Position Statement: breastfeeding in the UK

August 2017

This statement addresses breastfeeding in the UK; messages and recommendations should not be extrapolated to other populations

Key facts

- The UK has one of the lowest rates of breastfeeding in Europe. There are limited data available to compare trends in breastfeeding internationally, particularly at age 6-8 weeks when current UK data are recorded. An analysis of global breastfeeding prevalence found that in the UK only 34% of babies are receiving some breast milk at 6 months compared with 49% in the US and 71% in Norway[1].
- Breastfeeding rates in the UK decrease markedly over the first weeks following birth. In the 2010 UK Infant Feeding Survey, 81% of mothers in the UK initiated breastfeeding, but only 34% and 0.5% were breastfeeding at 6 and 12 months respectively[2]. Figures for England in 2015/16 show that while almost three quarters of mothers started breastfeeding (73.1%)[3], this fell to 43.2% at 6-8 weeks[4]. In Scotland, 49.3% of women were reported to be breastfeeding soon after birth, but only 38.9% at 6-8 week review[5].
- The prevalence of breastfeeding is particularly low among very young mothers and disadvantaged socio-economic groups, potentially widening existing health inequalities and contributing further to the cycle of deprivation. Data from the 2010 Infant Feeding Survey showed that 46% of mothers in the most deprived areas were breastfeeding, compared with 65% in least deprived areas[2].
- Explanations why the prevalence of breastfeeding in the UK is low are complex and multiple. Mothers may experience practical problems in establishing breastfeeding, and fail to access or receive adequate practical support. Maternal concern about whether an infant is receiving sufficient milk may result in reinforcement from friends, family and health professionals, to "supplement" with formula which undermines maternal milk production and is strongly associated with secondary lactation failure and premature cessation of breastfeeding[2]. Societal attitudes may lead to women feeling uncomfortable about breastfeeding in public or in the presence of peers and family members.[6]

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[1] The Lancet. Web appendix 4: Lancet breastfeeding series paper 1, data sources and estimates: countries without standardized surveys. 2016. Available from www.thelancet.com/cms/attachment/2047468706/2057986218/mmc1.pdf

[2] McAndrew F, Thompson J, Fellows L et al Infant Feeding Survey 2010. NHS Health and Social Care Information Centre. Copyright © 2012, Health and Social Care Information Centre

[3] NHS England. Statistical Commentary Q3 2015/16. Available from https://www.england.nhs.uk/statistics/statistical-work-areas/maternity-and-breastfeeding/

[4] Public Health England. Official Statistics Breastfeeding prevalence at 6-8 weeks after birth (Experimental Statistics). Available from https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/563003/2015_16_Annual_Breastfeeding_Statistical_Commentary.pdf

[5] Information Services Division Scotland. Breastfeeding statistics Scotland Financial year 2015/16. Available from https://www.isdscotland.org/Health-Topics/Child-Health/Publications/2016-10-25/2016-10-25-Breastfeeding-Report.pdf

[6] https://www.gov.uk/government/news/new-survey-of-mums-reveals-perceived-barriers-to-breastfeeding. Accessed 2 June 2017

Key considerations

- Establishing that breastfeeding is causally related to specific health outcomes is challenging as healthy term infants cannot be randomised to breastfeeding or to not breastfeed. Consequently data largely come from observational and quasi-randomised studies, with strong potential for confounding. Hence caution must be exercised in interpreting data, and care taken to reflect uncertainties accurately.
- Recent data from the most robust series of meta-analyses to date, with comprehensive assessment of study quality and sources of potential bias[7], indicate that breastfeeding is likely to be causally related to reduced risk of gastro-intestinal, respiratory and ear infections and reduced need for hospitalisation for infections, in all settings[7]. This protection is seen whilst the infant is receiving breast-milk, and is greater with exclusive than with partial breastfeeding. The protective benefits are large and the evidence consistent and biologically plausible.
- Breastfeeding is associated with increased scores on tests of intelligence, and might also protect against deaths in high and low income countries; evidence of reduced overweight, obesity and diabetes in childhood is much less secure.
- Breastfeeding is associated with reduced risk of malocclusion. Longer periods of breastfeeding have been associated with an increase in tooth decay, emphasising the importance of tooth-brushing twice a day with fluoride toothpaste once the first tooth has erupted.
- For mothers, breastfeeding provides protection against breast cancer and improves birth spacing[7]; breastfeeding may protect against ovarian cancer and type 2 diabetes, but the evidence for these benefits is less certain.
- A recent systematic review reported that it is possible to improve breastfeeding substantially with the use of interventions to support women in their homes and communities and through health services[8]. Support may be offered by professional or lay/peer supporters, or a combination of both. Strategies that rely mainly on face-to-face support are more likely to succeed[9].

Economic impact

- A report commissioned by the Unicef UK Baby Friendly Initiative[10] estimated that moderate increases in breastfeeding would save up to £40 million in NHS expenditure based on fewer General Practitioner consultations and hospital admissions; the report also highlighted savings to the family as there would be no need to buy formula.
- If 45% of babies were breastfed exclusively for four months and 75% of babies in neonatal care were discharged home breastfeeding, an estimated £17 million could be saved by reducing the costs of treating four conditions alone: infection of the lungs, gut, ears (approximately £11 million) and necrotising enterocolitis (approximately £6 million) [10]; this would also result in 50,000 fewer General Practitioner consultations.

[7] Victora CG, Bahl R, Barros AJD, et al, for The Lancet Breastfeeding Series Group. Breastfeeding in the 21st century: epidemiology, mechanisms, and lifelong effect. Lancet 2016; 387: 475-90

[8] Rollins NC, Bhandari N, Hajeebhoy N, et al, on behalf of The Lancet Breastfeeding Series Group. Why invest, and what it will take to improve breastfeeding practices? Lancet 2016; 387: 491-504

[9] Cleminson J, Oddie S, Renfrew MJ, McGuire W. Being baby friendly: evidence-based breastfeeding Support. Arch Dis Child Fetal Neonatal Ed 2015;100: F173–F178

[10] Unicef UK(2012), Preventing Disease and Saving Resources, https://www.unicef.org.uk/babyfriendly/baby-friendly-resources/advocacy/preventing-disease-and-saving-resources/ (last accessed 11 April 2017)

Key messages for health professionals

- RCPCH strongly supports breastfeeding, the promotion of breastfeeding, the provision of advice and support for women, and national policies, practices, and legislation that are conducive to breastfeeding.
- Breastfeeding is a natural process, however mothers may require support, knowledge and education. With such support, the expectation is that most women will be able to breastfeed.
- Mothers should be advised that the use of infant formula "supplements" or combined breast and formula-feeding may make it more difficult to establish exclusive breastfeeding.
- Mothers should be supported to breastfeed their healthy term infant exclusively for up to 6 months
- All infants require solid foods from 6 months for adequate nutrition. Solid food should never be introduced before 4 months (17 weeks) as this is associated with increased short-term risk of infection and later risk of obesity, allergy, and coeliac disease[11],[12].
- We recommend that mothers should be encouraged to breastfeed beyond 6 months, alongside giving solid food.
- Mothers should be supported to continue breastfeeding for as long as they wish; in countries such as the UK evidence is lacking to recommend any particular duration of breastfeeding.
- Mothers need to feel confident in their ability to breastfeed and to feel comfortable breastfeeding in public; this requires support from family, friends, professionals, the workplace and society at large so that breastfeeding is regarded as normal and natural.
- Some women cannot or choose not to breastfeed; this should be respected and appropriate support and education on infant feeding provided.
- RCPCH does not condone the promotion of infant formula, the provision of free formula samples to mothers or health professionals or non-evidenced claims of health benefits from infant formula and other nutritional products.
- Infant formula and other nutritional products must be based on rigorous, high quality research, development, and clinical evaluation, to ensure babies receive products that improve incrementally; this requires transparent, collaborative engagement between paediatricians, scientists, other healthcare professionals, and industry.

RCPCH recommendations

1. Increase initiation and continuation of breastfeeding

RCPCH calls on

- Public Health England to develop a national strategy to increase initiation and continuation of breastfeeding, based on a multidisciplinary approach, and sound evidence
- The Welsh Government to urgently review and update "Investing in a Better Start: Promoting Breastfeeding Wales" (2001)
- The Scottish Government to evaluate "Improving Maternal and Infant Nutrition: A Framework for Action" (2011)

[11] Scientific opinion on the appropriate age for introduction of complementary feeding of infants. EFSA Panel on Dietetic Products, Nutrition and Allergies. EFSA Journal (2009) 7 (12):1423

[12] Fewtrell M, Bronsky J, Campoy C, et al Complementary Feeding: A Position Paper by the European Society for Paediatric Gastroenterology, Hepatology, and Nutrition Committee on Nutrition. JPGN 2017 Jan; 64(1):119-132

- The Northern Ireland Public Health Agency to evaluate "Breastfeeding - A Great Start: A Strategy for Northern Ireland" (2013-2023)
- The NHS in England and the Welsh Government to follow the lead of the Scottish Government and the NHS in Northern Ireland by requiring all maternity services to achieve and maintain Unicef UK Baby Friendly Initiative accreditation; this requirement is currently met by all maternity units in Scotland and Northern Ireland. Accreditation includes:
    - Supporting pregnant women to recognise the importance of breastfeeding and early relationships on the health and wellbeing of their baby.
    - Enabling mothers to get breastfeeding off to a good start and to continue breastfeeding for as long as they wish.
    - Supporting mothers to make informed decisions regarding the introduction of fluids and foods other than breastmilk.
    - Supporting parents to have a close and loving relationship with their baby.
- Public Health England, Public Health Wales, Scottish Government and the Public Health Agency in Northern Ireland to undertake evidence based actions that promote breastfeeding and support women to breastfeed.
- Local authorities in England, Health Boards in Wales, Scottish Government and the Public Health Agency in Northern Ireland to ensure that local breastfeeding support is planned and delivered to mothers in the form of evaluated, structured programmes.
- The NHS in England, Wales, Scotland and Northern Ireland to ensure the preservation of universal midwifery services.
- UK Government and the Governments in Wales, Scotland and Northern Ireland to commit to adequate resourcing to preserve universal health visiting services
- Governments in each nation to ensure familiarity with breastfeeding is included as part of statutory personal, health and social education in schools.
- Employers to ensure career or life-time salaries are not adversely effected by a woman's choice to breastfeed.
- UK Government to legislate for breastfeeding breaks and facilities suitable in all workplaces for breastfeeding or expressing breast milk.

2. Data on breastfeeding

RCPCH calls on

- UK and devolved Governments to ensure reliable, comparable data are recorded across the UK, to measure breastfeeding initiation, at 6-8 weeks, and at suitable intervals up until 12 months of age with data analysed centrally to ensure that local, regional and national comparisons and monitoring of trends are conducted using consistent, comparable methods.
- UK Government to reinstate the UK-wide Infant Feeding Survey, which was cancelled in 2015.

3. Further research

RCPCH calls on

- The National Institute for Health Research and equivalent authorities in the devolved nations, to commission research to improve the evidence-base for several aspects of breastfeeding, including optimal duration/exclusivity for different groups of infants, approaches to encourage continuation, the long-term health effects for mother and baby, differences in infant outcomes between breast-feeding and feeding expressed breast milk, and methods to promote a supportive societal culture.

RCPCH activity to promote breastfeeding

- The RCPCH training curriculum for General Paediatricians[13] and all paediatric subspecialties requires trainees to understand the importance of breastfeeding and lactation physiology, be able to recognise common breastfeeding problems, have knowledge of formula and complementary feeding, and be able to advise mothers or refer for support.
- The RCPCH is committed to working with relevant authorities and agencies across the UK to progress the recommendations listed in this position statement, with the aim of achieving steady improvement in UK prevalence of breastfeeding.

Role and responsibilities of paediatricians

- All paediatricians should be aware of the RCPCH position on breastfeeding and encourage and support mothers, including those with preterm or sick infants, to breastfeed. They should avoid undermining breastfeeding through the inappropriate use of infant formula "top-ups", and advise women that the use of infant formula may make it more difficult to establish exclusive breastfeeding.
- Paediatricians not directly involved in advising women who are breastfeeding can contribute by supporting colleagues who undertake this role, and ensuring that systems and environments are conducive to breastfeeding and, where appropriate, milk expression.
- Paediatricians should be aware of local and national support for breastfeeding mothers (see "Resources" below).

Resources

NHS information on breastfeeding:
http://www.nhs.uk/Conditions/pregnancy-and-baby/Pages/benefits-breastfeeding.aspx (last accessed 11 April 2017)

Baby Friendly Initiative and how to achieve accreditation:
http://www.unicef.org.uk/BabyFriendly (last accessed 11 April 2017)

National Breastfeeding Helpline: 0300 100 0212
http://www.nationalbreastfeedinghelpline.org.uk (last accessed 11 April 2017)

Start4Life Breastfeeding Friend chatbot
https://www.nhs.uk/start4life/breastfeeding-feeding-well

Best Beginnings, including the BabyBuddy app
https://www.bestbeginnings.org.uk/professionals (last accessed 11 April 2017)
https://www.bestbeginnings.org.uk/baby-buddy (last accessed 11 April 2017)

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[9] Curriculum for Paediatric Training General Paediatrics Level 1, 2 and 3 Training Sept 2010. Revised and Approved by the GMC 16th April 2015; for implementation from 1st August 2015