



**World
Breastfeeding
Trends
Initiative**

**UK Report
2016**

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First Steps Nutrition Trust

Institute of Health Visiting

Lactation Consultants of Great Britain

La Leche League Great Britain

Maternity Action

National Infant Feeding Network

NCT

Northern Ireland Regional Breastfeeding Lead

Public Health England

Scotland Maternal and Infant Nutrition Coordinator

Unicef UK Baby Friendly Initiative

See p. 72 for further acknowledgements.

Abbreviations

ABM	Association of Breastfeeding Mothers
Acas	Advisory, Conciliation and Arbitration Service
ART	antiretroviral therapy
BFHI	Baby Friendly Hospital Initiative
BFI	Unicef UK Baby Friendly Initiative
BfN	Breastfeeding Network
BHIVA	British HIV Association
BMS	breastmilk substitute
BSISG	Breastfeeding Strategy Implementation Steering Group
CHIVA	Children's HIV Association
CHS	Child Health System (Northern Ireland)
CPD	continuing professional development
CRC	United Nations Convention on the Rights of the Child
DH	Department of Health
DHSSPS	Department of Health, Social Services and Public Safety (Northern Ireland)
DNA	deoxyribonucleic acid
DNS	Diet and Nutrition Survey
EBF	exclusive breastfeeding
EU	European Union
E	England
GMC	General Medical Council
GP	general practitioner
GPhC	General Pharmaceutical Council
HCP	healthcare professional
HIV	human immunodeficiency virus
HSC	Health and Safety Commission
HSCIC	Health and Social Care Information Centre
HSE	Health and Safety Executive
HV	health visitor
IBCLC	International Board Certified Lactation Consultant
IBCLE	International Board of Lactation Consultant Examiners
IBFAN	International Baby Food Action Network
IEC	information, education and communication
IF	infant feeding
IFE	Infant Feeding in Emergencies
IFS	Infant Feeding Survey
iHV	Institute of Health Visiting
ILO	International Labour Organization
IQ	intelligence quotient
ISD	Information Services Division (Scotland)
IYCF	infant and young child feeding
LLLGB	La Leche League Great Britain
MINF	Maternal and Infant Nutrition Framework (Scotland)
NBW	National Breastfeeding Week

NCT formerly the National Childbirth Trust

NGO non-governmental organisation

NHS National Health Service

NI Northern Ireland

NICE National Institute for Health and Care Excellence

NICU neonatal intensive care unit

NIFN National Infant Feeding Network

NMC Nursing and Midwifery Council

PHA Public Health Agency

PHE Public Health England

PHOF Public Health Outcomes Framework

RCGP Royal College of General Practitioners

RCN Royal College of Nursing

RCOG Royal College of Obstetricians and Gynaecologists

RCPCH Royal College of Paediatrics and Child Health

S Scotland

SCPHN specialist community public health nurse

SI statutory instrument

SMP Statutory Maternity Pay

The Code *International Code of Marketing of Breastmilk Substitutes* and subsequent relevant Resolutions of the World Health Assembly

UK United Kingdom

UN United Nations

Unicef United Nations Children's Fund

W Wales

WABA World Alliance for Breastfeeding Action

WBTi World Breastfeeding Trends Initiative

WBW World Breastfeeding Week

WHA World Health Assembly

WHO World Health Organization

Report cards

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 recommended in the <i>Global Strategy</i> ?		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 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 (the <i>Code</i>) enacted in national legislation and fully enforced?		6
UK The <i>Code</i> 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 <i>Code</i> 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

What is the WBTi?

The World Breastfeeding Trends Initiative (WBTi) is a collaborative national assessment of the implementation of key policies and programmes from the WHO's *Global Strategy for Infant and Young Child Feeding*. Unlike other assessments, the WBTi brings together the main agencies and organisations involved in aspects of IYCF in a particular country to work together to collect information, identify gaps and generate recommendations for action. This is the first WBTi assessment for the UK; the process is repeated every 3–5 years in order to track trends.

WBTi UK Core Group members

Association of Breastfeeding Mothers (ABM)
 Baby Feeding Law Group (BFLG)
 Baby Milk Action
 Best Beginnings
 Breastfeeding Network (BfN)
 Child and Maternal Health Observatory (CHIMAT)
 Department of Health
 First Steps Nutrition
 Institute of Health Visiting (iHV)
 Lactation Consultants of Great Britain (LCGB)
 La Leche League GB (LLLGB)
 Maternity Action
 Northern Ireland infant feeding lead
 NCT
 National Infant Feeding Network (NIFN)
 Public Health England (PHE)
 Scotland Maternal and Infant Nutrition Coordinator
 Start4Life
 Unicef UK Baby Friendly Initiative

Feeding practices: Indicators 11–15

Indicator 11 Early initiation of breastfeeding within 1 hour of birth	60%	9
Indicator 12 Mean percentage of exclusive breastfeeding for first 6 months	17%	6
Indicator 13 Median duration of breastfeeding	3 months	3
Indicator 14 Bottle feeding: percentage of babies of 0–12 months fed with bottle	88%	3
Indicator 15 Complementary feeding: percentage of babies receiving solids by 8 months	98%	10

Scores are out of 10: 0–3.5 4–6.5 7–9 >9 Subtotal 31/50

Feeding practices scores are calculated using WHO definitions and the data are drawn mainly from the 2010 Infant Feeding Survey.

Total score **81.5/150**

Committee on the Rights of the Child recommendations

The United Nations Committee on the Rights of the Child is the body of 18 independent experts that monitors implementation of the Convention on the Rights of the Child by its state parties. The UK is a signatory to the Convention and was last assessed in June 2016. The Committee recommends the following:

- Systematically collect data on food security and nutrition for children, including those relevant to breastfeeding, overweight and obesity, in order to identify root causes of child food insecurity and malnutrition.
- Regularly monitor and assess effectiveness of policies and programmes on food security and nutrition of children, including school meal programmes and food banks, as well as programmes addressing infants and young children.
- Promote, protect and support breastfeeding in all policy areas where breastfeeding has an impact on child health, including obesity, certain non-communicable diseases and mental health, and fully implement the *International Code of Marketing of Breastmilk Substitutes*.

Abbreviations: **BFI** Baby Friendly Initiative **HCP** healthcare practitioner **IF** infant feeding **IYCF** infant and young child feeding
WBTi World Breastfeeding Trends Initiative **WHO** World Health Organization

Policies and programmes: Indicators 1–10

Key gaps	Key recommendations	Score
Indicator 1 National policy, programme and coordination Is there national leadership and a strategy?		
a. No established UK-wide infant feeding (IF) group for sharing good practice. b. No national paid sustainable leadership as no IF committee or coordinator.	a. UK Government to support establishing a high-level, sustainable UK-wide IF group for policy leads and special advisors in IF, to share good practice. b. Government to set up a national, sustainable, strategic IF committee, with multi-sectoral representation, coordinated by a high-level funded specialist lead.	1
Indicator 2 Baby Friendly Initiative Do all mothers have access to accredited Baby Friendly maternity care?		
No mandate or dedicated funding to implement the Unicef UK Baby Friendly Initiative (BFI) nationally, and no time-bound expectation.	Government 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.	7.5
Indicator 3 International Code of Marketing of Breastmilk Substitutes Are the provisions of the Code implemented?		
The Code is not fully implemented in the UK and there is no enforcement of the Regulations.	Government to fully implement the Code in legislation, and the responsible authorities to enforce the Regulations.	6
Indicator 4 Maternity protection Do women have adequate paid maternity leave and breastfeeding breaks?		
a. No legally required provision for breastfeeding breaks or suitable facilities in workplaces, educational institutions and the judicial system. b. Access to employment tribunals limited by high fees.	a. Government to legislate for reasonable breastfeeding breaks and suitable facilities for breastfeeding/expressing in workplaces, educational institutions and the judicial system. b. Government to ensure that tribunal access is available to women from all income brackets.	6.5
Indicator 5 Health professional training Are relevant health professionals adequately trained in breastfeeding?		
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.	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 all HCPs who work with mothers, infants and young children. These to align with World Health Organization (WHO)/BFI standards.	5.5
Indicator 6 Community-based support Do all mothers have access to skilled breastfeeding support in the community?		
a. The future of health-visiting services in England is uncertain and, 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. b. No national listing of local breastfeeding support.	a. Commissioners to maintain the full range of health-visiting services, plus a range of integrated postnatal services to meet local needs, including voluntary sector breastfeeding support, with clear referral pathways b. Public Health England to work with its partners and explore options to enable families to access up-to-date information about local services.	7
Indicator 7 Information support Is there a national information, education and communication strategy, with accurate information?		
No national, multi-media communications strategy for infant and young child feeding (IYCF).	Government to create a national communications strategy which includes a public information campaign aimed at wider society.	4.5
Indicator 8 Infant feeding and HIV Are national policies and programmes to support HIV+ mothers in feeding decisions up to date?		
Lack of up-to-date training in HIV and IF.	Train HCPs/community workers on current WHO/British HIV Association recommendations.	6.5
Indicator 9 Infant and young child feeding during emergencies Do emergency guidelines include such protection?		
No national strategy addressing IYCF in emergencies.	Government to develop a national strategy on IYCF in emergencies that is integrated into existing emergency-preparedness plans.	0
Indicator 10 Monitoring and evaluation Are monitoring data collected regularly collected and used to improve IYCF practices?		
Current data collection is incomplete and too limited in scope.	Government to mandate additional routine data collection and incorporate into standard midwifery and health-visiting services.	5

Subtotal 49.5/100

Feeding practices: Indicators 11–15

Indicator 11 Early initiation of breastfeeding within 1 hour of birth	60%	9
Indicator 12 Mean percentage of exclusive breastfeeding for first 6 months	18%	6
Indicator 13 Median duration of breastfeeding	3 months	3
Indicator 14 Bottle feeding: percentage of babies of 0–12 months fed with bottle	88%	3
Indicator 15 Complementary feeding: percentage of babies receiving solids by 8 months	98%	10
Scores are out of 10: 0–3.5 4–6.5 7–9 >9		Subtotal 31/50

Feeding practices scores are calculated using WHO definitions and the data are drawn mainly from the 2010 Infant Feeding Survey.

BFI Baby Friendly Initiative **HCP** healthcare practitioner **IF** infant feeding **IYCF** infant and young child feeding **UK** United Kingdom
WBTi World Breastfeeding Trends Initiative **WHO** World Health Organization

Policies and programmes: Indicators 1–10

Key gaps	Key recommendations	Score
Indicator 1 National policy, programme and coordination Is there national leadership and a strategy?		10
No established UK-wide infant feeding (IF) group for sharing good practice.	Northern Ireland Government to support establishing a high-level, sustainable UK-wide IF group for policy leads and special advisors in IF, to share good practice.	
Indicator 2 Baby Friendly Initiative Do all mothers have access to accredited Baby Friendly maternity care?		9.5
No significant gaps.		
Indicator 3 International Code of Marketing of Breastmilk Substitutes Are the provisions of the Code implemented?		6
The Code is not fully implemented in Northern Ireland. Enforcement of the existing Regulations in Northern Ireland is uncertain (responsibility lies with district council environmental health officers).	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
No legally required provision for breastfeeding breaks or suitable facilities in workplaces, educational institutions and the judicial system.	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 relevant health professionals adequately trained in breastfeeding?		5.5
a. 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 accredited by the Unicef UK Baby Friendly Initiative (BFI). b. Further action needed in support of the Northern Ireland Breastfeeding Strategy to see full implementation and monitoring of breastfeeding in-service training standards across all professional groups.	a. 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. b. Northern Ireland Breastfeeding Strategy Implementation Steering Group to monitor and implement provision of all in-service training programmes.	
Indicator 6 Community-based support Do all mothers have access to skilled breastfeeding support in the community?		10
No gaps.		
Indicator 7 Information support Is there a national information, education and communication strategy, with accurate information?		9
No significant gaps.		
Indicator 8 Infant feeding and HIV Are national policies and programmes to support HIV+ mothers in feeding decisions up to date?		7.5
No significant gaps.		
Indicator 9 Infant and young child feeding during emergencies Do emergency guidelines include such protection?		0
No national strategy addressing infant and young child feeding (IYCF) in emergencies.	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 data collected regularly collected and used to improve IYCF practices?		10
No significant gaps.		

Subtotal 74/100

Feeding practices: Indicators 11–15

Indicator 11 Early initiation of breastfeeding within 1 hour of birth	60%	9
Indicator 12 Mean percentage of exclusive breastfeeding for first 6 months	10%	3
Indicator 13 Median duration of breastfeeding	5 days	3
Indicator 14 Bottle feeding: percentage of babies of 0–12 months fed with bottle	88%	3
Indicator 15 Complementary feeding: percentage of babies receiving solids by 8 months	98%	10
Scores are out of 10: 0–3.5 4–6.5 7–9 >9		Subtotal 28/50

Feeding practices scores are calculated using WHO definitions and the data are drawn mainly from the 2010 Infant Feeding Survey.

 Abbreviations: **BFI** Baby Friendly Initiative **HCP** healthcare practitioner **IF** infant feeding **IYCF** infant and young child feeding **UK** United Kingdom **WBTi** World Breastfeeding Trends Initiative **WHO** World Health Organization

Policies and programmes: Indicators 1–10

Key gaps	Key recommendations	Score
Indicator 1 National policy, programme and coordination Is there national leadership and a strategy?		
a. No previous WBTi Report for Scottish Government to consider. b. No established UK-wide infant feeding (IF) group for sharing good practice.	a. Scottish Government to ensure that its own strategic breastfeeding groups consider all aspects of the WBTi Report within its action plans b. Government to support establishing a high-level, sustainable UK-wide IF group for policy leads and special advisors to share good practice.	10
Indicator 2 Baby Friendly Initiative Do all mothers have access to accredited Baby Friendly maternity care?		
No significant gaps.		9.5
Indicator 3 International Code of Marketing of Breastmilk Substitutes Are the provisions of the Code implemented?		
The Code is not fully implemented in Scotland and enforcement of the existing Regulations is uncertain (Food Standards Scotland (FSS) monitors violations).	Government and FSS to support improvements to the current EU Commission Directive and strengthening of the UK Infant Formula and Follow-on Formula Regulations. The responsible policy areas and authorities to take coordinated action to enforce the Regulations.	6
Indicator 4 Maternity protection Do women have adequate paid maternity leave and breastfeeding breaks?		
a. No legally required provision for breastfeeding breaks or suitable facilities in workplaces, educational institutions and the judicial system. b. Access to employment tribunals limited by high fees.	a. Government to legislate for reasonable breastfeeding breaks and suitable facilities for breastfeeding/expressing in workplaces, educational institutions and the judicial system. b. Government to ensure that tribunal access is available to women from all income brackets.	6.5
Indicator 5 Health professional training Are relevant health professionals adequately trained in breastfeeding?		
a. 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 accredited by the Unicef UK Baby Friendly Initiative (BFI). b. Incomplete implementation of Maternal and Infant Nutrition Framework (MINF) action plan (2010–2021). c. There is low uptake of the short BFI online training for paediatricians and GPs and no consistent training for obstetricians. d. IF leads often have no IF qualification.	a. Institutions responsible for relevant pre-registration training standards and curricula to amend the MINF to ensure they 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. b. All relevant bodies to continue to implement the MINF action plan and identify remaining gaps. c. Government to amend the current MINF to ensure training standards, curricula and access to training enable doctors (paediatricians, obstetricians, GPs) to meet basic standards of knowledge in infant and young child feeding (IYCF), pre- and post-registration. d. Health boards to require IF leads to have an IF qualification.	6
Indicator 6 Community-based support Do all mothers have access to skilled breastfeeding support in the community?		
No gaps.		10
Indicator 7 Information support Is there a national information, education and communication strategy, with accurate information?		
No significant gaps.		9
Indicator 8 Infant feeding and HIV Are national policies and programmes to support HIV+ mothers in feeding decisions up to date?		
MINF does not cover HIV and breastfeeding. Misinformation on HIV and IF is widespread, and HCPs/ community workers do not all receive relevant training.	Government to extend the MINF to include HIV and breastfeeding, and train all HCPs/community workers on up-to-date WHO and British HIV Association recommendations on HIV and IF.	4.5
Indicator 9 Infant and young child feeding during emergencies Do emergency guidelines include such protection?		
No national strategy addressing IYCF in emergencies.	Government to develop a national strategy for IYCF in emergencies that is integrated into existing emergency-preparedness plans.	1
Indicator 10 Monitoring and evaluation Are monitoring data collected regularly collected and used to improve IYCF practices?		
There is no routine data collection beyond 6–8 weeks.	Government to set up additional routine data collection beyond 6–8 weeks, to include 4 months, 6 months, introduction of solids, 12 months and duration of breastfeeding, including qualitative data.	9

Subtotal 71.5/100

Feeding practices: Indicators 11–15

Indicator 11 Early initiation of breastfeeding within 1 hour of birth	60%	9
Indicator 12 Mean percentage of exclusive breastfeeding for first 6 months	17%	6
Indicator 13 Median duration of breastfeeding	6 weeks	3
Indicator 14 Bottle feeding: percentage of babies of 0–12 months fed with bottle	88%	3
Indicator 15 Complementary feeding: percentage of babies receiving solids by 8 months	98%	10

Scores are out of 10: 0–3.5 4–6.5 7–9 >9

Subtotal 31/50

Feeding practices scores are calculated using WHO definitions and the data are drawn mainly from the 2010 Infant Feeding Survey.

BFI Baby Friendly Initiative **FSS** Food Standards Scotland **HCP** healthcare practitioner **IF** infant feeding **IYCF** infant and young child feeding **MINF** Maternal and Infant Nutrition Framework **WBTi** World Breastfeeding Trends Initiative **WHO** World Health Organization **UK** United Kingdom

Policies and programmes: Indicators 1–10

Key gaps	Key recommendations	Score
Indicator 1 National policy, programme and coordination Is there national leadership and a strategy?		4
a. No established UK-wide infant feeding (IF) group for sharing good practice. b. No national paid sustainable leadership as no IF committee or IF coordinator.	a. Welsh Government to support establishing a high-level, sustainable UK-wide IF group for policy leads and special advisors in IF, to share good practice. b. 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?		6.5
Encouragement but no mandate or dedicated funding to implement the Unicef UK Baby Friendly Initiative (BFI) nationally, and no time-bound expectation.	Government to mandate and fully fund time-bound implementation and maintenance of the BFI across all health boards.	
Indicator 3 International Code of Marketing of Breastmilk Substitutes Are the provisions of the Code implemented?		6
The Code is not fully implemented in Wales, and there is no enforcement of the UK Infant Formula and Follow-on Formula and Regulations.	Government to support improvements to the current EU Directive and strengthening of the Regulations. The responsible authorities to take coordinated action to enforce the Regulations.	
Indicator 4 Maternity protection Do women have adequate paid maternity leave and breastfeeding breaks?		6.5
a. No legally required provision for breastfeeding breaks or suitable facilities in workplaces, educational institutions and the judicial system. b. Access to employment tribunals limited by high fees.	a. Government to legislate for reasonable breastfeeding breaks and suitable facilities for breastfeeding/expressing in workplaces, educational institutions and the judicial system. b. Government to ensure that tribunal access is available to women from all income brackets.	
Indicator 5 Health professional training Are relevant health professionals adequately trained in breastfeeding?		5.5
a. 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. b. Infant and young child feeding (IYCF) in-service training optional except for midwives and health visitors in health boards working towards/with BFI accreditation. c. IF leads sometimes do not have an IF qualification.	a. 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. These to align with World Health Organization (WHO)/BFI standards. b. Implementation of BFI standards across all relevant healthcare facilities to ensure minimum levels of in-service training in IYCF, including separate basic standards for paediatricians/GPs. c. Health boards to require IF leads to have an IF qualification.	
Indicator 6 Community-based support Do all mothers have access to skilled breastfeeding support in the community?		8
Variation nationally in antenatal and postnatal provision of breastfeeding education and support, individually and in groups. Little integration of community services.	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 national information, education and communication strategy, with accurate information?		7
No implementation of an information, education and communication strategy.	Government to implement an IYCF information, education and communication strategy, free from commercial influence.	
Indicator 8 Infant feeding and HIV Are national policies and programmes to support HIV+ mothers in feeding decisions up to date?		8.5
Misinformation on HIV and IF is widespread, and HCPs/community workers may not receive training.	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 Do emergency guidelines include such protection?		0
No national strategy addressing IYCF in emergencies.	Government to develop a national strategy on IYCF in emergencies, integrated into existing emergency-preparedness plans.	
Indicator 10 Monitoring and evaluation Are monitoring data collected regularly collected and used to improve IYCF practices?		5
Current data collection is incomplete and too limited in scope.	Government to mandate additional routine data collection beyond 6 months and incorporate into standard midwifery and health-visiting services.	

Subtotal 57/100

Feeding practices: Indicators 11–15

Indicator 11 Early initiation of breastfeeding within 1 hour of birth	60%	9
Indicator 12 Mean percentage of exclusive breastfeeding for first 6 months	13%	6
Indicator 13 Median duration of breastfeeding	2 weeks	3
Indicator 14 Bottle feeding: percentage of babies of 0–12 months fed with bottle	88%	3
Indicator 15 Complementary feeding: percentage of babies receiving solids by 8 months	98%	10

Scores are out of 10: 0–3.5 4–6.5 7–9 >9

Subtotal 31/50

Feeding practices scores are calculated using WHO definitions and the data are drawn mainly from the 2010 Infant Feeding Survey.

BFI Baby Friendly Initiative **HCP** healthcare practitioner **IF** infant feeding **IYCF** infant and young child feeding **UK** United Kingdom
WBTi World Breastfeeding Trends Initiative **WHO** World Health Organization



Introduction

‘Success in breastfeeding is not the sole responsibility of a woman – the promotion of breastfeeding is a collective societal responsibility’

Rollins, The Lancet, 2016¹

World Breastfeeding Trends Initiative

How babies and young children are fed has a significant impact on their health and wellbeing and on public health across the nation. Over recent decades there has been international agreement on key strategies to improve infant and young child feeding (IYCF) practices. These are summarised in the *Global Strategy for Infant and Young Child Feeding*² and the Innocenti Declaration.³

The World Breastfeeding Trends Initiative (WBTi) toolkit was developed by the International Baby Food Action Network (IBFAN) to help countries evaluate breastfeeding policies and practices in a systematic way.

The assessment and report are a collaborative effort for each country, bringing together government and civil society to highlight successes, pinpoint gaps and build consensus on recommendations for action. Over 100 countries have used the WBTi toolkit.

Despite many countries making clear commitments to global agreements, there is considerable variation in monitoring and implementation. The *International Code of Marketing of Breastmilk Substitutes*⁶ (the Code) is a good example. It was launched in 1981 and has been supported by numerous subsequent World Health Assembly (WHA) Resolutions to strengthen and add to the recommendations. Despite many decades of member state commitments to these international agreements, global implementation of the Code and Resolutions is still limited in many areas.⁷

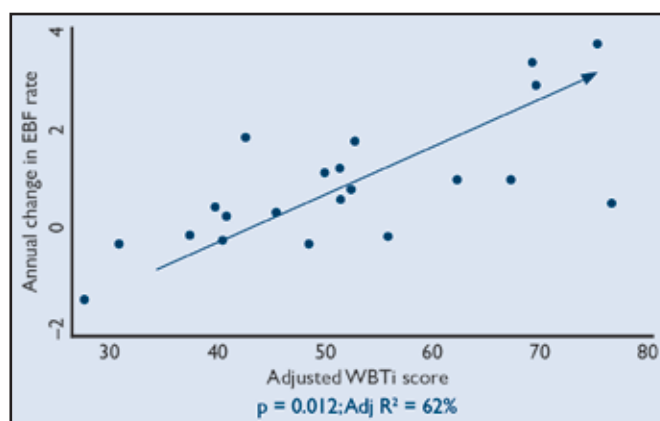
Analysis has shown that countries that have implemented the *Global Strategy* have seen greater improvements in their breastfeeding rates.⁸ It is only when multi-level interventions are combined that a multiplier effect begins to show results.⁹

The objectives of the UK WBTi report are to:

- bring together key organisations involved in infant and maternal health across the UK to collaborate on monitoring implementation of the *Global Strategy*;
- gather data on IYCF policies and programmes;

WHO recommendations for optimal infant feeding

- initiation of breastfeeding within an hour of birth;
- exclusive breastfeeding for the first 6 months;
- continued breastfeeding for 2 years or more;
- safe, nutritionally adequate, age-appropriate complementary feeding, starting around 6 months.^{4,5}



Annual change in percentage exclusive breastfeeding (EBF) rate by adjusted WBTi score (policy indicators 1–10). Higher adjusted WBTi score reflects improved implementation of the 10 key areas of policies and programmes.¹⁰ (Source: C. Lutter)

WBTi policies and programmes

1. National policy, programme and coordination
2. Baby Friendly Initiative (BFI)
3. Implementation of the Code
4. Maternity protection
5. Healthcare and nutrition systems
6. Support for breastfeeding mothers
7. Information support
8. Infant feeding and HIV
9. IYCF during emergencies
10. Mechanisms of monitoring and evaluation

- demonstrate how current breastfeeding policies and practices impact on breastfeeding initiation and continuation rates across the four nations of the UK;
- identify successes and gaps, and build consensus

Breastfeeding benefits the baby from top to toe^{7,8,9}

NOT breastfeeding is linked to an increased risk of

ear infections (otitis media)

tooth decay & dental malocclusion

chest infections (lower respiratory infections)

diarrhoea & vomiting (gastroenteritis)

death from gut infections in sick and premature babies (necrotising enterocolitis)

overweight/obesity later in life

Sudden Infant Death Syndrome (SIDS)

There is evidence to suggest

there may be a link between breastfeeding and educational attainment



Credit: Public Health England. © Crown copyright 2016

on recommendations for action;

- provide a baseline assessment of how effectively the UK is delivering its responsibilities to children as part of the *Global Strategy*.

Why infant and young child feeding is important

Key drivers behind the need to improve the protection, support and promotion of breastfeeding in the UK are:

- the impact of infant feeding on
 - infant and maternal physical and mental health;
 - supporting women's choices;
 - reducing inequalities and supporting human rights;
 - the economy – reducing health and social care costs and the impact on national productivity;
 - sustainability and the environment;
- the importance of:
 - appropriate infant feeding in emergencies;
 - protection from inappropriate promotion of breastmilk substitutes, which undermines breastfeeding.

Infant and maternal health

The 2016 *Lancet* series on breastfeeding¹ and the special issue of *Acta Paediatrica* commissioned by WHO highlight the impact of breastfeeding practices on a range of outcomes.¹¹ These findings agree with earlier analysis of the UK by the United Nations Children's Fund UK (Unicef UK).¹²

Protecting infant health Breastmilk provides optimum nutrition for the infant. It also contains many bioactive molecules that protect against infection and

Breastmilk and the brain

Breastmilk is a vital element in the development of the infant's brain. The composition changes over time to provide the essential building blocks required at each stage of brain growth and development. The variety and bioavailability of the components of breastmilk cannot be replicated in infant formula. Magnetic resonance imaging studies have found that babies who were artificially fed have less white matter as their brains develop – an effect still seen at 2 years of age.¹⁶

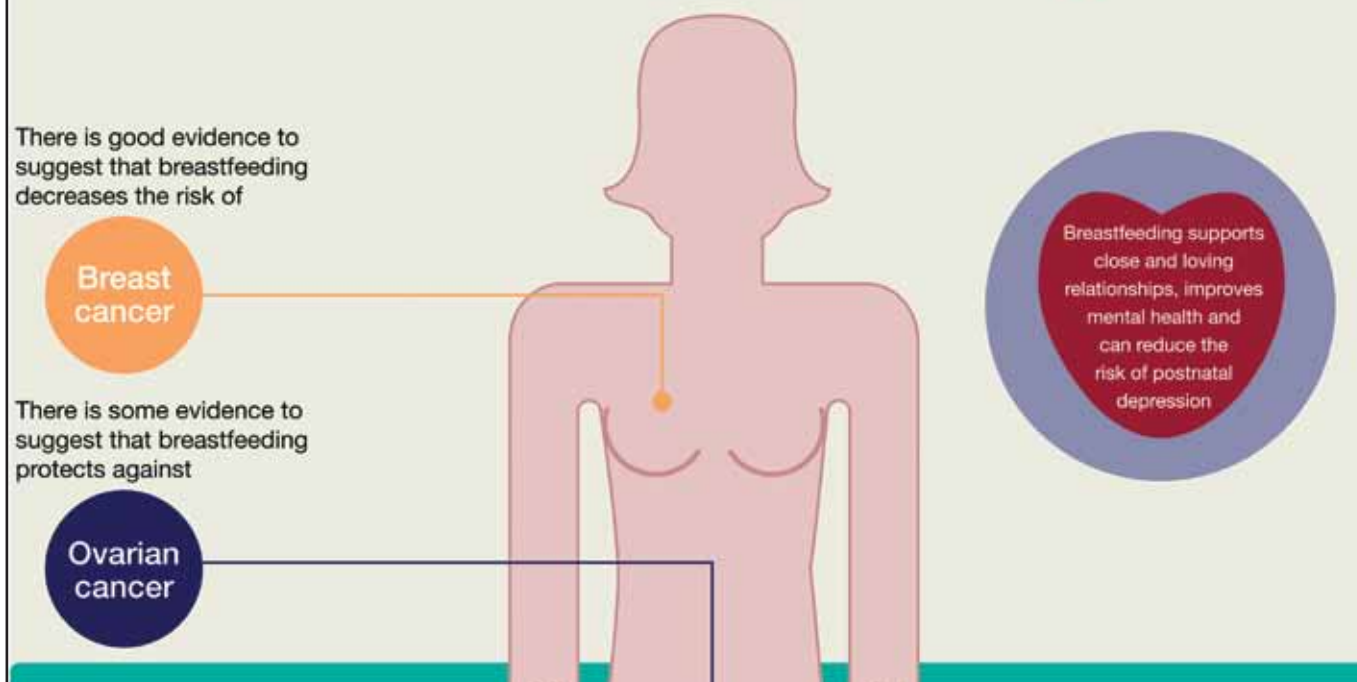
inflammation, and contribute to immune maturation, organ development and healthy microbial colonisation, supporting the short- and long-term health and development of the child. These effects are found in both high- and low-income settings.

Robust evidence shows that infants who are not breastfed are at higher risk of:¹³

- sudden infant death syndrome
- necrotising enterocolitis
- diarrhoea
- respiratory infections
- otitis media (ear infection)
- malocclusions
- overweight and obesity
- type 2 diabetes
- childhood leukaemia
- lower IQ

Studies show a dose-related response: fully formula-fed babies have the highest rates of sickness and

Maternal health benefits of breastfeeding^{10,11,12}



Credit: Public Health England. © Crown copyright 2016

hospitalisation; fully breastfed infants have the lowest.¹⁴ Breastmilk provides and supports the 'good bacteria' in a baby's gut, establishing a healthy microbiome which promotes a robust immune system. New research has expanded the field of epigenetics (genetic effects not encoded in the DNA of an organism) to include breastmilk and how it can change the epigenome (the way genes are expressed). This can affect the lifelong health of a baby and even future generations.¹⁵

Protecting mothers' health Research is revealing the impact of infant feeding on a mother's physical health and wellbeing. Breastfeeding resets her hormones after birth. In the short term, it helps reduce the risk of post-partum haemorrhage and delays the return to fertility. In the long term, it reduces the risk of breast, uterine and ovarian cancer, and of type 2 diabetes.¹⁷

When breastfeeding is going well it is protective of mothers' mental health, increasing resilience to stress and improving quality of sleep.¹⁸ Breastfeeding hormones have profound physiological effects on the mother's brain.¹⁹ These protective effects may enhance the experience of motherhood.

'In the UK we have excelled at placing barriers in the way of women who want to breastfeed, whilst at the same time insisting that "breast is best" – a lethal combination which sets women up to fail and then makes them feel really guilty about it.'

Sue Ashmore, Director Unicef UK Baby Friendly Initiative

Women can feel profound grief and guilt when they are unable to meet their own breastfeeding goals.²⁰ Many health professionals and policy-makers are parents too, so they can be influenced by their own experience. Encouragement of breastfeeding without skilled support available has in some quarters led to a backlash against the promotion of the practice.²¹ Mothers' descriptions of the grief they feel can be found in Part 2 of this report.²²

UK research shows that mothers who stopped breastfeeding before they were ready may have double the risk of postnatal depression.^{23,24}

Supporting women's choices

Women's voices should be one of the most powerful drivers behind strengthening policies and programmes in the UK. National surveys show that around 80% of mothers choose to breastfeed. By the time the child is 6 weeks of age, nearly 75% of mothers have introduced infant formula. Breastfeeding rates vary widely and decline sharply everywhere in the early weeks and months. By 6 months, although 34% of babies receive some breastmilk, only 1–2% are exclusively breastfed.²⁵

Thus, while 'most mothers in the UK want to breastfeed, most do not breastfeed for long. Repeated national Infant Feeding Surveys (IFSs) have shown that 90% of mothers who stopped breastfeeding in the first six weeks, and 60% of mothers who stopped by 8–10 months, wanted to breastfeed for longer.'²⁵

WHO states that 'virtually all mothers can breastfeed, provided they have accurate information, and the support of their family, the health care system and society at large'.²⁶

Cultural barriers in the UK

Despite promotional campaigns over the last 40 years, the cultural message remains that formula feeding is the 'normal' way to feed babies in the UK. Cultural barriers are complex and include embarrassment about feeding in public.²⁷

It has been shown that 'mothers prefer breastfeeding promotion aimed at their partners, families and throughout society'.²⁸

Reducing inequalities and supporting human rights

'Breastfeeding is a natural safety net against the worst effects of poverty. Exclusive breastfeeding goes a long way towards cancelling out the health difference between being born into poverty or being born into affluence. It is almost as if breastfeeding takes the infant out of poverty for those few vital months in order to give the child a fairer start in life and compensate for the injustices of the world into which it was born.'

James P. Grant, Executive Director of Unicef, 1980–1995

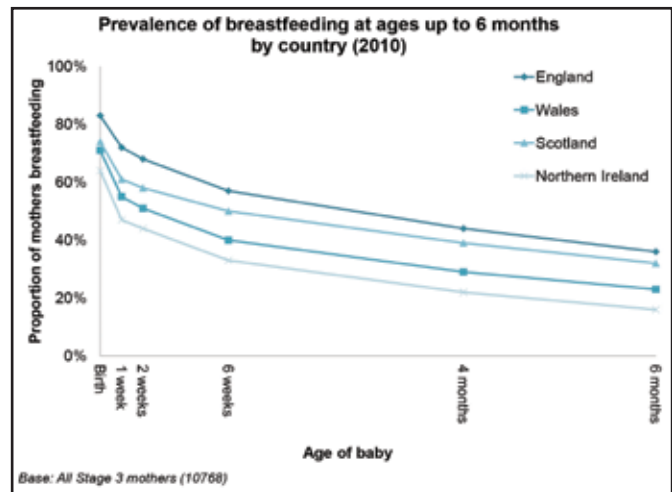
The mother and baby are a dyad, and they have rights as such. Each has explicit rights: both mother and baby require protection and support to make successful breastfeeding a reality.

Convention on the Rights of the Child The Convention on the Rights of the Child (CRC)²⁹ is an international treaty asserting that children must be viewed and treated as human beings rather than as passive objects of care and charity. Countries committed to the Convention are regularly audited on their obligations. In its 2016 UK report, the UN Committee on the Rights of the Child³⁰ expressed concern about

- the extremely low rate of breastfeeding in the UK;
- the fact that only 1% of women maintained exclusive breastfeeding for 6 months in 2010;
- the inadequate regulation of marketing of breastmilk substitutes.

The Committee urged the UK government to:

- promote, protect and support breastfeeding in all policy areas where it has an impact on child health, including obesity, certain non-communicable diseases and mental health;
- systematically collect data regarding food security and nutrition for children, including those that are relevant to breastfeeding, overweight and obesity, in order to identify the root causes of child food



Credit: *Infant Feeding Survey 2010, Figure 2.6*²⁵

- insecurity and malnutrition;
- fully implement the Code.

Infant feeding and inequality Breastfeeding rates vary widely across all four nations of the UK and within local communities, influenced by socioeconomic factors, culture and ethnicity. Formula feeding is widespread across the entire population, but it is generally young, poor, white British mothers who have the lowest breastfeeding rates.²⁵

Living in poor circumstances does not prevent parents from providing a loving and nurturing environment. However, children living in poverty are more likely to be exposed to complex social challenges.⁴ Research shows that babies who are not breastfed may be at higher risk of maternal neglect.³¹ Breastfeeding can provide the physical closeness and hormonal milieu to enhance emotional attachment, fostering the relationship and building the mother's confidence in her own mothering abilities.^{4,19}

Breastfeeding has a significant part to play in the government's efforts to reduce inequality^{32,33} and must be prioritised if we are to ensure that every child born in the UK has the opportunity to reach their potential, with optimal health and wellbeing.

The economy – reducing health and social care costs and the impact on national productivity

Infant feeding has a significant impact on the national economy.³³ In the UK, implementing interventions to improve breastfeeding outcomes could pay back within a year.¹²

The World Bank estimates that the global impact of not breastfeeding on cognitive development, human capital and national productivity is about 0.5% of gross national income per year in high-income countries.³⁵ It now includes breastfeeding as a key variable in assessing a country's economic health.³⁶ The cost to the National Health Service (NHS) of just five acute illnesses has been conservatively estimated at £48 million a year.¹²

‘If breastfeeding did not already exist, someone who invented it today would deserve a dual Nobel Prize in medicine and economics. For while “breast is best” for lifelong health, it is also excellent economics. Breastfeeding is a child’s first inoculation against death, disease, and poverty, but also their most enduring investment in physical, cognitive, and social capacity.’³⁶

Keith Hansen, Vice President for Human Development, World Bank

Obesity A recent meta-analysis suggests that breastfeeding is associated with a 13% reduction in the prevalence of child overweight or obesity, and is highly likely to be dose dependent – that is, the more breastfeeding, the lower the risk of obesity.³⁷ Child obesity in England costs around £51 million per year.³⁸

Family budgets Not breastfeeding entails considerable expense for families buying infant formula, bottles, teats, sterilising equipment and electricity. The price of standard powdered infant formula is currently 11p–26p per 100 ml, costing £30–£60 per month. Ready-to-feed milks cost considerably more.³⁹ Moreover, infants who are not breastfed have higher rates of illness, so parents need up to three times as much absence from work to care for their sick infant.⁴⁰

Sustainability and the environment

‘Infant feeding should be included in plans for sustainable food and development at every level.’⁴¹ Breastmilk is a fully sustainable food. Breastfeeding has no food miles, generates no greenhouse gases, requires no fuel and creates no pollution in manufacture, transport, storage or preparation. It is woven through all aspects of the Sustainable Development Goals, agreed by all countries including the UK, as shown by the World Alliance for Breastfeeding Action (WABA).⁴¹

Protecting families in emergencies

Breastfeeding provides food security for infants and young children during disasters, and immune protection against disease. All babies and young children are vulnerable, but formula-fed infants are particularly at risk if clean water and electricity are compromised.

Environmental cost of powdered milk

A kilogram of powdered milk generates:

- a carbon footprint of 21.8 kg of CO₂
- a water footprint of 4,700 l⁴²

Planning for safe infant feeding is a necessary part of emergency-preparedness plans at every level.

The UK is not immune to natural or man-made disasters. Flooding, contaminated water, terrorism and chemical/nuclear accidents can cause disruption to water or electricity supplies.^{43,44}

Protecting families from commercial exploitation

Breastfeeding is consistently undervalued. ‘It is a misconception that breastmilk can be replaced – that the benefits of breastfeeding only relate to poor countries. Nothing could be further from the truth.’⁴⁵

The promotion of breastmilk substitutes by manufacturers and distributors continues to be a substantial global barrier to breastfeeding. Promotion and marketing have turned infant formula from a specialised food for babies who cannot be breastfed into a food perceived as normal for any infant.⁴⁶

The 2016 MINTEL report on baby food and drink stated that sales of baby milk in the UK increased by £37 million between 2014 and 2016. Despite statements by WHO that follow-on milks are both unnecessary and unsuitable replacements for breastfeeding,⁴⁷ these products have had the biggest boost in terms of marketing spend in recent years. In 2015, for example, companies spent £16.4 million on follow-on formula marketing, which is approximately £21 for every baby born in the UK.⁴⁷

According to the MINTEL report, the main factor determining parental choice of milk was ‘brand’. This highlights the importance of developing ‘brand loyalty’. Companies spend considerable sums on advertising, conferences and study days, paying for travel, accommodation, meals and trips abroad to help maintain professionals’ loyalty to their brand.

A recent report reviewed the marketing of infant formula to healthcare professionals (HCPs) and found that advertising was frequently misleading and based on little or weak scientific evidence.⁴⁸

Report overview

The top joint recommendations for each WBTi indicator are listed in the UK Report Card, and the full set of recommendations can be found in the body of this report. Separate summary report cards for England, Northern Ireland, Scotland and Wales are included.

Examples of success and outstanding programmes across the UK are reported, but in many cases they are unevenly distributed. More work is required to ensure that families everywhere have access to high-quality support throughout their breastfeeding experience.

The BFI, for instance, is a world leader in the way it has centred its standards on the rights of the baby. Its high-quality curricula and HCP training reach far out of the hospital setting into the community.

The devolved governments of Scotland and Northern Ireland have made considerable commitments to improve breastfeeding rates and support for mothers.

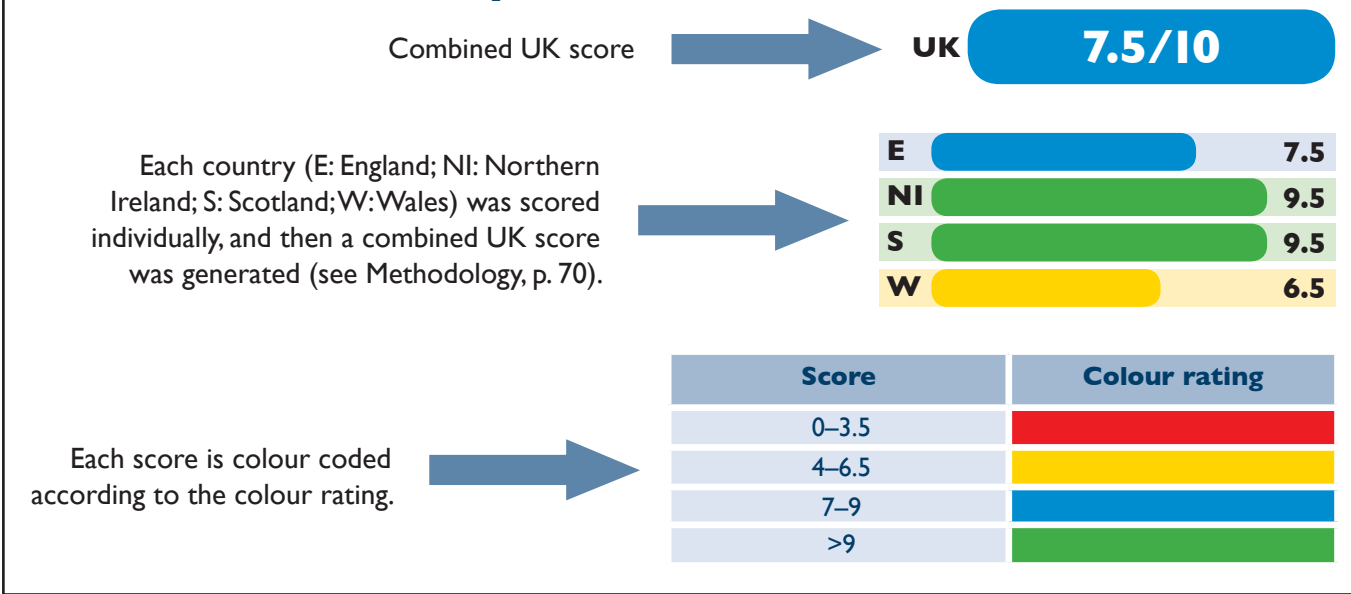
Other potential strengths include the high quality of support in some areas, especially when trained peer support is coordinated with continuity of care between midwifery and health visiting services, with access to specialists when required. However, these examples can

be isolated, and the future of the health visitor (HV) model, and many peer-support and community drop-in programmes, is currently uncertain.

To protect the health and wellbeing of mothers, babies, society and the environment, all families need enabling policies and access to skilled support at every step of their breastfeeding journey. Interventions must underpin the whole breastfeeding experience, including:

- birth in a supportive Baby Friendly-accredited maternity setting;
- access to skilled support in the community from HCPs, trained volunteers and mother support groups;
- a high standard of training and support through health and community services,
- strong protection of breastfeeding in the workplace and public life;
- robust regulation of the promotion of breastmilk substitutes;
- public awareness and support for breastfeeding throughout society;
- political will combined with strategy and coordination at the national level.

How to read this report



Country background

The UK comprises four countries: England, Northern Ireland, Scotland and Wales. Devolution has created a National Parliament in Scotland, a National Assembly in Northern Ireland and a National Assembly in Wales, while England is governed by the UK Parliament.

The devolution process started in 1999, when some powers were transferred from the UK Parliament to each of the four nations. Further powers continue to be transferred. These devolved powers concern matters such as education and health. There is universal access to public healthcare across the UK alongside some private provision.

Each country has its own breastfeeding strategies, policies and programmes, and so each requires a separate report card. Information specific to each country can also be found in subsections in the reporting of some indicators.

The total UK population is approximately 64 million. The most densely populated country is England, with 53 million inhabitants. Scotland has 5.3 million, Wales 3 million and Northern Ireland 1.8 million.⁴⁹ The UK scores in the report are weighted means, using population figures, so they are heavily influenced by the scores for England.

In 2014 there were approximately 700,000 births in England and Wales,⁵⁰ and more than a quarter of these were to mothers born outside the UK. There were about 55,000 births in Scotland⁵¹ and 24,000 in Northern Ireland⁵² in 2015.

Breastfeeding rates in the UK are among the lowest in Europe, with especially low rates among younger mothers, those in lower socioeconomic groups and those living in the north of England. These groups also have the poorest health and social outcomes. Higher breastfeeding rates among ethnic minorities, especially in London, may reflect immigration from countries with a stronger breastfeeding culture.²⁵

A detailed UK-wide IFS²⁵ was conducted across the UK every five years between 1970 and 2010, but it was discontinued before the 2015 survey began. However, Scotland is continuing with its own IFS. There is also some routine data collection in all four countries.



Statistics included in this report are based mainly on a combination of current data, where these exist, and information from the 2010 survey.

The 2010 IFS showed a small rise in the rate of breastfeeding initiation compared with the previous survey in 2005, and it reported that breastfeeding initiation was 81% overall in the UK. The rate was highest in England at 83%, followed by 74% in Scotland, 71% in Wales and 64% in Northern Ireland. However, both the IFS and routine data document a rapid fall-off in breastfeeding rates from birth, with the survey showing exclusive breastfeeding falling to 17% at 3 months and 1–2% at 6 months.

Statements supportive of breastfeeding from the four national departments of health can be found in Part 2.⁵³

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Indicators 1–10

Policies and programmes

Indicator 1

National policy, programme and coordination

UK

1/10



Key question *Is there a national infant and young child feeding/ breastfeeding policy that protects, promotes and supports optimal infant and young child feeding, and is the policy supported by a government programme? Is there a coordinating mechanism, such as a national infant and young child feeding committee and a coordinator for the committee?*

Background

Without national policy from its government, there is no guarantee of coordinated action to improve the situation in a country. In order to generate change, policy needs to have an associated strategy with an implementation plan. Monitoring is essential to check how implementation is progressing.

Since devolution in 1999, the UK has had four health systems. Thus health policy, strategy, implementation and monitoring have been delegated to the Scottish Government, Welsh Assembly and Northern Ireland Assembly, with the UK Government being responsible for England. The UK Department of Health (DH) is responsible for policy in England, Public Health England (PHE) is responsible for implementation, and the UK Government also runs the NHS in England.¹

England From 2008 to 2011 there was an infant feeding lead post and nine part-time employed regional leads.² Between 2008 and 2010 the DH (England) invested £7 million in local services in areas with marked inequality to support breastfeeding.³ From 2010 to 2011 there were cuts in funding, and the roles and investment ended.

Northern Ireland A national breastfeeding coordinator was appointed in 2002, followed by the

publication of *Breastfeeding – A Great Start: A Strategy for Northern Ireland 2013–2023* in 2013.⁴

Scotland Scotland was the first UK country to enact legislation protecting mothers feeding milk to a child under 2 years of age in public places (the Breastfeeding etc (Scotland) Act 2005).⁵ The national Maternal and Infant Nutrition Framework (MINF) document for strategy and action, *Improving Maternal and Infant Nutrition: A Framework for Action*, was produced in 2011.⁶

Wales The strategy document *A Strategic Vision for Maternity Services in Wales* was produced in 2011,⁷ and progress was reviewed in the *Reproductive and Early Years Pathfinder* progress report in 2012.⁸

Key findings

Public health policy across all four UK nations supports the *Global Strategy*⁹ in part and implementation varies between the four countries.

England The current DH policy on breastfeeding is unclear because the infant feeding recommendation of 2003 has been archived.¹⁰ The 2003 recommendation, reiterated in the National Institute for Health and Care Excellence (NICE) *Maternal and Child Nutrition* guidelines (2015), is EBF for the first 6 months, with breastfeeding then continuing alongside appropriate types and amounts of solid foods.¹¹ This is not fully in line with WHO recommendations, which explicitly suggest continued breastfeeding beyond 2 years.

Since 2011 there has been no national coordinator. From 2012 to 2015 there was a National Infant Co-ordinating Group/Breastfeeding System Group, set up by the DH,^{12,13} including representatives from Unicef UK BFI, two professional bodies (Royal College of Midwives and Institute of Health Visiting (iHV)), the National Infant Feeding Network (NIFN) and government departments. For more details, see Part 2.¹⁴

In 2012 the nine English regional infant feeding lead roles were dissolved as employed posts, but they continue as unfunded positions. NIFN, which is a network of infant feeding specialists operating through

Score table

Criteria	Possible score	E	NI	S	W	UK
I.1 A national IYCF/breastfeeding policy has been officially adopted/ approved by the government.	1	1	1	1	1	1
I.2 The policy recommends EBF for the first 6 months, complementary feeding to be started after 6 months and continued breastfeeding up to 2 years and beyond.	1	0	1	1	0	0
I.3 A national plan of action has been developed, based on the policy.	2	0	2	2	2	0
I.4 The plan is adequately funded.	2	0	2	2	1	0
I.5 There is a national breastfeeding committee/IYCF committee.	1	0	1	1	0	0
I.6 The committee meets, monitors and reviews on a regular basis.	2	0	2	2	0	0
I.7 It links effectively with all other sectors, such as health, nutrition and information.	0.5	0	0.5	0.5	0	0
I.8 It is headed by a coordinator with clear terms of reference, regularly communicating national policy at the regional, district and community levels.	0.5	0	0.5	0.5	0	0
Total score	/10	1	10	10	4	1

E: England; NI: Northern Ireland; S: Scotland; W: Wales; UK: United Kingdom (combined score)

regional meetings, was formed to enable sharing of evidence-based practice. It received some government funding for 2013–2015 but has not been funded since.

Northern Ireland Northern Ireland has a breastfeeding lead and a multi-stakeholder national breastfeeding committee, comprising government agencies and non-governmental organisations (NGOs), with clear workstrands. The Public Health Agency (PHA) leads implementation of the Northern Ireland Breastfeeding Strategy⁴ through a multi-disciplinary and inter-sectoral Breastfeeding Strategy Implementation Steering Group (BSISG). The country's NIFN receives funding from the PHA. For further details, see Part 2.¹⁴

Scotland IYCF policy is contained within the 2011 MINF⁶ that sets out a 10-year action plan. The framework is cross-sectoral, including health services, local government, employers, and the community and voluntary sectors. For further details, see Part 2.¹⁴ The breastfeeding recommendations are in line with WHO recommendations.⁶

The National Breastfeeding Committee, led by a breastfeeding coordinator, links with other sectors, and communicates policy at the regional and local levels.¹⁵ In 2016, Scotland hosted a meeting of infant feeding leads from all of the UK nations.¹⁵

Wales The Welsh *Infant Feeding Guidelines* recommend EBF up to 6 months, followed by continued breastfeeding alongside solid foods to 1 year and beyond.¹⁵

'The Welsh Government recognises the importance of breastfeeding and has tasked Public Health Wales,

Example of best practice

The European blueprint for action on breastfeeding provides a model national infant feeding policy, toolkits and recommendations developed specifically for a European context.¹⁹

*working in partnership with others, to address improving rates in Wales.'*¹⁷

Work is under way to develop an agreed all-Wales statement of strategic intent in relation to infant feeding, but the policy situation is currently unclear.¹⁸ In 2014, Public Health Wales reviewed its National Breastfeeding Programme, highlighting a need for a systems-based approach to have the greatest impact, with a focus on normalising breastfeeding in communities with low rates of the practice.

The Early Years Programme and the Nutrition and Obesity Prevention Programme will lead on the work, but without a dedicated national breastfeeding coordinator because the post was cut in February 2016. There is also no plan to have a national IYCF committee, but instead the work is to be included under the remit of a wider strategic group.¹⁸ For further details, see Part 2.¹⁴

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Gaps

- There is no established UK-wide infant feeding group for sharing good practice.
- **England** There is no national infant feeding strategy for England to implement WHO recommendations to protect, promote and support breastfeeding.
- **England** Funding for NIFN has been discontinued.
- **England** There are no clear current infant feeding recommendations.
- **England** There is no national paid sustainable leadership as there is no infant feeding committee or dedicated national coordinator.
- **Wales** There is no national paid sustainable leadership as there is no infant feeding committee or dedicated national coordinator.
- **Scotland and Northern Ireland** No gaps have been identified.

Recommendations

- The governments of the four home nations to set up a high-level, sustainable UK-wide infant feeding group, including representation of all the national infant feeding leads, to share good practice.
- **England** Government to set up a national, sustainable, strategic infant feeding committee, with multi-sectoral representation from government, health professional organisations and NGOs, coordinated by a high-level funded specialist lead.
- **England** The national strategic infant feeding body and specialist lead, once established, to develop and ensure implementation of a national infant feeding strategy for England, based on the *Global Strategy*.
- **England** Government to provide sustainable funding for NIFN.
- **England** The DH to set clear infant feeding recommendations based on WHO guidelines.
- **Wales** Government to set up a national, sustainable, strategic infant feeding committee, with multi-sectoral representation from government, health professional organisations and NGOs, coordinated by a high-level funded specialist lead.

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Indicator 2

Baby Friendly Initiative

UK

7.5/10

E	7.5
NI	9.5
S	9.5
W	6.5

Key questions What percentage of hospitals and maternity settings have been designated as ‘Baby Friendly’ based on global or national criteria? What is the quality of the Baby Friendly Hospital Initiative?

Background

The Baby Friendly Hospital Initiative (BFHI), launched by Unicef and WHO in 1991, provides evidence-based practice standards (the Ten Steps to Successful Breastfeeding), training programmes for staff and an accreditation process aimed at improving support for breastfeeding in healthcare settings. Research shows a strong association between implementation of the BFHI and increased breastfeeding rates.¹

The BFHI Ten Steps² include evidence-based practices, such as skin-to-skin contact during the first hour after birth, and keeping mothers and babies

together to enable breastfeeding to become effectively established,³ and avoidance of practices that undermine breastfeeding, such as non-medically indicated supplementation with breastmilk substitutes (BMSs).

The global BFHI criteria have been expanded in recent years to include support for mothers who are not breastfeeding and for those who are HIV positive.⁴ The new guidelines also recommend that Baby Friendly care be extended beyond the maternity setting into the community, so that mothers are supported to breastfeed exclusively for the first 6 months of their baby’s life.

In the UK the BFHI, known as the Baby Friendly Initiative (BFI), was adopted in 1994 by Unicef UK and expanded in 1998 to include its Seven-Point Plan for Sustaining Breastfeeding in the Community. In 2012 the UK BFI was further expanded to encompass neonatal units, early years community settings and universities providing education for midwives and HVs. For further details, see Part 2.⁵ These new standards aim to improve the health and wellbeing of mothers and babies – whether or not they are breastfeeding.⁶ The standards are based on evidence of the importance of

Current Unicef UK BFI standards for maternity units

Stage 1: Building a firm foundation

- Have written policies and guidelines to support the standards.
- Plan an education programme that will allow staff to implement the standards according to their role.
- Have processes for implementing, auditing and evaluating the standards.
- Ensure that there is no promotion of BMSs, bottles, teats or dummies in any part of the facility or by any of the staff.

Stage 2: An educated workforce

- Educate staff to implement the standards according to their role and the service provided.

Stage 3: Parents’ experiences of maternity services

- Support pregnant women to recognise the importance of breastfeeding and early relationships for the health and wellbeing of their baby.
- Support all mothers and babies to initiate a close relationship and feeding soon after birth.
- Enable mothers to get breastfeeding off to a good start.
- Support mothers to make informed decisions regarding the introduction of food or fluids other than breastmilk.
- Support parents to have a close and loving relationship with their baby.

Score table

Criterion	Possible score	E	NI	S	W	UK
2.1 Percentage of maternity facilities accredited as Baby Friendly. (%)						
0	0					
0.1–20	1					
20.1–49	2				2	
49.1–69	3	3				3
69.1–89	4					
89.1–100	5		5	5		
Total score	/5	3	5	5	2	3

Score table

Criteria	Possible score	E	NI	S	W	UK
2.2 BFHI programme relies on training of health workers using at least a 20-hour training programme.	1	1	1	1	1	1
2.3 A standard monitoring system is in place.	0.5	0.5	0.5	0.5	0.5	0.5
2.4 An assessment system includes interviews with healthcare personnel in maternity and postnatal facilities.	0.5	0.5	0.5	0.5	0.5	0.5
2.5 An assessment system relies on interviews with mothers.	0.5	0.5	0.5	0.5	0.5	0.5
2.6 Reassessment systems have been incorporated in national plans with a time-bound implementation.	1	1	1	1	1	1
2.7 There is/was a time-bound program to increase the number of BFHI institutions in the country.	0.5	0.5	0.5	0.5	0.5	0.5
2.8 Human immunodeficiency virus (HIV) is integrated into the BFHI programme.	0.5	0	0	0	0	0
2.9 National criteria are fully implementing global BFHI criteria.	0.5	0.5	0.5	0.5	0.5	0.5
Total score	/5	4.5	4.5	4.5	4.5	4.5
Total combined score, including score from table above	/10	7.5	9.5	9.5	6.5	7.5

E: England; NI: Northern Ireland; S: Scotland; W: Wales; UK: United Kingdom (combined score).

early care practices for the future wellbeing of children. They go beyond the Ten Steps and include a greater emphasis on early brain development and emotional attachment – an approach informed by the CRC.⁷

Since the introduction of BFI in the UK, tens of thousands of staff have been trained according to Baby Friendly standards, and UK breastfeeding initiation rates increased from 62% in 1990 to 81% in 2010.⁸ However, the extent of adoption of Baby Friendly standards varies across the four nations.

Key findings

Policy commitments to increase the number of Baby Friendly facilities vary greatly across the UK. Scotland and Northern Ireland both have strong, high-level commitments to ensure Baby Friendly accreditation. However, in England and Wales there is no leadership

Examples of best practice

- The BFI has developed new standards that go beyond global expectations.
- It now includes standards for maternity, health visiting, neonatal services and children's centres.
- It incorporates university standards for pre-registration midwifery and health-visiting programmes.
- Scotland and Northern Ireland have achieved 100% of births in Baby Friendly facilities.

or top-level policy commitment to increase such accreditation, although this is recommended by NICE as a minimum standard.⁹

New criteria to support facilities to embed the

Gaps

- **England and Wales** No mandate or dedicated funding to implement BFI nationally, and no time-bound expectation.

Recommendations

- **England** Government to mandate and fully fund time-bound implementation and maintenance of Baby Friendly standards in all healthcare settings. This requires working with DH, NHS England, PHE and Health Education England for Baby Friendly to be a service requirement.
- **Wales** Government to mandate and fully fund time-bound implementation and maintenance of Baby Friendly standards across all health boards. This requires working with Public Health Wales and NHS Wales.

Percentage Baby Friendly accreditation by service or training area, UK, 2016

Status	Maternity services	Health-visiting services	University midwifery programmes	University health-visiting programme
Fully accredited	58	62	36	15
Working towards accreditation	90	82	72	24

Births taking place in fully accredited Baby Friendly hospitals, 2016

Country	Percentage
England	52
Northern Ireland	100
Scotland	100
Wales	61

standards in a sustainable way are under development as part of the programme.

England The BFI has been endorsed in policy guidance, including NICE guidelines¹⁰ and the DH's top-level policy, the Healthy Child Programme.¹¹ This recommends 'adopting Unicef's Baby Friendly Initiative in all hospital and community providers', but there is no requirement to do so.¹²

Since October 2015, responsibility for commissioning health-visiting services in England has been handed over to local authorities, each of which decides whether or not to invest in Baby Friendly accreditation in the community and children's centres. Guidance on commissioning effective services was produced in July 2016 by PHE and Unicef UK.¹³

Northern Ireland The breastfeeding strategy for Northern Ireland, *Breastfeeding – A Great Start*,¹⁴ includes a commitment to achieve Baby Friendly accreditation in all maternity and community settings, and to support universities to achieve these standards

in their midwifery and health-visiting training courses.

All maternity units are now fully accredited. Some 80% of health-visiting services and 25% of Sure Start children's centres in Northern Ireland are accredited.

Scotland The Scottish Government's MINF¹⁵ includes a policy-level commitment to ensure full Baby Friendly accreditation of all maternity and health-visiting services. All maternity units are now fully accredited. All health-visiting services are either fully accredited or working towards accreditation. Neonatal units are not included in the framework but there is a commitment to them becoming Baby Friendly accredited, with funding to support this.¹⁶

Wales The Welsh Government's *A Strategic Vision for Maternity Services in Wales*¹⁷ endorsed the BFI as 'one mechanism for achieving better support for breastfeeding'. A commitment for all neonatal units in Wales to become Baby Friendly accredited was communicated by the first minister for Wales in 2012:¹⁸

'Universities providing midwifery, health visiting or neonatal nurse education in Wales will be encouraged to achieve the Unicef UK Baby Friendly University award ... There is an on-going commitment to support the Unicef UK Baby Friendly Initiative.'¹⁹

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Indicator 3

International Code of Marketing of Breastmilk Substitutes

UK

6/10

E		6
NI		6
S		6
W		6

Key questions *Have the International Code of Marketing of Breastmilk Substitutes and subsequent WHA Resolutions been implemented? Has any new action been taken to give effect to the provisions of the Code?*

Background

The Code was adopted by the WHA in 1981.¹ The Assembly is the world's highest health policy-setting body and is made up of the health ministries of member states. Subsequent Resolutions address changes in marketing practices and scientific knowledge, and questions of interpretation. Governments of the four nations of the UK have repeatedly endorsed the Code and subsequent Resolutions at the Assembly on each occasion when a new one is adopted. When reference is made to the Code, this automatically includes the subsequent Resolutions.

The *Global Strategy* calls for all governments to implement the provisions of the Code in their entirety.² The UN Committee on the Rights of the Child examines whether governments have implemented the Code when assessing progress in meeting their obligations under the CRC. The aim of the Code is to contribute to the provision of safe and adequate nutrition for infants through the protection and promotion of breastfeeding, and by ensuring the proper use of BMSs, when these are necessary, on the basis of adequate information and through appropriate marketing and distribution.

The provisions cover all BMSs, feeding bottles and teats, and they address aspects of the marketing of baby foods. They prohibit free and low-cost supplies. The 2005 Resolution states: 'ensure that financial support and other incentives for programmes and health professionals working in infant and young child health do not create conflicts of interest'.³

The Code

The Code does not prevent formula from being sold but from being promoted. It aims to protect breastfeeding and the right to accurate information.

What does the Code cover?

- formula milk;
- any food or drink that would substitute for breastfeeding (such as teas or foods aimed at babies under 6 months, or baby milks aimed at any age);
- bottles;
- teats.

Who/what does the Code apply to?

- governments;
- manufacturers, distributors and retailers of any of these items;
- health workers, professional or non-professional, particularly those concerned with maternal and infant nutrition;
- healthcare facilities (i.e. hospitals, clinics etc).

Key findings

The Infant Formula and Follow-on Formula Regulations (2007),⁴ which have been implemented separately, but identically, by the four countries of the UK, derive from European Commission Directives 2006/141/EC and 1999/21/EC (these replaced regulations similarly derived from earlier European Union (EU) directives and will be replaced with updated regulations in the near future). The regulations contain restrictions on the promotion of infant formula that have similarities to some of the provisions of the Code, but these do not apply to all BMSs or to baby foods. There are no regulations that address the marketing of feeding bottles and teats.

EU Regulation 609/2013 on Food Intended for Infants and Young Children, Food for Special Medical Purposes, and Total Diet Replacement for Weight Control came into force across the EU on 20 July 2016,⁵ implemented separately by the countries of the UK by statutory instruments (SIs). The SIs continue to give force to

Score table

Criteria (legal measures that are in place)	Possible score	E	NI	S	W	UK
3a Status of the Code (highest score is recorded)						
3.1 No action taken.	0					
3.2 The best approach is being considered.	0.5					
3.3 National measures awaiting approval (for not more than 3 years).	1					
3.4 Few Code provisions as a voluntary measure.	1.5					
3.5 All Code provisions as a voluntary measure.	2					
3.6 Administrative directive/circular implementing the Code in full or in part in health facilities with administrative sanctions.	3					
3.7 Some articles of the Code as law.	4	4	4	4	4	4
3.8 All articles of the Code as law.	5					
3.9 Relevant provisions of WHA Resolutions subsequent to the Code are included in the national legislation:						
a Provisions based on at least two of the WHA Resolutions as listed below are included.	5.5					
b Provisions based on all four of the WHA Resolutions as listed below are included.	6					
3b Implementation of the Code/national legislation						
3.10 The measure/law provides for a monitoring system.	1	1	1	1	1	1
3.11 The measure/law provides for penalties/fines to be imposed on violators.	1	1	1	1	1	1
3.12 Compliance with the measure is monitored and violations reported to concerned agencies.	1					
3.13 Violators of the law have been sanctioned during the last 3 years.	1					
Total score (3a + 3b)	/10	6	6	6	6	6

E: England; NI: Northern Ireland; S: Scotland; W: Wales; UK: United Kingdom (combined score)

the existing national regulations deriving from the earlier directives until specific EU delegated acts for each product category come into effect in 2020/2021. These measures continue to be narrower than the Code – for example, by allowing follow-on formula to be promoted. The SIs in England, Northern Ireland and Wales introduce an Improvement Notice regime, whereby enforcement officers can issue notices relating to composition, labelling, advertising and presentation. It will be a criminal offence not to comply with an Improvement Notice by the specified deadline. Scotland is not introducing a warning system and breaches can proceed straight to prosecution.

In the past, governments have claimed that they cannot fully implement the Code owing to EU regulations being narrower, although this is disputed by some legal experts. One EU country has already gone further than EU directives in prohibiting the advertising of follow-on formula. The vote on 23 June 2016 for the UK to leave the EU will, at some point, remove the apparent barrier to full Code implementation that is presented by EU membership.

Some, but not all, health organisations have policies regarding conflicts of interest and sponsorship by baby feeding companies. The DH and some health professional organisations are involved in partnerships

with manufacturers and distributors of products within the scope of the Code.

The failure to prevent the promotion of all BMSs means that the prohibition of infant formula promotion is also ineffective. Companies cross-promote infant formula by using the same brand on their follow-on milks and so-called 'growing-up' milks. The WHA and the NHS have both stated that these products are unnecessary. The advertising of these items for older babies effectively promotes the full range. Brands are also promoted through company mother and baby clubs, which are prohibited by the Code, and are used to gather contact details for marketing purposes.

Associated guidance notes⁶ issued by the DH include some provisions to stop promotion and cross-promotion of brand names, but these are not enforced. There have been no prosecutions for practices that break the law in the last 13 years, even when both the responsible enforcement authorities (e.g. Trading Standards) and the companies involved acknowledge that the law has been broken. The only prosecution was in 2003 under the previous regulations (introduced in 1995), where a company was convicted and fined for a 'cynical and deliberate breach of the regulations'. This pre-dates the 3-year window to gain a score under criterion 3.13. However, since 2009 the budget for

Examples of violations



▲ The UK Regulations prohibit idealising text and images on labels, but these are commonplace. Companies label the products identically to make them cross-promotional.



▲ These two screenshots, from television and internet advertising for follow-on milk, suggest that babies fed on the formula develop the balance, strength and stamina of a ballerina, and the mental skills of a mathematical genius.



◀ Danone gives a branded bear as a gift to pregnant women and new mothers to encourage them to join its parenting club. Emails are sent to members of clubs, timed to key dates during pregnancy and the child's development after being born – for example promoting a formula starter kit to pregnant women close to their due date). ►



Gaps

- The International Code and Resolutions are not fully implemented in the UK because most provisions of the regulations in place apply only to infant formula.
- Some health worker organisations and government programmes permit inappropriate conflicts of interest.
- Labelling of baby foods is not adequately addressed by legislation.
- Enforcement of existing regulations is lacking. European delegated acts introduced in 2016 and to be implemented in the UK are also not in line with the Code.

Recommendations

- Fully implement the International Code and subsequent, relevant WHA Resolutions in legislation covering:
 - all products promoted for use to 6 months of age;
 - follow-on formula (marketed for use from 6 months) and other milks for older babies;
 - feeding bottles and teats.
- Resolutions on ensuring there are no conflicts of interest in funding of health workers and health programmes to be respected by health worker organisations and in government programmes.
- Legislation to include labelling of baby foods, which should not be labelled for use before 6 months of age or include health and nutrition claims.
- The responsible authorities to take coordinated action to enforce the Regulations (2007).
- Government in each nation to introduce regulations and policies that fully implement the Code while working to bring EU delegated acts into line with the Code and ensure they do not present obstacles to full implementation.

Trading Standards services in England and Wales has been reduced by more than 40%, and staffing levels have decreased by approximately 53%.⁷

Preliminary findings from this WBTi report were submitted to the UN Committee on the Rights of the Child when it was assessing the UK in 2016, along with a monitoring report produced by Baby Milk Action.⁸

The Concluding Observations in June 2016 stated:

‘The Committee is concerned about the ... inadequate regulation of marketing of breastmilk substitutes ... [It] recommends that the State party [e.g. the UK] fully implement the [International Code, including the subsequent Resolutions].’⁹

In its last two reports on the UK (2002¹⁰ and 2008¹¹), the Committee also called for the UK to implement the Code, noting in 2008 that violations are common.

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Indicator 4

Maternity protection

UK **6.5/10**

E	6.5
NI	6.5
S	6.5
W	6.5

Key question *Is there legislation and are there other measures (policies, regulations, practices) that meet or go beyond the International Labour Organization standards for protecting and supporting breastfeeding for mothers, including those working mothers in the informal sector?*

Background

Protection for pregnant women and mothers of young children who are employed, through legislation, policies, regulations and working practices, enables mothers to continue breastfeeding, thereby minimising health risks and providing protection from discrimination. Mothers who are breastfeeding need breaks at work during which they can breastfeed their baby or express their milk, along with associated facilities.

Current international recommendations (ILO 2000) specify that women in employment should receive:

- health protection, job protection and non-discrimination for pregnant and breastfeeding women;
- at least 14 weeks of paid maternity leave;
- one or more paid breastfeeding breaks daily or daily reduction of hours of work to breastfeed.¹

Globally, much has been achieved, with a trend of stronger maternity entitlements and more country initiatives improving national laws and practices. However, further change is needed and World Breastfeeding Week 2015 revisited the theme.² A number of NGOs in the UK used the opportunity to raise awareness, both of existing resources and the need for legal protection for employed mothers who are breastfeeding.

Maternity protection for all women implies that women working in the informal economy should also be protected. However, globally, further progress to increase support for women working in the non-formal sector to breastfeed has been minimal. The Innocenti

Declaration update in 2005³ called for urgent attention to the special needs of women in the non-formal sector, and further monitoring of its application consistent with Maternity Protection Convention No. 183, 2000 and Recommendation 191 of the International Labour Organization (ILO), which encourage facilities for breastfeeding to be set up at or near the workplace.⁴

Healthy mothers contribute to family income and job security, employers' long-term profits, and a nation's socioeconomic health and stability.

Key findings

Maternity leave and pay

The UK has good legislation in place to protect maternity (and paternity) rights in terms of paid leave and shared parental leave (Maternity and Parental Leave Regulations 1999, Shared Parental Leave Regulations 2014). The legislation provides for up to 52 weeks' maternity or shared leave and 2 weeks' paternity leave.⁵

Statutory Maternity Pay (SMP) is paid for 39 weeks to employees who are eligible but, after the first 6 weeks, it is payable at a rate which is the lower of SMP or 90% of average weekly earnings.⁶ Women on low incomes can claim Maternity Allowance (paid at the same rate as SMP, currently £139.58 per week) for 39 weeks if they do not qualify for maternity pay from their employer. Both are below the National Minimum Wage for a full-time worker aged over 18.

The organisation Crossroads Women has observed that the low rate of maternity pay is a major disincentive for mothers to take prolonged maternity leave, so they return to work sooner than they would choose. Work can be difficult to combine with breastfeeding but mothers often assume the two are incompatible. Few women are aware that they are entitled to special considerations if breastfeeding.⁷

There is no legislation mandating the provision of paid breastfeeding breaks. If these are in place they are informal and voluntary arrangements with employers. Maternity Action, which works for women's rights, says:

'If your employer refuses to give breastfeeding breaks, see if you can use your lunch or other breaks or take them at a slightly different time. If

Score table

Criteria	Possible score	E	NI	S	W	UK
4.1 Women covered by the national legislation are allowed the following weeks of paid maternity leave (choose one): a any leave less than 14 weeks; b 14–17 weeks; c 18–25 weeks; d 26 weeks or more.	0.5 1 1.5 2	2	2	2	2	2
4.2 Women covered by the national legislation are allowed at least one breastfeeding break or reduction of work hours daily (choose one): a unpaid break; b paid break.	0.5 1	0	0	0	0	0
4.3 Legislation obliges private-sector employers of women in the country to (more than one may apply): a give at least 14 weeks paid maternity leave; b paid nursing breaks.	0.5 0.5	0.5 0	0.5 0	0.5 0	0.5 0	0.5 0
4.4 There is provision in the national legislation that provides for workplace accommodation for breastfeeding and/or childcare at work in the formal sector (more than one may be applicable): a space for breastfeeding/breastmilk expression; b crèche.	1 0.5	0 0	0 0	0 0	0 0	0 0
4.5 Women in the informal/unorganised and agriculture sector are (choose one): a accorded some protective measures; b accorded the same protection as women working in the formal sector.	0.5 1	1	1	1	1	1
4.6 (More than one may be applicable): a Information about maternity protection laws, regulations or policies is made available to workers. b There is a system for monitoring compliance and a way for workers to complain if their entitlements are not provided.	0.5 0.5	0 0.5	0 0.5	0 0.5	0 0.5	0 0.5
4.7 Paternity leave is granted in the public sector for at least 3 days.	0.5	0.5	0.5	0.5	0.5	0.5
4.8 Paternity leave is granted in the private sector for at least 3 days.	0.5	0.5	0.5	0.5	0.5	0.5
4.9 There is legislation providing health protection for pregnant and breastfeeding workers: they are informed about hazardous conditions in the workplace and provided with alternative work at the same wage until they are no longer pregnant or breastfeeding	0.5	0.5	0.5	0.5	0.5	0.5
4.10 There is legislation prohibiting employment discrimination and assuring job protection for women workers during the breastfeeding period.	1	1	1	1	1	1
Total score	/10	6.5	6.5	6.5	6.5	6.5

E: England; NI: Northern Ireland; S: Scotland; W: Wales; UK: United Kingdom (combined score)

your employer refuses a request to change your hours to enable you to continue breastfeeding, seek advice about indirect sex discrimination.⁸

Employees have some health and safety protection during pregnancy and for up to 6 months after their child's birth or for as long as they are breastfeeding, but this is hard to enforce if employers do not comply. Employees are entitled to 'reasonable adjustments' to working conditions or hours of work. If health and safety risks remain they are entitled to be offered suitable alternative work or to be suspended on full pay. Failure to comply could be classed as pregnancy or maternity discrimination. Refusal to make adjustments to allow breastfeeding at work could be

regarded as sex discrimination. A refusal to allow a woman to change her hours of work to enable her to continue breastfeeding could be deemed indirect sex discrimination.

Under the Equality Act 2010, it is unlawful for businesses and service providers to treat a woman unfavourably because she is breastfeeding.⁹ Employers must ensure that employees and other members of the public do not practice such discrimination.

Thus there is protection from discrimination on the grounds of pregnancy, childbirth and maternity leave, and from less favourable treatment for breastfeeding in a public place. However, employment tribunal fees were introduced in 2013 (except in Northern Ireland)



and it now costs £1200 to bring a discrimination claim. Employment tribunal fees constitute a significant financial barrier to accessing justice. The number of employment tribunal claims decreased by 70% following introduction of the fees.¹⁰ For details of the easyJet breastfeeding ruling in 2016, see Part 2.¹¹

Facilities for rest and for expressing/ breastfeeding

There is a specific entitlement under the Workplace (Health, Safety and Welfare) Regulations 1992 to access to rest facilities for both new and expectant mothers.¹² The Health and Safety Commission's (HSC's) guidance for employers concerning new and expectant mothers at work states: 'It is good practice to provide a healthy and safe environment for nursing mothers to express and store milk', although there is no legal requirement to do so.¹³ 'These facilities could be included in the suitable resting facilities you must provide for pregnant and breastfeeding mothers.' Although it is private, the toilet is never a suitable place in which to breastfeed a

Example of best practice

Northern Ireland Public Health provides excellent information for employers regarding support for breastfeeding mothers, but the government has not legislated for breaks.²⁰

baby, or to express and collect milk.

There is no legal protection for breastfeeding in the workplace. An amendment to the parental leave bill proposing breastfeeding breaks¹⁴ failed, but the UK Government then commissioned both the Advisory, Conciliation and Arbitration Service (Acas)¹⁵ and Maternity Action to produce guidance for employers. The latter includes the business case for accommodating breastfeeding.¹⁶ Maternity Action also produces information for employees.¹⁷ The Breastfeeding Network and NCT (formerly the National Childbirth Trust) have information on their

Gaps

- No legally required provision for breastfeeding breaks or breastfeeding facilities in workplaces and educational institutions.
- Access to employment tribunals is limited by high fees.
- Monitoring of provision for employees is provided by charities such as Maternity Action, not government agencies.
- The minimum rates of maternity pay and maternity allowance are below the minimum wage.

Recommendations

- Governments to legislate for reasonable breastfeeding breaks and suitable facilities for breastfeeding/expressing in workplaces and educational institutions.
 - Governments to ensure that tribunal access is available to women from all income brackets.
 - Government agencies to monitor provision for employees.
 - Governments to raise the minimum rate of maternity pay and maternity allowance to the recommended minimum wage level.
- Note:* Northern Ireland has no Equality Act, so women need to seek redress through the Sex Discrimination Act 1976.

websites about breastfeeding and employment.^{18, 19}

Although some large employers with a sizeable proportion of female workers have invested in providing excellent support for their employees who are breastfeeding, they seem to be the exception rather than the rule.

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Indicator 5

Health professional training

UK

5.5/10

E		5.5
NI		5.5
S		6
W		5.5

Key questions *Do care providers in these systems undergo skills training, and do their pre-service education curricula support optimal infant and young child feeding? Do these services support mother- and breastfeeding-friendly birth practices? Do the policies of healthcare services support mothers and children, and set out health workers' responsibilities under the Code?*

Examples of best practice

- The UK BFI has established accreditation for university midwifery and health-visiting pre-registration courses, which if universally adopted would provide consistent basic training in infant feeding.¹⁶
- More specifically, a London-wide practice assessment document for student midwives is available that incorporates the NMC's essential skills clusters in relation to infant feeding and the new BFI standards.
- WHO has published *Infant and Young Child Feeding: Model Chapter for Textbooks for Medical Students and Allied Health Professionals*.¹⁷

Background

In the UK, health practitioners who work closely with mothers, infants and young children (primarily midwives, nurses, HVs, general practitioners (GPs), paediatricians, obstetricians, maternity support workers and sometimes pharmacists and dieticians) have a crucial role to play in enabling optimal infant feeding, but they need to be trained in the relevant skills and knowledge. This should be covered in pre-registration training, with opportunities for further learning through in-service training.

Key findings

Standards and curricula for pre-registration health worker training

Broad, high-level standards are set by the Nursing and Midwifery Council (NMC) for the training of midwives,¹ nurses² and specialist community public health nurses (SCPHNs) across the UK.³ Training in one branch of nursing – adult, mental health, disabilities or children's (paediatric) – enables a nurse to become registered. They may then specialise further – for example, as a neonatal or practice nurse. Specific training enables a SCPHN to be a HV, school nurse, occupational health nurse or family nurse, or they may work in more

general public health roles. Helping with breastfeeding is a significant part of the role for midwives, HVs and neonatal nurses.

For undergraduate medical training, the General Medical Council (GMC) sets the high-level outcomes.⁴ Following graduation, medical students follow a two-year practice-based Foundation Programme⁵ and then specialise. The GMC approves and publishes the specialist curricula, which are produced by the relevant royal colleges – that is, the Royal College of Paediatrics and Child Health (RCPCH),⁶ the Royal College of General Practitioners (RCGP)^{7,8} and the Royal College of Obstetricians and Gynaecologists (RCOG).⁹ GPs and paediatricians in particular have contact with mothers with babies and young children, so it is crucial that pre-registration training covers IYCF adequately.

In mapping standards and curricula against the WHO Education Checklist, considerable variation was found. The checklist is drawn from WHO's own tool for assessing implementation of the *Global Strategy*.¹⁰ It is of concern that most universal minimum standards of pre-registration training for HCPs who work with mothers and babies, including HVs, GPs, paediatricians and dietitians, show significant gaps, with infant feeding sometimes not being mentioned at all. Of particular concern are the NMC's nursing and health-visiting

Score table

Criteria	Possible score	E	NI	S	W	UK
5.1 A review of health provider schools and pre-service education programmes for health professionals, social and community workers in the country indicates that IYCF curricula or session plans are adequate/inadequate.	Y = 2, SD = 1 N = 0	1	1	1	1	1
5.2 Standards and guidelines for mother-friendly childbirth procedures and support have been developed and disseminated to all facilities and personnel providing maternity care (see Part 2 for WBTi Annex 5b, 'Example of Criteria for Mother-Friendly Care').	Y = 2, SD = 1 N = 0	2	2	2	2	2
5.3 There are in-service training programmes providing knowledge and skills related to IYCF for relevant health/nutrition care providers.	Y = 2, SD = 1 N = 0	1	1	1	1	1
5.4 Health workers are trained in their responsibility under the Code implementation/national regulation throughout the country.	Y = 1, SD = 0.5, N = 0	0.5	1	1	1	0.5
5.5 IYCF information and skills are integrated, as appropriate, into training programmes focusing on diarrheal disease, acute respiratory infection, integrated management of childhood illness, well-child care, family planning, nutrition, the Code, HIV, breast cancer, women's health, non-communicable diseases etc.	Y = 1, SD = 0.5, N = 0	0.5	0	0.5	0	0.5
5.6 In-service training programmes referenced in 5.5 are being provided throughout the country.	Y = 1, SD = 0.5, N = 0	0	0	0	0	0
5.7 Child health policies provide for mothers and babies to stay together when one of them is sick.	Y = 1, SD = 0.5, N = 0	0.5	0.5	0.5	0.5	0.5
Total score	/10	5.5	5.5	6	5.5	5.5

E: England; NI: Northern Ireland; S: Scotland; W: Wales; UK: United Kingdom (combined score); Y: yes; SD: to some degree; N: no

(SCPHN) standards, especially if the HV had not previously qualified as a midwife. (For more information about Baby Friendly-accredited pre-registration training, see Indicator 2.)

A crucial role is played by infant feeding advisers, who are often midwives in hospital settings and HVs in community settings. Some are also International Board Certified Lactation Consultants (IBCLCs) or have undergone extensive Baby Friendly training, but there is no standard job description, competency framework, training standards, mentoring or regulation.

While specialist medical training covers some aspects of breastfeeding knowledge, there are many gaps, particularly in the practical aspects of what constitutes effective attachment at the breast, and maintaining breastfeeding when mother and baby are separated. The RCPCH does recognise the need for a strengthened breastfeeding outcome in the revised training, which is due to be available in 2018.¹¹

There are some basic topics which are not included in the curricula of the royal colleges but that may be covered at undergraduate level. However, it is unclear whether all medical schools cover them because each produces its own curriculum (within the broad minimum GMC standards).

The General Pharmaceutical Council (GPhC) sets high-level standards for pharmacy training, which do not mention infant feeding explicitly, although it would

be covered in some syllabus topics.^{12,13} Yet there are many reports of mothers receiving incorrect advice about medication during lactation from pharmacists and other health professionals, such as the findings of the MatExp online survey.¹⁴

Undergraduate dietitian training courses are accredited by the British Dietetic Association, which provides a curriculum framework.¹⁵ However, the infant feeding content would need to be greater to provide a more thorough basic understanding. Dietitians specialising in paediatrics undertake postgraduate master's-level modules, which include infant feeding, but the various training courses do not have a common curriculum.

The table overleaf shows a comparison of the high-level standards or competencies for training of relevant health professions, with IBCLC¹⁸ and breastfeeding counsellor training included for comparison. It shows mapping of the standards/competencies of each profession against a majority of the objectives, specifically those concerned with breastfeeding, in the WHO Education Checklist, used by WBTi in assessments.¹⁹ Interpretation is involved in assessing whether the standards/competencies of a particular profession address a specific objective, so the mapping can only indicate the extent to which minimum standards match the checklist objectives. Further details of the mapping are available in Part 2.²⁰

How well does pre-registration health professional training ...

	Factors influencing infant feeding	Antenatal care	Perinatal care	Process of milk production and removal	Benefits of optimal infant feeding	Guidance for successful breastfeeding	Management of common feeding problems
Midwife							
Nurse						e	
SCPHN (NMC standards)						f	
SCPHN (BFI-accredited course)							
Paediatrician	a						h
Obstetrician	a	c		a	a	g	i
GP	a			a			j
Dietitian (general)	b						
IBCLC							
BFC		d					

■ included
 ■ not included
 ■ unclear/partial
 ■ not applicable

a: The topic is not mentioned in the standards or syllabus for the specialism but may be included in the undergraduate syllabus

b: Principles covered but explicit mention of infant feeding only in paediatric dietitian training

c: Only breast examination mentioned

d: BFC provides antenatal preparation but not breast examination

e: Nurse supports breastfeeding in liaison with a registered midwife

f: Only mention of breastfeeding in standards is that a registered SCPHN (includes HV) may set up a health-promotion programme, such as a breastfeeding support scheme

g: Obstetrician devolves care to and supports midwifery colleagues

h: Paediatrician recognises common breastfeeding problems and refers appropriately

... match the WHO Education Checklist for lactation?

Babies with special needs (e.g. premature)	Facilitate successful lactation with maternal medical conditions/ treatments	Prescribe/ recommend medications compatible with lactation	Sustain lactation when mother and baby are separated	International Code and health worker responsibilities	Preventing or reducing mother-to-child HIV transmission	IYCF in emergencies
				o		
	k					
	l	m			p	
					q	s
		n				
		n			r	r

i: Obstetrician syllabus includes breast problems but unclear whether this includes breastfeeding

j: Aware of neonatal problems, such as jaundice and colic

k: Curriculum states support for diabetic mothers; some courses include training to prescribe ('nurse prescribing')

l: Syllabus mentions management of mastitis only

m: Safe prescribing in undergraduate curriculum and lactation to be included for obstetricians in curriculum rewrite

n: IBCLCs and BFCs do not prescribe or recommend medications but understand their effects

o: The Code is not mentioned in midwifery standards but is included in BFI-accredited training

p: Obstetrician curriculum includes HIV risk assessment; HIV and feeding options to be included in the future

q: Dietitian training does not mention HIV but some have specialised in this in relation to infant feeding

r: La Leche League GB is the only national breastfeeding support charity explicitly covering HIV and infant feeding

s: Dietitian training does not mention emergencies, but some have become skilled through working with immigrants

Gaps

- Most pre-registration training for HCPs who work with mothers, infants and young children (midwives, nurses, HVs, paediatricians, GPs, obstetricians, dieticians, pharmacists, maternity support workers) has many gaps in relation to the WHO Education Checklist³⁵ in high-level standards and curricula. Where there are many gaps, the breastfeeding knowledge included tends to be theoretical rather than the practical aspects of enabling mothers to initiate and continue breastfeeding.
- For medical professionals, pharmacists and nurses there is inadequate training on the effect of medications on breastfeeding.
- Infant feeding leads often do not have an infant feeding qualification.
- There is limited provision and take-up of in-service training in IYCF, and it is optional unless midwives and HVs are employed by trusts and boards that already have Baby Friendly accreditation or are working towards it. For example, there is low take-up of the short Baby Friendly online training for paediatricians and GPs. Baby Friendly accreditation only requires induction training in the infant feeding policy for doctors such as obstetricians and paediatricians.
- The Code is not explicitly mentioned in any code of conduct by the regulatory bodies, and professional organisations' policies are not in line with it. Sponsorship of some study events violates the Resolutions on avoiding conflicts of interest.
- No national policies for infants or toddlers to stay in hospital with their hospitalised mothers, or for parents to stay with their hospitalised babies (when medically possible), especially in neonatal intensive care unit (NICU) settings, resulting in inconsistency between hospitals.
- Access to skilled help with breastfeeding is variable on adult and children's wards..

Recommendations

- 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 all HCPs who work with mothers, infants and young children (primarily midwives, nurses, HVs, paediatricians, GPs, obstetricians, dieticians and pharmacists) and associated support workers.* These standards to align with WHO/BFI standards. Such training needs to include practical aspects of enabling breastfeeding as well as theory.
- Specific training on medications and their effect on breastfeeding for medical professionals, pharmacists and nurses, including accessing appropriate sources of information and guidance.
- Trusts and boards to require infant feeding leads to have an infant feeding qualification.
- Post-registration training through implementation of Baby Friendly standards across all relevant healthcare facilities to ensure minimum levels of in-service training in IYCF, including separate basic standards for paediatricians and GPs, with assessment and mentoring.
- The Code to be upheld by all health professional organisations in their policies and professional codes of conduct, and to be included in training. Revalidating bodies not to accept hours/education credits from study events for health workers where sponsorship or other corporate involvement creates a conflict of interest (e.g. by manufacturers and distributors of products within the scope of the Code).
- National guidance to be developed by individual governments to support babies/young children and their mothers staying together when either is hospitalised, where medically possible.
- Improved training for staff to support breastfeeding/continued lactation when either mothers or babies are hospitalised.

*Already achieved for NMC midwifery standards and Baby Friendly-accredited university courses.

Standards and guidelines for mother-centred childbirth procedures and support

Childbirth practices impact on the initiation of breastfeeding. Guidance for practice in England is provided by NICE through guideline CG190, Intrapartum care for healthy women and babies (2014), which followed a review of the 2007 guidance.²¹

The NICE guidance (which is good-practice guidance, not mandated policy) covers all the WHO criteria,²⁰ except that there is no explicit statement on staff understanding that there is a continuum of care for mother and baby. Scotland's MINF mentions person-centred, safe and effective maternity care.²² The Welsh vision for maternity services includes:



‘place the needs of the mother and family at the centre so that pregnancy and childbirth is a safe and positive experience and women are treated with dignity and respect’.²³

With regard to training, the NMC standards for midwifery give a good match to the criteria, with the only gap being the lack of mention of birth companions. The RCOG believes strongly in the importance of mother-centred care.²⁴

Overall, the standards and guidelines support a mother-centred approach. Whereas WBTi documents use the term ‘mother-friendly’, in the UK ‘mother-centred’ is used, but the terms mean the same.

In-service training programmes

Any maternity unit or community facility that is working towards Baby Friendly accreditation is required to provide training for its midwives/HVs. While the majority of maternity units (91%) and health-visiting services (83%) have achieved or are working towards Baby Friendly status, the remainder have not commenced the process, 20 years after the start of the Baby Friendly programme in the UK²⁵ (see Indicator 2). There is limited availability of other continuing professional development (CPD) training on infant feeding. There are significant differences between the countries. For example, in Scotland and Northern Ireland, all maternity units are Baby Friendly accredited.

Examples of best practice

- In-service training is required for working towards Baby Friendly accreditation.²⁶
- Scotland: All health boards are being issued with access to the BFI package for paediatricians.

There are short (30 minute) online training programmes produced by the BFI for paediatricians and GPs. The low uptake of this is disappointing, particularly in view of the limited pre-registration training.

Code training

The Code is not mentioned in the training standards and competences of the specific health professions considered. Baby Friendly, IBCLC and breastfeeding counsellor training include the Code.

The only mention found in relevant policies or codes of conduct^{27,28,29} of professional bodies was the 2005 sponsorship policy of the British Association of Perinatal Medicine, an affiliated specialist society of RCPCH, which appears to have adopted the 2005 International Pediatric Association guidelines.³⁰ Breastfeeding specialists, such as IBCLCs,³¹ the breastfeeding support voluntary organisations and infant feeding adviser networks, do include the Code in

their codes of conduct.

Not only is there a lack of training of health workers about the *Code* but there is also sponsorship by the baby feeding industry of some health professional conferences and study days. The International Board of Lactation Consultant Examiners (IBCLE) and the voluntary breastfeeding support organisations do not accept CPD for education events provided by the baby feeding industry.

Other training programmes

Other medical specialties were reviewed, and mentions of breastfeeding and infant feeding were found to be very limited. Family planning³² and breast cancer³³ in-service training do not mention breastfeeding.

Child health policies to keep mother and baby together

Newborns It is standard practice in maternity units for mothers and babies to be together, but not in neonatal units. However, the expansion of BFI standards to neonatal units is gaining momentum across the UK.

Children in hospital There is a long history of an expectation of unrestricted visiting by parents in the UK. The charity Action for Sick Children's Charter for Children's Health Services recommends that 'Every hospital admitting children should provide overnight accommodation for parents, free of charge.'³⁴

Mothers in hospital An informal online survey carried out for the WBTi assessment in November 2015 for mothers (with a baby or young child) who had been hospitalised showed that 67% of the 240 mothers responding could keep their baby with them when they had been hospitalised, at least most of the time, but for a child aged between 6 months and 2 years (63 responders) only 37% could.²⁰ There is inconsistency between hospitals because of a lack of national policies, although Scotland has a Health Promoting Health Service indicator for all health boards for such a policy. The Royal College of Nursing (RCN) in 2013 produced guidance which recommends that units 'provide facilities that allow mothers and babies to be together 24 hours a day to promote breastfeeding on demand'.³⁵ Whether the mother or her baby were hospitalised, between a third and a half of mothers did not feel that they received adequate assistance with breastfeeding.

Psychiatric mother and baby units These are relevant but there was insufficient time to gather data.

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Indicator 6

Community-based support

UK

7/10



Key question *Are there mother-support and community-outreach systems in place to protect, promote and support optimal infant and young child feeding?*

Background

The need for community-based support is recognised in the *Global Strategy*,¹ and is Step 10 of the BFHI.² Evidence clearly shows that skilled support increases rates of breastfeeding.³

Help needed by mothers includes accurate and timely information to help build confidence and resolve problems if they occur; evidence-based recommendations; compassionate care before, during and after childbirth; empathy and active listening; and practical guidance. The term ‘counselling’ has been interpreted here to mean such support.⁴

It is essential that those supporting mothers to breastfeed are properly trained and have up-to-date, evidence-based knowledge and skills. Mothers obtain information about breastfeeding from friends, family, books, social media, formula company advertising and baby clubs, as well as from health professionals. Any of these sources may have misconceptions or misleading information about breastfeeding and how it works, so it is essential that new parents receive accurate information to understand what is normal behaviour in a newborn baby, how to know if their baby is getting enough milk, the importance of EBF in the first 6 months and where to obtain skilled support if needed.

The network of support can be provided formally and informally, the latter by family, social networks and the wider community. There is a wide mix of people whose formal role includes supporting mothers to breastfeed, and they have a range of skills and training (see table on p. 38). Training to BFI standards is recognised as the minimum requirement for midwives and HVs (see Indicator 2), yet not all have received this training.

All mothers in the UK have free access to antenatal,

intrapartum and postnatal care through midwifery and health-visiting services. They can access formal support not only through routine care but also via support groups, peer-support schemes, helplines and individual contact with breastfeeding counsellors and IBCLCs.

It is more effective if breastfeeding support from all of these sources is integrated, and it is essential that clear pathways for referral exist for those mothers with more complex issues who need additional help or more specialised support.

NICE produces evidence-based public health guidelines.⁷ Two mention the provision of breastfeeding support several times: Maternal and Child Nutrition and Postnatal Care Guidelines.^{8,9} In England this guidance is not mandatory, and it is up to local commissioners to decide how it applies in their area. Although the devolved administrations in Scotland, Wales and Northern Ireland are often involved in the development of NICE guidance, it is up to them how the guidance applies in their countries.¹⁰

Key findings

Most mothers in the UK (63%) who stopped breastfeeding before their baby was 10 months old say that they would have liked to have continued for longer. Among mothers who stopped during the first 2 weeks, the proportion wanting to continue is much higher (86%).¹¹ There is little doubt that timely access to skilled breastfeeding support from trained professionals or volunteers would enable most mothers to continue breastfeeding for as long as they wish (see Indicator 2 for details of the extent to which Baby Friendly accreditation has been achieved, and Indicator 5 for information on HCP training).

Antenatal support

Almost all mothers attend antenatal check-ups (96%), but only three-quarters (76%) discussed infant feeding during their midwife appointments and only two in five (41%) had been taught how to position their baby for breastfeeding during their pregnancy.¹¹

Antenatal classes are run by the NHS and also by voluntary organisations, such as the NCT. Around two

Score table

Criteria	Possible score	E	NI	S	W	UK
6.1 All pregnant women have access to community-based antenatal and postnatal support systems with counselling services on IYCF.	Y = 2, SD = 1 N = 0	2	2	2	2	2
6.2 All women receive support for IYCF at birth for breastfeeding initiation.	Y = 2, SD = 1 N = 0	1	2	2	2	1
6.3 All women have access to counselling support for IYCF, and support services have national coverage.	Y = 2, SD = 1 N = 0	2	2	2	2	2
6.4 Community-based counselling through mother support groups and support services for the pregnant and breastfeeding woman are integrated into an overall infant and young child health and development policy (IYCF/health/nutrition policy).	Y = 2, SD = 1 N = 0	1	2	2	1	1
6.5 Community-based volunteers and HCPs are trained in counselling skills for IYCF.	Y = 2, SD = 1 N = 0	1	2	2	1	1
Total score	10	7	10	10	8	7

E: England; NI: Northern Ireland; S: Scotland; W: Wales; UK: United Kingdom (combined score); Y: yes; SD: to some degree; N: no

in five mothers (38%) attended antenatal classes, but fewer than three in ten (28%) said they discussed infant feeding during these classes.¹¹

Breastfeeding support at birth

Nearly seven in ten breastfeeding mothers (69%) said they were shown how to put their baby to the breast in the first few days. Just under half (48%) were informed about how to recognise that their baby was getting enough milk, but only two in five (37%) felt confident about doing this.¹¹

One in four mothers was highly critical of the level of support received in feeding their babies, particularly during the first 3 days following birth.¹²

More than four out of five breastfeeding mothers who experienced problems were offered help or support in hospital or at home, but those who did not receive help were almost twice as likely to have stopped breastfeeding within the first 2 weeks.¹¹

Postnatal support

Mothers clearly say that the care provided in the period 11–30 days after birth, when midwifery care has come to an end, is particularly poor. Less than half of first-time mothers felt that they had received all the help they needed.¹²

Most mothers were given the contact details of a voluntary organisation or community group which helps new mothers to breastfeed, but this varied considerably across the country, with mothers in England most likely to have been given these details (70%) and mothers in Wales least likely (51%).¹¹

There is wide variation in the provision of peer support across the country. A few areas have well-integrated programmes where all mothers have access to skilled support from volunteers and paid staff, as well as to more specialist support from breastfeeding

counsellors and IBCLCs when needed. In other areas the provision is poor and mothers may have to travel long distances to get the face-to-face help they need.

Mothers who experience complex breastfeeding problems may need additional help beyond the scope of peer supporters or HVs. Infant feeding leads are not required to have core competencies, training or mentoring, so standards vary considerably. This is a source of support that needs strengthening. Access to specialist support from IBCLCs or breastfeeding counsellors is variable throughout the UK.

‘Less than half of first-time mothers felt that they had received all the help they needed’¹²

An example of these complex cases is difficulty with breastfeeding associated with tongue-tie in the infant. A survey by the NCT in 2015 showed considerable variation in the availability and quality of NHS tongue-tie services for infants.¹³

England The Health and Social Care Act 2012 involved a major reorganisation of the NHS in England, giving responsibility for allocating budgets to local Clinical Commissioning Groups. In 2015, NHS England transferred the commissioning of services for children aged 0–5 years, including the health-visiting service, to local authorities. The guidance produced reiterated that HVs lead on delivering the Healthy Child Programme for that age range and also identified six high-impact areas, one of which is breastfeeding, where they can have a significant effect.¹⁴

In 2015–2016 there has been a significant reduction in breastfeeding support services across England. There is no national database of such support in England so it is hard to know the extent of these cuts. A snapshot

Who supports mothers to breastfeed in the UK?⁵

Role	Who are they?	Breastfeeding training
Midwife	Health professional caring for mothers antenatally, during birth and for the first 10–28 days postnatally.	Some have trained on BFI-accredited courses. Once qualified, well over half have undertaken BFI training (59% UK maternity services accredited).*
HV	Public health nurse caring for babies and children from 10 days up to 5 years old.	Few have trained on BFI-accredited course. Once qualified, over two-thirds have undertaken BFI training (64% health-visiting services accredited).*
GP	Generalist doctor providing routine care to mothers, babies and children of all ages.	University medical courses provide little breastfeeding education. Around 10% of GPs have accessed the BFI 25-minute e-learning package.*
Infant feeding lead	Specialist midwife or HV responsible for coordinating breastfeeding support in a hospital or local area.	Some have specialist training (e.g. IBCLC (see below) or similar level). There is BFI guidance for the role but no minimum standard. ⁸
Maternity support worker	Works under the supervision of a registered midwife.	Training is provided on the job but they can also study for a qualification.
Lactation consultant	Specialist breastfeeding consultant. Can have health professional or breastfeeding counsellor background. Some in private practice; most employed in maternity or community services, some as infant feeding lead.	Minimum 1000 hours of supervised breastfeeding support experience; minimum of 90 hours specialist breastfeeding education and internationally accredited exam; and 15 hours/year ongoing training.
Breastfeeding counsellor	Experienced breastfeeding mothers who offer support in the community, mostly voluntarily (Association of Breastfeeding Mothers (ABM), the Breastfeeding Network (BfN), La Leche League Great Britain (LLLGB) and NCT).** See Evidence into Practice Briefing. ⁹	Approximately 2 years' part-time training in all aspects of breastfeeding management and in counselling skills. BfN and NCT training externally validated. Ongoing supervision and training provided by voluntary organisation. Annual CPD requirements.
Peer supporter	Experienced breastfeeding mothers who offer support in their community, under supervision, usually voluntarily (NCT, BfN, ABM, LLLGB) or may be NHS trained.	16–36 hours training in breastfeeding support and listening skills. Ongoing supervision and training provided by voluntary organisation or NHS.

*See Indicator 2 for full details of BFI, and Indicator 5 for full details of HCP pre- and post-registration breastfeeding training. Also, there are large differences between the countries. For example, in Scotland and Northern Ireland all maternity units are fully accredited and more than 80% of midwives are BFI trained.

** More information about the services of the ABM (www.abm.me.uk), BfN (www.breastfeedingnetwork.org.uk), LLLGB (www.laleche.org.uk) and NCT (www.nct.org.uk) is available in Part 2.⁶

of these measures, with examples from over 30 areas across England, in breastfeeding support drop-ins, peer-support programmes, specialist infant feeding lead posts and IBCLC clinics, indicates the severity of the problem.¹⁵ The list is by no means comprehensive, and the true extent of cuts is likely to be much greater. Some of the services closing are exemplary and include case studies highlighted by NICE as examples of best practice. In February 2016 more than 33 organisations signed an open letter to the UK and devolved governments to highlight the effect of reducing breastfeeding support.¹⁶

PHE and Unicef UK recently published updated guidance to help those responsible for commissioning breastfeeding support services in their local area.¹⁷

There are case studies of good practice in Part 2.¹⁸

The current health-visiting service model in England – which includes five statutory visits – is only mandated until 2017. This mandate is currently under review, and there is uncertainty about whether it will continue beyond 2017, meaning that some local authorities may decide not to implement this universal service.

Northern Ireland The 10-year breastfeeding strategy for Northern Ireland, *Breastfeeding – A Great Start (2013–2023)*,¹⁹ includes the following expected outcomes:

- provide accessible breastfeeding, practical and problem-solving support from a midwife, or a HV, or maternity support worker;



- develop and deliver community support programmes, including peer support targeting those least likely to breastfeed;
- provide mothers of vulnerable infants with tailored information and support for breastfeeding, and, where appropriate, provide donor breast milk.

Mothers are able to find their local breastfeeding support group on the BreastFed Babies website, run by the PHA. This contains an updated list of all such groups in the country.²⁰ The agency also commissions La Leche League Great Britain (LLLGB) to provide breastfeeding counselling services in areas with gaps in support.

Scotland The Scottish Government's MINF²¹ includes a policy-level commitment to community support, such as:

- access to breastfeeding support groups and relevant organisations;
- access to the National Breastfeeding Helpline;
- access to peer/mother-to-mother breastfeeding support programmes.

All health board areas have some peer support. Most now have breastfeeding support groups, and mothers are able to find their local group on the feedgood website²² run by NHS Scotland and the Scottish Government, which contains an updated list of all such groups in the country.

Wales Mothers are able to find their local breastfeeding support group on the Health Challenge Wales website.²³ Peer support is no longer being

prioritised nationally as it is believed there are more effective approaches to breastfeeding support. However, individual health boards may decide to continue to use peer supporters.²⁴

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Gaps

- **England and Wales** 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. Peer-support services in the community are not universally available, and many have been closed or are under threat of closure.
- **England** There is wide variation nationally in the provision of quality antenatal and postnatal breastfeeding education and support, individually and in groups.
- **England** Baby Friendly accreditation of community services is uneven.
- **England** The future of health-visiting services is uncertain.
- **England** Many services are being cut as a result of a reduction in funding.
- **England** There is no national listing of local breastfeeding support, and local listings are patchy.
- **England and Wales** Poor data collection means that it is not possible to evaluate the local effectiveness of different models of support (see Indicator 10).
- **Northern Ireland and Scotland** No gaps identified.

Recommendations

- **England and Wales** Commissioners to ensure there is a range of integrated postnatal services that include both health professional and voluntary-sector breastfeeding support, meet local needs and provide clear access to specialist support.
- **England** Government to implement existing NICE guidelines on antenatal and postnatal breastfeeding information and support.
- **England** Government to make Baby Friendly accreditation in all maternity and community settings mandatory.
- **England** Commissioners to maintain the full range of health-visiting services, and maintain health visiting as a universal service.
- **England** Funding for public health to be protected.
- **England** PHE to explore options to enable families to access information about local services.
- **England and Wales** Governments to improve data collection to aid evaluation of services.

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Indicator 7

Information support

UK

5.5/10

E	5.5
NI	10
S	10
W	8

Key question Are comprehensive information, education and communication strategies for improving infant and young child feeding (breastfeeding and complementary feeding) being implemented?

Background

Evidence-based, appropriate information, free from commercial sponsorship and communicated well, is an important part of improving IYCF practices.

Across all four UK countries there is a universal maternity care service structure for women, from antenatal through to postnatal care, which offers numerous opportunities for conversations about infant feeding and sharing of information (see Indicator 6 for a description of the term ‘counselling’). These begin with an initial contact with a midwife or GP in early pregnancy (before 12 weeks gestation) and a ‘booking’ referral to a hospital antenatal clinic.

Women will then attend antenatal clinics either in hospital, if their pregnancies are considered high risk, or in community clinics. In NHS trusts that are Baby Friendly accredited, or are working towards it, at least one conversation about infant feeding should take place and written information is usually given. The midwife will continue to have postnatal contact until the infant is 10–28 days old, according to the mother’s or baby’s assessed need. HVs have several mandated contacts, including a ‘new birth’ home visit at 10–14 days after the birth. Every child in the UK has a named HV.

Key findings

Only Scotland and Northern Ireland have a communications strategy for infant feeding. Wales is reviewing information for parents and developing a suite of professional materials to support the effective

delivery of the messages around breastfeeding (e.g. information for professional groups, tools, training).¹

Each country provides information to families on breastfeeding in its own way, through its government health agency. There is online material from public health in Northern Ireland, Scotland, England and Wales. While much of the information available to parents and professionals in the UK is clear about the hazards of incorrect preparation of infant formula, it rarely mentions the short- and long-term effects of formula on the child’s health.

The NHS structure provides opportunities for information sharing with parents. It provides midwifery and health-visiting contacts with parents throughout pregnancy and until the child is over 2 years old, with discussion on a one-to-one basis. Midwives and HVs can also direct mothers to community support, national helplines and online resources for breastfeeding. However, information given may not be evidence based as a result of insufficient training of health professionals (see Indicator 5) and out-of-date resources. Training of midwives and HVs to BFI standards is not universal, particularly in England (see Indicator 2).

‘The iHV has produced breastfeeding information sheets of a high standard for mothers² and staff.’³

With regard to the accessibility of information to women who do not speak English or who have low literacy, health professionals in the NHS can use an interpreter service called Language Line.

The iHV has produced breastfeeding information sheets of a high standard for mothers² and staff.³

National Breastfeeding Week (NBW) was supported by the UK DH with items such as posters and bags, but in recent years funding and other resources have been discontinued. The campaign in 2015 was sponsored by a retailer that does not comply with the Code.

In 2016, NBW was promoted by Unicef UK as Breastfeeding Celebration Week 2016.⁴ Scotland now runs its own NBW and there were Scottish events for Breastfeeding Celebration Week UK (June 2016).^{5,6} In 2016, Northern Ireland’s PHA publicised World

Score table

Criteria (measures that are in place in the country)	Possible score	E	NI	S	W	UK
7.1 The national information, education and communication (IEC) strategy for improving IYCF ensures that all information and materials are free from commercial influence and that potential conflicts of interest are avoided.	Y = 2, SD = 0 N = 0	0	2	2	2	0
7.2 a National health/nutrition systems include individual counselling on IYCF.	Y = 1, SD = 0.5, N = 0	1	1	1	1	1
b National health/nutrition systems include group education and counselling services on IYCF.	Y = 1, SD = 0.5, N = 0	0.5	1	1	1	0.5
7.3 IYCF IEC materials are objective, consistent and in line with national and/or international recommendations, and they include information about the risks of artificial feeding.	Y = 2, SD = 1 N = 0	1	2	2	2	1
7.4 IEC programmes (e.g. WBW) that include IYCF are being implemented at the local level and are free from commercial influence.	Y = 2, SD = 1 N = 0	1	2	2	0	1
7.5 IEC materials/messages to include information about the risks of artificial feeding in line with WHO/Food and Agriculture Organization of the United Nations guidelines on the preparation and handling of powdered infant formula.	Y = 2, SD = 0 N = 0	2	2	2	2	2
Total score	/10	5.5	10	10	8	5.5

E: England; NI: Northern Ireland; S: Scotland; W: Wales; UK: United Kingdom (combined score); Y: yes; SD: to some degree; N: no

Breastfeeding Week (WBW).⁷ It is celebrated by some NGOs, using the material developed by WABA, but it is not observed or coordinated nationally in the UK.

In the UK, and in other countries, it is of concern that infant formula and bottle/teat manufacturers are increasingly targeting mothers during WBW.⁸ Another worry is that promotional campaigns that are not closely linked to easily accessible skilled help and support can trigger a backlash, such as the appearance of anti-breastfeeding articles in the media.⁹

The UK charities that provide breastfeeding support respond to the information needs of parents by having high-quality evidence-based material on their websites, and some, such as LLLGB,¹⁰ also produce a range of printed fact sheets. The BfN website offers information about breastfeeding and medication, plus a Drugs in Breastmilk helpline.¹¹ The charity Best Beginnings specialises in resources such as the Small Wonders DVD for use on neonatal units, with accompanying staff training.¹² First Steps Nutrition Trust is a public health nutrition charity publishing resources that include up-to-date independent information about infant milks.¹³

Tables listing information that is produced by governments, professional organisations of healthcare providers and NGOs are available in Part 2.¹⁴

England The Healthy Child Programme was set up in 2009 to improve the health of mothers and children through pregnancy and the first 5 years of life.¹⁵

Giving breastfeeding information is included in the guidance throughout the first year of the child's

life, but is not mentioned after 1 year. One of the intended outcomes is to increase rates of initiation and continuation of breastfeeding, thereby reducing obesity and social inequality.

In the last 8 years in England there has been a reduction in the amount of information that is available to parents. Notably, *The Pregnancy Book* (2016) and the *Birth to Five* book are now only available online.¹⁶ *Birth to Five* has not been updated since 2009. *The Pregnancy Book* provides up-to-date information and has a good chapter on infant feeding, which includes responsive feeding, information on positioning and attachment, common problems and how to get help.

Some of the information on the NHS Choices website on breastfeeding is out of date. A new bottle-feeding booklet on the NHS Choices Start4Life site gives accurate information for parents about the safe and hygienic preparation and storage of formula, but the long-term health consequences associated with formula feeding are not covered.

The availability of group sessions (Parentcraft classes and breastfeeding workshops) to meet local need is variable and there are no DH recommendations.

Northern Ireland and Scotland Northern Ireland and Scotland, which have a history of very low breastfeeding rates, have been working together to share good practice.¹⁷ Northern Ireland's BSISG has a communication plan that involves highlighting breastfeeding issues with the media. Scotland has updated the 'Off to a Good Start' leaflet, which

Examples of best practice

- Northern Ireland publicised WBW in 2016.²¹ The PHA has been encouraging everyone to show support for mothers who breastfeed in public. It acknowledges that many mothers are apprehensive about the practice. To counteract fear around it, the PHA highlights that 'over 400 businesses, council facilities and popular tourist attractions have signed up to the initiative to show their support for breastfeeding mums'. The agency provides a list of the many venues across Northern Ireland where breastfeeding mothers can be assured of a supportive welcome.
- Posters from NHS Health Scotland.^{22,23}
- Leaflets produced by the DH in England.
- A DVD from the charity Best Beginnings.

The first magical hour.
This poster highlights the importance of the first hour after birth and helps parents to understand how skin-to-skin contact leads to the success of self-attachment at the breast. (Credit: NHS Scotland) ▼

Breast milk versus formula.
This poster enables an easy understanding of the scientific differences in content between breastmilk and formula. (Credit: NHS Scotland) ►



Northern Ireland also provides to pregnant women. The PHA produces fact sheets on different aspects of breastfeeding, including a mother's and employer's guide to returning to work, what grandparents need to know

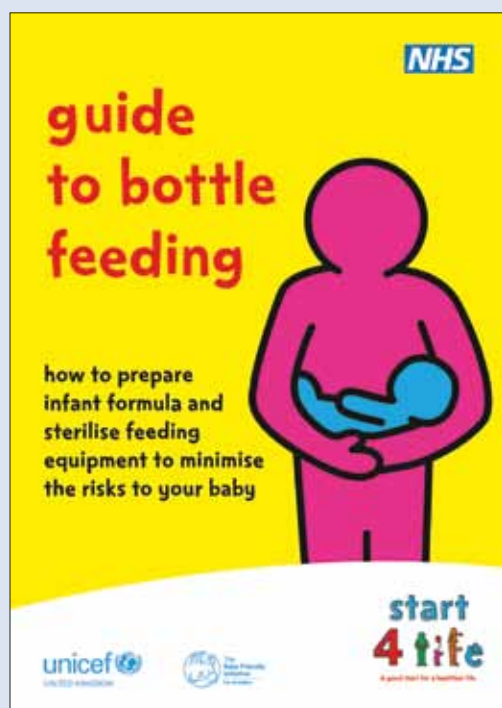
and information specifically for fathers.

Scotland has now developed a multimedia communications strategy and launched a new website in 2016 with links to all of its information for parents,

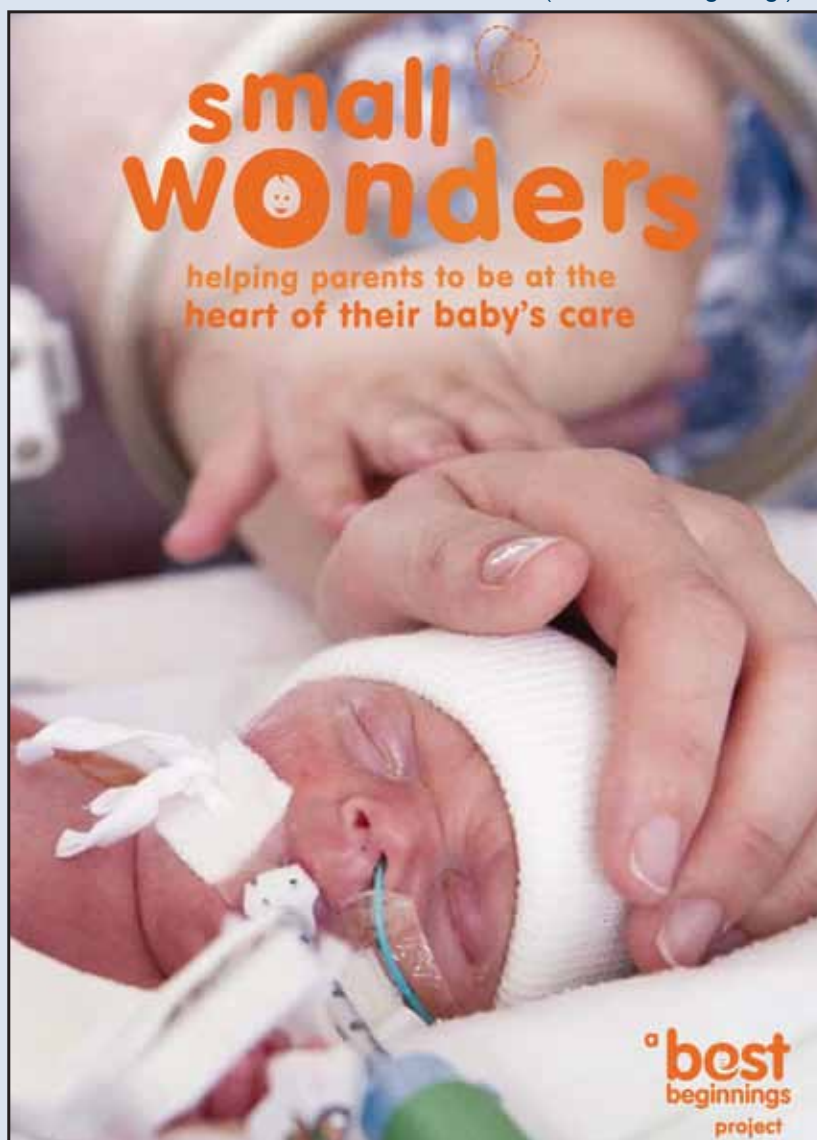


◀ Off to the Best Start. This leaflet presents breastmilk as the biological norm when discussing the risks of not breastfeeding. It contains clear information about effective attachment at the breast and lists signs that a mother can easily use to check whether her baby is feeding well.²⁴ (Credit: Public Health England)

Small Wonders – this DVD from Best Beginnings has had a significant impact on NHS practice in NICUs. It promotes parent-centred care, hand expressing and breastfeeding, and it has an accompanying staff training programme. It has been positively evaluated by two universities. Government funding (from the DH, Northern Ireland's PHA and the Scottish Government) is enabling enough copies of the DVD to be produced for many NICU parents to be given one.¹² (Credit: Best Beginnings) ▼



▲ Guide to bottle feeding – as well as providing practical instruction on how to make up bottles of formula, this leaflet encourages parents to feed in a responsive way with eye contact and skin-to-skin contact, following the baby's feeding cues.²⁵ (Credit: Public Health England)



including 'Ready, Steady Baby!', various apps and translations into other languages. A briefing paper lists resources that can be downloaded.¹⁸ The feedgood website provides a range of material for parents.¹⁹

Wales Wales Public Health has a website in both Welsh and English about breastfeeding,²⁰ with links to local support groups. However, the national infant feeding coordinator post has been cut so there is

Gaps

- **England** No national, multimedia communications strategy for IYCF.
- **England** NHS Choices website has some inconsistent and out-of-date information and there is no national database of breastfeeding support organisations that can be linked to a central website.
- **England** Risks of artificial feeding are not well understood by health professionals and mothers.
- **England** HVs are not always up to date and able to give evidence-based support.
- **Wales** No implementation of IEC programmes (e.g. NBW, WBW). They do have some communications material, such as their website, but this is out of date.
- **Scotland and Northern Ireland** No gaps identified.

Recommendations

- **England** Government needs to create a national communications strategy to:
 - provide accurate information in publications and online sources, liaising more with relevant organisations;
 - include WBW/National Breastfeeding Celebration Week;
 - launch a public information campaign aimed at wider society (family, community, workplaces).
- **England** DH to update the NHS Choices website to provide accurate information and details of breastfeeding support organisations.
- **England** Include information about the risks of artificial milk in health professional training and in information that is supplied to parents.
- **England** HVs to have up-to-date training on breastfeeding and developing close relationships between mothers and babies in order to deliver consistent, evidence-based support and information, free from commercial influence.
- **Wales** Implementation of IYCF IEC programmes at the local level, free from commercial influence.

no individual with key responsibility for promoting infant feeding, gathering data and ensuring that local information is kept up to date.

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Indicator 8

Infant feeding and HIV



Key question *Are policies and programmes in place to ensure that HIV-positive mothers are supported to carry out the national recommended infant feeding practice?*

Background

Recent research and the development of improved treatments for HIV¹ show that, when mothers and infants both receive appropriate antiretroviral therapy (ART) and the babies are exclusively breastfed, the risk of transmission of the virus can be less than 1%. It appears that EBF provides the baby with a level of protection that is lost if infant formula or other BMSs (including breastmilk fortifiers) are introduced. EBF can reduce transmission of the virus to a minimum, but combining formula feeding and breastfeeding will significantly increase the risk.

Until 2009, HIV infant feeding policy in the UK was formulated by the Expert Advisory Group on AIDS and the British HIV Association (BHIVA), with an underlying premise that mothers should formula feed, which was enforceable through court action.²

Given the high rates of mortality from formula feeding in many countries, WHO was prompted to release a comprehensive set of new guidelines on HIV and infant feeding in 2010.³ These state that the health authorities in each country should decide, based on a balance of the risks of formula feeding against the transmission of HIV, whether to principally counsel HIV-positive mothers to exclusively breastfeed alongside ART or to avoid all breastfeeding.

In 2010, BHIVA and the Children’s HIV Association (CHIVA) released a joint position statement on HIV and infant feeding in the UK.⁴ The guidelines recommended that HIV-positive mothers avoid breastfeeding from birth, but recognised that, in some circumstances, an HIV-positive mother might choose to breastfeed her baby. In this case, she should be intensively supported to breastfeed exclusively and to

avoid complications, such as mastitis or cracked nipples, which could increase the risk of HIV transmission.

In 2014 a review decided that the BHIVA position should remain unchanged, including the provision to support EBF for HIV-positive mothers on ART who have a strong desire to breastfeed.⁵

Key findings

The latest BHIVA/CHIVA position statement on infant feeding is mostly in line with the WHO 2010 guidelines, although it does not explicitly mention the Code.⁶ It recommends that free formula be provided via a starter pack and local arrangements, with the ongoing supply being dependent on individual circumstances. Free supplies are permitted by the Code, but not if they are provided direct from baby food companies, and they are to be continued for as long as the infant needs them (Article 6.7).

Some government guidance still recommends that all HIV-positive mothers avoid breastfeeding. For example, the NHS Choices website, a national health information resource, states unequivocally: ‘do not breastfeed your baby if you have HIV, because the virus can be transmitted through breast milk’.⁷ HIV testing of all pregnant women is mandatory in the UK, and ART is universally available through the NHS.

‘it appears that most HCPs have not received up-to-date training on HIV and infant feeding’⁸

While some highly motivated HIV-positive mothers have enlisted the help of their HCPs to breastfeed, it appears that most health workers have not received up-to-date training on HIV and infant feeding.⁸

Current BFI training and guidance for hospital administrators and staff, including in settings with high HIV prevalence, does not cover HIV. However, the Baby Friendly website directs staff to up-to-date information^{4,9,3} about the care of women who are breastfeeding with HIV. New information is disseminated via Baby Friendly research mailings and through the NIFN, which also provides a forum to

Score table

Criteria	Possible score	E	NI	S	W	UK
8.1 The country has a comprehensive updated policy in line with international guidelines on IYCF that includes infant feeding and HIV.	Y = 2, SD = 1 N = 0	2	2	0	2	2
8.2 The infant feeding and HIV policy gives effect to the <i>Code</i> /national legislation.	Y = 1, SD = 0.5, N = 0	0.5	1	1	1	0.5
8.3 Health staff and community workers receive training on HIV and infant feeding policies, the risks associated with various feeding options for infants of HIV-positive mothers and how to provide counselling and support.	Y = 1, SD = 0.5, N = 0	0.5	0.5	0.5	0.5	0.5
8.4 HIV testing and counselling/provider-initiated HIV testing and counselling/voluntary and confidential counselling and testing are available and offered routinely to couples who are considering pregnancy, and to pregnant women and their partners.	Y = 1, SD = 0.5, N = 0	1	1	1	1	1
8.5 Infant feeding counselling in line with current international recommendations and appropriate to local circumstances is provided to HIV-positive mothers.	Y = 1, SD = 0.5, N = 0	0	1	1	1	0
8.6 Mothers are supported in carrying out the recommended national infant feeding practices with further counselling and follow-up to make implementation of these practices feasible.	Y = 1, SD = 0.5, N = 0	0.5	1	1	1	0.5
8.7 HIV-positive breastfeeding mothers, who are supported through provision of ART in line with the national recommendations, are followed up and supported to ensure their adherence to ART.	Y = 1, SD = 0.5, N = 0	1	1	0	1	1
8.8 Special efforts are made to counter misinformation about HIV and infant feeding, and to promote, protect and support 6 months of EBF and continued breastfeeding in the general population.	Y = 1, SD = 0.5, N = 0	0.5	0	0	1	0.5
8.9 Ongoing monitoring is in place to determine the effects of interventions to prevent HIV transmission through breastfeeding on infant feeding practices and overall health outcomes for mothers and infants, including those who are HIV negative or are of unknown status.	Y = 1, SD = 0.5, N = 0	0.5	0	0	0	0.5
Total score	/10	6.5	7.5	4.5	8.5	6.5

E: England; NI: Northern Ireland; S: Scotland; W: Wales; UK: United Kingdom (combined score); Y: yes; SD: to some degree; N: no

A mother's dilemma

A mother, who is an asylum seeker, gives birth to her baby in an NHS hospital, but did not book for antenatal care and is found to be HIV positive while in labour. She is strongly advised by medical staff to feed her baby formula milk because of the risk of vertical transmission of the virus. Her family are not aware of her diagnosis and expect her to breastfeed, which is her cultural norm. She would be stigmatised if she did not. So, once she is home, she starts to breastfeed without telling the midwife she is doing so, but continues to give occasional formula feeds.

disseminate good practice. The Baby Friendly process encourages facilities to have care pathways in place to direct women with HIV to support with infant feeding.

There is 'a confidential national reporting scheme to monitor the prevalence of diagnosed HIV infection in

pregnant women and children...'. However, it is unclear whether the method of infant feeding is recorded, which would help to determine the risk of HIV transmission in the UK with EBF and maternal ART.¹⁰

Tight guidelines may appear to be safe, but in reality they can expose HIV-positive mothers who have not disclosed their status to their friends or family to greater risk. Such mothers may breastfeed when with others but then formula feed when alone.

Northern Ireland The national breastfeeding strategy only mentions HIV in the context of testing donor milk for milk banks. It does not include HIV and breastfeeding.¹¹ However, the nutrition guidelines are consistent with the BHIVA guidance.¹²

Scotland The national MINF does not cover HIV and breastfeeding.¹³

Wales The national infant feeding guidelines include up-to-date recommendations on HIV and breastfeeding, based on the 2010 BHIVA paper.¹⁴

Gaps

- Misinformation on HIV and infant feeding is widespread, and healthcare staff and community workers do not receive up-to-date training on the subject.
- Despite ongoing monitoring and recording of outcomes for all HIV-exposed babies in a central registry, the feeding method may not be recorded.

Recommendations

- Train all healthcare staff and community workers on up-to-date WHO and BHIVA recommendations on HIV and infant feeding.
- Further research and ongoing monitoring of the effects of interventions to prevent transmission through breastfeeding is required.

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Indicator 9

Infant and young child feeding during emergencies

UK

0/10

E	0
NI	0
S	1
W	0

Key question *Are appropriate policies and programmes in place to ensure that mothers, infants and young children will be provided with adequate protection and support for appropriate feeding during emergencies?*

Background

Disaster and emergency situations can and do occur in the UK.¹ Climate-related severe weather events mean flooding (for example) is becoming more common, leaving families without access to electricity, clean water or local shops from which to purchase formula. Other emergencies may include blizzards, power cuts, contamination of local water supplies and terrorist attacks. Responsibility for emergency planning has been devolved from the UK Government to local authorities.

Each local authority is tasked with developing its own guidance, with an expectation that local communities will take ownership, reflecting local needs.² Although emergency events are rare, local authorities and emergency responders must have guidelines to ensure that vulnerable babies are protected. If a mother is breastfeeding, she must be supported to continue, and if she is formula feeding, she will need access to a safe supply of formula for her baby.

Key findings

There are no UK-wide or national strategies addressing IYCF in emergencies, and no means of ensuring that it is addressed in local strategies. International guidelines are available from the Emergency Nutrition Network.³ Some guidelines have been developed that are smaller in scope, but they have limited accessibility. In 2007, *Guidance for Supporting Mothers with Infants during an Emergency* was developed by the British Red Cross, but this is not widely available.⁴ The Food Safety Agency has

Examples of best practice

- Baby Feeding Law Group (2015) *Information for Food Banks: Supporting Pregnant Women and Families with Infants*
- Unicef UK (2014) *The Provision of Infant Formula at Food Banks*.¹¹
- The NHS/BFI booklet *Guide to Bottle Feeding* contains information about bottled water.¹²
- Carothers, C. and Gribble, K. (2014) 'Infant and Young Child Feeding in Emergencies'.¹³
- US Government (2013) 'Infant Feeding During Disasters'.¹⁴
- In the aftermath of the Christchurch earthquake, the New Zealand Ministry of Health issued guidance on preparing for infant feeding in emergencies, for families with babies and for emergency planners and responders.¹⁵
- For further examples, see Part 2.¹⁶

some guidelines on safer preparation of infant formula if the water supply has been contaminated, but there are none on protecting breastfeeding.⁵

The Civil Contingencies Act 2004, together with its supporting statutory and non-statutory guidance, provides the framework for civil protection activity by local emergency responders around the country. The government publishes guidance on evacuation and shelter,⁶ including advice on the care and provision of vulnerable people, but there is no mention of mothers and infants. However, there are specific references and guidance for animals, including pets, livestock, and zoo and circus animals.

'There is government guidance for providing for animals, including pets, livestock, and zoo and circus animals, but there is no mention of mothers and infants.'

Other key documents aimed at preparing for emergencies and to guide agencies that may be involved

Score table

Criteria	Possible score	E	NI	S	W	UK
9.1 The country has a comprehensive policy on IYCF that includes infant feeding in emergencies and contains all basic elements included in the <i>Operational Guidance on Infant and Young Child Feeding in Emergencies</i> of the Infant Feeding in Emergencies (IFE) Core Group. ³	Y = 2, SD = 1 N = 0	0	0	0	0	0
9.2 Person(s) tasked with responsibility for national coordination with all relevant partners, such as the UN, donors, military and NGOs regarding IYCF in emergency situations, have been appointed.	Y = 2, SD = 1 N = 0	0	0	1	0	0
9.3 An emergency preparedness and response plan based on the practical steps listed in the <i>Operational Guidance</i> has been developed and put into effect in most recent emergency situations. It covers:						
a basic and technical interventions to create an enabling environment for breastfeeding, including counselling by appropriately trained counsellors, support for relaxation and wet nursing, and protected spaces for breastfeeding;	Y = 1, SD = 0.5, N = 0	0	0	0	0	0
b measures to minimise the risks of artificial feeding, including an endorsed statement on the avoidance of donations of BMSs, bottles and teats; standard procedures for handling unsolicited donations and procurement management; and use of any infant formula and BMS in accordance with strict criteria, the <i>Operational Guidance</i> and the Code.	Y = 1, SD = 0.5, N = 0	0	0	0	0	0
9.4 Resources have been allocated for implementation of the emergency preparedness and response plan.	Y = 2, SD = 1 N = 0	0	0	0	0	0
9.5						
a Appropriate orientation and training material on IYCF in emergencies has been integrated into pre-service and in-service training for emergency management and relevant HCPs.	Y = 1, SD = 0.5, N = 0	0	0	0	0	0
b Orientation and training is taking place as per the national emergency preparedness and response plan.	Y = 1, SD = 0.5, N = 0	0	0	0	0	0
Total score	/10	0	0	1	0	0

E: England; NI: Northern Ireland; S: Scotland; W: Wales; UK: United Kingdom (combined score); Y: yes; SD: to some degree; N: no



Gaps

- None of the countries has a national strategy addressing IYCF in emergencies.
- Guidance for agencies tackling emergencies fails to mention the specific needs of mothers and infants.
- **England, Northern Ireland and Wales** There are no resources or coordinators responsible for IYCF in emergencies.

Recommendations

- Each government to develop a national strategy on IYCF in emergencies based on WHO/international recommendations, integrated into existing emergency-preparedness plans, and communicate it to all the relevant agencies.
- Key documents to be made available for agencies working during emergencies to include IYCF guidance for emergency workers.
- **England, Northern Ireland and Wales** Each government to identify a coordinator to be responsible for IYCF in emergencies, and to develop resources and build capacity.

in planning and dealing with emergencies fail to mention the specific needs of mothers with infants.^{7,8,9}

Local authorities may provide information about emergency planning for residents – for example, recommending that families have an ‘emergency pack’ ready, including such things as a torch and batteries, dried foods and bottled water.¹⁰ Most have a good section on pets, but IYCF is almost entirely overlooked.

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Indicator 10

Monitoring and evaluation

UK

5/10



Key question Are monitoring and evaluation systems in place that routinely collect, analyse and use data to improve infant and young child feeding practices?

Background

The *Global Strategy* makes clear that each country is expected to create a detailed action plan to accompany its national infant feeding strategy,

‘including defined goals and objectives, a timeline for their achievement, allocation of responsibilities for the plan’s implementation, and measurable indicators for its monitoring and evaluation’.¹

Model policies suitable for high-income countries and toolkits for monitoring and evaluation are available in *Protection, Promotion and Support of Breastfeeding in Action: A Blueprint for Action*.²

Regular and robust data collection is essential to support evidence-based decision-making. Monitoring with evaluation of breastfeeding rates can inform whether programmes are effective, and identify areas or groups where targeted interventions are needed.

In the UK, data relating to infant feeding have been collected for some years by hospitals (for initiation of breastfeeding at birth) and by GPs and HVs (at 6–8 weeks). In England this has been in place from 2004 for initiation and 2008 for continuation at 6–8 weeks. Responsibility for national reporting, via the Public Health Outcomes Framework (PHOF), was transferred to PHE in 2014. Since 1999, the devolved governments of Scotland, Northern Ireland and Wales have taken responsibility for all aspects of health in their jurisdictions.³ Accordingly, different systems of monitoring have developed in each of the UK’s nations.

Between 1975 and 2010, the IFS, a major reference study, was conducted on a five-yearly basis – first in England and Wales, then extending to Scotland in 1980 and Northern Ireland in 1990.⁴

Mothers were surveyed three times during their

Definitions

Definitions used in the IFS

- *Incidence of breastfeeding* refers to the percentage of babies who were breastfed initially. This definition includes all babies who were put to the breast at all, even if it was only once. It includes giving babies expressed breastmilk.
- *Prevalence of breastfeeding* refers to the percentage of all babies who were being breastfed (including being given expressed breastmilk) at specific ages, even if they also received infant formula, solid food or other liquids.
- *Duration of breastfeeding* refers to the length of time that mothers who breastfed initially continued to breastfeed for (including giving expressed breastmilk), even if they were also giving their baby other milk and solid foods.

WHO definition of exclusive breastfeeding

- *Exclusive breastfeeding* means no food or drink, not even water, other than breastmilk (including milk expressed or from a wet nurse) for 6 months of life, but allows the infant to receive oral rehydration salts, drops and syrups (vitamins, minerals and medicines).⁵

baby’s first year and, in 2010, more than 10,000 mothers took part in the final survey when their babies were 8 to 10 months old.⁴ The survey’s aims were similar to those of the previous surveys – namely, to:

- establish how infants born in 2010 were being fed and provide national figures on the incidence, prevalence and duration of breastfeeding;
- examine trends in infant feeding practices, particularly comparing 2005 and 2010;
- investigate variations in infant feeding practices and associated influencing factors;
- establish the age at which solid foods are introduced;
- look at patterns of smoking and drinking behaviour before and after birth;
- measure the awareness and uptake of the Healthy Start scheme and assess how the vouchers are used.

Score table

Criteria	Possible score	E	NI	S	W	UK
10.1 Monitoring and evaluation components are built into major IYCF programme activities.	Y = 2, SD = 1 N = 0	1	2	2	1	1
10.2 Data/information on progress made in implementing the IYCF programme are used by programme managers to guide planning and investment decisions.	Y = 2, SD = 1 N = 0	1	2	2	1	1
10.3 Data on progress made in implementing IYCF programme activities routinely collected at national and subnational levels.	Y = 2, SD = 1 N = 0	1	2	2	1	1
10.4 Data/information related to IYCF programme progress reported to key decision-makers.	Y = 2, SD = 1 N = 0	1	2	2	1	1
10.5 Monitoring of key IYCF practices is integrated into the national nutritional surveillance system and/or health information system or national health surveys.	Y = 2, SD = 1 N = 0	1	2	1	1	1
Total score	/10	5	10	9	5	5

E: England; NI: Northern Ireland; S: Scotland; W: Wales; UK: United Kingdom (combined score); Y: yes; SD: to some degree; N: no

In 2014 the decision was made to cancel the IFS, so no survey was carried out in 2015.⁴

WHO recommends that breastfeeding is initiated within the first hour after birth, followed by EBF for 6 months. Thereafter, it advocates the introduction of solid foods alongside continued breastfeeding (complementary feeding) and that breastfeeding continue for at least 2 years. These recommendations are based on strong evidence for the health benefits of these practices.⁶ Data gathered on infant feeding should therefore correspond to these measures (see Indicators 11–15).

Key findings

While breastfeeding initiation and prevalence at 6–8 weeks continue to be measured in all countries of the UK, the IFS was the only source of data on the timing of breastfeeding initiation, EBF to 6 months and continued breastfeeding to 1 year.

Now that the survey has been discontinued, there is no other source of information for these important measures. Neither is there accompanying discussion of trends or qualitative data from mothers (except in Northern Ireland and Scotland), especially about their satisfaction with the duration of breastfeeding.

Indicators 11–15 relating to feeding practices have therefore been calculated using the 2010 survey data. They can be benchmarked against other participating countries, but it is unclear how there can be international benchmarking for the UK in the future.

Alternative options for data collection could be explored, such as a short survey focusing predominantly on the international benchmarks, or obtaining information from parents electronically – for example, using the interactive national Information Service for Parents, part of the NHS's Start4Life campaign.

England In England the monitoring and evaluation system was overseen by the National Infant Feeding Steering Group with the informal support of NIFN⁷ until 2015, so it is unclear who now has responsibility for its oversight.

Hospital and community-based midwives collect data on breastfeeding initiation, while HVs (and sometimes GPs) collect data on breastfeeding at 6–8 weeks during routine clinical checks. This information is reported quarterly by hospitals for breastfeeding initiation and service commissioners (local authorities) for infant feeding at 6–8 weeks. Collection of the data for the PHOF⁸ is recommended by PHE but not mandatory.⁹

National and local performance data collected on an aggregate basis (i.e. the totals for each area are submitted) is published annually as official statistics via the PHOF. The information has to reach the required coverage to be included, yet although the minimum acceptable coverage has been reduced from 90% to 85%, the data are incomplete so trends cannot be established. Thus monitoring is challenging and there is a lack of evidence for evaluation, yet local commissioners are expected to use this information to identify which services are in need of improvement.

There have been significant recent changes to the way in which the data are processed, with new datasets (Maternity Services Dataset and Children and Young People's Health Services Dataset) going live in 2015, and record-level data (i.e. individual records) for breastfeeding initiation and breastfeeding at 6–8 weeks now being submitted to the Health and Social Care Information Centre (HSCIC) on a monthly basis. The quality and coverage of information is therefore expected to take some time to be sufficiently complete to support statistical reporting.⁷ However, the potential analytical power of routine, record-level data collection is substantial. This includes segmentation by different

Gaps

- **England** New mandatory reduced data system from the HSCIC may take 2 years to mature, so current data collection is incomplete and too limited in scope.
- **Northern Ireland, Scotland and Wales** Data collection too limited.
- Loss of in-depth qualitative information to help guide decisions.

Recommendations

- **England** Mandate the following additional routine data collection and incorporate into routine midwifery and health-visiting services (to minimise cost and workload) by extending the Maternity Services Dataset and the Children's and Young People's Health Services Dataset:
 - 10 days (midwife handover to HV);
 - prevalence of exclusive and partial breastfeeding at 4 months and 6 months, introduction of solids, prevalence of breastfeeding at 12 months;
 - prevalence of breastfeeding at 2 years.
- **Northern Ireland** To collect beyond 12 months.
- **Scotland** To set up routine data collection beyond 6–8 weeks to include prevalence at 4 months, 6 months, 12 months and 2 years, and introduction of solids.
- **Wales** To collect beyond 6 months.
- Use smaller electronic surveys to gather more in-depth qualitative information to complement the quantitative data in the above datasets.

population groups to support the targeting of services, and tracking associations over time to provide an insight into ways to improve longer-term health and wellbeing outcomes.

The full range of data referred to in Indicators 11–15 could be collected by HVs at their currently mandated visits at 10–14 days, 6–8 weeks, 1 year and 2–2.5 years by extending the use of the Maternity Services Dataset and the Children's and Young People's Health Services Dataset. However, that mandate ends in 2017 and commissioning of health-visiting services became the responsibility of local authorities in October 2015, making the current situation uncertain.

Northern Ireland Northern Ireland's strategy for breastfeeding is set out in *Breastfeeding – A Great Start: A Strategy for Northern Ireland 2013–2023*.¹⁰ One of its four strategic outcomes is

'high quality information systems ... in place that underpin the development of policy and programmes, and which support strategy'.

Accordingly, Northern Ireland's BSISG has a monitoring and indicators workstrand that reports trends, and it aims to improve data collection.

Infant feeding statistics are collected from the Northern Ireland Maternity System and the Child Health System (CHS). Historically, the CHS has collated information about the feeding status of infants at discharge from hospital. However, in 2010 the system was updated to enable the recording of infant feeding

status at additional time points of 10 days, 6 weeks, 3 months, 6 months and 12 months, in line with the country's Healthy Child, Healthy Future framework. These data give an indication of the duration of breastfeeding.^{10,11}

The PHA produces an annual health intelligence briefing on breastfeeding. This details progress at regional and trust level and is shared with stakeholders. The agency also requires infant feeding method monitoring at regional and local levels against agreed objectives for contracts relating to breastfeeding.

Attitudes to breastfeeding are collected as part of other wider government surveys in Northern Ireland, including the annual Department of Health, Social Services and Public Safety (DHSSPS) Health Survey Northern Ireland¹² and the Young Persons' Behaviour and Attitudes Survey of 11–16-year-olds,¹³ but there is no regular interval for the inclusion of questions about breastfeeding.

Scotland In 2011 the Scottish Government launched its infant feeding strategy, *Improving Maternal and Infant Nutrition: A Framework for Action*.¹⁴ This includes the monitoring and evaluation of actions, inputs, outcomes and breastfeeding rates.

Local health board programmes are required to provide the Scottish Government with relevant information to monitor the implementation of the national strategy and evaluate its impact. The country's Information Services Division (ISD) provides

quarterly and annual breastfeeding data reports to the government and NHS boards.

All maternity settings in Scotland are now Unicef UK Baby Friendly accredited, and breastfeeding initiation rates are monitored via the BFI audit process (see Indicator 2). Unicef UK provides progress monitoring reports to the Scottish Government.

The proportion of mothers who initiate and continue breastfeeding, partially or exclusively, up to 6–8 weeks, is monitored and published annually by NHS National Services Scotland in *Breastfeeding Statistics Scotland*.¹⁵ Statistics are presented by the NHS board of residence, local authority, maternal age, deprivation and smoking status. Breastfeeding from birth (initiation) up to 5–7 days is collected via the blood spot screening system and reported annually by the hospital of birth. After that, the information is derived from data collected at routine child health reviews at around 10 days and 6–8 weeks of age, and this is recorded on the child health pre-school system (known as CHSP Pre-School). In this dataset, EBF is defined as having breastfed exclusively from birth and in the last 24 hours, in line with the WHO definition.

Following the cessation of the UK-wide IFS, the Scottish Government is considering various options for collecting information routinely on breastfeeding at 6 months and beyond, and on complementary feeding. At present, no data are collected routinely beyond 6–8 weeks. Work is under way with a Scottish-only IFS¹⁶ with a report due in 2017, which will be based on 2016–2017 data.

Wales In 2011 the Welsh Government published *A Strategic Vision for Maternity Services in Wales*,¹⁷ which covers breastfeeding. Members of Public Health Wales' Early Years Programme¹⁸ worked with the Welsh Government Maternity Strategy Implementation Group to develop a number of indicators for the maternity strategy. Those relating to breastfeeding were:

- percentage of women exclusively breastfeeding at birth (measured at birth);
- percentage of women exclusively breastfeeding at 10 days following birth;
- percentage of women breastfeeding at 8 weeks following birth.

Current data collection points are birth, 10 days, 6 weeks and 6 months. An all-Wales Report Card is planned to be produced shortly.¹⁹

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Indicators 11–15

Feeding practices

Indicator 11

Early initiation of breastfeeding

UK

9/10 (60%)

Key question *What percentage of babies are breastfed within the first hour following birth?*

Key finding

Skin-to-skin contact after birth is generally seen as normal practice in the UK, especially with the widespread adoption of the UK BFI protocols. The focus is on the baby having a first feed when ready rather than within an hour. According to the 2010 IFS¹ (chapters 2 and 4), the incidence of breastfeeding was 81% for the UK; 74% of these mothers who initiated breastfeeding put the baby to the breast in the first hour after birth, corresponding to 60% of all babies.

England More recent breastfeeding initiation data are available via the PHOF, but initiation is defined as the percentage of mothers who put their baby to the breast in the first 48 hours after birth. In theory, data are incorporated from all hospital trusts in England, but data collection is not mandatory and there are some gaps. For 2014/2015 the rate was 74.3%.

Initiation of breastfeeding within the first hour

WHO's key to rating (%)	IBFAN Asia guideline for WBTi	
	Score	Colour rating
0.1–29	3	
29.1–49	6	
49.1–89	9	
89.1–100	10	

Credit: IBFAN Asia

Initiation data by country

Country	IFS initiation rate (%)
England	83
Northern Ireland	64
Scotland	74
Wales	71

Data source: IFS 2010, which sampled the population of babies in the four countries of the UK.¹ Incidence of breastfeeding is defined as the percentage of babies put to the breast at least once.



Indicator 12

Exclusive breastfeeding for the first six months

UK

6/10 (17%)

E		6 (18%)
NI		3 (10%)
S		6 (17%)
W		6 (13%)

Key question What is the percentage of babies 0–6 months of age who are exclusively breastfed?

Key findings

Although around four out of five UK mothers start breastfeeding, there is a rapid decline in both any breastfeeding and EBF, particularly in the first few weeks after birth.

The 2010 IFS explains (Section 2.5) that the 1991 WHO definition of EBF is used (infant receives only breastmilk, and no other liquids or solids, with the exception of medicine, vitamins or mineral supplements). Mothers were asked whether the baby had been exclusively breastfed since birth, rather than taking a snapshot of the situation. This definition is a stricter measure than using EBF in the last 24 hours, so it is likely to give a lower figure.

The measure calculated here is the mean amount of EBF in babies younger than 6 months and has been worked out using the WHO tool.³ The percentage of UK babies aged 0–5 months fed exclusively with breastmilk was calculated as the mean of the values at 1, 3 and 5 months. The mean value of these is 17%.

As the infant death rate in the UK is low, it is sufficient to use percentages and not to convert to the actual numbers of infants.

The value can be understood as the total quantity of EBF in babies younger than 6 months and it is equivalent to just 17% of babies being breastfed exclusively for 5 months.

Exclusive breastfeeding for the first 6 months

WHO's key to rating (%)	IBFAN Asia guideline for WBTi	
	Score	Colour rating
0.1–11	3	
11.1–49	6	
49.1–89	9	
89.1–100	10	

Credit: IBFAN Asia

Percentage of babies 0–5 months exclusively breastfed

Age range (months)	%
0–1	30 (at 4 weeks)
2–3	17 (at 3 months)
4–5	5 (at 5 months)

Data source: IFS 2010¹

Percentage of babies 0–5 months exclusively breastfed, by country

Country	%
England	18
Scotland	17
Wales	13
Northern Ireland	10

Data source: IFS 2010¹

Indicator 13

Median duration of breastfeeding

UK **3/10 (3 months)**

E		3
NI		3
S		3
W		3

Key questions *Babies are breastfed for a median duration of how many months?*

Key findings

The WHO's IYCF Tool² defines the median duration as 'The age in months when 50% of children are no longer breastfed.' This is around 3 months (between 6 weeks and 4 months; Table 2.11 of the 2010 IFS¹ shows 55% of babies were being breastfed at 6 weeks, but only 42% at 4 months; see also 2010 IFS Figure 2.6).

The rapid decline in the breastfeeding rate in the first days and weeks after birth is illustrated by the short median durations.

There are marked differences between the different UK countries, but all four fall significantly below the WHO's recommendation of at least 2 years of breastfeeding alongside suitable complementary foods.

Median duration of breastfeeding

WHO's key to rating (months)	IBFAN Asia guideline for WBTi	
	Score	Colour rating
0.1–11	3	
18.1–20	6	
20.1–22	9	
22.1–24 or beyond	10	

Credit: IBFAN Asia

Median duration across the UK

England	6 weeks to 4 months (~3 months)
Northern Ireland	5 days
Scotland	6 weeks
Wales	just over 2 weeks

Data source: IFS 2010¹



Indicator 14

Bottle feeding

UK

3/10 (88%)

Key question *What percentage of breastfed babies up to 12 months of age are fed with any food or drink (even breastmilk) from bottles?*

Key findings

Using bottles and infant formula is perceived as culturally normal in the UK, and many mothers who are breastfeeding will offer occasional bottles of expressed breastmilk or formula.

In the 2010 IFS, 80% of mothers had already used a bottle at Stage 1 (babies of 4–10 weeks old). The Diet and Nutrition survey included babies up to 18 months. This shows that 88% of all babies had had a bottle by the age of 10–11 months.

For a graph illustrating the rapid introduction of formula by age of infant in the UK, see Part 2.⁵

Bottle feeding up to the first 12 months

WHO's key to rating (%)	IBFAN Asia guideline for WBTi	
	Score	Colour rating
29.1–100	3	
4.1–29	6	
2.1–4	9	
0.1–2	10	

Credit: IBFAN Asia

Percentage of children fed by bottle, by age

Age (months)	All children fed by bottle (%)	
	Yes	No
4–6	88	12
7–9	88	12
10–11	88	12
12–18	80	20
Total	84	16

Data sources: 2011 Diet and Nutrition Survey⁴

Indicator 15

Complementary feeding (introduction of solid food)

UK

10/10 (98%)

Key question What percentage of babies receive complementary foods at 6–8 months of age?

Key findings

According to the 2010 IFS¹ (Table 8.1), 94% of UK mothers had introduced solids by 6 months, but 75% had already introduced them by 5 months and 99% had introduced them by 9 months.

The Diet and Nutrition Survey (DNS) was based on all children who had been given food, which was 99% of those surveyed. Nearly all (98%) had been introduced to solids before 8 months.

In the UK, solids are often introduced before the recommended age of 6 months. According to the DNS, 74% of babies aged 5 months or younger had been offered solids and the mean age of introduction was 4.7 months. The UK BFI/DH Start4Life leaflet 'Introducing Solid Foods' is clear that the recommended age for introducing solids is 6 months.

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Complementary feeding, 6 to 9 months

WHO's key to rating (%)	IBFAN Asia guideline for WBTi	
	Score	Colour rating
0.1–59	3	
59.1–79	6	
79.1–94	9	
94.1–100	10	

Credit: IBFAN Asia

Age of child when they first had any food apart from milk

Age (months)	All children who have ever had any food apart from milk (%)
	Yes
≤3	10
4	32
5	32
6	22
7	2
8	1
9	0
10	0
11	–
12	0
Total under 8 months	98

Data sources: 2011 Diet and Nutrition Survey⁴



The way forward: A call to action

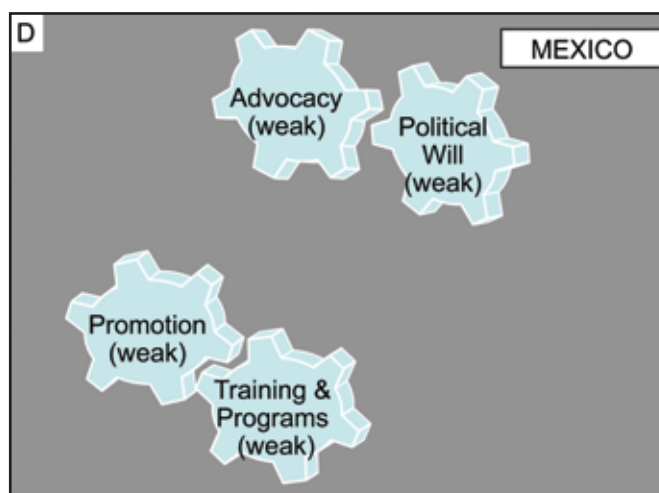
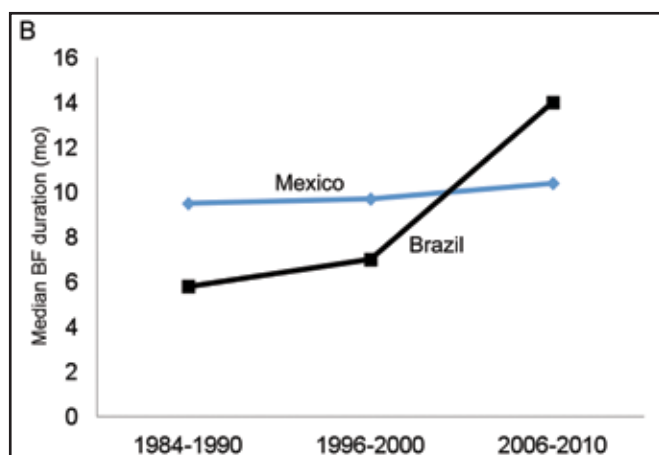
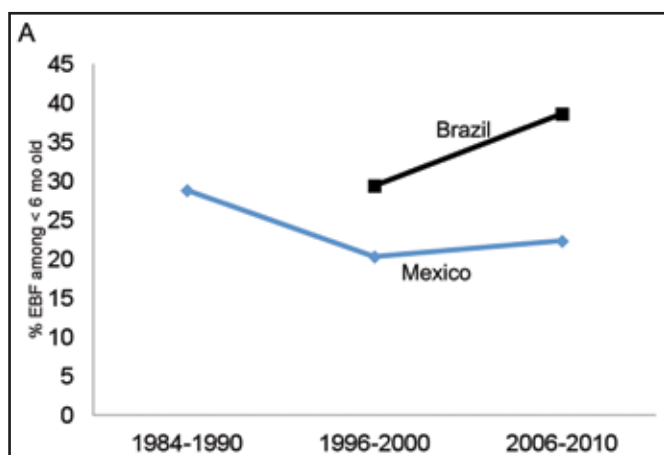
Improving policies, programmes and practice in the UK

Infant feeding should be at the heart of public health, and there is widespread agreement on the need for stronger policies and practices in the UK. However, despite the overwhelming evidence that breastfeeding protects and enhances health and wellbeing, it has become a contentious subject and progress in improving infant and maternal health through breastfeeding has been slow.

Interventions that have been shown to work have been well documented^{1,2,3,4} and are recommended in NICE guidance.⁵

Model policies and toolkits developed for use in high-income countries, specifically in a European context, can be found in the European Blueprint for Action on Breastfeeding,⁶ and a costing tool for planners covering the policies in the WBTi assessment is available.⁷

The Breastfeeding Gear Model illustrates the importance of having joined up and nationally coordinated policies and programmes across all sectors, which greatly increases the effectiveness of individual interventions. 'The key program components are highly interdependent; thus, once any of the key elements in the system starts to fail, the engine that drives the BF [breastfeeding] promotion program starts unraveling.'⁸



The Breastfeeding Gear Model. Countries that lack national coordination and sufficient joined-up policies and programmes see little improvement in breastfeeding rates. Thus rates in Mexico, where few programmes are in place and national coordination is weak, are relatively stagnant. Meanwhile in Brazil, with strong national coordination and a comprehensive and joined-up set of policies and programmes, breastfeeding rates have improved significantly.⁸

Political will and national coordination are essential components of the success of interventions overall.⁹

To highlight trends and progress, the WBTi assessment is designed to be repeated every 3–5 years. This report will provide a basis for the next assessment.

During the assessment process, awareness has been raised of the importance of breastfeeding for all families. More collaborative work is already happening. More than 30 organisations signed an open letter¹⁰ in response to the 2016 *Lancet* series on breastfeeding; several dozen organisations and thousands of individuals supported the BFI's call to action;¹¹ and a national meeting was convened on the development of a national infant feeding coalition.

At the political level, an All-Party Parliamentary Group on Infant Feeding and Inequalities has been formed to hear evidence and research, and to move infant feeding into every relevant area of policy and legislation.

Call to action

The recommendations in this report target gaps and have broad support, so they will help policy-makers and commissioners to use resources more effectively.

Some of the recommendations are relatively easy to put in place; others will be more challenging and complex. In other countries, governments have found that improving data collection and monitoring was a relatively simple way to improve scores and provide a starting point for developing appropriate interventions.

Action is needed at every level, from communities and local government, to the health system, and at national government level. Yet only national leadership will drive change forward sustainably. This report and its recommendations are our collective call to action to all our governments and to every level of society.

We are all responsible for the future of our nation's children.

Information sources

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Methodology

A UK WBTi Steering Group was established at the request of the Baby Feeding Law Group, composed of HCPs, IBCLCs and volunteer breastfeeding counsellors, drawn from a number of UK breastfeeding organisations. It coordinated a Core Group of around 20 organisations and individuals working in maternal and infant health, including governmental agencies, health professional bodies, voluntary mother support organisations and other relevant specialists and NGOs. The Core Group gathered and reviewed information and data from relevant UK organisations using the 2014 WBTi Assessment Tool questionnaire.¹ The Steering Group coordinated data collection and produced the report.

All organisations in the Core Group involved in policy discussions were independent of baby feeding industry sponsorship in accordance with WBTi practice and the position statement on Sponsorship and Conflict of Interest of IBFAN.² The Core Group met in September and December 2015 and February 2016, and data collection and analysis were undertaken by e-working groups to complete the report for publication in autumn 2016. Other relevant organisations working with mothers and children in all four nations of the UK, both governmental and civil society, were invited to submit referenced material for the report.

To track progress, the WBTi process is designed to be repeated at 3–5 year intervals.

Data collection and analysis

Data and information were collected following the methodology set out by WBTi's organising office at IBFAN Asia. Information was gathered via emails, letters, telephone calls, interviews, online surveys of mothers, parliamentary questions, ministerial questions and freedom of information requests. Where possible, the most current data available has been used (i.e. 2015–2016), but the most recent national IFS was in 2010.

The scoring for WBTi was adapted from WHO's 2003 *Infant and Young Child Feeding: A Tool for Assessing National Practices, Policies and Programmes*³ by IBFAN Asia to make it simpler to implement and more accessible, including a system of colour coding.

The WBTi Assessment Tool is designed to be

IBFAN Asia guideline for WBTi

Score	Colour rating
0–3.5	Red
4–6.5	Yellow
7–9	Blue
>9	Green

Credit: IBFAN Asia³

applied globally in a variety of national contexts, so the questions and scoring are necessarily very general. In most cases the score for each question within an indicator is either 2, 1, 0, or 1, 0.5, 0. If information or monitoring is available, a partial score is given even if the country has nothing in place for that item.

Scoring

Maximum score Adequate

Partial score Inadequate

0 No information

The outcome indicators of breastfeeding practices and breastfeeding rates are calculated according to WHO and WBTi definitions and methodology, using available statistics, such as the UK IFS.

One aspect of the UK assessment that differs from that of other countries is the extent to which the voices of women were included. Through social media and mother-support organisations, women were invited to share local experiences. For Indicator 5 this included a survey of women's experiences of breastfeeding in hospital, and for Indicator 6 women's experiences of peer support and the impact of cuts on local breastfeeding groups were collected.

As most health-related issues are devolved to the four nations, each country was scored individually and then an overall score for the whole of the UK was calculated, weighted for population. In some cases, most or all of the four nations are covered by the same UK legislation (see Indicator 3 on the Code and Indicator 4 on Maternity Protection) or the same health-professional training standards (Indicator 5).

Evidence of implementation or gaps is required for each item that is scored. Some respondents submitted proposed scores, and the Steering Group assessed the evidence to assign a preliminary score for each item. The scores were submitted to the full Core Group, along with the text of the findings for each indicator, to allow for corrections and consensus agreement. Different parts of the report were also sent to two external reviewers for comment.

The final draft of the report was submitted to the WBTi office at IBFAN Asia for verification, based on the evidence, references and sources of information listed in the report and to be cross-checked against other standard references, such as the International Code Documentation Centre's *State of the Code by Country* report⁴ for Indicator 3, and WABA's *State of Maternity Protection by Country*⁵ for Indicator 4.

Each indicator chapter in this report offers an explanation of the subject area, data collected, score table and recommendations for action. Based on the gaps identified, the Core Group developed recommendations, with the key ones agreed by consensus to form the basis of the report card. Input was encouraged at every stage from all Core Group members. Report card summaries were prepared for the UK overall as well as for each individual nation.

Limitations

The WBTi Assessment Tool and scores are necessarily very broad as the tool is designed to produce a summary of IF policy and programmes in countries with different national systems all over the world. As the data and results are generated by the agencies and organisations within a country, it is not an external assessment and the data and information are only roughly comparable between different countries.

This report represents the first summary of wide-ranging policies and practices in the UK based on the *Global Strategy*. Some data proved difficult to access, and some organisations that were contacted did not participate in the assessment process. The scoring was made by consensus and is therefore subjective, although discussions among a range of individuals and organisations across the UK strengthened the

scoring process and the recommendations.

The quality of research on infant feeding varies. Much work in the UK has relied on loose definitions such as 'ever breastfed' v 'never breastfed', and it is clear that this can obscure many of the effects being studied.

'It is essential that future data collection and research commissioned in the UK use standardised definitions and qualitative data from mothers in order to fully understand the impact of infant feeding method.'

Strengths

The two core strengths of the WBTi are the collaborative nature of the process, which gives weight to the joint recommendations, and the breadth of the assessment across many policy areas.

The assessment provides a summary of policies and practices in the UK in 2016, and a baseline from which developments can be measured. The gaps identified and information collected here may support policy-makers, commissioners, health professionals, researchers and NGOs to resource interventions more effectively.

The recommendations for action have been developed by the Core Group so have the backing of a range of governmental, health professional and civil society organisations.

Information sources

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Additional organisations consulted

British Dietetic Association
Cabinet Office
Department of Health
General Medical Council
General Pharmaceutical Council
Nursing and Midwifery Council
Public Health Agency Northern Ireland
Public Health Scotland
Public Health Wales
Royal College of General Practitioners
Royal College of Midwives
Royal College of Paediatrics and Child Health
Royal College of Obstetricians and Gynaecologists
Unite, the Union of Community Practitioners and Health Visitors Association
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Summary of key gaps

- England has no national infant feeding strategy and there is no formal route to communicate or share best practice across the four home nations.
- The Unicef UK Baby Friendly Initiative is not mandatory in all relevant healthcare settings.
- The International Code of Marketing of Breastmilk Substitutes and subsequent Resolutions are not fully implemented or enforced.
- There is no legal requirement for breaks at work for breastfeeding/expressing milk.
- There is insufficient training of all health professionals in essential infant feeding knowledge and skills.
- Mothers in some areas lack access to skilled breastfeeding support.
- Data collection is inadequate.

Summary of key recommendations

- UK Government to set up a permanent multi-sectoral infant feeding body in England to develop national strategy, and the home nations to have a formal arrangement to share best practice.
- All governments to achieve and maintain full implementation, with funding, of the Unicef UK Baby Friendly Initiative in all relevant healthcare settings.
- All governments to fully implement and robustly enforce the International Code of Marketing of Breastmilk Substitutes and subsequent Resolutions.
- All governments to update legislation to include breaks for breastfeeding/expressing milk and associated facilities in the workplace.
- All health professional training bodies to set standards for health professionals that meet World Health Organization/Baby Friendly Initiative guidelines.
- Commissioners throughout the UK to ensure full access to skilled breastfeeding support.
- All national infant feeding strategies to include the collection of quality data built into health systems.

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**‘Success in
breastfeeding
is not the sole
responsibility of
a woman – the
promotion of
breastfeeding is a
collective societal
responsibility’**

The Lancet

IBFAN’s World Breastfeeding Trends Initiative is a collaborative process to monitor the implementation of the Global Strategy for Infant and Young Child Feeding and to generate action.
worldbreastfeedingtrends.org

