Why don’t more women breastfeed their babies in North Lincolnshire?

Introduction
Breastfeeding is one of the most important things that parents can do to protect and promote the health of their newborn infants.

Yet local breastfeeding rates are at least 20% below the national average. Not only do fewer North Lincolnshire women try breastfeeding their babies at birth – when they do, they are more likely to give up within the first few days and weeks. In 2008/9 breastfeeding rates at birth were 58% in North Lincolnshire compared with over 70% nationally. In the same year, 29% of North Lincolnshire women were still breastfeeding at 6-8 weeks compared with at least 50% nationally.

Breastfeeding is a major health inequalities issue. National and local research data show that women from poorer communities and particularly young, low income White women, are least likely to breastfeed. Yet their babies are at greater risk of poor health, childhood infections and hospital admissions. Targeting these groups could impact significantly on local child health inequalities and the incidence of long term conditions in later life and could reduce the cost of poor health both to families and to the NHS.

Breastfeeding at 6-8 weeks is both a key national performance indicator and a local priority for health improvement, with a commitment to more than double current rates by 2014 to almost 64%. This means encouraging an additional 500+ women a year to continue breastfeeding for at least 6-8 weeks.

Meeting this target is likely to present a considerable challenge. Not least because more than a third of North Lincolnshire births are to women who live in our most deprived neighbourhoods, where rates of breastfeeding at birth do not exceed, (and in some places fall well below) 44% and where continuation rates at 6-8 weeks are as low as 11%. Even in our most affluent communities initiation and continuation rates do not match the national average of 75% and 50% respectively.
Aims
The main aims of this study were to

- find out what is preventing more local women from breastfeeding their babies;
- identify key messages to inform a series of local, targeted social marketing campaigns
- suggest how services might be improved to help support local women to breastfeed for longer.

Methods
- Thematic analysis of 13 focus groups with Mums and Dads;
- At least 1 of these groups reflected the needs of BME communities
- 2 were with men/Dads.
- 3 were with young Mums and Dads (<19 yrs)
- All parents were recruited via community development workers and family support staff across North Lincolnshire.
- The focus of the research was on the Acorns and Crosby areas of North Lincolnshire – our two most deprived areas – where breastfeeding rates are lowest.
- However focus groups also took place in our rural communities as well as in some of our more affluent urban areas.
- Analysis of 4 professional focus groups with health visitors, midwives and peer supporters.

Results
Some of the most common perceptions and barriers to breastfeeding include:

- Commonly held view that artificial milk is a good enough substitute for breast milk - in spite of research evidence to the contrary.
- Breastfeeding perceived as an outmoded and impractical alternative to artificial feeding.
- Breastfeeding viewed as an unnecessary, eccentric and messy bodily function.
- Decision to use artificial milk rather than breastfeed perceived to be a personal lifestyle choice rather than a child and maternal health issue.
- Fear of exposing breasts and offending the general public, family, peers and partner
- Fear of excluding partner and being 'burdened' with fulltime care of infant
- Fear of failure, pain and being overwhelmed by the additional physical and emotional demands of breastfeeding
- Fear that breastfeeding will impede return to 'normal life' and return to work in particular
- Lack of role models and informal sources of support and advice in the immediate family and local community
- Nowhere in the Town centre for women to breastfeed
- Breastfeeding perceived by women as unattractive to men and a challenge to their sexual identity and independence.
- Perception that if breastfeeding doesn’t happen naturally and painlessly in the first three days, then there must be something terribly wrong.

Attitudes to breastfeeding are often formed in early life – hence the urgent need to normalise breastfeeding amongst the young and promote the health benefits from an early age. However, with fewer than 1 in 3 women still breastfeeding their babies at 6-8 weeks in North Lincolnshire, it is unlikely that many young people will have the opportunity to see a baby breastfed first hand.

This was confirmed by a small survey of young people who attended North Lincolnshire’s ‘Youth Debate’ in the autumn of 2008. Of the 50 local young people who took part in an opportunistic survey, only a handful had seen a relative or friend breast feed their baby. Although many young people were aware of the health benefits, (awareness being highest...
amongst older teens), few said they would consider breastfeeding themselves. The main barriers they identified were embarrassment, lack of time, fear of pain, and fear of damaging their figure.

Many of these negative perceptions are shaped by the attitudes of family, partners, friends and the general public. Relatively few of the women we spoke to had any experience of breastfeeding within their immediate family and social networks. Few had attended parentcraft sessions during their pregnancy. Social and cultural attitudes, rather than health messages thus exert a very strong influence on women’s decision to breastfeed.

In spite of this, many women said they might consider breastfeeding their next child, whilst others regretted not persevering with breastfeeding their babies for longer. This suggests that more women could be persuaded to breastfeed with the right information and advice, and with more positive encouragement and support, from partners, family and friends.

The research also suggests a significant level of unmet need for breastfeeding support in the first two weeks after birth in North Lincolnshire. The first 3-4 days post delivery were regarded by parents as critical to success, as it was usually at this point that problems arose and that they ceased feeding.

You start worrying that they’re not getting enough and it all starts going down hill from there. You blame yourself.’

Many of the women we spoke to had ceased feeding within the first week, largely as a result of:

- Soreness
- Fears that baby was not getting enough milk
- Tiredness
- Baby not latching on
- Lack of confidence that things would improve

The input of the midwifery team, and especially the specialist breastfeeding midwife in these first few days were regarded by professionals and parents alike as invaluable, particularly for women with severe problems or complex needs.

However many women were reluctant to bother the midwifery team further once they were discharged home and felt that significantly more low level support could be delivered in the community through a combination of trained supporters, volunteers and local mentors. Few if any of the women we spoke to had heard of peer mentors.

‘I only rang the midwife out of desperation – but you know how busy they are. In the night, when things get really bad you really don’t want to bother them. You know they’ve got more important things to deal with and that they can’t drop everything and come out’

‘You give it a go in hospital, but its all very different when you get home and when your milk comes in. It all takes time to settle down – you need someone you can call on for help – not necessarily a nurse or a midwife – to get you through the first week or two.’

‘Women need more information on the highs and lows – and how some of the common problems can be overcome.

‘Get a breastfeeding Mum and a bottle-feeding Mum into parentcraft to talk about the advantages and disadvantages of each’.

They tell you it’s the best thing and then they leave you to get on with it. I was given a leaflet with a number on it – but when I rang it no one answered”

‘Its one thing encouraging more women to give a first feed – but if the
help isn’t there afterwards you feel really let down.’

‘If only I had known what to expect and who to talk to. I rang the hospital in the early hours and they told us to come in. The midwife was really good but she could see that I was struggling and the baby was just past it at that point and she suggested that I try formula so I did.’

Women were also clear that these peer supporters should be recruited from local neighbourhoods, have a good understanding of their local communities and be accessible to local women.

“If they want us to use peer supporters then tell us who they are or at least give us a number of a local Mum who is interested in giving help so we know how to get over some of the early problems’

‘Peer supporters should be introduced to women earlier on – at antenatal visits and on the ward.’

“We need a link person attached to every Children’s Centre so that women know where to access help in their own community.’

Another commonly mentioned barrier was the lack of ‘baby friendly’ places in Scunthorpe. Few women in our study could name any cafes or shops in North Lincolnshire where nursing mothers would feel comfortable feeding their babies and most said they would be unwilling to breastfeed in public for fear of drawing attention to themselves or causing offence to others. What facilities there were, we were told, were smelly, overused and often unclean and uncomfortable.

“We need drop in centres all around the town and across the whole of North Lincolnshire where women know they can call in and feed. Children’s Centres, GP surgeries and so on’

Marketing messages
When asked for ideas and themes for a local breastfeeding marketing campaign, parents and professionals offered the following suggestions:

• Celebrate the breastfeeding choice – reward women, their partners and families make them feel special and empowered

• Avoid imagery which shows breasts exposed – it reinforces fears about causing offence or having to hide away to feed their babies. It also supports a very strong local misconception that breastfeeding is all about exposing breasts.

• Tackle the image of breastfeeding as old fashioned and unnecessary. Sell it as a modern convenient product for busy families (which can also save you time and money and keep you looking good) the same way that instant mash was marketed in the 1970s!

• Tell it like it is – keep it real for women and families. Yes it might mean some sacrifices and changes to daily routines – but they’re worth it in terms of the health benefits. Women and families don’t know what they’re missing.

• Use messages which challenge local myths and misconceptions about breastfeeding that get handed down between generations and within communities.

• Use local people and familiar voices to get the message across.

• Reassure families that whilst some problems are common in the early days they can be overcome with a little support at the right time.

• Direct your campaigns at significant others, partners and extended family. Their role is
crucial to supporting breastfeeding Mums.

- Target young people. They are the parents of tomorrow and have limited familial experience of breastfeeding. Begin early and get the message across to children and young people in nursery primary and secondary schools.

- Involve local people in the design of these campaigns.

**Segmenting the market**

Effective social marketing depends on knowing how to persuade people to change their behaviour in the desired direction. What the benefits and costs of these actions might be for different social groups, and how best to engage people with a simple but effective marketing message. This approach requires knowing more about people’s attitudes, habits and beliefs as well as the types of messages they are most receptive to.

An essential starting point to understanding your target group is the process of ‘audience segmentation’. Basically this means dividing the market or audience into segments or subgroups of people with similar characteristics, needs, attitudes and behaviours. The idea being that these audience subgroups can be prioritised, and resources focused where they are likely to be most needed and where they will be most effective.

There are already a number of tools on the market that provide us with some of this additional information on household types and customer behaviour. Mosaic Public Sector is one such tool. Basically, it segments the population into 11 different household ‘types’ (and 61 sub-groups) according to the age, occupation, and income of the main householder, the location and type of housing, and the spending patterns, health behaviours, pastimes, and habits of household members.

Table 1 below shows the distribution of these national Mosaic types across two years worth of local births. It also shows the proportion of women who breastfeed at birth and at 6-8 weeks within each Mosaic group. (These groups are described in more detail in the appendix.)

**Establishing the target audience**

Identifying the key audience for a social marketing campaign usually involves finding and agreeing answers to the following three questions.

- Who are the biggest group, not just numerically, but in terms of impact on our overall goal (health improvement reducing health inequalities)?

- If we focused on one group over another, what would be the knock-on effect on other audience segments?

- Who is the target audience for a marketing campaign – the patient/service user, a significant other or the general public?

**Traditional working families**

Groups D and H, (traditional working families and affluent blue collar workers) are numerically the biggest groups in North Lincolnshire, accounting for almost half of all births and almost two thirds of all artificially fed babies. Increasing initiation and continuation rates amongst this group could make a significant impact on our overall rates. Currently between 50% and 57% of this group initiate breastfeeding, with only 28% continuing to 6-8 weeks. Raising continuation rates by 10% per year in these two groups alone, would result in a 4 percentage point increase in our overall rates each year. This would take us more than half way towards our challenging 5 year target.
Groups F and G – very low income families and Teen Mums have the lowest breastfeeding rates, and are likely to be the hardest to shift in behavioural terms.

Whilst numerically small, Group F are perhaps the most vulnerable. Doubling breastfeeding rates amongst this group would make little impact on our overall rates, but would impact significantly on inequalities in infant health. They are also the Groups G and D of tomorrow – so we need to intervene now.

Group G is significantly larger in number than Group F and is the second most deprived Mosaic group. Persuading this group to breastfeed and for longer is likely to require a very different approach to one designed specifically for Group F or for Group D and could take longer to achieve. However, this would have the greatest impact on reducing inequalities.

Both groups are likely to require a specific, long term and multifaceted approach if we are to convince more women in these groups to breastfeed and for longer.

Groups B and C, our more affluent and upwardly mobile professional families, already have higher than average breastfeeding initiation rates and might be persuaded to breastfeed for longer with only a modest amount of additional support and advice. For example, through the establishment of local support networks and voluntary groups in the area, eg La Leche and NCT.

What attitudes and behaviours characterise these groups?

For example,
• How much do they know about the health and other benefits of breastfeeding?
• Where do they get this information?
• What are the perceived costs and benefits of breastfeeding vs formula feeding for each
• Who in their groups are likely to care most deeply about this issue?
• Which groups are likely to be most vociferous?

The pen portraits in the appendices attempt to answer some of these questions. The quotes used and categorisations made, are based entirely on the words of local parents and professionals. More work is required to segment these groups into ‘breastfeeding types’, and to develop an appropriate single marketing message and strategy for each.

The map and tables below show how these groups are distributed geographically across North Lincolnshire wards and the five localities.

As the table shows, those groups who are least likely to breastfeed are located primarily in our most deprived wards – namely Brumby, Crosby, Frodingham and Town.
<table>
<thead>
<tr>
<th>Mosaic Group</th>
<th>All N Lincs Births (2006/8) %</th>
<th>Deprivation rank where 1 = most deprived 11 = most affluent</th>
<th>Breastfed at birth (2006/8) %</th>
<th>Breastfed at 6-8 weeks (2006/8) %</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Group E</strong></td>
<td>0.1%</td>
<td>6</td>
<td>75%</td>
<td>50%</td>
</tr>
<tr>
<td>High quality recent graduates</td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td><strong>Group C</strong></td>
<td>14%</td>
<td>10</td>
<td>72%</td>
<td>49%</td>
</tr>
<tr>
<td>Suburban comfort</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Group A</strong></td>
<td>1.8%</td>
<td>Most affluent</td>
<td>71%</td>
<td>67%</td>
</tr>
<tr>
<td>High income earners successful careers</td>
<td></td>
<td></td>
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</tr>
<tr>
<td><strong>Group J</strong></td>
<td>3%</td>
<td>7</td>
<td>70%</td>
<td>45%</td>
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<tr>
<td>Secure income – urban dwellers</td>
<td></td>
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<td></td>
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<tr>
<td><strong>Group K</strong></td>
<td>3%</td>
<td>8</td>
<td>69%</td>
<td>56%</td>
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<td>Traditional farming communities</td>
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<tr>
<td><strong>Group B</strong></td>
<td>13%</td>
<td>9</td>
<td>65%</td>
<td>27%</td>
</tr>
<tr>
<td>New starter families</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Group D</strong></td>
<td>31%</td>
<td>5</td>
<td>57%</td>
<td>22%</td>
</tr>
<tr>
<td>Traditional working families</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td><strong>NORTH LINCOLNSHIRE AVERAGE</strong></td>
<td>57%</td>
<td>29%</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Group H</strong></td>
<td>15%</td>
<td>3</td>
<td>50%</td>
<td>16%</td>
</tr>
<tr>
<td>Affluent blue collar</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Group F</strong></td>
<td>4%</td>
<td>Most deprived</td>
<td>37%</td>
<td>3%</td>
</tr>
<tr>
<td>Young single parents</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Group G</strong></td>
<td>14%</td>
<td>2</td>
<td>35%</td>
<td>12%</td>
</tr>
<tr>
<td>Low income families in deprived communities</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Group I</strong></td>
<td>0%</td>
<td>4</td>
<td>0%</td>
<td>0%</td>
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<tr>
<td>Older people with social care needs</td>
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</tbody>
</table>
Figure 1
Births to women in Mosaic Groups B, C, D, H, G (2006/8)
Table 2  
**Births to women by key Mosaic groups and locality (2006/8)**

<table>
<thead>
<tr>
<th>Locality</th>
<th>B New starter families</th>
<th>C Suburban comfort</th>
<th>D Traditional working families</th>
<th>F Hard pressed teen parents</th>
<th>G Low income families in deprived communities</th>
<th>H Affluent blue collar</th>
</tr>
</thead>
<tbody>
<tr>
<td>Axholme Area</td>
<td>7%</td>
<td>19%</td>
<td>5%</td>
<td>1%</td>
<td>2%</td>
<td>14%</td>
</tr>
<tr>
<td>Barton Area</td>
<td>25%</td>
<td>30%</td>
<td>13%</td>
<td>7%</td>
<td>13%</td>
<td>8%</td>
</tr>
<tr>
<td>Brigg Area</td>
<td>22%</td>
<td>28%</td>
<td>9%</td>
<td>-</td>
<td>3%</td>
<td>10%</td>
</tr>
<tr>
<td>Scunthorpe North</td>
<td>13%</td>
<td>5%</td>
<td>35%</td>
<td>33%</td>
<td>26%</td>
<td>10%</td>
</tr>
<tr>
<td>Scunthorpe South</td>
<td>33%</td>
<td>19%</td>
<td>39%</td>
<td>57%</td>
<td>57%</td>
<td>58%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>100%</strong></td>
<td><strong>100%</strong></td>
<td><strong>100%</strong></td>
<td><strong>100%</strong></td>
<td><strong>100%</strong></td>
<td><strong>100%</strong></td>
</tr>
</tbody>
</table>

Table 3  
**Births to women by key Mosaic groups and by ward (2006/8)**

<table>
<thead>
<tr>
<th>Ward</th>
<th>B New starter families</th>
<th>C Suburban comfort</th>
<th>D Traditional working families</th>
<th>F Hard pressed teen parents</th>
<th>G Low income families in deprived communities</th>
<th>H Affluent blue collar</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ashby</td>
<td>16.3%</td>
<td>1.4%</td>
<td>9.5%</td>
<td>5.1%</td>
<td>6.3%</td>
<td>16.4%</td>
</tr>
<tr>
<td>Axholme Central</td>
<td>1.9%</td>
<td>6.6%</td>
<td>0.4%</td>
<td>0.0%</td>
<td>0.0%</td>
<td>2.9%</td>
</tr>
<tr>
<td>Axholme North</td>
<td>3.0%</td>
<td>6.6%</td>
<td>4.1%</td>
<td>0.0%</td>
<td>1.0%</td>
<td>10.1%</td>
</tr>
<tr>
<td>Axholme South</td>
<td>1.7%</td>
<td>5.6%</td>
<td>0.4%</td>
<td>1.5%</td>
<td>0.6%</td>
<td>0.0%</td>
</tr>
<tr>
<td>Barton</td>
<td>5.8%</td>
<td>7.0%</td>
<td>5.2%</td>
<td>7.4%</td>
<td>6.7%</td>
<td>6.1%</td>
</tr>
<tr>
<td>Bottesford</td>
<td>10.7%</td>
<td>9.2%</td>
<td>8.6%</td>
<td>0.0%</td>
<td>0.0%</td>
<td>0.2%</td>
</tr>
<tr>
<td>Brigg and Wolds</td>
<td>1.7%</td>
<td>13.4%</td>
<td>3.9%</td>
<td>0.0%</td>
<td>1.4%</td>
<td>7.4%</td>
</tr>
<tr>
<td>Broughton &amp; Appleby</td>
<td>8.6%</td>
<td>6.0%</td>
<td>2.3%</td>
<td>0.0%</td>
<td>0.0%</td>
<td>2.6%</td>
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<tr>
<td>Brumby</td>
<td>3.2%</td>
<td>1.2%</td>
<td>3.6%</td>
<td>23.5%</td>
<td>30.4%</td>
<td>21.5%</td>
</tr>
<tr>
<td>Burringham &amp; Gunness</td>
<td>1.3%</td>
<td>0.8%</td>
<td>2.1%</td>
<td>9.6%</td>
<td>2.2%</td>
<td>0.9%</td>
</tr>
<tr>
<td>Burton upon Stather &amp; Winterton</td>
<td>9.9%</td>
<td>16.6%</td>
<td>4.2%</td>
<td>0.0%</td>
<td>6.7%</td>
<td>0.6%</td>
</tr>
<tr>
<td>Crosby and Park</td>
<td>5.8%</td>
<td>0.8%</td>
<td>19.2%</td>
<td>5.9%</td>
<td>19.0%</td>
<td>7.6%</td>
</tr>
<tr>
<td>Ferry</td>
<td>7.1%</td>
<td>7.0%</td>
<td>2.7%</td>
<td>0.0%</td>
<td>0.0%</td>
<td>1.7%</td>
</tr>
<tr>
<td>Frodingham</td>
<td>0.2%</td>
<td>0.0%</td>
<td>7.3%</td>
<td>27.2%</td>
<td>16.1%</td>
<td>10.1%</td>
</tr>
<tr>
<td>Kingsway with Lincoln Gardens</td>
<td>3.4%</td>
<td>4.0%</td>
<td>10.2%</td>
<td>4.4%</td>
<td>5.0%</td>
<td>8.1%</td>
</tr>
<tr>
<td>Ridge</td>
<td>10.7%</td>
<td>8.0%</td>
<td>2.1%</td>
<td>0.0%</td>
<td>1.0%</td>
<td>2.0%</td>
</tr>
<tr>
<td>Town</td>
<td>7.3%</td>
<td>3.8%</td>
<td>14.2%</td>
<td>15.4%</td>
<td>3.4%</td>
<td>1.5%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>100.%</strong></td>
<td><strong>100.%</strong></td>
<td><strong>100.%</strong></td>
<td><strong>100.%</strong></td>
<td><strong>100.%</strong></td>
<td><strong>100.%</strong></td>
</tr>
</tbody>
</table>
### Table 4
Breastfeeding rates at birth and at 6-8 weeks by ward

<table>
<thead>
<tr>
<th>Ward</th>
<th>At birth</th>
<th>6-8 weeks</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ashby</td>
<td>59%</td>
<td>10%</td>
</tr>
<tr>
<td>Axholme Central</td>
<td>74%</td>
<td>51%</td>
</tr>
<tr>
<td>Axholme North</td>
<td>60%</td>
<td>24%</td>
</tr>
<tr>
<td>Axholme South</td>
<td>63%</td>
<td>44%</td>
</tr>
<tr>
<td>Barton</td>
<td>66%</td>
<td>26%</td>
</tr>
<tr>
<td>Bottesford</td>
<td>67%</td>
<td>22%</td>
</tr>
<tr>
<td>Brigg and Wolds</td>
<td>65%</td>
<td>29%</td>
</tr>
<tr>
<td>Broughton &amp; Appleby</td>
<td>70%</td>
<td>26%</td>
</tr>
<tr>
<td>Brumby</td>
<td>36%</td>
<td>12%</td>
</tr>
<tr>
<td>Burringham &amp; Gunness</td>
<td>48%</td>
<td>14%</td>
</tr>
<tr>
<td>Burton upon Stather &amp; Winterton</td>
<td>62%</td>
<td>27%</td>
</tr>
<tr>
<td>Crosby and Park</td>
<td>47%</td>
<td>12%</td>
</tr>
<tr>
<td>Ferry</td>
<td>66%</td>
<td>29%</td>
</tr>
<tr>
<td>Frodingham</td>
<td>44%</td>
<td>9%</td>
</tr>
<tr>
<td>Kingsway with Lincoln Gardens</td>
<td>57%</td>
<td>18%</td>
</tr>
<tr>
<td>Ridge</td>
<td>65%</td>
<td>27%</td>
</tr>
<tr>
<td>Town</td>
<td>54%</td>
<td>22%</td>
</tr>
<tr>
<td>North Lincolnshire average</td>
<td>57%</td>
<td>29%</td>
</tr>
</tbody>
</table>

Breastfeeding initiation rates in North Lincolnshire by ethnic group  2006/8

- White: 55%
- Bangladeshi: 50%
- Indian: 78%
- Pakistani: 54%
- Polish: 78%
Service improvements
Many parents and professionals identified inconsistent advice from health professionals, as well as some negative attitudes towards breastfeeding, as a barrier to both initiation and continuation. Indeed, some professionals felt that at times the wrong advice from health colleagues often undid a lot of their hard work.

'My GP did not know what to do with us. He said I had mastitis and should stop feeding – so I did.'

'I went into hospital for minor surgery and the doctor told me I'd have to stop feeding – but I know now that isn't right – I could've carried on with the right help'

'My health visitor kept going on and on about how she wasn't putting on enough weight, so at 12 weeks I gave up and did as she suggested and put her on formula milk'

'When you're on the maternity ward and you want to talk to someone about breastfeeding you sort of get to know which midwives to ask and who not to ask'

All clinical staff should be equipped to deliver or at least signpost parents to appropriate and consistent advice about common breastfeeding problems and to appropriate sources of support.

The reasons why breastfeeding initiation rates are relatively low, (and declining) amongst some of our BME communities are not fully understood.

Health professionals told us there was a tradition of 'mixed' feeding amongst Bangladeshi women in North Lincolnshire, and assumed this must be linked to religious traditions. Indeed, some health workers told us that Muslim women regarded early breast milk (colostrum) as 'unclean', and that 'religious teachings' prevented Muslim women from breastfeeding until at least the 3rd day after birth.

Interestingly, none of the Pakistani and Bangladeshi women we met during the course of this research had heard of such a practice. Nor could we find any local religious support for this. In fact we were told by a local religious scholar that Muslim teachings encouraged rather than prohibited women from exclusive breastfeeding at birth and that there was no religious foundation for this practice.

More work is needed to engage the support of our local BME communities and to identify and overcome any specific cultural or practical barriers to breastfeeding.

Many of the women we spoke to were keen to be involved further in discussions with commissioners and providers. Local agencies should harness this enthusiasm and create more opportunities for local parents to be involved in shaping local services and delivering public health messages. This might mean a radical step change in practice and attitudes by providers.

Parents’ 3 key priorities
i. More information on breastfeeding during pregnancy and more opportunities to hear about the pros and cons directly from parents.
ii. A positive attitude to breastfeeding within the health service – and consistent advice from all health staff on what to do if problems arise
iii. Quicker and easier access to breastfeeding support, on the ward and in the community, including an out of hours service. This should include less formal buddyng, such as volunteer ‘health trainers’, as well as more formal professionalised peer support services.
Professionals’ 3 key priorities
i. Introducing breastfeeding on the school PSHE curriculum.
ii. Investing in peer supporters – with a dedicated team led and trained by the specialist midwife
iii. Consistent advice and support from health professionals supported by a package of training for key staff.

New developments
As the research was underway a number of interventions aimed at raising breastfeeding initiation and continuation rates were either planned or in progress. These reflect many of the observations and recommendations made by this research and include:

- the withdrawal of freely available formula milk in hospital for clinically well babies
- the introduction of breastfeeding information packs for women at their 20 week scan
- a review of peer support services in North Lincolnshire
- the launch of a new North Lincolnshire ‘Framework for Action on Breastfeeding’ in collaboration with North Lincolnshire Council
- Creation of a breastfeeding coordinator post at a senior level within NHS North Lincolnshire

Next steps for social marketing campaign
• Present findings of research to key partnership groups
• Social marketing consortium to review existing breastfeeding marketing messages and make recommendations
• Social marketing consortium to develop a business case to help identify funding for a local marketing campaign
• Establish a reference group of parents in shaping peer support services and in developing a local marketing strategy.

Steering Group
The work was conceived and planned by Wendy Brownbridge, Debrah Smith, Sue May, John Berry, Lynne Ashcroft and Louise Garnett

Acknowledgements
The Consultation team was drawn from staff working in the Public Health directorate in NHS North Lincolnshire, Northern Lincolnshire and Goole NHS Hospital Trust, the Acorns Neighbourhood Management Team and North Lincolnshire Council. Key members were:

Sally Czabaniuk
Jenny Gavin-Allen
Michelle Farrell
Dean Gillon
Louise Garnett
Jane Goodwin
Sarah Griffiths
Bob Hulme
Jane Kaye
Farzana Khanum
Tracey Wartnaby and
Richard Wilcock

We would also like to say a big thank you to all of the Children’s Centre and Community Centre managers and staff who helped us make contact with parents and made us all feel welcome. Particular thanks are due to Shandal, Najma, Ruijya, Denise, Rae, Jo and Collette for their outstanding support at Henderson Avenue, Greeson Hall and Westcliff Dropin2.

Thanks are due too to all of those health visitors, midwives and peer supporters who gave their time to talk to us.

Finally, we would like to express our sincere thanks to all those young people, parents and members of the public who willingly gave up their time to share their views and experiences. We hope we have done your views justice.

A more detailed research report is available on request from Louise Garnett at louise.garnett@nlpct.nhs.uk and can be found at www.northlincolnshire.nhs.uk
Appendices

Behaviours, perceptions and understandings of different social segments

Groups D (31%) Traditional working families and H (15%) Affluent Blue Collar, together make up 48% artificial feeders

‘I wish I’d given it a go – I might do with my next one’
‘They don’t tell you how hard it is – I know people who have breastfed and they’ve been up all night – baby crying – sore nipples.
‘It’s my body and my choice. They should let you make up your own mind’
‘My partner and in laws won’t be able to help me with childcare’
‘What’s wrong with formula milk – my lot are healthy enough – and they give it out in hospital?’
‘You can’t see how much they’re getting with breastmilk’
‘People like me don’t breastfeed – it’s not done round here’

Attributes | Wants/Needs | Marketing Actions & Priorities
--- | --- | ---
20 - 35 year olds | Consistent messages from opinion leaders and significant others on health and other benefits. | Appeal directly to grandparents & partners for support
53% breastfeed at birth, 26% ay 6-8 weeks | Partner and family approval | Kill myths and misconceptions
Skilled workers and service sector | Opportunities to share experiences | Use images of local women
Modest income – women part time | Feeding to fit in with family life | Stress convenience and cost
Attend antenatal and parentcraft | To feel accepted & valued for breastfeeding | Stress your choice the right choice
Receptive to health messages | To feel empowered not embarrassed | Exposure of breasts unnecessary
Heavily influenced by local norms | | 
Health knowledge partial | | 
Traditional gender roles | | 
Close knit families and communities | | 
Strong work ethic, value thrift | | 
Exposure to breastfeeding limited | | 

<table>
<thead>
<tr>
<th>Perceptions</th>
<th>Barriers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Formula milk is a good enough substitute for breast milk</td>
<td>Women not making informed choice</td>
</tr>
<tr>
<td>A good Mum is one who can pacify her baby</td>
<td>The health profession can’t make their minds up</td>
</tr>
<tr>
<td>A healthy satisfied baby is one that feeds every four hours and settles after every feed</td>
<td>Breastfeeding is ‘eccentric’ – I’d stand out and be unsupported</td>
</tr>
<tr>
<td>A healthy baby is one that completes the bottle at every feed</td>
<td>Breastfeeding stops Dads from getting involved</td>
</tr>
<tr>
<td>If you want to breastfeed you have to stay in hospital longer and take up a bed unnecessarily</td>
<td>At the end of the day it comes down to personal choice</td>
</tr>
<tr>
<td>They give out formula milk in hospital so it must be alright for baby</td>
<td>Breastfeeding is a big commitment. Its my body – my choice</td>
</tr>
<tr>
<td>They tell you its best for baby. But leave you to cope alone</td>
<td></td>
</tr>
<tr>
<td>Its like labour they don’t tell you the bad stuff</td>
<td></td>
</tr>
<tr>
<td>Nobody round here breastfeeds – do they?</td>
<td></td>
</tr>
<tr>
<td>Women don’t need to breastfeed it’s a feminist thing</td>
<td></td>
</tr>
<tr>
<td>There’s no where to breastfeed in Town anyway</td>
<td></td>
</tr>
<tr>
<td>Breastfeeding stops Dads from getting involved</td>
<td></td>
</tr>
<tr>
<td>I won’t be able to feed and go back to work</td>
<td></td>
</tr>
<tr>
<td>B’feeding will ruin my figure</td>
<td></td>
</tr>
<tr>
<td>B’feeding will tie me down – I’ll get depressed</td>
<td></td>
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<tr>
<td>At the end of the day it comes down to personal choice</td>
<td></td>
</tr>
</tbody>
</table>

Template adapted from CHIME Insight Toolkit Oxford Social Marketing
Group F (4%) Hard pressed teen parents - make up 6% artificially fed babies

‘Breastfeeding? No way am I getting my bits out in public’
‘I’m not having people staring at my girlfriend’
‘Yuck I couldn’t stand the thought of it’
It ruins your figure
I can’t go out if I’m breastfeeding – who’d look after it
I won’t be able to wear normal clothes
‘It might save us time and money’
‘Preparing bottles in the night is a pain – but breastfeeding’s not for me’

Attributes
15-17 year olds - mainly white
Very low income - heavily dependent on parents and extended family
Low rates of breastfeeding – 37% at birth, 3% at 6-8 weeks
Limited knowledge/understanding of health benefits
Unlikely to attend parentcraft
Low aspirations and low self esteem
Breastfeeding ‘rude’, ‘weird’ & unattractive
Partners unlikely to support breastfeeding
Grandparents unlikely to have experience and may want or need to be involved in childcare
Heavily influenced by family, peers and partners and how they are perceived by own age group

Wants/Needs
Positive role models
Access to tailored peer support – younger mentors
Confidence building
Normalisation messages pre conception and throughout pregnancy re health and other benefits
Recruit young women into buddyng service/stress work and social opportunities

Marketing Actions Priorities
Need a specific focused message to build their confidence
Celebrate this as an achievement
Use visual imagery that is modern/accessible/attractive
Use a recognizable celebrity alongside local women
Appeal to grandparents
Show imagery of young women combining breastfeeding with ‘normal’ life
Need to post in places where young people frequent rather than in antenatal access points
### Group F - Hard Pressed Teen Parents 4%

#### Perceptions

- Unlikely to consider feeding options prior to birth
- Breastfeeding complicated – not as easy as bottle feeding
- Formula milk as good as breast milk
- Breastfeeding = ‘Hard life’
- Boys don’t like it – breasts are sexual objects not functional
- ‘Fear’ exposure of breasts and offending others
- Breastfeeding = ‘weird’ - associated with ‘unsavoury’ bodily functions
- Breastfeeding is the preserve of older, middle class women
- Likely to present late and not take up parentcraft or baby clinic
- Not confident asking professionals for information or help
- Assume it won’t work for them
- Feel they’ll be judged badly whatever they do.

#### Barriers

- Not making an informed decision
- ‘Breastfeeding’ = ‘Hard life’
- ‘I’ll fail - be no good at it’
- Breastfeeding = unattractive and uncool
- Likely to present late and not take up parentcraft or baby clinic
- Not confident asking professionals for information or help
- Assume it won’t work for them
- Feel they’ll be judged badly whatever they do.

### Deep insight

- Feel they’ll be judged badly whatever they do.
- Feel they’ll be judged badly whatever they do.

**Key message that might change their behaviour?**

- Feel they’ll be judged badly whatever they do.
- Feel they’ll be judged badly whatever they do.
Group G (14%) Very low income families living in deprived communities - make up 21% artificially fed babies

<table>
<thead>
<tr>
<th>Attributes</th>
<th>Wants/Needs</th>
<th>Marketing Actions Priorities</th>
</tr>
</thead>
<tbody>
<tr>
<td>White - 20-35 year olds Low income – high levels of benefit dependency Larger families – many lone parents Lowest rates of breastfeeding – 37% May initiate once – (on advice from health professionals) Little exposure to breastfeeding within immediate peer/family/community Health issues not a priority Information about breastfeeding passed on within social groups Unlikely to attend all routine antenatal and parentcraft sessions Not receptive to leaflets and traditional marketing methods Limited knowledge of health benefits</td>
<td>A sustained long term multi faceted campaign Local champions and buddies in local neighbourhoods Access to low level family support to make breastfeeding a practical option.</td>
<td>Challenge local myths and misconceptions Stress practical benefits and rewards Use a familiar and influential face/voice to sell message Avoid imagery where breasts are exposed Low take-up of parentcraft, antenatal, or Children’s Centres so need to engage in other ways. Health issues - not a priority focus</td>
</tr>
</tbody>
</table>

‘Tried it once couldn’t get on with it – doesn’t work for everyone’ ‘Don’t like the idea’ ‘Women don’t have to do it – with modern formula’ ‘I don’t know why they keep going on about it’ ‘You can’t satisfy breastfed babies – they cry all the time’ ‘Life is too hard – I haven’t got the time or energy’ ‘I hear it makes you depressed’ ‘I saw on the TV that a baby died cos it was allergic to breastmilk’ ‘Who’s going to look after the rest of the kids while I breastfeed?’
Group G - Very low income families living in deprived communities – 21% of all bottle feeders

**Perceptions**

- Breastfeeding ruins your figure, makes you depressed
- Breastfed babies don’t sleep
- What’s wrong with formula milk?
- Tried it once didn’t work
- You’ll never get the kids off you
- I’ve got enough on my plate without sitting feeding all day
- Can’t share the night feeds
- You can’t smoke drink eat what you want or go out for weeks
- My inlaws will be on at me to bottle feed
- No one likes to see women get their bits out
- No one does it round here
- My man doesn’t like the idea
- I wasn’t breastfed and neither were my kids and we’re all healthy enough
- No one’s telling me what’s best for me and my kids
- At least you can see what’s in formula milk and how much your baby’s getting
- They tell you one thing and then it’s all changed again

**Barriers**

- Not making an informed choice
- I need to get my life back
- Breastfeeding not for people like me
- Can’t believe everything they (professionals) tell you

**Key Message**

They tell you one thing and then it’s all changed again

Template adapted from CHIME Insight Toolkit, Oxford Social Marketing.
Group B (new starter families) and Group C (suburban comfort) – make up 20% artificially fed babies

My husband wants to help too – he can’t if I breastfeed

Some men feel a bit excluded and threatened and want to be more involved

I can’t think about breastfeeding and going back to work

My Mum and his Mum never breastfed and won’t be able to help

I really wanted to give her the best start – I’m determined to try harder with my next one

‘Breastfeeding’s great in theory – if it works for you’

‘It was hard work but worth it in the end’

‘There’s nowhere out here for expectant and new Mums to meet.’

‘You feel let down by services if you choose to have your baby in Doncaster – they wash their hands of you’
<table>
<thead>
<tr>
<th>Groups B and C</th>
<th>Attributes Group C</th>
<th>Attributes Group B</th>
<th>Wants/Needs</th>
<th>Marketing Actions Priorities</th>
</tr>
</thead>
<tbody>
<tr>
<td>Suburban comfort</td>
<td>(14% all births - 9% all formula fed babies in North Lincolnshire)</td>
<td>New starter families</td>
<td>Would use 3rd sector groups if available in their area</td>
<td>Could be persuaded to breastfeed for longer with the right support</td>
</tr>
<tr>
<td></td>
<td>➢ Starting families later</td>
<td>(13% all births – 11% all formula fed babies in North Lincolnshire)</td>
<td>Reassurance and advice about weaning</td>
<td>Reinforce messages about the health benefits and the practicalities of combining with work.</td>
</tr>
<tr>
<td></td>
<td>➢ White collar and small business</td>
<td>➢ Similar to Group C – but younger</td>
<td>Reassurance and advice about common problems</td>
<td>Develop user friendly ‘what to do if’ tools</td>
</tr>
<tr>
<td></td>
<td>➢ Dual income - career focused</td>
<td>➢ Well educated</td>
<td>Need local support networks to maintain feeding</td>
<td></td>
</tr>
<tr>
<td></td>
<td>➢ Very health conscious</td>
<td>➢ Above average income</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>➢ Relatively high rates of breastfeeding – 72%</td>
<td>➢ Two working parents</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>➢ Likely to seek out information themselves</td>
<td>➢ Busy lives – likely to use private childcare</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>➢ Attend antenatal and parentcraft</td>
<td>➢ Attend parentcraft and all routine antenatal</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>➢ Returning to work – likely to use private childcare and have access to domestic help in the home</td>
<td>➢ Health conscious and receptive to health messages</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>➢ Concerns about weaning prior to return to work</td>
<td>➢ Above average rates of initiation - 65%</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>➢ May have tried initiating breastfeeding previously – but had poor experience</td>
<td>➢ Continuation rates much lower</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>➢ Concerns about work/childdcare</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>➢ Partners and extended family supportive and responsive to health messages</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
New starter families and suburban comfort - 27% all births

**Perceptions**
- You feel guilty and useless when it doesn’t come naturally
- To be honest I didn’t see anything wrong with formula – I assumed it must be OK
- Its like labour – they don’t tell you how hard it is.
- Midwives haven’t got the time
- There’s no support when things go wrong
- I wanted to give my baby the best start in life – I feel let down cos I didn’t get enough help
- Partner wanted me to do it – but he doesn’t have the hassle of breastfeeding
- You know breast is best – but it isn’t practical
- Can’t breastfeed and have a career
- Why would you want to when everyone makes it so hard
- You have to be really determined and confident to breastfeed
- No one thanks you for breast feeding
- Even my friends get embarrassed when I breastfeed

**Barriers**
- No one tells you how hard it is
- Women get little or no support when things go wrong
- Inconvenient and impractical
- Breastfeeding is still taboo – so why do it

*Template adapted from CHIME Insight Toolkit, Oxford Social Marketing*
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