceived obstacles and pressures.

- Structure services with minimal initial categorisation of mothers according to feeding behaviour, emphasising the need for mother-centred approaches.

- Within a framework of integrated infant feeding support, provide expert breastfeeding support services and implement policies that make breastfeeding decisions easier to realise and culturally acceptable. Ensure that the rationale for investing in protecting breastfeeding decisions, in a context where most mothers stop breastfeeding before they plan to, is widely understood.

- Within a framework of integrated feeding support, improve access to individualised support for formula use as and when mothers need it, minimising the need to rely on commercial information sources.

Priority 2: Promote the concept of an investment or adjustment period (Table 9)

- Identify, appraise and develop the evidence to understand any impact of antenatal and perinatal breastfeeding education on maternal confidence and on preventing problems.

- Improve signposting to high-quality information and skilled problem-solving support, especially in the early postnatal period.

- Develop broad cultural awareness that, during the early weeks, new mothers who decide to breastfeed benefit from informal support from family and friends that enables them to focus on establishing feeding.
Priority 3: Develop models of support that are mother-centred and proactive (Table 10)

- Increase capacity for infant feeding support in the community by developing well-integrated systems of supervised peer support and breastfeeding counselling, alongside access to health professional services. Use settings that are comfortable and convenient for new mothers and fathers. Enhance support from family and friends. Develop the evidence about how best to enhance support from family and friends.

- Incorporate evidence for the importance of relationship-building into intervention design.

- Re-affirm maternal experience and psychological well-being as key outcomes for feeding support interventions.

- Develop an evidence base to support the effectiveness and acceptability of a range of proactive support models.
<table>
<thead>
<tr>
<th>Identified injections</th>
<th>Link to NCT 2020 strategic theme</th>
<th>Progress (June 2013)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Review the language, tone and content of infant feeding information, and promote a discourse shift away from the idea of one-off, unconstrained 'choices' towards more of a focus on real, continuing experiences and perceived obstacles and pressures.</td>
<td><strong>Positive images</strong>/ Work to influence media and popular culture to ensure an accurate presentation of the transition to parenthood stage, while always working to correct any inaccurate portrayal of parenthood.</td>
<td>NCT <em>Message framework</em> published (2012) for staff, volunteers and practitioners, after considerable stakeholder involvement and consultation, sets out very clearly NCT’s values and approaches to infant feeding.</td>
</tr>
<tr>
<td>Structure services with minimal initial categorisation of mothers according to feeding behaviour, emphasising the need for mother-centred approaches.</td>
<td><strong>Confident parents</strong>/ Enhance NCT baby feeding information and services, providing information focused on parents’ needs, and continue to lobby for better support for feeding, in partnership with other organisations.</td>
<td>The Impact Review Implementation Group advised the one, comprehensive NCT helpline project, and recommended clarification that parents can access the helpline for any aspect of feeding. Training days on use of formula milk have been held for breastfeeding counsellors, to improve capacity to meet needs around formula feeding. Implementation group proposed changes to the NCT website Info Centre. NCT contributed to the development of new UNICEF Baby Friendly Initiative standards.</td>
</tr>
<tr>
<td>Within a framework of integrated feeding support, provide services and implement policies that make breastfeeding decisions easier to realise and culturally acceptable. Ensure that the rationale for investing in protecting breastfeeding decisions, in a context where most mothers stop breastfeeding before they plan to, is widely understood.</td>
<td><strong>Confident parents</strong>/ Enhance NCT baby feeding information and services, providing information focused on parents’ needs and continue to lobby for better support for feeding, in partnership with other organisations.</td>
<td>NCT <em>Message framework</em> (2012) sets out clearly the rationale for why NCT has a very explicit focus on breastfeeding.</td>
</tr>
<tr>
<td>Within a framework of integrated feeding support, improve access to one-to-one support for formula use when parents need it. Minimise the need for parents to rely on commercial information sources.</td>
<td><strong>Confident parents</strong>/ Enhance NCT baby feeding information and services, providing information focused on parents’ needs and continue to lobby for better support for feeding, in partnership with other organisations. <strong>Positive images</strong>/ Challenge any inappropriate commercial pressure on new parents and parents-to-be wherever they are being persuaded to buy products they do not need or that may be harmful, and provide them with information and alternatives.</td>
<td>The Impact Review Implementation Group advised the one, comprehensive NCT helpline project, and recommended clarification that parents can access the helpline for any aspect of feeding. Training days on use of formula milk have been held for breastfeeding counsellors, to improve capacity to meet needs around formula feeding. Implementation group proposed changes to the NCT website Info Centre.</td>
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</table>
## Priority 2: Promote the concept of an investment or adjustment period

<table>
<thead>
<tr>
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<th>Link to NCT 2020 strategic theme</th>
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</tr>
</thead>
<tbody>
<tr>
<td>Identify, appraise and develop evidence to understand any impact of antenatal and perinatal breastfeeding interventions on maternal confidence and on preventing and overcoming problems.</td>
<td><strong>Confident parents</strong>/ Enhance NCT baby feeding information and services, providing information focused on parents’ needs, and continue to lobby for better support for feeding, in partnership with other organisations. <strong>High-quality information</strong>/ Ensure NCT public health information is evidence-based, non-judgemental and user-friendly.</td>
<td>Article in <em>Perspective</em> December 2012 setting out the evidence to inform the content of an antenatal breastfeeding session.</td>
</tr>
<tr>
<td>Improve signposting to high-quality information and skilled problem-solving support, especially in the early postnatal period.</td>
<td><strong>Confident parents</strong>/ Tailor NCT multi-channel support, including web-based and telephone services, to ensure parents get the information they need, when they need it, based on their current stage in the transition to parenthood.</td>
<td>Implementation group proposed changes to the web-based info-centre.</td>
</tr>
<tr>
<td>Promote broad cultural awareness that, during the early weeks, new mothers who decide to breastfeed benefit from informal support from family and friends that enables them to focus on establishing a breastfeeding relationship.</td>
<td><strong>Positive images</strong>/ Work to improve the general population’s understanding of the transition to parenthood and its implications.</td>
<td>NCT has developed a values statement: ‘Values and approaches to baby feeding support’.</td>
</tr>
</tbody>
</table>
### Priority 3: Develop models of support that are mother-centred and proactive

<table>
<thead>
<tr>
<th>Identified injections</th>
<th>Link to NCT 2020 strategic theme</th>
<th>Progress (June 2013)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Increase capacity for infant feeding support in the community by developing well-integrated systems of supervised peer support and breastfeeding counselling, alongside access to health professional services. Use settings that are comfortable and convenient for new mothers and fathers. Enhance support from family and friends. Develop the evidence about how best to enhance support from family and friends.</td>
<td><strong>Supportive services</strong>/ Help develop solutions to address the dilemmas facing professionals over balancing budget and capacity constraints with trying to offer excellent individualised care. <strong>Confident parents</strong>/ Redevelop the curriculum for NCT practitioners to increase their flexibility and feeding support skills. <strong>Confident parents</strong>/ Continue to provide paid-for services (antenatal classes, postnatal courses etc.) to individual parents and via contracts with other providers.</td>
<td>Full merger with Baby Café provides an infrastructure for improving local accessibility to support for breastfeeding, within a social model which is mother-centred. NCT continues to expand its peer support work, emphasising integration with NHS and children’s centre services.</td>
</tr>
<tr>
<td>Incorporate evidence for the importance of relationship-building into intervention design.</td>
<td><strong>Supportive services</strong>/ Ensure the treatment of parents and families is respectful when they interact with public services. <strong>Supportive services</strong>/ Champion parent participation in service and policy design, delivery and evaluation. <strong>High-quality information</strong>/ Ensure NCT public health information is evidence-based, non-judgemental and user-friendly.</td>
<td>NCT has developed a policy briefing on <em>What it means to be parent-centred</em> (2013) NCT’s parent-centred approach forms part of NCT training courses for antenatal teachers, breastfeeding counsellors, postnatal leaders and ‘pregnancy, birth and beyond’ PBB practitioners.</td>
</tr>
<tr>
<td>Re-affirm maternal experience and psychological well-being as key outcomes for feeding support interventions.</td>
<td><strong>Supportive services</strong>/ Ensure the treatment of parents and families is respectful when they interact with public services. <strong>High-quality information</strong>/ Work to better understand the interdependency between parent and child well-being.</td>
<td>NCT <em>Message framework</em> (2012) for staff, volunteers and practitioners outlining values and approaches to infant feeding has been developed.</td>
</tr>
<tr>
<td>Develop an evidence base to support the effectiveness and acceptability of a range of proactive models.</td>
<td><strong>High-quality information</strong>/ Ensure NCT public health information is evidence-based, non-judgemental and user-friendly.</td>
<td>NCT has contributed to a collaborative research bid to undertake a review of breastfeeding peer support services from a realist research perspective. Presentations and workshops on impact review findings were provided for practitioners and volunteers at each of the 2020 Strategy roadshows. A presentation on the importance of proactive baby feeding support was given at NCT breastfeeding counsellors’ forum 2012.</td>
</tr>
</tbody>
</table>
Appendix A: Workshop outputs from 2010 annual conference

Thirty-five NCT members and volunteers participated in this conference workshop, lasting an hour and a half, which explored NCT’s role in providing infant feeding support. The group activities were prefaced by a short presentation setting out the aims of the impact review and the long-running issues relating to impact identified from the reviews of the literature, from the mapping of NCT activity and from NCT feedback survey responses. The main group then split into four sub-groups who worked to identify key issues, strengths and challenges for NCT in relation to ‘early days’, ‘formula/mixed feeding’, ‘transparency and trust’ and ‘breastfeeding culture’. All participants consented to anonymised data being used as part of the impact research. The summary points below are based on the views expressed during, these workshops.

Group 1: Early days

This workshop sub-group discussed NCT strengths and weaknesses relating to supporting feeding in the ‘early days’.

Key issues
- Parents often feel unprepared for difficulties with breastfeeding.
- Breastfeeding support is not sufficiently available accessible or approachable.

NCT strengths
- Breastfeeding counsellors, helplines, home visits, information packs, education, leaflets, website, early days postnatal classes, antenatal classes (peer support), coffee groups, breastfeeding cafes, supporting health professionals in clinics, postnatal ward visits.

NCT could do differently or better
- Antenatal classes should prepare parents for the ‘reality’ of breastfeeding, covering the stresses of the first week during antenatal classes and preparing parents for emotional stress and upheaval.
- NCT should acknowledge that breastfeeding is not easy for all women and that early difficulties can often be worked through. NCT should address the impact of women’s disappointment when they experience difficulties and feeding intentions are not carried out, recognising the emotional needs of women related to breastfeeding.
NCT should be more proactive in offering support. It would be positive to carry out a pilot project to proactively contact parents from antenatal classes after birth, offering support. NCT should ensure that breastfeeding counsellors attend reunion meet-ups. NCT could move towards a 'sign up' for postnatal feeding support or, alternatively an 'opt out' of postnatal feeding support approach in the antenatal period. NCT could do more to market a continuing package of NCT services (e.g. antenatal course plus postnatal course or sessions) to prospective parents.

NCT should have a greater focus on fathers’ needs and contribution to feeding and feeding support; services should encouraging fathers to access support.

NCT should think about how to reach parents not attending antenatal courses, e.g. signposting to breastfeeding counsellors or peer support.

NCT should work with local health professionals and facilitate joined-up working through service contracts, and direct referral to clinical services when they are needed.

NCT should explore ways of developing paid roles for postnatal breastfeeding support.

Group 2: Formula/mixed feeding

This workshop sub-group discussed NCT strengths and weaknesses relating to supporting parents who are using formula milk.

Key issues

- A lack of information for mixed/formula feeding antenatally.
- Mixed/formula feeding mothers feel guilty and abandoned (including by NCT).
- There is a need for more breastfeeding counsellors.
- No good national feedback on experience of using NCT services.

NCT Strengths

- Bumps and babies groups are welcoming to all.
- NCT’s focus is on empowering women.
- Breastfeeding counsellors do support all mothers, including talking through stopping breastfeeding.
NCT could do differently or better

- Antenatal classes could be more inclusive of mothers intending to formula feed – including by providing written information.
- Breastfeeding counsellors could attend bumps and babies groups. This would increase opportunities for problem-solving and also make this resource available to mothers using formula milk.
- Breastfeeding counsellors could talk more about formula feeding.
- Listen more to mothers’ experiences. How can we meet their feeding support needs? Enable parents to feed the way that they would like to.
- Develop work with schools to provide early education on breastfeeding.
- Continue to tackle inappropriate TV advertising.
- Develop a ‘feeding experiences’ sheet for new mums to read and share.
- NCT needs more breastfeeding counsellors to increase capacity to support all parents with feeding support needs.
- NCT should offer a one-hour session with a breastfeeding counsellor postnatally as part of course.

Group 3: Transparency and trust

This workshop sub-group discussed the challenges for NCT in maintaining transparency and trust in relation to work on infant feeding.

Key issues

- There is a perception that if women are not breastfeeding they will be, or feel, negatively judged by individuals (and NCT).
- NCT not sufficiently inclusive; there is a perception of NCT as a ‘breastfeeding-only’ organisation.

NCT Strengths

- NCT does and uses evidence-based research.
- NCT draws on ‘parents’ own experiences’.
- NCT focuses on emotional support.
- NCT offers peer support through antenatal groups.
NCT could do differently or better

- NCT could take a more proactive approach: breastfeeding counsellors could contact mothers directly in the days and weeks after birth; antenatal drop-ins, for example 'bra fitting'
- NCT training could be more inclusive. NCT should be sure that its breastfeeding counsellors are not judgemental.
- NCT should listen directly to mothers more – e.g. by running focus groups to understand how to support the needs of formula/mixed feeding mothers better.
- Helping mothers to let go of breastfeeding when it doesn't work out
- NCT should develop its evidence-based practice – e.g. How much evidence is there that a two-hour antenatal session has the desired impact?

Group 4: Breastfeeding culture – unmet needs/improvements

Key issues

- We do not live in a breastfeeding culture.
- There is a lack of education about feeding issues among both health professionals and general population.

NCT Strengths

- NCT is influential in policy terms.
- Recent NCT developments are all in the right direction: training peer supporters; couples’ classes; discounts for classes (though take-up is low); having a dedicated breastfeeding session; NCT Helpline available to all; increasing collaborative work with NHS.
NCT could do differently or better

- NCT needs to focus on education for health professionals (midwives, health visitors, GPs) and address the content of health professionals’ training.
- NCT should get involved in early education in schools; make schools ‘baby friendly’
- NCT should campaign to stop formula advertising, so that children don't see it.
- NCT should target fathers – especially those harder to reach – to challenge the notion that ‘dads help by giving a bottle’.
- NCT should learn from elsewhere: what happens in places where breastfeeding rates are high?
- Increase reach and awareness of NCT.
- Promote discounts (get discounts subsidised externally).
- Increase working with NHS.
Appendix B: Summary of key messages identified from focus group with 16 mothers at 2010 NCT annual conference

Attendees at NCT’s 2010 annual conference who had had a baby in the last three years were invited to sign up for the focus group. Participants were informed that the purpose of the focus group was to better understand some of the issues that have begun to emerge from the review. Drawing on their own experiences as mothers and as NCT members and volunteers, participants were invited to explore what NCT does well, to identify any unmet needs, and to consider what NCT might do better or differently in future. Sixteen mothers participated. The group included women from England and Scotland. All participants were, or had been in the past, NCT volunteers, as well as members. The focus group was held over a lunch-time session at NCT’s annual conference, and lasted 45 minutes. All participants consented to anonymised data being used as part of the impact research.

Key points are presented here. A more detailed analysis of this focus group is available separately.

Key points

- Pain and other problems related to breastfeeding are common and distressing in the early days, and can require significant internal motivation and external support to be overcome. A better understanding of the ‘normal range’ for breastfeeding pain would be useful for new mothers, as well as greater awareness of the symptoms of specific common problems so that mothers know when to seek help.
- For women who plan to breastfeed, formula feeding can be associated with strong feelings of failure and guilt.
- NCT has a difficult path to tread between on the one hand providing encouragement and support for breastfeeding to women who may not be getting that encouragement and support from elsewhere and on the other being inclusive to all parents regardless of feeding choices. The non-judgemental approach practised by breastfeeding counsellors is felt to be right – but not enough women experience this one-to-one contact. The need to respond to individual feeding decisions has implications for the content of NCT antenatal classes as well as for the ethos of bumps and babies/postnatal groups – with the recommendation for a clear emphasis on supporting the mother however she is feeding her baby.
• Fathers have an important role to play in supporting mothers in their feeding choices; and can provide practical and emotional support when problems arise.

• Friends and peers are important sources of information about what to expect and can be a source of empathetic support.

• Skilled face-to-face support for breastfeeding is highly valued and in some cases is perceived as making the difference between continuing to breastfeed and switching to formula feeding. NCT should continue to expand the number of trained breastfeeding counsellors working in the community and should seek ways of providing more visible and proactive breastfeeding counsellor support.

• Access to skilled face-to-face support is seen as a matter of luck and is not perceived as universal. Access to community-based support (statutory and voluntary) is subject to geographic variation.

• Those providing community-based peer support need to be clear whether this is primarily social support or skilled problem-solving support. Women can also be confused about their eligibility for support, for example being unsure whether support is suitable for breastfeeding women with older babies.

• Helplines (including the NCT Breastfeeding Helpline) are seen as less useful in solving feeding problems than face-to-face support. It should be made explicit that the NCT Helpline is open to non-members.

• Women continue to encounter ignorance from health professionals about common breastfeeding problems – including thrush. Women need to be informed and assertive enough to manage any gaps in professional knowledge. NCT can fulfil an important information and advocacy role in this respect.

• Professionals, including health visitors, GPs and midwives, need training in diagnosing and managing breastfeeding problems – this is an area where NCT could become more engaged.
Appendix C: Options for implementation emerging from breastfeeding counsellors’ e-discussion

NCT breastfeeding counsellors and breastfeeding counsellor students were invited to participate in an e-discussion as part of the research, and were recruited via the NCT breastfeeding counsellors’ Yahoo! group (open to all counsellors and students). Participants were asked to think of the discussion as a ‘long-distance focus group’, to draw on their own experiences and to respond to the ideas and suggestions of others. All participants consented to data being used as part of the impact research, and were aware that, unlike the NCT breastfeeding counsellors’ Yahoo! group, the information and ideas provided would be anonymised and used for research purposes. This is a summary of the e-discussion.

- 111 breastfeeding counsellors and breastfeeding counsellor trainees joined the online discussion group (out of a possible 421 breastfeeding counsellors and breastfeeding counsellor trainees invited from the NCT-BFC list)
- 55 members contributed to the discussion by posting a message (50% of all discussion group members)
- 137 messages were generated.

Topics were introduced to the discussion by members of the project team, picking up on themes identified from other sources of feedback and through a review of existing research about experiences of feeding babies in the UK and evidence of effectiveness for different types of interventions. Topics included:

(i) NCT breastfeeding counsellors' core values
(ii) preparing parents for feeding problems
(iii) proactive postnatal support
(iv) expectations of the early weeks
(v) talking about formula feeding antenatally
(vi) meeting the needs of mothers who are formula feeding and mixed feeding postnatally
(vii) working with school children
(viii) peer support
(ix) breastfeeding counsellors' wider roles.

Transcripts from the discussions were anonymised, coded by two members of the research team.
and thematically analysed.

Key points are presented here. A more detailed analysis of this e-discussion group is available to NCT members on Babble, the NCT intranet and from the NCT Library.

**Values and strengths associated with the breastfeeding counsellor role**

NCT breastfeeding counsellors felt that they provided a unique form of help with breastfeeding that is highly valued by new mothers. Participants identified core qualities related to the mother-to-mother, non-judgemental, counselling approach that they bring to their interactions; the quantity of time (and continuity of care) that they were often able to give to individual mothers; as well as the depth of knowledge about their subject that breastfeeding counsellors build up through training and experience. However, some breastfeeding counsellors felt that these qualities are not always well recognised, and that NCT was not currently doing enough to promote and communicate this unique service, and that the postnatal one-to-one help aspect of breastfeeding counsellors’ role was not prized highly enough by NCT. Participants felt that a shared understanding across NCT about the breastfeeding counsellor role and NCT’s stance on (breast) feeding issues was not as strong as it could be. Breastfeeding counsellors also recognised that there was much variation in terms of capacity to provide voluntary support, as well as in experience.

The following options for improvement were suggested through the discussion:

- **NCT could look at ways to better communicate to parents the unique role of breastfeeding counsellors in helping with breastfeeding, and should look at ways of more effectively marketing to potential commissioners these counsellors’ depth of training and valued unique approach to working with mothers.**

- **NCT could look at ways of ensuring consistency and quality of breastfeeding counsellors’ knowledge and skills, including through: increasing opportunities for experience to be passed on to newer counsellors; improving access to study days specifically around breastfeeding; and working with breastfeeding counsellors to build up the evidence base around the content and quality of the breastfeeding counsellor service.**

- **NCT could seek ways to collate and celebrate the local influencing, lobbying and campaigning work that NCT breastfeeding counsellors undertake.**
NCT could work with all stakeholders within the charity to develop a common language and concept base in relation to feeding issues and in relation to the charity’s central role in protecting breastfeeding. This should include increasing opportunities for joint training and joint working with other specialist workers as well as developing a common knowledge base across NCT about feeding issues; including among existing and newly appointed head office staff, volunteers and specialist workers.

Supporting and protecting the ‘early days’ of parenthood

Breastfeeding counsellors felt that parents were often unprepared for the reality of life with a new baby, were poorly supported with feeding, often experienced conflicting or misleading advice, and faced many barriers to seeking help. Participants discussed the different ways that they provided information to new parents to help them prevent and manage feeding problems, as well as the kind of broader information they would wish to convey to help parents get a ‘good start’ (including emphasising family and social support). Breastfeeding counsellors felt that antenatal information about overcoming breastfeeding problems should not be presented in such a way as to put new mothers off breastfeeding (and some saw this as a risk). Breastfeeding counsellors were using a range of techniques to address pain and problems in the antenatal session. Breastfeeding counsellors also discussed different models of antenatal and postnatal care that might result in mothers accessing NCT postnatal support sooner and more effectively.

The following options for improvement were suggested through the discussion:

- NCT could consider ways of leading a wider cultural shift around attitudes to the first few weeks with a baby, so that this is more widely viewed by parents, their families and the wider society as a special ‘investment’ period, with a greater emphasis on quiet time and ‘babymooning’, while breastfeeding and life with the new baby are becoming established.
- Drawing on existing experience and good practice, NCT could work with breastfeeding counsellors to ensure that parents are aware of the factors associated with a ‘good start’ to breastfeeding (and to life with a new baby generally) and feel better enabled to take steps to achieve a context that is supportive of that ‘good start’; this should cover the need for wider practical and social support as well as NCT information that fully integrates feeding issues with other aspects of life with a new baby (normal newborn behaviour, sleep, nappies, family support, care of siblings, who can help etc.).
• Drawing on existing experience and practice, and taking account of the need to present breastfeeding positively to expectant parents, NCT could work with interested breastfeeding counsellors to research and evaluate the impact of different ways of providing information about recognising and overcoming common feeding problems.

• Working within the capacity constraints of breastfeeding counsellors and other specialist workers, and taking account of ethical, practical and funding issues identified, NCT could work with interested counsellors to develop and evaluate different models of breastfeeding counsellor involvement in providing antenatal education as well as models of proactive postnatal support using breastfeeding counsellors and/or peer supporters.

**Needs of mothers who are formula feeding or mixed feeding**

Many breastfeeding counsellors were concerned that their role in providing antenatal education about *breastfeeding* was not fully understood or appreciated. While breastfeeding counsellors do not ‘teach’ formula feeding antenatally, they do provide information and support to individual mothers using formula milk in the context of breastfeeding, and are relatively knowledgeable about formula milk. Participants identified some key areas where NCT could usefully provide more support and information to parents using formula milk, but a number of participants also felt that more research was needed to identify the needs. Participants saw room for improvement in the information and language around feeding issues on the NCT website.

The following options for improvement were suggested during the discussion:

• NCT could ensure that it provides independent information for mothers using formula milk on appetite control, skin-to-skin contact and ways of holding the baby while feeding, making up bottles, timing and frequency of feeds, and re-lactation.

• NCT could further research the support and information needs of mothers who are using formula milk.

• NCT could provide evidence-based information to parents who have introduced formula but want to continue to breastfeed about the best way of sustaining stable mixed feeding (or of returning to full breastfeeding where that is desired).

• NCT could review the information on feeding provided through NCT’s website, with attention to content, language and tone.
Peer support

Participants had mixed views about peer support; while recognising the potential strengths of peer support, particularly in overcoming capacity issues, they tended also to be concerned about reputational risk to NCT of poor peer support and about role confusion with breastfeeding counsellors.

The following options for improvement were suggested during the discussion:

- NCT could seek to ensure that its own peer support is distinguished by health professionals and commissioners as being of high quality and linked to good supervision, training and project management.
- NCT could communicate to external stakeholders the superior training and experience of NCT breastfeeding counsellors and should market NCT breastfeeding counsellor services as well as the services of NCT-trained peer supporters.

School children

Participants were generally enthusiastic about the idea of NCT working with school children, seeing this as a key to a more breastfeeding-friendly future. Participants made a number of practical suggestions and raised issues relating to potential barriers.

The following option for improvement was suggested during the discussion:

- Drawing on the ideas, suggestions and experience of breastfeeding counsellors who have an interest in this area, NCT could seek to develop ways of providing school children with greater experience of and knowledge about breastfeeding so that these future parents are better able to consider breastfeeding as a realistic possibility for their own babies.
References


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