Breastfeeding Needs Assessment for Thurrock

March 2020

thurrock.gov.uk

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Note:

This report was initially written in 2019 ahead of the Covid-19 pandemic and therefore the search parameters of the literature review and the social marketing element reflect this. The data in sections 1 and 2 have been updated subsequent to the pandemic due to a refreshed method for collecting breastfeeding initiation data being established and published.

Insight kindly provided from Thurrock Mums & Dads:

"None of them covered the fact that baby feeds so often to stimulate milk and not to worry. The biggest criticism I found from people around me was how baby was on all the time. 'Clearly not getting enough' is people's view. I felt pressure from those around me to give baby a bottle."

"Brilliant – hate breast is best with no explanation. Also hate mums feeling they failed because they stopped. I know mums that have suffered terribly because of this. I think lots of mums don't know how milk is made. How the baby gets the milk out. The feedback cycle – feeding or expressing to produce more.

Contents

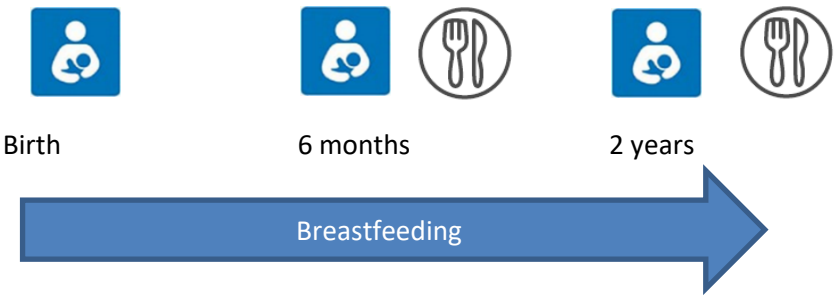
1. Introduction

1.1 National and International context

Low breastfeeding rates present as a serious public health issue. Infants who are not breastfed may be unable to take advantage of a number of health and wellbeing benefits; such as positive impact on attachment, a reduction in Sudden Infant Death Syndrome (SIDs), reduction in childhood illnesses and disease, as well as nutritional benefits. The low rates of breastfeeding in the UK, which can also have an impact on future health, represent a serious public health challenge. There is a need therefore to prioritise breastfeeding as part of Early Years and Public Health policy and to better understand why this picture presents.

The UK is one of the most poorly performing countries in the world in terms of breastfeeding continuation. Nationally, 68% of babies receive breastmilk as their first feed (1) but only 48% mothers continue to breastfeed at 6-8 weeks. This falls even further by 6 months of age with only an estimated 1% of babies being breastfeed exclusively. (2) The World Health Organisation (WHO) and United Nations International Children's Emergency Fund (UNICEF) recommend that breastfeeding continue from birth to age 2 years and exclusively for the first 6 months of life. (1), (2). The WHO have set a global target to achieve 70% first feed breast milk and 70% exclusive breastfeeding up to 6 months by 2030. (5)

World Health Organisation (WHO) & UNICEF (1)



1.2 National policy context

There are numerous policies relating to breastfeeding. NICE guidance recommend development of an overall infant feeding strategy which promotes breastfeeding, supports safe formula feeding and helps families to develop positive emotional relationships with their babies. This guidance places emphasis on positively influencing the child's future educational attainment, social skills, self-efficacy and self-worth. At the other end of the spectrum: Health Matters, WHO and UNICEF advocate for the Baby Friendly Initiative (BFI) in which breastfeeding is promoted for the first 2 years of life and exclusively for the first 6 months. If organisations become BFI accredited they should not promote formula feeding, bottles or teats, and the standards advocate for breastfeeding care being the standard offer opting for a hard line nudge towards breastfeeding (see Appendix 1 for WHO and UNICEFs' 'ten steps to successful breastfeeding').

1.3 Local Context

In Thurrock 59.1% of babies born in 2018/19 had their first feed as breastmilk. The average for babies in England was 70% and in the East of England region as an average it was 67.4% for 2018/19 (see Figures 18 and 19 included in the data section 2.4 on p21).

In Thurrock as with the UK nationally, breastfeeding rates (exclusive or partial/combination feeding) reduce quite considerably by 6-8 weeks post birth, to only 48% in 2019/20.

This Health Needs Assessment supports Goals A and E of Thurrock's Health and Wellbeing Strategy, namely; Opportunity for All and Healthier for Longer respectively (3) This will support domain 3 within the Health and Wellbeing Strategy refresh due to be published in 2022.

The Brighter Futures Children's Partnership Strategy due for publication in 2021 is supported by this needs assessment with Breastfeeding featured in Strategic Priority 2 'All Children are able access the services they need and be healthy' as one of the aims to increase the proportion of children as a healthy weight.

1.4 Local Response

A deeper understanding of the complexities relating to the drivers and influences associated with breastfeeding discontinuation at 6-8 weeks is needed at both a local and national level. The purpose of this Health Needs Assessment is to gain a better understanding of the complexities surrounding breastfeeding and provide evidence based recommendations to inform service delivery.

1.5 Objectives

The objectives of this Health Needs Assessment are to:

- Understand the demographics relating to Breastfeeding in Thurrock including key health data, breastfeeding prevalence, local contextual information and how the national context in relation to breastfeeding relates to this.
- Describe the local offer in Thurrock to support families to breastfeed.
- Understand what the published evidence base tells us works to support families to initiate and continue breastfeeding.
- Review what other areas locally and nationally are doing to increase breastfeeding prevalence by supporting families to breastfeed.
- Develop an in depth understanding of local families and professionals experiences of breastfeeding.
- Articulate a call to Action, making recommendations from the findings of this health needs assessment.

1.6 How we undertook this piece of work

1.6.1 Analysis of need

Need has been be identified in a robust way by providing;

- a descriptive analysis of the demography and the service offer in Thurrock,
- a web search and discussions with relevant stakeholders to support the development and mapping of the local offer in Thurrock,
- a review of the published evidence base and comparison of good practice in other areas,
- a commissioned piece of social marketing research, consulting with Thurrock families and stakeholders to provide an in depth look at families' experiences of breastfeeding.

By identifying what supports families in Thurrock to breastfeed, what prevents or stops families from breastfeeding and identifying how can we maximise and extend the positive elements to overcome barriers will lead to the development of recommendations for a strategy to support this.

1.6.2 Literature Review

Aubrey Keep Library (NELFT) have completed a literature search of the published evidence base.

The main search parameters for the literature review were "Effective interventions for promoting uptake and maintenance of breastfeeding" and "Best practice for increasing breastfeeding rates". Keywords included; breastfeed, breastfed, community, local area, promotion, intervention, education, increase, uptake, maintenance; and continuation. The inclusion criteria for the literature review included papers published within the last 10 years (2008-2018), and written in English. Papers were excluded if they were written in a language other than English or were older than 10 years.

1.6.3 Social Marketing Research

A piece of qualitative social marketing research was commissioned from Upshot Marketing in 2019. The research focussed on the lived experiences of women and their families in Thurrock relating to breastfeeding, using surveys and focus groups, taking a thematic analysis approach. This piece of research is discussed later in the report in section 6 and the findings and insights from this research are incorporated within the recommendations in section 8.

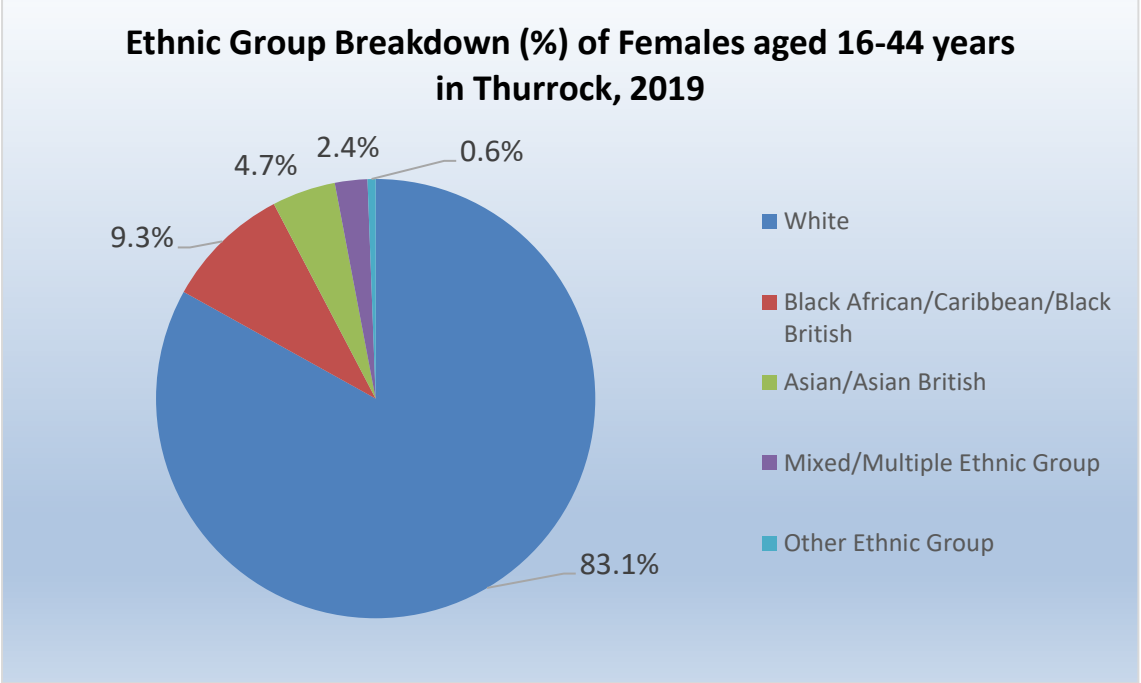
2 Data

2.1 Local Demographic information

In 2020 Thurrock had a total population of 175,531. Of this total population there were 37,002 women defined as being of child bearing age during the same time period. The age range used is in accordance with the Office of National Statistics definition that a women's childbearing age commences at age 15 and ends when they reach 45 years of age (4). The population of 0-2 year olds was 7,487 in 2020.
The total population is set to rise to 205,470 by 2043 (17% increase). The population of individuals of child bearing age is also set to rise to 39,377 (6.4% increase) with the 0-2 year olds cohort projected to increase to 8,241 by 2043 (10% increase during the same time period).

Figure 1 below shows that the majority of women of childbearing age are of white ethnicity, followed by those from black ethnic groups. This is interesting to note because there is evidence that suggests mothers from Black and Minority Ethnic (BME) groups are more likely to initiate breastfeeding than white mothers are. Moreover, evidence has told us that they are also more likely to continue breastfeeding at 3, 4 and 6 months after birth (5). In Thurrock, births to BME women account for 22.4% of all births, which is significantly higher than the East of England and England percentages (see Figure 17 below). This suggests that the figures relating to breastfeeding rates in Thurrock could be skewed by the proportion of breastfeeding mothers from BME groups, particularly in certain areas of the borough such as South Chafford, Chafford & North Stifford, West Thurrock & South Stifford, Grays Riverside, Grays Thurrock, and Tilbury Riverside & Thurrock Park where there are a high proportion of BME groups (see Figure 3 below). This knowledge is important when exploring the barriers to breastfeeding in non-BME groups in particular and work to remove those barriers to increase uptake in this sub-group of the population. Further Information relating to births in BME groups is included later in this report under section 2.4.

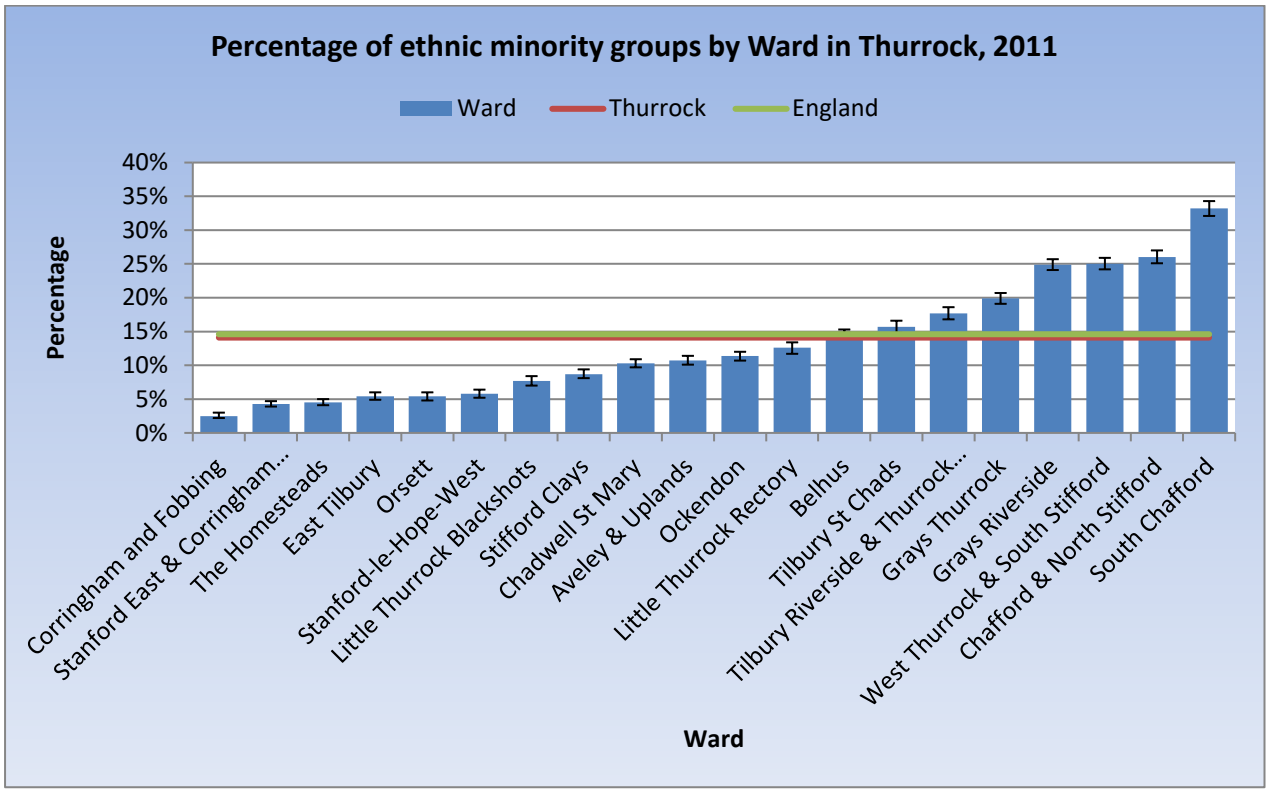
Figure 1: Ethnic Group Breakdown (%) of Females aged 16-44 years in Thurrock, 2019.



Source: ONS Population Denominators

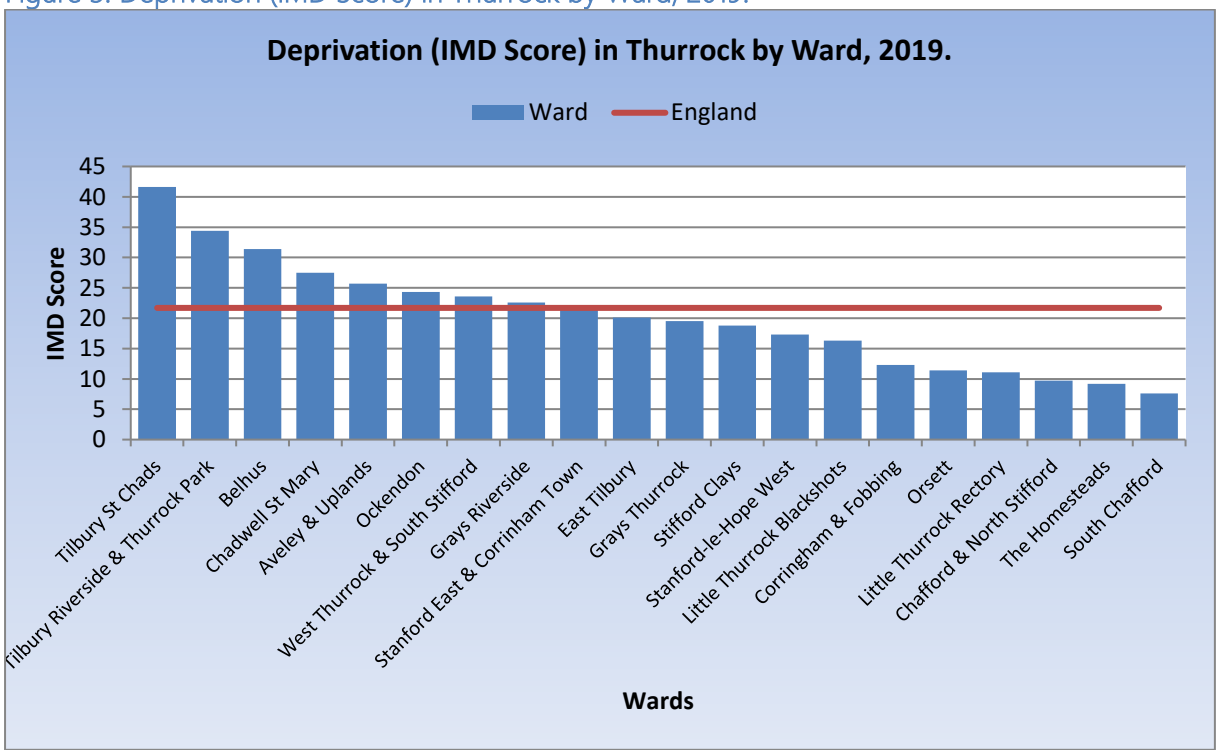
There is a wide variance in the percentage of BME groups by ward in Thurrock ranging from 2.5% (Corringham) to 33.2% (South Chafford) as shown by Figure 2. Some caution needs to be taken when interpreting this data as it is from the 2011 census, population changes are likely to have affected ethnicity prevalence within Thurrock wards. Migration patterns into and out of the borough since the census will likely impact the diversity of ethnicity observed within Thurrock. This may be seen in terms of the number of adults of child-bearing age as well the number of infants being born and general population growth. Further information can be found in the demography JSNA (6). In terms of promoting breastfeeding, it will be important to monitor and understand how the population changes over time so that services can be responsive to changes in terms of breastfeeding support.

Figure 2: Percentage of ethnic minority groups by Ward in Thurrock, 2011.



Source: Local Health 2011.

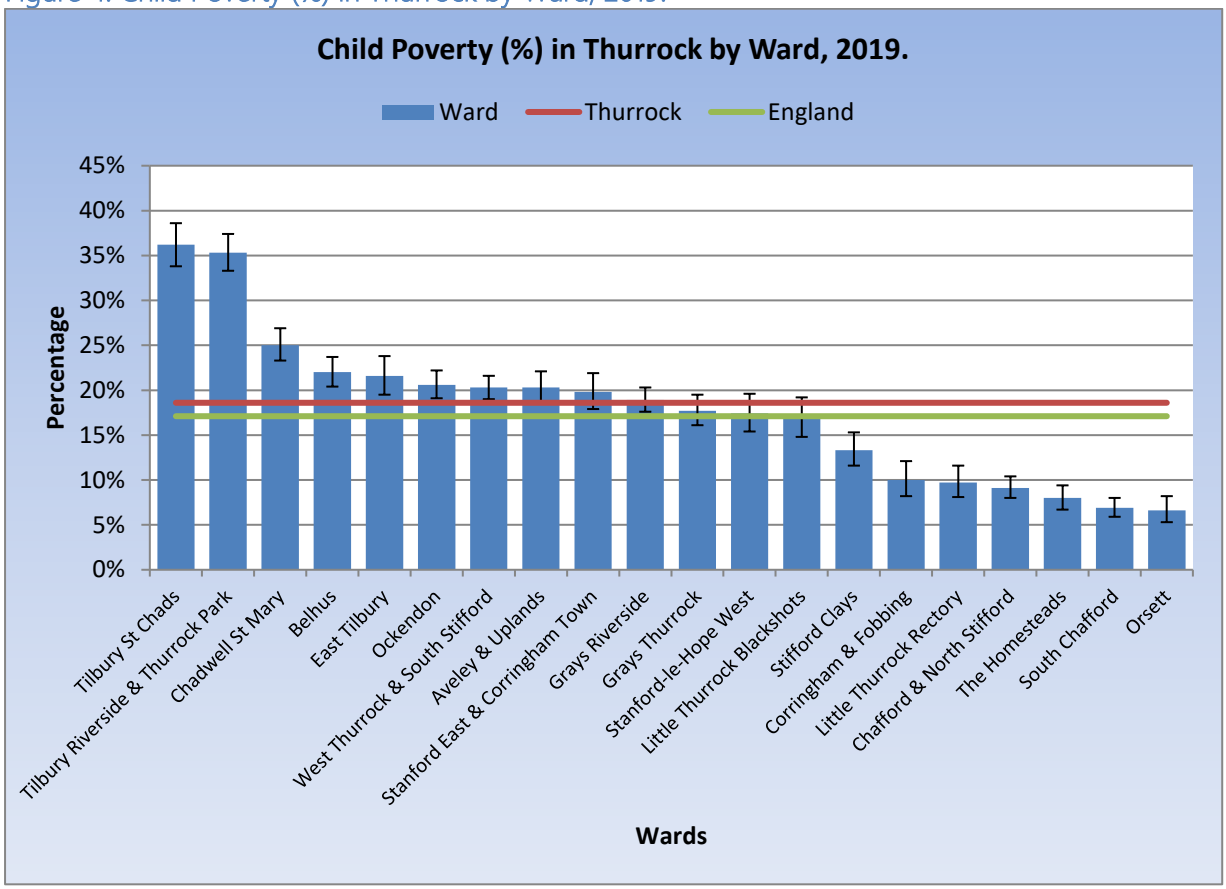
Figure 3: Deprivation (IMD Score) in Thurrock by Ward, 2019.



Source: Local Health, 2019.

Thurrock is a very diverse borough with a wide variety of ethnicities, cultures and religious groups. There is also wide variety in affluence with pockets of high deprivation alongside more affluent areas. Figure 3 above shows deprivation (IMD Score) by ward in the borough. As can be seen, both wards that comprise Tilbury have the highest IMD score as well as the largest proportion of child poverty. Conversely South Chafford experiences the lowest level of deprivation and second lowest proportion of child poverty (see Figure 4 below).

Figure 4: Child Poverty (%) in Thurrock by Ward, 2019.



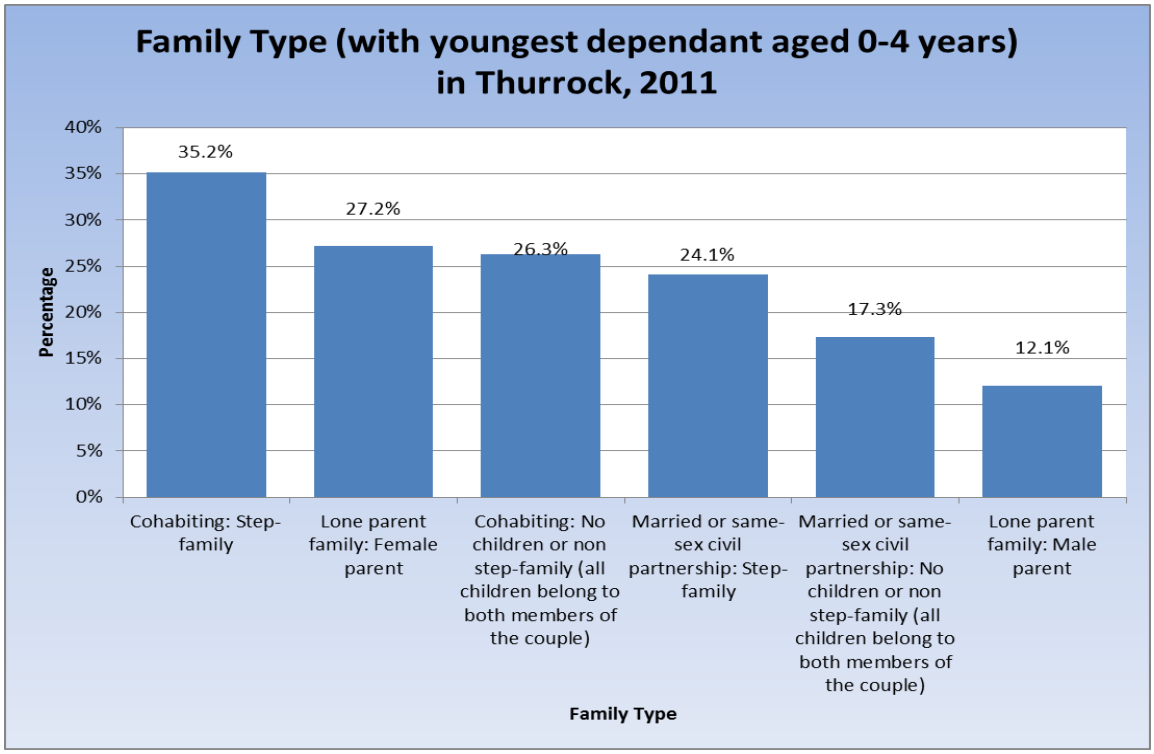
Source: Local Health, 2019.

In Thurrock a total of 45.8% of households have children, with 34.8% of households having dependent children. Those who are married or in a civil partnership with dependent children make up the largest household type in Thurrock (17.9%) followed by lone parent households (7.6%). It should be noted that this data is from the 2011 census and as such household composition may have changed, particularly in light of migration patterns, population change and growth.

The majority of parents within 'couple families' who both work, are employed full-time (74.9%). Of 'couple families' where only one parent is working, this is largely due to the family reporting the other parent looking after the family or home (56.6%). Conversely for lone parent families where the parent is working, the largest proportion are working part-time (24.9%). This could be due to a number of reasons which may include childcare costs. Just over a quarter of lone parents are not working due to looking after their family or home. Figures are similar for families with two or three plus dependants (7).

Cohabiting[1] families with step-children make up the largest family type whose youngest dependent child is aged 0-4 years (35.2%). This is followed closely by lone parent families (female parent) who account for 27.2% of families with a young child/children (see Figure 7 below). As lone female parents make up the second largest proportion of family types with very young children, it could present additional challenges to breastfeeding if they are the sole earner and need to return to work quickly to support their family (see Figure 6 above). It is important to be mindful of this understanding in interpreting the evidence base and making recommendations. Considering how to support lone female parents to continue breastfeeding even upon returning to work is one such consideration. Working with employers around their workplace offer in relation to breastfeeding is one possibility as well as looking to ensure this family type is represented in the social marketing research and any coproduction of service offer and development is another consideration.

Figure 5: Family Type (with youngest dependant aged 0-4 years) in Thurrock 2011.



Source: Nomis/ONS Census 2011 (most recent available)

[1] A 'cohabiting family' can be defined as a couple living together in the same household who are not married but may be in a civil partnership and of the same or opposite sex.

What does this mean for Thurrock?

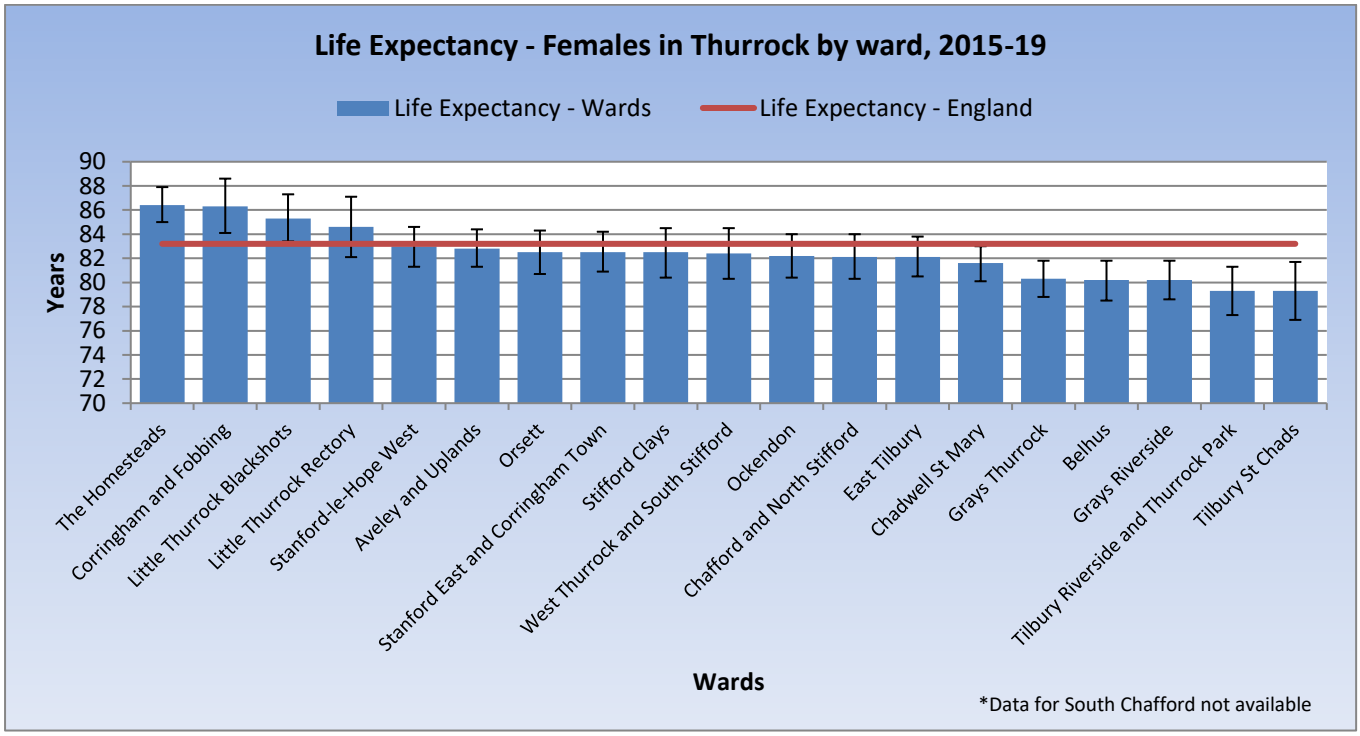
- During the next 20 years, the population in Thurrock is predicted to rise both in women of childbearing age and in children aged 0-2 years.
- There are more people from BME groups in Thurrock than the regional average. Births to BME women account for 22.4% of all births in Thurrock. Mothers from Black and Minority Ethnic (BME) groups are more likely to initiate breastfeeding than white mothers are. This could be masking true breastfeeding rates observed in Thurrock. Attention to this is important when exploring the barriers to breastfeeding in non-BME groups in particular and work to remove those barriers to increase uptake in this sub-group of the population.
- A diversity of affluence/deprivation exists in Thurrock with varying rates of child poverty observed in different wards ranging from approximately 8% in South Chafford to 40 % in Tilbury Riverside and Tilbury Town. The is important in relation to breastfeeding as evidence shows that women in more disadvantaged circumstances are less likely to breastfeed.
- In Thurrock a total of 45.8% of households have children, of which 34.8% have dependent children. Most families have two parents cohabiting or married and of those who both work, 75% both work full time, conversely of single parent families where the parent works only 25% work full time. Supporting parents to be able to return to work whilst breastfeeding will be important for Thurrock.

2.2 Key Health Data

Life expectancy in Thurrock varies widely across and within wards. For females this ranges from 86.4 years in The Homesteads to only 79.3 years in Tilbury St Chads (a difference of 7.1 years). For males, those residing in Corringham and Fobbing have a life expectancy of 83.1 compared to only 75.9 years for those living in Tilbury Riverside and Thurrock Park (a difference of 7.2 years) – see Figures 6 and 7 below. The healthy life expectancy for males in Thurrock is similar to the England average. However, the healthy life expectancy for females in the borough is significantly lower than the England average, as shown in Figure 10 below. Healthy life expectancy is defined as the number of years of life lived in good health.

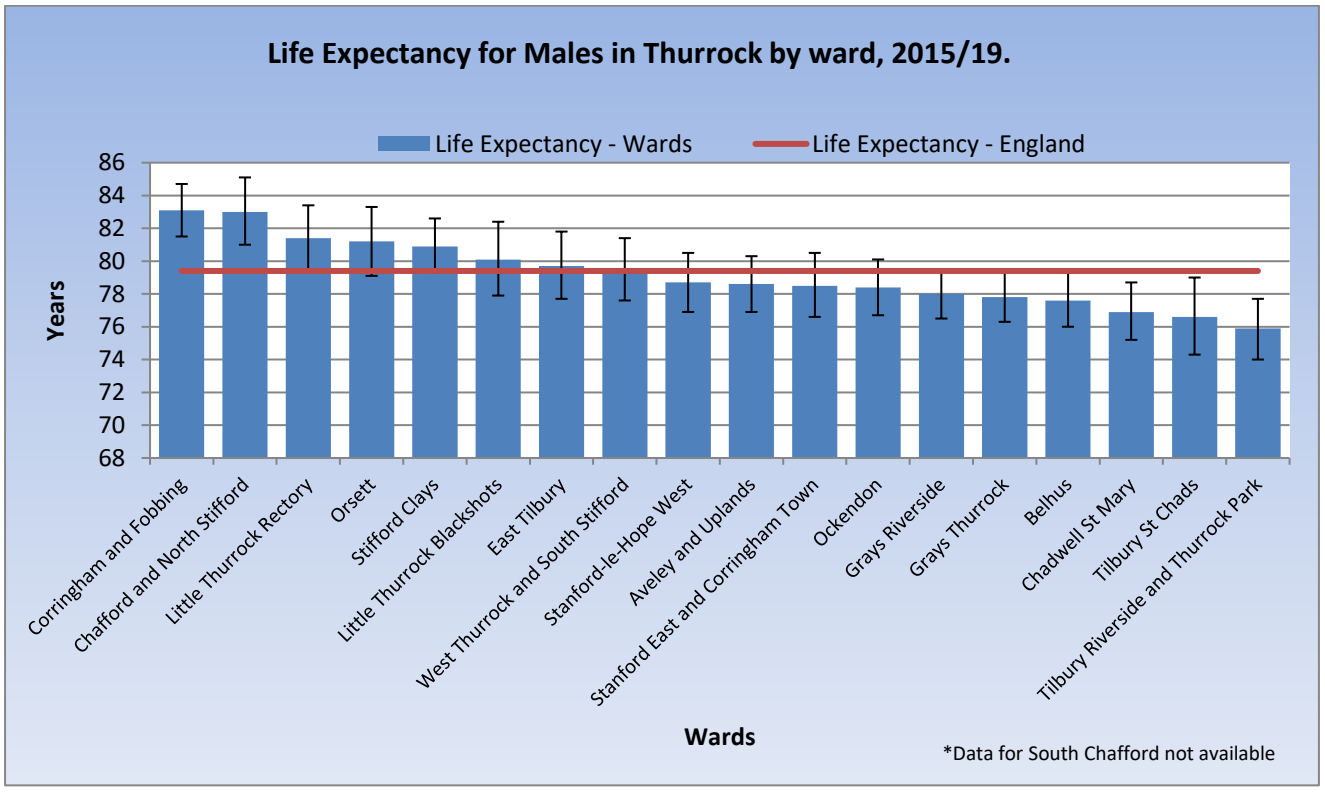
Breastfeeding prevalence in Thurrock may be indirectly contributing to observed healthy life expectancy. The benefits of breastfeeding are well established within the evidence base including a reduction in the risk of becoming obese, developing Diabetes, Cardiovascular and other diseases as well as reducing the risk of mothers developing some Cancers. Breastfeeding is also known to protect against Sudden Infant Death Syndrome (SIDS) and reduced incidence of some childhood illnesses that may also affect infant mortality rates. Low breastfeeding rates in Thurrock coupled with the fact that families on low income are less likely to breastfeed has the potential to widen the gap in health inequalities and life expectancy (5).

Figure 6: Life Expectancy (Females) in Thurrock by Ward, 2015-19.



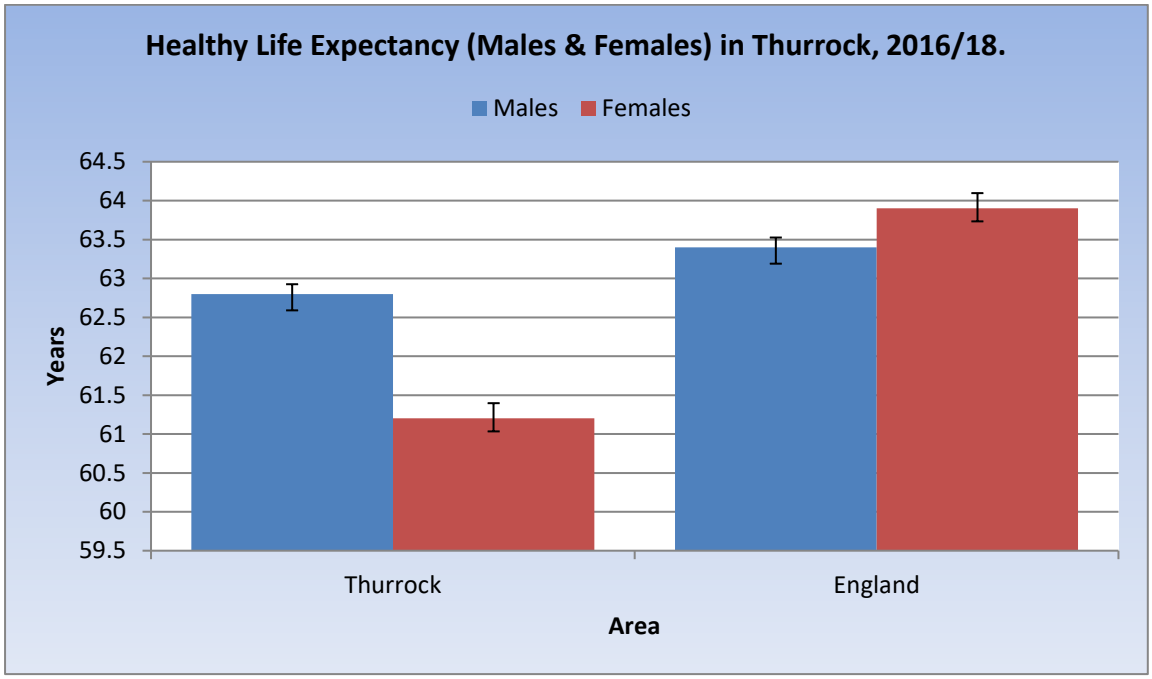
Source: Local Health, 2015-19.

Figure 7: Life Expectancy (Males) in Thurrock by Ward, 2015-19.



Source: Local Health, 2015-19.

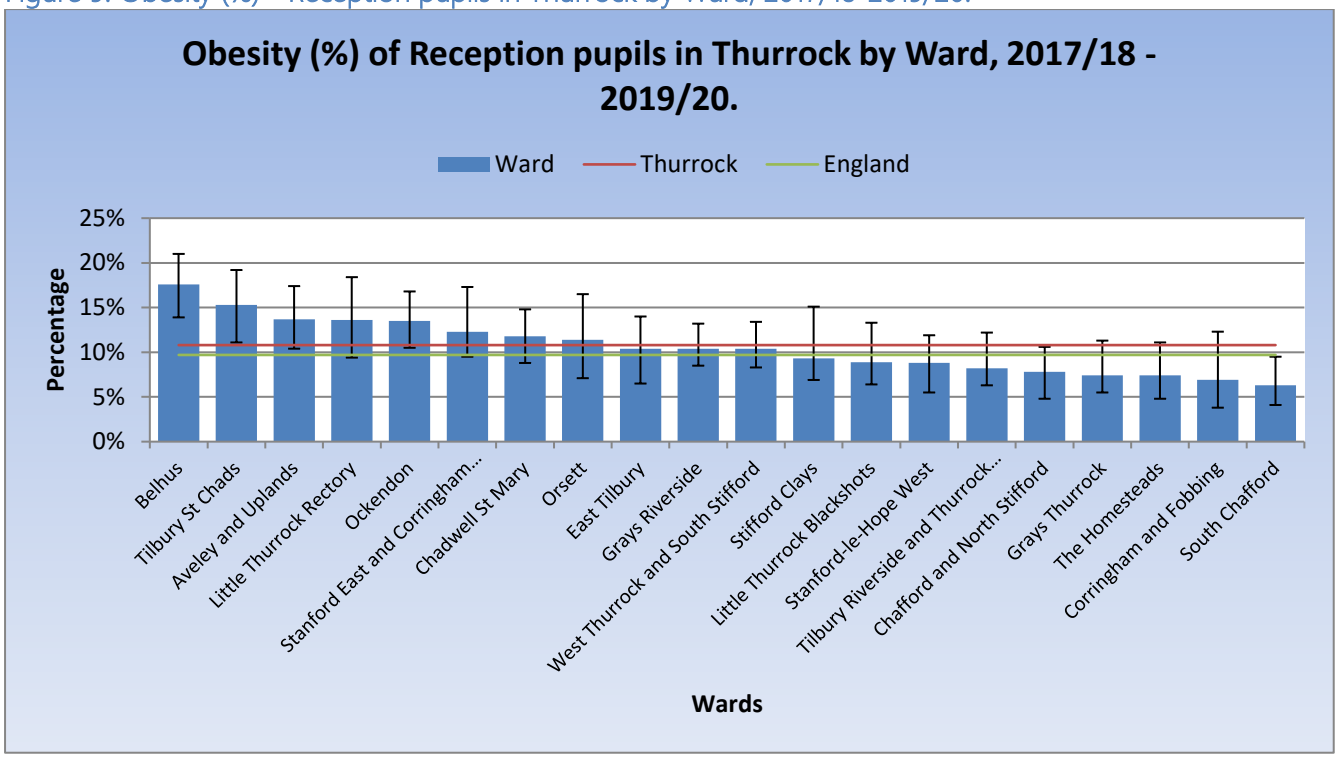
Figure 8: Healthy Life Expectancy in Thurrock & England (Males & Females), 2016-18.



Source: ONS, 2016/2018.

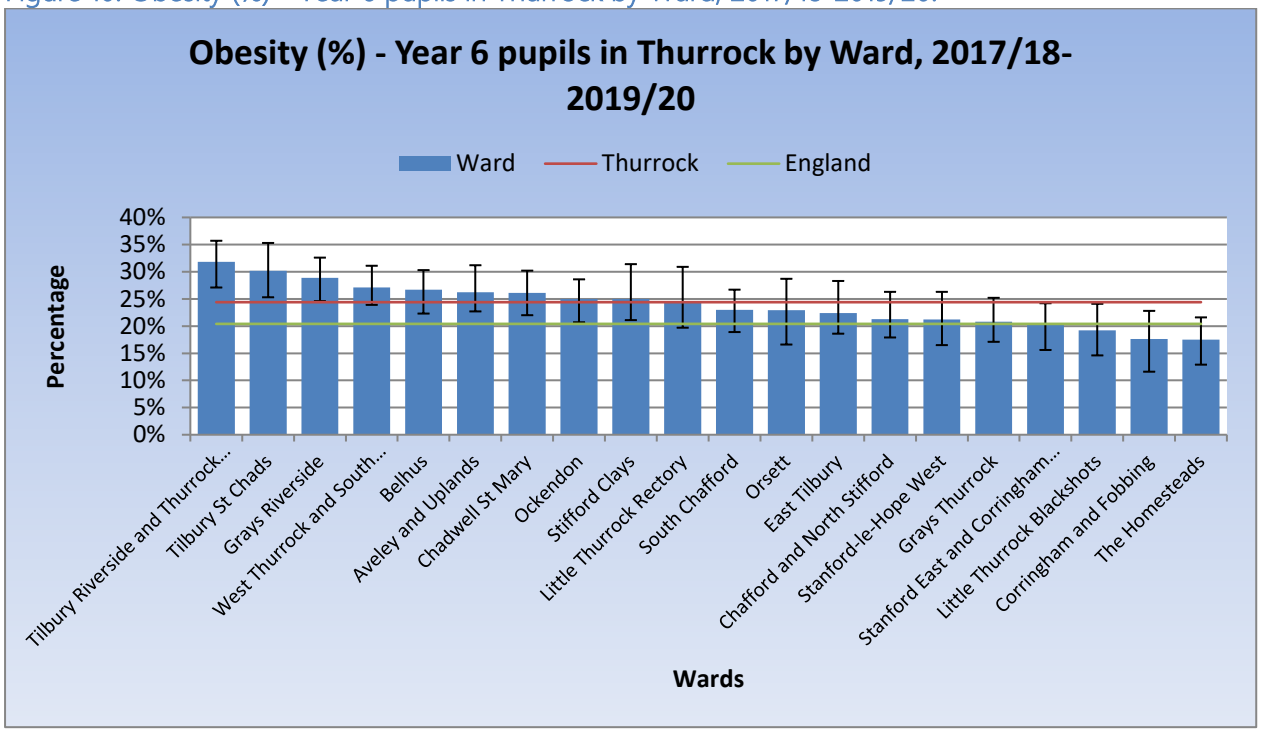
Figures 9 and 10 below show the obesity rates of Reception and Year 6 pupils by ward in Thurrock. Obesity rates in Reception pupils are similar to the Thurrock and England averages for the majority of wards, with the exception of Belhus where rates are significantly higher than the National average and South Chafford where rates are significantly lower. There are significantly higher rates of obesity in year 6 pupils than both Thurrock and England averages in Tilbury Riverside and Thurrock Park, Tilbury St. Chads and Grays Riverside. Obesity rates are significantly higher than the England Average in 8 Thurrock wards (Tilbury Riverside and Thurrock Park, Tilbury St. Chads, Grays Riverside, West Thurrock and South Stifford, Belhus, Aveley and Uplands, Chadwell St Mary and Ockendon). At Year 6, four wards have significantly lower obesity prevalence than Thurrock average (Homesteads, Corringham and Fobbing, Little Thurrock Blackshots, and Stanford East and Corringham). It should be noted that the ward level data in the figures below is modelled data estimated from MSOA prevalence and should be interpreted with caution. Breastfeeding is associated with reduced risk of children becoming obese later in life. The current low breastfeeding rates in the borough could be contributing to the obesity prevalence observed in year R and year 6 children. Although it is recognised that obesity is an extremely complex and multi-faceted issue.

Figure 9: Obesity (%) - Reception pupils in Thurrock by Ward, 2017/18-2019/20.



Source: PHE 2017/18 – 2019/20

Figure 10: Obesity (%) - Year 6 pupils in Thurrock by Ward, 2017/18-2019/20.



Source: PHE, 2017/18-2019/20

What does this mean for Thurrock?

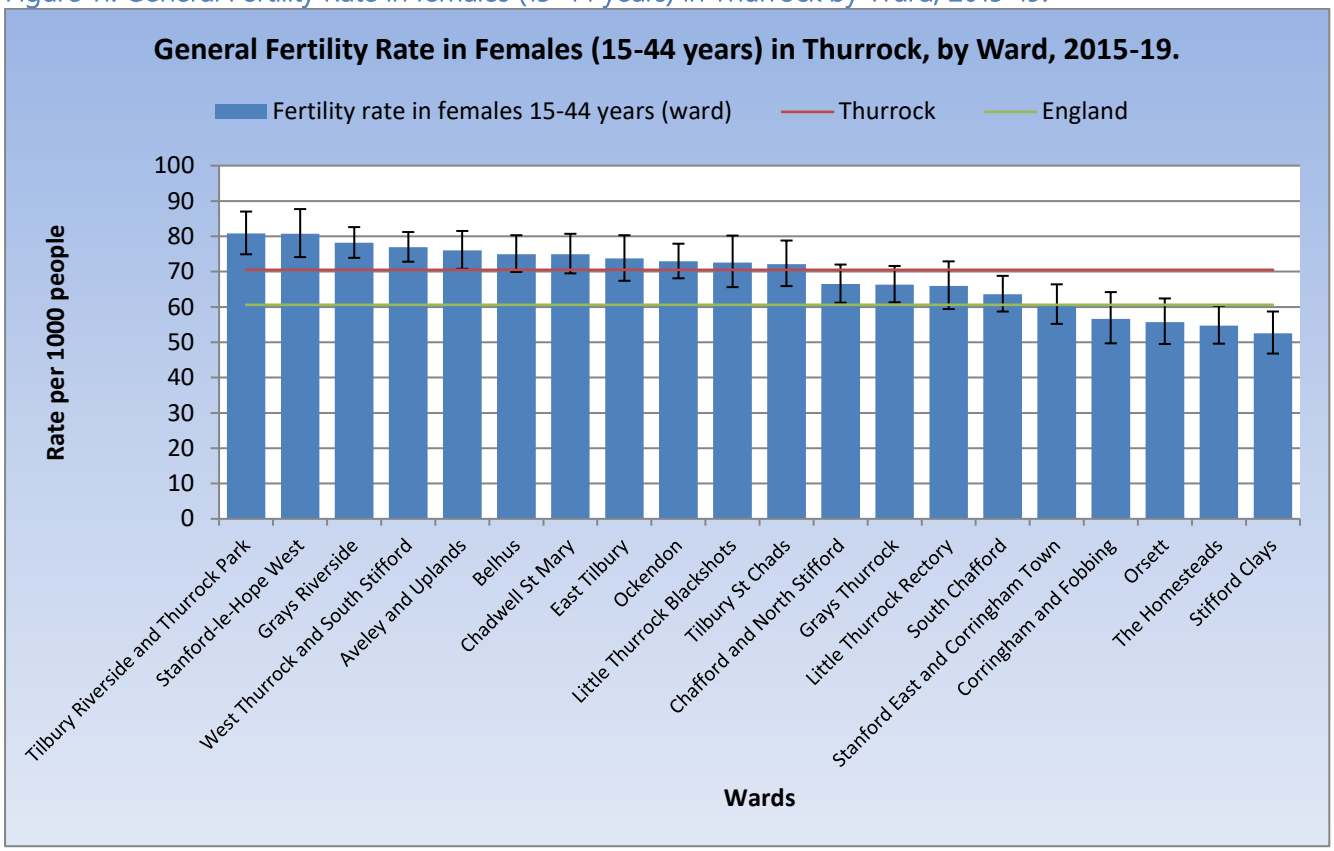
- On average women in Thurrock live longer than men with a smaller gap in life expectancy between the most deprived and affluent wards than observed in men.
- Healthy life expectancy for men in Thurrock in statistically similar to the England average however in women it is significantly lower. This tells us that on average women live longer but in poorer health. Healthy life expectancy in women could be linked to a low breastfeeding prevalence.
- Health benefits of breastfeeding are well established in the evidence base. Low breastfeeding rates in Thurrock coupled with the fact that families on low income are less likely to breastfeed has the potential to widen the gap in health inequalities and life expectancy.
- Obesity at reception year is statistically similar to the national average however, there are two wards in the West of Thurrock where obesity is statistically higher than the national average: Belhus and Ocekndon. In year 6 (age 10-11) obesity is Thurrock significantly higher than the regional and national average. This is important, as breastfeeding is associated with a reduced risk of children becoming obese later in life. We know that if a child is obese at reception year in school only 2 in 10 return to a healthy weight by year 6. Preventing obesity is a complex challenge requiring system wide change; increasing breastfeeding initiation and duration could play an important part in this.

2.3 Maternal and Paternal data

There is a wide variance in the fertility rates of females (aged 15-44 years) by ward in Thurrock. This ranges from 80.8 live births per 1,000 in Thurrock Riverside & Thurrock Park to only 52.5 per 1,000 in Stifford Clays. The fertility rates in 13 of the 20 wards) are significantly higher than the England average as seen in Figure 13 below. It appears that more couples in the more deprived boroughs become pregnant than in the more affluent wards, there may be a variety of factors contributing to this. This data does not tell us how individual lifestyle choices impact on this.

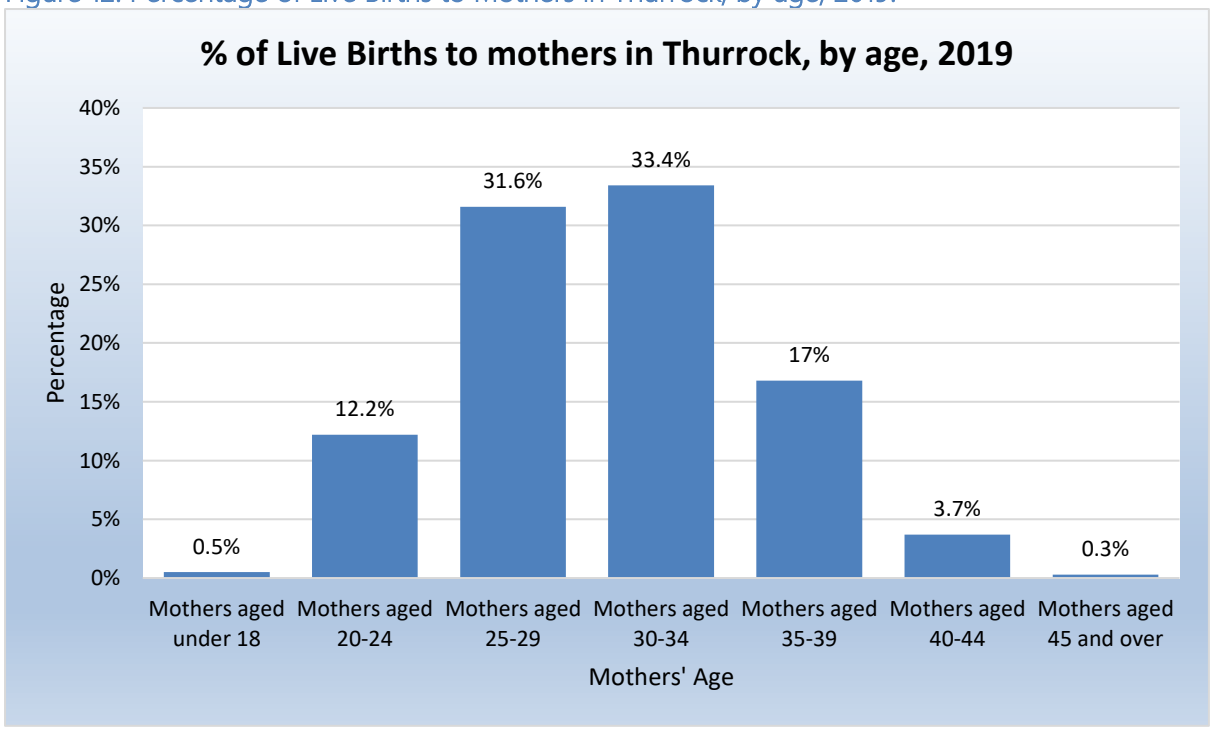
At Basildon and Thurrock University Hospital (BTUH) there were 4062 births in 2019/20 with an additional approximate 150 births taking place in the community. Of these births, approximately just over half – 2,415 births) (59% in 2019/20) are to Thurrock residents with the rest coming from surrounding areas, mostly from the Basildon area (NELFT 2019/20).

Figure 11: General Fertility Rate in females (15-44 years) in Thurrock by Ward, 2015-19.



Source: Local Health, 2015-19.

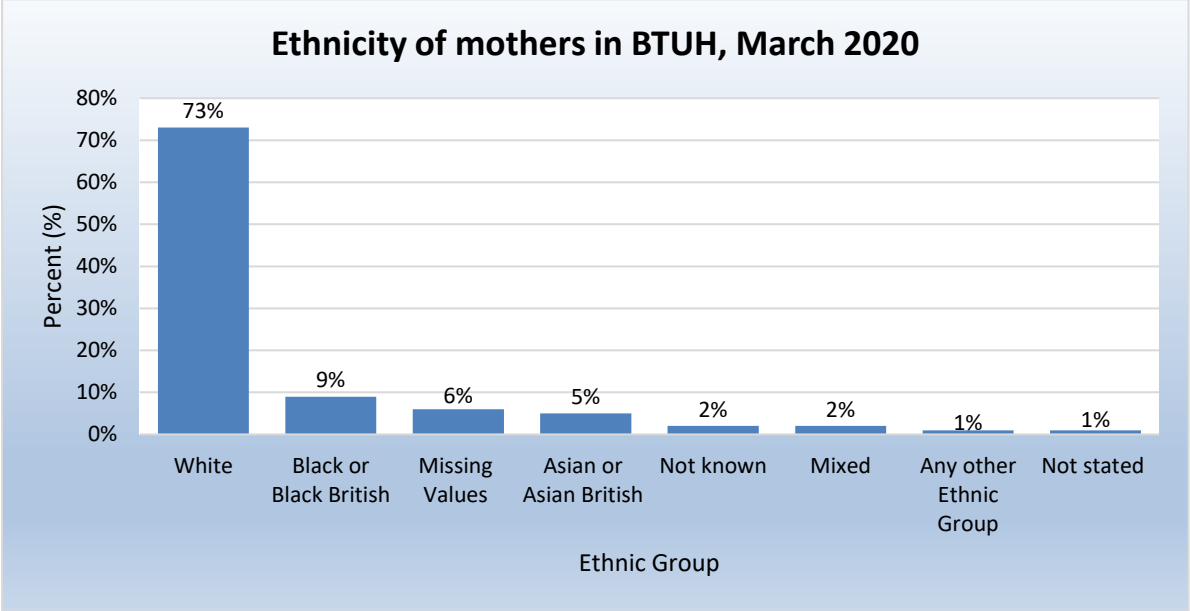
Figure 12: Percentage of Live Births to Mothers in Thurrock, by age, 2019.



Source: NOMIS, 2019.

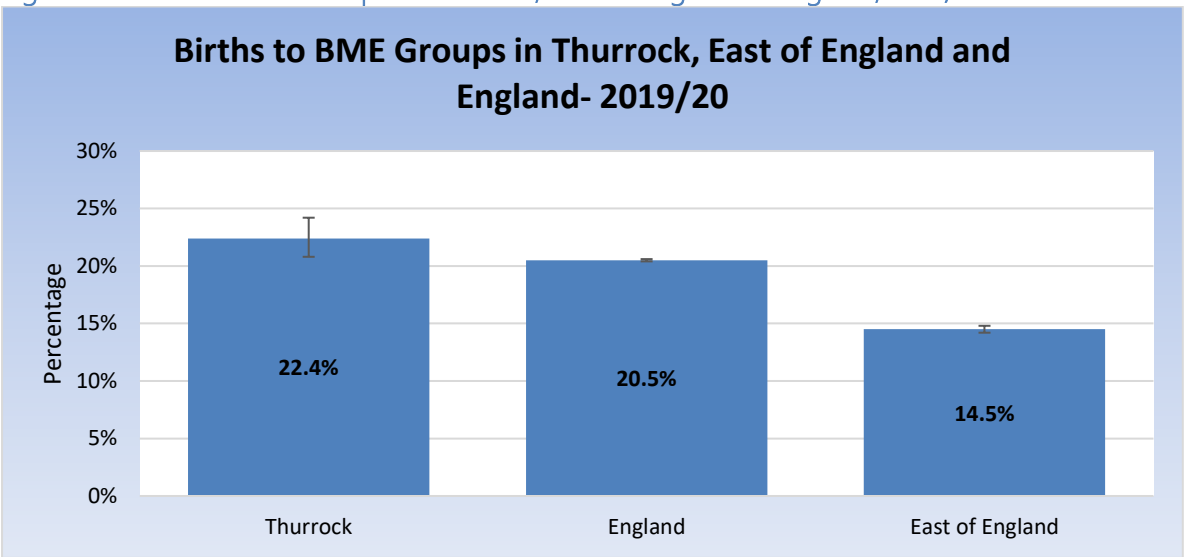
Figure 12 above highlights that women aged between 25 and 34 account for the largest percentage of births in Thurrock. In addition, there is a much higher percentage of white mothers in Thurrock and other local areas as outlined in Figure 13 below. However, births to BME women account for 22.4% of births in Thurrock which is significantly higher than the East of England and England percentages (see Figure 14 below) although this is consistent with the ethnic diversity observed in Thurrock, highlighted in figure 1 (p7).

Figure 13: Ethnicity Status of Pregnant Women at BTUH and all submitters, 2018.



Source: Maternity Service Data NHS Digital 2019 for October 2018.

Figure 14: Births to BME Groups in Thurrock, East of England & England, 2018/19.

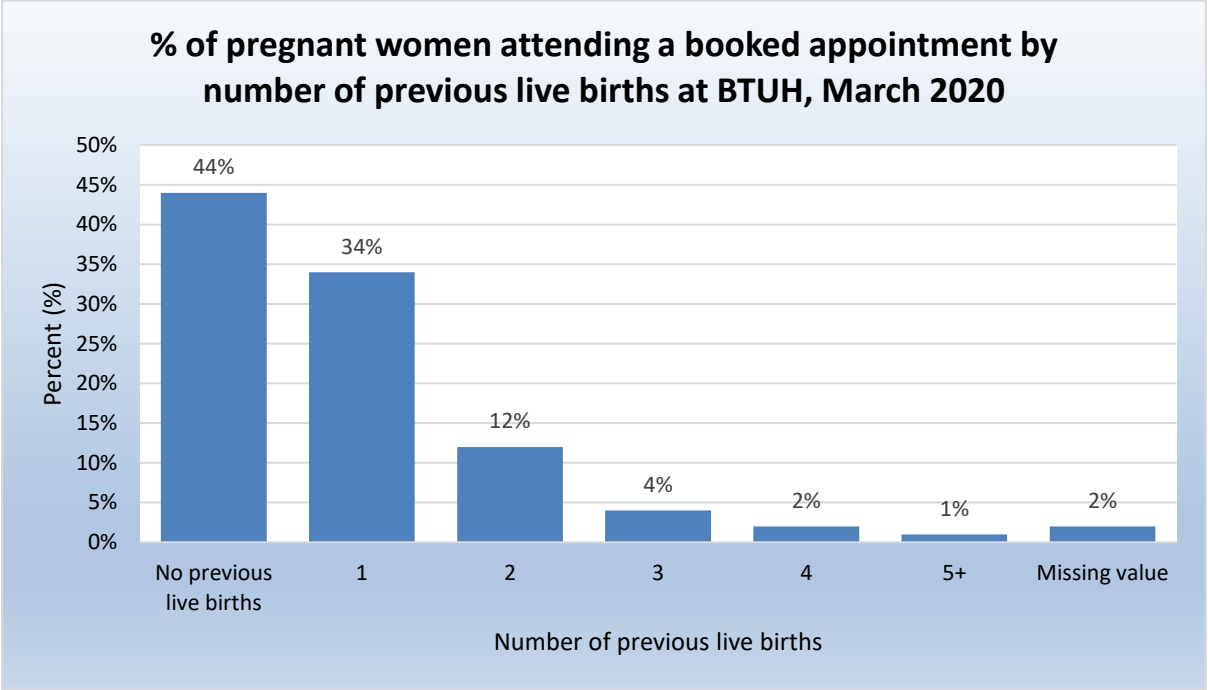


Source: PHE Fingertips – Child and Maternal Health, 2018/19.

Figure 15 below shows the percentage of pregnant women who attended antenatal booking appointments at BTUH by number of previous births. In March 2020 at BTUH 44% of the women were attending booked appointments for their first child with 7% of those attending having previously had at least three children. Most of the booking

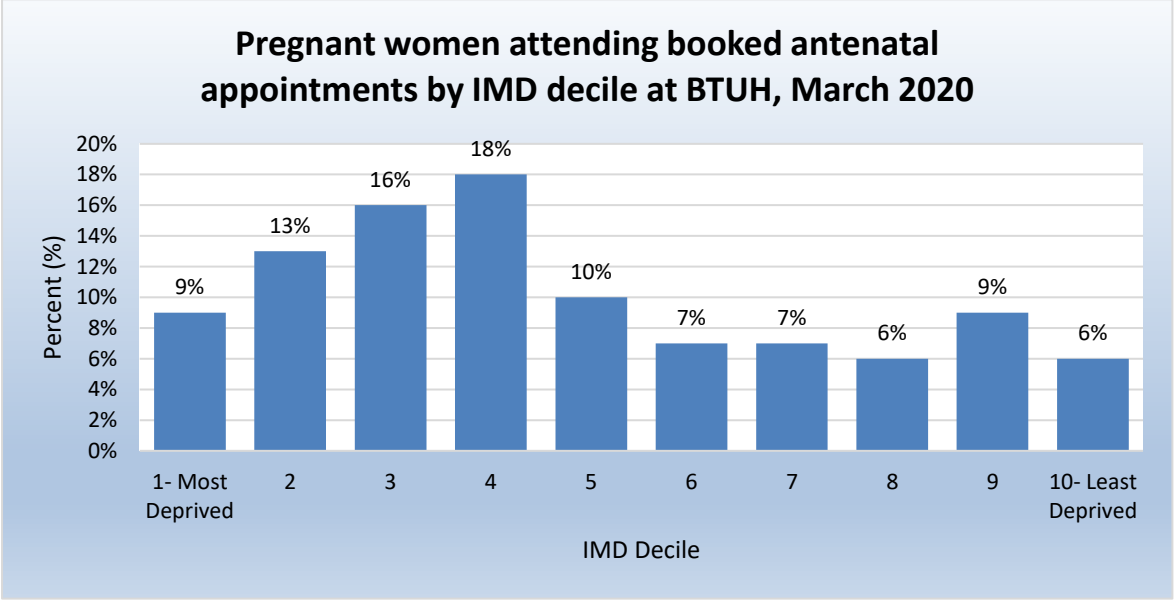
appointments were for the first or second child. Families attending appointments were able to seek and receive advice and initiate early conversations with health professionals about breastfeeding.

Figure 15: % of pregnant women attending a booking appointment by number of previous live births at BTUH, 2020.



Source: Maternity Service Data NHS Digital 2021 for March 2020.

Figure 16: % of pregnant women attending antenatal appointments by IMD decile at BTUH, March 2020.



Source: Maternity Service Data NHS Digital 2021 for March 2020.

Pregnant women living in areas of higher deprivation (decile 1-4) make up the largest percentage (56%) of booking appointments within antenatal services at BTUH (see figure 16 above). This initial antenatal appointment presents an opportunity for health professionals to initiate early conversations with these families.

The Healthy Child Programme recommends that a pregnant woman is offered an antenatal visit from a health visitor from 28 weeks of pregnancy, as well as within the two weeks following the birth. As highlighted earlier in this report there are currently between 2200-2400 births to mothers in Thurrock each year (2018-20). Health Visitors have a target to visit all new mums (a minimum of 95%) and their babies and partners if possible, within their home within 14 days of birth. In 2016/17 this was achieved for only 93.7% of new births. This increased to 94.5% in 2017/18 and meeting the performance target in 2018/19 at 97.2%. It was subsequently 98.1% in 2019/20 and 97.6% in 2020/21.

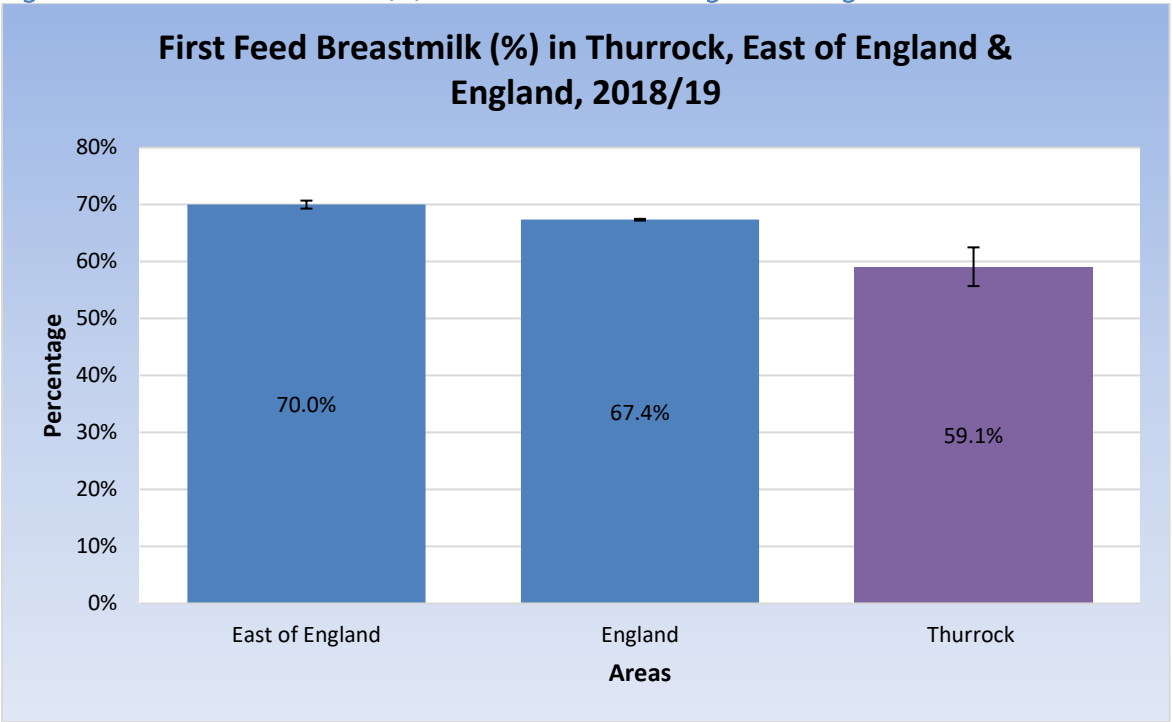
What does this mean for Thurrock?

- Fertility in Thurrock is variable although on average it is higher than the England average.
- There are approximately 2200 to 2400 births in Thurrock every year, the majority take place at BTUH.
- There are a higher proportion of births to BME mothers in Thurrock (22.4%) than in the East of England. Women from BME groups are more likely to breastfeed and so the low prevalence of breastfeeding in Thurrock does not reflect this. Data showing the ethnicity of women breastfeeding is not available to be able to explore this further at a lower level.
- Pregnant women living in areas of higher deprivation in decile 1-4 make up the largest percentage, 60% of booking appointments within antenatal services at BTUH. This is important given the fact families on low income are less likely to breastfeed (5).
- Families attending appointments were able to seek and receive advice and initiate early conversations with health professionals about breastfeeding. It is important to ensure that there are multiple opportunities and methods to engage pregnant families in conversations about breastfeeding whilst looking to engage families within booking appointments.

2.4 Breastfeeding Data

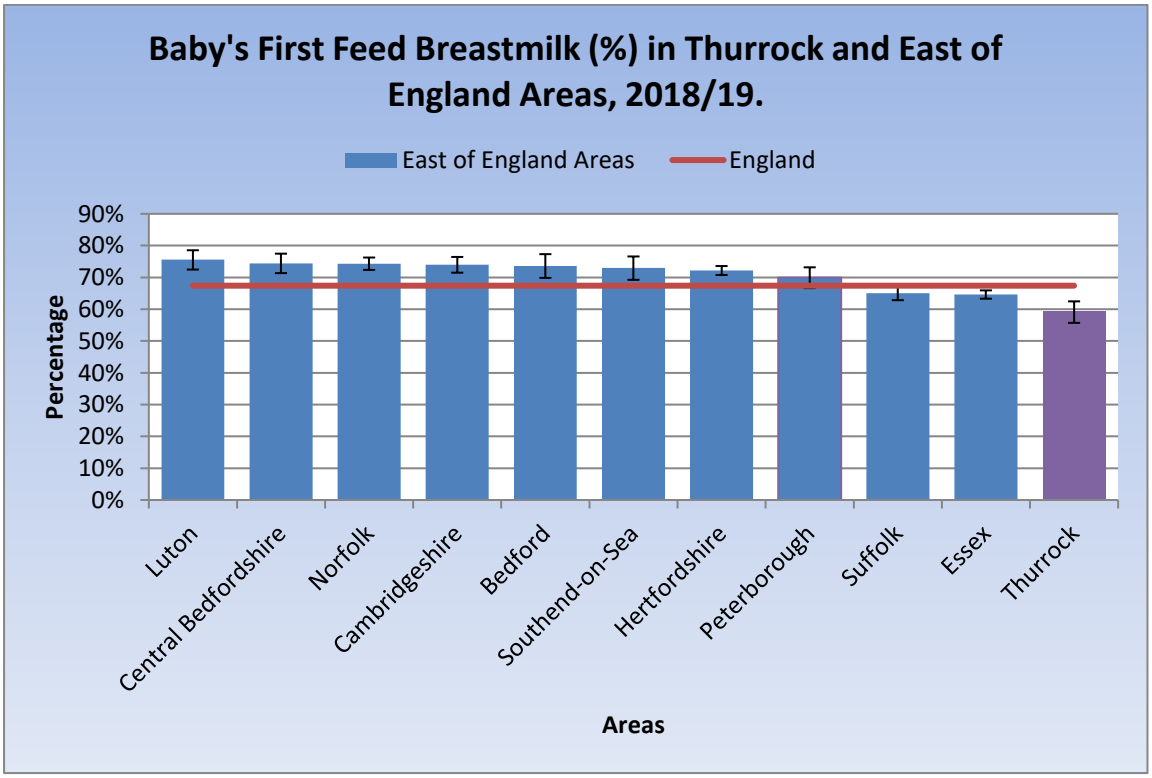
In Thurrock, first feed breastmilk rates are low at 59.1%; this is significantly lower than the regional and national averages (70% and 67.4% respectively in 2018/19) (see Figures 17 and 18 below). Moreover, Thurrock has the lowest first feed breastmilk rate across the whole of the East of England (See Figure 18). Reductions in breastfeeding rates in Thurrock are large, by 6-8 weeks post birth breastfeeding (exclusive or partial) was only 48% in 2019/20 (see figure 19). This is statistically similar to the England average. *Data was not available from Norfolk, Hertfordshire, Suffolk, or Milton Keynes as comparators.*

Figure 17: First Feed Breastmilk (%) in Thurrock, East of England & England, 2018/19



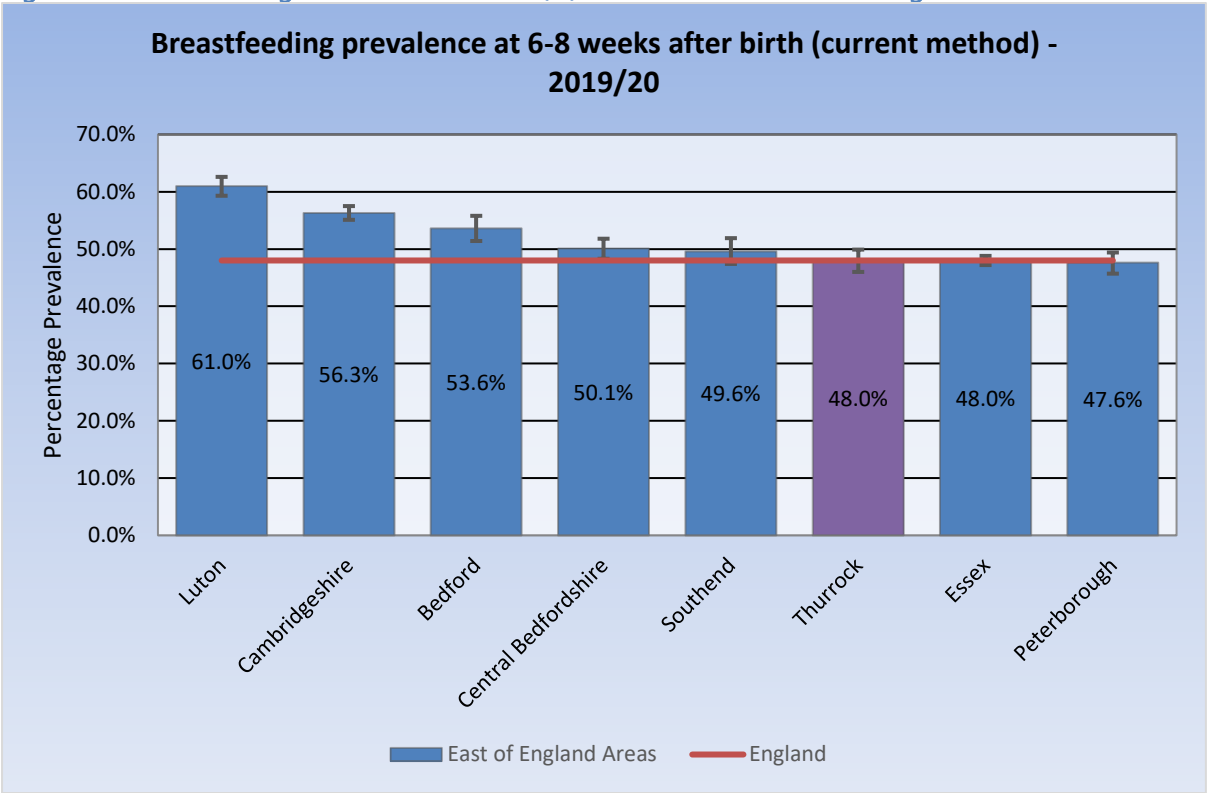
Source: PHE Fingertips – Child and Maternal Health Profiles, 2018/19

Figure 18: First Feed Breastmilk (%) in Thurrock and East of England Areas, 2018/19



Source: PHE Fingertips – Public Health Profiles, 2018/19 (most recent comparable data available)

Figure 19: Breastfeeding Rates at 6-8 weeks (%) in Thurrock and East of England Area, 2019/20



Source: Public Health England Fingertips National Child and Maternal Health Profile

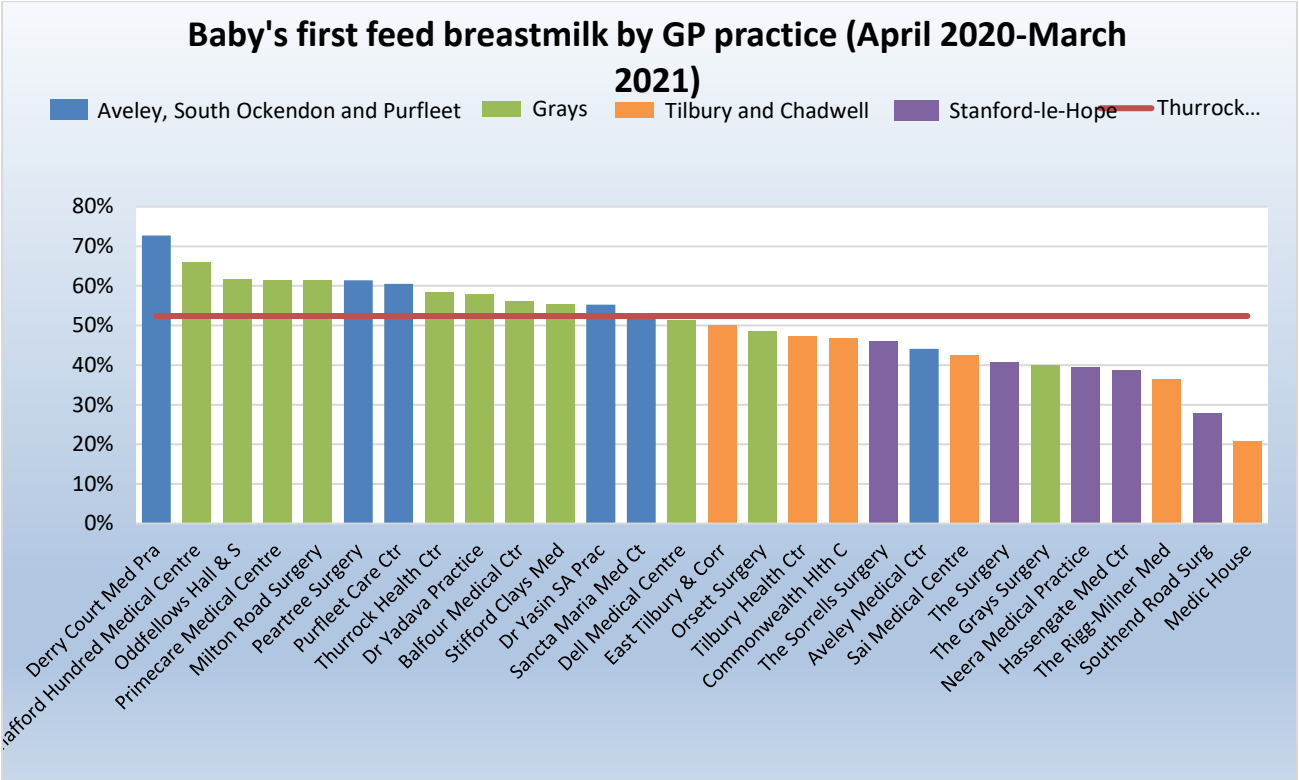
Within Thurrock, there is a level of variation in rates of early breastfeeding. This can be seen below at practice level[2].

It can be seen that practice-level first feed breastmilk (FFBM) prevalence ranged from 20.8% (Medic House) to 72.7% (Derry Court Medical Practice). It appears from Figure 20 below that most of the GP practices with the highest prevalence are within the Grays PCN area, and conversely all of the Tilbury and Chadwell and Stanford-le-Hope PCN practices have lower FFBM rates than the Thurrock average.

The breastfeeding rates in the East of Thurrock more generally are lower at 6-8 weeks than areas with a higher proportion of BME groups which seems to support the research that suggests women from BME groups are more likely to breastfeed and to maintain breastfeeding than white women (5). Figures 6 and 7 on p10 and 11 show deprivation (IMD Score) and percentage of Child Poverty by ward. The East of the borough and in particular Tilbury have much higher levels of deprivation than Aveley and Grays. The lower prevalence of breastfeeding observed in the more deprived wards supports the evidence that breastfeeding rates in the UK are significantly lower among families on a lower income (5).

[2] Note – in order to understand approximate locations of these GP practices, a colour code has been applied to show the Primary Care Network area of each practice.

Figure 20: Percentage of babies who received breastmilk as their first feed, by GP practice in Thurrock, 2020/21.



Source: NHS Arden & GEM Commissioning Support Unit.

The map below shows the location of GP surgeries who have either low breastfeeding uptake (Gold) or high drop-out rates (Red) as well as the location of the Children's Centres (Blue). As can be seen by the map the location of the Children's Centres are well placed to support families, as they are in close proximity to GP practices where low uptake and high drop-out rates are prominent.[3]

[3] This map (2) was created when completing the social marketing research in 2019 and so the currency of the data is noted and caution applied in interpretation.

Map 1: Location map of GP surgeries with low uptake &/or high drop-out rates of breastfeeding and location of Children's Centres.

Source: PHE Annual Breastfeeding Statistical Release 2017/18

Key:
Gold = GP cohorts with low breastfeeding uptake
Red = high drop-out rates
Blue = children's centres (blue)

What does this mean for Thurrock?

- In Thurrock first feed breastmilk rates (59.1%); are significantly lower than the regional and national average.
- Thurrock also has the lowest first feed breastmilk rate across the whole of the East of England (See Figure 23).
- Reductions in breastfeeding rates in Thurrock are large, by 6-8 weeks post birth, breastfeeding (exclusive or partial) was 48% (2019/20).
- Children's Centres are well placed to support families, as they are in close proximity to GP practices where low uptake of breastfeeding and high drop-out rates by 6-8 weeks are observed.

3 Existing Local Offer

NELFT – Healthy Families offer around Breastfeeding (2019)

The commissioned offer from the Public Health team at the Council in relation to Breastfeeding is delivered by NELFT through the Healthy Child Programme; Brighter Futures Healthy Families Service. All staff within the service are Baby Friendly Initiative (BFI) level 3 accredited (over a 2 day course) to support them to deliver support around breastfeeding[4]. As part of their core offer through the Healthy Families Service NELFT conduct an Infant Feeding assessment routinely, both during the antenatal and postnatal periods. This assessment contains provision of information/support relating to parents feeding intention and staff give evidence based information for parents to inform their choice. This is recorded on a Parent Health Record. Although the Healthy Families Service offer is mostly delivered once the child is born, support is offered in the form of an antenatal visit to as many parents as possible, this is dependent upon notification from maternity services that a woman is pregnant.

NELFT contact all parents once they have given birth via telephone, and send out a Mother's questionnaire (twice annually) to assess mothers, and to enable signposting/support as needed. As part of this biannual audit 30 breastfeeding and bottle feeding parents are contacted and their feedback informs the annual update for staff and changes are made to the service in response.

There are five mandated contact points within the Health Visiting service (Healthy Families) the first three offer the most opportune times to support with breastfeeding: antenatal, new-born (10-14 days after birth), and 6-8 weeks following birth. Support and advice is offered for positioning, attachment and where any other concerns can be discussed and methods found to alleviate these issues. For example, there is a tongue tie clinic at BTUH – should infants be struggling to feed that health visitors can refer to.

In partnership with the Children's Centres, NELFT run infant feeding drop in sessions, Child Health Clinics and 'Introduction to Solid food' sessions both within the Children's Centres and Thurrock Health Centre (outlined below)[5]. The team also link with BRAs[6] and signpost to this service which is a local breastfeeding peer support group in Stanford-le-Hope (detailed below) and part of the community and voluntary sector.

NELFT also provide information about Parents 1st (who offer a course for fathers) on all of their promotional resources e.g. leaflets and website who are also part of the community and voluntary sector and not currently commissioned by the Council.

[4] Recently (August 2021) the Healthy Families Team have been re accredited at level 3 for the Baby Friendly Initiative.

[5] Virtual support has continued to families throughout the Covid 19 pandemic in 2020/21. The infant feeding clinics have been running by appointment throughout the pandemic.

[6] Breastfeeding Reassurance And Support (BRAs)

As part of the new birth visit and visit at 6-8 weeks after birth, Health Visitors support breastfeeding and are required to undertake a Maternal Mood Assessment that aims to identify whether new mums are having any difficulties in adjusting to motherhood and identify any mothers that may be at risk of post-natal depression. During the last few years between 89 and 85% of mums received one, this proportion has remained similar between 2016/7 (95.8%) 2017/18 (90.7%) and 2018/19 (89.2%) (Healthy Families Service NELFT performance data) Since 2017 there has been a target to increase this to a minimum of 93%, this target has been delivered every month of the contract year 2019/20 at the time of writing this report, ensuring as many women as possible benefit from this assessment. The evidence base has demonstrated that that postnatal illness can affect breastfeeding with emerging evidence suggesting this relationship could be bi-directional (8). Therefore maximising this opportunity to support women's emotional health and wellbeing can play an important part in supporting breastfeeding as well.

Children's Centres

Children's centres work in partnership with other services to deliver support for families including breastfeeding and infant care. Children's centre staff are trained by the Healthy Families staff in regards to infant feeding. All the premises adhere to the Unicef international infant feeding Code[7]. Full details of the timetables for Children's centres can be found on the Thurrock Council Website (9) and it is also included as Appendix 8. The offer varies between Children's Centres with some offering a more comprehensive offer than others e.g. Ockendon. In terms of equity of service this is something that needs to be reviewed and addressed, particularly in relation to breastfeeding prevalence. Offering the same service in each area is important in terms of access to universal provision but providing targeted support in areas of greater need as identified in the data section could contribute to increasing breastfeeding prevalence. Looking at the areas of highest deprivation and areas with families of white British ethnicity as shown in the data section as well as looking at the areas where the GP practice observed prevalence is low could form part of this strategy.

Thurrock BRAs (Breastfeeding Reassurance and Support) Community Interest Company (CIC)

Thurrock BRAs Incorporated Community Interest Company (CIC) is a local breastfeeding peer support group in Stanford-le-Hope launched in 2016. Groups are run by skilled trained Association of Breastfeeding Mothers (ABM) Mother Supporters and a qualified breastfeeding Counsellor. They aim to support families with any breastfeeding issues, concerns or worries and meets weekly (during term-time) at Hardy Park. They also provide support on introducing solids and general parenting support. BRAs has a Facebook page providing support and advice through posts and information about events that may be useful to families (10).

[7] The International Code of Marketing of Breastmilk Substitutes - Baby Friendly Initiative (unicef.org.uk)

Parents 1st

Parents 1st specialise in effective volunteering and peer support during the key life change of pregnancy, birth and becoming a parent.

The team offer a range of friendly and free activities during pregnancy, birth and post birth.

They include:

- One-to-one visits to expectant mothers and fathers from a Pregnancy Pal;
- Birth Buddy support; support through the pregnancy, birth; buddies and can be with the family immediately after birth and can support with feeding.
- Antenatal sessions for mums; which cover information about both breast and bottle feeding.
- Expectant dads workshops cover the following topics;
    - Relaxation for you and your partner
    - Labour and birth.
    - Changes ahead.
    - Practical baby care including feeding and winding (11).

Further information can be sound on the Parent's 1st website. As noted above NELFT promote this service via their website and within their services.

Feeding Together

The NHS BTUH Feeding Together infant feeding service encompasses provision of information, support and understanding, to ensure a positive feeding experience for all mothers and their babies. The offer includes:

- A fully accredited UNICEF Baby Friendly maternity unit
- Information and support to pregnant women and new mums on breastfeeding and infant feeding issues
- Home visits and telephone support to assist mums in getting feeding off to a good start
- Training, resources and support for infant feeding across South West Essex (12).

Feeding Together also have a Facebook page where practical support and advice can found around infant feeding (covers breastfeeding and bottle feeding) for example on how to get a good latch and how to implement paced feeding for mothers who are bottle feeding. It also promotes local events that may be useful for families (13). The Feeding Together work is undertaken by health professionals at BTUH.

Table 1: Places of Support in Thurrock

The table below details the full offer of services to support Thurrock families to breastfeed.

Universal Services: - Midwife (appointments with midwifes are available at most Children's Centres in Thurrock). - Health Visitor appointments/visits. (NELFT Healthy Families Service) - Breastfeeding drop-ins e.g. at clinics. - Children's Centres - see table of events above. (Including drop in sessions for infant feeding) - NHS BTUH Feeding Together Service - National Breastfeeding Helpline on 0300 100 0212.
Charity/Voluntary Sector: - Local breastfeeding support groups e.g. BRAs in Stanford-le-Hope - Peer mentors (volunteer mothers) - Thurrock NCT groups - Parents 1st
Websites/Forums: - Feeding Together Facebook Page - BRAs Facebook Page - Net Mums Online Community Forum - https://www.netmums.com/ - http://human-milk.com – this covers the science behind breastmilk and breastfeeding. - https://www.babycentre.co.uk – commercial site but contains information about common concerns families might have in relation to infant feeding including, milk supply, expressing, managing sore and painful nipples and latching amongst others. - Start4Life breastfeeding website – https://www.nhs.uk/start4life/baby/breastfeeding/ - Start4Life breastfeeding friend (operated by Facebook Messenger or Amazon's Alexa). - Maternity Direct+ - has a website page where expectant or new parents can ask questions/request support and advice 24/7 https://www.facebook.com/maternitydirect/
Other: - Family and breastfeeding friends.

What does this mean for Thurrock?

- There is a universal offer from commissioned Public Health and Acute Health services as well as some community and voluntary sector services to support families along with the national websites and helplines from charities and NHS partners.

- Looking at the equity of provision in the localities around Children's Centres in Thurrock alongside the data showing breastfeeding prevalence is an important approach when designing or revising the service offer. There is an opportunity for Children's Centres to play a key role in increasing breastfeeding prevalence in Thurrock.

- The social marketing research in chapter six looks at Thurrock families' awareness of and satisfaction with the service offer and will be important insight when looking at promoting the services and the best approach to this, as well any future commissioning and design.

4 Literature Review Summary

4.1 Introduction to Breastfeeding

What is breastfeeding?

Breastfeeding, also known as nursing, is defined as …'the feeding of babies and young children with milk from a woman's breast'. Breastfeeding is one of the most effective ways to ensure child health and survival however nearly two out of three infants are not exclusively breastfed for the recommended six months. (14)

What proportion of new mums breastfeed?

As noted in the introduction of this needs assessment the UK is one of the most poorly performing countries in the world in terms of breastfeeding continuation past the early weeks. Although initiation rates are comparatively high (to 6-8 week rates) at around 80%, reductions in breastfeeding rates from birth to 6-8 weeks are quite large, reducing to approximately 43.2% of mothers still breastfeeding at all (either exclusively or partially. Exclusive breastfeeding refers to the mother only feeding their infant breastmilk, whilst partial breastfeeding involves mixed feeding practices of both formula and breast milk). These rates fall even further at 6 months with only about 1% of all mothers breastfeeding their infants exclusively (1), (2).

Why is this important?

These low rates of breastfeeding can have an impact on infant health through increased risk of infection and illness in the first few months of life. Breastmilk contains anti-bodies that help to protect the infant from contracting infections and supports their developing immune systems. In addition breastfeeding protects infants against pneumonia and necrotising enterocolitis (1) and lowers the risk of infants developing other respiratory and ear infections. There are multiple examples in the evidence base of the science behind breastfeeding and its protective factors.

One study reviewed suggests that use of breastfeeding substitutes is also associated with increased risk of infants developing these illnesses (15). Hospital admissions for respiratory tract infections in 1 year olds in Thurrock (57.5 per 10,000 population) were similar to both the regional and national rates (72.4 and 83.5 per 10,000 population respectively) in 2016/17 (16). Moreover, hospital admissions for asthma in 10-18 years olds in Thurrock was similar to the East of England rate (65 and 100.7 per 100,000 population) (16). This is perhaps indicative of the relatively low breastfeeding rates nationally as well as locally. Perhaps surprisingly, 67% of people do not believe there are any biological differences between breast and formula milk (17). Health professionals cite the importance of supporting families to understand the difference between breast milk and formula to enable them to make an informed decision (18).

In turn evidence from the Early Intervention Foundation suggests that there are lower levels of infant mortality attributable to infections in breastfed babies, and although reasons for this are unclear there are theories which propose that an infant's dietary system is unable to tolerate and fully digest complementary foods such as formula milk at such a young age (1). The rate of infant mortality in Thurrock is 3.1 per 1,000 population and is similar to both the regional and national rates (19). Furthermore, mortality from causes considered preventable is significantly higher in Thurrock (197.3 per 100,000 population) compared to the East of England and England rates (160.2 and 181.5 per 100,000 population respectively) (19). Infants who are not breastfed (either partially or exclusively) place both mother and infant at increased risk of poor health later in life, including increased risk of becoming obese, developing Diabetes and Cardiovascular disease amongst other conditions.

Why do more women not choose to breastfeed?

This literature search aims to review the published evidence for effective interventions to promote uptake and maintenance of breastfeeding and look at any areas of best practice to support with the development of recommendations for a Thurrock strategy to address this. The published policies related to breastfeeding are reviewed alongside published research supporting and challenging the guidance within the policies in section 4.3.

4.2 Promotional material to encourage and inform families about breastfeeding

Key points:

- Research suggests some mums are not convinced by the information around the benefits of breastfeeding.
- Knowledge and benefits of the health benefits alone is not enough to encourage women to breastfeed.
- Providing information to adolescents that corrects misconceptions about breastfeeding is vital in supporting them to develop positive attitudes towards breastfeeding at an early age.

Despite the numerous health benefits, breastfeeding rates remain low and it has been suggested by some that knowledge and promotion of the health benefits alone is not enough to encourage women to breastfeed and in-fact some mothers believe that focusing on only the health benefits can take away from breastfeeding becoming normalised (18), (20). There is an abundance of research that explores additional factors that may also be acting as barriers to breastfeeding, such as feeling uncomfortable about breastfeeding in public (20), (21). This suggests a need for promotion and awareness raising of the wider benefits such as convenience, cost and closeness/bonding which women involved in research have reported would be welcomed (18). In one piece of research one women stated:

"Breastfeeding is about so much more than health. It is about cuddles, closeness and bonding. It saves time, costs nothing and you can never forget to take it out with you. Why don't we emphasise these things more?" (18).

For low income families not knowing about the wider benefits, particularly perhaps cost could in part explain the low uptake of breastfeeding in this cohort of the population.

Published research suggests that successful breastfeeding promotion depends upon understanding an individual's point of view and intervening on those terms. This was part of the rationale for undertaking a piece of social marketing research relating to infant feeding (see Section 6).

Much of the research highlights the fact that current promotional materials fail to provide 'real world' images of breastfeeding and can therefore deter some women from making the choice to breastfeed (20), As such promotional resources are more likely to be effective if they depict mothers and babies in 'everyday' social situations. The Baby Friendly Initiative uses an evidence based approach to supporting families around breastfeeding and good infant nutrition as well as developing positive loving relationships with their baby/babies (22). Introduction of the Baby Friendly Initiative (BFI) has supported

some improvements to resources e.g. the BFI 'You're Welcome to Breastfeed here' posters for businesses to display.

There are also some issues relating to timing of breastfeeding education, promotion and support which are usually targeted towards pregnant women. This is significant in light of the growing recognition that decisions regarding infant feeding choices are often made before pregnancy and the beginnings of this thought process may commence as early as during adolescence (23). Findings from one study that examined the impact of an infant feeding classroom activity on breastfeeding knowledge and intentions suggests that adolescents' knowledge of, and intention towards breastfeeding may be positively influenced during their teen years. Furthermore, providing information to adolescents that corrects misconceptions about breastfeeding is vital in supporting them to develop positive attitudes towards breastfeeding at an early age (23). At 10-weeks post-intervention increases in intentions to breastfeed remained and it is possible that this was due to students further discussing the topic with friends and families or undertaking their own research following the study. Moreover, of the pupils who participated in this study 87% reported believing that breastfeeding should be included in the school curriculum.

4.3 Research exploring how policies influence families to breastfeed.

Key points:

- NICE recommend an overall infant feeding strategy is developed promoting breastfeeding although supporting safe formula feeding and promoting families developing positive emotional relationships with their babies.
- WHO and UNICEF advocate breastfeeding promotion for the first 2 years of life and exclusively for 6 months
- BFI accredited organisations should not promote formula feeding, bottles or teats.
- A Thurrock approach should take the positives from all of these approaches in developing a strategy that supports families to breastfeed and promotes healthy choice.

Research in 2012 (24) examined goals, assumptions and dilemmas associated with breastfeeding education and support. The authors highlighted three main dilemmas based on the different ethos and approaches to breastfeeding support. National Childbirth Trust's (NCT) ideology centres on 'quality of experiences' and parents having every opportunity for positive feeding experiences contrasted by WHO/UNICEF's 'health outcomes' view; the authors pose ways to overcome these dilemmas.

Dilemma 1 – should we promote breastfeeding or promote choice?

The authors propose that ongoing support should be offered to mothers in relation to their infant feeding decisions whilst equally protecting their decisions to breastfeed.

Dilemma 2 – Should we prepare parents for difficulties they might experience during the breastfeeding journey or give the view that breastfeeding is straightforward and easy?

It is suggested by Trickey et al (24) that professionals should be promoting the concept of investment and adjustment here; being realistic that breastfeeding can be difficult, particularly in the early days but that investing time and responding to the baby's need can help overcome problems; offering reassurance that it does become easier over time.

Dilemma 3 – should professionals provide proactive or reactive support e.g. waiting for mothers/families to initiate requests for support?

The authors suggest developing models that are both mother-centred and proactive.

The findings of the social marketing research described later in this report (Section 6) reflect these dilemmas and resonate with the views of families in Thurrock.

Research suggests that although there are policies and guidance in place to support families around breastfeeding these are not necessarily getting through to families; or are being diluted by other attitudes or influences (18).

4.4 Benefits of, and Barriers to Breastfeeding

Key points:

- There are multiple short and long term health benefits to mothers and babies in breastfeeding.
- Increased exclusive breastfeeding in the population could result in cost savings to the NHS
- Increasing the number of infants who are breastfed could be an important strategy for improving the health and wellbeing of children, women and families as well as society in general (23).
- There are numerous barriers, beliefs and misconceptions relating to breastfeeding resulting in women choosing not to breastfeed.

Benefits

The benefits of breastfeeding are well evidenced. For example, breastfeeding has multiple health benefits for both mother and baby, some of which are outlined in Section 4.1 above. Other health benefits include reduced risk of Sudden Infant Death Syndrome

(SIDS), ear and respiratory infections, childhood Leukaemia and development of allergies later in life.

One study suggests that supporting women to continue exclusively breastfeeding up to 4 months could save the NHS at least £11 million annually. Moreover, doubling the percentage of mothers who are breastfeeding for between 7-18 months could potentially save £31 million, by reducing maternal breast cancer, reducing A&E attendance and hospital admissions due to infant or mother poor health as well as enhancing quality of life and life expectancy (15).

Breastfeeding also reduces the risk of long term health conditions later on in life, including type 2 diabetes, cardiovascular disease as well as protecting the infant from becoming obese in later childhood and adulthood. Some researchers suggest that breastmilk may contain hormones that support the body to metabolise food more readily and efficiently (1).

Health benefits for the mother include lowered risk of developing both breast and ovarian cancer, osteoporosis, diabetes and cardiovascular diseases.

It is also widely recognised that the many health benefits associated with breastfeeding also provide children with the best start in education e.g. through optimal brain development, protection from illness which can lead to visual or hearing impairments or Learning Disabilities (LDs) and enables better eye focus leading to reading and learning readiness (23).

The wider and tangible benefits of breastfeeding are perhaps not as widely promoted as the health benefits are but perhaps should receive a higher profile in terms of supporting breastfeeding to become normalised. They include benefits such as reduced cost, convenience and opportunity to bond with the baby.

Breastfeeding is an intimate experience that involves skin-skin touch, eye contact and closeness. It can support the infant in recognising their mother's face and voice and the mother can talk or sing to the infant, which research shows to be supportive of later language development. It also creates a great opportunity for quality time between the mother and infant. The positioning of infants during breastfeeding is optimal to allow these things to take place, although it could be possible to maximise these benefits with bottle feeding (if breastfeeding is not possible) if they are widely understood by families. UNICEF provide comprehensive information about the benefits and importance of skin-to-skin contact (25). For example, families can initiate skin to skin contact while feeding their infant or at other times whilst at home. Some websites such as Essential Parent (who work with leading medical experts such as UNICEF) provide guidance and tutorials about how this can be achieved, as well as how to safely bottle feed (26). It is unclear to what extent these behaviours will impact maternal and child outcomes in the absence of breastmilk.

Interestingly whilst women report mainly being told about the health benefits of breastfeeding, in one study with male partners, some males cited viewing breastfeeding as cheaper and more convenient (21). This research aimed to highlight the different perspectives, of parents in terms of what fathers thought about or were told about breastfeeding compared to mothers.

Based on the evidence reviewed the following represent key drivers that promote breastfeeding:

- Mother-centred discussion and information
- Convenience
- Cost
- Being (perceived) as being/ or being a good mum
- Being able to provide their baby with something no-one else can.
- Peer support
- Giving mum the option for wider involvement of the father and other family members in supporting and encouraging breastfeeding.

Barriers

The perceived barriers are also well documented throughout research with mothers and can be broken down into several key themes, including but not limited to; practical difficulties, freedom and independence – leading to perceived inability to undertake daily activities, lack of support from wider family, health and needs of the baby, time, views of others and societal embarrassment (20).

One of the most commonly cited reasons for choosing to bottle feed relates to perceived insufficient milk supply. A pilot study using a home-based programme was undertaken which aimed to reduce the number of women who perceive having insufficient milk supply, with a focus on evaluating the short term impacts of the programme. It was hypothesised that mother's lack of confidence around breastfeeding as well as their misinterpretation of infant's behaviour would be contributory factors to this perception. The programme was delivered during 3, 10 and 15 hour home interventions at 6, 13 and 27 weeks postpartum. Results suggest that the programme significantly increased (over time) the mother's self-efficacy and sensitivity to their baby's behaviour and self-efficacy as well as a reduced mother's perception of their baby's crying as related to insufficient milk supply. Based on the results, this programme has the potential to support breastfeeding continuation by building mother's confidence around breastfeeding (27).

Other more practical barriers relate to the presence of other children and needing to care for them, need to return to work and also the lack of public facilities in which to breastfeed. For some, breastfeeding is perceived as requiring prolonged unpaid maternity leave and this added to the feelings of dependency and lack of freedom (20).

The barriers to breastfeeding from the perspectives of dads have some similarities with those reported by mums. In terms of feeling uncomfortable about their partner breastfeeding in public, lack of support from wider family or the belief that bottle feeding is better and more convenient, wanting to get involved in feeding their baby and to give their partner a break (21). However, one study that aimed to explore the relationship between men and breastfeeding found that the majority of participants (65%) reported that they would feel comfortable with their partner breastfeeding in public, with only 3.4% reporting they would feel completely uncomfortable. One limitation of this study was that it relied on self-reporting by participants, as such it may have been subject to bias, in terms of men wanting to give socially acceptable answers. It is still an interesting insight and one that was explored as part of the social marketing research undertaken in Thurrock (see Section 6).

4.5 Mothers and Breastfeeding

Key points:

- Having encouragement from social and support networks makes mums more likely to breastfeed and breastfeed for longer.
- Women experience breastfeeding past six months as being viewed as socially unacceptable.
- Mums report feeling 'shamed' if they choose not to or struggle to breastfeed and discontinue.
- Mums report often feeling insufficiently reported and unprepared for the realities of breastfeeding.
- There is good evidence that support from fathers is critical to breastfeeding success in terms of initiation and maintenance and should be central in breastfeeding strategies and education.
- It shouldn't be assumed that teenage mums are less likely to breastfeed.

Some research suggests that background is really important; mothers who were breastfed, had family and friends who were or had breastfed, were encouraged to breastfeed, had a supportive network, attended antenatal classes and who had positive beliefs about breastfeeding were more likely to breastfeed and continue to breastfeed over a longer duration (28). In one study where young mothers were interviewed about their experiences of breastfeeding, one participant suggested that the term infant feeding 'choice' is one of the barriers to breastfeeding and cites:

"I believe that having the choice about how to feed your baby is where the problems start! If breastfeeding was considered the normal way to feed your baby and formula only used when this was not possible then mothers wouldn't be so confused about having to choose and would breastfeed with confidence." (28).

In the same research mothers acknowledged that breastfeeding was not always straightforward and they were not void of any difficulties or the negative attitudes of others e.g. as the infant grew past the newborn stage and particularly as the baby reached 6 months. This is reflected in other research such as in one study with women who continued to breastfeed beyond 6 months and who reported that they felt they were viewed as 'suspicious' and experienced disapproval particularly in a public context (29). However, they were able to overcome these problems due to their beliefs around breastfeeding coupled with the feeling that there was nothing to be ashamed of/worried about.

Mum shaming

*R*esearch from Cardiff University highlights that for a minority of mums the literature provided at appointments is perceived to be 'pushy' and 'insulting.' Additionally, some mums felt that there is too much pressure applied by midwives to breastfeed and this resulted in them feeling judged and as though they had failed when they stopped breastfeeding, didn't feed for as long as they had hoped, or weren't able to at all.

This feeling of negativity is cited as a reason for not breastfeeding for as long as some women would like and it is thought that this can contribute to post-natal depression (30) .

This research termed this concept 'mum shaming' and this is referred to in online forums and anecdotally in focus groups although it is acknowledged that each individual's construct of what this includes could be different. The Urban Dictionary defines 'Mom' Shaming as criticising or degrading a mother for her parenting choices because they differ from the choices the shamer would make. For example 'this woman is mum shaming me for not breastfeeding my daughter' (31).

Echoed widely throughout the research, was the fact that women did not feel that they were sufficiently supported and prepared for the realities of breastfeeding. This was also mirrored in the views provided by men within the evidence base as well as by mums and dads in Thurrock who participated in the Social marketing research (see Section 6). The research suggests that equipping women and their families with support about how to overcome any challenges is likely to increase their confidence and in turn support them to breastfeed for longer (18).

There is clear evidence across the research base that support from fathers is critical to breastfeeding success, both in terms of breastfeeding initiation and maintenance perhaps relating to reduced stress on mothers, with several studies highlighting a need for programmes to be developed that offer support to both parents. Currently, antenatal and post-natal care do not usually include information and training for fathers/partners as a priority (32), (33). Some evidence proposes that men/partner's greater involvement at all stages of the pregnancy not only helps them to support their partners but also gives couples an opportunity to conceptualise and adapt to their family transition together (33).

The views of adolescent and young mothers mirror those found in other research particularly around the need for consistent information that informed them about the realities of breastfeeding. Adolescent and young mothers often also cited that they perceived it as difficult to get information about breastfeeding from health professionals. They reported that they found health professionals tended to assume that they would formula feed and therefore did not talk to them about breastfeeding (34).

4.6 Fathers, Partners and Breastfeeding

Key points:

- Fathers and partners role in breastfeeding can be easily overlooked or undervalued.
- Partners, fathers and families are influential in women's choices around breastfeeding.
- Men have reported feeling excluded by health professionals from breast feeding education
- In particular in lower income households it is reported that the infants father plays a crucial role in supporting decisions around breastfeeding
- It is acknowledged that a lot of research around Fathers is second hand information and reflects the views of the mother. More research into fathers' opinions attitudes and beliefs would be beneficial.

The role of fathers and partners in the decision about whether to breastfeed or not is often undervalued and not always given as much consideration by health professionals. However, increased attention is starting to be paid to the role of men in breastfeeding (21). The evidence highlights that fathers and partners have an important influential role to play in determining the initiation and continuation of breastfeeding in terms of how actively they participate in the breastfeeding decision, their knowledge about the benefits of breastfeeding and their attitudes towards breastfeeding.

Research suggests that education and support about breastfeeding for fathers improves breastfeeding rates and that women who enjoy the full support of their partners are more closely bonded to their children and are more responsive and sensitive to their needs (35).

The table below illustrates that including dads in education and support around infant feeding choices can have a positive impact on breastfeeding rates. For example, offering manual demonstrations and education during visiting hours in hospital leading up to discharge increased the breastfeeding rate from 12.8% at baseline to 56.4%, an increase of 44%.

Table 2: Research highlighting the effectiveness of targeting dads for breastfeeding education.

Effectiveness of targeting dads for breastfeeding education				
	Control baseline	Mums only	Mums and dads	Improvement
	Exclusive breastfeeding at six months			
Manuals, demonstrations and education during visiting hours, up to discharge	12.8%	33.3%	56.4%	44%
Couples session + leaflet	15%		25%	10%
6 sessions (3-4 hrs) + certificate	24%		63%	39%
60-90 min session	18%		40%	22%

Source: Mahesh et al 2018 (35).

In particular, women from low income households report the vital role that the infant's father plays in supporting their decision about whether to breastfeed (36). For example if fathers view breastfeeding as best for the infant and its ability to develop close bonds then a woman is more likely to breastfeed. Conversely, fathers who are concerned or embarrassed about the mother of their baby breastfeeding in public, or feel that breastfeeding is bad for the breasts, makes them ugly or de-sexualises them then a woman may choose to initiate bottle-feeding practices (36). Clearly addressing some of these attitudes and beliefs may have an important impact on breastfeeding initiation for some families.

However, much of the research provides indirect reports of father's views via mothers and as research directly with fathers is growing it is being uncovered that father's actual views differ and are often more positive than the previous perceptions and accounts given by women suggest. One aim of the Social Marketing Research specifically aimed to target dads/partners to gather their views on this topic (see Section 6 for details).

Furthermore, it is also reported that men seldom receive information directly from health professionals and research suggests they often feel directly or indirectly excluded from health promotion around breastfeeding with one participant stating:

"The information was all aimed at my wife. What she could eat, do experience etc... I know she was the key player here but I felt that it is was nothing to do with me. When we went to the antenatal classes they did a session on breastfeeding. They sent all the dads down to the pub that night." (21).

This reflects other research that notes the importance of fathers in breastfeeding success and the need for programmes of support targeted towards both parents (32) (33), (37). Furthermore, the means by which a father can support their partner may not be apparent

to them and thus providing guidance and useful information on the types of support may help fathers to feel more competent and included. For example, supporting with household chores and the care of other children as well as emotional support through encouragement (37). The research goes on to say that if fathers are more included in the process then mothers will feel better supported, fathers will feel more included and the infant will reap the benefits of an environment in which breastfeeding is the norm (37).

As with mothers, fathers often report having the misconception that breastfeeding will be easy and would like health professionals to provide information about the realities of breastfeeding (21), (37).

4.7 Extended breastfeeding and feeding twins and multiple babies

Key points:

- Breastfeeding past one year in the UK is not common practice despite WHO and UNICEF recommendations, although this is not being routinely recorded to have an evidenced picture of this.
- A survey in 2010 found 2/3rds of mums who stopped breastfeeding by 8 months would have liked to carry on for longer.
- Benefits to breastfeeding a toddler are less acknowledged and discussed.
- Benefits of breastmilk for twins and multiples are the same as for single babies however as multiple babies are more likely to be born prematurely there are extra benefits.

Long-term breastfeeding (extended breastfeeding) is considered to be when women continue to feed their baby/babies past one year of age which is consistent with WHO and UNICEF recommendations as previously outlined.

However, there are few women in the UK that breastfeed past the age of six months and even fewer past the age of 12 months, with this not routinely being recorded. Although in many societies, extended breastfeeding is culturally normal with the age of weaning from the breast ranging from two to four years, this is not yet socially accepted in the UK or more widely (38). One reason for this may be related to the reported experiences of mothers who choose to breastfeed for longer. Unfortunately these women often face criticism for their choices and as previously cited; in one study women who breastfed past 6 months reported that they perceived being viewed as 'suspicious' (29). This could in turn influence others' decisions about whether to breastfeed for longer and may continue to prevent breastfeeding from becoming normalised. Dr Amy Brown states that until society changes its views, extended breastfeeding is likely to continue to attract criticism and misunderstanding; suggesting that more needs to be done to promote the normality of

extended breastfeeding, coupled with raising awareness about the continued benefits of breastmilk for older infants as well as mothers (38).

It is difficult to put a figure on how many UK mums breastfeed beyond the first year. But in a 2010 survey, about a third of mums in England and Scotland were continuing to breastfeed their babies at six months and about two thirds of mums who stopped breastfeeding by eight months to ten months said that they would have liked to have carried on for longer. (39)

Although babies over the age of one get most of their nutrition from solid food, breastmilk still provides immunity from some illnesses, as well as nutrients and vitamins (40). Breastfed toddlers get ill less often than those who do receive breastmilk, it is also beneficial for a toddler fighting illness (41).

Baby Centre UK cites one of the benefits of breastfeeding a toddler to be giving both mother and child the opportunity to relax at a busy time in a toddler's development with the prolactin and oxytocin released to mums on feeding helping to make mums feel calm and connected with their growing toddler. (42) Feeding an older child can help them to be independent rather than the misconception that it can make children clingy, with Baby Centre pointing out that forced weaning from the breast may not necessarily create a more confident child (43).

The benefits of breast milk for twins or multiples are the same as for single babies. However, as multiple babies are more likely to be born prematurely, there are extra benefits. Premature babies may find breast milk easier to digest and tolerate due to their immature digestive system although it may need to be expressed and tube fed to very premature babies if they are unwell or very tiny (44).

Mothers can opt to breastfeed their infants either separately or simultaneously and there are a variety of different breastfeeding positions to support mums with finding a way that works for them and their babies. Guidance exists which provides information to enable health professionals to support families with multiples to breastfeed. It is important to remember that each individual baby is different and as such may require different support to establish and maintain breastfeeding (44).

It is important to ensure that families who are expecting twins or multiples are supported during the antenatal stage to feel empowered to make an informed feeding decision. This should be reinforced by factual information and families should be offered additional support around a breastfeeding approach to meet their families' needs.

4.8 Health Professionals and Breastfeeding

Key points:

- Some studies report health professionals feeling uncomfortable telling a mother how to feed their baby and have concerns they will make a women feel guilty for choosing not to breastfeed, highlighting a confidence and training issue.
- Capacity and resourcing is highlighted in the literature as a barrier to adequate support to families from health professionals
- Health professional can play an important role in supporting mothers returning to work around maintaining breastfeeding although capacity is highlighted as an issue here too.

Many providers still feel uncomfortable 'telling a mother how to feed their baby' with many feeling that they will make the mother feel guilty recommending breastfeeding especially if the mother chooses not to breastfeed (45). Additionally, for some health professionals' their lack of knowledge and/or confidence that they will be able to solve breastfeeding problems may mean that they do not promote breastfeeding even if they have a positive attitude towards it (46). The personal experience of health professionals can also have a positive or negative impact on the support and advice they provide to families about breastfeeding.

In one study in which health professionals were interviewed about their views and approach around breastfeeding three main themes emerged that impact on the support offered to families by professionals.

- Theme 1 – helping women to make a decision about breastfeeding was deemed to be a big responsibility and health professionals often struggled to find a balance between supporting mothers to breastfeed versus being seen as 'bullying' women to breastfeed.
- Theme 2 – factors shaping professional practice which is informed by 3 key dynamics; professional experience, training and CPD and personal experience. One study found that 90% of pediatricians felt that their breastfeeding experiences affected their clinical advice to mothers (45). Other research suggested that although personal experience may impact on clinical advice given this can be either helpful or unhelpful. One participant felt that it was okay to share personal experience (either positive or negative) as long as it was supplemented with advice about how to overcome any difficulties by sharing experience of what worked for them and focusing on the research (46).
- Theme 3 – Practical issues with accessing training e.g. capacity, which may make it difficult to stay-up-to-date with current knowledge (46).

Research suggests that there is a crucial role for health professionals in supporting women and their families around breastfeeding. For example, health professionals can help dispel myths or concerns about breastfeeding by asking open-ended questions about what the families have heard and then providing them with factual, evidence-based information to support them to make an informed decision. It is recognised that due to capacity and resourcing restrictions health professionals do not always have time to hold these conversations with families and this suggests a need for investment in resource within the current NHS system.

Reseach highlights that health professionals who suggest converting to formula are not only undermining a families' confidence, but if followed will actually reduce the amount of breast stimulation and in turn reduce the milk supply which will affect a mother's ability to breastfeed exclusively. Furthermore, while there are some maternal or infant factors that deem formula supplementation necessary these are very rare in terms of healthy babies (45).

In terms of addressing the support needs of mothers who are returning to work, professionals can start conversations about how to maintain breastfeeding at regular health visiting and other health professional checks. As above it is recognised that current capacity issues within the workforce may reduce professional's time to have these conversations which as noted is something that requires addressing.

4.9 Cultural Differences in Breastfeeding

Key points:

- Breastfeeding is more prevalent in families where English is not the first language and where an additional language to English is spoken.
- In some cultures breastfeeding is viewed positively as a natural way to feed infants however in some culture feeding in public and particularly in front of men is forbidden as compromising a women's modesty.
- Breastfeeding policies and strategies need to be aware of differing cultural acceptability's in order to be inclusive and successful.

Culture profoundly influences health knowledge, attitudes and behaviour and this is particularly true of infant feeding (20). In the UK there is a high rate of breastfeeding among black and Asian mothers. Moreover, breastfeeding initiation tends to be more common in those who speak a language other than English (82%), or in addition to English (82%) compared to English alone (63%) (5). The research also proposes that it is possible that more 'traditional' mothers within Black and Minority Ethnic (BME) groups are more likely to breastfeed. For some cultures although breastfeeding is viewed positively as a natural way to feed an infant and is often linked to beliefs around the milk providing

spiritual nourishment, breastfeeding in public, particularly in front of men is forbidden as it is viewed as compromising a women's modesty (47).

Research with men relating to their views and experiences of infant feeding found that in some cultures men had strong views on breastfeeding with one participant stating:

"I have always pushed it with her to. Even if she wanted to stop I don't think I would just let her stop right away" (21).

Similarly in some countries such as Eastern Uganda women choosing not to breastfeed would likely incur cultural sanctions:

" I would report her to the LCs (Local Chairman) and she will cease being my wife" (21).

As such this research highlights the need for those implementing breastfeeding policies to pay attention to the different social, economic and cultural profiles of all ethnic groups. Thurrock has an increasingly diverse ethnic profile and so policy and strategy in relation to breastfeeding can benefit from drawing from different cultural perspectives; as well as recognising the need to be reflective and responsive to difference.

4.10 Society and Breastfeeding

Key points:

- Research suggests that cessation of breastfeeding is largely related to negative influences culturally and socially.
- Breastfeeding education and promotion needs to be targeted more widely in society.
- The social marketing research in Thurrock found feeding in public to be a key concern of the mothers taking part.
- The sexualisation of breasts as well as celebrity culture around body image may be playing an important part in the low breastfeeding prevalence in the UK
- Formula advertising and misconceptions around formula being of equivalent benefit to infants could be playing an important part in families' choices around infant feeding.

Research suggests that cessation of breastfeeding is largely related to negative influences within the cultural and social environment (20). In one study women highlighted a need for breastfeeding promotion and education to be targeted towards the wider family and society rather than just women themselves (18). Breastfeeding in public appears from the research to be one of the key reasons women stop breastfeeding. As highlighted earlier some women believe that breastfeeding restricts independence and their ability to undertake daily tasks such as going out and this may in turn be related to feeling

uncomfortable about breastfeeding in public. There is a need for breastfeeding to become the normal course of behaviour, however this relies on work being undertaken to break down the barrier around breastfeeding public which can only be achieved if women and their families experience breastfeeding in public as an everyday occurrence. This creates quite a 'catch 22' cycle. A good starting point would be for promotional materials to show breastfeeding in everyday settings rather than in clinical settings as has been the tradition.

The sexualisation of breasts coupled with the celebrity culture of having the 'perfect' figure immediately following birth may also play a part in the low rates of breastfeeding in the UK. The new age of social media which is so readily available may be further exacerbating this issue by openly promoting breasts as sexually provocative rather than as maternal, natural and designed to feed a women's young. Some researchers suggest that in many western countries including the UK breasts are portrayed with a sexual connotation whereby they are often more exposed than a mother feeding her infant, and yet the latter is perceived as being more uncomfortable (48).

Formula advertising may also play a role in the low breastfeeding rates in the UK, particularly as babies get older. Although in the UK there are regulations which place restrictions on what formula companies can promote or market about formula or breastmilk substitutes to families with babies under six months, currently no regulations exist to control how formula companies market their products to families with children aged six months and over. This loophole allows widespread advertising across various mediums and companies can potentially make claims that there are no real differences in breast or formula milk. Furthermore, by using similar or the same branding across all of their products companies can effectively promote all of their products including those for babies under six months without breaking UK law (49). This in turn provides families with misleading information that may influence their behaviour and may account for the high percentage (67%) of individuals who believe that there are no differences between breast and formula milk (18).

5 How other areas are supporting families to Breastfeed.

Other areas are doing some good work in terms of promoting breastfeeding and trying to raise initiation and maintenance rates of breastfeeding within their locality. Each is described briefly below (please note this is not exhaustive list and there are other local authorities who are providing good breastfeeding support).

Southend-on-Sea Midwifery 1-2-1 Breastfeeding Support Service

This one year pilot (running from September 2018) in partnership with Southend University Hospital Foundation Trust provides 1-2-1 breastfeeding support at home during the first 6 weeks post-birth and is delivered by Infant Feeding Support Workers to mothers who are eligible for this additional support with referral via several pathways.

The aim of project is to increase initiation and maintenance rates by providing information about the benefits of breastfeeding, how to get off to the best start, developing a relationship with baby and what support partners can provide. It mirrors the support offered by midwives during the antenatal period. Sessions focus on good positioning and attachment, hand expressing of milk, safe parenting and relationship building, brain development and about how partners can support, coupled with advice about how to access support groups and provision of additional information. The pilot is running alongside the Breastfeeding Support Group being undertaken by Southend YMCA (50).

Brighton and Hove – Breastfeeding Team

Brighton and Hove have a comprehensive breastfeeding support offer coordinated by their Breastfeeding Team. Their work includes provision of drop in clinics which are open to all pregnant and breastfeeding mothers, peer support volunteer run groups which are located both in the postnatal ward and in the community and targeted work towards areas where breastfeeding rates are lowest. The team also promote breastfeeding awareness through their Facebook page. They use the page to share stories and videos and provide advice about common issues that families might experience. The team work closely with the Children's Centres. Additionally, they have implemented a Brighton Breastfeeding Initiative (BBI), a network of health professionals and voluntary groups/organisations that are promoting breastfeeding across the locality (51).

Bristol City Council – Baby Friendly City

Bristol was the first city to achieve UNICEF Baby Friendly City status in 2010 and this required health professionals such as maternity staff and Children Centre staff to undertake additional training around supporting breastfeeding. Since 2010 the breastfeeding offer has expanded and now includes a network of 14 community breastfeeding support groups run across the city, attended by trained breastfeeding supporters and Children's Centre staff. Some of these groups offer additional support that is provided by breastfeeding trained counsellors employed by the council and located in each of the 4 localities across the city. As well as attending groups Breastfeeding Supporters also make home visits and provide contact via telephone.

For the last eight years Bristol have provided a targeted intervention aimed at mothers living in areas where breastfeeding rates are lowest. Women are contacted by a trained breastfeeding supporter at 28 weeks of pregnancy and offered time to discuss feeding and nurturing their baby. They provide support, information and encouragement and partners and wider family members such as grandmothers are encouraged to be part of the discussion as it is recognised in the research that family play an important role in breastfeeding success (52).

Leicestershire County Council – Support Fathers works

Leicestershire has created an offer targeted towards fathers which aims to involve fathers and offer support to prepare them for parenthood and to ensure that they do not feel isolated. The offer includes production of a film produced by young fathers (which is also used as a training resource for professionals), a dedicated website 'Becoming Dad' which contains the video alongside information and support, coupled with Father's groups run at Children's Centres.

6 Social marketing research in Thurrock

6.1 Background

Nationally much is known about the benefits of and barriers to breastfeeding, views of mothers, health professionals and others. In scoping this needs assessment it was acknowledged that the local data for Thurrock provides a limited understanding of infant feeding behaviour in the borough but that there were still several key questions that warranted further exploration and understanding:-

- What would support/influence the uptake of breastfeeding in Thurrock?
- What would support/influence maintenance and duration of breastfeeding in Thurrock?
- How do women's partners influence initiation and maintenance of breastfeeding?
- Is there a consistent approach across the health landscape in relation to breastfeeding?
- Who is best placed to support women and their families around initiating/continuing breastfeeding?
- Where are the opportunities for initiating/continuing conversations about breastfeeding?

The Social marketing research [8] aims to answer these key questions in exploring the underlying and complex relationship families have with breastfeeding and the drivers associated with breastfeeding in Thurrock, particularly exploring maintenance beyond the initial weeks following birth. Understanding the lived experience of women and their families in Thurrock triangulates need in a robust way to inform this needs assessment.

Although the research was aimed at all expectant parents/ parents with babies/toddlers, it aimed to target certain groups, where gaps in local knowledge relating to breastfeeding choices exist. These included:-

- Black and Minority Ethnic Groups (BME)
- Low income families

[8] A link to the full report is included in Appendix 2. Additionally, appendices 3-7 contain poll and survey questions (for various stakeholders) as well as topic guides for the qualitative research.

- Single parent families
- Different age groups (younger and older mothers)
- Those with disabilities
- Working women/families
- Partners (to better understand their role and perspective. Much of the research undertaken relating to infant feeding is undertaken with women or where women are asked to give their views on men's perspectives relating to this topic. In reality the views of male partners in terms of breastfeeding differ to those women believe men hold (see section 4.6 above).

6.2 Methodology

A mixed methodology was used for this social marketing insight, including:

Desk research

- Thematic analysis on forum posts on Mumsnet and other South Essex groups to steer the development of topic guides for qualitative and quantitative insight.
- A brief literature scan, taking in relevant research, to inform topic guide development.
- Review of literature given to women about breastfeeding, taking in all information sources mentioned in polls, focus groups, surveys and interviews

Consulting key staff

- Midwives, maternity nurses and health visitors were invited to share their experiences and views and specify the support they offer, including any variances and challenges by area. Clinical leads were contacted by phone and asked to distribute an e-survey link to members of staff. The e-survey was anonymous. (n=35)
- GPs were also invited to contribute their views via an anonymous e-survey. As there were no responses, printed copies were handed out at a council meeting, which generated two responses (one from a safeguarding role and the other unknown) 12 surgeries were contacted to complete phone interviews, targeted according to maternity cohort; low uptake and high breastfeeding drop out rates. Phone interviews were completed with five of these – from surgeries with large maternity cohorts, resulting in 39% coverage (n=7).

Consulting mums and their partners (qualitative and quantitative)

An opinion poll was completed using a short online survey that asked about intentions to breastfeed; what influenced choice and how they would describe themselves in terms of age, ethnicity, location and work status. The poll was promoted via Maternity Direct and Feeding Together Facebook pages, via Mumsnet, the maternity teams at Basildon

Hospital and in the community; the health visiting team and via outreach at Lakeside Shopping Centre, Children's Centres, food banks, community venues and GP surgeries.

The online poll (n=342) was the gateway to further research, allowing mums to opt in as they wanted to and ensuring continuing data capture:

- A longer online survey covering the whole user journey (n=111)
- Focus groups (n=26) with expectant mums; mums with babies; mums with toddlers and a group with mums and partners so we could discuss the importance of their role.

In each group a discussion was had regarding information and support, interspersed with key questions arising from the e-survey, answered by a BTUH infant feeding expert, as well as an open Q&A session.

- Telephone interviews (n=30) with mums and dads.

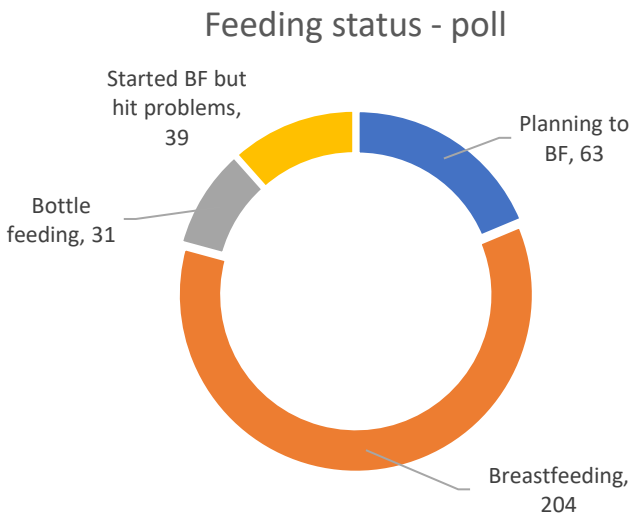
6.3 Main Findings/Themes

The full social marketing research report is included as appendix two, the Key findings and themes are summarise in the section below and have been incorporated in to the recommendations in section seven.

6.3.1 Findings from the online poll:

A poll was conducted with a total of 337 participants including expectant mums or mums (N= 329) and dads (N=8). Of these participants, 204 reported that they were breastfeeding, 63 participants were planning to breastfeed, 39 participants had started breastfeeding but converted to bottle feeding after experiencing problems and the remainder of participants (N=31) reported that they were bottle-feeding (formula).

Figure 23: Poll; Participants self-reported Feeding Status.



Source: Upshot Marketing, 2019.

It is important to note that poll respondents are likely not a proportionate representation of the Thurrock population of mothers of infants as a whole. The age of the babies of the respondents was not recorded making it difficult to explore with accuracy how similar or representative the sample was. Thurrock published data shows that 70.6% of women initiate breastfeeding and by 6-8 weeks this has reduced to 48% (PHE-Fingertips).

As more of the respondents of the poll report breastfeeding their babies, the views of the respondents in the interviews and focus groups are likely to be more supportive and knowledgeable about breastfeeding than the general population of Thurrock mothers. It is important to be aware of this potential bias when drawing conclusions from the research.

Table 1 below shows the breakdown in more detail. The majority of participants reported that they either intended to breastfeed (expectant parents) or were breastfeeding (to include exclusive or combination feeding) at the time of the research.

An overwhelming proportion of expectant mums (N=71) were intending to breastfeed (N= 65, 91%). Of those intending to breastfeeding 35% (N=23) intended to exclusively breastfeed and 40% (N=26) were planning to combination feed. Combination (combi) feeding or partial feeding involves the family both breast and formula feeding their baby. Of expectant mums who planned to breastfeed 25% (N=16) did not state or were undecided about whether they would exclusively breastfeed or combi feed.

Similarly mums with babies (N=212) largely reported that they were breastfeeding N= 170, 80%). Of those were breastfeeding 41% (N=70) were exclusively breastfeeding and 37% (N=63) were combi feeding. Of mums with babies, 22% (N=37) who reported that they were breastfeeding at the time of research did not specify whether they were exclusively breastfeeding or combi feeding. Of mums with toddlers the largest percentage were exclusively breastfeeding their child.

At the time of the research 13% (N=28) of mums with babies had reported that they had started to breastfeed but had experienced problems and had converted to bottle feeding making a total of 20% (N=42) of women with babies bottle feeding. Similarly of mums with toddlers 16% (N=10) had experienced problems with breastfeeding and had converted to bottle feeding making a total of 31% (N=19) of mums with toddlers bottle feeding. There was a mix of responses from dads regarding their partner's breastfeeding status (see Table 3).

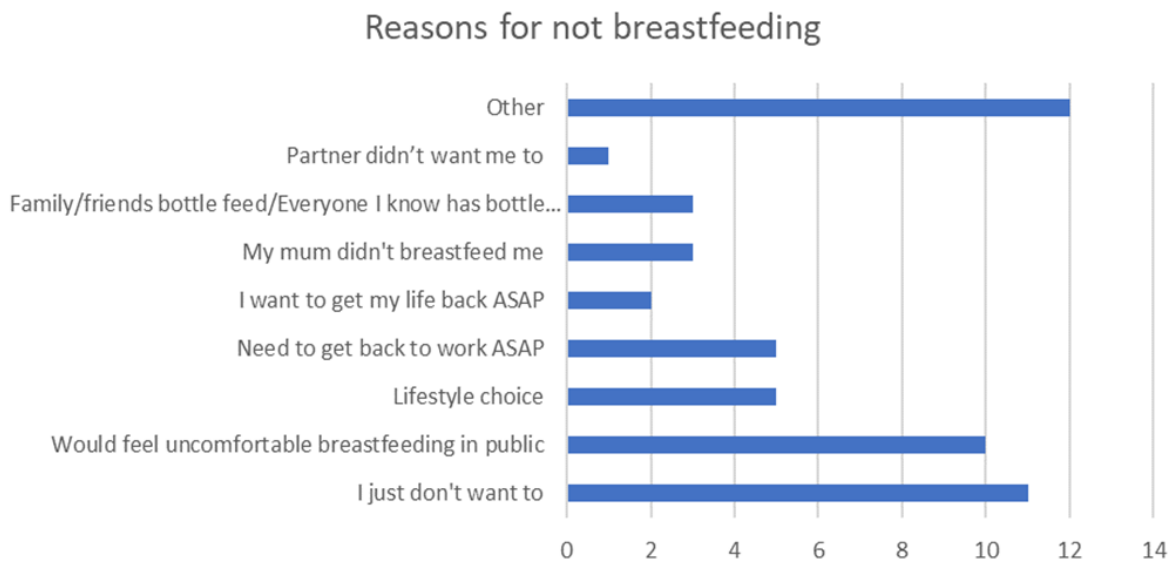
Table 3: Poll; Participant's Feeding Status by Segment. N= 337 (5 missing responses).

Feeding Status by Segment			
	Expectant Mums (Intentions) N= 71	Mums with Baby (including New-born) N=212	Mums with Toddlers N = 51
Breastfeeding (%)	91%	80%	69%
Bottle Feeding (%)	9%	20%	31%
Exclusive Breastfeeding (EBF) (% of total breastfeeding)	35% (of the 91% intending to breastfeed)	41% (of the 80% who were breastfeeding)	83%(of the 69% who were breastfeeding)
Combination Feeding (CF) (% of total breastfeeding)	40% (of the 91% intending to breastfeed)	37% (of the 80% who were breastfeeding)	17% (of the 69% who were breastfeeding)
Half of all Dads surveyed (4/8) said that their partner hit problems and stopped breastfeeding. 2 dads reported that their partner was breastfeeding with the remaining 2 dads reporting that their partner was bottle feeding.			

Source: Upshot Marketing, 2019.

The Chart below shows the reasons the poll participants selected for choosing not to breastfeed.

Figure 24: Poll Results: Reasons for choosing to bottle feed.



Source: Upshot Marketing, 2019.

One of the most common reasons for choosing to bottle feed selected was that women and their families felt uncomfortable about breastfeeding in public. 'Partner did not want me to' was not a common reason given in Thurrock (see Figure 25 below). Other reasons provided by participants for choosing to bottle feed included but were not limited to; there was not enough support in hospital, health of mother or infant, complications during birth and previous bad experience.

One of the main reasons for women opting to bottle feed within the poll element of the research was that they did not like the idea of breastfeeding. Within the qualitative elements this was explored further and it was found this related to concerns about body image e.g. concerns about changing appearance, anxiety and confidence about appearance, the research discusses the rise of the celebrity culture and pressure to lose weight quickly after birth. These lifestyle choices were sometimes reinforced by family and friends.

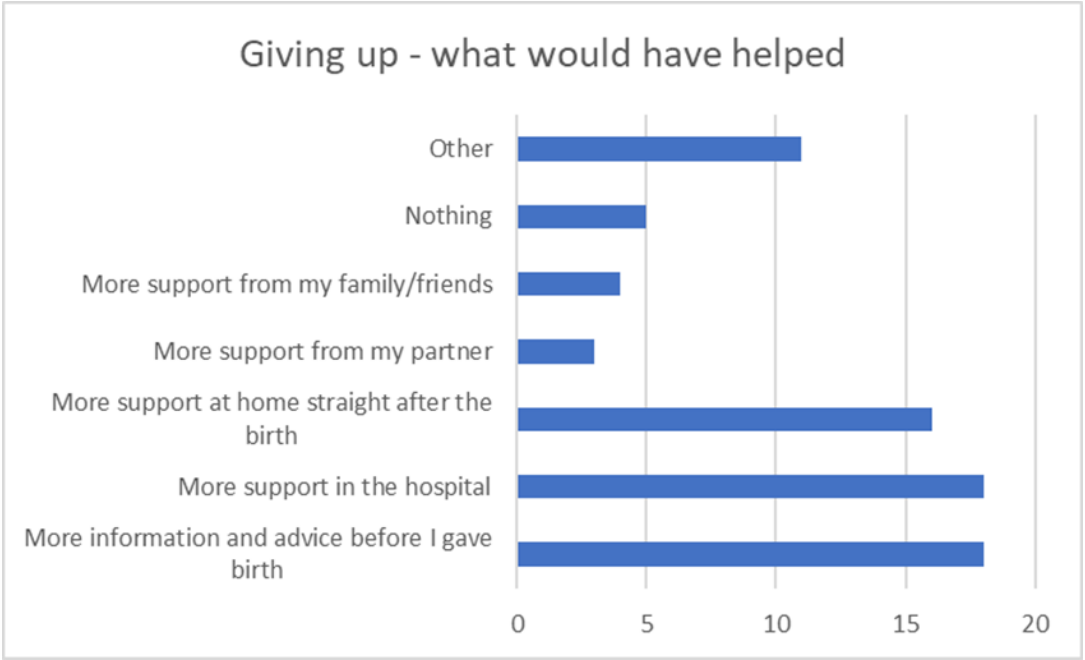
It is also noted that the category with the largest response is 'other' and it is likely that this response along with the choice selected 'I just didn't want to', which was the second largest option chosen by respondents; may indicate an inability or unwillingness to articulate their feelings behind their choice. It is probable that the reason(s) may be one of the other options given. Therefore, caution is prudent when looking at the weighting given to this poll alone in implementing changes and recommendations.

Although these findings suggest a need to promote existing resources such as Start4Life and provide support for women to help them to feel confident and reassured about breastfeeding in public in terms of practical support, for example, positions that make it easier to breastfeed in public coupled with support around women's legal rights to breastfeed in public.

Figure 25 below outlines the reasons chosen by the poll participants for stopping breastfeeding and what may have supported them to continue.

Figure 25: Poll Results: Reasons for Stopping breastfeeding/ what would have helped to support continuation.

Concern baby wasn't getting enough milk	**15**
Latching on	11
Too difficult/stressful	10
Too painful	9
Other medical reasons	6
Wanted to share feeding with partner	5
Took too long/constant feeding too restrictive	4
Didn't like feeding in front of others	3
Mastitis	3
Didn't fit with routine	2
Placenta delivery injection (too difficult/painful)	2
Too tiring	2
Didn't fit with routine	2
Felt bottle would help baby sleep	1
Inverted nipples	1
Just didn't like it	1
No time - other children	1
Felt bottle would help baby sleep	1
Just didn't like it	1
Other medical reasons – C-section, tongue tie	6
Other – could have been addressed with support	10



Source: Upshot Marketing, 2019.

As can be seen the main reasons given by the poll participants for stopping breastfeeding were concern that the baby wasn't getting enough milk, difficulties with the baby latching on (which may relate to the concern about them not getting enough milk), and feeling that breastfeeding was too difficult or stressful. Conversely more advice and support was cited as the biggest support mechanism that would have helped women to continue breastfeeding.

For example, information on the science of breastmilk and about the size and capacity of a baby's stomach may help to reassure women about how much milk is enough, alongside better face to face support or virtual support in terms of techniques for developing a good latch. Support around these issues would potentially ease the stress women experience in relation to breastfeeding.

> *"It's good to understand how my milk adapts to what my baby needs at that time. So when he's unwell, my body reacts. Helps spur you on at times when you want to give up."*

Families felt health professionals were often quick to turn to formula or supplementing with formula when families experienced problems with breastfeeding particularly in relation to weight gain.

Of those who participated in the poll broken down in the chart 23, 24 and 25 (n=337) 23% reported taking to breastfeeding well which leaves over three quarters (77%) of women requiring support. Based on local maternity data this accounts for 1,893 families per annum, and 158 families per week requiring support.

Additionally there is the potential for the need for support to increase if C-Section rates continue to increase (by 4% annually - (53)) which can make breastfeeding more difficult, perhaps due to medical needs, separation following birth and recovery for mothers. Better support for women who give birth via C-Section needs to be developed and embedded within the existing local offer in Thurrock,. C-Section was given as a frequent treason for stopping breastfeeding (Figure 25, poll responses) and so awareness around this for midwifes and health visitors to be able to offer additional support for these families and reassurance that it need not be a reason to stop breastfeeding should be reinforced in the Thurrock offer in the future.

Similarly women felt undiagnosed tongue tie[9] was a reason for them stopping breastfeeding and is another area that would benefit from midwifes and health visitors being aware to offer additional support and information to families around treatment for this and to dispel any myths that it needs to stop women from breastfeeding. Additionally

[9] **Tongue-tie** (ankyloglossia) is a condition in which an unusually short, thick or tight band of tissue (lingual frenulum) tethers the bottom of the **tongue's** tip to the floor of the mouth. If necessary, **tongue-tie** can be treated with a surgical cut to release the frenulum (frenotomy).

earlier identification of this issue could lead to a quicker resolution with less disruption to the feeding process.

Figure 26 below shows the sources of information that the families in the poll would find useful or value in making a decision about breastfeeding:

Figure 26: Poll Results: Useful sources of information as ranked by participants.

Information sources you would value and/or use	
Information in my maternity pack	246
Discussions with my health visitor	185
Discussions with my midwife	150
Information from the Children's Centre	143
Breastfeeding support team at hospital	132
Advice from my mum	115
Antenatal classes	115
NHS website	115
Advice from my friends	98
Breastfeeding apps (AmazonAlexa/Google/Facebook)	89
Parenting book	85
Peer supporter (a local mum)	70
Local support group	68
Parent/infant feeding charity e.g. Parents 1st / NCT	56
Telephone helpline	31
Baby parenting app	11
Online forum	12
Other - breastfeeding groups (3); info about bottle/formula feeding (2); Yummmy Mummies FB group; lactation consultants	8

Source: Upshot Marketing, 2019.

The value of maternity packs was highlighted as the leading useful source of information for families in Thurrock, followed by face to face support through discussions with a Health Visitor or midwife (see Figure 26 above). Throughout the research the need for more support/information that is factual, up-to-date and realistic about what breastfeeding is like, delivered at the right time and available in the first few weeks following birth was emphasised.

Although participants reported that face-to-face was their preferred support mechanism they were open to virtual support through Facetime or Skype, if it meant more women could get the support they need, as they recognised that resources are limited and felt that virtual support may reduce the burden on resources.

Participants also suggested development of a 'single point of access resource', which contains all of the information that a family requires to make an informed decision about breastfeeding.

6.3.2 Findings from the Surveys

A summary of the findings from the survey carried out with 111 participants online, driven from the online poll is included below in the form of thematic analysis:

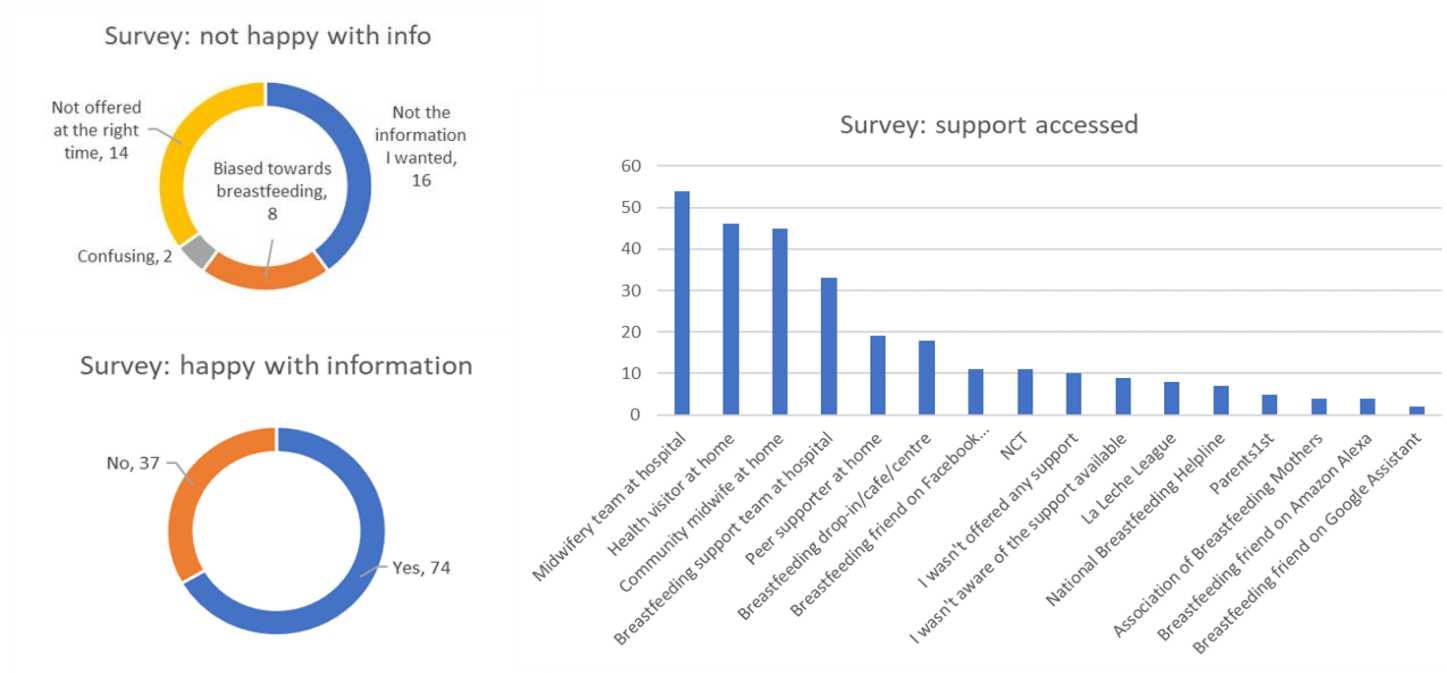
Views on the Sources of Information available

> *"Information that tells you it's going to be a tough journey would be good. The need to stay more hydrated than normal. I didn't research breastfeeding because I didn't think it would be a big deal. But if I'd been better informed I wouldn't have given up so quickly."*
>
> *"It's easy to not realise how you have to learn how to do it and the baby does too."*

As reflected in the findings of the poll, the most valued resources were discussions with midwives or maternity consultant and health visitors as well as information contained in the maternity packs. Interestingly, advice from family and friends was rated higher than the NHS website. This may have been due in part to the fact that family and friends were readily available.

As can be seen in Figure 27 below for the most part families were happy with the information provided but of those who were unhappy, the main reasons given were issues with the content and timing. Suggested improvements to the information provided included; problem solving information, honesty about how difficult breastfeeding can be coupled with reassurance it will get better, unbiased and current information, sharing of case studies, information about combi-feeding (reoccurring theme), practical videos e.g. showing a good latch as well as sufficient information to support families to make an informed choice. It should be noted that there are many resources available which offer support to combat some of the suggested improvements to information, which highlights the need for better promotion and awareness raising of resources to families.

Figure 27: Survey Results: Views on Information around Breastfeeding.



Source: Upshot Marketing, 2019.

Views on practical support available to support breastfeeding.

For the most part women and their families reported that the support provided by different professionals across the maternity landscape was consistent (N=77). For those who did not find this to be the case (N=34) they reported the following issues:

- Outdated information
- Insufficient support for problems
- Need for encouragement and support
- More information needed at different times during the antenatal to postnatal journey – importance of the right information provided at the right time
- Differing advice provided – which was confusing
- Emphasis on breastfeeding, no information provided on bottle feeding to support making an informed choice.
- Participants reported that some professionals were more helpful than others and/or had more knowledge about managing difficulties.

6.3.3 Qualitative Findings

The below is a summary of the findings from the focus groups held with 26 participants and the phone interviews held with 30 participants:

Information

The researchers tested out different types of information sources to evaluate what is useful and needed in Thurrock. The main information source being promoted in Thurrock is the 'Off to the Best Start' leaflet from Start4Life. Mums with toddlers were more likely to have seen this leaflet than mums with new-borns with one in four expectant mums reporting seeing this leaflet. The reason why expectant and new mums may not have seen this leaflet was that the full version is not currently available in print as the Department for Health are no longer supplying them to hospitals.

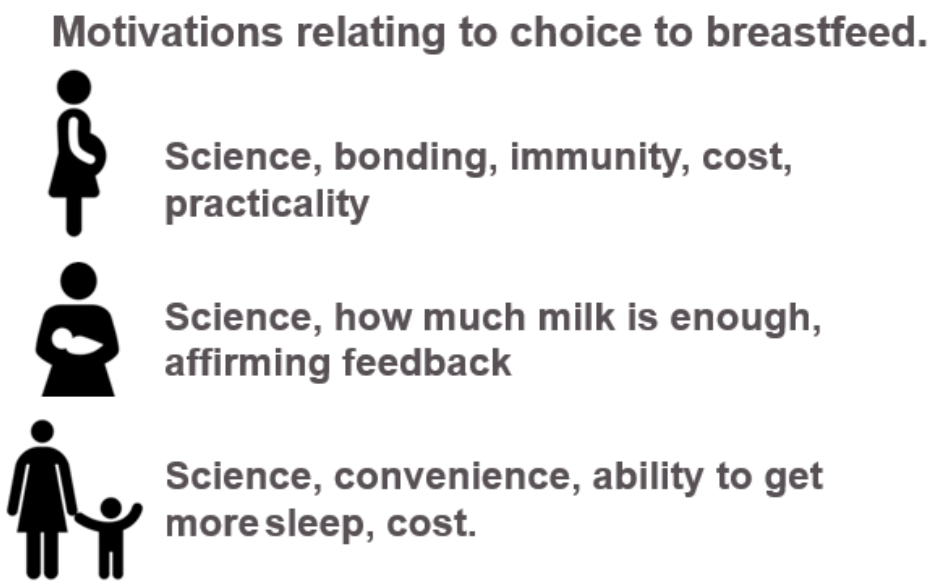
Of the mums who participated in the focus groups or phone interviews most indicated that they preferred printed literature that they could take away with them and reference when needed and which could be shared with partners. Conversely expectant mums preferred a conversation with a health professionals than printed literature, although they did report finding some elements of the printed information relating to expressing and latching useful.

Although the infant formula and responsive bottle feeding leaflet is available, families in the focus groups did not recall being provided with any information relating to bottle feeding from their midwife and gained information on this from family and friends.

The UNICEF breastfeeding checklist was very popular with the mums who participated in the focus groups and of those who did not receive this checklist they felt it would have been useful.

Information and resources that illustrated the science behind breastmilk and differences between breast and formula milk were viewed as really important by parents in the focus groups, with dads finding the science and logic behind breastfeeding particularly useful. As can be seen in the figure below regardless of where women and their families were in the antenatal/postnatal journey, all valued the information that supported their understanding of the science behind breastmilk and believed it to be a motivating factor relating to infant feeding choice.

Figure 28: Motivations relating to breastfeeding choice by participant type.



Source: Upshot Marketing, 2019.

Forum post analysis within the social marketing research carried out suggested that some mums are not convinced by the information around the benefits of breastfeeding and the science behind breastmilk and feel that and negativity regarding the impact of not breastfeeding is scaremongering tactics and that formula milk is just as good.

Antenatal classes

Around half of mums in the focus groups had participated in antenatal classes. The main feedback was that infant feeding was either not covered in antenatal classes, where the focus was on care of the baby more generally or where it was included this was very light touch. All participants felt that an antenatal class focusing specifically on infant feeding would be really useful.

Support

> *"The team on the ward at Basildon hospital gave me great hands on help when I was there. I'm not sure how successful I would have been without them!"*

Figure 29 below highlights the types of support that women and their families at different stages of the antenatal/postnatal journey rated as most important in supporting them to make an informed decision around infant feeding and to encourage breastfeeding initiation and maintenance past the early weeks. Video was also suggested as an effective

medium for offering support to solve practical difficulties e.g. around positioning and promoting a good latch.

Support to promote breastfeeding for those who had had a C-Section was reported as high priority alongside the need to for earlier identification and treatment of tongue tie.

The key support that parents suggested in hospital included:

- Encouragement
- Health professionals not making assumptions e.g. that young mums will want to formula feed or that that mums with other children will not require support.
- Further training for midwives and health visitors and provision of current information for better signposting.
- Resource to enable midwives to spend more time with mother and baby
- Help to use a breast pump
- More information about combi-feeding.

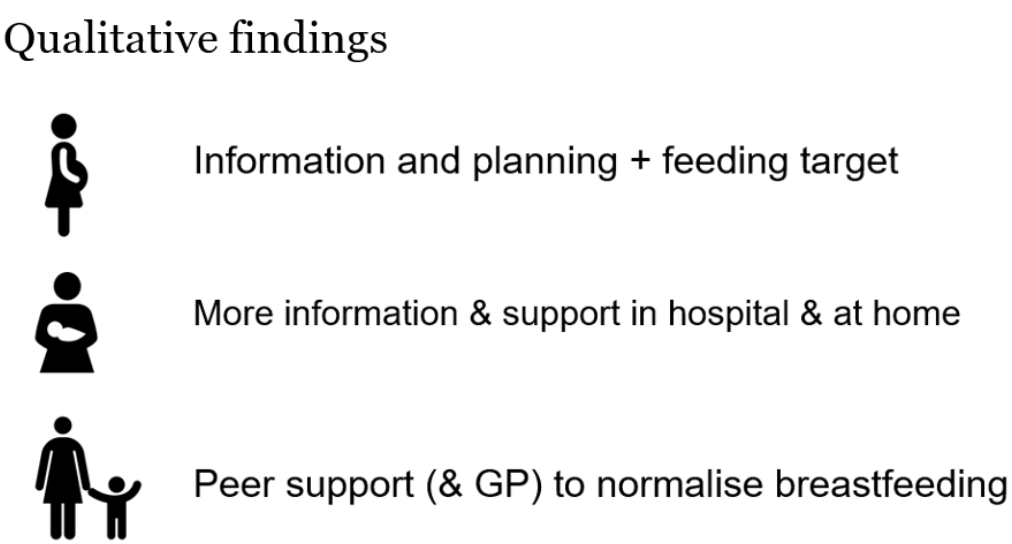
The key support that parents suggested for at home included:

- Weekly texts to reinforce information provided before the birth or whilst in hospital.
- Drop in clinics at the hospital, GP practice or community centre
- Better promotion of the Feeding Together Facebook page.
- Face to face support groups.
- Virtual support through Skype or Facetime.

The key support that parents suggested for in the community included:

- Local support groups
- Online forums
- Support around returning to work

Figure29: Support Mechanisms for encouraging breastfeeding initiation and maintenance as outlined by participants.



Source: Upshot Marketing, 2019.

In terms of who is best placed to support families with breastfeeding, parents reported that the role was unimportant to them and that what matters is health professionals:

- Having good, current and specialist knowledge.
- Are encouraging and supportive – help mums to build their confidence and reduce anxiety
- Offer person-centred support
- Are able to diagnose tongue tie and offer support.

6.3.4 Role of Dads/Partners

The social marketing research found that in Thurrock there are several types of dads in terms of their views and perspectives on breastfeeding:

- Desire to be involved – support through maternity nurses is usually to encourage dads to develop a bond with their baby through other means such as skin-to-skin contact. Conversely the UNICEF bottle information highlights that bottle feeding can be a bonding experience for dads and their babies however, it does not include information about expressing milk to enable dads to be able to be involved or other bonding activities such as participating in bath/bedtime routines.
- In support of breastfeeding and happy to support
- Supportive of breastfeeding but fairly passive in terms of seeking information
- Ambivalent.

Some mums wanted dads to be involved in feeding the baby and as such bottle feeding was the default for achieving this.

However, all of the dads involved in the research reported being pro-breastfeeding although there was variance in terms of the research they undertook prior to birth. Mums in Thurrock tend to be the information seekers but dads were keen to be involved in decision making and were receptive to information. Some dads focussed more on the welfare of their partner particularly if the birth was complicated or their partner had a C-Section.

Although for the most part dads were supportive of breastfeeding they reported feeling unprepared for the realities of breastfeeding and like mums want factual and realistic information about what breastfeeding will be like.

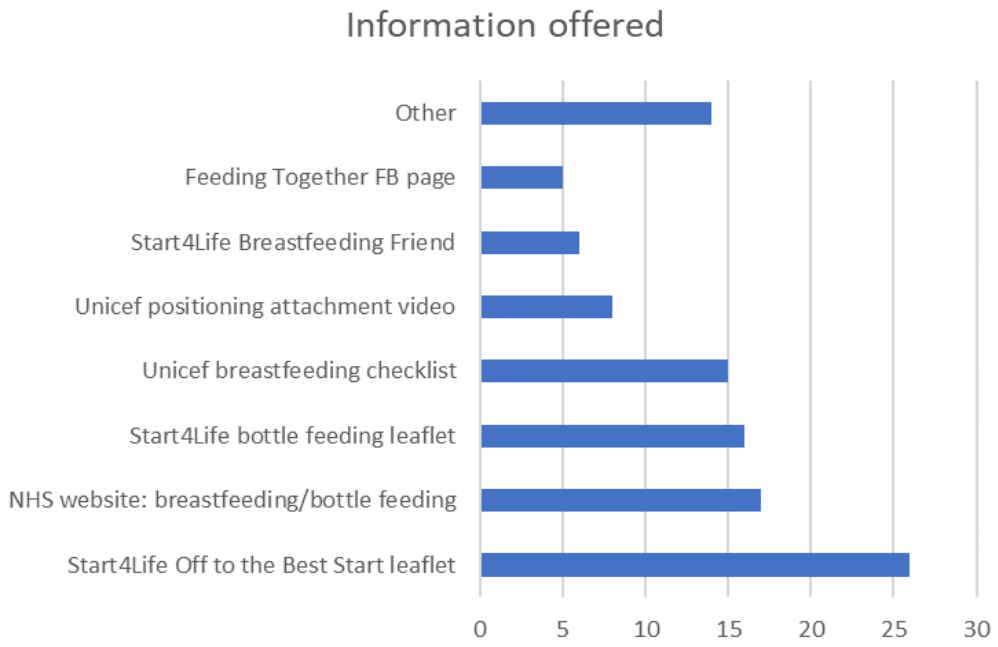
Dads also reported that if they were able to stay overnight at BTUH where applicable (as in Darenth Valley hospital) with their partner and new-born the first night after birth they would be able to support their partner with any difficulties, help build their confidence and reduce some of the burden on NHS staff.

6.3.5 Views of Maternity Professionals

A total of 35 maternity professionals participated in the research. The views of maternity professional's largely mirrored parents' views. The majority of maternity professionals reported that services could be more joined up and highlighted that support is greatly reduced when services are understaffed. There is a recognition that midwife and health visitors' capacity building is required. They reported that investment in training is now a third of the value in 2014/15 but that all professionals' need regular training and frequent information updates. There is a need for all professionals to promote policy and key messages.

The figure below shows the types of information offered by maternity professionals and as mentioned earlier in this report the 'Off to the Best Start Leaflet' was promoted most often in Thurrock (although as noted this is no longer available in hard copy).

Figure 30: Information offered by Maternity Professionals to support breastfeeding.



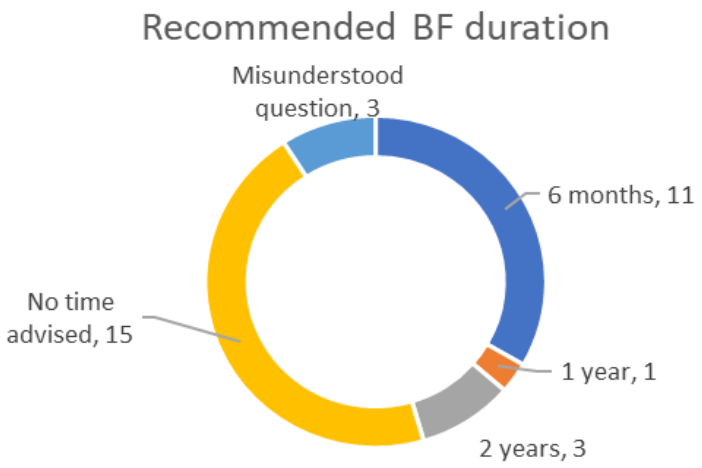
Source: Upshot Marketing, 2019.

Maternity professionals were asked if they recommend a timeframe for breastfeeding and if so, how long did they recommend. As can be seen in the figure below most maternity professionals did not advise on a recommended length of time to breastfeed, followed by those advocating for six months. Only two of the professionals who participated in the research stated they recommend breastfeeding for two years (as per WHO and UNICEF's recommendation).

One professional said that they advise women to take each day individually and to view each day of continued breastfeeding as a bonus. They did advise that weaning should not take place until after six months. This advice does not support the perspective put forward by WHO and UNICEF and makes it difficult for families wishing to develop an infant feeding strategy, as this requires them to identify a common goal. Moreover, it is well evidenced that intention predicts behaviour and omitting this information could lead to confusion about how long to breastfeed for. For example, the Theory of Planned behaviour states that a person's attitude, societal norms and perceived behavioural control influence their intentions to engage in a particular behaviour which in turns influences behaviour (54).

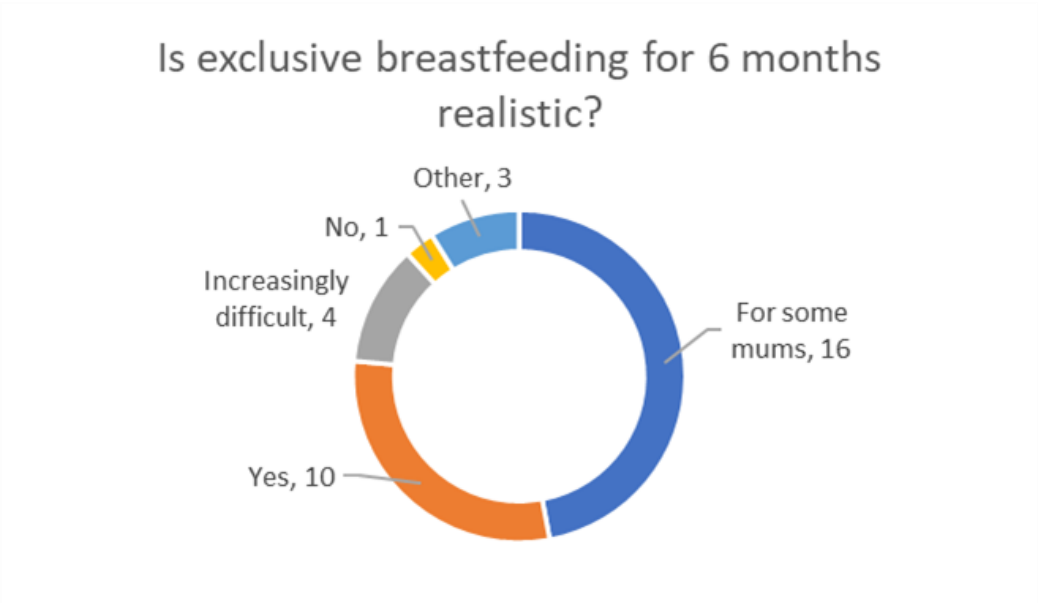
Conversely, for the most part maternity professionals did report that they felt that exclusive breastfeeding for the recommended (WHO and UNICEF) six months is realistic (See Figure 31 below). Like families maternity professionals highlighted a need for more awareness raising about the different options available to families e.g. combi feeding.

Figure 31: Views of Maternity Professional about recommended breastfeeding duration.



Source: Upshot Marketing, 2019.

Figure 32: Views of Maternity Professionals about whether exclusive breastfeeding for 6 months is realistic.



Source: Upshot Marketing, 2019.

6.3.6 Views of GPs

A total of seven GPs participated in the research. The main views/information provided by GPs included:

- View that there are not enough Health Visitors or Midwives
- Recognition that GPs have insufficient knowledge, and are not as influential as they could be with a view that mass re-education is required.
- Consistent guidance on the information and support they should be offering o families is needed. GPs suggested that this could be added to EMIS/SystemOne.
- Highlighted that Thurrock CCG are developing an online resource for GPs around breastfeeding.
- GPs highlighted that they would be happy to promote breastfeeding via their websites and TV screens in their reception/waiting rooms.
- Need for more E-Communications via Maternity Direct
- Informed researchers that they used to work more closely with maternity professionals but due to pressures on resources this is no longer the case.

7 Conclusion:

In Thurrock, the BFI approach has been promoted and has been a requirement of commissioned services. The learning from this Health Needs Assessment has led to consideration of alternatives to be able to support families effectively given that current rates at 6-8 weeks are so low. In an ideal scenario the BFI would be promoted in the fullest sense and women would feel empowered and supported. However, with families currently reporting[10] mixed satisfaction with support services, acknowledged disinvestment in services and pressure on staffing, women not feeling comfortable to breastfeed in public and not feeling supported by 'society' in their choice around breastfeeding; it is recommended that a fresh 'Thurrock approach' is taken. Responsive to families' views and experiences, supporting choice whilst still remaining consistent with the guidance from NICE and the NCT.

[10] See section 6 – Social marketing research in Thurrock, for a full analysis of Thurrock families' views.

8 Recommendations:

1. System wide change:

The system in Thurrock does not operate independently from the wider health system. The local hospital where the majority of women give birth (BTUH) is sited in Basildon and part of a wider Mid and South Essex Health and Care Partnership area.

Therefore, it is recommended that:

- Public Health develop a breastfeeding strategy for Thurrock to deliver these recommendations collaboratively with partners and stakeholders.

- That a 'Thurrock approach' will follow NICE guidance and be responsive to local findings. Offering support to and empowering families in making a healthy choice to exclusively breastfeed for 6 months and longer. The approach will include information around safe and responsive bottle feeding practices to support choices around expressing breast milk and formula feeding as needed (although formula feeding will not be actively promoted).

- To incorporate the findings of this Health Needs Assessment into the 0-5 wellbeing model to be tackled and driven as part of a wider piece of work collaboratively with Brighter Futures partners.

- Seek agreement with the Local Maternity and neonatal System (LMNS) to develop a Single Point of Access Information pack (to include online offer) and pathway containing consistent information and practical advice around :
    - Nutritional benefits and the science behind breastfeeding
    - Practical support with latch and tongue tie
    - wider benefits
    - health benefits
    - information on sources of support
- This information pack should contain the UNICEF breastfeeding checklist (which was reported as a popular and useful resource in the social marketing research) and be co-produced with families to capture lived experience and ensure the resource is meeting the needs of families in relation to providing a 'realistic picture' of breastfeeding and the potential challenges which is supportive and reassuring.

- Through the strategy delivery plan work with partners within the LMS area to strengthen the links between Midwives and Health Visitors, Primary Care and wider health professionals to ensure that the antenatal offer is equitable and consistent between professionals and across the LMS area in message and approach throughout the pathway.

2. Develop a Digital Offer:

Digital resources and communications have been highlighted through the social marketing research and the evidence base as being a good way to increase the capacity of services that support families. This medium has been found to be acceptable to families in Thurrock with the opportunity to reach an increased number of families in a cost effective way.

Therefore, it is recommended that:

- Public Health lead on the development of a digital solution to provide information to families in an accessible way, with links to practice videos and information about the science behind breastfeeding as part of the 0-5 wellbeing offer. This offer could include weekly text messaging/email service also providing encouragement and reassurance to families.

- The findings of the Social marketing research suggest that parents found information about the science behind breastmilk and nutritional differences between breast milk and formula useful in supporting them to make an informed decision. Video and other resources do exist that focus on the science and should be incorporated as part of the digital offer (included above).

- Commissioners develop and incorporate Virtual Support via Skype or Face time into service specifications for breastfeeding support in future contracts. This could be via a webinar where families can ask for advice and support and health professionals can respond to multiple families at the same time who may be experiencing similar issues.

3. Messaging/Normalising Breastfeeding:

Messaging and the need to normalise breastfeeding has been consistently raised throughout the social marketing research and this is also extensively discussed within the evidence base.

Therefore, it is recommended that:

- The new improved local offer needs to consider three elements of messaging in relation to breastfeeding:
  1) Being really clear on what the message is including:
     a. Nutritional benefits and the science behind breastfeeding
     b. Wider benefits
     c. Health benefits
     d. Normalising breastfeeding including extended breastfeeding
     e. Supporting families' choices around breastfeeding and offering guidance.

  2) The level and sufficiency of the message – is it delivered at the right time, in the right way, accurate/factual and realistic

  3) Consistency of messages- developing a consistent approach across the landscape to include Thurrock and Mid and South Essex through the LMS.

- A place based approach is taken as part of the strategy delivery plan to normalise breastfeeding in the community and wider environment by working with businesses through the business forums to enhance the number of breastfeeding friendly venues (through the BFI) in Thurrock and make this visible to the community.

- As part of the strategy delivery plan, actions to support employers with information and advice about being breastfeeding friendly and how to support mothers to continue breastfeeding once they return to work.

- The production of local/new resources or literature to provide positive images that normalise breastfeeding in everyday scenarios be developed to support the local offer (as part of the Brighter Futures communications plan).

4. Service/support offer:

The social marketing research highlighted that there was a differing level of knowledge and advice provided by different professionals, that there is opportunity for further professional groups and services to be more supportive of breastfeeding. The observed prevalence rates of breastfeeding in GP practice areas highlights very different rates that do not appear to be consistent with other demographic factors related to breastfeeding such as deprivation and ethnicity.

Therefore, it is recommended that:

- A consistent training offer is developed and a re-fresh of training for Primary Care, wider Maternity and other health care professionals be delivered, including wider support staff in the system such as children's centre staff.

- Expansion of breastfeeding training for pharmacies and GPs with the development of Breastfeeding Champions within Primary Care and Children's centres as part of the strategy delivery plan.

- As part of the new improved service offer introduce the concept of a family 'plan' to demonstrate the commitment to breastfeeding. This will support the wider family to understand and respect the parents' decision to breastfeed whilst promoting inclusion of family members being able to support in ways other than feeding the infant.
  For example; providing a drink or snack for the new parents, helping with bath time, changing or winding the infant. The purpose being to give the new parents periods of respite and allow bonding to still occur with other family members without disrupting the breastfeeding relationship. There is potential for the 'plan' to incorporate other important areas such as immunisations.

- Work with school nurses (through Healthy Families Service) and schools to offer an education programme as part of PHSE to children about breastfeeding. This is in line with evidence that decisions about infant feeding are usually made before pregnancy and often in adolescence (23).

5. Involving Dads and partners

The evidence reviewed in section 4 and the social marketing research in section 6 highlight that Dad and partners do not always feel involved in antenatal and newborn care in particular around breastfeeding education and decision making. Evidence shows Dads can play an important support role in this process and their view is particularly influential in families of lower socio economic status.

Therefore it is recommended that:

- The LMNS work towards routine inclusion of Dads and partners in all feeding discussions as part of antenatal provision through maternity services (linked to the training refresh and incorporated into the 0-5 wellbeing model).

- An inclusive session focussing on breastfeeding and targeted to both parents is built into the future antenatal offer (To be actioned by maternity and health visiting services as appropriate)

- Public Health work with Children's Centres to improve the equity of their offers – to include breastfeeding classes, tailored to both parents as part of the Early Help transformation project.

6. Specialist Support

The social marketing research allowed a rich exploration of a sample of Thurrock families' views in relation to support for specialist areas that may be acting as a barrier to breastfeeding such as when a women has a c section and when a baby has tongue tie.

Therefore, it is recommended that:

- A review of breastfeeding support for women who have had C-Sections within the existing maternity offer is undertaken (arose as feedback within the social marketing research) to be driven through the LMS.

- Earlier identification and treatment of tongue tie to be driven through the LMS and review any existing pathway for treatment and support for this issue, to maximise opportunities to advise new parents and support to them continue breastfeeding.

- Strengthen the pathways for women with postnatal depression and those with identified or suspected postnatal illness to ensure timely support with breastfeeding to facilitate initiation and maintenance.

9 References

1. **Early Intervention Foundation.** *What works to enhance the effectiveness of the Healthy Child Programme: An Evidence Update.* 2018.

2. In 2010 in England, **McAndrew F, Thompson J, Fellows L, Large A, Speed M, Renfrew MJ (2012)** Infant Feeding Survey 2010, Health and Social Care Information Centre http://www.ic.nhs.uk/statistics-and-data-collections/health-and-lifestyles-relatedsurveys/infant-feeding-survey/infant-feeding-survey-2010

3. **Thurrock Council.** *Thurrock Health and Wellbeing Strategy, 2016-2021.* 2016/2021.

4. **Office of National Statistics (ONS).** Childbearing for Women born in different years in England and Wales, 2017. *Office for National Statistics.* [Online] 2017. https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/conceptionandfertilityrates/bulletins/childbearingforwomenbornindifferentyearsenglandandwales/2017.

5. *Racial/Ethnic differences in Breastfeeding initiation and continuation in the United Kingdom and comparison with findings in the United States.* **Kelly, Y.J. & Nazroo, J.Y.** 2006, Paediatrics.

6. **Thurrock Council.** *Demographics and Population JSNA.* s.l. : Thurrock Council, 2015.

7. **NOMIS/ONS .** Family Status by number of parents working by number of dependent children by economic activity. *NOMIS/ONS.* [Online] 2011. https://www.nomisweb.co.uk/query/construct/summary.asp?mode=construct&version=0&dataset=761.

8. *Breastfeeding and Postpartum Depression: An Overview and Methodological Recommendations for future research.* **Pope, C.J. & Mazmanian, D.** 2016.

9. **Thurrock Council.** Children's Centres. *Thurrock Council.* [Online] 2018. https://www.thurrock.gov.uk/childrens-centres..

10. **Facebook.** SS17 BRAs. *Facebook.* [Online] 2019. https://www.facebook.com/SS17BRAS/.

11. **Parents 1st.** What we offer and where. [Online] Parents 1st , 2019. https://www.parents1st.org.uk/what-we-offer-and-where.

12. **Basildon and Thurrock University Hospital Trust.** Feeding Together. [Online] NHS, 2019. http://www.basildonandthurrock.nhs.uk/wards/childrens-and-maternity/1160-feeding-together.

13. **Facebook.** Feeding Together. *Facebook.* [Online] 2019. https://www.facebook.com/pg/FeedingTogether/posts/?ref=page_internal.

14. **WHO.int.** ***World Health Organisation International.*** **[Online] [Cited: 11 02 2020.] https://www.who.int/health-topics/breastfeeding.**

15. ***Potential Economic Impacts from improving breastfeeding rates in the UK.*** **Dokhel, S., Quigley, M.A., Fox-Rushby, J., McCormick, F., Williams, A., Trueman, P., Dodds, R. & Renfrew, M.J. 2015, Arch Dis Child, Vol. 100.**

16. Public Health England . Public Health Profiles. ***Public Health England Fingertips - Public Health Profiles .*** **[Online] 2016/17. https://fingertips.phe.org.uk/search/asthma%20hospital%20admissions#page/0/gid/1/pat/6/par/E12000006/ati/102/are/E06000034.**

17. Swansea University. ***Department of Public Health, Policy and Social Sciences.*** **2018.**

18. ***What do Women really want? Lessons for breastfeeding promotion and education.*** **Brown, A. 3, s.l. : Department of Public Health, Policy and Social Sciences, Swansea University, 2016, Vol. 11.**

19. Public Health England. Public Health Profiles. ***Public Health Profiles .*** **[Online] 2015-2017-. https://fingertips.phe.org.uk/search/mortality%20in%20children#page/0/gid/1/pat/6/par/E12000006/ati/102/are/E06000034/iid/92488/age/1/sex/4.**

20. ***What is the problem with breastfeeding? A qualitative analysis of infant feeding perceptions.*** **Stewart-Knox, B., Gardiner, K & Wright, M. s.l. : The British Dietetic Association, 2003, Journal of Human Nutrition Dietetics, Vol. 16.**

21. ***Men's views and experiences of infant feeding: A qualitative systematic review.*** **Earle, S. & Hadley, R. 2018, Maternal Child Nutrition, Vol. 14.**

22. UNICEF. UNICEF UK Baby Friendly Initiative - Theory of Change. ***UNICEF UK Baby Friendly Initiative.*** **[Online] 2019. https://www.unicef.org.uk/babyfriendly/wp-content/uploads/sites/2/2019/04/Baby-Friendly-Initiative-Theory-of-Change.pdf.**

23. ***The Effects of an Infant Feeding Classroom Activity on the Breastfeeding knoweldge and intentions of adolescents.*** **Walsh, A., Moseley, J. & Jackson, W. 3, 2008, The Journal of School Nursing, Vol. 24.**

24. ***Goals, dilemmas and assumptions in infant feeding education and support. Applying theory of constraints thinking tools to develop new priorities for action.*** **Trickey, H., & Newburn, M. 1, 2012, Maternal and Child Nutrition, Vol. 10.**

25. UNICEF. Skin-to-Skin Contact. ***UNICEF- The Baby Friendly Initiative .*** **[Online] 2019. https://www.unicef.org.uk/babyfriendly/baby-friendly-resources/implementing-standards-resources/skin-to-skin-contact/.**

26. Essential Parent. Bottle Feeding - Keeping the Bond. [Online] 2019. https://www.essentialparent.com/lesson/bottle-feeding-keeping-the-bond-6063/.

27. ***Pilot test of a home-based programme to prevent perceived insufficient milk supply.*** **Wood, N.K. Sanders, E.A., Lewis, F.M., Woods, N.F. & Blackburn, S.T. 2017, Women and Birth, Vol. 30.**

28. ***Young Mothers who choose to breastfeed: the importance of being part of a supportive breastfeeding community.*** **Brown, A., Lee, M. & Raynor, P. 1, Midwifery, Vol. 27.**

29. ***"Why aren't you stopping now?!" Exploring account of white women breastfeeding beyond six months in the East of England.*** **Newman, K.L. & Williamson, I.R. 2018, Appetite, Vol. 29.**

30. Brown, A. ***Breastfeeding Uncovered: Who really decides how we feed our babies.*** **s.l. : Pinter and Martin Ltd, 2016.**

31. Urban Dictionary/E-Dictionary. Mom-Shaming. ***Urban Dictionary.com.*** **[Online] 16 February 2017. https://www.urbandictionary.com/define.php?term=mom-shaming&amp=true.**

32. ***Maternal and Paternal experiences and satifiscation with a co-parenting breastfeeding support intervention in Canada.*** **Abass-Dick, J. & Dennis, C.L. 2018, Midwifery, Vol. 58.**

33. ***Breastfeeding Initiation and Duration in first-time mothers: Exploring the impact of father involvement in the early post-partum period.*** **Hunter, T. & Cattelona, G. 2, 2014, Health Promotion Perspectives, Vol. 4.**

34. ***Adolescent Mothers' breastfeeding social support needs.*** **Grasseley, J. 2010, The Association of Women's Health, Obstetric and Neonatal Nurses .**

35. ***Effectiveness of targeting fathers for breastfeeding promotion: Systematic Review and Meta-analysis.*** **Mahesh, P.K.B., Gunathunga, M.W., Arnold, S.M., Jayasinghe, C., Pathirana, S., Makarim, M.F., Manawadu, P.M. & Senanayake, S.J. 2018, BMC Public Health, Vol. 18.**

36. Fatherhood Institute. ***Fatherhood Institute Research Summary: Father's and Breastfeeding.*** **2018.**

37. ***Views of Fathers in Ireland on the experience and challenges of having a breastfeeding partner.*** **Bennett, A.E., McCartney, D & Kearney, J.M. 2016, Midwifery, Vol. 40.**

38. ***An exploration of the experiences of mothers who breastfeed long-term: What are the issues and why does it matter?*** **Dowling, S., & Brown, A. 1, 2013, Breastfeeding Medicine, Vol. 8.**

39. McAndrew F, Thomson J, Fellow L, et al. 2012. Infant feeding survey 2010: summary. Health and Social care Information Centre. ***catalogue.ic.nhs.uk.*** **[Online] https://sp.ukdataservice.ac.uk/doc/7281/mrdoc/pdf/7281_ifs-uk-2010_report.pdf.**

40. S., Buckley. Extended breastfeeding: the gift of a lifetime. . ***Essence (Magazine of the Australian Breastfeeding Association).*** **2006, Vol. 42, 1.**

41. NCT. Breastfeeding: how long? National Childbirth Trust. www.nct.org.uk [pdf file, accessed December 2013]. [Online] 2010.

42. ***Parental concerns about extended breastfeeding in a toddler. .*** **Stein MT, Boies EG, Snyder DM. 5, s.l. : Pediatrics, 2004, Vol. 114. 1506-9.**

43. Baby Centre . Extended Breastfeeding. ***Baby Centre.*** **[Online] 2019. https://www.babycentre.co.uk/a8496/extended-breastfeeding.**

44. The Multiple Births Foundation. ***Guidance for Health Professionals on feeding Twins, Triplets and Higher Order Multiples.*** **2011.**

45. ***Promote breastfeeding in the Outpatient Setting: It's Easy! Current problems.*** **Sriraman, N.K. 2017, Pediatric Adolescent Health Care , Vol. 47.**

46. ***Barriers to breastfeeding: a qualitative study of the views of health professionals and lay counsellors.*** **Tennant, R., Wallace, L.M. & Law, S. 2006, Community Practitioner, Vol. 79.**

47. ***Nourishing Body and Spirit: Exploring British Muslim mother's constructions and experiences of breastfeeding.*** **Williamson, I.R. & Mahomed Sacranie, S. 2012, Diversity and Equality in Health and Care , Vol. 9.**

48. ***Breast is best: just maybe in private?*** **Sayers, R. 618, 2014, British Journal of General Practice, Vol. 64.**

49. UNICEF. The International Code of marketing breastmilk substitutes. ***UNICEF - The Baby Friendly Initiative.*** **[Online] 2019. https://www.unicef.org.uk/babyfriendly/baby-friendly-resources/international-code-marketing-breastmilk-substitutes-resources/the-code/.**

50. Better Start Southend. Better Start Southend - Midwifery 1-2-1 Breastfeeding Support Service . ***Better Start Southend.*** **[Online] 2019. https://abetterstartsouthend.co.uk/midwifery-1-2-1-breastfeeding-support-service/.**

51. Brighton and Hove Council/ Sussex Community NHS Foundation Trust. Breastfeeding Team (Brighton and Hove). [Online] 2019. https://www.sussexcommunity.nhs.uk/services/servicedetails.htm.DirectoryID-16280.

52. Bristol City Council. Breastfeeding in Bristol. [Online] 2019. https://www.bristol.gov.uk/social-care-health/breastfeeding-in-bristol.

53. ***Stemming the global Caesarean Section Epidemic.*** **The Lancet. 10155, 2018, The Lancet, Vol. 392.**

54. Conner M. & Norman, P. ***Predicting Health Behaviour.*** **s.l. : Open University Press, 2005.**

55. ***Factors that positively influence breastfeeding duration to 6 months: A literature reivew.*** **Meedya, S. Fahy, K & Kable, A. Women and Birth, Vol. 23.**

56. Early Intervention Foundation. ***What works to enhance the effectiveness of the Healthy Child Programme: An evidence update.*** **2018.**

57. Local Government Association. ***Fit for and during pregnancy; The role for Local Government.*** **2018.**

58. Niven, M. ***Effective Interventions for promoting uptake and maintenance of breastfeeding.*** **s.l. : Aubrey Keep Library and Knowledge Service, July 2018.**

10 Appendices

Appendix 1 - WHO and UNICEF 'ten steps to successful breastfeeding'

These steps outline the ten principles of best practice that NHS professionals should utilise in supporting women and their families to have a positive experience of breastfeeding. They are split into two categories entitled 'critical management procedures' and 'key clinical practice.'

Critical Management Procedures

1.

a) Comply fully with the international code of marketing of breastmilk substitutes and relevant World Health Assembly resolutions.

b) Have a written infant feeding policy in place that is routinely communicated to staff and parents/carers.

c) Establish on-going monitoring and data management systems.

2) Ensure staff members have sufficient knowledge, competence and skills to support breastfeeding.

Key Clinical Practice

3) Discuss the importance and management of breastfeeding with pregnant women and their families.

4) Facilitate immediate and uninterrupted skin-to-skin contact and support mothers to initiate breastfeeding as soon as possible after birth.

5) Support mothers to initiate and maintain breastfeeding by supporting them to manage common difficulties.

6) Do not provide breastfed new-borns any food/fluids other than breastmilk unless medically advised.

7) Enable mothers and their infants to remain together and practise rooming-in 24 hours per day.

8) Support mothers to recognise and respond to their infant's cues for feeding.

9) Counsel mothers on the use and potential risks of feeding bottles, teats and dummies.

10) Coordinate discharge so that parents and their infants have timely access to ongoing support and care.

Evidence suggests that by NHS professionals following the 10 abovementioned steps, this significantly improves breastfeeding rates, including uptake, duration and exclusive breastfeeding.

Appendix 2 – Link to Full Social Marketing Research Report

Infant_feeding_rep
ort_final FINAL V1 - I

Appendix 3 – Summary of Poll Questions

Thank you for taking the Thurrock infant feeding poll, which is anonymous and for mums (including mums to be) and their partners.
We'd appreciate your honest views, which will be used to help Thurrock Council and the local NHS shape their services around your needs.
You will have the option at the end of the poll to answer a short survey, for which we are offering a £10 e-gift card as a thank you for your time.
But if you only have a few minutes to do the poll, we are very grateful for your opinions. Thanks for joining in!

Which of the following are you?										
Expectant mum	Are you planning to breastfeed?	Y = How long for?	What info / support do you value?			Interested in continuing with survey? £10 e-gift card Yes/No	If yes, additional questions include: 6 tick boxes for demographic profiling 3 questions about service access and parental experience 7 questions about info and support	Interested in further research? Free Q&A session with a breastfeeding specialist Opt in to a telephone interview and receive a £15 e-gift card	Thank you. Please provide your email address so we can get back to you on that.	Anything you'd like to add?
		N = What made you decide not to breastfeed?	What info / support do you value?							
Mum with new-born / mum with baby / mum with toddler	Are you breastfeeding?	Y = How long have you been breastfeeding?	How long do you plan to breastfeed for?	How have you found it?	What info / support do you value?					
		N = What made you decide not to breastfeed			What info / support do you value?					
		I started but hit problems and stopped	What problems did you encounter?	What would have helped you overcome these problems?	What info / support do you value?					

Dad	Is your partner breastfeeding?	Yes	How long does she plan to breastfeed for?	How have you found it?	What info / support do you value?					
		No but we're expecting and she is planning to	What info / support do you value?							
		She started but hit problems and stopped	What problems did she encounter?	What would have helped her overcome these problems?	What info / support do you value?					
		No	Why is that?	What info / support do you value?						

Appendix 4 – Topic Guide for online Survey

Topic Guide for Mums who CHOSE TO BREASTFEED

- What made you decide to breastfeed?
    - To my baby from infection and disease
    - It's more convenient than bottle feeding
    - It's free
    - To bond with my baby
    - My milk is a perfect match for baby's need

- Was there enough/the right information available to you about breastfeeding?
    - Yes/No

- Was information available to you at the right time?

- How long did you breastfeed for / have you been breastfeeding for?

- Are you feeding breast milk alone or a combination of breast and bottle?

- How long do you plan to breastfeed for?

- What should we be doing in Thurrock to support mums who choose to breastfeed?

- What do you think women need to help them maintain breastfeeding for the recommended 6 months?

- How does your partner feel about your breastfeeding?
    - Did you choose together?
    - Is he supportive?
    - How long would he like you to breastfeed for?

- Who is best placed to support women and their families around initiating breastfeeding?
    - Examine the entire journey from Antenatal to postnatal care, exploring where opportunities exist for initiating/continuing conversations about breastfeeding.
    - Is there a consistent approach across the health landscape?

- Who is best placed to support women and their families around continuing breastfeeding?
    - Examine the entire journey from Antenatal to postnatal care, exploring where opportunities exist for continuing conversations about breastfeeding.
    - Is there a consistent approach across the health landscape?

Topic Guide for Mum who CHOSE NOT TO BREASTFEED

- What made you decide not to breastfeed?

- How did your partner feel about breastfeeding?
    - Did you choose together?
    - Had you chose to breastfeed, would he have supported you?
    - Did anyone else influence your choice?

- Were you happy with the information available to you about infant feeding?
    - Yes/No
    - If no, what? Timing / content / format
    - If yes, what info was most useful?

- How could health professionals improve the information provided to mums about infant feeding?

- Did you feel that all the health professionals who supported you (before and after the birth of your baby) were supportive of your choice?
    - Yes/No
    - If no, why?

- Did you ever consider giving breastfeeding a go?
    - Yes – what happened?
    - No – why not?

- Which of the benefits below do you feel are strong reasons to breastfeed?
    - To protect my baby from infection and disease
    - It's more convenient than bottle feeding
    - It's free
    - My milk is a perfect match for baby's need
    - For the health of both me and my baby
    - None of these
    - Other

- Is there anything that would change your mind about breastfeeding?

Appendix 5 – GP Consultation Survey

GP survey - infant feeding

Independent agency Upshot has been commissioned by Thurrock Council to conduct research into the local drivers, barriers, information and support needs around infant feeding, to help inform a Needs Assessment and subsequent strategy.

As part of this, we're keen to hear your views and experiences around infant feeding information and support in Thurrock, The aim of this research project is to understand what is needed to better encourage and support breastfeeding uptake and continuation in Thurrock.
Thank you for sharing your thoughts.

1) Uptake in Thurrock varies enormously, from 30% at its worst to 86% at its best.
What needs to be done to support/influence the uptake of breastfeeding in Thurrock?

2) Where do you refer pregnant and new parents for support?

Basildon & Thurrock University Hospital (or other hospital)

Maternity Direct

Health visitors

Children's Centres

Start4Life

NHS website

*Other - Write In (Required): **

*Other - Write In (Required): **

*Other - Write In (Required): **

3) Do you feel that maternity services work well together in supporting mums?
Is it joined up enough? Consistent? Could it be improved?

4) Who is best placed to support women and their families around initiating breastfeeding?

5) What infant feeding resources do you give / promote to parents?

Start4Life Off to the Best Start leaflet

Start4Life Breastfeeding Friend

UNICEF breastfeeding checklist

NHS website content around breastfeeding and bottle feeding

Start4Life bottle feeding leaflet

UNICEF positioning and attachment video

*Other - Write In (Required): **

*Other - Write In (Required): **

*Other - Write In (Required): **

6) What guidance and support do you currently offer around complimentary feeding?

7) What do you advise as the ideal duration for breastfeeding? The Start4Life leaflet (which is the main leaflet used in Thurrock) doesn't specify advised timescales.

8) How do mums respond to the advice on continuing breastfeeding? Do you feel that exclusive breastfeeding for 6 months is realistic?

9) Is there anything missing to support women in breastfeeding for at least 6 months? What needs to be done to support/influence breastfeeding in Thurrock, especially in the first weeks when mums struggle the most?

10) Who is best placed to support women and their families around continuing breastfeeding? (Exclusive breastfeeding up to 6 months and continued alongside complimentary feeding up to 2 years as per WHO guidance)

Appendix 6 – Maternity Professionals Survey

Thurrock Maternity Professional's Survey

1) Uptake in Thurrock varies enormously, from 30% at its worst to 86% at its best. What needs to be done to support/influence the uptake of breastfeeding in Thurrock?

2) Do you feel that maternity services work well together in supporting mums?

3) Who is best placed to support women and their families around initiating breastfeeding?

4) What are the key decision points around infant feeding, for mums, from your perspective?

5) In your experience why do parents not engage with ante-natal sessions? How would you describe them– is there a mixed profile or a specific type, or a bias?

6) We know that the majority of mums start breastfeeding in hospital, but struggle to maintain it at home and need help in the first few days. How do the various teams work together to ensure mums get the help they need?

7) What is required to enable more support for women who want to breastfeed? And who is best place to do this?

8) What infant feeding resources do you give / promote to parents?

[ ] Start4Life Off to the Best Start leaflet

[ ] Start4Life Breastfeeding Friend

[ ] UNICEF breastfeeding checklist

[ ] NHS website content around breastfeeding and bottle feeding

[ ] Start4Life bottle feeding leaflet

[ ] UNICEF positioning and attachment video

[ ] Other - Write In (Required): _____ *

[ ] Other - Write In (Required): _____ *

[ ] Other - Write In (Required): _____ *

9) What guidance and support do you currently offer around complimentary feeding?

10) What do you advise as the ideal duration for breastfeeding? The Start4Life leaflet (which is the main leaflet used in Thurrock) doesn't specify advised timescales.

11) How do mums respond to the advice on maintaining breastfeeding? (Exclusive breastfeeding up to 6 months and continued alongside complimentary feeding up to 2 years as per WHO guidance)

12) Do you feel, based on your experience, that 6 months exclusive breastfeeding is realistic?

( ) Yes

( ) For some mums

( ) Increasingly difficult to breastfeed exclusively for lifestyle/work reasons

( ) Other - Write In (Required): _____*

( ) No

13) Is there anything missing to support women in breastfeeding for this duration? What needs to be done to support/influence the maintenance of breastfeeding in Thurrock?

14) Who is best placed to support women and their families around continuing breastfeeding?

Appendix 7 – Topic Guide for Focus Groups/Phone Interviews

Focus groups topic guide

INFORMATION

- What info was given to you by your maternity nurse in the run up to your birth?
- Was there anything missing?
- Did you search out info on your own – what?
- Did you attend any antenatal classes that covered feeding options?
- Here are some examples of leaflets and links… would any of these have been useful to you?

a) Leaflets

- Off to the best start leaflet
- Infant formula and responsive bottle feeding leaflet – pages 3-6
- Mothers breastfeeding checklist

b) Apps/websites?

- Best beginnings app – two very short videos on infant feeding
https://web.bestbeginnings.org.uk/web/videos/breastfeeding
https://web.bestbeginnings.org.uk/web/videos/formula-feeding

- Feeding together FB page – run by Basildon Hospital infant feeding support specialists – soon to become an app
https://www.facebook.com/FeedingTogether/

- NHS
https://www.nhs.uk/conditions/pregnancy-and-baby/problems-breastfeeding/

c) Do these videos fill information gaps and answer questions you may have?

- The science behind breast milk – very short videos
https://www.youtube.com/watch?v=xJxBl2DtV30

https://www.youtube.com/watch?v=vUvwLhcqgtM
https://www.youtube.com/watch?v=B6VvF44aWrk

- What's right for mum and baby

https://www.youtube.com/watch?v=NuS2lnOkBWE

- Personal experiences and tips on combination feeding

https://www.youtube.com/watch?v=flQblK0L2ig

Q&A SESSION

Common questions arising from our research:

- Sore nipples – what works and are cabbage leaves a myth?
- How much is enough milk?
- How can I boost milk supply through diet?
- Topping up with formula – does it make baby sleep better?
- Pros and cons of combination feeding and how to go about choosing formula as / when / if you're ready to
- Community support – what groups are available?
- Transition when returning to work. Expressing and bottle feeding.
- Introducing solids – baby led or fixed time? Why 6 months? When to convert to cow's milk?

SUPPORT

- Talk me through your experiences of breastfeeding

- What do you feel should have happened to make you feel better supported?

- What led to you stopping and what might have helped you to maintain breastfeeding?

OR IF STILL BREASTFEEDING

- What would you say has contributed to your breastfeeding success?

THE ROLE OF PARTNER (GROUP WITH DADS)

Research facts:

- Education and support about breastfeeding for fathers improves breastfeeding rates (Maycock et al, 2013)
- The quality of mothering provided to an infant has been linked with supports the mother receives from her partner (Guterman & Lee, 2005)

- Women who enjoy the full support of their partners are more closely bonded to their children, and more responsive and sensitive to their needs (Feiring, 1976)
- Greater father involvement in infant care and other household tasks is correlated with lower parenting stress and depression in mothers (Fisher et al, 2006)

What dad's need/want/feel:

- Knowledge about breastfeeding
- Positive attitude towards breastfeeding
- Involvement in the decision making
- Practical support
    - Accepting, learning and implementing the support role
    - Meeting mum's needs
    - Parental leave
- Emotional support
    - Affection, reassurance, encouragement

AND FINALLY….

- What support is needed for Thurrock mums to help them maintain BF for as long as they wish to – availability, timing, format.

- Who is best placed to provide that?

- Anything else?

THANKS AND CLOSE

Appendix 8 – Thurrock Children's Centres local offer around Infant Feeding and Care

Table 4: Children Centre's offer around infant feeding and infant support 2018/19.

Name of Children's Centre	Monday	Tuesday	Wednesday	Thursday	Friday
Aveley			Midwife appointments** 9.30-3.30pm	Midwife appointments** 9.30-3.30pm Introduction to solids*** 9.30-11am 2 year old development assessment checks 1-5pm	Child health clinics, baby weighing 9.30-11.30am 1 year old development assessment checks 12.30-5pm
Chadwell		Midwife appointments** 9-2pm	Child health clinics, baby weighing 9-12.30pm	Introduction to solids*** 10-11.30am	
Ockendon	Midwife appointments** 1-4pm Child health clinics, baby weighing 2-3.30pm	Midwife appointments** 9-1pm 1 year old development assessment checks 9.30-1pm 2 year old development assessment checks 12.30-5pm	Midwife appointments** 9-1pm Child health clinics, baby weighing 9.30-11.15am Parents first support course 9-11am	Infant feeding drop-in for 0-12 months 1-4pm	Midwife appointments** 9-1pm

			Introduction to solids*** 9.30-11.30am		
Purfleet	2 year old development assessment checks 9.30-1pm	Introductions to solids*** 9.30-11.30am 1 year old development assessment checks 9.30-1pm Child health clinics, baby weighing 1.30-3.30pm		1 and 2 year old development assessment checks 9.30-1pm	
Stanford		Child health clinics, baby weighing 9.30-11.30am Introduction to solids*** 1.30-3pm	Child health clinics, baby weighing 1.30-3pm		
Stifford	Midwife appointments** 9-1pm				Midwife appointments** 9-1pm
Thameside	1 year old development assessment checks 12.30-4pm	2 year old development assessment checks 9-12.30am	Midwife appointments 9-1pm Child health clinics, baby weighing 9.30-10.30am at Stifford children's centre and 3-4pm at Thameside	2 year old development assessment checks 1-4pm Midwife appointments** 1-4pm Child health clinics, baby weighing 1-2.45pm at Beacon Church,	

			Introductions to solids 10-11am Infant feeding support **** 2-4pm	Drake Road, Chafford Hundred	
Tilbury	Child health clinics, baby weighing 9.30-11.30am Parents first support course 9.30-12.30pm 1 year old health checks 12.30-5pm Infant feeding support**** 1-3.30pm	Midwife appointments **9-5pm 2 year old health checks 9.30-1pm	Midwife appointments** 9-3pm	Child health clinics, baby weighing 1.30-3.30pm Midwife appointments** 9-5pm	Midwife appointments** 1-4.30pm

** Midwife appointments include pre-natal checks and support for mother and baby and should be booked in advance.

***For ages 0 to 8 months. A programme that supports parents and Carers with introducing solid foods to their baby. Should be booked in advance.

**** Support sessions for families to discuss any matters relating to feeding their baby, such as breast feeding, formula feeding and introducing solid foods.