Brenner & Co

Impact on Urban Health

Breastfeeding in focus: Insights from the sector

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In this report

Foreword

The Children's Health and Food programme at Impact on Urban Health is working towards a world where all children have equitable access to healthy, nutritious food as they grow up – no matter where they live or what family they come from.

The food options that are most consistently affordable and available should be the healthiest, regardless of where you live. However, too often this isn't the reality for children and families, who can find themselves navigating unequal access to support services during early infancy and a commercial food industry that saturates neighbourhoods with unhealthy food options as children grow up. We live in a country where per calorie, healthy food is almost twice as expensive as unhealthy food.[i]

The importance of nutrition for baby and child health is clear, yet there are considerable gaps in national food policies for the early years, especially around breastfeeding and infant feeding – the so-called 'baby blind-spot'. Government policy (or lack thereof) affects local policy, which in turn affects support services on offer for families. Factors such as economic inequality and structural racism also impact the options that are available and accessible to mothers and can shape their experience of services that they do access. This is a health equity issue, and it is one that can be tackled.

Impact on Urban Health commissioned this report to better understand how policy and practice could shift towards a more equitable system for infant feeding and support. While we recognise that a wealth of research on breastfeeding already exists, our aim was to understand breastfeeding policy and practice issues directly from diverse perspectives of those working in and around breastfeeding, from statutory health services to community support services, from academics to NGOs and campaigning organisations, as well as national and local government bodies.

We believe the resulting report does justice to the complexity of this issue and the sector. There are many important and nuanced factors that shape baby feeding choices and the length of time mothers breastfeed. We've seen the power held by the Commercial Infant Milk Formula (CIMF) industry, which often fills information gaps left by overstretched statutory and community services, yet we've also been inspired by the energy and practical desire for change across all parts of the system. Research participants have shared not only their experience as professionals, but also their personal experience as mothers and carers. Many participants went over and above to contribute to the project, offering time, expertise, resources, and signposting.

The recommendations for change in this report are derived from interviewees who we believe are best positioned to identify the necessary policy and practice shifts to create an infant feeding food system that ensures all children have the best start in life. We would like to thank all those who contributed, and the team at Bremner & Co who have led this research with great care and empathy.

We're proud to share these insights and recommendations more widely across the sector, with local and national decision-makers, and with all who can play a role in achieving a more equitable system for all infants and families.

Carole Coulon
Children's Health and Food programme portfolio manager, Impact on Urban Health

About

Impact on Urban Health

Impact on Urban Health, part of Guy's & St. Thomas' Foundation, focuses on addressing health inequities by making urban areas healthier places for everyone to live. They focus on a few complex health issues that disproportionately impact people living in cities – children's health and food, multiple long-term conditions, the health effects of air pollution and children's mental health. They take a place-based approach, which means developing an understanding of how the local environment, social context and economic factors affect people's health. They partner with other organisations to deliver projects, conduct research and amplify their results.

Bremner & Co

Bremner & Co is a food policy consultancy working to make the food system fairer. Founded in 2015, they focus on improving food policy and practice so that everyone has the right to good, nutritious, healthy food. They started their journey running the office of the School Food Plan for the Department for Education, delivering policies and plans to improve England's school food culture. Since then, they have worked on food systems research, advocacy and partnership building, strategy and policy. They have worked with international, national and local governments, not-for-profit and charitable organisations, academics and schools, with the aim of transforming our food system. They have a focus on child nutrition across the life course, from breastfeeding through to leaving further education.

Contributors

Impact on Urban Health and Bremner & Co would like to thank the organisations and individuals who work in the breastfeeding sector for their involvement in this work. They would also like to give special thanks to Vicky Sibson from First Steps Nutrition Trust, for her expertise, insightful feedback and invaluable counsel throughout the drafting process. Her thoughtful advice and guidance have greatly contributed to the quality and depth of this report.

Introduction

and project background

Impact on Urban Health work to ensure all children have the opportunity to thrive, regardless of where they grow up. Key to this is making sure parents can adequately feed their babies, however they choose to do so. Good nutrition and health in the very early years play a crucial role in a child's development and growth and can also contribute to better child health.

To this end, Impact on Urban Health commissioned Bremner & Co to conduct a comprehensive landscape review of breastfeeding in England, aiming to provide an up-to-date picture of current policy and practice, identify barriers to breastfeeding and explore levers of influence. This research is pertinent to Impact on Urban Health's broader work on children's health and food because breastfeeding and infant feeding are essential components of food policy yet are often overlooked in policy and advocacy. Infant feeding has significant long-term impacts on dietary habits, health, and well-being. By acknowledging the importance of breastfeeding and infant feeding, policymakers can more effectively address food security issues and promote healthy development from the earliest stages of life. The lack of focus on infant feeding within food policy creates a significant barrier to improving breastfeeding rates and ensuring adequate nutrition for infants, underscoring the need for a more comprehensive approach that draws infant feeding in food policy discourse.

The primary goal of this project was to report on the perspectives of stakeholders with expertise in the sector, uncovering insights that would help define Impact on Urban Health's role in the breastfeeding sector and inform its future direction. The review aimed to uncover current issues related to breastfeeding policy and practice, infrastructure, and funding and culture, providing a solid foundation for strategic planning and advocacy efforts.

In this context, 'infrastructure' refers to the essential systems and support mechanisms that enable and sustain breastfeeding practices. This includes healthcare facilities, support services, training and education programmes, workplace policies, community resources and supply chains. These components support the implementation and sustainability of breastfeeding policies and practices.

Identifying the correct terminology for breastfeeding support is complicated as there is a wide range of services offered. The report makes a distinction between routine support delivered by NHS midwives and health visitors (henceforth known as universal) versus support delivered by charities, breastfeeding helplines and peer-to-peer support (henceforth known as charity and community support). It is recognised there is a wide range of charity and community breastfeeding support, including peer support from organised, highly skilled, trained volunteers with lived experience, mum-to-mum peer support within communities, paid-for support from lactation consultants and doulas (trained professional providing one-to-one support through pregnancy, labour and birth).

The report focused on the perspectives of individuals working in the breastfeeding sector. It is not a lived experience report of breastfeeding or formula feeding mothers (although some lived experience views were gained during the interviews). The primary fieldwork was conducted between July and August 2023, during the Conservative administration. Secondary fieldwork was conducted between February and July 2024. During this period, those interviewed were asked to review and provide feedback on the first draft. This second phase of the research occurred in the lead-up to the 2024 general election, with Labour coming into power on 4th July 2024.

Breastfeeding was the focus of the research, but the report makes reference to the experiences of formula-feeding mothers and the influence of the Commercial Infant Milk Formula (CIMF) industry because both were identified as critical to the discussion. As one interviewee put it, 'it's not entirely possible just to focus on breastfeeding when the UK has a formula feeding culture' (Charity). Additionally, there was extensive news coverage around food insecurity among formula feeding mothers at the time of interviewing (July-August 2023). So, the report explores formula-related issues through the lens of the cost-of-living crisis, pathways to formula for the food-insecure and the divisive cultural narratives around how breastfeeding is talked about. To ensure that the research comprehensively reflected perspectives across the sector, and in acknowledgement of the influence of the CIMF industry, a representative from the CIMF industry was also interviewed. However, they were not invited to participate in the second phase of the research.

While the report critiques the CIMF industry, it is not a critique of mothers who choose formula feeding. Indeed, the interviewees emphasised that 'breastfeeding groups are not anti-formula but against exploitative marketing practices'.[i] *(Charity)*.

This report uses terms like 'women', 'mothers' and 'breastfeeding' for clarity and to reflect the majority experiences that are the focus of this research. However, we recognise that birthing and lactating parents or caregivers who do not identify as women also chest- and breastfeed.

Executive Summary

> "The first word that springs to mind would be inadequate. There isn't clear leadership on breastfeeding. It doesn't have a particular home and there isn't a policy. It's inadequate, piecemeal." *(Charity)*

Breastfeeding contributes to improved immunity, cognition, health and overall development of the baby, alongside being proven to protect women against ovarian cancer, breast cancer and type 2 diabetes. It also supports the bond between the mother and infant.[ii] Increases in breastfeeding rates are associated with reductions in greenhouse gas emissions and water consumption, which are linked to the production and use of infant formula.[iii] Yet, the UK still faces significant challenges in enabling and supporting women to breastfeed during the critical early months of a baby's life. The UK has some of the lowest breastfeeding rates globally (only 1% of mothers are exclusively breastfeeding at 6 months)[iv] and scored 1/10 on the World Breastfeeding Trends Initiative for national policy, programmes and coordination.[v]

The research found that government policy and political will are lacking, regulations to support breastfeeding mothers at work are weak, and local authorities and the workforce are underfunded and under-resourced. This underfunding has an impact on the support breastfeeding mothers can access. There are insufficient numbers of midwives and health visitors, leaving both professions with time constraints, and significant cuts to infant feeding teams. Face-to-face support and contact time with mothers in the first few days after birth are crucial but are currently not universally available. Workplace legislation does not support breastfeeding – there are no paid-for breaks, policy is based on voluntary guidance and mothers are still feeding in toilets and cupboards.

The significance of the charity and community support sector was strongly emphasised by most of our interviewees. They recognised the critical role these organisations play in providing accessible, empathetic and practical breastfeeding support to mothers, often bridging gaps left by underfunded and under-resourced universal healthcare services. Peer supporters and community-based initiatives offer relatable, ongoing assistance that many mothers find more effective and comforting than traditional healthcare settings. This sector's contribution is vital for fostering a supportive breastfeeding environment and enhancing overall maternal and child health outcomes. This sector is also underfunded, reliant on volunteers and suffers from short-term government funding. There's a 'growing tendency of local authorities and health bodies to push more and more work into these commissioned services and with huge uncertainty about financing' *(Charity)*.

Whilst there is evidence of higher breastfeeding rates in some minority ethnic groups, the research found mothers from these groups face barriers. Interviewees reported Black mothers' negative experiences of breastfeeding support. Levels of deprivation also impact breastfeeding support and access to formula. Mothers in the most deprived areas are much less likely to breastfeed.

Tensions were uncovered between the desire to protect and not undermine breastfeeding, while simultaneously supporting formula-feeding mothers. The space was often described as divisive and toxic and some of the interviewees felt that it can be very challenging to achieve both. The tension was attributed to the influence of the CIMF industry but evidence from the media content analysis indicated the media and society itself also contribute to this discord through shaming of mothers and depictions of

ceasing breastfeeding as being a mother's failure. The interviewees emphasised how the influence of the CIMF industry creates significant barriers to breastfeeding initiation and duration, which was evidenced by the literature.[vii]

At the time of primary fieldwork (July-August 2023), the political and media focus was on formula pricing and issues with food security for formula feeding mothers. This was a focus for some Labour politicians and was regularly making headlines. The party's focus on formula also concerned elements of UK legislation restricting the marketing of CIMF, particularly its perceived restriction over the use of supermarket vouchers on formula (although the law does not restrict this) and its advice around the distribution of formula in emergencies. Labour have not publicly outlined their plans around breastfeeding but have indicated a strong focus on early years by announcing plans for a review into the early years sector and appointing a Minister for Early Education.[vii]

There was a strong desire from the interviewees to 'normalise' breastfeeding but also a recognition that this would take a significant cultural shift. Figure 1 below visualises the complexity of the landscape for breastfeeding and the interconnected factors that act as barriers to the initiation and continuation of breastfeeding.

Figure 1: Barriers to breastfeeding: a complexity map
(Source: Bremner & Co and Impact on Urban Health, Designed by the Food Foundation)[ix]

The interviewees believed there are various avenues for creating lasting change, albeit not one clear route for impact. The recommendations in this report are built on their reflections. The interviewees' top priorities were to fund charities and NGOs, and support for policy and advocacy. These were followed by investing in research, undertaking work on framing and communications, and trialling place-based initiatives. As of the time of writing, the UK is undergoing political and cultural changes that require strong, strategic advocates and leaders across breastfeeding, health and food systems arenas. Breastfeeding policy must be included in food policy and advocacy as it plays a pivotal role in children's health and development outcomes, supports food security, delivers economic benefits and addresses inequalities in access to nutritious food.

Research Goals

The aim of this research was to report on breastfeeding policy and practice issues from the perspective of those working in and around breastfeeding and to highlight the barriers that contribute to breastfeeding initiation and continuation. We wanted to answer, 'how does the environment in which women are making decisions about breastfeeding impact their choices?'

Methodology

The research involved two phases and used a mixed-methods approach. The first phase involved 28 semi-structured interviews with people working in the field of breastfeeding, from a cross-section of organisations, including academia, charities, government (national and local), health professionals, members of parliament and industry. Alongside the interviewees, we conducted desk research to understand the policy and practice landscape. Finally, we conducted a media and visual content analysis of newspaper articles that mentioned and visually portrayed breastfeeding from the top circulating UK national newspapers. The second phase took a co-design approach, in which we shared the first draft of the report with 11 of the interviewees. They used a Microsoft form to provide feedback on the themes and findings, which were then integrated into the report.

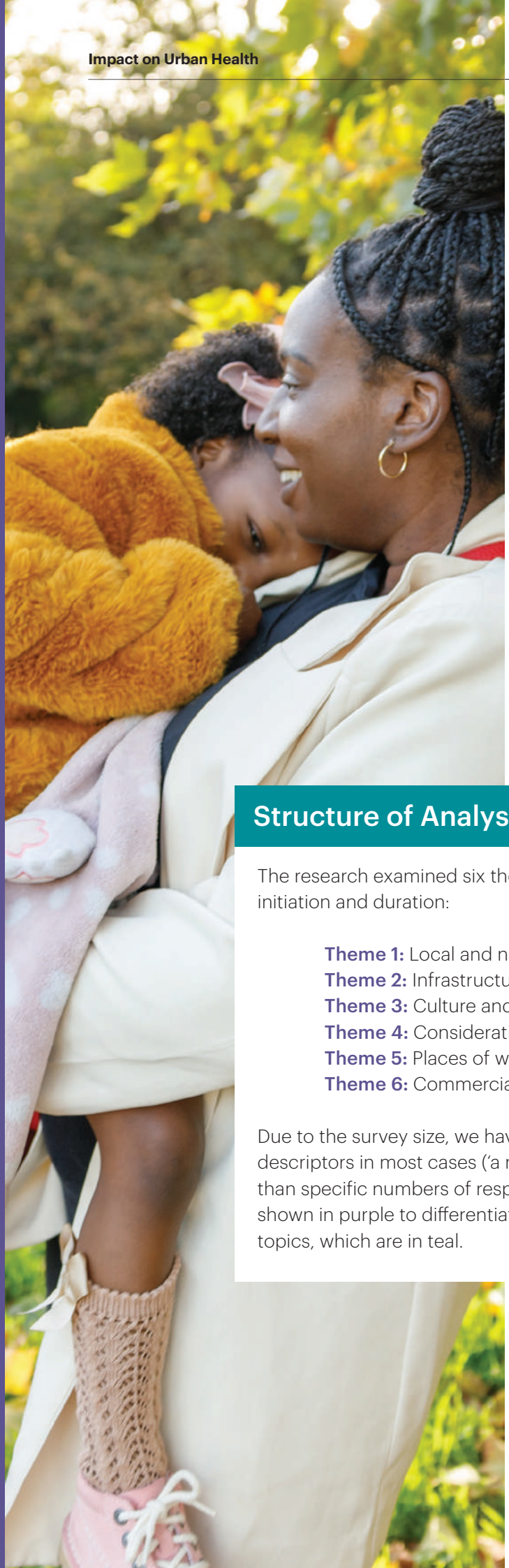
Research Limitations

This research reports on the perspectives of those operating within the system. There was a good range of sectors, with n=14 charity/NGO/campaigner (henceforth referred to as charity), n=5 local government or members of parliament, n=5 health sector, n=3 academia and n=1 industry. This ensured a broad set of views. Only one man was interviewed. A considerable number of women interviewed articulated that it was difficult to separate their personal experiences of breastfeeding from their professional experiences, which means the evidence generated includes both.

The research guide included questions concerning those living in disadvantaged areas and the impacts of policy and practice on different communities in England. In terms of differences by ethnicity and culture, organisations representing Black mothers engaged with the project, but the research did not comprehensively reflect organisations from multiple ethnicities. Other organisations were contacted but were unable to contribute due to time constraints, which echoes findings from this research about an under-resourced support sector. Although we acknowledge the significance of intersectionality in shaping individual experiences and outcomes, intersectionality was not within scope of the report. Therefore, the report does not examine the complex interplay of overlapping social identities such as race, gender, socioeconomic background and sexuality.

There were strong concerns from the interviewees regarding conflicts of interest. The research team gave formal statements confirming that the research was not funded by industry. This is reflective of the view of the campaigning sector (and extensive evidence)[x] that the CIMF industry uses underhand tactics to influence research.

One potential interviewee declined to participate, believing sufficient breastfeeding research exists; interviewees from the campaigning sector believed they know what needs to be done, are frustrated it is not being done and believe action, not research, is what is needed. Many interviewees were keen to understand the purpose and outcomes of the



research. Impact on Urban Health had similar feedback with exploratory work on breastfeeding in 2021 and were asked to fund staffing/practice. Nevertheless, this report fills an important gap by shedding light on the wider views of people from the sector. It is an up-to-date, cross-sector, mixed-method research piece that is both novel and useful.

Alongside some constructive criticism of the project goals and outcomes, many organisations went over and above to contribute to the project, giving time, documents, resources and signposting. Some interviewees asked to be re-interviewed so they could contribute further. There is a real appetite and desire for change in this sector. Conversely, it was very difficult to locate, contact or interview representatives of the Conservative government. The only feasible engagement was over email; many representatives declined to be interviewed and instead supplied formal policy positions.

Structure of Analysis

The research examined six themes concerning barriers to breastfeeding initiation and duration:

Theme 1: Local and national policy (including data)
Theme 2: Infrastructure and support
Theme 3: Culture and media
Theme 4: Consideration of demographic characteristics
Theme 5: Places of work or study
Theme 6: Commercial Infant Milk Formula industry

Due to the survey size, we have deliberately used approximate proportion descriptors in most cases (‘a minority’, ‘the majority’, ‘some’, ‘several’) rather than specific numbers of respondents. Direct quotes from stakeholders are shown in purple to differentiate them from media headlines and other research topics, which are in teal.

Background

The benefits of breastfeeding for both the baby and the mother are well documented. Breastmilk provides children protection from infectious diseases and malnutrition, helps with cognitive development, reduces asthma, contributes to low mortality rates and reduces the long-term risk of obesity and disease.[xi] There is some evidence linking breastfeeding with increased performance in intelligence tests[xii] and educational attainment,[xiii] which regularly feeds into media attention on breastfeeding.[xiv] Breastfeeding mothers also benefit from protection against breast and ovarian cancers, type 2 diabetes, cardiovascular disease and postpartum depression.[xv] Analysis also indicates that by increasing breastfeeding, the NHS could save £48million a year (based on the reduction of illnesses associated with formula feeding).[xvi]

Recent research into the hidden economic value of breastmilk argues that breastmilk is a crucial contributor to food production, food security and health. Breastfeeding's potential contribution to food production is reduced by 70-80% in North America and Europe due to cultural or structural barriers to breastfeeding. The research has resulted in the development of the Mothers' Milk Tool, which measures and makes visible the value of breastfeeding as a capital asset.[xvii] Breastfeeding as food production has also been identified as a climate change intervention, since increases in rates of breastfeeding would lead to reductions in greenhouse gas emissions and water consumption associated with the production and use of infant formula.[xviii]

The World Health Organisation (WHO) recommends exclusive breastfeeding until six months for optimal growth, development and health, followed by breastfeeding alongside nutritious foods up to the age of two or older. This view has been endorsed by the government advisory body the Scientific Advisory Committee on Nutrition (SACN).[xix] SACN's 2023 guidance advised the government to consider strategies to support feeding babies into the second year of life.[xx] UK policy states breastfeeding is 'an important public health priority'.[xxi] The Conservative government's political focus on productivity and the workforce, evidenced by the Back to Work budget[xxii] and the 30 hours free childcare policy,[xxiii] has likely impacted breastfeeding, particularly among mothers who are more economically vulnerable.

The UK has some of the lowest rates of breastfeeding globally.[xxiv] The data shows that a large proportion of mothers use infant formula. However, research indicates 80% of women would have liked to breastfeed for longer.[xxv]

67%

Breastfeeding initiation rates from July 2023 indicate that 67% of babies receive breastmilk as their first feed, compared to 26% receiving formula.[xxvi]

32%/18%

6-8 week data from 2022/2023 show 32% of infants are exclusively breastfed and 18% of infants are partially breastfed at 6-8 weeks.[xxvi]

34%

The Infant Feeding Survey 2010 indicates 34% of mothers are breastfeeding at 6 months (this can be alongside formula or complementary foods).[xxviii] This compares to 71% in Norway, 61% in Sweden and 57% in Germany.[xxixi]

1%

Only 1% are exclusively feeding at 6 months.[xxx] This compares to 39% in the Netherlands, 28% in Belgium and 28% in Spain.[xx]

Breastfeeding initiation is highest in mothers aged 30+, those who completed further education and those in managerial/professional roles – these mothers also tend to breastfeed for longer. Mothers in routine/manual roles or those who have never worked are least likely to initiate breastfeeding and have a higher probability of stopping breastfeeding after a week.[xxxii] Breastfeeding rates are strongly influenced by levels of deprivation; mothers living in the most deprived areas of the UK are 40% less likely to initiate breastfeeding than those living in the least.[xxxiii] Mothers with disabilities tend to have lower rates of breastfeeding.[xxxiv]

Mothers from minority ethnic groups are more likely to initiate breastfeeding, breastfeed at various stages and breastfeed for longer. However, exclusive breastfeeding rates are similar between white mothers and those from minority ethnic groups, indicating a culture of mixed feeding among minority ethnic groups.[xxxv]

Figure 2: Percentage of infants who received breastmilk for their first milk according to levels of deprivation across England, 2020/2021 (Source: Fingertips, 2023)[xxxvi]

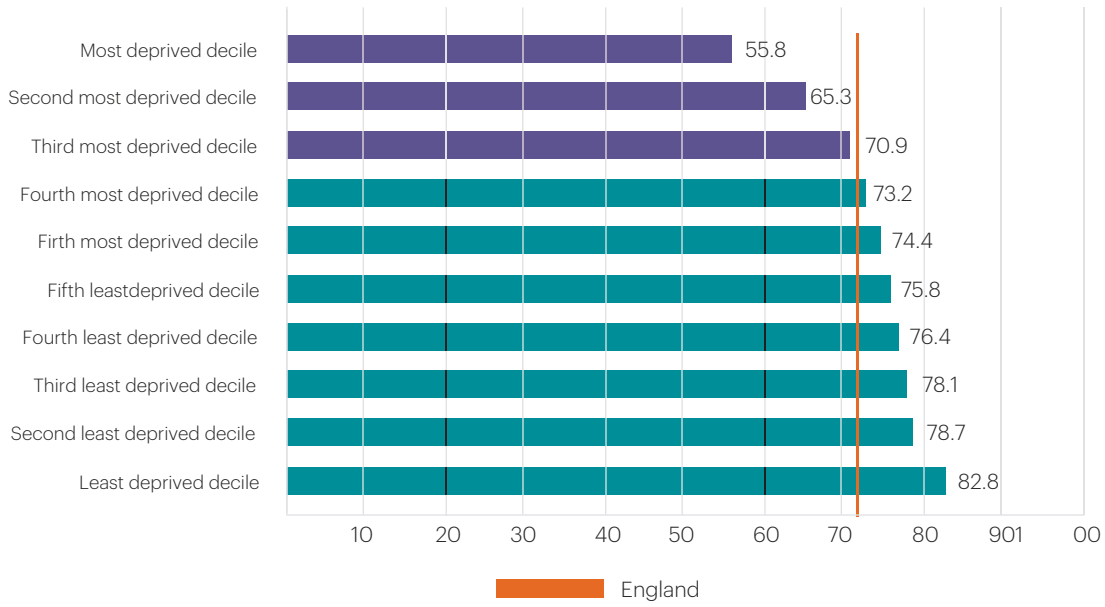
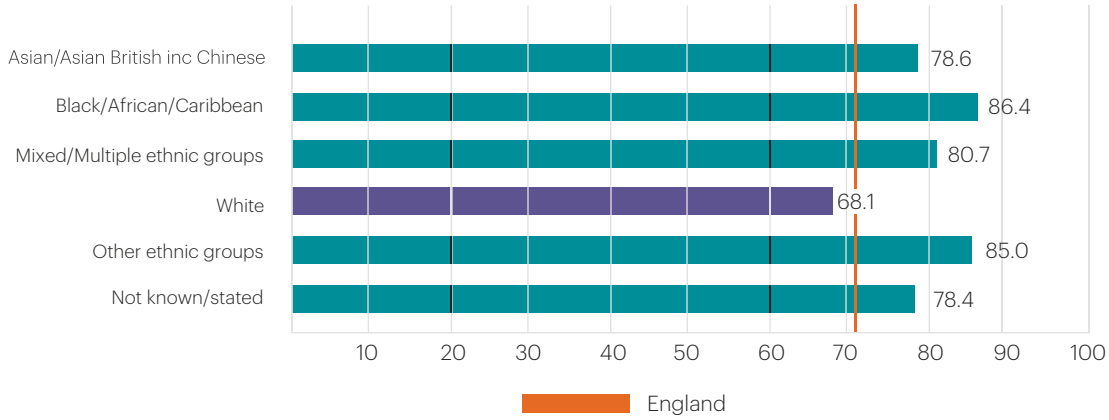


Figure 3: Percentage of infants who received breastmilk for their first milk according to ethnic group across England, 2020/2021 (Source: Fingertips, 2023)[xxxvii]



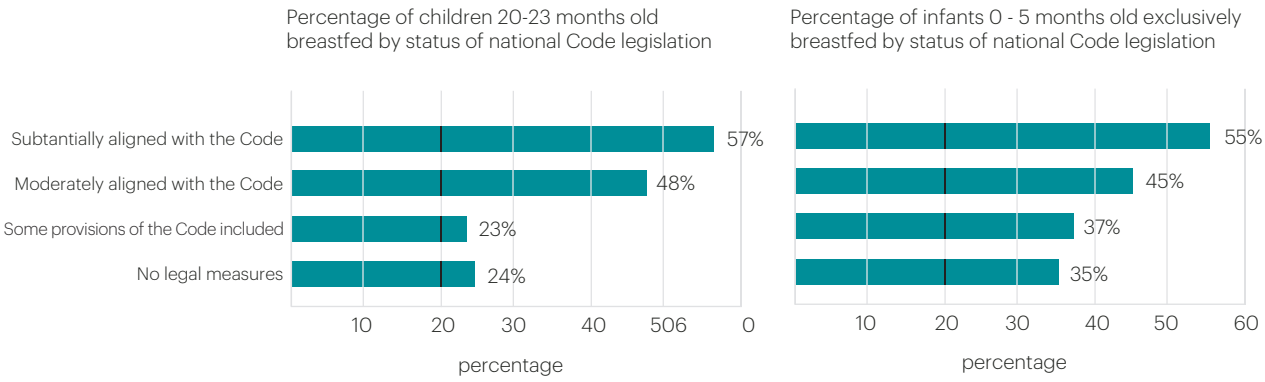
At the time of writing, media attention was focused on reports of some mothers turning to unsafe formula feeding practices,[xxxviii] against the backdrop of the cost-of-living crisis and formula costs increasing by up to 45%.[xxxix] This media attention galvanised one charity to launch a Formula for Change campaign, which was backed by the former Shadow Health Secretary, Wes Streeting. The campaign called for reform to marketing legislation but the interviewees argued the campaign's criticisms of legislation has caused confusion, was ambiguous and spread misinformation. Academia has also questioned the resilience of the infant formula supply chain, which relies on imports from a highly concentrated supplier market.[xl]

Breastfeeding policy is shaped by both national and devolved governance, leading to significant variations in support and outcomes across the UK. Support infrastructure falls broadly into two categories: universal support (midwives, health visitors, antenatal and postnatal care) and charity and community support sector support (peer-to-peer support groups, online groups, breastfeeding cafes and doulas). Cultural and social attitudes toward breastfeeding also have a significant influence on breastfeeding outcomes.[xlii]

There are several important initiatives in the breastfeeding space:

- The Baby Friendly Hospital Initiative (BFHI) is a global programme, developed by UNICEF and the WHO in 1991. It aims to support and protect breastfeeding by formalising standards and practices in settings where mothers breastfeed (e.g. hospitals).
- The UNICEF UK Baby Friendly Initiative, introduced to the UK in 1994, focuses on improving healthcare for infants, mothers, caregivers and families. This initiative is referenced and supported in a range of government and policy documents across the UK, including the National Institute for Health and Care Excellence (NICE) guidance. The programme supports maternity, neonatal, community and hospital-based children's services to improve their care. It also works with universities to provide midwives and health visitors with the necessary foundation of knowledge to support families. The programme's principles are rooted in the UN Convention on the Rights of the Child and the Sustainable Development Goals, both of which highlight the universality of children's rights.
- The Becoming Breastfeeding Friendly (BBF) initiative was developed to help countries assess the strength of their breastfeeding environment and design initiatives to scale up policies and programmes.[xlii] A review of the BBF process in England, published in 2022, highlighted the need for a dedicated national breastfeeding strategy, improved coordination and stronger leadership to enhance data collection, monitoring and the sharing of local strategies.[xliii]
- The World Health Assembly International Code of Marketing of Breastmilk Substitutes (the Code) and its resolutions are an international set of recommendations for the regulation of marketing of breastmilk substitutes.[xlivi] The World Health Assembly is the decision-making body of the WHO. Although one of the Code's aims is to prevent the undermining of breastfeeding as de facto, it exists to protect all parents and carers from commercial influences so they can make informed decisions, however the baby is fed. In particular, the Code aims to prevent the marketing of unnecessary products and the use of harmful claims, as well as those that aren't backed up by evidence.[xlv] A UNICEF global report on levels of implementation of the Code found strong alignment with the Code in national legislation is closely tied to increased breastfeeding rates (see *Figure 4*),[xlvi] yet only some elements of the code are enshrined in UK law.
- Other programmes and initiatives include the Breastfeeding Friendly scheme, run by The Breastfeeding Network (BfN), which operates to make public spaces/organisations recognisable as safe breastfeeding spaces.[xlvii]

Figure 4: How breastfeeding rates globally correlate with alignment to the Code (Source: UNICEF, 2023) [xlviii]



Theme 1

National and local policy

The first research phase was undertaken between July-August 2023, during a Conservative administration. The second phase was undertaken in the run up to the 2024 general election.

1.1 An absence of strategic breastfeeding policy and leadership

There was unanimous agreement among all those interviewed that the Conservative government showed a lack of political or strategic leadership for breastfeeding. Andrea Leadsom was identified as the MP with responsibility for early years, championing the Family Hubs project. However, interviewees (and the research team) could not easily identify which MP had ministerial control for breastfeeding. This also applied to those working within the government.

> It's been very difficult to find somebody who is the minister with consistent responsibility for breastfeeding, and infant feeding more widely, across government. And it seems to sort of chop and change, almost even depending on what these ministers may be interested in. *(MP)*

It took the research team considerable time to identify a policy lead for breastfeeding in the Conservative government. The Department for Health and Social Care (DHSC) confirmed that Minister Neil O'Brien, Parliamentary Under Secretary of State at DHSC, had an overall responsibility. He articulated the government's position on breastfeeding in a parliamentary session in 2023:

- The government are committed to promoting and supporting breastfeeding.
- Encouraging and supporting women to breastfeed is a priority. They recognise breastfeeding may not be a viable option but they 'continue to create' a supportive environment for women, ensuring they can make informed decisions.
- They provide breastfeeding advice and guidance through social media, email and the NHS Start for Life website.
- They make a 'continued' commitment to breastfeeding, policy development and investment.[xlix]

However, the interviewees told us that overarching breastfeeding policy is inadequate, lacking or 'non-existent.' All interviewees spoke of a lack of joined-up approach, referring to the absence of breastfeeding in wider relevant policies and of a breastfeeding strategy. There was, however, a well-respected All Party Parliamentary Group (APPG) on infant feeding at the time of writing, which was led by former MP Alison Thewliss (the APPG has not appointed a new lead MP since Alison Thewliss lost her seat). One interviewee, who has worked in this space for over 20 years, argued there has been reluctance to have breastfeeding experts in the civil service since 2010. Pre-2010 there was an infant feeding lead in the government. At the time of writing, there were also concerns that those responsible had minimal breastfeeding experience and a national infant feeding lead is needed to develop a national strategy.

> The [Conservative] government doesn't have that much interest in breastfeeding. Policymakers are myopic, very short-sighted, and funding is very limited. *(Academia)*
>
> Breastfeeding is always an afterthought, so there's never any joined-up thinking about breastfeeding and what's really needed. *(Charity)*
>
> The lack of investment, I just find it appalling. The [Conservative] government isn't valuing the importance of parenthood and clearly breastfeeding is part of that. *(MP)*

1.2 A myriad of disparate policies that concern breastfeeding

There is no single policy or strategy document that lays out the government's approach on breastfeeding and no mention of breastfeeding in the Labour manifesto. Policies that incorporate or concern breastfeeding are set out in various policy documents covering the workplace, public spaces, formula, local authority guidance, NICE guidance and particular initiatives, such as the Family Hubs service (Start for Life). Figure 5 shows the breadth of these policies, interspersed with the interviewees' challenges to their efficacy. They argued that the monitoring and accountability frameworks in which these policies are set are inadequate. Legislation is considered weak, particularly for women returning to the workplace. Interviewees from the campaigning sector felt strongly that the restrictions on CIMF were unpoliced and subject to frequent contraventions, which is reflected in the literature.[I] Interviewees from academia argued that human rights alone do not necessarily mean that more women will be 'compelled to breastfeed' or make it easier but:

> It means that women should not be prevented from breastfeeding and are entitled to proper health support, protection from misinformation on infant and young child feeding, and family and societal support so that they are able to breastfeed. *(Academia)*

Figure 5: UK policy concerning breastfeeding (Source: Authors' own)

	Overarching policy	Policy deliverables	Practice issues
Healthcare	**Health and Care Act 2022:** provides the structure for joined-up working by making Integrated Care Systems (ICS) statutory bodies. Sets out legal duties for collaboration between LAs/NHS.	Requires ICSs to address specific needs of babies, children and young people in their 5plans and appoint a children's lead. Local Maternity Systems are the maternity component of ICS and deliver the Better Births and NHS Long Term Plan commitments.	*The Health Care Act came in last year and set up these new ICS, so that's good in principle. But in practice, there isn't really that joined up work and there's very little understanding of the changes that have come in.* (Charity)
	The Start for Life Programme: £50m funding for breastfeeding support in 75 LAs between 2022-2025.	Funded budget line that mentions breastfeeding support for the first time. 6 action areas dedicated to improving access and creating joined-up services. 'Minimum expectations' and 'go further' options. Services delivered through Family Hubs.	The short time frame makes it difficult to set up a sustainable service and puts huge pressure on LAs to deliver. It creates a postcode lottery. *How are you going to develop an integrated, coherent approach with different levels of resource in different areas. It's all just a great big mess, which is why you really need a national strategy and funding. (Charity)*
	Maternity Transformation Programme: aims to achieve the vision outlined in Better Births of a safer, more personal and kinder maternity service through local leadership and joined-up action across organisations, delivered by LMSs.	Delivers the commitments of the **NHS Long Term Plan:** for all maternity services to have an accredited infant feeding programme (such as the UNICEF UK BFI). **Provides Postnatal Care Guidance** which encourages LMSs to develop breastfeeding strategies. **Perinatal Equity Strategy Guidance** requires LMSs to implement a breastfeeding strategy as part of their equity plan.	The Postnatal Care Guidance has become less of a priority and hasn't been published officially, meaning postnatal care commitments haven't fully come to fruition.
	Commissioning Guidance for Infant Feeding, 2016: co-produced by UNICEF UK and PHE, advises local commissioners on infant feeding services. **Health matters: giving every child the best start in life, 2016:** advises health professionals and local authorities on services from pregnancy to 2 years. **Best start in life:** cost-effective commissioning, 2018: advises local commissioners on delivering cost-effective interventions from pregnancy to 5 years.	Aims to increase rates of breastfeeding across England. Emphasises the importance of creating an environment that encourages and supports breastfeeding, referring to the UNICEF UK BFI. Includes 11 interventions, two of which are focused on breastfeeding uptake.	*How things work at that local level depends on who the commissioner is. Each area does things differently and, with limited funds in a lot of areas, there's a lot of buck passing. The local authority will say, "Oh, no, the NHS needs to do that." Or the NHS will say, "Oh, no, the local authority needs to do that." It's usually down to personalities - if you have a commissioner who understands things then you'll have a good service. We've seen areas where good services have been shut down just because there is a commissioner who doesn't get it. (Charity)*
	NICE Postnatal Care guidelines, 2021: advises healthcare professionals on the postnatal care of mothers and infants in the first eight weeks after birth.	Advises healthcare professionals to discuss breastfeeding with women and provide information and support pre- and post-birth.	Healthcare professionals report insufficient time and resources to fully incorporate breastfeeding support into ante and postnatal care.
	SACN report: feeding young children aged 1 to 5 years: SACN is the government's advisory panel and advises that breastfeeding should continue into the second year of life.	Although it recommends breastfeeding into the second year, data is only collected up to 6-8 weeks.	There is a paucity of data indicating whether breastfeeding rates are in line with national recommendations.
Space and the workplace	**The Equality Act 2010:** Prohibits discrimination against a breastfeeding woman.	UK law states treating a breastfeeding woman unfavorably is discrimination. In Scotland, it's an offence to stop someone from breastfeeding in public and is subject to fines.	Mothers aren't always aware of the Equality Act. How workplaces should adjust *'is not really explicit so it makes it more difficult to ask for these adjustments to be made.'* (MP)
	Workplace Regulations 1992: Employers must offer rest facilities for breastfeeding mothers.	This is designated as 'suitable facilities' for rest.	There are no paid breastfeeding breaks and no requirement to provide facilities to breastfeed. Workplaces are poorly set up for breastfeeding.
	Management of Health and Safety at Work Regulations 1999: Employers must manage risks for women of childbearing age and breastfeeding women.	Onus is on breastfeeding mother to communicate her needs rather than the organisation to proactively accommodate.	*The health and safety regulations will not apply to most work environments, so it doesn't really do anything. (Academia)*
	ACAS Accommodating breastfeeding employees in the workplace: signposted to by government.	Voluntary guidance for employers outlining best practice – it is written for employers rather than employees.	*ACAS guidance is just there if employers are having issues with employees. It has zero legal framework, or legal enforcement. (Academia)*
Formula	**Infant formula and follow on formula regulations (2007), updated in 2020 to reflect EU directive (EU delegated regulation 2016/127):** Prohibits advertising of infant formula (not follow on formula) – no point-of-sale advertising or use of promotions (coupons/vouchers), no health or nutrition claims allowed on infant formula, labelling restrictions that distinguish between infant and follow on formula.	There's no enforcement of the legislation. DHSC defer to local authorities to enforce (but enforcement doesn't happen). There's evidence of contravening the legislation with health and nutrition claims.	*The International Code is only partly incorporated in law. If that was strengthened, that would give more protection. But then really making sure the law gets implemented is important because, at the moment, there is no national monitoring. It relies on people sending in reports complaining.* (Charity)

1.3 UK government's underperformance against breastfeeding metrics

The World Breastfeeding Trends Initiative (WBTI) UK report card assesses policies and programmes according to WHO principles.[lii] The UK scored 1/10 for national policy, programme and coordination. The report also highlighted underperforming areas such as monitoring and evaluation, maternity protection and the health-professional training.

Figure 6: UK report card on the state of infant and young child feeding (Source: WBTI, 2016)[liii]

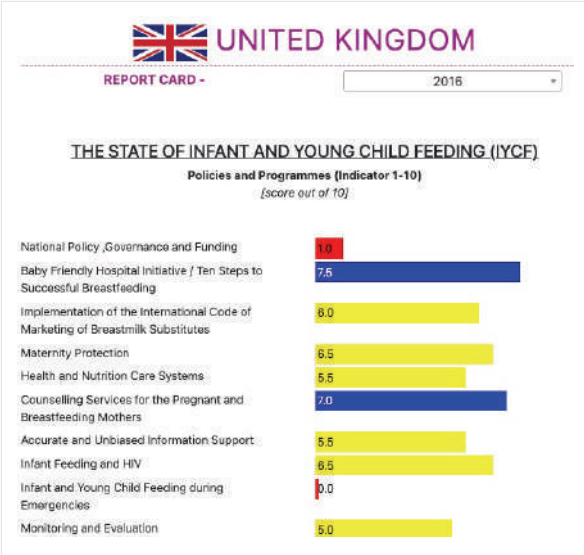
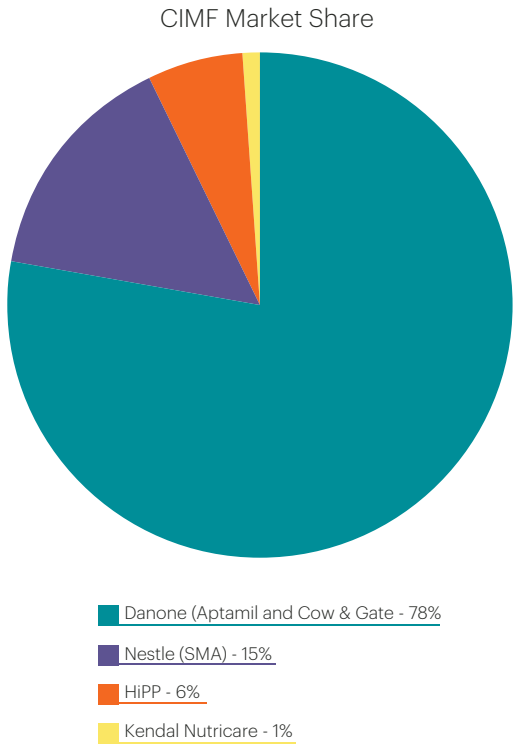


Figure 7: CIMF share of market (Source: Sibson et al., 2023)[liv]



The WBTI report gave the UK 0/10 for infant feeding in emergencies, such as climate catastrophes, wars or pandemics. The interviewees noted that the consequence of gaps in data collection is that a local authority may not know how many babies need formula or breastfeeding support if a crisis occurs. Research indicates the need for better scenario planning for potential crisis situations such as:

- Lack of access to fresh water to safely sanitise bottles and use in formula preparation.
- Potential impact on breastfeeding mothers if there is limited access to food or water.
- Supply-chain impacts if imports of formula are restricted or inaccessible.[lv]

The latter point is particularly important, as more than 95% of the CIMF on the UK market is imported and the market is dominated by just five brands and four companies. Within that, Danone accounts for 78% of the market, with its Aptamil and Cow & Gate brands,[lvi] meaning that if the UK's imports were restricted, there could be supply issues. This could have serious consequences for infant feeding in the UK.

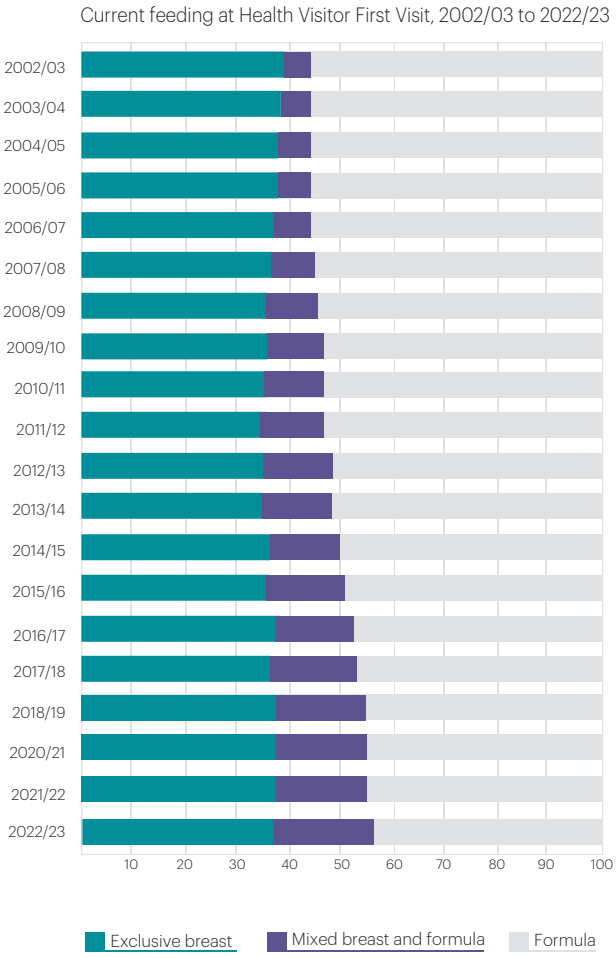
1.4 Scotland's national policy and practice leadership

Many of those interviewed point to Scotland as having a superior approach to breastfeeding policy. The Scottish Government put breastfeeding into their programme for government[lvii] and invested funding in breastfeeding programmes. Scotland has an infant feeding strategy and had a National Maternal and Infant Nutrition Coordinator appointed until recently. The interviewees reported there is an identifiable lead in government that is approachable and engaged with the sector. Scotland also implements stretch goals to reduce the drop-off in breastfeeding rates at 6-8 weeks by 10% by 2025. The Infant Feeding Statistics Scotland report provides more comprehensive data on breastfeeding than current data collection in England.[lviii]

> What we see in Scotland is a clear vision for breastfeeding and a government playing a role in really leading and shaping delivery according to that vision. There's a clear plan in place. *(Charity)*
>
> Scotland is so far ahead with the public health policy. It's a bit embarrassing always being so far behind in England. *(Local Government)*

The rates of breastfeeding in Scotland are slightly behind England but have increased over the past ten years. In 2022/2023, 47% of infants in Scotland were breastfed at 6-8 weeks (compared to 49% in England), with 28% being exclusively breastfed (compared to 32% in England).[lix] Breastfeeding rates have increased particularly among mothers from more deprived areas and younger mothers who tend to breastfeed less. Consequently, inequities in breastfeeding have decreased.[lx] In North Lanarkshire breastfeeding rates have increased by 20% in the most deprived areas, leading to the local authority being the first to receive gold in the Breastfeeding Friendly Scotland Local Authority Award. The council has introduced various initiatives across its services focused on promoting breastfeeding, improving the workplace environment and fostering a culture where breastfeeding is embraced as the norm.[lxi]

Figure 8: Increasing breastfeeding rates in Scotland, mostly due to an increase in mixed breast and formula feeding
(Source: Public Health Scotland, 2023) [lxii]



1.5 The current political agenda – policy vs politics

Following over a decade of perceived political inertia, the interviewees saw the election as an opportunity to push breastfeeding into the policy arena. However, policy-wise there was little reference to breastfeeding in election manifestos in the lead up to the election, which was referred to as a 'baby blindspot'.[lxiii]

Figure 9: Post by Sally Hogg from X
(Source: @SalHogg, 2024)[lxiv]

There was concern at the time of research, particularly from interviewees from the charity sector, that the politics, i.e. Labour's focus on the cost-of-living crisis and amendments to legislation around formula, was detracting from the wider issue of insufficient breastfeeding policies, lack of access to support and the high cost of formula. The Labour government has not stated a policy position on formula regulation or marketing since being elected in July 2024.

1.6 How useful is government data on breastfeeding?

Since the UK wide Infant Feeding Survey was discontinued in 2015, breastfeeding data collection has been inconsistent and incomplete, exacerbated by multiple changes in who collects the data and how. Indeed, the current data are described as 'experimental,' reflecting the level of change and ongoing evaluation of the system. Previously, the survey collected information about mothers' intention to breastfeed, initiation and breastfeeding at several points for up to nine months. Currently, only two data points are collected: initiation data, by the NHS England Maternity Services Dataset, and data at 6-8 weeks, by local authorities. Currently, there are no national data on the levels of breastfeeding at 6 months or the prevalence of breastfeeding for up to two years. Datasets use various reporting metrics and terms, which often make the data difficult to interpret.

The quality of both datasets is patchy and marred by various factors. The Maternity Services Dataset has undergone several changes to the collection and structure of the data, leading to gaps in coverage, where some trusts are unable to submit data.[lxv] The 6-8 week data is collected on a voluntary basis from local authorities as part an 'interim' system, which is in place whilst the long-term Community Services Dataset solution reaches full coverage. Data collection is resource-biased and inconsistent among regions. The inconsistencies and gaps in collection make regional comparisons across England difficult and mean the data are not representative of the whole country. As one stakeholder put it:

> It's limited because they only capture up to 6-8 weeks and the data is incomplete. We know some areas don't report, it's inaccurate and there are errors in it, so we don't really know on a national level how we're performing. It's so piecemeal, you can't compare one area with another. *(Health)*

The interviewees drew attention to staff and training-related issues that affected data collection. Midwives and health visitors are 'underpaid, under-resourced, overworked, over-stretched' (Charity), possibly impacting the accuracy of data input. Furthermore, there is some confusion and lack of training around the specific wording used for data collection, which has resulted in inaccuracies and invalidated the data.

> There's confusion around the wording of that form because health visitors have a different understanding of what mixed feeding is. It's a frustrating issue, it's so small and it can be fixed so easily. *(Local Government)*

The paucity of data on breastfeeding was highlighted as evidence of a government that did not prioritise breastfeeding.

> Data is another issue where, if on a national level, it was made statutory for that data to be collected, then it makes it a lot easier for us to make the case. It's hard to make it a priority and without it being statutory. *(Local government)*

The interviewees also highlighted the dichotomy of SACN recommending for breastfeeding in the second year of life but the official data only measuring breastfeeding until eight weeks.

> The data is inadequate: it stops so early and it's very patchy. It should match up to the public health recommendations to exclusively breastfeed to six months. It doesn't really make any sense. *(Charity)*

Local authorities consider the evidence base to be 'poor', which stops commissioners being able to review how effective their services are. The Conservative government appeared to recognise the critical importance of 'reliable data on rates of breastfeeding to ensure that policies are having their desired effect and to better target our interventions' (*Minister Neil O'Brien*).[lxvi] DHSC and the Office for Health Improvement and Disparities (OHID) have commissioned a new infant feeding survey across England, with the results anticipated for 2024.[lxvii] However, the interviewees felt the consultation for this was weak and that their views may not have been listened to.

1.7 Local policy challenges for breastfeeding programmes and services

1.7.1 Devolvement of breastfeeding services

As part of the public health grant changes in 2015, commissioning of public health initiatives for 0-5s was mainly devolved from the NHS to local authorities. Breastfeeding programmes and support form part of the 0-19 public health grant, from which local authorities determine their own funding allocations. There is no ringfenced or mandatory spending stipulations for breastfeeding. Funding for health visitors within local authorities comes from this budget, whereas midwives and on-ward care are covered by NHS funding.

> There was nowhere that said you need to have a breastfeeding support service. And they had limited funds and the funding also decreased in real terms over time, so they were looking for cost savings. Breastfeeding was an easy thing to cut because it wasn't a statutory service. *(Charity)*

The government offers guidance to local authorities on best practice commissioning, encouraging 'evidence-led services.'[lxviii] This includes information provision, breastfeeding welcome programmes, monitoring and evaluation, embedding breastfeeding in all policies and ensuring no promotion of CIMF in any facilities or by staff members, so that breastfeeding is 'protected'.

The interviewees argued that the devolvement of public health, combined with a 26% decline in real terms of the public health grant in the last 10 years[lxix] and a lack of any national strategy providing a blueprint, have created inconsistencies, a post-code lottery and a lack of a joined-up approach, without any levers for accountability. This has been exacerbated by funding issues and differences in political priorities at the local level. There is also the unanimous view that funding is insufficient.

> Local authorities who are cash strapped are having to prioritise, and some will prioritise breastfeeding but others won't because they are focusing on firefighting and high-end safe guarding. *(Health)*

> It depends on the local leadership, you need a local strategy to drive it, you need local governance accountability mechanisms to keep it on track. These things don't happen by accident. Implementation is absolutely crucial and if that's lacking, then generally things don't happen. And it's just huge variations between them. *(Health)*

A report by the Better Breastfeeding campaign in 2018 revealed that 142 of the 326 local authorities in England (44%) had experienced cuts to breastfeeding support.[lxx] Examples of these cuts included: funding cuts for breastfeeding volunteers across several local authorities, a reduction in paid peer supporter posts from 10 to 5 in Sunderland, cuts to infant feeding advisor roles in Redbridge and to baby café funding in multiple local authorities, and specialist services being offered on referral-only basis in Lambeth and Southwark.

A recurring phrase was that breastfeeding policy was a 'postcode lottery', subject to the level of funding local authorities can assign and if they were in receipt of the government's new Family Hubs funding. The breastfeeding support offering also depends on the level of political will of the local authority.

> We have a bit of a postcode lottery because it's all devolved decision-making, so that fragments it and makes policy even more variable between authority areas. In terms of any national blueprint or standard or levers or accountability mechanisms, we're severely lacking. *(Health)*

> Obviously, councils could protect funding for statutory services but if breastfeeding support was a statutory requirement, in addition to what health visitors provide, I think that that would help ring fence it. It's not funded enough. But it's also not prioritised enough. *(Local Government)*

Justifying investments is also difficult for local authorities because of the lack of data, as outlined above.

> If you don't have the kind of political sponsorship within the council, then it isn't going to get prioritised. *(Charity)*

In research examining changes to breastfeeding peer support services across England and Wales between 2015 to 2019, the BfN used freedom of information requests to analyse local authority breastfeeding services.[lxxi] It identified the complexity of breastfeeding support funding and the lack of transparency over what is being spent. It showed a consistent reduction in peer support services over time, as well as varying budget allocations for breastfeeding peer support in local authorities, consistent with the view of services being a postcode lottery. Funding ranged between £40,000 and £380,000 in London, £1,700 to £190,000 across the UK for unitary authorities, and £20,000 to £424,000 across county councils.

Many services and settings are working towards UNICEF UK Baby Friendly Initiative accreditation, including 99% of maternity services and 89% of health visiting services.[lxxi] UNICEF UK Baby Friendly Initiative accreditation of maternity services is an expectation of the NHS Long Term Plan.[lxxii] However, actual full accreditation is currently only in 44% of maternity services and 69% of health visiting services.[lxxiv] Local government interviewees talked about the intensity of the UNICEF UK Baby Friendly Initiative; the resources and the time required are high. It was referred to as the 'Cinderella service' as it is normally the first one to get dropped, despite evidence to show it contributes to increased breastfeeding rates.[lxxv]

Local and national government interviewees outlined how those working in breastfeeding have a strong desire to provide excellent services but are restricted by funding and resources. It also impacts local authorities' relationships with the health visiting services; resources have dwindled, services have been cut and healthcare professionals see local authorities as responsible.

> They're really struggling to be able to provide a service that they aspire to. More and more being required of them without the funding to support that. *(Charity)*

> It's difficult in terms of our relationship with [health visitors] because they see us as cutting funding but it's the government giving us less money year on year, which is difficult to navigate. *(Local Government)*

One local authority interviewee felt that the services were not frequent, proactive or engaging enough to provide support to mothers, particularly to more vulnerable mothers.

> The services are far and few between, to be honest. There's not an awful lot going on in the community to support breastfeeding. And it's hard to know what sort of training some of these organisations have received, how consistent the messages are with the services we would want to commission, and how they link with other support that mum is receiving. *(Local Government)*

They also described challenge of providing the right services to promote breastfeeding while also supporting mothers who cannot or choose not to breastfeed.

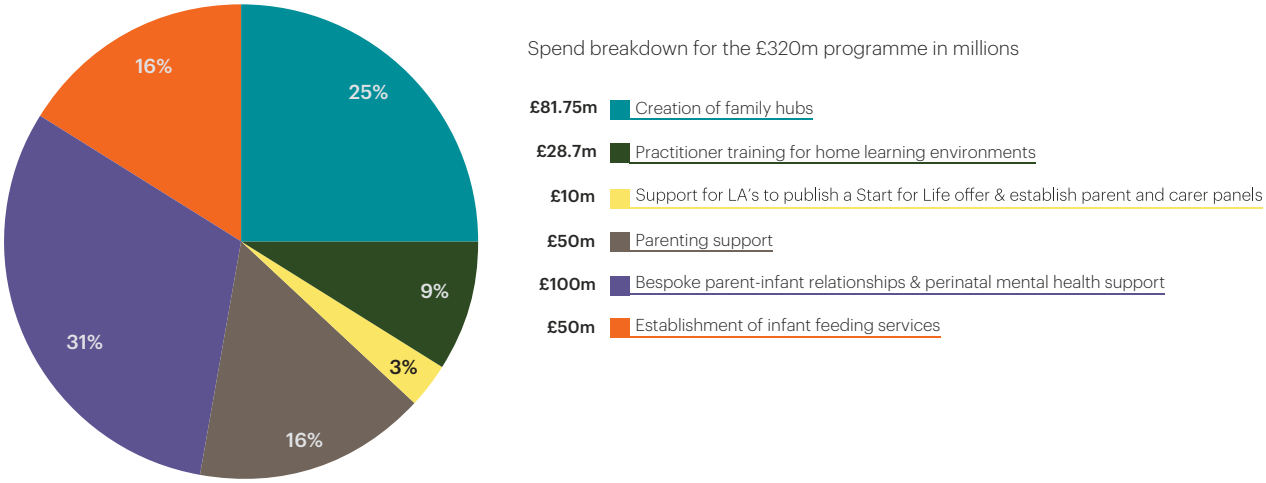
The new Integrated Care Systems, which came into place in the 2022 Health Care Act,[lxxvi] aimed to convene local authorities, NHS and stakeholders together to deliver excellent local healthcare services – including breastfeeding. In practice, the interviewees told us, 'there isn't really any joined-up work' (Health) and that this vision is yet to come into fruition. The split between NHS breastfeeding support and local authority health visitor support requires good coordination and, at present, there is great variation across the country.

1.7.2 Family Hubs and breastfeeding funding

One of the Conversative government's breastfeeding policy initiatives for England involved the implementation of Family Hubs, which provides a framework for designing new service offerings under the 'Start for Life'[lxxvii] programme. This programme, initiated in 2021 and led by the DHSC and the DfE, includes breastfeeding support and various other services. At the time of interviewing, many Family Hub initiatives were still in the planning stages, reflecting a programme that had not yet been fully realised.

- The programme included a £302 million 3-year fund for 75 local authorities, with 14 local authorities acting as trailblazers.
- Priority was given to local authorities with high levels of deprivation and poor health and educational outcomes. This funding was broken into £82 million for the establishment of Family Hubs, £100 million for parent-infant relationships and perinatal mental health support, and a bespoke budget line of £50 million for investment in infant feeding services.
- Local authorities have been expected to use funding to design and deliver bespoke breastfeeding support in line with the local strategic needs. There is a focus on parents being able to access in-person, virtual and digital infant feeding support whenever (including antisocial hours) and wherever (at home, at a family hub or in hospital) they need it.
- A small proportion of the funding was assigned to national breastfeeding initiatives, including an e-learning programme with the early years workforce and capacity building for the National Breastfeeding Helpline. The interviewees told us the National Breastfeeding Helpline plays an essential role in filling the service provision gaps on a local level, particularly as it's a 24-hour service.
- The objective of this work was to improve the evidence base for breastfeeding interventions, building a case for further (universal) future funding.

Figure 10: Spend breakdown of the £320m programme (Source: HM Government, 2022) [lxxviii]



Several interviewees responded positively to the new Family Hubs programme. They highlighted that the programme was underpinned by Andrea Leadsom's 'Vision for the 1,001 Critical Days' review,[lxxix] which received good cross-party support and consultation with groups like Better Breastfeeding. It also incorporated a significant funding line specifically for breastfeeding support. These interviewees felt the Family Hubs programme represented a major step forward in the government's approach to policy.

> That's the first time that any government, in fact, has had a budget line for breastfeeding support – that word "breastfeeding support". It's a real breakthrough to have that as a budget line. *(Charity)*

> Family Hubs funding is game changing for a lot of local authorities. *(Local Government)*

However, many of those interviewed raised criticisms about this initiative. These were largely around the programme not being universal and lacking long-term funding, making it unsustainable. There were concerns regarding the extensive requirements stipulated by the government for Family Hubs versus the funding allocated. Minimum expectations included virtual services, online information, leaflets, brochures, 1:1 support post-birth, a virtual and face-to-face breastfeeding service, including peer support and lactation consultants, loan equipment, staff training, data collection, antenatal classes, language services, and an infant feeding strategy.

We were told local authorities feared developing a raft of services and support mechanisms only for funding to be taken away in 2025. They were concerned about the impact that would have on breastfeeding women and the potential inconsistency in support.

> The Family Hubs funding is finite. It's going to end March 2025 and then we're going to have to pull those resources. So, it's all very well giving us the funding, but it's not a sustainable way of running a service. *(Local Government)*

In the second phase of research, conducted during the third and final year of funding, interviewees identified that 'work is starting to take shape' (Charity) on Family Hubs, although there is some variation in progress. We were informed that local authorities have significantly expanded their online services and utilised community assets innovatively, investing in local programs. Indeed, qualitative research with local authorities by the Local Government Association (LGA) indicates that no local authority is independently managing all Family Hubs

services, with some relying almost entirely on commissioning services. The LGA found the transition to Family Hubs has enabled local authorities to deliver their services in a more integrated manner alongside services like midwifery, CAMHS, health visitors, maternity services and school nursing. The concept of Family Hubs as a 'one-stop shop' that gives families access to a wide range of support in one convenient location was popular with local authorities. In general, there was strong enthusiasm among local authorities. However, those that missed out on the Family Hubs funding expressed having to carefully manage resources to provide support to families in greatest need.[lxxx]

Although local authorities have had to set their budgets for the new year, there hasn't been a clear indication yet as to whether the funding will be continued or if there will be a cliff edge funding cut, which would undermine the great progress achieved so far. The stakeholders told us positively that Andrea Leadsom had been working within government to secure political commitment for the longevity of Family Hubs but they continued to argue there is a real need for long term investment and equity of access. Their concerns are supported by the LGA's research, which found the main challenge is maintaining the progress made and ensuring the long-term availability of these services for families. The LGA argue that continuous research and impact assessment are essential to establish a solid evidence base of good practices for the future.[lxxxi]

There has also been significant advocacy work around Family Hubs, including by a coalition of 60 charities called the Health Policy Influencing Group, convened by the National Children's Bureau the Council for Disabled Children and the Children and Young People's Health Policy Influencing Group.[lxxixi] The National Children's Bureau has coordinated a shared statement that calls for the 'continuation of this funding until the new government is ready to mobilise a clear, budgeted, and deliverable longer-term early years and family help policy of its own.'[lxxxiii]

1.8 Southwark: A Case Study

Southwark's breastfeeding rates are higher than the average across England. In 2021/22, 90% of babies received breastmilk as their first feed[lxxxiv] (compared to 72% across England).[lxxxv] From 2018/19 to 2021/22, 55% of infants were exclusively breastfed at 6-8 weeks[lxxxvi] (compared to 33% across England in 2021/2022),[lxxxvii] while 30% were partially breastfed and 15% not breastfed at all. The data showed that in areas with higher levels of deprivation, rates of exclusive breastfeeding decreased and rates of no breastfeeding increased. Almost 20% of children in the most deprived quintile were not breastfed at all, whereas in the least deprived quintile, this figure is less than 10%.[lxxxvii]

Exclusive breastfeeding rates are highest among mothers aged 30-39 and mothers from a white ethnic group; they're lowest among mothers from a Black, Asian, or unknown minority ethnic group. White and mixed minority ethnic groups have the highest rates of children who are not breastfed at all due to their decreased likelihood of partial breastfeeding.[lxxxviii]

In terms of policy, Southwark refers to breastfeeding in its Food Security Action Plan 2019[xc] and Healthy Weight Strategy 2022-2027.[sxci] Up till recently, it has subscribed to NCT's Breastfeeding Welcome Scheme. This is now discontinued and the local authority are looking at creating a replacement scheme. The health visiting services have achieved Stage Two UNICEF UK Baby Friendly Initiative accreditation and are working towards their Stage 3, while their neonatal unit has already achieved Stage 3. Southwark plans to make their Children and Family Centres UNICEF UK Baby Friendly Initiative accredited too, to support their commitment to being breastfeeding welcome.

Southwark was one of the local authorities that received Family Hubs funding, which stipulates the requirement of an infant feeding strategy.

At the time of research, a strategy was being drafted for the southeast of London and will include a chapter dedicated to Southwark, with local priorities and actions. Southwark are also commissioning a new app called Baby Buddy:

> **The app that we're commissioning has quite a strong evidence base behind it around increasing and improving breastfeeding confidence and self-efficacy. And we're going to try and make it available in different languages as well so that simple barrier isn't an issue.** *(Southwark Council)*

Despite these positive steps, interviewees from Southwark Council felt the services in Southwark are not frequent, proactive or engaging enough to provide the support mothers need, particularly more vulnerable mothers.

> **The services are few and far between, to be honest. It's hard to know what sort of training some of these organisations have received, how consistent the messages are with the services we would want to commission, and how they link with other support that mums are receiving.** *(Southwark Council)*

They stated local data collection is an 'issue', pointing out issues with data validity and the lack of clarity around rates of breastfeeding after 6-8 weeks. The interviewees reflected that clearer national level policy would help to set the expectation, as well as a level of accountability, for services and data collection carried out on a local level.

Finally, the interviewees described the challenge of providing the right services that promote breastfeeding whilst also supporting mothers who choose not to breastfeed or can't. They felt they have little insight on formula-feeding mothers, aside from anecdotal evidence.

Theme 2

Infrastructure and support

The lack of central and local government funding was perceived to have numerous effects on breastfeeding practices. Services are overstretched across maternity units and local authorities in infant feeding teams. Funding has also dramatically impacted the midwife and health visitor workforce. The interviewees referred to this as a 'workforce crisis'.

2.1 A universal support network in crisis

Midwives and health visitors play a crucial role in supporting breastfeeding but both professions are experiencing shortages in workforce numbers. Midwives are 'the lead professional for the care and support of women and newborn infants, and partners and families' and work across all stages from pre-pregnancy to the early weeks of the baby's life.[xcii] Analysis by BBC News indicates there is a shortfall of 2,500 midwives in England, leading to concerns about safety amongst staff currently working as midwives.[xciii]

Health visitors work with families with a child aged 0-5.[xciv] As the only professional, in some cases, to come into contact with infants at home prior to school, they are well-positioned to identify households who may need greater support.[xcv] However, the Institute of Health Visiting reports that there has a been a decline in 40% of health visitors since 2015.[xcvi] Despite health visitors noting greater levels of need and inequality associated with the cost-of-living crisis, there aren't enough health visitors to address the rising need, and the quality of support local authorities can provide has been significantly impacted. For example, A Manifesto for Babies reports that 20% of infants are not receiving their health visitor check at one year old.[xcvii] The impact of health visitor cuts was echoed by many interviewees, who saw inconsistencies in health visitor support across the UK following varying investment levels.

> We have 152 local authorities in England with 152 different models of health visiting. There is a national blueprint in the healthy child program but there are no levers or mechanisms to hold local areas to account and so it's a bit of a free for all. Some areas are delivering excellence and families are well supported but in other areas they may get virtually nothing. *(Health)*

One government interviewee advised us that she had analysed the NHS Long Term Plan and deduced that 'they do not have the numbers to create a safe service' (MP). Therefore, health visitors are focusing on safeguarding as a priority, which ultimately affects breastfeeding support.

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

Positively, in 2024 the Labour government released its action plan on child health, which aims to: 'create the healthiest generation of children ever'. The plan commits to, 'training more health visitors so parents don't always end up having to seek help from the GP or A&E because they can't get the advice they need about their baby's health.'[xcviii] Research indicates that more than half of infant feeding leads in England have experienced funding cuts to services for mothers and babies and 28% reported cuts to specialist breastfeeding support.[xciix]

Infant feeding posts have reduced, Infant Feeding Coordinators are covering larger areas and unable to offer as much support.[c]

One impact on midwives and healthcare professionals is the amount of time they can give new/prospective mothers. A midwife we interviewed gave an overview of the number of checks she must complete with a new mother – 14 in total and the time available to her was 20 minutes. She advised us that some local authorities only allot midwives 15 minutes.

Figure 11: Example of number of checks in a post-natal appointment (Source: Interviewee)

Example of checks: a newborn blood spot check, immunisations, physical exam, carbon monoxide monitoring, vaccination schedules, advice on healthy diet, weight and sleep, minor ailments, accident prevention, infant and family mental health, oral health and breastfeeding.

There was a great desire to spend more time understanding the barriers to breastfeeding, but this was not feasible within the time available.

> It's the time, you know, and the funding of staff. You want to spend a good hour with a woman if you're going to physically help her with breastfeeding, but you've got 20 minutes. It's just not long enough. *(Health)*

This was echoed by UNICEF UK: 'midwives have more tasks to complete and less time to spend supporting women with breastfeeding issues.'[ci] The outcomes for both midwives (over-stretched and frustrated) and mothers (getting less support than needed) are negative.

> Midwives are trying to cover and create a safe service in the most extraordinarily difficult circumstances. We don't have the staff, we don't have the infrastructure. Parents are ultimately being let down and the importance of breastfeeding, not only for the nutrition of the baby, but also bonding with the mother, and all the other wider benefits that have come from that are being lost. *(MP)*

> A mother who can't breastfeed needs somebody to sit down beside her, watch her feed and take the time to think up solutions that work for her. That takes time, but it's time really well spent. *(Health)*

The interviewees outlined the importance of women's access to services immediately after birth. A local government interviewee told us that it is the first 3-5 days post-discharge when breastfeeding drops off the most and it can be difficult to access support immediately; one local authority only had three drop-ins that ran for two hours on Monday, Tuesday, and Thursday. If you need immediate support on Fridays, you must wait until after the weekend. This shows a lack of continuity from the postnatal ward to the community. Again, local authorities can provide varying levels of services; one London borough with more significant funding sends texts to all new mothers post-discharge and informs them of available services. They also call vulnerable families that are likely to discontinue breastfeeding.

2.2 The impact of insufficient healthcare professional training

The interviewees reported gaps in healthcare professionals' training, which in turn leads to a fragmented approach to breastfeeding support across the country.

> Most professionals are not learning about breast[feeding]. Their level of understanding is so low. We haven't made that a priority in educational training. *(Charity)*

Following pre-registration university training, in-service BFI training, usually provided by the NHS Trust, differs between midwives and health visitors and depends on local authority investment. In local authority frameworks and government guidance, midwives and health visitors are given a lot of responsibility for breastfeeding 'but they haven't been required to have a lot of training' (Academia).

> What we're hearing reported is that there is variation in the level of training provided to staff, depending on where you work. Some people have signed up to the BFI and they drive hard and do brilliantly, and other areas are just saying that's too hard, we can't do it. Some will do something in between, kind of made up, depending on what their capacity is. *(Health)*

A mother who has been discharged by a health visitor postnatally may assume a GP is the first port of call, as the first access point to the NHS, but one interviewee stated:

> GPs are not familiar with anything beyond the basics – they do not have breastfeeding as part of their training. There's a lot of misinformation and/or just lack of understanding of what's normal infant behaviour. But then the solution is, 'oh, give them a bottle. *(Academia)*

The GP Infant Feeding Network is a network of trained professionals advocating for best practice in infant and young child feeding. Its website serves as a clinical resource hub, offering materials to support the delivery of high-quality patient care.[cii] There is also now a well-established peer support group for doctors called Breastfeeding for Doctors.[ciii] It aims to improve the advice and support given to breastfeeding doctors. Additionally, the interviewees outlined that charities and NGOs advise clinical practitioners on interactions between prescribed (and non-prescribed) drugs and breastfeeding.

There was also concern about the quality of training on breastfeeding provided in university courses (only 40% of midwifery courses and 21% of health visitor courses are UNICEF UK BFI accredited).[civ]

2.3 An underfunded and 'exhausted' charity and community support sector

The interviewees strongly advocated for the benefits that the charity and community support sector brings to breastfeeding mothers, including not just peer-to-peer services but also helplines, which are seen as an 'amazing service' (Charity). Interviewees explained how there is a variation in peer-to-peer and breastfeeding counsellor trainings but that, in the main organisations, training is externally accredited. This expertise and training, they argued, is sometimes overlooked, leading to a 'view that they are just cheap alternatives to the health service' (Charity).

Evidence shows peer support is perceived by mothers as a positive influence on their breastfeeding journey.[cv] Peer support is supported by the WHO and NICE. The interviewees strongly believed there should be more peer-to-peer support services across the UK and they should be adequately funded (by government). The importance of face-to-face interactions with breastfeeding mothers via classes was strongly highlighted by those interviewed, as was proactive contact with new mothers. These classes not only offer specific breastfeeding support but also support emotional connections with other mothers, which can be important for maternal mental health.

> I would say the group are not just all about breastfeeding support. They're about connection. *(Health)*

> In my opinion, peer support is the way to crack cultural barriers. Get a mum who lives in that community who's breastfed and suddenly she's like an informed friend and a role model. *(Charity)*

2.3.1 Insufficient funding for charity and community support sector support

Cuts in funding have extended to the charity and community support sector too – infant feeding support groups have seen a 47% cut and there have been 40% cuts in peer-to-peer or 1:1 support.[cvi] There was concern about the over-reliance on the charity sector to deliver breastfeeding support and inadequate funding for the important work they do – even with the additional ringfenced funding from the Family Hubs.

> On paper, it's going to look like the government is committing lots of money for breastfeeding. The reality is that, yes, the budget commitment has been made, but in reality, it's not going to be spent because the procurement process around it is so heavy and complex that the money doesn't get out of the door. *(Charity)*

> It's bizarre that these services exist on such a shoestring, such a volunteer basis. It should be properly funded so that these things are available to everybody, wherever they happen to be. *(MP)*

Funding has been allocated to NGO/charity organisations from the £50 million breastfeeding support package. The interviewees indicated that the length of funding undermined their ability to run effective and sustainable services. Government and local authority contracts are often short, in 6-month increments. Thus, the charity sector faces significant barriers to long-term planning and resource management.

> Organisations are trying to run what we would consider essential long-term services without really knowing, one year from now, whether they have the funding in place. We need a different funding model because, otherwise, between one baby and the next, we don't know if the service is going to be there. *(Charity)*

> Contracts are renewed every other year, so it's difficult for small charities to plan. You've got to bring in the workforce to do it. It can be quite unsettling. *(Health)*

Charities and NGOs struggle to operate their baseline services, which means it is difficult for them to develop their work or expand their offerings:

> What incentive does that give to community organisers to develop this work. You don't have the ecosystem, the infrastructure or funding helping you to backfill the money. *(Charity)*

Many of these services are run by 'mainly women in their own free time.' The interviewees argued that women are unpaid and not adequately recognised. The BfN research showed over a quarter of respondents said that peer supporters were voluntary: 'we are hanging on but only because of the passion of these remarkable women.'[cvii]

> I'm hugely grateful for charities but that isn't how we should be running essential baby nutrition services. If we're really interested in the welfare of babies/mothers then it should be a statutory provision. *(MP)*

> We should be paying women. It shouldn't be seen as women's work or a woman's issue. *(Charity)*

The interviewees reported a decrease in breastfeeding peer-to-peer group provision, which is particularly notable in rural areas. Classes are not universally available. Therefore, some parents are excluded.

2.3.2 A patchwork of access to support

In addition to the postcode lottery and unavailability of services, mothers face language and cost barriers.

> Access to services is a barrier. Do you have the language? Is the service free? Is it in the area? Do they need to travel? How long is it gonna take to get there – as well as dealing with the stresses of having a new baby?. *(Charity)*

Location and costs can also be problematic for women trying to access peer-support and breastfeeding cafés. The NHS offers a breastfeeding support locator on its website and the authors tested the services using various postcodes across rural and urban areas. It's worth noting that one stakeholder told us this locator is not officially updated and can list breastfeeding advisors without credentials.

- In an outer London borough (Zone 4), the nearest café was 2 miles away.
- In North Essex, the nearest La Leche league was 7 miles away.
- In rural Warwickshire, the nearest support group was 9.7 miles away.
- From the Impact on Urban Health office, support services were more evenly distributed, with one being 0.5 miles away. The second search results were for an NCT facility. NCT is a charity offering a range of paid for and free services. Its antenatal courses, delivered by qualified practitioners, are paid for but 20-80% discounts are offered based on household income. NCT also offers free antenatal courses in partnership with local NHS trusts in a few areas.[cviii]

This indicates how access to some support services is not universally available and is impacted by location and financial circumstances.

Theme 3

Culture and the media agenda

3.1 'Breastfeeding is weird'

Many of the interviewees talked about how breastfeeding is not normalised in some cultures and that 'we've created this culture that is so unwelcoming and uncomfortable' (Academia). Some of the interviewees talked about breastfeeding being viewed as 'unusual' (MP), some referred to it as being seen as 'weird' (Health).

> We're fighting against a culture in our society where breastfeeding is seen as undesirable and weird by some groups. *(Health)*

However, there is recognition that this differs according to ethnicity, with some communities having much higher breastfeeding rates. Conversely, an interviewee for an organisation supporting Black mothers talked about her experiences of Black women associating formula feeding with wealth, seeing it as 'a privilege to be able to formula feed your baby' (Charity). The interviewee talked about it as a generational issue, with many no longer exposed to breastfeeding, meaning it's not seen as normal.

3.2 The influence of familial norms, friends and the home

The interviewees noted that a mother's decision to breastfeed and willingness to continue is greatly influenced by her circle of family/friends. Mothers often adhere to the breastfeeding norms of the family and base their decision of whether to breastfeed on what their own mother and grandmother did. Academic evidence indicates that mixed or negative messages from close families or partners can undermine breastfeeding decisions.[cix] This finding was reflected in this research. The sector noted partners can negatively influence breastfeeding outcomes, feeling they have 'less of a role if the mother is breastfeeding' (Charity) or sometimes expressing discomfort about the mother revealing her breasts in public; a finding reflected in other studies.[cx] Family and friends who do not attribute value to breastfeeding can undermine a mother's perseverance by recommending that she uses formula, rather than taking over some of the domestic tasks around the house.

> You may have all the support around you but if the people around you don't value breastfeeding then you could be having issues. You know, 'why don't you just get baby bottle because you're tired? Why are you torturing yourself in this way? Just get some formula?' *(Charity)*

Also significant is the influence of older generations in the family. Several existing studies evidence the significant role of intergenerational breastfeeding influences,[cxi] and its prevalence within shared households.[cxii] One interviewee explained that in intergenerational households 'older family members have a huge influence, especially on inappropriate weaning practices, mixed feeding and inappropriate bottle-feeding practices' (Local Government). This influence of older family members led another interviewee to set up an educational group specifically for grandmothers.

The interviewees also highlighted that some mothers felt embarrassed about feeding in front of their family members. This issue was particularly discussed with regard to South Asian families and intergenerational cohabitation.

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

It's worth noting a systematic review of migrant mothers' experiences in high-income countries found husbands, partners and others members of the family helped to promote breastfeeding for longer and exclusively. However, the mothers found there was an unfriendly attitude towards breastfeeding in the country they migrated too, as well as limited support.[cxiii]

Finally, the interviewees highlighted that some mothers from low socioeconomic backgrounds face further barriers to breastfeeding at home due to poor living conditions. That said, as one interviewee highlighted, unsanitary living conditions also impact the safety of formula feeding by compromising the sterilising process.

> Barriers to breastfeeding at home are interlinked with so many kinds of structural inequalities. There are women who are living in housing that is just really disgraceful, with mould all over the place, living in cramped conditions with lots of relatives, so they don't have space or a place to breastfeed. *(Charity)*

3.3 Breastfeeding in public

The Equality Act 2010 protects breastfeeding mothers from discrimination in public and workplaces. Some interviewees commented that breastfeeding in public has become more acceptable, noting that 'less women are talking about how embarrassed they feel' (Health). However, the interviewees overwhelmingly agreed that breastfeeding in public tends to be an uncomfortable and stigmatising experience due to prevailing cultural norms. A systematic review of studies in OECD countries found widespread evidence of this sentiment amongst breastfeeding mothers.[cxiv]

> I've had parents say 'I try to breastfeed the baby and everyone's just up in arms.' It's really bizarre. I think it's still quite shameful to do outside for a lot of parents. They say, 'well, it's easier to give a bottle when you're in public because when you breastfeed your child, everyone's looking at you like you've got two heads.' If you're breastfeeding, you can't go out. It's really isolating. *(Charity)*

> I think culturally, in this country, we are still uncomfortable seeing women breastfeed in public and that is definitely a barrier. *(Charity)*

The midwife interviewed talked about her experience helping mothers in South Asian families who wanted to feed privately at home and took formula with them when they left the house, as they felt it was culturally inappropriate to feed in public. One interviewee also noted a lack of awareness of the Equality Act 2010 and the rights it affords mothers.

> When I tell mothers antenatally that the 2010 Equality Act gives them protection from harassment, normally they're surprised – they don't realise there is legal protection for them. *(Charity)*

Another key challenge interviewees raised in connection with the cost-of-living crisis is that there are few clean and safe breastfeeding spaces that mothers can use without having to pay. This disproportionately impacts low-income mothers.

> It can be challenging in terms of cost of living, if you've got to go into a cafe to feed your baby, you've got to buy something. In the winter you can't breastfeed outside. I think that that can be a challenge. *(Local government)*

These findings are consistent with a systematic review of OECD countries, which found that mothers often feel uncomfortable about breastfeeding in public and are nervous about encountering conflict, particularly young and low-income mothers and those from marginalised minority ethnic groups. It found a lack of widespread awareness of legislation that safeguards breastfeeding as well as inadequate enforcement of this legislation. It also highlighted a lack of public understanding of what constitutes normal infant feeding behaviour, as well as feelings of disgust when seeing breastfeeding in public.[cxv]

The interviewees expressed that we do not see or experience breastfeeding in public very often, making it not a cultural norm. This is tied up with the sexualisation of breasts and the narrative that breasts should be 'covered up'. This is reaffirmed by representation in the media.

> People are so used to not hearing about breasts, they want to cover their ears when they hear about breasts, and our media have done very well to produce a picture of breasts to be something else. *(Academia)*

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

However, there are some seeds of change – in July 2024, campaigners, including celebrity Fleur East, took to London Underground to promote the #freethefeed campaign, with the aim of empowering breastfeeding mothers to feel safe to feed on public transport. This campaign was supported by Transport for London (TfL), who advise any women to make themselves known to TfL if they experience issues breastfeeding whilst using their services. TfL state they are committed to 'providing a safe and inclusive network for people travelling with young children.' [cxvi]

Image 1: Fleur East and breastfeeding mothers on the London Underground (Source: BBC)[cxvii]

3.4 Societal and maternal education about breastfeeding

Many interviewees discussed the lack of societal education on breastfeeding, with calls for it to be in the curriculum and recommendations to provide training for families or partners. They suggest that ensuring that breastfeeding is viewed positively from an early age, as well as understood and supported by society and families would lead to a step change in breastfeeding rates.

> We teach sex education at schools and talk about being pregnant. My 10-year-old already knows what being pregnant is. But then when you talk about breastfeeding, they go 'eeugh' and they don't want to hear about that. So, we need to put breastfeeding back on the curriculum, start to normalise breastfeeding so generations know that breastfeeding is a natural process. *(Academia)*

The interviewees noted there is a lack of education for mothers on breastfeeding, particularly around what to expect, and the challenges women face around latch and milk supply. Some interviewees felt this is exacerbated by the government and public health officials not wanting to say that breastfeeding can be hard, out of concern that this may make it seem like a difficult option.

Figure 12: Better Health Start for Life website on breastfeeding

(Source: Better Health Start for Life, 2023).[cviii]

> Women are not educated on how hard breastfeeding can be. The narrative says it's easy and it's not. I get that public health does that because they want to persuade you to do it, but it's not helpful. *(Health)*

> You're told breastfeeding is best but then you've got no support. And also, breastfeeding is hard. *(Academia)*

The Better Health Start For Life breastfeeding guidance talks about breastfeeding as a skill that requires mastery, but also talks about it being the 'easiest and most satisfying' way to feed.[cxix]

The guidance excludes the fact that women who exclusively breastfeed can spend on average 17 hours a week doing so, with an additional 11-12 hours on 'associated emotional care (soothing, holding or cuddling.'[cxx] There is an understandable reticence from healthcare and government to be clear that breastfeeding can be difficult, time intensive and painful. However, in the absence of a transparent portrayal, mothers often face unexpected hurdles, which may increase their likelihood of stopping.

The interviewees felt that particular emphasis was needed to prepare mothers at the antenatal stage and to 'sow the seed'. They highlighted the importance of educating expectant mothers about what typical baby behaviour is, where they can go for help when they need it and, crucially, what the first few days to six weeks might be like. For many, supporting mothers pre-birth is essential to increasing breastfeeding rates.

> It's about antenatal education. I don't think there's enough information about what's normal infant behaviour. It's about those first six weeks and knowing where you can get that support and signposting. How many women know there's a national breastfeeding helpline? *(Academia)*

One interviewee talked about how information provision also needs to be nuanced because 'certain groups don't want to be told what to do' (Academia).

> Pushing for breastfeeding turns them other way. They think 'I don't want to be pressured, so I'm not even going to entertain the idea.' *(Academia)*

3.5 Formula Feeding Culture

As previously stated, the aim of this research was to report on the landscape of and views across the breastfeeding sector. Breastfeeding was the focus of the research but formula was regularly referred to and, therefore, identified as critical to the discussion. This section reflects the views that were uncovered during the research.

Most of those we interviewed talked about the UK having a 'formula-feeding' culture, where breastfeeding is not seen as the cultural norm and is more common than breastfeeding. This was seen as a significant barrier to breastfeeding initiation and duration. The interviewees talked about how formula is seen culturally as an easier option, which means mothers are advised to switch by trusted circles when they experience difficulties.

> Sometimes they switch quite quickly because of something somebody has said: "that baby's not sleeping very well" or "you're getting tired. Why don't you give him a bottle of formula?." So really undermining her intention to breastfeed. *(Charity)*

The research highlighted divergent cultural narratives that create division in how breastfeeding is talked about. The interviewees referred negatively to the famous slogan 'breast is best', arguing it is antiquated, divisive, can be stigmatising and is unhelpful to their efforts to protect and increase breastfeeding rates: 'we don't need that slogan anymore, we need to change the language, so we are not undermining a mother' (Health). One interviewee argued that it was the CIMF who introduced the 'breast is best' language. The interviewees told us they preferred that breastfeeding be seen a normal activity, not a 'best' to aspire to.

'Breast is best' came out of the CIMF industry and has been used to undermine the statements of those who advocate for breastfeeding. Insidious marketing tactics like this are not new and are exactly the same tactics used in developing countries in the 1980s and 1990s. (Charity)

Yet our research indicated that, culturally speaking, the 'breast is best' narrative continues to play out. Further, it runs alongside another narrative, 'fed is best', fuelling divisions across the infant feeding space. This report recognises that acknowledging this division in narrative runs the risk of contributing to it. However, the purpose of this research was to report on the perspectives of those in the sector, including a media analysis, and it was apparent that the 'breast is best'/'fed is best' debate exists. This debate plays out not only in the media but also in academia, where breastfeeding science is being publicly questioned.

> There is also anti-breastfeeding in charities, NGOs, academics, health professionals, who are not on the same page and some of them are quite influential and strong. *(Charity)*

The interviewees told us this division around how breastfeeding is talked about is harmful because it creates barriers to progress on increasing breastfeeding rates and further empowers the CIMF industry. We were told that, in reality, most families combine breastfeeding with formula feeding but a debate about what is 'best' has been exacerbated by the media and industry.

The baby feeding industry (formula, baby foods, bottles, teats) and the media thrive on dividing us, on segmenting their market, on clickbait. (Charity)

The authors have interpreted the two notions of 'breast is best' and 'fed is best' as follows:

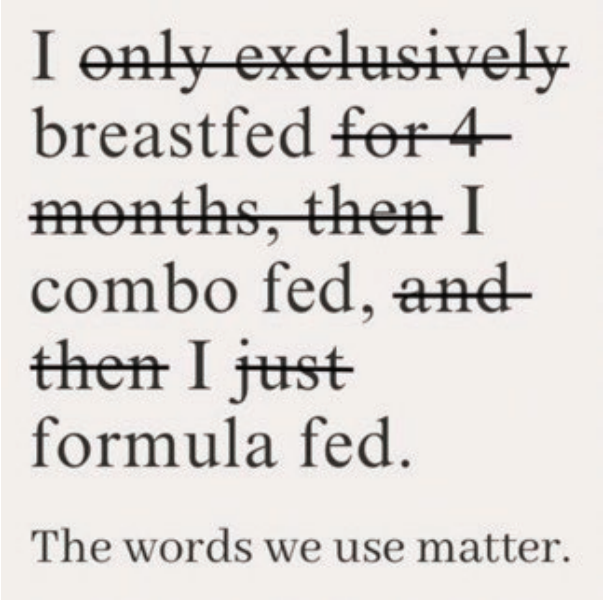
- *Breast is best*: that breastfeeding is best for mothers and babies and should, therefore, be protected, supported, promoted and not undermined. In the second phase of research, the interviewees strongly argued for a more nuanced interpretation. They felt the report should distinguish between the promotion of breastfeeding as a public health recommendation, based on scientific evidence that breastfeeding is optimal for child and maternal health, from the ideological and harmful slogan of 'breast as best'.

> A public health recommendation says the optimal way to feed a baby is to breastfeed. That's a recommendation for all healthy women and babies in the UK. It's judged to be applicable to the vast majority and to lead to health benefits for the vast majority, which will translate to population-level benefit. However, it is at the same time known that some individual women and some babies cannot or should not breastfeed, and they will ned to use formula. This is the best thing for their health. The two things must and do coexist. Both can be correct. *(Academia)*

- *Fed is best*: women should be supported to feed in the way that best protects the mother's mental and physical health, whether that be breastfeeding, mix feeding or formula feeding[cxxi] – see *Figure 13*. One academic wrote, 'the moralisation of infant feeding is detrimental for mothers' [cxxii] and argued policy needs to remove the focus on one infant feeding method. Opposing views from the charity sector argued that public health recommendations and associated scientific evidence around breastfeeding are not in themselves 'moralising', rather they represent the optimal policy advice.

Figure 13: Example social media post advocating for fed is best

(Source: @dearsundaymotherhood) [cxxiii]



Within this debate, the authors came across further competing narratives around infant feeding, across the interviewees, desk research and media analysis, that make the entire space not only confusing for mothers but also relatively hostile. These narratives are:

- That the 'breast is best' advocates (often referred to in the media as a 'brigade') are 'nanny-statist' and are potentially putting women off breastfeeding.
- That breast is best is anti-feminist and undermines a woman's right to choose the best way to feed her child.
- That breastfeeding is a barrier to 'childcare egalitarianism',[cxxiv] can impact a father's ability to bond with the baby and places infant-feeding burdens exclusively on women.
- That the 'fed-is-best' argument undermines breastfeeding and promotes a formula-feeding culture.
- That you can be pro-breastfeeding and 'pro-family, pro-mum, and pro-women' simultaneously by supporting formula-feeding mothers.
- That you cannot be pro-breastfeeding and pro-formula.

Breastfeeding, the most emotionally charged battleground in the field of motherdom. (Angelini, Sunday Times, 2023)

The view that formula feeding mothers are being disproportionately stigmatised and that the 'breast is best' narrative can be detrimental was argued by industry:

> So, we are not saying people should switch to formula. We're saying you need to see the world as it is, as opposed to as you would like it to be, and you need to give people a choice. Of course, breastfeeding is best, but you shouldn't be made to feel like your child is going to be in some way useless or inferior if you're using infant formula because it's not true. *(Industry)*

There was recognition by all the interviewees that, at present, the cultural narrative around breastfeeding is divisive, emotive and conflicting. Many NGOs and campaigners have a dual approach, where they both advocate for protecting and supporting breastfeeding mothers but also offer information and suggestions on safe formula feeding practices. However, despite this, the narrative is often presented in a 'them and us' way.

> It's just a really messy space. Lots of finger pointing, not constructive and very divisive. *(Charity)*

> It's such an emotive topic. It gets some people's backs up and you get accused of formula shaming. *(Academia)*

Interestingly, a study on internalised stigma among mothers who do not breastfeed found mothers who opted not to breastfeed reported minimal personal or public stigma. Comparatively, mothers who could not breastfeed felt more internalised stigma, believing that others viewed them as failures.[cxxv]

3.6 The media agenda on breastfeeding

Agenda-setting theory argues that media portrayals can shape how the public and government view an issue and the extent to which they place importance on it. Things that are 'deemed relevant by the news media (...) become relevant to public opinion too.' [cxxvi] The way in which the media frames an issue, such as breastfeeding, can influence how the public (and government) perceive it. This is particularly useful to Impact on Urban Health for framing, messaging and policy and advocacy in this space. This media analysis shows work is needed to change the image of breastfeeding.

The media portrayal of breastfeeding was complex and divisive. On the one hand, it framed breastfeeding as idealised, magical and best for mother and baby, magnified by showing celebrities breastfeeding in a deified fashion.

Conversely, it contributed to the narrative of shame around breastfeeding, referring to the country's low breastfeeding rates and mothers' experiences of feeling like a failure, being shamed in public and being stigmatised for using formula. Extensive celebrity coverage also portrayed the negative impacts on the physical body, sex drive and mental health. The previously mentioned competing narratives were borne out in newspaper articles, illustrating the complexity in how breastfeeding is talked about and the confusion this creates.

> It really is down to individual mothers to raise Britain up from its shameful place near the bottom of the world breastfeeding rankings. *(Bennet, The Guardian, 2023)*

> Parents should be supported in making their decision about how to feed their baby, and should have that choice respected, whatever their feeding journey. *(Bawden, The Guardian, 2023)*

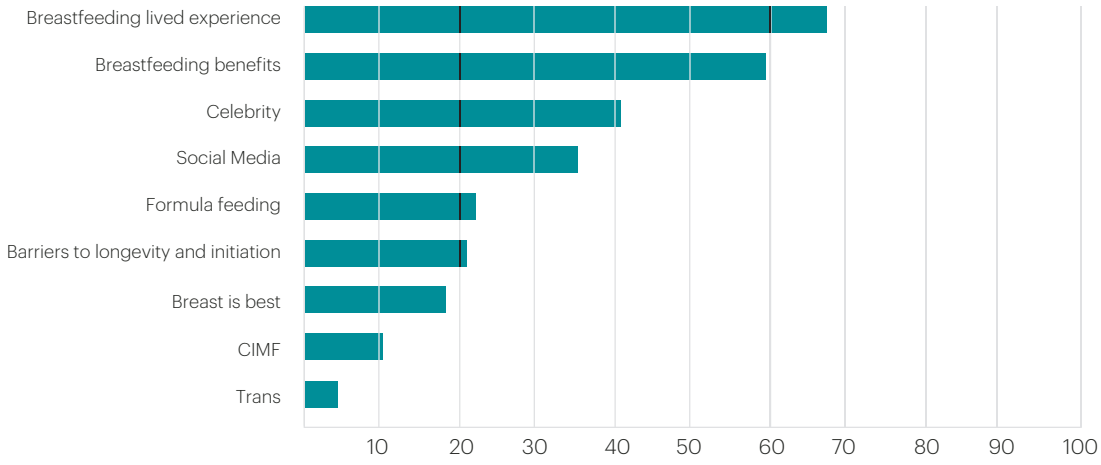
In comparison, the media also rarely highlighted systemic barriers to breastfeeding, such as the influence of government policies or the CIMF industry. The sentiment media analysis showed breastfeeding is a mixed picture – of the 66 articles analysed, 41% were both positive and negative, 45% were exclusively negative, 3% were neutral and 11% were exclusively positive. Most articles on breastfeeding were in the right-wing press. There was also a tendency towards sensationalised language within headlines and texts; sensationalism can be harmful to and impair the rational decision-making of the reader.[cxxvii]

> 'Milk shoots out like a water pistol': I'm a new mother and there's a LOT I didn't know about breastfeeding before I had a baby. *(Kalsi, The Daily Mail, 2023)*

> 'It has come with some hyper sexualization'; Pregnant Ashley James details the unwanted attention and awful online comments she has faced about her body and breastfeeding. *(Parkin, The Daily Mail, 2023)*

The overall leading themes were 1) the lived experience of breastfeeding mothers, which included the physical and mental health challenges and issues with breastfeeding in public, 2) breastfeeding benefits and 3) celebrity experiences.

Figure 14: Overall breastfeeding themes by percentage of mentions (Source: Authors' media content analysis)



3.6.1 Breastfeeding lived experience

67% of articles discussed the lived experience of breastfeeding women. Close to a third of the articles mentioned either the physical or mental challenges women experience with breastfeeding. Some of these descriptions were visceral. As discussed earlier, this may create the sentiment that breastfeeding is an overwhelming act to undertake.

> She assumed she would breastfeed easily too (...). It didn't work out that way: breastfeeding is agony and, after four weeks of fighting through the pain, Wolfarth was sent to A&E. *(Angelini, Sunday Times, 2023)*

Almost a quarter of the articles mentioned breastfeeding in public. Several articles reported on feeding older children in public, which was framed as inappropriate and 'unusual' or 'bizarre'. The narratives were often sensationalised: 'the six-year-old would yell "boobies!", run to her mum and pull up her shirt in public places' (Blaquiez, The Daily Express, 2023). The remaining articles highlighted incidents of mothers being asked to cover up or go somewhere else when breastfeeding publicly. 11% of the articles talked about the sexualisation of breasts.

> A mum has told how she was subjected to a traumatic experience while trying to express milk in a public venue. Pumping in the toilets would've been bad enough, she should've offered you a clean space as well. *(Stephens, The Daily Express, 2023)*

While the consensus is that local authorities, businesses, and organisations are much more supportive of women breastfeeding in public, and that women being challenged is less frequent, media coverage of isolated events would give the overall impression that public confrontation is a ubiquitous occurrence, which, understandably, makes women feel less secure doing it.

3.6.2 Breastfeeding benefits

74% of the articles referred to the benefit s of breastfeeding. 39% mentioned benefits for the baby and 8% mentioned benefits for the mother. Almost a third of the articles (27%) described breast milk as a 'wonder-food' and breastfeeding women as 'wonder-women'. The language referred to breastfeeding as a heavenly thing, earthy, magical, nurturing and liquid gold. Mothers talked about feeling like their 'big boobs have a pure purpose. I feel so mother earthly' (Bullen, The Daily Mail, 2023).

> We are constantly discovering mind-blowing ways in which this remarkable liquid serves a newborn. *(Hill, Daily Mail, 2023)*

3.6.3 'Breast is best'

17% of the articles included the phrase or referred to the sentiment of 'breast is best'. 'Breast is best' was used both positively and negatively throughout these articles (n=11), with one article being positive in sentiment overall, six being negative and four being both positive and negative. The majority of these articles (n=8) also reported negatively on the principles of 'breast is best', using phrases such as 'nanny-state' and 'breastfeeding brigade' mentioned.

> The 'breast is best' edict, largely set by UNICEF's breastfeeding guidance, has become so pervasive in Britain that many local authorities have interpreted it as meaning that formula shouldn't be handed out, lest this discourage people from attempting to feed their babies the 'natural' way. *(Lytton, The Independent, 2023)*

These findings illustrate the complexity and nuance behind the 'breast is best' narrative, as discussed in *section 3.5*. Combined with the findings from *section 3.6.2*, they indicate how the media contributes to the divisiveness around how breastfeeding is framed. The diverging framings used in the media undoubtedly cause complications for charities, NGOs

and healthcare providers in managing their messages and trying to communicate the benefits of breastfeeding. For example, we were told by interviewees that these organisations, including UNICEF UK, purposely avoid the term 'breast is best'. One article questioned whether '35 years of breastfeeding advocacy has improved the physical and mental health of babies and their parents' (Piccolino, The Guardian, 2023)

> Breast milk is a wonderful thing. Yes. More than one thing can be true at the same time. Yes, breast milk has health benefits. But fed babies are healthy babies. *(Lytton, The Independent, 2023)*

3.6.4 Celebrity and social media

41% of the articles featured celebrities, such as Molly Mae Hague and Katherine Ryan. The portrayal of celebrities was both positive and negative. Celebrities were depicted as iconic role models – female models breastfeeding backstage after runway walks and celebrities embracing and extolling breastfeeding. Conversely celebrities discussed how breastfeeding had changed their breasts and their body: 'they just became really saggy and (...) it just affected my confidence' (Devereaux-Evans, The Daily Mail, 2023).

Over one-third of the articles mentioned social media. These described the criticism and attention that celebrities face when sharing their breastfeeding journey, such as being accused of attention-seeking and receiving sexualised comments. Many of the critical comments on breastfeeding mothers were by other mothers. The Sun acknowledged that 'the internet is rife with criticism for mums and breastfeeding' (Cliff, The Sun, 2023).

> 'During this time, my inbox has been flooded with creepy comments from men (weird to sexualise someone breastfeeding), and judgemental comments from women about how often they're out, or about me attention seeking. *(Bullen, The Daily Mail, 2023)*

3.6.5 Formula Feeding

Formula feeding was mentioned in close to a quarter of all articles. The predominant narrative on this was the shame and guilt that mothers felt about moving to formula. Many articles reported that women felt like they needed permission from those around them to formula feed.

> After breastfeeding for up to eight hours a day, Bland felt she could give herself permission to combi-feed with formula. On reflection, she wishes someone had said earlier that it would be OK. *(Medlicott, The Independent, 2023)*

The media portrayed the formula's product placement on supermarket shelves as contributing to feelings of shame and stigma. Towards the summer months, articles began to refer to food insecurity and formula-feeding mothers. This included articles relating to parents stealing formula.

> In many supermarkets, baby formula has a security tag, like a bottle of whisky, and when I see that tag I always think of shame itself, clamped to its side (..). a product shrouded in such guilt. *(Wiseman, The Guardian, 2023)*

3.6.6 Barriers to breastfeeding initiation and duration

21% of the articles portrayed barriers to breastfeeding initiation and duration. There was a much lower focus on the lack of policy, government support, funding or lack of rights or access. The media's coverage focused more on celebrities, salacious stories and the 'breast is best' narrative than questioning or reporting on the structural and systemic issues underpinning breastfeeding rates.

> Sue Miller says male politicians' poor attitude and profit-driven formula manufacturers are the barriers. *(Miller, The Guardian, 2023)*

3.6.7 CIMF

The influence of the CIMF industry had considerably fewer mentions than social media, celebrity or experiences of breastfeeding mothers. Only 9% of the articles discussed misleading formula advertising and 5% focused on corporate lobbying and sponsorship. Several articles discussed the ways in which the CIMF uses social media, influencers and chat services to promote their products.

> Formula sales are very profitable for manufacturers, breastfeeding is not.
> *(Miller, The Guardian, 2023)*

3.6.8 The visual portrayal of breastfeeding

The visual images used to accompany breastfeeding articles presented showed an idealised view of the act of breastfeeding; the predominant images were happy children (73%) and happy breastfeeding mothers (44%).

Notably, close to 70% of the articles showed a woman feeding her baby in a private space (at home, etc.) and 13% showed a headless breastfeeding woman. In line with the media articles, one third of the photos were celebrities. Breastfeeding in public spaces only featured in 12% of the photographs. Unhappy breastfeeding women only featured in 3% of articles. This may contribute to the unhelpful societal view that breastfeeding is a private space endeavour. Of all the images, only two showed non-white women, which indicates an issue with representation and diversity.

Figure 15: Visual images of breastfeeding in UK Press (Source: Authors' own)

Theme 4

Consideration of demographic characteristics

4.1 How race influences access to support

Mothers from minority ethnic groups face several barriers when using breastfeeding support services, including cultural and language barriers. Interviewees who represented Black mothers said that breastfeeding support was neither representative nor culturally accessible. Breastfeeding support groups use promotional material showing white mothers, attendance is mainly made up of white mothers and the information provided is geared around a white mother's experience. The groups also fail to capture cultural differences and preferences for caring for a baby. Consequently, Black mothers felt alienated and excluded.

> Make the groups more inclusive. Stop talking about pink nipples. 'Watch out for the mother's areola, it's going to go from pink to almost brown.' Well, hello? Mine never started off as pink. Let's stop making black bodies 'other'. *(Lorna Phillip)* [cxxviii]

> Culturally, there were a lot of questions I had that nobody else could relate to. *(Kala Ingram-Peters)* [cxxvix]

Black mothers don't feel they are listened to. They don't feel they have access to the same level of services and feel the need to self-censor when trying to seek support, for fear of being seen as an 'angry, Black woman'. One interviewee described the 'mental gymnastics of being very careful so your assertiveness can't be misconstrued' (Charity).

> Black women are not entitled. I liken it to never being offered the full menu; for Black women, they are offered a reduced menu. *(Charity)*

> Black mothers don't feel listened to. And when we don't feel listened to, we decide to deal with it ourselves our way. And any mother who's having real difficulties with establishing breastfeeding will end up giving up. *(Academia)*

These issues are compounded by a lack of evidence on Black and maternal health, which means that the cultural nuances impacting whether a mother breastfeeds are not fully understood. Breastfeeding rates are higher among Black women. However, their experience of breastfeeding support services is often negative, with likely consequences for breastfeeding outcomes.

4.2 How socio-economic status influences access to support

The interviewees highlighted a myriad of challenges faced by mothers from lower socioeconomic backgrounds when trying to access support. Breastfeeding support is not always accessible to low-income mothers, with some services being paid for services, such as NCT's antenatal courses (although discounts are offered based on income). One interviewee described this as:

> ...a breastfeeding class system. You pay for [classes], you need money to spend on pumps... The more deprived you are, the less support you have around. *(MP)*

Another interviewee noted that lower-income mothers don't always get the same level of support as their wealthier peers because healthcare professionals assume low-income mothers are more likely to use formula and, therefore, feel they should prioritise their limited time and resources elsewhere. The interviewees noted the significant challenges mothers, living in deprived areas, face when they feel isolated and do not have the right support. One interviewee also highlighted 'the stress that is related to coping and managing a low income, which makes everything so much harder' (Charity).

Finally, the interviewees reflected on the economic pressure faced by low-income mothers, which often forces them into 'making choices which more affluent women don't have to make' (MP), like returning to work earlier than intended. One interviewee noted that mothers from lower-income households (earning less than £50,000 annually) took four months less maternity leave than the UK average. This causes mothers to face the additional financial burden of formula. As one interviewee put it:

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

The cost-of-living crisis is exacerbating the challenges faced by low-income mothers. A survey by Maternity Action found the number of women returning to work earlier than planned because of the cost of living and insufficient maternity pay increased from 42% in 2022 to 58% in 2023. The survey also found most of the respondents reduced their heating usage, leading in some cases to damp, mould and health problems, while many adopted unhealthy eating habits and meal skipping. Over half of mothers reported increased stress and declining health due to the cost of living.[cxxx]

4.3 Breastfeeding support for food insecure mothers

The interviewees stressed the importance of supporting food insecure mothers to breastfeed, particularly within the context of the cost-of-living crisis. Breastfeeding can protect infants and young children against food security by providing access to safe and nutritious food that meets their dietary needs and preferences. In doing so, breastfeeding can also support food system resilience, particularly during times of crisis.[cxxxi] Additionally, for low-income households, breastfeeding offers a solution to the non-affordability of formula.[cxxxii] Salmon suggests a food security approach to breastfeeding policy is needed so that breastfeeding is acknowledged as a form of food production requiring social, legal and economic protections in order to ensure infants' and young children's access to a secure supply of food.[cxxxiii]

First Steps Nutrition Trust also calls for reforms to the Healthy Start scheme, which supports pregnant women and mothers with children under four, to better assist breastfeeding mothers facing food insecurity. They highlight healthcare providers' concerns that the scheme does not encourage breastfeeding since it includes infant formula and lacks guidance on voucher usage and breastfeeding support resources. Recommendations for reform include increasing voucher value, offering an enhanced package for breastfeeding mothers during the first year, and providing information on accessing support like the National Breastfeeding Helpline during the first year.[cxxxiv]

4.4 The breastfeeding experiences of mothers with disabilities

Although the impact of having a disability on breastfeeding was not discussed during the interviews, the literature shows that mothers with disabilities tend to have lower rates of breastfeeding.[cxxxv] A qualitative study exploring the breastfeeding experiences of disabled women across various disability types found most of the participants attempted breastfeeding but faced challenges. These challenges included problems with communication, and difficulties with latch, supply and medical complications. The participants also experienced distress caused by societal and healthcare pressures to breastfeed. The study found that supportive, culturally competent healthcare, such as knowledgeable lactation consultants, enhanced breastfeeding success, while a lack of support and the aforementioned barriers often lead to giving up.[cxxxvi]

4.5 Services for people like me

Our findings are echoed by research by the BfN, which investigated whether breastfeeding services adequately represent diverse populations and whether this affects attendance: 'they might not have the confidence to walk into a room of posh mums with Bugaboos, or might feel awkward of breastfeeding in public... I think those sorts of things can put you off, like it's not what people from your background do.'[cxxxvii] The research indicated that peer support attendees were mostly attended by white, middle-class women, who had knowledge the support existed. Even groups held in ethnically diverse areas did not have ethnically diverse attendees.[cxxxviii] The interviewees noted there is underrepresentation across breastfeeding services because only time- and resource-rich people can volunteer.

> It's women who are time rich, financially rich, maybe education rich. We haven't got the qualified breastfeeding supporters from different communities. *(Health)*

Theme 5

Places of work or study

6.1 The workplace

Many of the interviewees felt the government's breastfeeding workplace policy illustrated an underlying assumption that 'it's private, you'll do it at home or you'll take care of it yourself. It's not the employer's responsibility' (Charity). This is illustrated by the below infographic from the Conservative administration (*Figure 16)* from social media, which demonstrates the unrealistic expectations placed on mothers to juggle work and breastfeeding – 'try to find childcare close to your work so you can breastfeed in breaks.'

There is minimal legislation protecting breastfeeding in the workplace (see *Figure 5*). Government regulations prohibit discrimination against breastfeeding mothers and employers are obliged to offer breastfeeding employees an area to rest and lie down. Employers must also regularly assess workplace risks for breastfeeding employees. The voluntary ACAS guidance provides further non-mandatory recommendations for employers. The charity sector has urged the government to put more policy support behind this but it has been met with reticence.

> We wrote to MPs and the government and everybody's like, 'Oh, well, we don't want to make a burden on business. And we're not a nanny state.' *(Charity)*

Figure 16: Post by Better Health Start for Life from X, previously Twitter, providing 'tips' for breastfeeding at work (Source: @Better Health Start for Life, 2023) [cxxxix]

The US approach goes a step further. Employers must provide a 'reasonable break time for an employee to express breast milk for her nursing child for 1 year after the child's birth each time such employee has need to express milk' and that must be 'a place other than a bathroom that is shielded from view and free from intrusion'.[cxl] In contrast, El Salvador have recently issued a law stating employers must provide a breastfeeding room that meets government guidance and paid breastfeeding breaks.[cxli]

The interviewees agreed that support for breastfeeding mothers who wanted or needed to return to work is inadequate. A survey conducted by one of the academics found that breastfeeding mothers had both positive and negative experiences when returning to work, which was dependent on the workplace. However, consistent to all experiences was that 'the onus was always on the woman to ask for what they need' (Academia). The interviewees widely agreed the burden of having to initiate and manage conversations around how the workplace can accommodate breastfeeding is a barrier.

> It's still very much up to the mother to raise it, to explain, unless she's just lucky that she has an employer or line manager who is understanding. Again, there's such variation depending on the attitudes of managers. Whereas, if there were legislation set out really clearly, this is an obligation well, you just do that. *(Charity)*

Many workplaces are not set up to accommodate breastfeeding. Many of the interviewees told stories of mothers having to breastfeed in toilets. Some workplaces have a policy and a breastfeeding room but have not fully considered the practicalities of breastfeeding and the time that is needed. For example, the room may be located far away, without any facilities for washing up equipment and storing milk. One of the academics interviewed found considerable anxiety among mothers about fridge storage, with some feeling embarrassed about storing their milk next to their colleagues' lunch and others worrying about the temperature of the fridge because the door is constantly being opened. A study of NHS breastfeeding doctors returning to work showed how policies often do not translate into practice.[cxlii] The NHS provides clear guidance on what should be provided for women (time, storage, space, etc.). However:

78%
of women were unaware of the local breastfeeding policy. Of those that were, only **7%** were informed of the policy by their employer.

6%
of women had a breastfeeding risk assessment on their return to work.

50%
did not have access to a lockable room, **51%** to a fridge and **69%** to adequate time.

55%
were interrupted whilst expressing.

52%
of women reported embarrassment and humiliation at work.

23%
of women expressed in changing rooms, **32%** in toilets, **25%** in their cars, **15%** in cupboards.

Again, the impact of the workplace on mother's ability to breastfeed varies across the socio-economic gradient. One of the academics interviewed found that mothers who continue to breastfeed when they return to work are typically older, white women who are highly educated. Inadequate maternity pay, exacerbated by the cost-of-living crisis, is forcing many mothers to return to work within a few months, hindering their ability to breastfeed and affecting their postpartum recovery, mental wellbeing, and bonding with their baby.[cxliii]

> Going back to that point about health inequalities, it's going to be women with less bargaining power in the workplace and with less opportunity to stay off work who are going to be most impacted by that. *(Charity)*

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

Adequate maternity and workplace support have the potential to transform breastfeeding rates, with positive long-term health outcomes. Evidence suggests that extending paid maternity leave is associated with increased breastfeeding initiation and duration. Additionally, the availability of paternity leave, taken alongside the mother, contributes to her overall health and extends the duration of exclusive breastfeeding.[cxlv] A systematic review of workplace-based interventions to encourage breastfeeding have found these interventions are effective in extending breastfeeding duration and deterring formula use.[cxlvi] Likewise, the availability of appropriate breastfeeding facilities at work has been linked with greater duration of breastfeeding and lower levels of sickness among employees' babies in their first six months of life.[cxlvii]

While several of the interviewees pointed out that some employers, particularly in small or resource-stretched organisations, can feel daunted and unsupported in understanding how to act, there are pockets of best practice. The Working Families Benchmark is a list of the UK's most flexible and family-oriented employers, as well as best-practice examples. The list for 2022 includes the British Army. The organisation has established a breastfeeding peer network and created a maternity and breastfeeding passport, which details the legal requirements a mother can expect at work wherever she is posted. Working Families advise employers to outline a breastfeeding policy that takes a flexible, case-by-case approach and encourages an open and supportive working culture. Our interviewees felt the government could incentivise organisations to support breastfeeding mothers to return to work.

The focus of the Conservative government on addressing productivity and workforce concerns without simultaneously offering sufficient support for breastfeeding mothers may have undermined breastfeeding outcomes, particularly affecting low-income mothers. However, through effective workplace interventions, there is an opportunity for future government policy to both support mothers to breastfeed and return to work.

6.2 Places of study

Several interviewees also highlighted that better and mandated support for breastfeeding mothers returning to places of study is also needed. There is limited literature on the experiences of breastfeeding students in the UK. According to a US study on enablers and barriers to expressing on college and university campuses, poor expressing and storage facilities and insufficient time were seen as barriers, while suitable expressing facilities, access to expressing equipment and social support on-campus were seen as enablers.[cxlviii] A Canadian study on the experiences of breastfeeding students on a university campus found all the participants felt isolated and worried about others' perceptions of them. The participants found there was a lack of breastfeeding spaces, which caused them difficulties with pumping comfortably, ultimately impacting their breastfeeding duration. Many of the participants felt they were forced to stop breastfeeding early to continue their studies.[cxlvix]

The NHS has produced a Start for Life leaflet on 'breastfeeding after returning to work or study'.[cl] When discussing what rights women have if they want to continue breastfeeding after returning to study, the leaflet highlights the protection against discrimination granted by the Equality Act 2010. However, it notes that course-providers are not required to offer breastfeeding facilities and can decide whether or not children are allowed to be on campus, though a course-provider's refusal to allow a student to use campus services because they are breastfeeding could constitute discrimination.

Theme 6

Commercial Infant Milk Formula

7.1 CIMF marketing and legislation

The view of all the interviewees (bar those from industry) was that the practices of the CIMF industry and the legislation that underpins formula marketing present the most significant barriers to women both initiating and continuing breastfeeding. Our NGO and charity interviewees were keen to state clearly that they recognise the importance of formula and that they are 'not aware of anyone working in breastfeeding who does not absolutely recognise that formula is important. The issue is marketing and the accessibility of formula, it is not formula per se'. (Charity).

> There are so many ways in which mothers can be subtly influenced by the advertising and that can undermine their confidence in their own ability to breastfeed. There's a tendency to focus on things like colic and poor sleeping and they may say 'this formula looks good and my baby is colicky so maybe this formula will help.' So they can get misled into formula feeding. *(Charity)*

The influence of the CIMF industry's multi-faceted and highly effective marketing strategies on infant feeding decisions and the industry's clear violations of the Code are well-documented.[cli] Several criticisms levelled at industry were raised by the interviewees, which are discussed below.

The CIMF industry spend a significant amount on formula advertising (in 2018 this was reported to be £13.2million).[clii] These figures don't account for digital spend, such as social media, influencers and partnerships. A report by the WHO, exposing the extent of exploitative marketing strategies used by the CIMF on social media platforms, found digital marketing makes up 80% of exposure to formula marketing in some countries. Social media is used in all countries to collect personal information and send personalised promotions directly to mothers. The industry uses techniques that aren't recognisable as advertising, including influencers and user-generated content, or the promotion of baby clubs and advice services. These techniques breach the Code but evade scrutiny from regulatory authorities.[cliii]

The CIMF industry use a range of pervasive and personalised techniques, particularly ones that exploit parents' anxieties, self-doubts and aspirations, whilst establishing themselves as a trusted source of advice.[cliv] Qualitative interviews with industry, undertaken in 2020, reported that mothers were categorised for marketing purposes into blue, yellow and red, according to their needs. Marketing is subsequently targeted towards them using these insights.[clv] Other evidence suggests commercial baby foods use words with emotional connotations, particularly under the theme of 'love'.[clvi]

Figure 17: Global market segmentation: blue, yellow and red mothers (Source: Hastings et al., 2020)[clvii]

Blue: *"are mothers who are all about ambition, they are about raising a capable, healthy, happy baby, these are the mothers who would be booking this baby into nursery school when the baby is six months old, they are already looking for the right university, I mean this baby has after-school tutors, the mother is thinking very hard about getting everything right so that this baby has a happy and healthy life, hopefully a successful, middle class future, and so everything that she does is about optimizing baby's future prospects. Those are Blue mothers;* [brand name] *is aimed at these mothers."* Key marketing slogans: *"our most advanced formulation yet"; "inspired by forty years of breast milk research"; "their future starts today".*

Yellow: *"so* [for] *Yellow mothers it's all about happiness, so success to her is a giggling baby, if the baby is happy she is happy, it's about creating a loving, happy home for that baby to bloom and be content. You can see that in [brand name]. I can show you a [brand name] ad that is bang on Yellow mothers, it's called the 'giggling baby's' ad and it is literally just babies giggling, it's adorable and it's what those mothers want, yeah."*

Red: *"things that Reds do are aimed at enhancing the sense of happy, cocooned childhood, so Red brands would do things like you know give you, you sign up for our baby club and we will send you a baby book so that you can keep your precious memories of you and your baby and your family. It's just anything that enhances that sense of safe cocooning, safe environment."* (FME)

The CIMF industry play on parents' anxieties by focusing on common baby behaviours resulting from adapting to their post-birth environment, like crying, poor-sleep and colic, and by offering formula as the solution:[clviii] 'they pathologise normal baby behaviours and the solution given is formula' (Charity). The CIMF industry add unsubstantiated health and nutrition claims to formula packaging, in violation of the Code and the UK law, even manipulating scientific and medical information to validate these claims.[clix] Evidence from a study by University College London showed that 18% of formula packs had health claims and 41% had nutritional claims that are not allowed under guidance from the DHSC.

When DHSC was approached for comment, they argued it is for local authorities to enforce.[clx] Interviewees told us local authorities are not provided any support in enforcing the guidance from government enforcement authorities, who are themselves under-resourced.

In addition, the CIMF industry has diversified its product range, which now includes infant formula (marketed for use from 0-6 months, but suitable for use from 0-12 months), follow-on (growing-up (12-36 months) and special formula. Not only does this expansion allow the industry to grow new markets that target a wider set of parents, it enables the industry to exploit a loophole in the UK's legislation, which is weaker for products for babies older than six months, and benefit from the cross-marketing of products.[clxi] Our interviewees pointed out that cross-marketing also applies to formula-feeding equipment, such as bottles and teats.

The highly publicised Lancet series, published in 2023, found marketing by the CIMF industry has 'altered the infant and young child feeding ecosystem', highlighting wider, sophisticated practices that systematically undermine breastfeeding. These include lobbying tactics, corporate philanthropy and influencing the scientific, healthcare and academic community.[clxii]

The global CIMF market is dominated by six companies that aggressively compete for market share. However, the avoidance of regulation, normalisation of formula-feeding and expansion of the market are in the interests of all the companies, so they cooperate by lobbying via trade organisations and business interest groups.[clxiii] Lobbying efforts are coordinated across various policy and decision-making forums, including three key regulatory organisations for infant feeding: the World Health Organization (WHO), Codex Alimentarius Commission (CAC), and World Trade Organization (WTO). They focus on influencing standard-setting processes, limiting regulatory protections for breastfeeding and preventing revisions to the Code.[clxiv] Efforts are also directed towards influencing government policy. From 2007 to 2018, the six top companies in the US market collectively invested $184.2 million in lobbying the US government.[clxv] These efforts are bolstered by lobbyists from the dairy industry, who have a vested interest in expanding CIMF markets.[clxvi]

The CIMF use corporate philanthropy to promote themselves through a strong image of corporate social responsibility.[clxvii] In a recent example, a prominent UK brand, Tommee Tippee, (which sells infant feeding bottles and teats), partnered with the Maternal Mental Health Alliance in a project that offers guidance to parents experiencing perinatal health problems.[clxviii] The CIMF industry were found to use the Covid-19 pandemic as a marketing opportunity. Violations of the Code included suggesting their products enhance immune function, linking products with health authorities, providing counselling and support services to parents and funding education events for health professionals on COVID-19 and feeding practices for infants and young children.[clxix]

The CIMF industry also target healthcare professionals,[clxx] understanding that, 'collaboration with healthcare professionals is key for formula milk companies, both to imply to consumers that their brand has scientific grounding and credibility, and to use health professionals as conduits for marketing.'[clxxi] They exploit the fact that health professionals are the main source of education for parents on infant feeding and are trusted. A variety of healthcare professionals, including paediatricians, nurses, dietitians and hospital administrators, are encouraged to pass on specific information, meaning they sometimes (knowingly or unknowingly) echo the company's marketing messages. The WHO and UNICEF found that formula companies approach healthcare professionals in all the countries they surveyed countries but attempts to target healthcare professionals in the UK have reduced in recent years.[clxxii] A charity stakeholder suggested:

> This could be down to the implementation of UNICEF UK Baby Friendly Initiative in the UK that has helped put restrictions in place in settings where Baby Friendly is being implemented. *(Charity)*

When talking about the CIMF industry, the language the interviewees used was war-like, with many of them talking about the 'battle'. The lack of government intervention or attention to the CIMF was also universally presented as a serious concern.

> The formula industry is winning that battle, and that's because it's almost like government have stepped out of the space. *(MP)*

> We can see the 'Battle of the Baby Milk industry,' and the amount of money they're pouring in promoting their products versus services, which are non-existent. The formula industry is winning that battle. *(MP)*

Indeed, the interviewees assigned responsibility for the success of the CIMF industry's practices on government – for a lack of action surrounding enforcing and upholding legislation and failing to ensure legislation accounts for new and innovative approaches, such as the use of social media.

For the interviewees, the strong feelings were directly tied to the imbalance of power. The CIMF companies wield significant spending power (with sales amounting to $55 billion annually according to the Lancet)[clxxiii] and influence over mothers, healthcare professionals and the media. They can effectively lobby and shape policy. In contrast, NGOs and charities working with mothers face limited funding and contract instability. This situation is further compounded by inadequate government funding and a shortage of midwives and health visitors.

> The industry spend millions, no billions, shaping cultural and societal attitudes in unethical ways. By comparison, you have an underfunded universal and community sector who must spend time reporting and securing contracts, which could be spent on improving reach. It is a fight, but not a balanced one. *(Local Government)*

Interviewees from the campaigning and NGO sectors were the strongest advocates for strengthening legislation and ensuring that legislation matches policy.

> The International Code of marketing is only partly incorporated in law. If that was strengthened, that would give more protection. But then really making sure the law gets implemented is important because there is no national monitoring. It relies on people sending in reports complaining. *(Charity)*

They point to incoherence between NHS guidance, which states that follow on formula is not necessary, and UK legislation, which allows 'pervasive advertising for follow on formula' (Charity). Industry practices undermine women's confidence in breastfeeding and create mixed messages, which in turn creates anxiety. In the absence of readily available or appropriate breastfeeding support, this can lead to women to turn to formula instead of persevering with their breastfeeding journeys.

This view was strongly contested by representatives of industry. They claim compliance with the Code 'to the extent that it's bad for business' (Industry). When challenged with academic evidence, suggesting they use sophisticated marketing techniques, they argue that:

> This idea that companies like ours are running around thinking there's an exciting way to exploit young mums is bollocks. We put rules in place where laws don't exist to try and support breastfeeding. Talk to our marketers, you will be deeply underwhelmed. They're not geniuses. Did they think about demographics? Yes. Is it ultimately people writing things that sound a bit like slogan and trying to sell them to people? Also yes. It's not that sophisticated. We are held accountable all the time. *(Industry)*

The industry representative argued that they are not only pro-breastfeeding but also 'pro-family, pro-mum and pro-women.' They believe the breastfeeding 'debate' has become toxic, with a 'them and us' approach, where most of the responsibility is directed at industry, detracting from lax government policy and practice.

> The debate has become quite shrill. And anti-women. *(Industry)*

7.2 Information provision for formula-feeding mothers

There was concern among some interviewees regarding mothers' access to information about formula feeding. These interviewees felt that the position of 'protecting and not undermining breastfeeding', and the legislation and guidance that underpins this (from government, local authority and UNICEF UK), can simultaneously undermine the experience of formula-feeding mothers. This was a particular concern for local governments.

> Women are not being supported in terms of how to bottle feed appropriately, in a similar way to breastfeeding. *(Local Government)*

> Local authorities can't promote bottle feeding and can't even talk about bottle feeding in a group setting. They can't display any information on bottle feeding. The Children and Family Centres have to hide it and only give it to someone if they ask for it. I agree with that in terms of wanting to promote breastfeeding but there is unsafe bottle feeding, for example people aren't sterilising. *(Local Government)*

> There needs to be more information about how to prepare formula safely. *(Academia)*

It's worth noting not all the interviewees felt there is insufficient information for formula feeding mothers, arguing 'it's in the companies' interest to say parents want more info' (Charity). These interviewees highlighted resources such the NHS website[clxxv] and a Start for Life/UNICEF UK Baby Friendly Initiative leaflet.[clxxvi] They noted that information is also provided on a one-to-one basis when requested, in accordance with rules, informed by the Code and research, that aim to prevent the undermining of breastfeeding. One interviewee argued the issue is not that there is a lack of information, rather that the rules regulating the dissemination of this information can be misunderstood and misinterpreted, meaning information isn't provided.

> This is a real challenge. There is information accessible and available – from NHS, UNICEF UK Baby Friendly Initiative and First Steps Nutrition Trust supplements with more detailed information on formula types, for example, because the NHS advice on these is ambiguous and insufficient.... but this is dwarfed by misinformation from companies. *(Charity)*

The current approach is creating policy incoherence and unintended consequences. The lack of attention to formula feeding mother means they are turning to unsafe practices and are 'left to find out all the information themselves' (Health). Some health representatives argued the CIMF industry take the opportunity to capitalise on mothers' lack of knowledge about formula-feeding through pervasive marketing and use women's anxieties to sell products.

The industry representative argued that women don't have sufficient information on formula. They claimed the healthcare system is 'pro-breastfeeding – if people don't want to breastfeed or they can't breastfeed, they don't really get a lot of support' (Industry). Industry argued that the information they provide meets a need that they have identified through their own research. Their research with healthcare professionals and mothers showed that 'they constantly tell us that they want more information' (Industry).

> A lot of healthcare professionals don't know how to advise on infant formula. So, the vast majority of healthcare professionals also said they don't feel like they can give any information because they think their policies are too restrictive. *(Industry)*

Qualitative research by UK mothers showed that many would have liked more support from healthcare professionals but 'some felt this abruptly stopped when they were no longer viewed as potential breastfeeders.'[clxxvii] Mothers asked for guidance on which specific brand to use but healthcare professionals weren't able to provide it. One interviewee told us this is

because all brands have similar compositions by law and no comparative studies of brands on babies' behaviour have been carried out. Indeed the NHS website advises that, 'all infant formulas will meet your baby's nutritional needs, regardless of brand or price. By law, all infant formula sold in the UK must meet the same standards.' [clxxviii] Some noted the ambition of protecting breastfeeding may also be contributing to feelings of shame: 'I know lots of women have said how guilty they feel about bottle feeding in public. I don't think that's addressed really' (Health).

7.3 Access to formula for food-insecure mothers

An area of concern for those interviewed was how women experiencing food insecurity could access infant formulas.

> We're now in the cost-of-living crisis. Things are really difficult. We see these mothers go to food banks to ask for formula. We're seeing these mothers water down formula so they can make it stretch further. It's not good practice. *(Academia)*

Debate around access to formula for food-insecure mothers was high on the UK media agenda at the time of writing, heightened by the former Labour Shadow Health Secretary's call to reform legislation around the use of supermarket vouchers on formula. Representations of infant feeding in the media are important as they hold significant influence over public opinion and debate.[clxxix] The Labour Party pointed towards evidence of women stealing formula milk or watering it down as justification for this policy focus. There was widespread media coverage of individuals creating their own campaigns to deliver formula to food banks. The Metro newspaper's well-supported campaign (working with Feed), Formula for Change,[clxxx] aimed at helping people find more affordable ways to access formula. This campaign has been backed by several celebrities.

Our interviewees told us the Labour Party's support for the Formula for Change campaign and associated media coverage on the use of supermarket vouchers on formula has created confusion, exacerbating the spread of misinformation that could be harmful to vulnerable groups. A recent policy brief by the Baby Feeding Law Group UK has debunked some misconceptions about the purpose and impact of UK legislation on the marketing of CIMF. It notes the law does not prohibit families from spending supermarket vouchers on formula.[clxxxi] The use of vouchers in supermarkets for the purchase of formula only breaches legislation when these vouchers are being used to induce a sale. Therefore, it is up to the supermarket to amend their policy in a way that is compliant with the law.[clxxxii] The briefing also highlights that shoppers have to spend hundreds of pounds to accumulate enough points for just one container of baby formula, thereby calling into question the premise of the Formula for Change campaign.[clxxxiii]

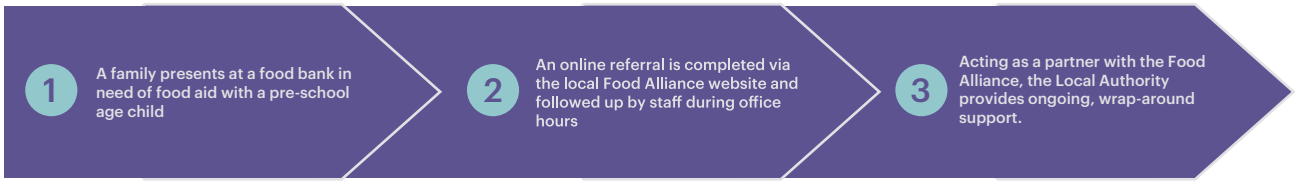
Campaigners and our interviewees have also warned against easing restrictions on the marketing of CIMF.[clxxxiv] As the Baby Feeding Law Group UK states, restricting marketing does not limit access to formula, nor cause high prices. It's the overpricing of formula by CIMF companies and prioritisation of high profit margins that cause high prices and make formula inaccessible to low-income households.[clxxxv]

Although it is permissible for food banks to provide formulas according to national and international law, some large food banks chose not to distribute formula following guidance from UNICEF UK in 2014: [clxxxvi] 'Formula milk should NOT be given to the mother for her infant as it may not be the most appropriate type and may cause the baby harm.' [clxxxvii] UNICEF UK guidance has since been updated and recommends that, 'food banks do not accept or distribute donations of infant formula for babies.' [clxxxviii] This recommendation is based on concerns about the safe and consistent supply of infant formula from food banks and the impact on families, who could also face delays in accessing the necessary support they are eligible for. UNICEF UK advises that food bank staff and volunteers shouldn't be responsible for implementing the necessary strategies that meet babies' complex short- and long-

term feeding needs; this is the responsibility of the local authority. Additionally, as our interviewees highlighted, recipients of assistance from food banks are likely to have greater needs which cannot be solved by being given formula. For example, they may have housing needs that prevent them from being able to safely prepare and store formula. However, the interviewees also raised concerns about the reliance on local authorities to supply formula to mothers.

Joint guidance from UNICEF Baby Friendly Initiative, First Steps Nutrition Trust and the National Infant Feeding Network provide a framework for supporting families who are food insecure with infants under 12 months. The guide covers taking a cash-first approach and the distribution of formulas through the local authority (see *Figure 18* as one example). UK charity, Feed, advocates that all local authorities should have emergency feeding pathways and has developed guidelines designed to assist food banks, baby banks and other charitable organisations while local authorities develop their own emergency infant formula provision pathways in line with this guidance.

Figure 18: An example pathway for food insecure mothers accessing formula by UNICEF UK – another example is shown in *figure 19* (Source: UNICEF 2022) [clxxxix]



However, in practice, not all local authorities distribute formula – some don't have the pathways in place, some have insufficient funding and some are concerned about undermining breastfeeding. As one interviewee noted, many local authorities are working on setting up pathways but this is a new process which will take time to implement. The same interviewee told us provision pathways are being implemented successfully in Scotland.

> [Handing out formula as a LA] is something I'm looking at as part of our strategy because I know there there's a code around the marketing and promotion of formula. But there's an exception where local authorities and health boards can give out formula. So, we're looking at whether we can work with our food banks to do it. But it's really difficult. *(Local Government)*

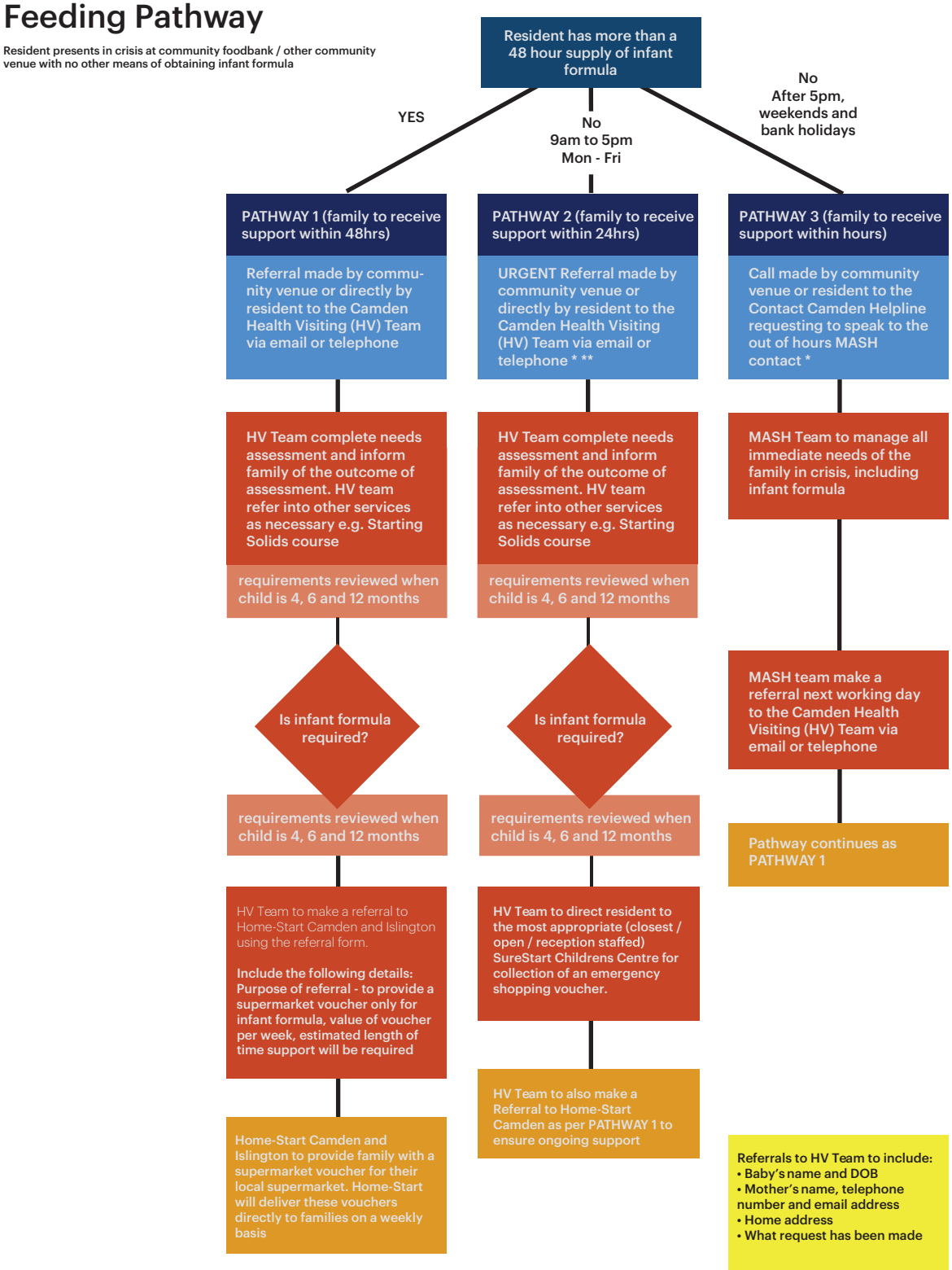
Interviewees were concerned that some of the pathways are complicated and rely on having adequate resources within the local authority. An example of the various departments and coordination needed is shown by Camden's Crisis Infant Feeding Pathway (see *Figure 19*), reported by UNICEF to be the best-practice approach.

The government representatives interviewed for this study argue that one of the solutions to the above issues is to prioritise a cash-first approach. The guidance from UNICEF UK Baby Friendly Initiative, First Steps Nutrition Trust and the National Infant Feeding Network also advocates for the adoption of a cash-first approach. Cash options such as crisis funds or shopping vouchers can be offered by the local authority and can help to maintain dignity and choice for families. Furthermore, this approach removes any element of commercial influence within the local authority, whilst offering immediate access to formula (as opposed to a pathway involving several departments). This includes adopting a cash-first approach – cash options such as crisis funds or shopping vouchers can be offered by the local authority. Cash options can help to maintain dignity and choice for families.[cxc]

> You're just giving the mother the cash to make the decision as to how she feeds the baby. And I think that's probably the most sensible position you can get to. You can make the choice with some degree of dignity and control over life. *(Government)*

Scotland was again identified as leading the way in identifying this issue and adopting a national approach. In August of 2023, the Scottish Government held a cross-sector event focused on infant food insecurity.[cxci] The report outlined how, during the cost-of-living crisis, it isn't the formula cost alone which is prohibitive for food-insecure mothers. It is also the equipment, such as sterilisers and bottles, and the fuel required to heat water. The report advocated for a cash-first approach,[cxcii] which has been further outlined in a toolkit from national government. This toolkit provides guidance to local agencies, frontline workers and volunteers on how to better support low-income families and mothers who are unable to afford formula. It provides advice on the development and enhancement of local response pathways to ensure food insecure mothers can feed their babies.[cxciii]

Figure 19: Camden Crisis Infant Feeding Pathway (Source: UNICEF UK, 2022) [cxciv]



* Referrals should always be made to the health visiting team in the first instance, or the MASH team if out of hours. However, if a resident presents in crisis, and is unable to wait up to 24 hrs to speak with a health visitor or the MASH team, an emergency shopping voucher can be provided to enable the family to buy their baby's usual formula. A referral must be made to the health visiting team to follow up with the family. If there are any safeguarding concerns, a referral must be made to Children's Services.

** Should a resident in crisis with <48 hour supply of infant formula present to Early Years workers they are able to issue a voucher directly before referring into pathway 1.

One of the concerns raised by interviewees from the charity sector is that the focus on food banks, vouchers and amendments to legislation detracts from the wider governmental failure to support breastfeeding or to protect formula-feeding mothers during the cost-of-living crisis with adequate financial support. For example, regarding Healthy Start, there have been calls for the government to increase the allowance and address the low uptake of the scheme by implementing an auto-enrolment process and expanding eligibility to households on Universal Credit and with No Recourse to Public Funds.[cxcv] Only two out of 533 constituencies in England achieve the government's target (75%) for Healthy Start program participation.[cxcvi]

It's worth noting that some food insecure mothers choose to use formula due to concerns about their own diet and inability to buy healthier foods and the perceived potential impact this might have on the quality and quantity of their breastmilk.[cxcvii] There is also concern that swift amendments to legislation set a dangerous precedent.

A report on the food experiences of people seeking asylum in London highlighted the many challenges mothers face around infant feeding. The food provided in hostels is not nutritionally adequate for breastfeeding mothers and no additional support or food is offered. There's a lack of sterilising, preparing and storing facilities, both for formula and breastmilk. report found mothers often rely on water from an unsterilised tap in a communal bathroom to prepare formula. Additionally, the weekly allowance of £8.86 (which is meant to cover all household costs) is insufficient to buy healthy foods and barely covers the cost of a tin of formula.[cxcviii]

7.4 Formula pricing

Underpinning much of the discussion about the cost-of-living crisis is the impact of the cost of infant formula. First Steps Nutrition Trust, which has led on advocacy in this area, reports that the seven formulas by leading suppliers Danone and Nestlé rose 24.6% between March 2021 and April 2023. One brand, Mamia, rose by 45%.[cxcixi] The Competitions and Market Authority reported concerns about the pricing of infant formula and associated high profits, finding that mothers could save up to £500 per year by shopping around.[cxcix] This prompted the initiation of a formal investigation into the CIMF industry, which would allow the CMA to 'use its compulsory information gathering powers, rather than rely on firms providing information voluntarily.'[cci] However, the scope of this investigation has since been reduced from 'a more extensive market investigation', which may have resulted in penalties for specific companies, to a 'market study' that develops recommendations to government.[ccii]

The CMA have released preliminary findings, suggesting that 'the combined effect of the current regulatory framework, the behaviour of manufacturers and suppliers and the needs and reactions of people buying formula, are resulting in poor market outcomes', and will proceed with making further recommendations for regulation.[cciii] First Steps Nutrition Trust have expressed disappointment at the cancellation of an in-depth investigation, as well as at the misrepresentation of CMA findings in the media that marketing restrictions alone are the primary cause of high formula prices for parents.[cciv] This form of misrepresentation in the media is pervasive and problematic, and prompted the UK Baby Feeding Law Group UK's guidance on UK legislation on the marketing of CIMF.[ccv]

The government's Healthy Start vouchers don't cover the cost of infant formula (see *Figure 20*). The formulas also range hugely in price. For example, in April 2023, the price of seven infant formulas ranged from £9.75 to £19,[ccvi] despite regulations stipulating that the nutritional composition must be the same (see *Figure 21*).

Figure 20: Unit cost of infant formula compared with Healthy Start Allowance

(Source: First Steps Nutrition Trust, 2023) [ccvii]

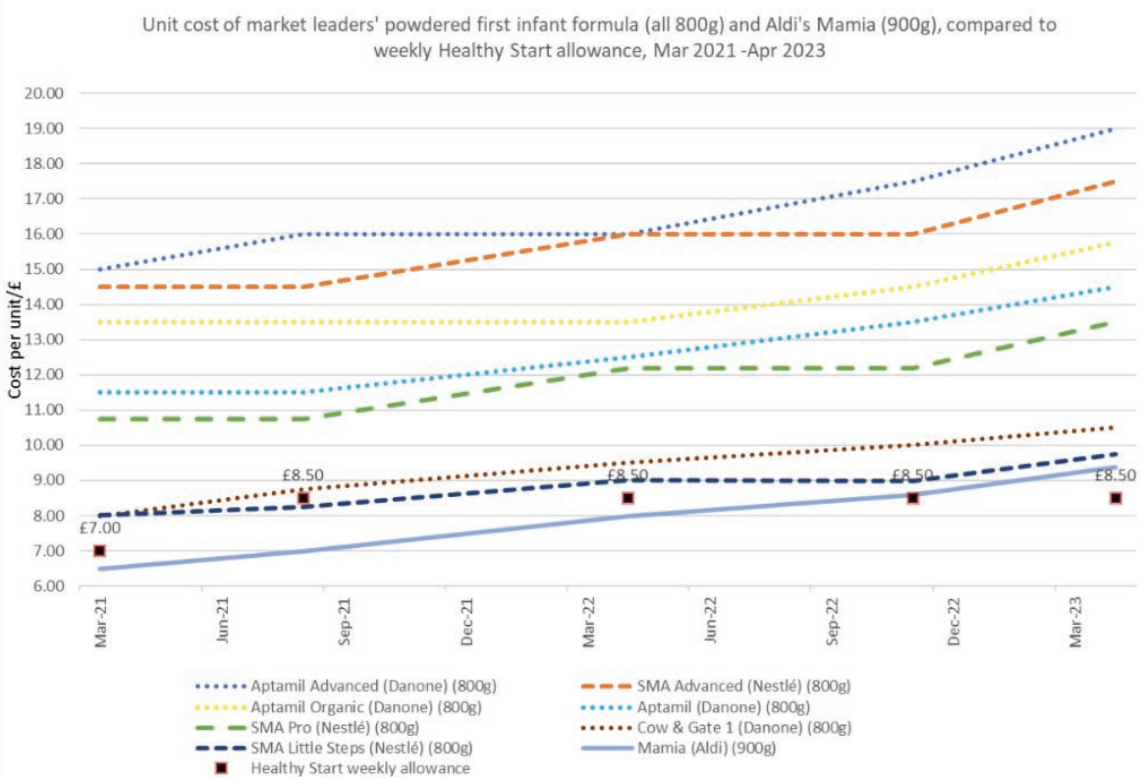
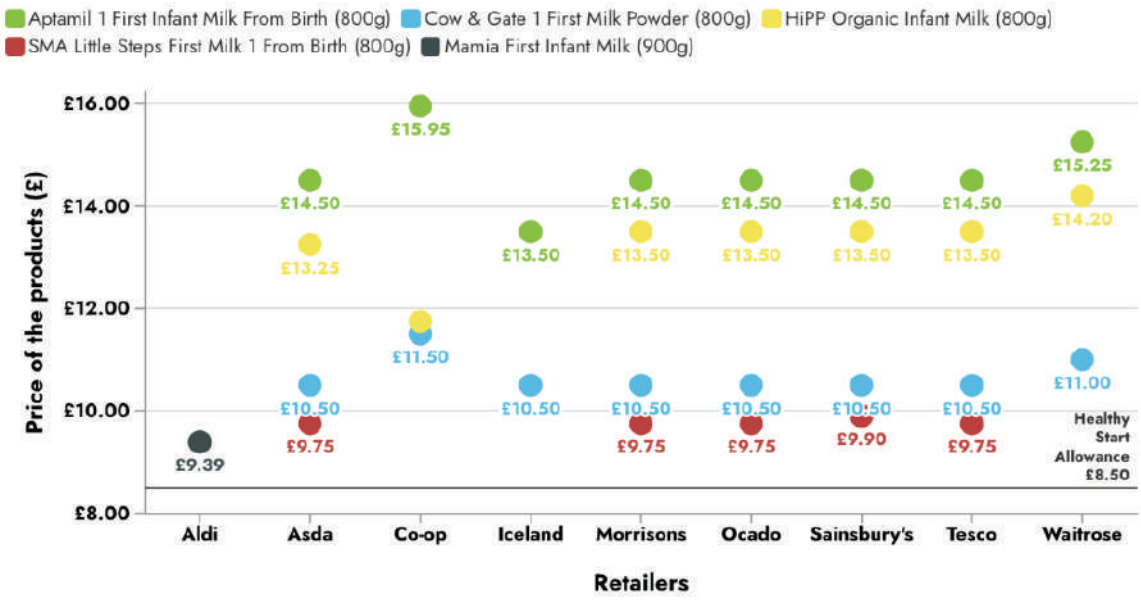


Figure 21: Cost of Formula Milk powder per unit/tin (Source: The Food Foundation, 2023) [ccviii]



The interviewees raised concerns that the range in prices can cause mothers to believe they are doing better for their baby by buying a more expensive tin. They also argued that many women cannot afford the increase in formula and, therefore, are turning to unsafe feeding practices.

> The really tragic thing is that quite often those families, in wanting to do the really best thing for their child, they'll be going out to buy the most expensive formula possible, thinking they're doing their child a favour - it's quite likely a parent has gone without food for something like that. *(Charity)*

The Food Foundation's tracking of formula prices between June 2023 and February 2024 indicated that the price of some 800-900g tins of first infant formula had fallen. This was potentially a result of increased pressure on the formula industry following an announced CMA investigation into the sector. [ccixi] The recent cancellation of the CMA's in-depth investigation, in favour of a market study, may have further impacts on price trends.[ccx] In August 2023, Iceland became the first UK supermarket to commit to reducing the price of its own infant formula,[ccxi] a move that, in and of itself, was within regulations. However, its further promotion was not.[ccxii] Anecdotally, we were told during interviews that NGOs and campaigners gave mixed responses to this. Some were supportive but others argued this move undermined breastfeeding and gave prominence to formula. Iceland also announced the launch of two new formula products by SMA in early 2024, which will be the cheapest formulas available at the time of writing, at £7.95.[ccxiii] These products join Aldi's comparatively smaller Cow & Gate formula (700g at £8.49) as the only formula products that don't exceed the Healthy Start Allowance.[ccxiv]

Figure 22: The change in price of infant formula (per unit/tin) from June 2023 to February 2024
(Source: The Food Foundation) [ccxv]

	Aptamil 1 First Infant Milk From Birth (800g)	Cow & Gate 1 First Milk Powder (800g)	HiPP Organic Infant Milk (800g)	Kendamil First Infant Milk Stage 1 (800g)	Mamia First Infant Milk (900g)	SMA Little Steps First Milk 1 From Birth (800g)
Aldi	NA	£8.49*	NA	NA	£8.99 (-£0.40)	NA
Asda	£13.50 (-£1.00)	£10.50	£13.50 (+£0.25)	£10.00*	NA	£9.75
Co-op	£14.00 (-£1.95)	£10.75 (-£0.75)	NA	NA	NA	NA
Iceland	£11.20 (-£2.30)	£9.75 (-£0.75)	NA	£9.25 (-£2.25)	NA	NA
Morrisons	£13.50 (-£1.00)	£10.50	£13.50	NA	NA	£9.75
Ocado	£13.50 (-£1.00)	£10.50	£13.50	£12.00	NA	£9.75
Sainsbury's	£13.50 (-£1.00)	£10.50	£13.50	£12.00	NA	£9.75 (-£0.15)
Tesco	£13.50 (-£1.00)	£10.50	£13.50	£11.00*	NA	£9.75
Waitrose	£13.50 (-£1.75)	£10.50 (-£0.50)	£13.50 (-£0.70)	£12.00 (+£0.16)	NA	NA

Price changes are shown in brackets unless stated otherwise. NA means the product is out of stock or was not available to purchase from the retailer in question in either June or Feb.
£8.49* is for 700g of the product & price change could not be tracked as it is the new addition in Nov 2023.
£10.00* &£11.00* are 900g

The Food Foundation

Best practice: Case Study

This report has predominantly focused on systemic barriers to breastfeeding and, as the research guide focused on these barriers, much of the research paints a complex and negative picture. However, some of the interviewees pointed to areas of best practice, and it is important to share where there is evidence of positive breastfeeding practices and good policy. As mentioned in this report, Scotland is frequently pointed to as a government with a high-level focus on policy and practice. In addition, Tower Hamlets was mentioned as a borough that also demonstrated great practice, with higher-than-average breastfeeding rates.

Tower Hamlets

Tower Hamlets Council runs a baby feeding and wellbeing service that delivers antenatal, face-to-face workshops, called 'Getting ready to breastfeed', and proactively contacts mothers within 48 hours after birth so they are aware of the support on offer. The service is also on the ward to help maternity care systems that do not have sufficient capacity. The service runs drop-in groups at the Children and Family Centres, as well as a peer support group. It offers home visits to vulnerable mothers and provides infant feeding support in both English and Bengali. In addition to the Baby Feeding service, Tower Hamlets also has a peer support service provided by the BfN, which trains and manages local volunteers who support infant feeding.

Tower Hamlets have employed a full-time Baby Friendly Coordinator in the Royal London on the Maternity Ward for the past 10 years. This role is involved in staff education, data collection and UNICEF UK Baby Friendly Initiative auditing and has dramatically improved the level of training and culture around breastfeeding support. The UNICEF UK Baby Friendly Initiative review of the Royal London Hospital maternity unit called the baby feeding service the crown jewel of their service – whilst the baby feeding service is not an NHS funded or delivered service, it remains a valuable part of the maternity care offer at the Royal London Hospital.

The services offered by Tower Hamlets are only possible because of the funding they receive as a borough with higher levels of deprivation. The borough noted that despite offering great services, their data on breastfeeding rates are poor (reflecting the national issue of poor data), which makes the continuation of the services a constant challenge.

'We've been really lucky that we've been able to protect the funding for our services, which many local authorities haven't. We know the importance of the first 1001 days. When you have these services that it's difficult to provide data for, it's really difficult to protect that funding.' (Tower Hamlets)

Recommendations from the breastfeeding sector

The recommendations in this report are derived from those interviewed, who Impact on Urban Health believes are best positioned to identify the necessary policy and practice shifts to create an infant feeding food system that ensures children have the best start in life.

The interviewees recognised that increasing breastfeeding initiation and duration is complex and there is no single solution that is likely to dramatically change breastfeeding trends. There was strong agreement that multiple interventions and policy support are needed. These can be summarised as follows and provide an outline for further strategic direction.

Policy and leadership

For government to:

- Provide better leadership and a fully funded, comprehensive infant feeding strategy.
- Make breastfeeding a statutory service within local authorities and ensure that data is adequately captured, comprehensive and regularly updated.
- Provide funding to both the universal support network and the charity and community support sector to create enabling environments for breastfeeding mothers.

> We need more lactation consultants and infant feeding specialists in the NHS and out in the community working in spaces where women from all backgrounds feel safe and comfortable to go. *(Academia)*

- Strengthen the CIMF industry legislation so that it protects breastfeeding and enforces existing legislation.
- Improve legislation to support mothers returning to work by, for example, making the ACAS guidance statutory and increasing maternity pay. This should also include working with and supporting small and medium sized enterprises to protect breastfeeding in the workplace.
- Create initiatives to change societal norms, such as featuring breastfeeding within education from an early age, so it is seen as a norm and women feel comfortable (and have adequate space) to feed in public. This should include breastfeeding being part of the national curriculum.

Framing and Communications

For organisations who fund and advocate for breastfeeding policy and practice change to:

- Undertake work on framing and messaging in the policy and advocacy space, which at times is portrayed as divisive and shouty.
- Promote messaging that acknowledges the challenges women face without shaming them.
- Promote messaging that positively addresses ideology regarding breastfeeding in public.
- Promote messaging that focuses on solutions to improving uptake and communicates the benefits to women and their families.
- Advocate for breastfeeding policy to be aligned with national improvements in GDP and reduced burden on the health system. Likewise, advocate for breastfeeding to be included in food policy and remove the 'baby blindspot'. A particular focus on this should be how inequality affects the outcomes for children from birth.

Advocacy, influence and coalition building

For organisations who fund and advocate for breastfeeding policy and practice change to:

- Provide funding and support to NGOs and charities that advocate for stronger legislation on the marketing of all breastmilk substitutes, including commercial milk formulas. This was the priority for most of the interviewees. Numerous interviewees specifically requested funding and support for the Baby Feeding Law Group UK, The Breastfeeding Alliance and First Steps Nutrition Trust. This funding was deemed necessary to ensure these organisations can focus on delivering their objectives rather than on fundraising efforts. According to stakeholders, such support is crucial for enabling women to make informed decisions on infant feeding, which is a stated but inadequately implemented government goal.

> I still feel that the area that is being underinvested and underappreciated is the protection angle. *(Charity)*

- Lobby and advocate across the political parties for women's and babies' health to be a political priority. This includes influencing government to commit to long-term funding of universal services and the charity and community sector and working with the government on a breastfeeding strategy.
- Use their influence with the private sector to garner greater support for women who breastfeed at work.
- Provide opportunities for collaboration and coalition-building. The interviewees believed there are lots of existing collaborations where breastfeeding should be in scope but is not seen as relevant.

> Leadership at national level is key of course, but also the grassroots level collaborations and work is what probably makes the real tangible difference. *(Academia)*

Funding place-based interventions

For organisations and academics to produce evidence and use it effectively with government to:

- Identify the gaps and barriers in breastfeeding support across the UK.
- Undertake polling research with government to understand which policy levers could have most impact.
- Create case studies and intervention analysis to determine what 'good' looks like. Use this evidence to advocate for national funding of good practice. This involves identifying initiatives, local authorities or programs that have demonstrably improved outcomes for breastfeeding mothers, and analysing the necessary funding, strategy and political will needed to achieve these improvements.
- Commission cost-benefit analysis to assess the impact of investing in infant feeding. We hope this will show:

> That the investment you put into nourishing babies will have a life course impact, particularly around the child's development. *(MP)*

Funding information provision

For organisations who fund and advocate for breastfeeding policy and practice change to:

- Fund independent information provision for women and families on breastfeeding. Organisations such as First Steps Nutrition Trust and HENRY were identified as having the skillset but not the funding to provide this service.
- Fund independent information provision for women and families on formula and formula feeding. Our stakeholders recognised that this is a gap.
- Fund NCT groups so they can offer wider provision to those who cannot afford to pay for classes.

Funding place-based interventions

For funding organisations and local authorities to create demonstrator place-based interventions that support women to breastfeed by:

- Creating sheltered places for women to breastfeed within existing locations, such as libraries.
- Funding infant feeding staff or peer support teams. Focus areas that were recommended, in particular, were:
  - One-to-one support in the first few days of life 'to ensure consistent, accessible and evidence-based programmes are available for all families' (Charity).
  - Support for areas with high need such as high infant mortality, malnutrition or increased levels of food insecurity.
  - Greater peer-to-peer support for women from minority ethnic groups.
- Trialling a cash-first approach to support formula feeding mothers. The interviewees emphasised that this should not undermine breastfeeding.
- Funding the breastfeeding friendly scheme in areas of high need.
- Piloting breastfeeding equivalents of Access to Work so that small to medium employers can access guidance, training and grants to support breastfeeding women.
- Funding successful initiatives developed through Family Hubs.

Conclusion

This report set out to capture the perspectives of those working in and around breastfeeding, and create a policy and practice landscape of breastfeeding at local and national levels. The research was cross-sector – it heard from representatives from a variety of organisations informing breastfeeding policies, practices, campaigning and advocacy. It also heard from industry.

Breastfeeding plays a pivotal role in children's health and, yet, national food policies have long neglected this crucial area, resulting in gaps in support services. The absence of coherent leadership and policy, alongside underfunding of universal and charity and community support services, perpetuates these gaps. The research identified the complex, interconnected network of barriers to breastfeeding, many of which disproportionately impact marginalised groups. These barriers echo the broader challenges to children's health, as identified in Impact on Urban Health's Children's Health and Food Programme —inequities in access, underpinned by economic inequality and structural racism, remain pressing concerns. Addressing these systemic challenges is essential to fostering a more equitable environment for all families, regardless of where they live or their background.

While the findings reveal many areas for concern (and indeed development), there are also promising opportunities for demonstrable impact. With the right funding, leadership and political will, there are clear avenues for creating a breastfeeding-friendly system. As reflected in the recommendations, the path forward must involve stronger policy and national leadership, robust support for charities and NGOs, investment in research, framing and communications, and a focus on place-based initiatives to ensure that all infants have access to the nutrition they need. Breastfeeding policy must be integrated into the broader food system and food policy, with an eye toward tackling inequalities in access to nutritious food—ensuring that every child has the best possible start in life.

Appendix 1: Research methodology in detail

Stakeholder interviews

The main part of the research involved interviews with people working in the field of breastfeeding. We worked with Impact on Urban Health and their partners to identify suitable contacts from a cross-section of organisations. The sectors included academia, local and national government, NGOs, charities and campaigners, health and industry. 28 interviews were scheduled and conducted in person and online. The interviews were semi-structured, working with a prepared research guide. They were transcribed and analysed to identify themes, areas of agreement and divergence. Informed consent was secured from all participants, and it was made clear that all views and comments would be anonymised.

Desk research

We also conducted desk research to understand the current policy and evidence landscape around breastfeeding and formula feeding. For this we used existing research from Impact on Urban Health, academic databases, grey literature and webinars. Our research was guided by our research questions, which were informed by an initial review of the literature.

Media and visual content analysis

Nexis, a news and business research database, was used to search the top circulating UK national newspapers for articles mentioning breastfeeding between Jan-July 2023. Articles were found in The Metro, The Daily Express, The Daily Mail, The Daily Telegraph, The Guardian, The Independent, The Sun, The Times and The Sunday Times. The inclusion criteria included: at least three mentions of breastfeeding and articles focused on England. Articles were excluded if they were promotions, advertorials, duplicates or letters. Irrelevant articles were removed from the sample, resulting in n=66 articles. For the visual content analysis, the text-only articles from Nexis were manually matched to online equivalents newspaper articles, resulting in n=63. Using a grounded theory approach,[ccxvi] thematic codes were generated from the articles and a coding framework created. The visual imagery was reviewed and categories added to the framework. Manifest content was logged: headline, title, author, stakeholder voices, image type and sentiment. Latent content was then interrogated to create thematic areas. All data was recorded onto the coding framework and then data analysed.

Stakeholder engagement

In a second phase of research, we asked the interviewees to review the first draft of the report. We received responses from 11 stakeholders from the charity/advocacy/campaigner sector, academia and the health sector. In recognition of the sensitivity and concern around sharing the draft report insights with industry, the industry representative was not invited to comment on the draft report. The interviewees provided their reflections via a Microsoft form. They were asked to comment on whether each of the themes adequately reflected the landscape and issues around breastfeeding and where they felt most impact could be made address these issues.

Appendix 2: Full WBTI report card

WBTi World Breastfeeding Trends Initiative (WBTi)

UK Report Card 2016

Policies and programmes: Indicators 1–10

Key gaps	Key recommendations	Score
Indicator 1 National policy, programme and coordination Is there a national infant and young child feeding strategy, a national coordinating committee and a national coordinator, as recomended in the *Global Strategy*?		1
UK No established UK-wide infant feeding (IF) group for sharing good practice. **E & W** No national paid sustainable leadership as no IF committee or coordinator.	**UK** Governments of the four home nations to support establishing a high-level, sustainable UK-wide IF group for policy leads and special advisors in IF, to share good practice. **E & W** Each government to set up a national, sustainable, strategic IF committee, with multi-sectoral representation, coordinated by a high-level funded specialist lead.	
Indicator 2 Baby Friendly Initiative Do all mothers have access to accredited Baby Friendly maternity care?		7.5
E & W No mandate or dedicated funding to implement the Unicef UK Baby Friendly Initiative (BFI) nationally, and no time-bound expectation.	**E & W** Governments to mandate and fully fund time-bound implementation and also maintenance of the BFI nationally, in accordance with the National Institute for Health and Care Excellence's (NICE's) guidance.	
Indicator 3 International Code of Marketing of Breastmilk Substitutes Are the provisions of the International Code and subsequent World Health Assembly Resolutions enacted in national legislation and fully enforced?		6
UK The *Code* is not fully implemented in the UK and there is no enforcement of the Regulations that are in place.	**UK** Government to fully implement the *Code* in legislation, and the responsible authorities to take coordinated action to enforce the Regulations in place.	
Indicator 4 Maternity protection Do women have adequate paid maternity leave and breastfeeding breaks?		6.5
UK No legally required provision for breastfeeding breaks or suitable facilities in workplaces, educational institutions and the judicial system.	**UK** Government to legislate for reasonable breastfeeding breaks and suitable facilities for breastfeeding/expressing in workplaces, educational institutions and the judicial system.	
Indicator 5 Health professional training Are all health professionals who work with mothers and babies adequately trained to support breastfeeding?		5.5
UK Most pre-registration training for healthcare practitioners (HCPs) who work with mothers, infants and young children has many gaps in the high-level standards and curricula, unless it is BFI accredited.	**UK** Institutions responsible for relevant pre-registration training standards and curricula to set mandatory minimum standards for core knowledge on breastfeeding and young child feeding for HCPs who work with mothers, infants and young children. These to align with World Health Organization (WHO)/BFI standards.	
Indicator 6 Community-based support Do all mothers have access to skilled breastfeeding support from health professionals and others in the community?		7
E The future of health visiting services in England is uncertain. **E & W** In some areas, there is little or no integration of NHS community services with voluntary sector breastfeeding support, and no clear access to a skilled lactation specialist.	**E** Commissioners to maintain the full range of health visiting services. **E & W** Commissioners to ensure there is a range of integrated postnatal services that include voluntary sector breastfeeding support, meet local needs and provide clear access to specialist support.	
Indicator 7 Information support Is there a comprehensive national information, education and communication strategy, with accurate information on infant and young child feeding at every level?		5.5
E No national, multi-media communications strategy for infant and young child feeding (IYCF).	**E** Government to create a national multi-media communications strategy which includes a public information campaign aimed at wider society (partners, extended family, community, workplaces).	
Indicator 8 Infant feeding and HIV Are national policies and programmes to support HIV+ mothers in their feeding decisions supported by up-to-date evidence?		6.5
UK Misinformation on HIV and IF is widespread, and HCPs/community workers do not receive up-to-date training on HIV and IF.	**UK** Train all HCPs/community workers on up-to-date WHO and British HIV Association recommendations on HIV and IF.	
Indicator 9 Infant and young child feeding during emergencies Are guidelines in place to provide protection to infants and young children in case of emergency?		0
UK No national strategies addressing IYCF in emergencies.	**UK** Each government to develop a national strategy on IYCF in emergencies that is integrated into existing emergency-preparedness plans.	
Indicator 10 Monitoring and evaluation Are monitoring and evaluation data regularly collected and used to improve infant and young child feeding practices?		5
E The UK 5-yearly Infant Feeding Survey has been discontinued. Current data collection is incomplete and too limited in scope.	**E** Government to mandate additional routine data collection and incorporate into standard midwifery and health-visiting services (to minimise cost and workload) incorporating WHO-compatible definitions and including qualitative data.	

UK United Kingdom **E** England **W** Wales **Scores are out of 10:** 0–3.5 4–6.5 7–9 >9 **Subtotal 50.5/100**

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