

Bristol Social  
Marketing Centre

Social marketing to  
encourage initiation  
and continuation of  
breastfeeding in  
Penhill & Pinehurst,  
Swindon

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# Social marketing to encourage initiation and continuation of breastfeeding in Penhill& Pinehurst, Swindon

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## Executive Summary

- NHS Swindon has targets to increase the initiation and duration of breastfeeding to 6-8 weeks and beyond. A number of interventions have been implemented to increase local breastfeeding prevalence, including the UNICEF Baby Friendly Initiative and the family nurse partnership.
- Traditional health education approaches on their own do not appear to have much impact. Our own work and indicative results elsewhere position co-creation as a potentially highly effective strategy to use within deprived communities; its potential to embed behaviour change sustainably is clear.
- Integrating programmes that address cultural perceptions of breastfeeding with targeted work aimed directly at vulnerable segments, which in turn are co-ordinated with strong ante and post-natal support, education programmes and peer supported group sessions will maximise the chances of increasing breastfeeding.
- The UWE project team recruited women and some family members to individual interviews and women from four different categories (pregnant, did not breastfeed, tried breastfeeding but gave up and breastfed beyond 6-8 weeks) to focus groups. In total, 28 individuals took part in the project. Participants were asked a range of questions designed to elicit information about norms surrounding infant feeding, how decisions about feeding were reached, individual's knowledge concerning the benefits of breastfeeding and social and private attitudes towards breastfeeding.
- The norm in both Pinehurst and Penhill is to bottle feed babies. Mothers gained knowledge about breastfeeding for a range of sources, but the timing and volume of NHS leaflets could be problematic. The main reason given for breastfeeding was the associated health benefits for babies. The main reason given for bottle feeding were convenience and ease of feeding in public.
- Following these interviews, six professionals involved in services for mothers and babies were interviewed. This cohort was selected to include managers and practitioners from the midwifery and health visiting services for Penhill and Pinehurst.
- Lack of support for breastfeeding women is a problem. Contributing factors were thought to include lack of resources in the wider health and social care context, particularly with regard to home visits in the first month after birth. Provision of information appears to rely heavily on written literature, which women may not read. A coherent and integrated service was seen as the ideal to support and promote breastfeeding, but there was some concern expressed about how well the support workers and healthcare professionals worked together.

- The general consensus is that there is very little community engagement in these areas and many women are unwilling to access locally based groups where they might learn about breastfeeding or observe other mothers breastfeeding.
- Co-creation as an approach depends upon engaging and involving community members, and with levels of involvement and interaction in these communities so low, it was agreed to proceed with a continued focus on breastfeeding interventions, with Uscreates leading on designing and developing ideas, making and directing decisions and activity, and audience members contributing feedback and thoughts. The co-creation process was adapted to be delivered one to one with mobile researchers visiting mothers at home.
- A design exercise facilitated mothers to build up a description of the ideal support service along a number of descriptors. This activity led to the plan to re-design and re-launch the Breastmates service. This existing breastfeeding support service satisfied most of the requirements for an ideal service that mothers had described. These characteristics guided the re-design of the Breastmates offering to include home visits, and to promote both online and telephone support for urgent needs.
- Uscreates carried out a co-creation process with women in order to re-design the existing Breastmates brand and marketing materials. The marketing combined several support avenues and channels within one identity, presenting a more united front, and giving women a choice of how to access support.
- The overall recommendation after the pilot phase is to continue to use the co-created Breastmates brand, and roll this out across Swindon. With face to face engagement and promotion having the biggest impact on uptake and attendance, continue with this as the primary focus for promotion activities.
- The other attendant promotion components (Facebook, Breastmates site, Textmagic) should be tweaked as per the recommendations above, and continue as low cost methods to increase general awareness of Breastmates, and provide a professional and unified means of reinforcing messages delivered by the face to face activity.

## Background to the project

The World Health Organisation ([www.who.int/topics/breastfeeding/en/](http://www.who.int/topics/breastfeeding/en/)) acknowledges breastfeeding as the best means of giving infants a normal, healthy start to life. Breastfeeding not only provides the correct amount and balance of nutrients for optimal growth and development, it also protects against many illness for both baby and mother, both while breastfeeding occurs and after weaning from the breast.

Breastfed babies are many times less likely to develop respiratory infections and gastroenteritis in the first year of life than bottle-fed babies. Their mothers have a reduced risk of ovarian and breast cancer and may find it less difficult to return to their pre-pregnancy weight than mothers who do not breastfeed. There is also some evidence that non-breastfed children have a greater risk of obesity in later childhood. Breastfeeding in the first year of life reduces the risk of infant mortality.

NHS Swindon has targets to increase the initiation and duration of breastfeeding to 6-8 weeks and beyond. Swindon breastfeeding prevalence is measured at initiation and at 6-8 weeks. Breastfeeding prevalence is lowest in the areas of greatest deprivation.

NHS Swindon is implementing a number of interventions to increase local breastfeeding prevalence. These include the UNICEF Baby Friendly Initiative ([www.babyfriendly.org.uk/](http://www.babyfriendly.org.uk/)) and the family nurse partnership which focuses on support to teenage mothers, including breastfeeding advice and support.

The Baby Friendly Initiative is being implemented in:

- the Swindon community (Stage 1 assessment achieved March, 2012), and
- the Great Western Hospital (Stage 2 assessment due May, 2013)

## *Project aim*

To develop a social marketing intervention research project to support an increase in breastfeeding prevalence in women with the lowest prevalence of breastfeeding in Swindon, namely, mothers in the Penhill and Pinehurst areas.

## *Project scope*

The project was designed to have both core and extended scope.

### *Core scope objectives*

1. Collate and analyse existing data related to any demographics of breastfeeding prevalence at initiation and 6-8 weeks within the Penhill and Pinehurst communities compared to Swindon as a whole.
2. Compile an updated literature review concerning choice of early infant feeding (i.e. breast or bottle).
3. Identify why breastfeeding is not considered a normal and desirable choice of feeding by a large number of the Penhill and Pinehurst communities. Gain an understanding of attitudes towards existing and best practice interventions.
4. Identify:
  - a. drivers and influences behind bottle feeding
  - b. barriers to breastfeeding
  - c. current local provision to support breastfeeding in Penhill and Pinehurst
5. Produce a set of specific, actionable recommendations to increase breastfeeding prevalence in the target audience, which will ensure effective and sustainable change, including actions that could be implemented by NHS Swindon staff and partners that do not require high costs to implement.
6. Establish the approach and identify the duration of the recommended intervention.

### *Extended scope objective*

1. Implement the intervention.
2. Evaluate the intervention.

## Methods

The project used a unique co-creation and social marketing model of research and implementation that cut across both its Core and Extended Scopes.

### *Key stakeholders*

Key stakeholders were identified as women of childbearing age from both communities, including those either pregnant or with children younger than six months of age; health professionals involved in delivering services directly to childbearing women, in particular, midwives and health visitors; and health professionals/managers involved in strategic development of relevant services.

### *Meeting the core scope objectives*

*Objective 1:* Data from NHS Swindon concerning breastfeeding rates collated and analysed.

*Objective 2:* An updated literature review concerning choice of early infant feeding was compiled. This review built on an extensive literature review of breastfeeding in disadvantaged areas previously undertaken for research projects in Bristol and Cornwall.

*Objectives 3 and 4:* Empirical research was conducted with women, family members and health professionals to identify why breastfeeding is not considered a normal and desirable choice for feeding babies by a large number of the inhabitants of Penhill and Pinehurst.

*Objective 5:* A co-creation process was initiated in order to produce a set of specific, actionable recommendations to increase breastfeeding prevalence in the target audience.

*Objective 6:* Activities planned may have a behaviour change basis in social marketing principles, that is, designed to give attention to the motivational requirements of breastfeeding, and to meet these in a variety of possible ways – dictated by the co-creation process.

*Objective 7:* Associated timescales for implementing recommendations were developed as part of the co-creation process.



### *Extended scope*

*Objective 1:* Implementation of co-created brand and service re-design of Breastmates to extend the support offering and implement marketing utilising new materials.

*Objective 2:* Qualitative feedback was collected from Breastmates service users, Breastmates providers, and relevant health care professionals, feeding into recommendations for continuation.

### *Ethics*

Ethical approval for the project was gained from a University of England research ethics sub-committee.

## Breastfeeding rates in Swindon

NHS Swindon has targets to increase the initiation and duration of breastfeeding to 6-8 weeks and beyond. Breastfeeding prevalence is measured at initiation and at 6-8 weeks. Available data show that breastfeeding prevalence is lowest in the areas of greatest deprivation, which include Pinehurst and Penhill.

Evidence from the National Infant Feeding Survey published in 2011 showed that breastfeeding initiation rates in the UK in 2010 were highest in mothers from the managerial and professional social classes (90%). Mothers in routine and manual occupations (74%) and those mothers who have never worked (71%) had the lowest levels of breastfeeding. Furthermore, the Survey provided evidence that educational level was important in rates of initial breastfeeding – only 63% of those mothers who left full-time education before age 16 were breastfeeding initially, compared to 91% of mothers who left full-time education after age 18.

Data for Swindon breastfeeding initiation and prevalence in 2009/2010 showed that rates of breastfeeding at initiation and at 6-8 weeks were greatest in the North (83%/50%) and South (78%/48%) respectively, with Central South (69%/45%) and Central North (61%/31%) having lower rates (Table 1).

**Table 1: Breastfeeding initiation and prevalence (2009/2010)**

<i>Locality</i>	<i>Breastfeeding initiation (%) (2009)</i>	<i>N</i>	<i>Breastfeeding prevalence at 6-8 weeks (%) (2010)</i>	<i>N</i>
Central North	61	725	31	148
Central South	69	727	45	298
South	78	504	48	399
North	83	357	50	399

Penhill and Pinehurst are in Central North, and are among wards with the highest levels of deprivation in Swindon. Breastfeeding prevalence at 6-8 weeks measured in 2012 through Children’s Centres indicate that only 15% of mothers attending Sure Start centres in Penhill and Pinehurst were still breastfeeding. This compares with a rate of just over 48% for Swindon overall.

## Literature Review: Executive Summary

- Breastfeeding rates in the UK are low compared to other developed countries. Breastfeeding has lost its position as the normal way to feed a young baby, with negative cultural positioning, social disapproval, media hostility, and inherent British aversion to public exposure all playing a part. However perhaps the key driver has been the marketing power of formula milk suppliers who have normalised bottle feeding.
- To counter these problems, the potential of social marketing is being explored in small scale campaigns, run within PCTs in the last few years. Using social marketing to encourage breastfeeding is still in its infancy, and it has yet to emerge in the literature as a clear set of strategies; however, it does have considerable potential.
- Our own work, and indicative results elsewhere position co-creation as a potentially highly effective strategy for use within deprived communities; its potential to embed behaviour change sustainably is clear. However, more case studies and large scale trials are required to generate an evidence platform.
- Traditional health education approaches on their own do not appear to have much impact. The Cochrane Review of Breastfeeding (1998, and also found in Hoddinott *et al.* 2011) examined traditional health education focusing on the health benefits of the baby: there was reasonably clear evidence that such approaches used in isolation are of limited use; however, combined with other methods, health education can be effective.
- There may be potential to focus on non-health benefits to promote breastfeeding, for example, its possible cost savings, or its convenience when travelling.
- In general, multi-faceted interventions are potentially more effective than those with single components.

Within the context of the above key issues, social marketing has a number of possible roles:

- The benefits of breastfeeding to both baby and mum may not be explicit and clear to our audience – social marketing can make them clear.
- There may be merit in communicating immediate health benefits for the baby, such as reduced ear infections and allergies.
- The social and cultural position of breastfeeding remains uncertain. It is sometimes seen as embarrassing, or ‘not normal’ to do and these things are amplified in public. Social

marketing has potentially very important roles in creating the right social environment. US (*Loving Support*) and UK (*She's a Star*) examples have shown some (limited) evidence of positive effect. More explicit social norms campaigns are thin on the ground and certainly worth exploring.

- The above roles of social marketing are clearly things to take forward into in-depth research. But we should not lose sight of the evidence that professional and personal support appears to be vital. Given that breastfeeding is not currently seen as 'normal' or everyday, mothers can feel vulnerable. Support in its various guises is, therefore, a core foundation of the profession's offer: practical help, information based help, help with self-esteem, and emotional support. The requirement for supporting breastfeeding in the UK led to the Baby Friendly hospital initiative. This programme could be strengthened further by appropriating peer support as a key element: US *WIC*, *Best Start*, and *Centering Pregnancy* programmes all suggest that peer led facilitation approaches, in which concerns are acknowledged and dealt with, outperform 'expert led' approaches.
- Our final point concerns the integration of all of these elements. Integration is often discussed as a key issue within the marketing and other literatures. Hence, integrating programmes that address cultural perceptions of breastfeeding with targeted work aimed directly at vulnerable segments, which in turn are co-ordinated with strong ante- and post-natal support, education programmes, and peer supported group sessions, will maximise the chances of increasing breastfeeding.

The full literature review can be found in Appendix A.

## Perceptions about breastfeeding

In this section of the report, key findings are presented concerning project stakeholders' perceptions about breastfeeding. Full analyses can be found in Appendices B and C

### Women's perceptions

The UWE project team recruited women and some family members to individual interviews, and women from four different categories to focus groups. A separate focus group was held for women from each category: 'pregnant', 'did not breastfeed' 'tried breastfeeding but gave up' and 'breastfed successfully'. Recruitment was managed by an independent professional recruiting consultant, and started at Penhill and Pinehurst Children's Centres. Fliers were distributed printed with contact numbers, but these were not effective. Recruiters went door-to-door in the immediate area, and also approached potential participants in parks. They also attended two clinics in the area. Snowball sampling was used to recruit sufficient individuals to the project. Participants were each paid £20 to take part in either an individual interview or a focus group.

In total, 28 individuals took part in the project (Table 2). Six women were interviewed individually, of whom three had breastfed or expressed milk for between two and six months, two had breastfed for approximately two weeks and one had never tried breastfeeding. One partner and one grandmother also took part in individual interviews.

**Table 2: Details of individual interviewees**

<i>Research number</i>	<i>Feeding method</i>	<i>Duration</i>
R1	Breastfeeding/expressed milk	9 weeks
R2	Bottle-fed	n/a
R3	Breastfed	2 weeks
R4	Breastfed	+/- 2 months
R5	n/a – grandmother	n/a
R6	n/a – partner	n/a
R7	Breastfed	2 weeks
R8	Breastfed	+/- 6 months

Twenty women participated in four focus groups: four pregnant women (three of whom had had children before), six women who had bottle-fed their babies from birth, five women who had tried breastfeeding but who had given up, and five women who had breastfed successfully. Participants were asked a range of questions designed to elicit information

about norms surrounding infant feeding, how decisions about feeding were reached, individual's knowledge concerning the benefits of breastfeeding and social and private attitudes towards breastfeeding.

The interviews and focus groups were audio-recorded and transcribed verbatim. Data were analysed thematically, giving rise to themes concerning decision-making about how to feed, knowledge, influences, practicalities, barriers and support from health professionals. Additional information about the type of support that women would like to receive was gleaned by Uscreates, during their process of asset mapping in the two communities. Five women contributed to this process, of whom three breastfed, one bottle fed, and one had personal experience of both methods of feedings.

### *Key findings – women's perceptions*

- The main reason given for breastfeeding was the associated health benefits for babies.
- The main reasons given for bottle feeding their babies were convenience in terms of other people being able to feed the baby and being able to feed easily and in a socially acceptable way when in public.
- Most participants knew that breastfeeding is beneficial for babies in the short-term; there were mixed views about the long-term benefits of breastfeeding for babies.
- A few women knew that breastfeeding also has benefits for women.
- Participants gained knowledge about breastfeeding from a range of sources, including websites. The timing and volume of NHS leaflets can be problematic; women reported not reading the leaflets they were given.
- Participants reported traditions of both breastfeeding and bottle feeding within their own families. Partners were reported to be generally supportive of breastfeeding, no matter how women were feeding their babies.
- The norm in the two areas is to bottle feed babies.
- The main barriers to breastfeeding reported were pain, embarrassment about feeding in public and uncertainty about the amount of milk that babies are getting.
- Some women were sure of their rights with respect to breastfeeding in public, while others thought that it was not 'allowed'.

- Some women expressed the view that younger women are less comfortable about breastfeeding generally, either because of being less confident about their bodies or because bottle feeding allows them to revert to a 'freer' lifestyle.
- Women who were daunted by the problems/practicalities of breastfeeding, but who wanted their babies to benefit from breast milk, resorted to expressing their milk and feeding it to their babies by bottle. However, this could also be problematic.
- Some of the pregnant women felt that they got good support from their midwives.
- Most participants did not feel that health professionals provide adequate support for breastfeeding mothers either at home or in the hospital, and expressed their feelings quite vehemently. Lack of time seems to be a contributing factor to this situation. When health professionals do offer support, it can be interpreted as authoritarian, or even bullying, behaviour. Some women felt that they were 'forced' to breastfeed.
- On-going support early in the postnatal period and support available at any time of day or night was considered very important. Women also said that they would like to have peer group support and drop-in facilities where they could discuss problems with a health professional on a one-to-one basis. Women wanted face-to-face support in their own homes or in a community setting, although telephone advice could also be acceptable. Content desired included emotional support, information and practical help/demonstration.

### *Health professionals'/managers' perceptions*

Following the interviews with the mothers and their families, a purposive sample of six professionals involved in services for mother and babies was interviewed. The sample was selected to include both managers and practitioners from the midwifery and health visiting services for Penhill and Pinehurst. The interview schedule was based on the findings from the data collected from the women. All the interviews were conducted on a one-to-one basis, with the exception of one interview held jointly with two managers from the health visiting service.

The interviews and focus groups were audio-recorded and transcribed verbatim. Data were analysed thematically. Findings are presented concerning two main areas, social issues and service issues.

### *Key findings – health professionals'/managers' perceptions*

- One of the main barriers to increasing the breastfeeding rate is that bottle feeding is the cultural norm in both areas. However, a degree of change may slowly be taking place.
- The influence of mothers and grandmothers has a significant effect on women's decisions about how to feed their babies, and on the social support they receive for their feeding choice.
- Wider social norms and practices, in both the local and national context, have an effect on breastfeeding rates.
- Lack of support for breastfeeding women is a problem. Contributing factors were thought to include lack of resources in the wider health and social care context, particularly with regard to home visits in the first month after birth.
- Some women start breastfeeding in hospital because of a perception that healthcare professionals think they should do so, rather than because they actually want to breastfeed.
- Women having appropriate information early in pregnancy is important for promoting breastfeeding.
- Provision of information appears to rely heavily on written literature, which women may not read.
- For successful promotion and support for breastfeeding, women need a coherent, integrated service. There were different opinions expressed about how well different healthcare professionals and support workers actually work together.
- Desired initiatives to promote breastfeeding in the area included providing family support workers, working with families early in pregnancy, working with younger people, providing drop-in sessions, working with Children's Centres and linking with the NSPCC pregnancy education programme to provide breastfeeding information.
- Many women in these areas are unwilling to access locally based groups where they might learn about breastfeeding, or observe other women breastfeeding.



### *Comparison of women's and health professionals'/managers' perceptions*

The responses of women and health professionals were compared for consistency. The perceptions of the two stakeholder groups were roughly consistent about social issues influencing breastfeeding (Table 3). However, health professionals may place too much emphasis on family influence. A number of breastfeeding women said that family members had bottle-fed, while some women who were bottle feeding reported family members breastfeeding. In addition, the grandmother interviewed related how she had tried unsuccessfully to encourage her daughter to breastfeed (see Appendix B for details).

**Table 3: Comparison of women's' and health professionals' perceptions about social issues influencing breastfeeding**

<i>Women's perceptions</i>	<i>Health professionals'/ managers' perceptions</i>
The norm in the two areas is to bottle feed babies.	One of the main barriers to increasing the breastfeeding rate is that bottle feeding is the cultural norm in both areas.
Participants reported traditions of both breastfeeding and bottle feeding within their own families.	The influence/experience of mothers and grandmothers encourages women to bottle feed their babies.
Some women were sure of their rights with respect to breastfeeding in public, while others thought that it was not 'allowed'.	Wider social norms and practices, in both the local and national context have an effect on breastfeeding rates.

The women and the health professionals were also in agreement about most issues concerning the service provided to pregnant and breastfeeding women (Table 4). However, although a number of women suggested that access to support groups could promote breastfeeding in the community, health professionals reported that, in their experience, women from the two areas were unwilling to attend locally-based groups (see Appendix C).

**Table 4: Comparison of women’s’ and health professionals’ perceptions about support provided and required for breastfeeding**

<i>Women’s perceptions</i>	<i>Health professionals’/ managers’ perceptions</i>
<p>Most participants knew that breastfeeding is beneficial for babies in the short-term.</p> <p>Participants gained knowledge about breastfeeding from a range of sources. The timing and volume of NHS leaflets can be problematic; women reported not reading the leaflets they were given.</p>	<p>Women having appropriate information early in pregnancy is important for promoting breastfeeding.</p> <p>Provision of information appears to rely heavily on written literature, which women may not read.</p>
<p>Most participants did not feel that health professionals provide adequate support for breastfeeding mothers either at home or in the hospital. Lack of time seems to be a contributing factor to this situation.</p> <p>Professional support can be interpreted as authoritarian behaviour. Some women felt that they were ‘forced’ to breastfeed.</p>	<p>Lack of support for breastfeeding women is a problem. Contributing factors were thought to include general lack of resources, particularly with regard to home visits in the first month after birth.</p> <p>Some women start breastfeeding in hospital because of a perception that healthcare professionals think they should do so.</p>
<p>On-going support early in the postnatal period and support available at any time of day or night was considered very important.</p> <p>Women wanted face-to-face support in their own homes or in a community setting, although telephone advice could also be acceptable. Content desired included emotional support, information and practical help/demonstration.</p> <p>Women also said that they would like to have peer group support and drop-in facilities where they could discuss problems with a health professional on a one-to-one basis.</p>	<p>Desired initiatives to promote breastfeeding in the area included providing family support workers, working with families early in pregnancy, working with younger people, providing drop-in sessions, working with Children’s Centres and linking with the NSPC pregnancy education programme to provide breastfeeding information.</p> <p>Many women in these areas are unwilling to access locally-based groups where they might learn about breastfeeding, or observe other women breastfeeding.</p>

## Social engagement

All the women who participated in the interviews and focus groups conducted by the UWE researchers were asked about engagement by individuals at a community level. There were reports of an annual fete organised by the school in Penhill, and of mother-and-baby/toddler groups in both communities. However, the general consensus was that there was very little engagement otherwise, and that neither community was particularly cohesive. In this context, engagement may describe levels of involvement and participation in public society, or levels of 'neighbourliness', 'community spirit' or interaction between members.

The co-creation process led by Uscreates had the following aims:

- i. To engage local people with the project and issue.
- ii. To co-create ways to support mothers in breastfeeding.
- iii. To empower local people to shape, develop and co-deliver interventions.

The process comprised two initial steps; namely, asset mapping and face-to-face creation of intervention ideas (see Appendix D).

### *Asset mapping*

Local leaders, places, events, activities, community strengths, etc. were identified and mapped with the stakeholders and local people to deepen understanding of the communities. Individuals at 14 different locations and events were engaged and asked to map assets, and 12 individuals took part in more in-depth conversational interviews.

The Engagement Lead (Uscreates) used this information to start building relationships with the community to gain the depth of local insight and contacts needed for successful co-creation.

Questions asked included:

- What do you like, and what do you dislike, about your area?
- Who do you respect in your area?
- How would you describe your area to someone from out of town?
- Who do you see or talk to regularly in your area?

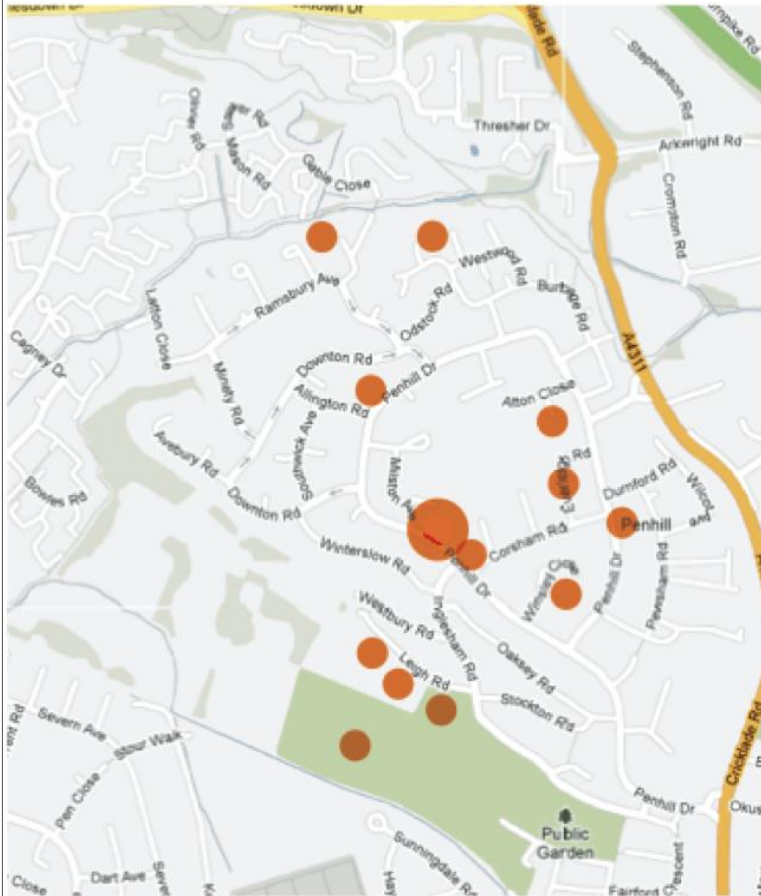
- Why did you move to your area?
- What services exist for young people, mums, and families?
- Who does a lot for the community?
- How do people find out about events, services and groups?
- What venues are there locally? Who runs them?
- Do people tend to attend community events? What motivates them to do so?
- Are people engaged in the community?
- If people are not engaged and do not attend things, how can we reach them?
- Are there any volunteer schemes or networks locally? Who runs them?
- What clubs, groups, regular meetings (tenants and residents etc.) are there?

### *Community descriptions*

Both areas presented with low levels of community spirit, community cohesion, and interaction between residents. Successful community development and engagement has been minimal in both areas, with stakeholders such as community workers repeatedly asserting that they had never seen such low levels of community involvement before.

One reason for disengagement was thought to be the effect of a large proportion of social housing, with a concomitant transient population who had not actively chosen to live in either area, and was therefore assumed to have little commitment to the community. Other reasons given were the perception of high crime levels causing unsafe streets, and very low ownership of common/shared spaces. Though there were suggestions for the reasons behind the low involvement and interaction, these were couched as possibilities and best guesses, with nobody professing to have the definitive answers.

## Penhill Assets



Penhill has a mixed history of community interaction in that residents did raise £5,000 to prevent the closure of a community centre. There is a profusion of community venues and events with 12, assets mapped including:

- Community centre
- John Moulton Hall
- a community newsletter
- the Children's Centre
- the Penhill Carnival
- Sevenfields Fun Day

However, individuals also reported feeling unsafe at night due to high levels of drug use and young people 'on the street'.

Fig 1: Penhill assets mapped geographically

“Working here I have truly come to understand “hard to reach” – there are people who just won't engage with offers and services.” *Community worker*

# Pinehurst Assets

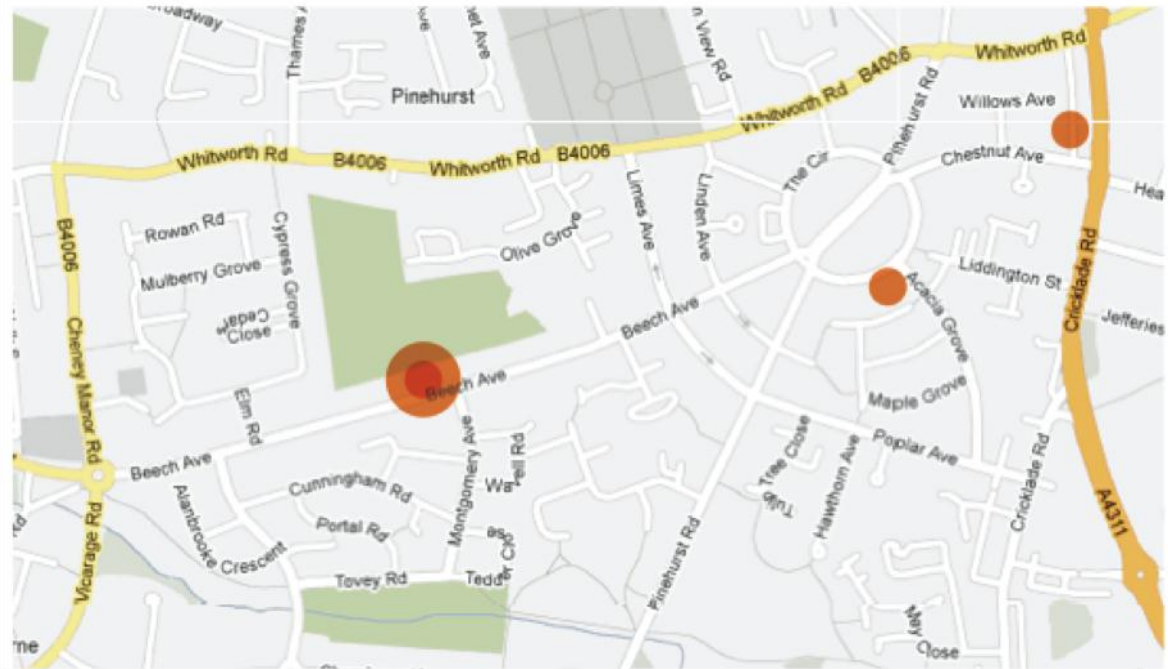


Fig 2: Pinehurst assets mapped geographically

Pinehurst has only four community assets mapped, and very low levels of community interaction or involvement in civic life. For example, a new library was built, to be handed over to community volunteers; however, this did not happen as no residents were interested in voluntary involvement. There is also friction between the two communities, although they border one another. Residents from each community appeared to be suspicious of each other (see Appendix E for more detail).

“If you don’t have kids and, therefore, meet people through school, you just won’t meet anyone. Such low levels of interaction, I don’t know any of my neighbours’ names.” *Community worker*

## *Face to face co-creation of intervention ideas*

It was planned to design and deliver co-creation activities with the full involvement of local people recruited via the research and the initial engagement work. During these activities, it was expected that volunteers would assist researchers in generating a programme of

support/events/communication responding to the objectives initially set by NHS Swindon, checked with local people.

The results of the interviews, focus groups and asset mapping were fed into the planning of two co-design workshops, one to be held in each area. Taxis, childcare and lunch were offered to participants in order to help overcome reported low levels of attendance at community group events. The aims of the co-creation events were:

- i. To share insights from the research and asset mapping.
- ii. To generate ideas and opinions about how to promote breastfeeding locally.
- iii. To create ownership and confidence in any strategies developed.

Eight women confirmed attendance at the events, but only one came to the Penhill event, and none to the Pinehurst event. Follow-up calls revealed that many reported having forgotten about the event (despite having received reminders); others had been put off by logistics; and many preferred to be consulted in their own homes about possible strategies. The lack of attendance appeared to substantiate the health professionals'/managers' perceptions that women in these areas are unwilling to access locally-based groups.

### **Pause and reflect**

At this stage a pause and reflect meeting was held to review the appropriateness of the planned methodology in light of the insights into the communities revealed by the asset mapping, and non-attendance at the co-creation events.

Co-creation as an approach depends upon engaging and involving community members, and with levels of involvement and interaction in these communities so low, this meeting reviewed two proposed alternatives for delivering the remaining stages of the project within the available budget.

#### ***1) Uscreates led, breastfeeding focus***

This proposed a continued focus on breastfeeding interventions, with Uscreates leading on designing and developing ideas, making and directing decisions and activity, and audience members contributing feedback and thoughts. This represented a reduced level or intensity

of co-creation, one more appropriate to the levels of involvement it was feasible to expect from these communities.

## **2) Stakeholder led, community focus**

This proposed a shift in focus to explore the reasons and factors affecting the extremely low levels of community involvement and interaction. Uscreates working with key community stakeholders to train and empower them to investigate and analyse the causal factors, and identify ways in which to increase community spirit, interaction and involvement. This would be of benefit to any future efforts to involve the communities with services or campaigns.

It was felt among the steering group that with the funding being allocated to breastfeeding, and in mind of current and planned council led community development as part of the locality and regeneration agendas, to select proposition 1, continuing with a focus on breastfeeding and Uscreates leading on design and delivery.

### **At home co-creation**

Given the issues experienced with attendance at centralised workshops, the co-creation process was adapted to be delivered one to one with mobile researchers visiting mothers at home. A total of five 2-hour sessions were carried out.

With the insight stage analysis completed by UWE and built into the co-creation process, the activities carried out with participants focused on generating understanding and ideas around the support needs of mothers. Both stakeholders and mothers had identified the immediate post-natal period as a 'flashpoint', when the need for support can be extreme and the impact on breastfeeding of not receiving it negative.

Exercises included:

1. Mapping women's feelings, emotions and support needs along their pregnancy experience journey
2. Mapping instances of good or bad support (from peers or health care professionals)
3. Determining what characteristics shaped good support
4. Collecting feedback on existing support methods
5. Designing their ideal support



# Breastfeeding experience map: Zoe

5 children. Bottle-fed first, breastfed the remaining. Lives with partner of 19 years.

positives  
negatives

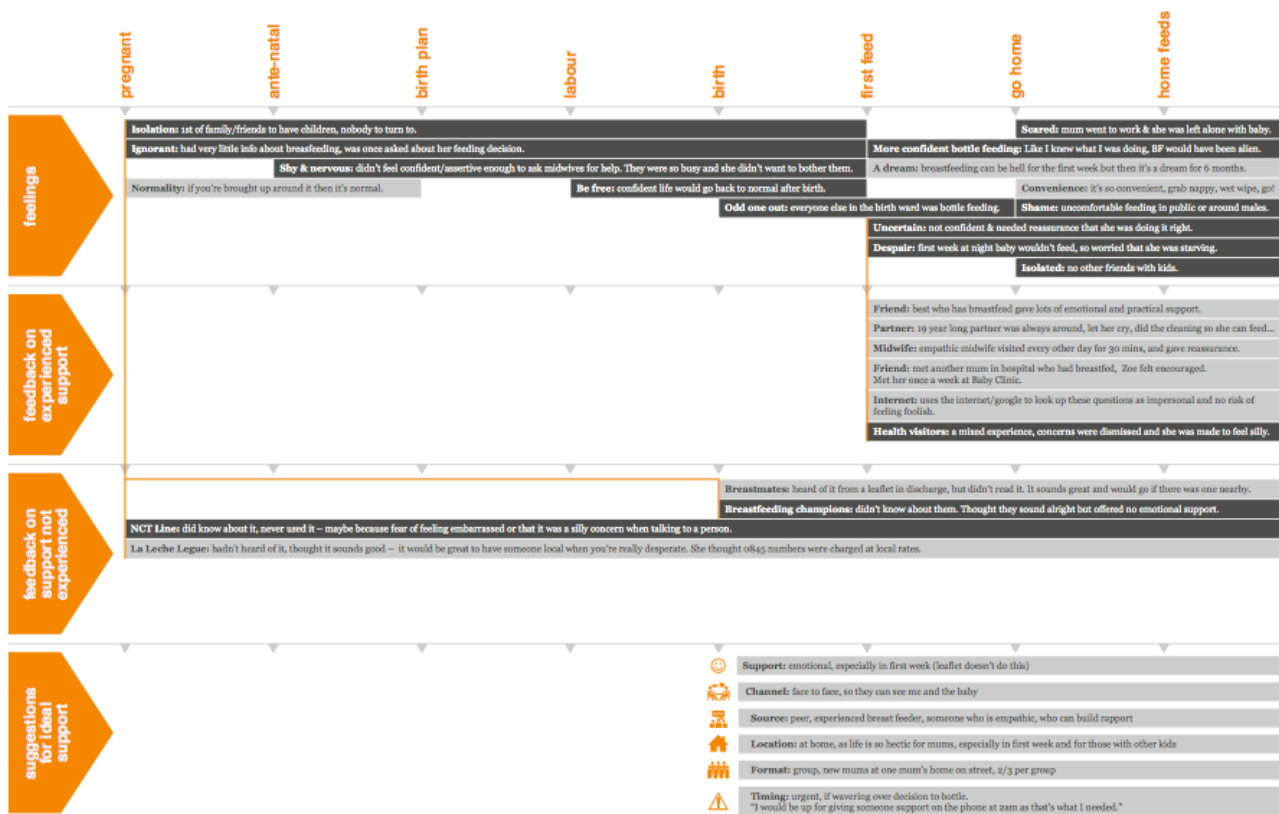


Fig 3: Example experience map

This last design exercise facilitated mothers to build up a description of the ideal support service along a number of descriptors: appropriate channel, format, location, source, type of support, and timing. The ideal support service designed by mothers included:

- Informational, practical, and emotional support types
- Face to face channel
- Both expert and peer sources
- Both group and individual formats
- Both at home and community settings for delivery locations
- Immediate availability for urgent support needs

Reviewing and analysing this activity led to the plan to re-design and re-launch the Breastmates service. This existing breastfeeding support service satisfied most of the requirements for an ideal service that mothers had described. These characteristics guided

the re-design of the Breastmates offering to include home visits, and to promote both online and telephone support for urgent needs.

Breastmates as described to mothers garnered the best feedback on existing support methods, and provided a vehicle for delivering informational, practical and emotional support through a combination of input from both trained experts, and peer support.

Breastmates primarily offers support to mothers through peer groups meeting at Children's Centres across Swindon, with trained breastfeeding counsellors and peer supporters present. There had previously been a peer support group in Penhill at the Children's Centre which had ceased due to poor attendance. Interviews with mothers and stakeholders had revealed three key reasons for the low uptake of Breastmates support:

1. The low background level of community interaction and involvement in group activity
2. A lack of alternative support formats for those who could not or did not wish to attend a group
3. Very low levels of awareness of the existence of Breastmates

While the first reason was beyond the remit of this project, the design of the implementation phase aimed to tackle reasons 2 and 3.

## Implementation

The implementation phase saw deployment of marketing materials and activity in order to increase awareness of the Breastmates service, and the provision of alternative means of support within Breastmates for those who would not attend groups.

The final outputs of the implementation phase were:

- Launched Breastmates service provision in Penhill and Pinehurst
- Extended and integrated the Breastmates service offer to include home visits, online and telephone support (provided by NCT, National Breastfeeding Line, and La Leche League)
- New co-created Breastmates brand including guidelines and templates

The aims of this pilot period were to ascertain if marketing activity using the new brand could raise awareness of the groups, test demand for alternative support methods such as home visits, and determine what input and resources are required from partners such as Children's Centres to continue delivery.

### *Co-created Breastmates service and brand*

Uscreates carried out a co-creation process with women in order to re-design the existing Breastmates brand and marketing materials. The new brand was applied to a range of collateral including:

- **Posters:** displayed at key locations such as libraries, Great Western Hospital (GWH), GP surgeries, and community centres
- **Flyers:** designed as invitations, enclosed within an eye catching purple envelope to stand out in the hospital discharge pack
- **Stickers:** to apply to the outside of discharge packs highlighting the invitation within
- **Fridge magnets:** containing a range of useful phone numbers for immediate support
- **Badges:** distributed to group attendees to identify as a Breastmates member

The marketing combined several support avenues and channels within one identity, presenting a more united front, and giving women a choice of how to access support.

The marketing messages offered women the choice of support from an integrated Breastmates service offering four different means of receiving support:

- **Peer support groups** – the existing Breastmates group model was tweaked to include a rotating specialist speaker each week to deliver additional useful information or training in relevant subjects such as baby massage. The groups were delivered at Children's Centres
- **Home visits** – with many mothers expressing the need for at home visits, expressly to fill the gap between the community midwife visit and the first Health Visitor visit, it was clearly communicated that they could request a counsellor provide support at home
- **Facebook group** – directing women to the existing Breastmates Facebook group which provides women with a way of accessing peer support and help at times convenient to them
- **Telephone line** – the many help lines available for breastfeeding advice were united within the Breastmates material, presenting women with the relevant numbers alongside alternative support methods

The brand guidelines, design templates and materials will be provided with this report in a designer's pack for future use and applications (see Appendix F).

### *Marketing and promotion process*

Promotion of the pilot Breastmates service ran in parallel across:

- **Face to face promotion** – services were equipped with materials and information to proactively recruit women to the Breastmates service, with the Health Visitor team, community midwives, Children Centre staff, and Breastmates peer supporters carrying out promotion
- **Online promotion** – a Facebook advertising campaign was initiated directing women to the Breastmates website ([www.swindonbreastmates.co.uk](http://www.swindonbreastmates.co.uk)) which provided information on how to access support
- **Passive promotion** – printed materials (posters and invitations) were displayed in community locations and distributed through Breastmates peer supporters

The marketing materials all contained a call to action, prompting those requiring support to send a text message to a contact phone number. This phone number fed into an online contact management service called Textmagic. This service allows for centralised communication via text messages, and it was envisaged it would provide the primary contact and interactive communication channel for the pilot.

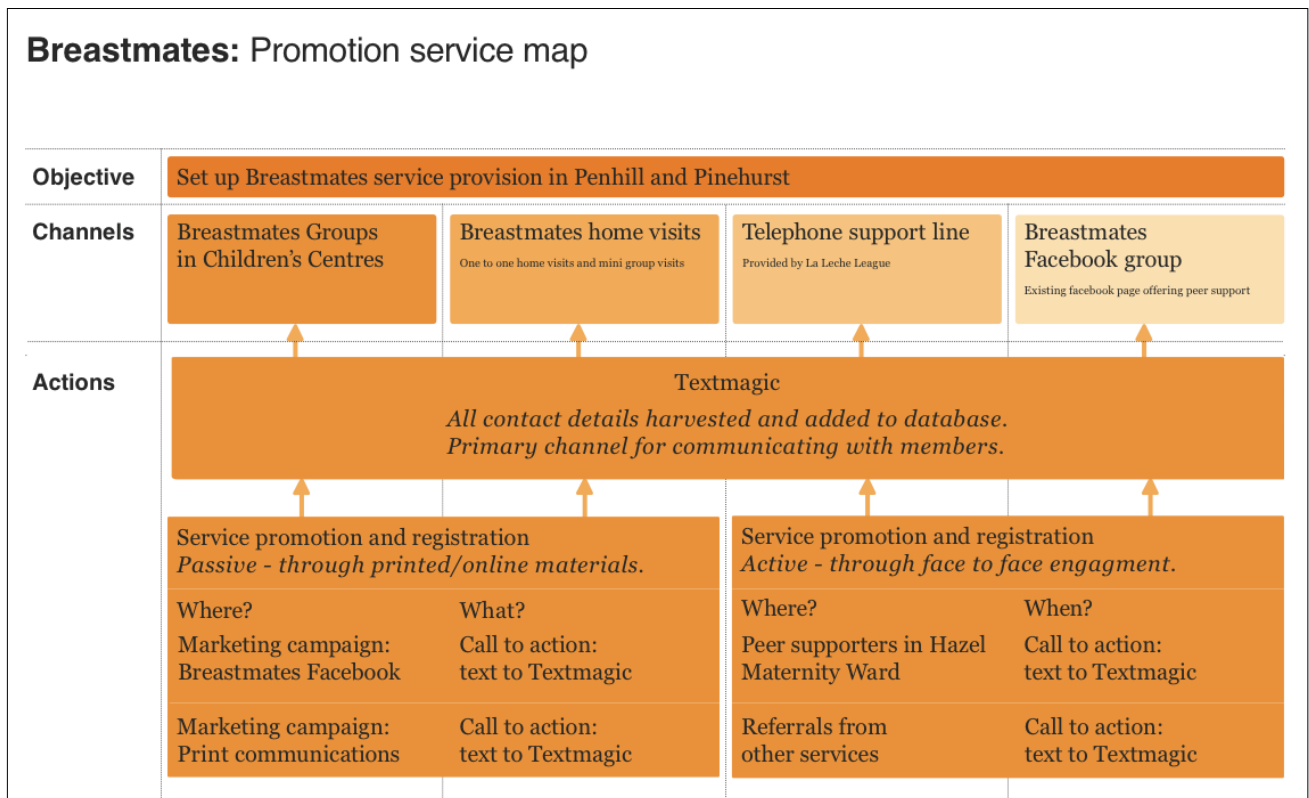


Fig 4: Planned promotion service map

## Evaluation

Descriptive data about each project element follows, with interpretation, evaluation and recommendations.

### *Promotion: face to face.*

Health Visitors, midwives, Breastmates counsellors, and Children's Centres staff were equipped with invitation packs and evaluation tools, briefed to refer eligible mothers to the Breastmates service, and asked to keep a tally of the number of referrals made or invitations given out to mothers during the pilot period.

**Table 5: Service referral numbers**

<i>Service</i>	<i>Referrals</i>
Health Visitors	5+ (incomplete data)
Midwifery: GWH	10-20
Midwifery: community midwives	(incomplete data)
Children's Centres	0
Breastmates	(incomplete data)

Unfortunately not all services kept a tally of the invitations given out, or were not able to provide them in time to be included in this report.

Data provided by GWH puts the average number of new mothers in the relevant postcodes at 11 per month. Therefore the numbers provided seem to be within what might be expected over a month long pilot.

Health Visitors reported anecdotally that women at baby clinics had responded well to the offer, though they felt that the word 'group' might be intimidating and could be replaced with 'drop in'. Midwives at GWH stated women recalled being given the purple invitation pack in their discharge pack, indicating that it was successful in standing out from the other printed materials.

Follow up calls with providers revealed that for some the invitation and recruitment process had become passive in delivery – i.e. waiting for women to ask about Breastmates. The intent was that promotion and recruitment would be proactive – i.e. identifying relevant mothers and informing them about the support.

***Recommendation***

We recommend continuing the service referral route as a key channel to offer Breastmates support to women. We would recommend some briefing for providers on the difference between active and passive recruitment, and identifying whether any additional support in terms of communication training or staff time to identify eligible mothers is needed.

In addition Breastmates counsellors report that the informality of Breastmates as a service, placing it outside the framework of NHS provision, may impact the attitude and confidence with which health care professionals refer women into it. Suggestions include bringing Health Visitors into group sessions so they can observe, and building relationships between Breastmates counsellors and Health Visitors.

***Promotion: online.***

The Facebook advertising campaign ran from 02.02.13 to 18.02.13 and provided a low cost marketing mechanism in terms of raising awareness and directing Facebook users to the Breastmates site.

**Table 6: Online marketing data**

<i>Facebook</i>	<i>Data</i>
Impressions (number of times shown on Facebook)	1,177,702
Clicks (link to Breastmates site)	273
Total cost	£166

<i>Breastmates site</i>	<i>Data</i>
Average visits per day	26
Peak visits in one day	80

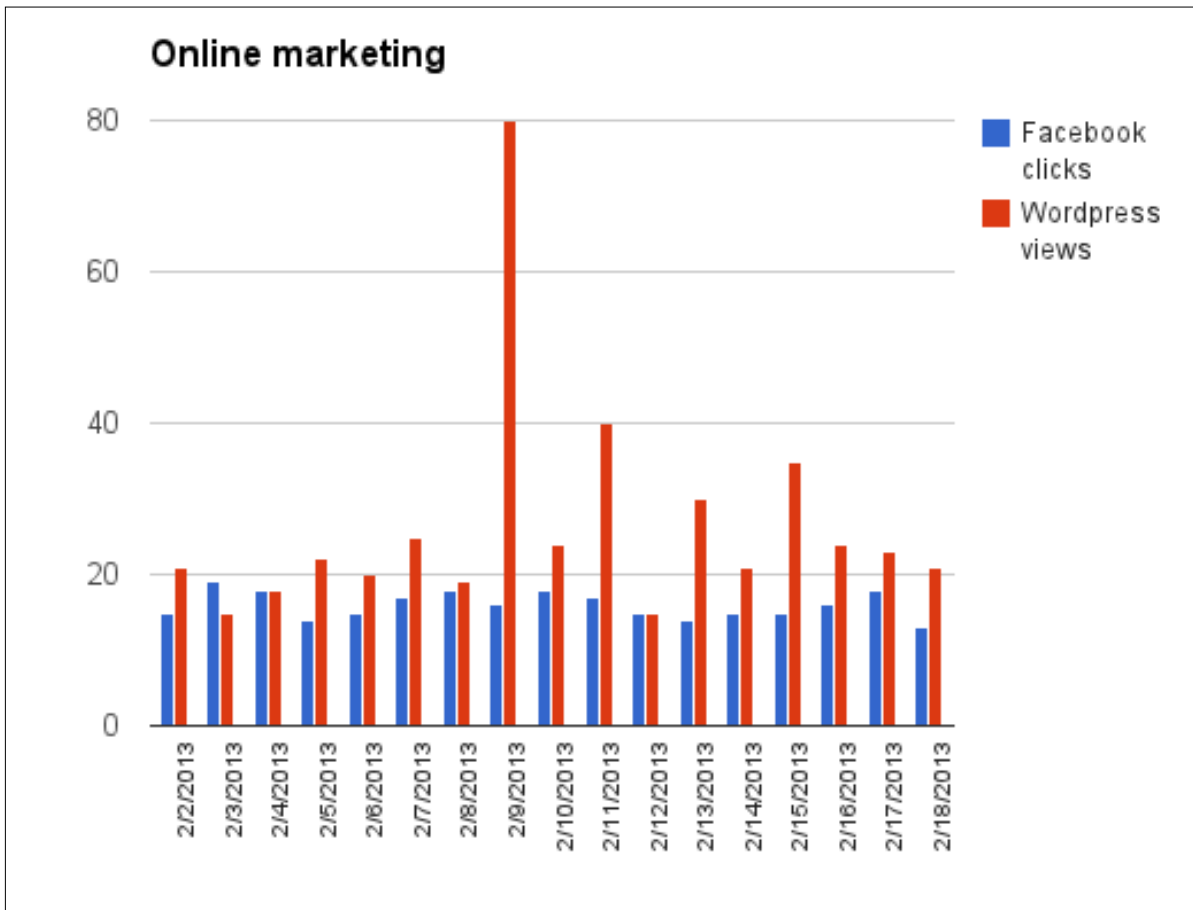


Fig 5: Clicks on Facebook advert compared to visits to Breastmates Wordpress site

The anomalous peak on the 9<sup>th</sup> February of 80 visitors was likely to have been caused by a member of the Facebook group sharing the link with her friends, illustrating the effectiveness of social link sharing.

While the numbers reached by the online marketing are encouraging, and the cost per exposure often lower than printed materials, this does not necessarily translate into action and uptake. When interviewing mothers who did access Breastmates support of one kind or another, none identified the Facebook adverts or the Breastmates site as the method of discovery of the service.



### *Recommendation*

Review the purpose of the Facebook advertising, and potentially repurpose it as a cost effective means of delivering messages and information in a targeted way. While it may not result in changes to behaviour, and face to face promotion seems more effective in driving up support uptake, online marketing can provide a background awareness raising element to reinforce face to face promotion activity.

The Breastmates site provides an attractive single point of reference and information towards which direct enquiries can be directed (currently there is nowhere online to serve this function), is very low cost, and requires little management time in order to keep up to date.

### *Promotion: text message service*

A key measurement of the effectiveness of the marketing techniques was planned to be the Textmagic text contact system, as all the marketing materials prompted women to contact this number. To date, the Textmagic service has not received any text messages from mothers, though it has been tested multiple times and functions correctly.

Evaluation interviews with mothers have not revealed an obvious or clear reason why it has not been used as intended. Some interviewees stated that they were aware of the contact number on marketing materials yet found it easier and quicker to simply talk to their Health Visitor or Children's Centre staff for more information.

The lack of contacts through this system may also be in part because of the relatively short time the marketing materials displaying the contact number have been in place. The locations that women from the pilot areas spend their time shopping or socialising are also not necessarily within Penhill or Pinehurst, yet in order to limit the scope of the pilot to these areas marketing was not carried out in Swindon town centre, for example.

The outbound texting service has proved useful in sending weekly reminders to women attending the groups, and communicating what special talk will be taking place. Women state that receiving the texts provided them with a nudge to attend, and they valued having information about the speaker ahead of time.

### *Recommendations*

Repurpose the texting service to provide a means of sending information and reminders to existing Breastmates members. It is a low cost, pay per use model, and provides an efficient communication tool with templates and automated texting functions.

Replace the texting service number on marketing materials with another single point of contact for the Breastmates service to be monitored and managed by a Breastmates counsellor.

### *Promotion: marketing materials*

Interviews with Breastmates members and stakeholders probed into the design of the marketing materials and collected feedback on the brand identity. This was mostly positive, with both groups stating that the brand identity provided attention-grabbing photography, the hand drawn typeface added an element of fun, and the copy had a relatively informal tone of voice.

For further details of the co-creation of the brand identity please refer to the brand guidelines (Appendix F) which accompany this report.

Some mothers and stakeholders could not recall seeing the materials in Penhill and Pinehurst though, and felt that the distribution of the materials should be higher with greater presence across the areas. During the pilot period materials were distributed to a total of 10 locations across both areas.

Breastmates counsellors did note that word of mouth was beginning to develop among the social networks of group members, which is a potentially more effective channel for promoting the service organically.

### *Recommendations*

Maximise the power of word of mouth promotion by equipping existing Breastmates group members with recruitment packs, including badges and invitations, and ask them to pass them on to friends and family.

In addition use the brand guidelines and templates to adapt and roll out materials for Breastmates provision across Swindon, and initiate a large-scale outdoor marketing campaign targeting central locations with high footfall such as the town centre shopping districts.

### *Support delivery: telephone*

Tracking and measuring the delivery of telephone support provided to women in the areas by the NCT, National Breastfeeding Line and La Leche League was problematic. The NCT and National Breastfeeding Line do not record the geographical point of origin of phone calls they receive.

La Leche League does record the dialling code, but received no calls from Swindon dialling code landlines during the pilot period. It is possible they received calls from mobiles during this time, which are not geographically identifiable.

Interviews with members of the Penhill support group revealed that they thought the phone numbers would be useful for situations when support or an answer was needed quickly, though they also stated they use the internet for urgent informational support needs.

### *Recommendation*

Continue to market and promote the three help lines within Breastmates marketing activity to provide a unified menu of support options with alternatives to suit different support needs and situations. Regularly check in with La Leche League and Breastmates users to ascertain whether mothers are accessing this type of support, and for what needs, and feed this insight into the marketing of this support channel.

### *Support delivery: groups.*

Within the pilot period of a month the Penhill support group has seen four women join and attend regularly. The Pinehurst group saw three attend in the first week, and none subsequently. Follow up calls with these three women reveals this was because one mother joined the Penhill group as it was closer to her, and another mother was due to give birth shortly.

Interviews with the women attending have provided uniformly positive feedback.

Mothers really value the social element of the group:

- “I feel supported in the group, and I like going to meet and chat to other like-minded mothers.”
- “I keep myself to myself, so the only other people I see are at Baby Buddies and Breastmates.”

The group has provided them with both expert informational support, and peer emotional support:

- “The counsellors are great, really easy going and good to talk to, a wealth of knowledge and information and explain things very clearly.”
- “The different talks each week have been interesting, especially the one about baby-led weaning.”
- “It’s the experience of the other mums which is great; everyone’s been through different things.”
- “You can get answers to questions you might have, stuff you just can’t find out about on the internet.”

Going to the group also provides them with a different context within which breastfeeding is the norm:

- “In the group setting with other mums breastfeeding feels normal, as opposed to outside the group.”

The group has provided the encouragement and support to help mothers maintain breastfeeding:

- “I feel really encouraged to continue breastfeeding beyond the recommended 6 weeks.”

Breastmates counsellors indicate there are two peer supporters keen to continue the Penhill group, and two breastfeeding champions (based at Children’s Centre) beginning training shortly. Additionally, one of the Penhill group mothers is interested in becoming a peer supporter herself, and has been put in touch with a counsellor to discuss the training programme.

Most of the mothers attending found out about the Breastmates group through face-to-face marketing, either at the Baby Buddies or Baby Massage groups at the Children’s Centres or through word of mouth from mothers already attending the support group.

### *Recommendations*

Breastmates staffing provision is a question that needs reconciling, with voluntary counsellors uncertain they can continue to deliver these sessions alongside their other commitments. One suggestion is for a breastfeeding champion and peer supporter to run the groups, with counsellors attending intermittently, though women highly valued the expert knowledge and empathic approach of counsellors.

Staff at Children’s Centres felt that they could have contributed more to the organisation and delivery of the groups, and that there are questions regarding funding and capacity to continue hosting the groups. With the Penhill group proving more popular, suggestions included continuing this group and referring Pinehurst mothers to it.

### *Support delivery: home visits.*

To date no mothers have requested a home visit from a Breastmates counsellor in either area. This may be because the promotion activity during the pilot which resulted in mothers accessing support has been face-to-face engagement by services, or word of mouth, and in both cases these conversations may not have covered the offer of home visits.

Another potential reason may be because in the short pilot period there simply have not been any mothers with breastfeeding support needs who would prefer home visits to peer group support.

Interviewing mothers in the support group

- “If I was a first time mum I would find these helpful.”
- “I think it’s a good idea for those with concerns about meeting others, who are shy or find it difficult getting out and about.”

### *Recommendation*

Formalising the home visits as part of the Breastmates service was one of the key project elements arising from both the insight, asset mapping and at home co-creation sessions. Some mothers cannot attend groups due to logistical barriers (location, convenience and large families); some mothers will not attend groups due to shyness or nervousness. Mothers stated that the key time they required support was within the first fortnight after birth when they were mostly confined to their homes.

Therefore, we recommend continuing to offer the home visits, and ensure women are aware of them as an option by briefing those carrying out face to face promotion, namely relevant services and Breastmates members, to communicate this offer clearly.

This will allow those mothers with support needs who will not or cannot attend groups to receive help. It is possible that in receiving these home visits and building up trusting relationships with the counsellors, mothers may feel more positively about attending the group sessions and less shy or nervous if that is a barrier to joining.

### *Support delivery: Facebook.*

The size of the Breastmates Facebook group has increased, though it should be noted that members have been joining from across Swindon. The total group size has increased from 235 members on 14.01.13 to 260 members on 22.02.13. Anecdotally the mothers that have joined the Penhill support group have also joined the Facebook group.

The group is a closed forum, and so Uscreates asked Breastmates counsellors to pose evaluation questions to group members to collect feedback, however, responses had not been submitted at the time of writing this report.

### *Recommendation*

The Facebook group size is large enough to overcome a common problem with low interaction encountered when starting online forums from scratch, referred to as the 1% rule of participation. A rule of thumb, this states that in online groups 1% create content, 9% edit or comment on that content, and 90% simply view the content without contributing.

With low numerical group sizes this can lead to problems with a lack of content and interaction. The Breastmates Facebook group is large enough that this problem is largely mitigated.

Facebook can provide mothers with timely peer support, and can be particularly useful when other sources are unavailable, provided other members are online. Given the asset mapping which revealed many of the target audience are already on Facebook, and use it to communicate between themselves, it provides a potentially convenient and frictionless method of communicating with, and encouraging support between, mothers in the areas.

### *Overall recommendation*

The overall recommendation after the pilot phase is to continue to use the co-created Breastmates brand, and roll this out across Swindon. With face to face engagement and promotion having the biggest impact on uptake and attendance, continue with this as the primary focus for promotion activities.

The other attendant promotion components (Facebook, Breastmates site, Textmagic) should be tweaked as per the recommendations above, and continue as low cost methods to increase general awareness of Breastmates, and provide a professional and unified means of reinforcing messages delivered by the face to face activity.

## Next steps

### *Short term:*

- Uscreates provides necessary design templates, tools, information and insight to continue the extended Breastmates provision
- Uscreates transfers to NHS Swindon ownership of Breastmates Wordpress site, Facebook advertising campaign, and Textmagic account
- NHS Swindon removes Textmagic contact number from marketing materials, replaces with alternative point of contact, print and distribute
- NHS Swindon briefs services on promoting the alternative support formats Breastmates offers in conversation with mothers
- NHS Swindon liaises with relevant stakeholders across Swindon prior to launching the new marketing materials Swindon wide

### *Medium term:*

- Job swap or shadowing to bring Health Visitor team into closer contact with and understanding of Breastmates as a valuable support service
- NHS Swindon makes any adaptations necessary to localise marketing materials for Breastmates provision across Swindon, prints and distributes
- NHS Swindon initiates wide-scale outdoor marketing campaign using bus stops, billboards and central locations to raise awareness



Bristol Social  
Marketing  
Centre

Social marketing to  
encourage initiation  
and continuation of  
breastfeeding

Stella Warren,  
Alan Tapp, Louise  
Condon & Katie  
Collins,  
June 2012

## Executive Summary

- Breastfeeding rates in the UK are low compared to other developed countries. Breastfeeding has lost its position as the normal way to feed a young baby, with negative cultural positioning, social disapproval, media hostility, and inherent British aversion to public exposure all playing a part. However, perhaps the key driver has been the marketing power of formula milk suppliers who have normalised bottle feeding.
- To counter these problems, the potential of social marketing is being explored in small scale campaigns, run within PCTs in the last few years. Using social marketing to encourage breastfeeding is still in its infancy, and it has yet to emerge in the literature as a clear set of strategies; however, it does have considerable potential.
- Our own work, and indicative results elsewhere position co-creation as a potentially highly effective strategy for use within deprived communities; its potential to embed behaviour change sustainably is clear. However, more case studies and large-scale trials are required to generate an evidence platform.
- Traditional health education approaches on their own do not appear to have much impact. The Cochrane Review of Breastfeeding (1998, and also found in Hoddinott et al, 2011) examined traditional health education focusing on the health benefits of the baby: there was reasonably clear evidence that such approaches used in isolation are of limited use; however, combined with other methods, health education can be effective.
- There may be potential to focus on non-health benefits to promote breastfeeding, for example, its possible cost savings, or its convenience when travelling.
- In general, multi-faceted interventions are potentially more effective than those with single components.

Within the context of the above key issues, social marketing has a number of possible roles:

- The benefits of breastfeeding to both baby and mum may not be explicit and clear to our audience – social marketing can make them clear.
- There may be merit in communicating immediate health benefits for the baby, such as reduced ear infections and allergies.
- The social and cultural position of breastfeeding remains uncertain. It is sometimes seen as embarrassing, or ‘not normal’ to do and these things are amplified in public. Social marketing has potentially very important roles in creating the right social environment. US (*Loving Support*) and UK (*She’s a Star*) examples have shown some (limited) evidence of positive effect. More explicit social norms campaigns are to be thin on the ground and certainly worth exploring.
- The above roles of social marketing are clearly things to take forward into in-depth research. But we should not lose sight of the evidence that professional and personal support appears to be vital. Given that breastfeeding is not yet seen as ‘normal’ or everyday, mothers can feel vulnerable. Support in its various guises is, therefore, a core foundation of the profession’s offer: practical help, information based help, help with self-esteem, and emotional support. The requirement for supporting breastfeeding in the UK led to the Baby Friendly hospital initiative. This programme could be strengthened further by appropriating peer support as a key element: US

*WIC*, *Best Start*, and *Centering Pregnancy* programmes all suggest that peer led facilitation approaches, in which concerns are acknowledged and dealt with, outperform 'expert led' approaches.

- Our final point concerns the integration of all of these elements. Integration is often discussed as a key issue within the marketing and other literatures. Hence, integrating programmes that address cultural perceptions of breastfeeding with targeted work aimed directly at vulnerable segments, which in turn are co-ordinated with strong ante- and post-natal support, education programmes, and peer supported group sessions, will maximise the chances of increasing breastfeeding.

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## Summary of current literature on breastfeeding; implications for social marketing

We begin the main body of this report with a review of the current literature on breastfeeding. This identifies the issues that breastfeeding in the UK faces, explaining the reasons for the UK's relatively poor performance. The review then moves to a brief description of co-creation and social marketing before concluding with some examples how social marketing has been used to encourage initiation and continuation of breastfeeding.

The next phase of our work for you will be a small qualitative study comprised of focus groups and in-depth interviews to enable us to explore the specific local context to the issues. Detailed outcomes and resulting recommendations will be provided to you. The study will then be submitted for academic publication.

This review of the current literature builds on previous breastfeeding research projects carried out in disadvantaged areas in Bristol and Cornwall. Although our work for NHS Bristol (Rhodes et al. 2009) focused specifically on the infant feeding intentions and behaviours of teenage mothers (under 18 at conception), the findings from our study may also apply to the mothers of Penhill and Pinehurst in Swindon.

We will start by briefly reviewing the benefits of breastfeeding, before moving onto the situation in the UK.

### The benefits of breastfeeding

Breastfeeding is widely acknowledged to be nutritionally superior to bottle feeding and to confer long-term health benefits on both mother and child. A breastfed infant has a reduced risk of gastroenteritis, severe lower respiratory tract infections, ear infections, dermatitis, asthma, obesity, type 1 and 2 diabetes, childhood leukaemia and sudden infant death syndrome (SIDS) (Eidelman 2012; Brenner and Buescher 2011; Duijts et al. 2010; Monterossa et al. 2008). In addition, it has been suggested that breastfeeding could also improve children's cognitive skills and non-cognitive development (Borra et al. 2012). Continued and prolonged exclusive breastfeeding has shown to reduce instances of infant hospitalisation for diarrhoea and lower respiratory tract infections, although the protective effect diminishes soon after cessation (Quigley et al. 2007).

For mothers, breastfeeding is associated with a reduced risk of type 2 diabetes, breast cancer, ovarian cancer and maternal postpartum depression (Ip et al. 2007). There is also limited evidence to support a reduced risk of maternal osteoporosis (Cooper et al. 2009) and some benefits in terms of return to pre-pregnancy weight (NHS 2012).

Combined, these factors present a powerful case for the promotion of breastfeeding, reflected in national and international guidelines with the World Health Organization recommending that babies be breastfed exclusively until six months and, after weaning, continue to be breastfed to two years and beyond (World Health Organization 2003).

From a financial viewpoint, since mothers and their babies would benefit from the protective effect of breast milk, it follows that this would result in a reduction of hospital admission with the associated cost savings. Based on 2009/10 data, the East Midlands Public Health Observatory predicted that an increase in breastfeeding rates of five per cent could potentially save them approximately £1 million through reduced hospital admissions of children with gastroenteritis and respiratory tract infections (Flaherty et al. 2011).

### Problems in the UK

In the UK, breastfeeding rates are generally lower than other developed countries, including those with comparable maternity leave policies, and lower than the UK average in

economically disadvantaged groups (Bolling et al. 2007; UNICEF 2008; Boyer 2012). In 2005, 88 per cent of UK mothers in managerial and professional occupations breastfed initially, compared with 65 per cent of mothers in routine and manual occupations. At six weeks, the figures were 65 per cent and 31 per cent respectively and overall, less than one per cent of UK babies were reported to be breastfed exclusively at six months (Bolling et al. 2007).

Early findings from the 2010 UK Infant Feeding Survey reported an overall increase in the incidence of breastfeeding across all socio-economic groups, most significantly amongst the lowest occupational classification, with a nine per cent increase to 74 per cent, narrowing the gap between the highest and lowest occupational groups (NHS 2011). However, these early findings only report the incidence of breastfeeding (infants who were breastfed initially, even if only once) with a more detailed analysis of prevalence of breastfeeding due later this year.

Mothers who are most likely to stop breastfeeding early are young mothers, mothers who leave school early, single mothers, first time mothers and white mothers (Kelly and Watt 2005; Jackowitz 2007). Breastfeeding could make a vital contribution to reducing inequalities in health (Raisler 2000), reflected in the NHS's requirement for Primary Care Trusts to increase breastfeeding rates by two per cent per year, with a particular focus on disadvantaged groups (Department of Health 2002). In addition, NICE suggests that: "Where appropriate, interventions should be targeted towards disadvantaged white women, with particular focus on those who are teenagers or lone parents" (NICE 2006:8). More recently Cattaneo (2009) suggested greater success could be gained from such interventions if they were embedded in a local plan tailored to the specific needs of deprived groups.

### Breast vs bottle

What emerged from the UWE Bristol study (Rhodes et al. 2009) was the cleverness with which formula milk suppliers marketed their products, using powerful creative images that link their product with 'happy babies'. The respondents did not themselves use the word 'happy', but did associate successful feeding with words like 'content' and 'settled'. In turn, these images were themselves associated with a baby that was full-up, well-fed and often linked with being asleep. These were the things that were important to respondents. In their eyes, a crying baby was a source of stress, and crying often signalled a hungry baby. Respondents found it difficult to trust their natural instincts and felt that it was much easier to calculate a baby's milk intake when bottle feeding, commenting that with breastfeeding 'you don't know how much they are getting' (Rhodes et al. 2009). Formula milk suppliers will have researched these issues in great depth, and will use these insights to generate promotional campaigns that reflect the mothers need for reassurance that they are doing all they can to feed their baby 'properly' (in their eyes equalling 'full up').

The formula milk industry focuses its resources on getting across the message that bottle feeding is the norm in society. It is in their commercial interests to promote bottle feeding as being safe for infants and convenient, especially when feeding in public or for partners or other carers to share the feeding experience, and implying that the bottle will inevitably be introduced (Marsden and Abayomi 2012; Mahon-Daly 2002; Dermer 2000). In the past, formula milk was routinely advertised as a necessary supplement to breast milk (Rosenberg et al. 2008) and although the practice of advertising of infant formula products is now banned, follow-on formula for toddlers is still marketed in a way that associates the health benefit claims with a product line that includes infant formula (Berry et al. 2011).

In the US, whilst the media includes some reports on the benefits of breastfeeding, it has been claimed that the main discourse on breastfeeding focuses on problems (Dermer 2000). Research from the UK (Williams 2007) noted that breastfeeding was perceived as difficult, bottle feeding as easier:

*“Qualitative studies report that breastfeeding is perceived as being something which is difficult. This is reinforced by the way it is frequently portrayed in the media as problematic to the extent that breastfeeding can seem ‘daunting’ or ‘alien’. In one study, mothers reported being advised by the midwife to have a stock of bottles and formula in the home ‘just in case’. This perception of breastfeeding being problematic is grounded in the reality of the experience with nearly one in two breastfeeding mothers having problems.”*

Williams also pointed out that UK mothers are often not convinced of the benefits:

*“Studies mention that parents are told that ‘breast is best’, but not told why. Mothers were sceptical about how much better breast milk actually is compared with infant formula, because most babies seem to do perfectly well on infant formula”.*

Williams speculated that:

*“...compared with the marketing of infant formula which uses complex technical justifications for their product, perhaps breastfeeding promotion is not sufficiently technical to be convincing”.*

Quite apart from any physical problems encountered, clearly there are a range of influences that affect initiation and continuation of breastfeeding across the population, for example, an inability to integrate breastfeeding with the rest of a mother’s life given the need to return to work/education; the attitude of a partner or family member and fear of social stigma (Condon et al. 2010; Boyer 2012). It is likely that barriers to breastfeeding have a greater impact on disadvantaged groups such as mothers with low levels of education and income and it may also be the case that additional factors affect feeding decisions in the target groups of Penhill and Pinehurst. For instance, breastfeeding for the recommended period could restrict a mother’s usual activities if they are unwilling to breastfeed away from the home (Condon et al. 2010). Common features of adolescents’ attitudes to breastfeeding are ambivalence and uncertainty (Wambach and Cohen 2004) and this difficulty is often addressed by an intention to combine breast and bottle, an approach which is likely to lead quickly to full time bottle feeding. This is an issue which needs to be addressed in terms of knowledge and promotion of a full commitment to breastfeeding.

We also note Williams (2007) discussion of Heining’s studies with patients which indicate that when an individual is under stress, they will attempt to calm themselves through denial, disassociation and reinterpretation of their goals. For the breastfeeding women in the study, their major worries were about their babies crying, sleeping and not getting enough to eat. Heining suggests that low income breastfeeding mothers experiencing these problems are in a situation of stress and may not perceive that their problems can be remedied, so do not seek out solutions but are forced to accept the alternative feeding behaviour of using formula.

In professional public health, the emphasis has not surprisingly been on health related triggers and barriers, yielding a list of which Table 1 is typical.

Table 1: Health driven factors influencing feeding decisions

1. Desired behaviour - Incentives	
What incentives currently exist that encourage/support exclusive and continued breastfeeding?	<ul style="list-style-type: none"> <li>• Wide recognition from public and health sector that 'breast is best'</li> <li>• Personal vindication that providing baby with best start in life.</li> <li>• Fulfilment of obligation to be a 'good mother'</li> <li>• Health benefits for baby</li> <li>• Health benefits for mother</li> <li>• Can help with weight loss (if prolonged)</li> <li>• Free</li> <li>• Convenient, portable, available day and night</li> <li>• Nice thing to do</li> <li>• Bonding</li> </ul>
2. Desired behaviour - Barriers	
What barriers/blocks currently limit/restrict exclusive and continued breastfeeding?	<ul style="list-style-type: none"> <li>• Lack of understanding (mothers and health professionals) of early physiology of lactation and good conditions for establishment of breastfeeding</li> <li>• Society valuation of 'sleeping through the night' as soon as possible, which impairs establishment of breastfeeding.</li> <li>• Ambivalence of health professionals or reluctance to promote breastfeeding because they do not want to make mothers feel guilty</li> <li>• Tiring, demanding</li> <li>• A chore</li> <li>• Perceived as problematic</li> <li>• Early difficulties if not supported can be painful/lead to failure</li> <li>• Problems with seeking appropriate help – services opt-in, may not be local, not available 24/7</li> <li>• Fear of failure</li> <li>• Responsibility for feeding cannot be shared with others</li> <li>• Embarrassment</li> <li>• Conflict with fulfilling obligation to be a 'good partner'</li> <li>• Not what peers do</li> <li>• Concerns about feeding out of the home</li> <li>• Social stigma of continued breastfeeding</li> <li>• Returning to work</li> <li>• Acceptability of expressed breast milk</li> <li>• Family spacing &lt;2years can prevent continued breastfeeding</li> <li>• Seen as a choice, rather than completion of biological nurture</li> <li>• Breastfeeding women perceived as 'brazen'.</li> <li>• Contraindication with medications, smoking, alcohol and recreational drug use</li> </ul>

Source: Williams 2007



In this review we are seeking deeper insights into the problem than would be obtained from health considerations alone. Hence, in the sections to follow, we concentrate on psychological and sociological influences that may affect infant feeding decisions.

### Feeding in public and the response of others

In the UK, there is an enduring myth that breastfeeding mothers could be prosecuted for indecent exposure when in fact the right to breastfeed in public has been covered since 1975 by the Sexual Discrimination Act and, more recently, by Section 13 of the Equalities Act (2010). However, the law only covers breastfeeding in a public place for infants up to six months old, whilst mothers who wish to breastfeed children up to the age of two have been protected by Scottish law since 2005 which made it a criminal offence (with fines of up to £2,500) for anyone preventing a mother breastfeeding a child under two 'in any place in which the public has access and in which the child is entitled to be' (The Scottish Parliament 2005). Despite the protection of the law, there is still a social stigma associated with breastfeeding in public places in the UK and initiatives designed to encourage cultural change (for example, 'Breastfeeding Welcome Here') so that mothers have the confidence to breastfeed in public are crucially important to increased duration rates (Boyer 2012).

In 2009, the National Childbirth Trust surveyed over 1,200 UK mothers and reported that 60 per cent of respondents considered the UK was not breastfeeding friendly, 65 per cent stated they did not intend to even try breastfeeding because they felt too self-conscious and 54 per cent of those that had breastfed in a cafe, restaurant, or coffee shop had been asked to move (NCT 2009).

In much of the literature there was significant agreement amongst mothers that feeding in public (and some private places) was seen as a daunting prospect and a source of great anxiety, with perceptions of the judgement of others causing them to modify their behaviour (Mahon-Daly and Andrews 2002; McFadden and Toole 2006; Smyth 2008; Boyle 2011).

*"I would rather let her cry than get them out in front of my dad. I think he was relieved too when I said to the midwife she was going on the bottle."*

(Mahon-Daly and Andrews 2002:70)

*"My friend, she goes into the toilet in the café we usually go to because everyone stared. She didn't like to keep going into the toilet. It is a nice café and nice people, but staring puts you off."*

(McFadden and Toole 2006)

Many even report that they felt feeding 'shouldn't' be done in public and it is unacceptable to others.

*"Some people take it too far and do it out in public. That is not good...That stuff is supposed to be private. Your baby doesn't want everybody seeing it. Who wants to walk past and see somebody's body part just because your baby's hungry?"*

(Hannon et al. 2000)

Young mothers reported the pressure to be discreet when breastfeeding in public to the extent that it was seen as an unusual behaviour, rather than the natural social norm.

*"Young girls my age, you just see them with their bottles really...I don't think I've seen any girls breastfeeding when I've been out anywhere."*

(Condon et al. 2012)

The definition of 'public' can be variable and individual. Being at home in a 'private' space may still effectively mean feeding in front of others.

*"My brothers and their friends, they're always yelling before they come in the house: 'Are the boobs out?' ... My dad and everybody else leave the room while I latch her on and then I cover up and everybody comes back in. My problem is manoeuvring so that I'm modest about it ... I really don't mind if anybody sees me, it's just what other people feel, and having three males in the house, that makes it a little bit difficult."*

(Raisler 2000: 259)

Women could even find that breastfeeding excluded them from social interaction within their own home because others refused to be in the same room (McFadden and Toole 2006). This detachment by family members, while not necessarily meant to be unsupportive, could certainly be interpreted in that way.

*"My father-in-law helped dissuade me from breastfeeding. He would leave the room or not enter when I was feeding. There was a feeling of isolation."*

(Mahon-Daly 2002: 70)

The very common reference to feeding in public being 'embarrassing' is likely to relate to the potentially conflicting sexual and nurturing roles of the breast and the fact that this part of the body is almost always covered in western cultures (McFadden and Toole 2006; Smyth 2008; Stearns 1999). Some women may struggle to contend with what could be a difficult period with their sexual partner, choosing not to, or stopping breastfeeding prematurely (Mahon-Daly and Andrews 2002).

Williams (2007) noted in her literature review the suggestion that, because our society places a high value on our body image and control, mothers may find the physiological changes associated with breastfeeding distressing and so give up breastfeeding in order to regain control. She notes that a woman's attitude to breastfeeding and her perseverance is linked to the perceived change in her previous body image and function. This seems to suggest that women who are more body conscious and concerned with their sexuality may be more at risk of stopping breastfeeding. There is also a suggestion that women who are more confident with handling their own body are more likely to breastfeed.

Breast milk itself was in some cases regarded as 'disgusting', like other bodily fluids that 'leak from the body', so leading to further difficulties associated with storing expressed milk in a fridge where it could be recognised (Boyer 2010; Raisler 2000). In addition, many breastfeeding facilities made available to nursing mothers by retailers are situated next to (or even rooms within) the public toilets, underlining the view that breastfeeding is another 'form of excretion' (NikAzhari et al. 2012: 533).

These attitudes clearly affect women's perceptions of breastfeeding as a major commitment. Many mothers felt that, because they could not feed in public, opting to breastfeed substantially limited their activities and freedom. For some the embarrassment of feeding in front of others – even within their own home - impacted their infant feeding choices.

Negative body images are also an issue:

*"Breastfeeding causes your chest to sag and my appearance is too important. I've seen it. My boyfriend's sister, she look like an old lady by her chest."*

(Hannon et al. 2000:404)

*“If you take out your tits in public the chavs think you’re a slag.”*

(BBC 2011)

The two main implications here are that better and clearly identified breastfeeding facilities in public places are required but also that there are major issues to be addressed across the broader population to promote more positive attitudes to breastfeeding in general, and to ‘public’ breastfeeding in particular.

Breast-pumps are a potential means of avoiding public breastfeeding. Milk is expressed so that the infant can be bottle fed in situations where otherwise the mother may be embarrassed or uncomfortable and allows others, such as partners or other carers, to share the feeding experience. This is an approach which appears to have met with some success (Wambach and Cohen 2008; Hannon et al. 2000) but carries with it issues of additional costs (the purchase of a breast pump), the requirement to learn a new technique and to be supported in starting and continuing to use it, issues of milk storage and the fact that some mothers find expressing milk a difficult process. Although breast pumps used for this purpose may help individual mothers concerned about public feeding, ultimately this approach supports the concept of breastfeeding as a hidden activity.

Breastfeeding does need an act of will and can be embarrassing and discomforting and so does involve an element of self sacrifice. Speculating for a moment, it may be possible to make up for this sacrifice with self-centred benefits; or the appeal could be based on ‘it’s the right thing to do’ and so hoping that the need for moral acceptance is a more powerful influence.

### **Social and family influences**

Maternal feeding decisions are shaped by a wide range of influences including personal, social, cultural, economic, clinical and psychological factors (Swanson and Power 2005).

The role of the baby’s father is significant from their contribution to the initial feeding decision through to their continued support during breastfeeding, but this may vary with the level of the father’s involvement with the baby and the parents’ continuing relationship (Ineichen et al. 1997; Greene et al. 2003). Specifically, decisions to initiate bottle-feeding are influenced by the mother’s perception of the father’s attitude (Arora et al. 2000).

Given that this is the case, it is interesting to note that mothers’ assumptions of fathers’ negative attitudes towards breastfeeding are often exaggerated (Kessler et al. 1995), with fathers often having more positive attitudes than their partners expected. Using social marketing techniques, this misperception could be directly exposed and mothers could be encouraged to discuss attitudes to breastfeeding with their partners, rather than make assumptions about their views. Kenosi et al’s study concluded that the majority of the antenatal breastfeeding advice was directed solely at mothers, missing the opportunity to educate and involve fathers and ignoring the potential support from fathers which may affect breastfeeding motivation, confidence and breastfeeding rates (Kenosi et al. 2011).

The overall implication here is that fathers could be targeted when breastfeeding is promoted to establish positive attitudes towards this method of feeding and to provide education on how best to support their partner. In one study, a two hour class for fathers on childcare and breastfeeding saw breastfeeding initiated by 74 per cent of women whose partners attended compared with 41 per cent of women whose partners did not attend (Wolfberg et al. 2004). Peer support schemes for expectant fathers have also shown some success (Stremmler and Lovera 2004).

Williams (2007), in the Brighton trial literature review took a more negative view asserting that:

*“Reports of fathers experiencing jealousy of breastfeeding or exclusion are common. This jealousy can be jealousy of the baby taking the mother away from the father, and/or jealousy of the mother’s relationship with the baby.”*

(Williams 2007:64)

To counter this Williams suggests that fathers need to be made aware that breastfeeding is demanding of the mother and may precipitate feelings of envy and uselessness and to encourage men to find their own way of developing a bond with the baby. Some writers describe the need to assist the father in coming to terms with his feelings during the period of exclusive breastfeeding.

It is often reported that fathers experience negative emotions in relation to breastfeeding: feeling excluded from the infant’s care, prevented from establishing their own relationship with the baby and jealous of the infant/mother relationship (see, for example, Gamble and Morse 1993). Educating fathers to be aware that such feeling may arise and to assist them in coming to terms with these emotions can be beneficial (Dykes 2003). The support and views of the baby’s father are clearly key in the making of feeding decisions. However, the effect may be impacted by the varying levels of involvement of the baby’s father in the infant/mother’s life.

The other powerful influence in a mother’s life is likely to be her own mother (Dykes 2003; MacGregor and Hughes 2010). For young mothers, the grandmother is frequently reported to be a source of information prior to the initial decision on feeding methods and highly influential in the decision itself, with their approval being closely associated with the initiation of breastfeeding (Rhodes et al. 2009). Positive influences for breastfeeding, such as being breastfed themselves and observing breastfeeding, are directly related to their own mother’s attitude to breastfeeding. These attitudes will help shape the teenage mother’s perception of social norms and her own beliefs.

For adolescent mothers, the negative impact of direct discouragement from their mothers is similarly powerful:

*“My mother she don’t like it ... ugh, why don’t you give her a bottle.”*

(Wambach and Cohen 2008:6)

Grandparents’ negative attitudes to breastfeeding may also relate to feeling excluded by breastfeeding because it prevents them from taking full care of the baby (McFadden and Toole 2006), or it may result from out-of-date knowledge, family or social norms.

Positive support from a parent encourages not only breastfeeding initiation but also continuation. In one study, long term breastfeeding adolescent mothers all reported support from their own mother or father (Wambach and Cohen 2008); in another, the majority of adolescents had involved their mother in the decision-making process (Hannon et al. 2000). Given the need for ongoing ‘in home’ support for breastfeeding and the practical limitations of providing readily available professional support when common problems occur, it would seem that grandmothers could present a unique resource for supporting the continuation of breastfeeding. Surprisingly, although there is support in the literature for the important role of grandmothers there is little or no literature on campaigns or interventions that target this group.

Health care professionals have also been reported as sources of encouragement, discouragement or influence in the feeding decision, especially where no extended family was present (Ineichen et al. 1997; Wiemann et al. 1998; Raisler 2000), but there were mixed reviews through issues of time pressure, lack of availability of healthcare professionals or guidance, promotion of unhelpful practices and conflicting advice (McInnes and Chambers 2008). However, in other instances, excellent professional support to initiate breastfeeding was acknowledged. Certainly in the Bristol cohort, health professionals were less influential in the pre-birth decision-making process but once feeding decisions were made, peer supporters and health professionals were cited as an important source of assistance with early breastfeeding (Rhodes et al. 2009).

In summary, a mother's decision to breast or bottle feed is informed by her own attitudes and beliefs, together and heavily influenced by her perceptions of what other people – her partner, family, friends, health professionals and wider society - think.

### The effect of social norms

Cultural and social norms are known to be important components of behaviour change (Ajzen 1985). Shifting community values and beliefs can take time and social marketing can be a powerful tool in addressing deeply held values by promoting things as 'normal'. Sweden's breastfeeding initiation and continuation rates are considerably higher than the UK, attributed to two decades of nationally implemented, multi-faceted interventions (Protheroe et al. 2003).

In the UK, amongst less well off sectors, the 'social norm' is still to bottle feed. Addressing this through social marketing has been a high priority for a number of NHS trusts. Such programmes do not have to involve expensive advertising: Bristol NHS has taken steps to help normalise breastfeeding in public places, with 'Breastfeeding Welcome Here' signage in restaurants an example. Such measures can be combined with clamping down hard on the illegal discouragement of breastfeeding still sometimes found.

The timing of the decision to breastfeed or not appears to vary substantially (Arora et al. 2000; Ineichen et al. 1997). For example, Wambach and Cohen's (2008) study showed that longer term breastfeeding adolescent mothers had made early pregnancy decisions to breastfeed and prior exposure to breastfeeding meant that young women were significantly more likely to intend to breastfeed themselves (Hannon 2000; Greene et al. 2003). This, and other research (Ineichen et al. 1997; Giles et al. 2007 and 2010; Condon et al. 2010; Marsden and Abayomi 2012), points to exposure to breastfeeding being associated with a positive attitude towards it, which in turn leads to an increased likelihood of breastfeeding intention and higher levels of self-efficacy. Such a social learning hypothesis is also supported by cross cultural comparison studies, where teenagers from countries with higher rates of breastfeeding are more likely to have positive intentions to feed in this way (Wambach and Cole 2000).

As noted above, the decision to breast or bottle feed can be influenced by 'significant others', such as partners, siblings and grandmothers (Rhodes, et al. 2009; MacGregor and Hughes 2010). The kind of support family members offer to a new mother may depend on their own experience or customs and within a largely bottle feeding culture (economically disadvantaged groups), collective knowledge and acceptance of breastfeeding appears to have been lost (Dykes 2003). An important trigger for the minority of breastfeeding mothers within this group who then chose to switch to formula milk has been a perception of the lack of support from the majority of friends and family who chose to bottle feed their babies

(Brown et al. 2011a) potentially leaving nursing mothers experiencing social isolation within their own communities.

The cultural tone of breastfeeding is to some extent both created and reflected by the media. The huge power of the UK media unfortunately rarely exerts a positive influence with a study from 2003 finding that favourable images of breastfeeding were seldom seen (Green et al. 2003). This trend seems to have continued with the press capitalising upon breastfeeding as a topic that will provoke controversy. A recent example (May 2012) was the Time Magazine's provocative front cover promoting attachment parenting – a Google search for the story returned over 5 million hits from the media and social commentators worldwide (see, for example The Guardian 2012).

Reflecting the personality of the nation, the general public perception in the UK is that breastfeeding should be discreet and private, borne out by anecdotal evidence from nursing mothers who report extreme and often hostile anti-public breastfeeding attitudes (see, for example, Bristol Evening Post 2012; The Guardian 2011; BBC News 2010; Daily Mail 2009). An important implication here is that societal embarrassment has led to breastfeeding becoming a 'hidden' activity, one rarely seen in public (Boyer 2011). This leads to reducing levels of exposure to breastfeeding and the positive attitudes that engenders. This in turn potentially perpetuates embarrassment and negative attitudes as exposure and the 'normality' of breastfeeding reduces (Greene et al. 2003; Acker 2009; Brown et al. 2011b).

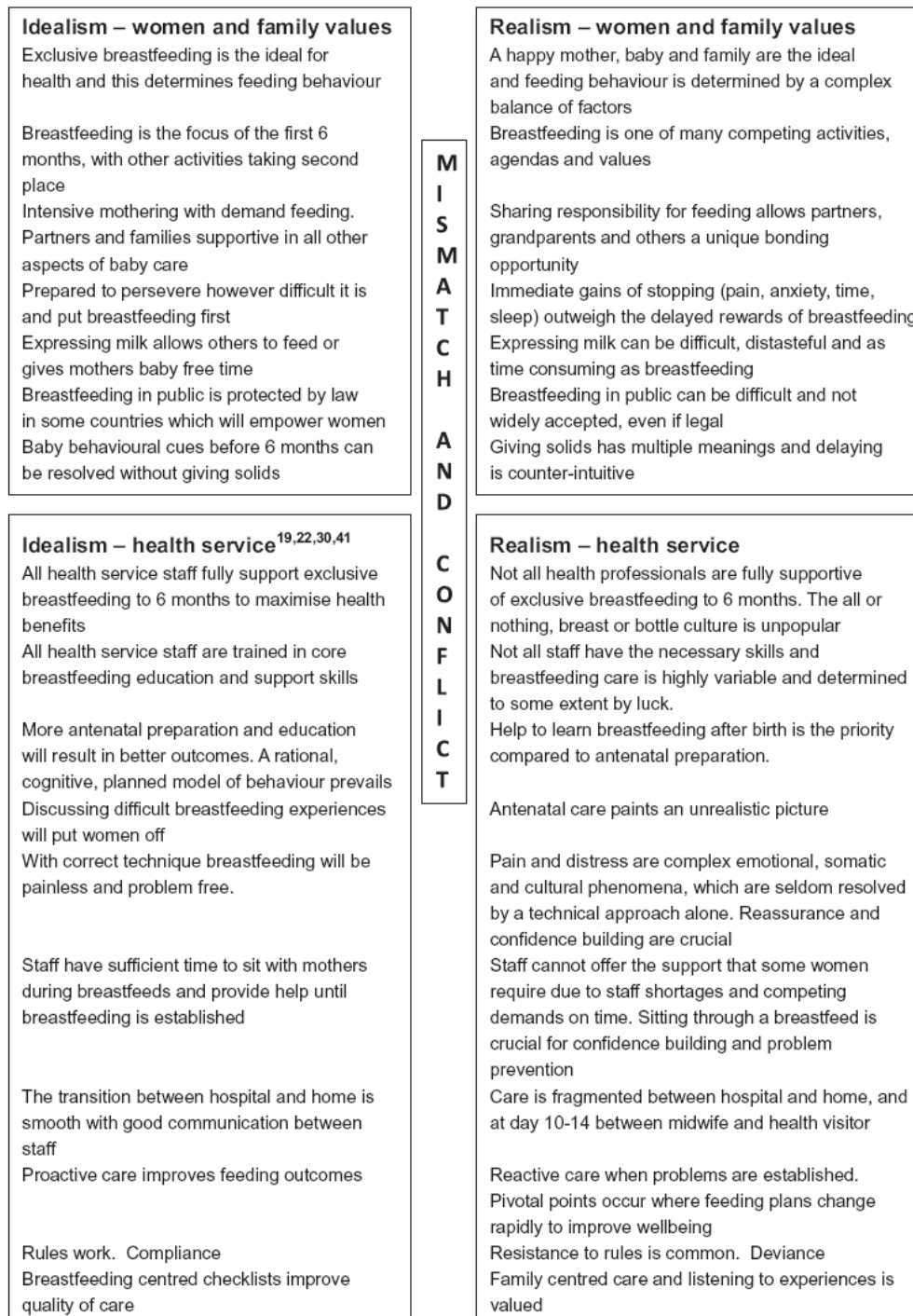
### Physical and emotional problems

There are a number of genuine medical difficulties associated with breastfeeding which cause many mothers to stop breastfeeding prematurely (Huggins 2000; Bolling et al. 2005). However, the majority of reasons for giving up are not biological and relate to breastfeeding management issues and proper technique (Neifert 2001; Skafida 2012).

There is a difficulty presented here in that, if mothers are not made aware of potential problems and clearly signposted to sources of help, then they may feel that they are unusual in struggling, will not have strategies in place to overcome problems and become disheartened and be disinclined to continue (Raisler 2000). However, to clearly flag these potential problems may discourage initiation; in a sense providing an easily articulated 'reason' to not begin or to not continue breastfeeding.

Hoddinott et al. (2012) warn of the dangers of ignoring the multiple problems that parents face in the real world which can influence a decision to stop breastfeeding. The figure below illustrates the mismatch and conflict between perceptions of ideal and real positions between families and professionals, highlighting the danger of setting unattainable targets (such as exclusive breastfeeding for six months) rather than achievable incremental goals.

Figure 1: Idealism and realism: Mismatch within and between families and health services



Source: Hoddinott et al. 2012: 5

This concludes our review of the literature related directly to breastfeeding. In the next section we briefly introduce and describe co-creation before moving onto social marketing.

## Co-creation

### Collaborative methods for behaviour change

Collaboration with audiences and users has long been advocated by public health practitioners (NICE 2008) and in the health promotion literature (Glanz et al. 2008; Lefebvre and Flora 1988). Drawing primarily upon Community Organisation (CO) methods, co-created interventions are also emerging in social marketing practice as “the process by which groups of people are helped to mobilise resources, and in other ways develop and implement strategies for reaching specific behavioural goals for a social good” (Collins et al. 2011, adapted from Minkler and Wallerstein, 2005:287).

Co-creation leans fairly heavily on community development for its inspiration. Co-creation approaches aim to empower target communities to generate their own solutions, with experts adopting a facilitation role rather than remote prescription and imposition of ‘outsider’ expertise. The idea is that power lies with the local community, with the objective of engendering a feeling of ownership and control of their own lives. Co-creation involves a series of stages. Typically, the process begins with stakeholder identification, seeking out local people who are willing to volunteer to get involved. Local ‘assets’ are then identified – these could be anything of value that lies within the community, including local facilities, local talent, amenities, existing networks, and so on. A series of workshops are then held in which ideas are generated, leading to a set of specific plans and decisions about what to do in response to the brief. A plan of events and activities is typically drawn up, and then the activities will be directed by the group themselves, with help from the advisors. In this way, a sense of ownership is created, and the chances of sustained change are much greater.

Other methods that have some common ground with CO are Community Based Prevention Marketing (CBPM) and Community-Based Social Marketing (CBSM). As well as similarities to CO, these methods have much in common to one another: Both aim to inform intervention design, originated in North America and each were spearheaded largely by a single academic (Professor Carol Bryant and Dr Doug McKenzie-Mohr respectively). Both appear to have been developed in response to particular issues: health promotion and disease prevention in the case of CBPM and pro-environmental behaviours with CBSM. CBPM draws explicitly upon CO methods (Bryant et al. 1999) and involves working in partnership with communities to apply a social marketing framework based upon exchange theory and the 4Ps (e.g. see Kotler et al. 2003). Formative research and segmentation techniques are used to identify perceived costs and benefits of the ‘product’ and to isolate distinct markets to receive the intervention (e.g. see Parsons et al. 2004; Forthofer and Bryant 2000). A marketing plan is created with the community and messages, materials and strategies pre-tested (e.g. see Salazar 2004).

CBSM’s stated intention is to merge expertise from social marketing with psychological knowledge (see McKenzie-Mohr and Smith 1999; McKenzie-Mohr 2000), and does not advocate collaborative methods explicitly. CBSM is a process that encompasses four or five steps: first, a practitioner of this approach should seek to uncover barriers to desirable outcomes and then, based upon these insights, choose what specific behaviours to promote. Next, a programme is designed to overcome barriers and promote desirable behaviour. Thirdly, the programme should be piloted and finally, evaluated (McKenzie-Mohr 2000). In their book, McKenzie-Mohr and Smith (1999) include a fifth stage: rolling out the successful pilot to the whole community. Other than regarding geographical communities as a target for behaviour change programmes, it is not clear why the term ‘community’ is so strongly associated with this approach as its philosophy appears to be routed primarily in



the psychology of the individual, though some suggested strategies do cover such topics as challenging social norms.

## The role of social marketing

Defining the role of social of social marketing within the sphere of breastfeeding professional services

In this section we concentrate on applying the principles of social marketing in encouraging breastfeeding (the supporting theories can be found in Appendix 1). We then examine the (limited) evidence of social marketing practice in the breastfeeding sector, before finishing with a discussion of improvements to this best practice in future.

Social marketing begins by seeking to understand why people behave in a particular way and what might prevent them from changing their behaviour (Gordon et al. 2006; Lowry et al. 2009; Opel et al. 2009; Shircore and Ladbury 2009; Mulgan 2010). Rather than a unique set of tools, social marketing can be viewed as a planning approach or framework and sits together with other disciplines such as education, support services, community development, professional help and so on. It does not seek to replace these disciplines but looks to work alongside them, achieving the desired changes in behaviour through context specific and tailored interventions. Deep, rich insights are sought into the optimal mechanisms for changing a specific behaviour (rather than simply increasing awareness). These may be offering rational benefits based on self-interest, but may also be based on non-cognitive mechanisms, such as habit change or emotional arousal (Andreasen 1995; Kotler et al. 2003).

Interest in the use of social marketing to encourage breastfeeding has grown with the recognition that, amongst difficult to reach groups, traditional health education approaches have met with limited success (Grier and Bryant 2005; MacGregor and Hughes 2010), while regulatory approaches have, certainly in the UK, been deemed inappropriate.

One of the problems with public health messages is that a behaviour at any point in time, and any subsequent health benefit, tend to be dislocated from each other. People may exercise regularly, but many of the health benefits are not immediate and tangible – they are longer term and diffused. The same is true of breastfeeding – hence, the health benefits to the individual or their baby could be a leap of faith requiring trust in a health message they have received. In addition, these health benefits may be complex and difficult to picture - “tell me again – how does breastfeeding lead to my baby having lowered risk of obesity?” This is not easy material to absorb.

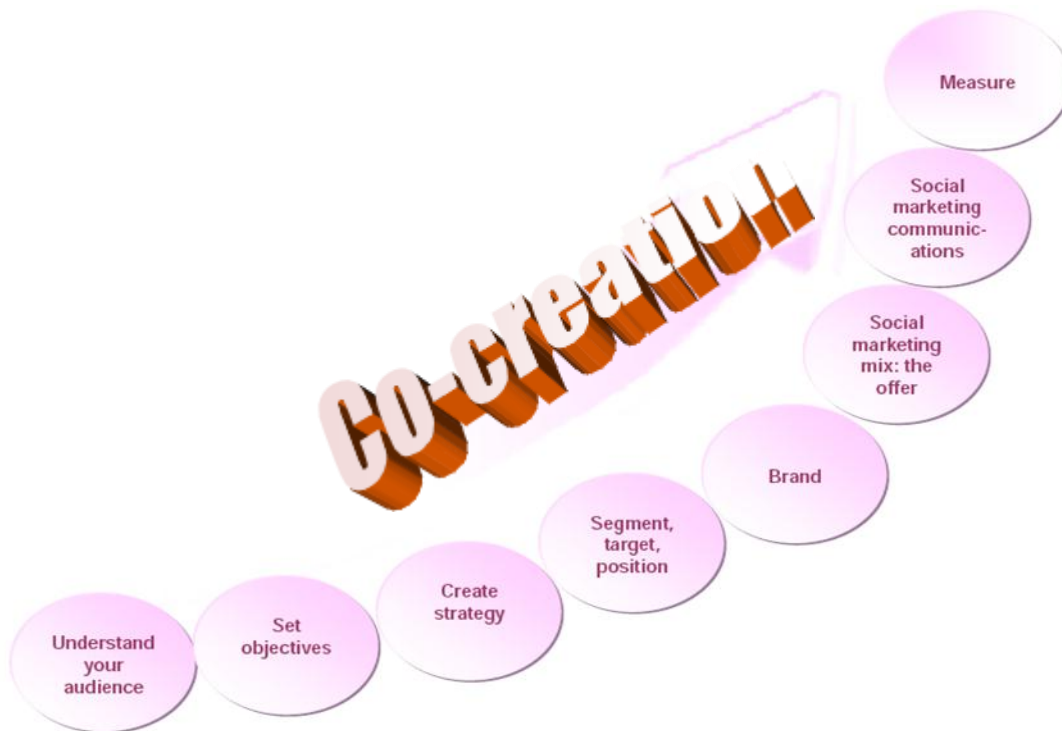
Social marketing could be deployed to overcome this lack of tangibility using creative techniques that, for example, commercial advertisers have fine-tuned using visual metaphors. The UK Department of Health-funded ‘fatty cigarette’ advert graphically portrayed the build up of fatty deposits caused by smoking and proved very successful in gaining attention, and there is evidence that this campaign had some success in achieving behaviour change (British Heart Foundation 2011).

Sometimes social marketing may work within its own boundaries, as a solus technique. Examples include the most visible approaches of social marketing such as social advertising – which in some instances may work ‘alone’ in trying to influence and persuade. However social marketing often works in an integrated manner with another profession. An example may be the way in which social marketers may help in the design of a support programme for breastfeeding mothers. The added value of social marketing may be the way in which core principles are deployed. These include understanding the mindset of the breastfeeding mother, deploying the principles of exchange and competition, thinking about products or services for support, or designing effective communications materials. But the strength of social marketing is not necessarily any particular one of these activities in

isolation, but that they are comprehensively joined together in a disciplined and rigorous step by step process:

### The social marketing planning process

Figure 2: The social marketing steps



### Applying the core principles of social marketing to breastfeeding

The foundation of social marketing is to ask: How do our citizens live their lives? Why do they behave the way they do? These understandings are in turn based on a philosophy which says that different people behave in different ways for various reasons. The consequence of this is that we need to acknowledge differences between groups through segmentation. You have already written this into the brief by isolating particular areas in Swindon where statistics show a low rate of initiation and continuation of breastfeeding.

Only by understanding the contextual circumstances of a specific audience can we move to accurate design of programmes or interventions that address behaviour change.

Our second core principle, therefore, concerns programme design. Social marketing programme design principles are ensconced by social marketing expert Bill Smith's "fun, easy and popular" shorthand. Well known within the profession, this is explained:

Fun = an attitude, an expectancy of an outcome. So, marketers should design services and offers that people are likely to find attractive.

Easy = an expectation by the audience that they will be able do an activity without trouble, and without being humiliated. This is related to what psychologists call self efficacy, what planned behaviourists call perceived behavioural control, or what sensible people would call confidence. This concept applies strongly to breastfeeding where (lack of) confidence is an important consideration.

Popular = an expectation that the behaviour is socially normal; perhaps that lots of other people also undertake the behaviour; that if you do as well you will have a sense of belonging, be part of a community, be amongst friends, and be unremarked in a crowd.

At the moment, breastfeeding does not occupy such a position in British society. Ruth Moss of [lactivist.co.uk](http://lactivist.co.uk) illustrates this amusingly with her breastfeeding bingo below – these are the typical responses a breastfeeding mother might expect from those around them:



This is another important theme for us to explore in our primary research.

Moving back to our discussion of social marketing principles, underpinning the fun, easy and popular design characteristics is the knowledge that people need more motivation to do something than merely that it is healthy. Hence the response of health education – that if only they knew the health facts, people would change – is often inadequate. Social marketing acknowledges the principle of ‘competition’: that in their everyday lives people have choices about how to behave, and often choose unhealthy ways of behaving because it suits them to do so. They often do something unhealthy because instant pleasure can be obtained as a result, or because it is easier to do so, or because everyone around them is doing the unhealthy thing – so they feel “Why shouldn’t I?”

### Social marketing solutions: Strategic considerations

Strategic considerations for breastfeeding include:

- Social marketing is part of wider considerations of support and care and large scale medically driven programmes, for example Baby Friendly hospitals. Social marketing programmes will need to fit into these infrastructures.
- The main competition to breastfeeding is bottle feeding. Bottle feeding may be seen as normal, convenient, and easier. It may mistakenly be seen as better for the baby.
- Social marketers can create brands that can act as powerful attractors for the behaviour we wish to promote. Branding is an important consideration for breastfeeding.

- (Social) marketing is not a physical science, but relies on judgements that are tested in practice. Evidence can be gathered, but judgement is always important. One such area for breastfeeding will be the resource balance between trialling products/services on the one hand and communications on the other. Further discussion of the roles of this mix of elements follows later.
- Another key consideration is to achieve the right balance between face-to-face and remote (media) engagement with the audience. It is usually the case that face-to-face approaches are the more powerful in converting behaviours. Remote methods have a lower cost per individual in terms of message awareness, though this on its own is often inadequate in changing behaviour.
- Ultimately we trade off scarce resources so that we arrive at an affordable 'cost per breastfeeding mum' figure for our marketing.
- Breastfeeding has important unique contextual factors. First, breastfeeding has something in common with social acts of kindness or environmental acts to change for the benefit of society in that it has very few obvious personal benefits. It is ultimately more strongly linked to the benefit of the child. Second, breastfeeding is different to many health behaviour changes such as dieting, giving up smoking, or travel mode switches: all these can be endlessly put off. Deciding how to feed your baby on the other hand is an 'active decision point' that has a specific moment in time, is public, and cannot be avoided. In dieting or smoking cessation people can be serial contemplators, or fail many times and ultimately succeed. Breastfeeding has much more a moment of truth about it. This implies that breastfeeding may respond to structured marketing programmes that can be planned strongly around the birth date. Database and direct marketing can often be effective in such situations.
- Breastfeeding, like many social behaviours, may respond differently to social marketing depending on whether the audience is a 'new acquisition' or 'existing customer'. That is, following commercial marketing logic, we should adapt our marketing approaches to someone new to breastfeeding for the first time, versus the approach needed to ensure maintenance of breastfeeding over time. It is likely that persuasive communications are more important in breastfeeding initiation, while support and service provision are more important for retention.

### Social marketing and breastfeeding: Evidence

The NICE systematic review of 2006: Promotion of Breastfeeding – initiation and duration, Evidence into Practice Briefing (see also Williams 2007) examined the evidence base and we have re-presented the following (most important to this study) points:

Table 3: NICE conclusions on breastfeeding promotion

**Shown to be effective**

- Peer support
- Professional support
- Education
- Multisectoral interventions
- Media programmes

**Appear promising**

- Combination of supportive care, teaching breastfeeding technique, rest and reassurance for women with 'insufficient milk'
- Regional/national breastfeeding targets with supporting activities and/or penalties/incentives.

**Appear ineffective or harmful**

- Written educational materials used alone
- GP clinic visit at one week postpartum
- Single home visit by community nurse following early discharge

**Shown to be ineffective or harmful**

- Restricting timing or frequency of feeds or mother/baby contact.
- Discharge packs containing samples or information on formula feeding
- Topical agents for prevention of nipple pain
- Breast-pumping before establishment of breastfeeding in woman at risk of delayed lactation.
- Combined antenatal education and telephone support for high income women and women who intend to breastfeeding – (existing high rates suggest resources better spent elsewhere)

Sources: Williams 2007; Dyson et al. 2007

Note the support for media campaigns from the NICE Review. The US CDC guide to breastfeeding interventions also suggests that US media campaigns, particularly TV commercials, have been shown to improve attitudes and initiation rates of breastfeeding.

Let us now look more closely at solus social marketing attempts to encourage breastfeeding.









## **Overview of SM interventions**

What is the best design for social marketing programmes? It is of little surprise that, while knowledge and awareness may be important in creating positive attitudes to breastfeeding, they are unlikely to be sufficient to effect behaviour change (Dewan et al. 2002). In fact, it has been reported that information alone can have a neutral or even negative effect (Raisler 2000).

A better approach is what NICE calls the use of 'multifaceted interventions'. These deliver several components simultaneously to the same population group. This has the benefit of addressing a package of barriers to continued breastfeeding, so that one does not stand in the way of the effectiveness of another. Our experience from other sectors would suggest that co-ordinating ante- and post-natal support, education programmes, peer support and group sessions, possibly incentives, together with strong marketing communications, affords the best chance of increasing breastfeeding.

The next table summarises the high profile social marketing interventions discussed in the literature.

Table 4: High profile social marketing interventions from US and UK

Campaign	Aim	Lead	
Be a Star	Lancashire breastfeeding information and support campaign	4 x UK PCTs - Central Lancashire, Bolton, East Lancashire and Blackburn with Darwen	
Loving Support Campaign	National breastfeeding promotion campaign, through WIC	National WIC Breastfeeding Promotion Project	
Centering Pregnancy	Group sessions to improve health habits among pregnant women and young families.	Centering Healthcare Institute Inc.	
Breastfeed with Pride: At all times, in all places	Community-based approach to encourage breastfeeding among Hispanic/Latino women	Connecticut Family Nutrition Program: Infants, Toddlers & Children	
National Breastfeeding Awareness Week	Motivate mothers to initiate and sustain breastfeeding	Department of Health	
Coventry Superbaby	Encourage mothers to take up breastfeeding and tackle perceived barriers to feed in public places	Coventry City Council. Coventry PCT & National Childbirth Trust	
Best for Babies	To make it easier for women to breastfeed in public and when returning to work	Brighton & Hove Health City Partnership	
Other people can eat here, so why can't he?	Promotes breastfeeding and aims to encourage the general public to support breastfeeding mothers, rather than being embarrassed or offended by breastfeeding	Health Promotion Agency for Northern Ireland	



Let us take a closer look at three major social marketing programmes in play:

### Be a Star



This campaign emerged from the experiences of Little Angels (a peer support Social Enterprise that aims to support, promote and protect breastfeeding and 'Make Breastfeeding Fashionable') who first developed the campaign with Central Lancashire PCT. Our hypothesis throughout this report has been that the health benefits of breastfeeding do not, on their own, serve as a prime motivator for teenage mums. This is taken one step further by Little Angels spokeswoman who believed that there is no point discussing any benefits of breastfeeding with teenage mums from deprived backgrounds because they cannot reconcile the idea of breastfeeding being 'something for them'. Breastfeeding is seen as a 'sitting cross-legged under a tree humming' thing – miles away from the reality of their lives.

Such negative social attitudes can best be changed through strong role models. The ideal role models will be their own mother, peers, friends and wider family but these are often absent for these mums. Be a Star was an attempt to use social marketing to change the perceptions about breastfeeding by creating attractive, public, visible, and credible role models using a media driven campaign. This campaign is also about normalising breastfeeding in public.

Be a Star is about creating a brand: the heroic mum. The tone was about confidence, pride in doing something so good and even defiance in the face of some negative attitudes from sections of society. The campaign included a website <http://www.beastar.org.uk/> and blog, posters on bus shelters and other outdoor media, plus a series of radio ads on local commercial radio stations listened to by the target group.

This campaign appeared to be purely communications based with few overt links to any services or support though the website gave contact details of local children's centres. The idea of *Be a Star* has been taken on by seven other PCTs. (The Guardian 2008). According to the National Social Marketing Centre case study website, the early results for *Be a Star* were:

- Pre-launch March 2008 until May 2008; increases in breastfeeding initiation rates within the target group (18-25 year olds):
- Preston: from 52% to 63%
- Central Lancashire: from 52% to 63%
- Increase in breastfeeding initiation rates in Bolton locality for all mums from 65% to 82% (May 2008)
- Be a Star launched in six areas with approximately 1,200 primary target audience members
- Three 'Stars' trained as peer-to-peer supporters and one enrolled on midwifery course within six months of involvement
- 77,000 hits to the Be a Star website

## The Women and Infant Children (WIC) programme: Loving Support makes Breastfeeding Work



This is a US example that is seen by social marketers as a strong campaign due in part to its place as a case study in the Kotler et al. book 'Social Marketing' (2003). The WIC programme is aimed at disadvantaged women whose breastfeeding rates lag behind their middle class counterparts.

This approach emerged from research that found that the idea of bonding with the baby was considered central to the mother's sense of doing a good job; and that breastfeeding was seen as a way of achieving this. Breastfeeding was seen as a 'special time', a chance to get really close to their baby.

The research also highlighted sacrifices made that acted as deterrents: public embarrassment; work, school and social life inconveniences; anxieties about pain and their competence to breastfeed; and a perceived lack of support from friends and family.

The ensuing media campaign emphasised bonding; the 'special joy' of breastfeeding. There was a clear emphasis on the emotional benefits of breastfeeding rather than just the health benefits. The emotional benefits were also seen as a way of competing with bottle feeding. The author of the study, Carol Bryant, noted the emphasis on encouragement, with the target audience for this message being family, partners and friends of the mother.

Communications elements acted as a strong galvaniser for the ramping up of support services: the campaign energised professionals and volunteers in the area to work towards the common goal. Staff training, community outreach programmes and the development of a breastfeeding resource directory were all there to help the helpers; the programme was rolled out within communities as well as through the media campaign – "Go where the mums are".

The programme appears to have had success in increasing breastfeeding rates: the test site had 45 per cent breastfeeding rates at hospital discharge and 31 per cent at four months, compared to control site figures of 31 per cent and 19 per cent respectively.

## Centering Pregnancy Programme



The Centering Pregnancy programme is a US based model of pre-natal care.

One key element for breastfeeding lies with the ante-natal group discussions. The design element of note here is the use of facilitation rather than lecturing. This allows the facilitator to draw out existing attitudes in a non-threatening environment; and to work on these using non-threatening facilitation techniques. Peer support is also an

important part of these programmes and of course peer groups are particularly important in getting through to teenagers.

Let us take a closer look at these facilitation style education programmes. These programmes are marketed as friendly and supportive, peer led and choice driven. But we should not be in any doubt that these techniques are designed to be persuasive. There is a recognition that clinician led, top down approaches are not as effective as they could be, and that young mums come in with a possible set of attitudes, opinions, possibly misinformation, and so on. These programmes recognise that fact-driven lectures are off putting and such lectures have not addressed the reasons why the prior set of beliefs exist

in the first place. The programmes seek to address all the problems of lack of confidence, belief of social disapproval, and so on. Overcoming the ignorance of breastfeeding health benefits is just one component of these programmes.

Grady and Bloom (2004) (with study and comparison group sizes ranging from 124 to 233) found that self reported breastfeeding rates (46 per cent) at discharge from the programme were almost double those of the 1998 comparison group (28 per cent).

### WHO/UNICEF Baby Friendly Initiative



UNICEF guidelines create an infrastructure of education, training and support for breastfeeding. Here, social marketing is a small component of a larger programme. Some social marketing principles appear to be deployed, in particular some form of face to face 'segmentation' (treating different people in different ways), and programme design to maximise the appeal of breastfeeding.

The scheme covers all aspects of service provision and care to promote and apply supportive breastfeeding practices.

UNICEF claim babies born in accredited Baby Friendly hospitals are 28 per cent more likely to be breastfeeding within the first week than those delivering in other units (UNICEF 2005). The Millennium Cohort Study Child Health Group concurs with UNICEF's claim for initiation, but not duration, and suggests other strategies be employed to support mothers to breastfeed for the recommended duration (Bartington et al. 2006). Studies in various countries have reported an increase in breastfeeding rates in accredited hospitals (see, for example, Philipp et al. 2001; Broadfoot et al. 2005). However, an evaluation of hospitals in the Czech Republic concluded that, after an initial increase, breastfeeding rates actually declined over a six year period (Mydililova et al. 2009).

### Best Start Programme



The Best Start programme is a US based social marketing approach to breastfeeding that concentrates on a sensitive approach to promoting breastfeeding amongst low income women. Focus groups identified the unique needs and concerns of low income women towards breastfeeding amongst 35 areas of the US.

This led to the development of a three step approach that included asking open ended questions to elucidate client led answers, acknowledging concerns and seeking to reassure, and carefully targeting educational messages using a tone designed to maximise buy-in. Perceived social norms were explicitly addressed and tackled. Note the similarities with the Centering Pregnancy programme.

The social marketing element here is the use of a social marketing expert (Carol Bryant) to create the programme – with strong emphasis placed on the tone and approach used such that it is led by the understanding that motivating the mother can only be done if they are persuaded accordingly.

Ryser (2004) studied the effects of a Best Start approach versus a control group. Using small sample sizes she concluded that the programme increased positive breastfeeding sentiment, intention and initiation compared to the control group.

### **What seems to have worked?**

A number of studies have shown that emotional and informational support assisted adolescents in initiating and continuing breastfeeding (Wambach and Cohen; Wolfberg et al. 2004). Information should be consistent, and supplied by known individuals. Knowledge alone is not sufficient to overcome barriers to breastfeeding (Raisler 2000) but tacit knowledge gained from exposure is more influential (Greene et al. 2003). Support groups specifically aimed at younger mothers have had some positive impact (Ingram et al. 2008), as have peer counselling schemes (Raisler 2000). Acknowledging that breastfeeding is not without its challenges and providing information and support for overcoming difficulties can help to enable continued breastfeeding (Ineichen et al. 1997). However, it should be acknowledged that these findings came largely from qualitative studies where mothers were asked to self-report their decision making process. In order to know if these findings are generalisable to the wider population further research is required.

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## Appendix 1

### The use of theory in constructing social marketing solutions

This is intended as a practical report but also one that is thoroughly underpinned by theory and by well grounded principles. We have identified two areas where a theoretical underpinning is important. Firstly, what consumer behaviour change theories might be useful to us? Secondly, can we apply communications theories to a social marketing communications solution?

There are a number of theories of potential use. These include the Theory of Planned Behaviour, the Stages of Change Model, and Habit theories. We also believe that emotion based models are of use to communications design – more of this later.

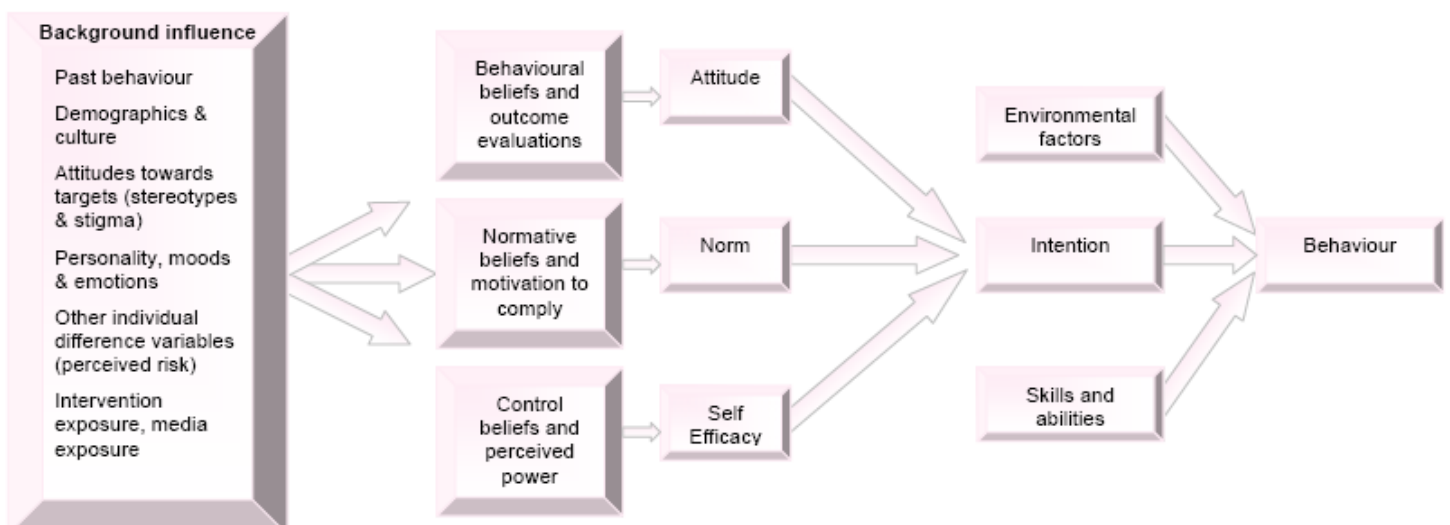
Let us have a short look at these models and how they could be applied to breastfeeding.

### Integrated Theory of Planned Behaviour

The integrated Theory of Planned Behaviour (TPB) (Ajzen 1985) is important for your consideration. TPB is a social cognition theory which proposes that motivation alone is not enough to change behaviour and that individuals employ rational decision making, forming intentions to carry out behaviours they believe will result in value outcomes. All of the key components – attitudes/beliefs about an outcome; social norms, and behavioural control – are directly applicable to breastfeeding and have shown themselves to be significant.

There is yet to be a well developed literature of evidence that points to the TPB as a strong predictive tool for breastfeeding, although Leffler (2000) reviewed studies of adolescents' attitudes towards breastfeeding which indicated that these were correlated with rates of initiation. Kloben et al. (1999) found some apparently predictive power of the TPB with low income women in the Southern US. In their study of new mothers in Scotland, Swanson and Power (2005) thought the overall TPB framework was a helpful method to measure the perceived social pressure in relation to the maternal infant feeding decision. More recently Giles et al. (2007b), in a Northern Ireland, study piloted a questionnaire based on the TPB to 121 schoolchildren and found "strong support for the predictive power of the TPB" (Giles et al. 2007b:8).

Figure 3: The Integrated Theory of Planned Behaviour



Source: Fishbein (2000)

There are elements of the Theory of Planned Behaviour which are clearly useful: bringing beliefs, social norms and behavioural control (self efficacy) into one model looks powerful. Attitudes and beliefs are complex areas to understand. Breastfeeding is a fundamentally unselfish act that has limited benefits for oneself, but important long term health benefits for one's baby. There are, of course, emotional benefits for the mother linked to the satisfaction of being a good parent. Attitudes related to such emotions should probably be a priority for social marketers.

One of the problems with the TPB is that it emphasises cognitive, logical decision making, and this may not be appropriate for breastfeeding behaviours. (In general, we would warn against over-reliance on any model – none will usually explain more than 20-40 per cent of the variance in behaviour). So, if logical thinking does not necessarily model breastfeeding well, what does? We think that habit based theories, such as those championed by Ehrenberg (Bird and Ehrenberg 1970) in his studies of supermarket fast moving goods, may offer help to us.

Figure 4: Habit – The 'Awareness –Trial- Reinforcement' model



Ehrenberg's emphasis is on unthinking routine. This applies to breastfeeding in that if the mother has not given much thought to how she will feed the baby, then she may unthinkingly fit in with whatever is expected of her by her own family, or the health profession, or whatever happens to befall her in terms of advice at the time.

### Stages of Change Model

We have already noted that breastfeeding is a one-off decision that has a set point – when the baby is born – and cannot be put off or revisited at a later date. The Stages of Change model is perhaps of some use in providing a predictive structure for pregnant teenagers: to what extent are they passing through pre-contemplation, contemplation, preparation, action and finally maintenance of regular breastfeeding?

We have found little in the literature to help us. This will be investigated in our primary work.

### Social Cognitive Theory

Social Cognitive Theory (SCT) looks a good bet for breastfeeding. SCT is about social learning and self image development – which look 'on paper' to be important components of breastfeeding. The usefulness of social cognitive theory is its encompassing nature. Applied to breastfeeding, the theory suggests people's self image of themselves as a good parent, or a loving mother, or as someone who is 'doing their best' motivates them to behave in ways that keep up that self image. At the same time people learn from observation that others get social rewards – maybe admiration - for being a good parent so they might copy that behaviour to get the same rewards. At the heart of Bandura's (2005) work on Social Cognitive Theory is the idea of self regulation, which involves self observation – keeping tabs on ourselves. We judge ourselves and our performance, and will mentally reward ourselves for good behaviour or punish ourselves for poor outcomes.

Commercial marketers use such social and psychological forces a lot in their advertising strategies: “Buying X will make you feel good and will gain the adulation of others”. The trick for social marketers is to position their desired behaviours as desirable to the self image of the target audience.

### Social marketing communication solutions

Advertising techniques can be used tactically to support a particular programme or activity. Communications can highlight a programme and bring it to people’s attention. Advertising can also be used strategically across the region to do something more ambitious – change social norms, build an idea that could be branded as an alternative lifestyle, shock or ‘jolt’ people into re-thinking their lives, and so on. Such campaigns can be expensive, but appropriate use of press and PR provides a workable opportunity to get such messages across at lower cost.

Are mass communication approaches appropriate for encouraging breastfeeding? We have adapted and added to the Hastings et al. (2008) review of health promotions and the Health Development Agency’s review of health promotions (Protheroe et al. 2003) and would suggest public health mass communications are a good idea when:

- Wide exposure is desired – for example, the health benefits of breastfeeding are not as well understood by the public as, say, the dangers of smoking have come to be. However, merely raising awareness without addressing motivations does not usually work. To address this, mass communications could be used to brand breastfeeding as the choice for parents who prioritise happy, healthy babies. “Good parenting is about happy babies: breastfeeding = happy babies”. This must however be underpinned by the everyday experience of the mums – does this claim have any credibility?
- When public discussion may help the message process: there remains to be a public level of social discourse about breastfeeding, putting pressure on change.
- When there is a need to normalise the behaviour. Mass media can make an activity feel ‘normal’, so that it is more likely to be accepted as such.
- When support to communications campaigns can be provided on the ground. The evidence we have seen so far points strongly to breastfeeding being best tackled with a joined up combination of population level activity allied to local, face-to-face activity.
- When other methods have failed. Very creative marketing communications can help persuade ‘hard to shift’ people.

### Social marketing communications models applied to breastfeeding

The FCB (Foote, Cone and Belding) Grid helps us. The next diagram illustrates its use in social marketing generally and then specifically with breastfeeding. In the diagram each box illustrates:

- ❖ Relevant theories
- ❖ How ‘learn-feel-do’ (cognition, emotion, and action) link up
- ❖ A general social marketing example
- ❖ Appropriate social marketing tactics to encourage behaviour change

Figure 5: The FCB Grid adapted for social marketing generally and breastfeeding in particular

	Thinking	Feeling
High involvement	<p>Theory of Planned Behaviour Learn – Feel – Do Change travel from car to bus to save money/time <i>Social marketing tactics:</i> Present benefits clearly to influence attitudes</p>	<p>Social Cognitive Theory; social norms Feel – Learn – Do Give up 4x4 to adjust to new self-image <i>Social marketing tactics:</i> Association: build up emotion based images of people that target relates to</p>
Low involvement	<p>Ehrenberg ATR theory; Habit theories; Cialdini fixed action pattern theories Do – Learn – Feel Use stairs not lift <i>Social marketing tactics:</i> Pledges; reciprocation deals; stim-response posters Make trial of new behaviour easy</p>	<p>Rossiter-Percy theory; Cialdini fixed action pattern theories; fear appeals Do – Feel – Learn Smoker – emotion driven quitting <i>Social marketing tactics:</i> Fear appeals; shock imagery</p>

What kind of ‘involvement’ and ‘thinking-feeling’ takes place with a decision to breastfeed or not? It is likely that a mixture of possibilities exist:

- Deciding to breastfeed may, for some, be a high involvement decision, possibly made over a period of time with some contemplation. For others (teenagers) breastfeeding may not be something given much thought. If so, low involvement marketing may be effective.
- Breastfeeding may be a mixture of both thinking and emotion with, typically, the emotions more hidden. So, the thinking/cognition revolves around how breastfeeding benefits the health of the baby – and hence that it is the right thing to do. A thought process accompanies this. On the other hand, emotions may relate to confidence, self image or social norming with the individual asking: “Am I capable? Can I perform competently? Is it normal to breastfeed? Is it me?”

So, emotions and cognition are probably both important. We may, therefore, need messages that take people through a thinking process towards breastfeeding, emphasising the need to make a decision, that breastfeeding is best, and so on. However, to account for emotional sequences we need something different. This brings us to the Rossiter-Percy motivation model.

### Emotion-based messages using the Rossiter Percy (R-P) Model

The suggestion from Rossiter (1987) is that many other models, such as the Health Belief Model, the Theory of Planned Behaviour, and the Social Cognitive Theory, are all examples of Knowledge – Attitude – Behaviour models. They all have their uses, but not so much for designing message content. Instead, emotions are used to design the message because emotions are seen as the ‘energisers of actions towards the goal’. Hence, emotions are linked to motives.

The R-P model uses negative motives and positive motives. The idea is that we exist in an equilibrium and can shift to negative states (problems) or positive states (sensory gratification). In these states we look for ways to shift back to equilibrium or to fulfil sensory gratification.



## Appendix B: Women's' perceptions about breastfeeding

The UWE project team aimed to recruit women and some family members to individual interviews, and women from four different categories to focus groups. A separate focus group was held for women from each of these categories: 'pregnant', 'did not breastfeed' 'tried breastfeeding but gave up' and 'breastfed successfully'.

Recruitment was managed by a professional independent recruiting consultant, and started at Penhill and Pinehurst Children's Centres. Fliers were distributed printed with contact numbers, but these were not effective. Recruiters went door-to-door in the immediate area, and also approached potential participants in parks. They also attended two clinics in the area. Snowball sampling was used to recruit sufficient individuals to the project. Participants were each paid £20 to take part in an either an individual interview or a focus group.

In total, 28 individuals took part in the project. Six women were interviewed individually, of whom three had breastfed or expressed milk for between two and six months, two had breastfed for approximately two weeks and one had never tried breastfeeding. One partner and one grandmother also took part in individual interviews. Table 1 gives details of individual interviewees.

**Table 1: Breastfeeding initiation and prevalence (2009/2010)**

<i>Locality</i>	<i>Breast feeding initiation (%) (2009)</i>	<i>N</i>	<i>Breast feeding prevalence at 6-8 weeks (%) (2010)</i>	<i>N</i>
Central North	61	725	31	148
Central South	69	727	45	298
South	78	504	48	399
North	83	357	50	399

Twenty women participated in four focus groups: four pregnant women (three of whom had had children before), six women who had bottle fed their babies from birth, five women who had tried breastfeeding but who had given up, and five women who had breastfed successfully.

Participants were asked a range of questions designed to elicit information about norms surrounding infant feeding, how decisions about feeding were reached, individual's knowledge concerning the benefits of breastfeeding and social and private attitudes towards breastfeeding.

The interviews and focus groups were audio-recorded and transcribed verbatim. Data were analysed thematically, giving rise to themes concerning decision-making about how to feed, knowledge, influences, practicalities, barriers and support from health professionals. These findings are presented below.

### Decision-making about how to feed

There were a variety of reasons why women made the initial decision whether to breastfeed or bottle feed. For some, breastfeeding was explicitly associated with better health for the baby:

*“I think it's probably better to feed them with your breast milk, so I will do that with this one as well.”*

R1

*“I was influenced by all these leaflets and midwives talking to me throughout the pregnancy, like...the breastfeeding is like best for the baby, and stuff, and because I didn't see why it wouldn't be, and I didn't think that it's going to inconvenience me like that, so we just sort of went with it.”*

R8

*“The first few days, because I knew it was like good for him, that's why I made sure I done it for that.”*

...

*“That was like me as well, I think that's why I wanted to do it.”*

...

*“First milk's the best milk isn't it?”*

Group 3 participants, tried breastfeeding but gave up

*“I just wanted to breastfeed both of mine because obviously that is better for the babies and then they get all the nutrients and everything.”*

...

*“I just thought it would be better for [baby] .It like more convenient and just really for the health benefits for him really.”*

Group 4 participants, breastfed successfully

Other reasons for breastfeeding included issues of cost and convenience:

*“What stuck out for me, money, convenience, the cost...the happiness of the baby.”*

R3

*“Just because I know it's [breastfeeding's] good for him and I suppose, in a way, it's easier, because you don't have to sterilise all the bottles and things like that, and also it was good for my body as well. It was just one of those things I thought I might as well try.”*

R7

Interviewer: How are you planning to feed the babies that are coming?

Participants: *“I'm breastfeeding.”... “Breastfeeding.”...“Breastfeeding.” ...“Breastfeeding.”*

Interviewer: So what's made you [all] decide to breastfeed?

Participants: *“I'm a bit more mature ... I think it's more because it's seen more now, to me, it's sort of like encouraging me to do it more.”*

...

*“I didn't realise you can like express it, so like now I know, you can take that out with you. So I'm just going to try it this time.”*

Group 1 participants, pregnant

The baby's prematurity was a reason given by one woman for initiating breastfeeding:

*“I did breastfeed for a couple of months because she was in special care.”*

R4

Women with premature babies appeared to be more likely to start breastfeeding, as reported by another woman, relating her sister's experience:

*“When my sister had [baby], she was nine weeks prem, the hospital did give her a lot of support, and they said to her it's better to give him that, to give him the goodness, where he's so early.”*

R1

Women who decided to bottle feed their babies also gave a variety of reasons for their choice. These included convenience, distaste for breastfeeding, certainty about the amount of milk the baby is getting and pain:

*"I didn't really decide up until the last minute really ... I'm kind of embarrassed to feed out in public as well ... so I probably would have just been stuck indoors all the time ... and also, with my partner, it's easier, you know, I can send him to do the bottles as well.*

R2

*"I just decided I was going to bottle feed because I'd bottle fed with my other daughter as well... it was just easier for me."*

...

*"I'm going to bottle feed him, yes, same as what I done with my daughter."*

...

*"I don't like the thought of the baby clinging on to my boobs, so I thought, no."*

...

*"I was put off by sort of a bad experience."*

...

*"You know what your baby's having."*

...

*"The only reason I got put off [breastfeeding] is like same as what you said, I don't like the thought of that either, but other than that, I asked a few of my mates that have had kids, and every one said that they bottle feed now, but every one of them said that they tried breastfeeding, it just hurt too much."*

...

*"That's why I didn't even bother trying. I just put her straight on [the] bottle."*

Group 2 participants, did not breastfeed

Similar reasons were given by women to explain why they had stopped breastfeeding after initiating it:

*"I did want to start, the breastfeeding, and then we expressed ... it's just easier bottle feeding."*

R4

*"I started off trying to breastfeed but ... after two weeks I was just like knackered, so I went on to bottle feed him then."*

R7

*"I started, it hurt, I stopped."*

...

*"It's because I didn't know how much he was eating, like when I was feeding him, it was like he was non-stop hungry ... so I was doing both boobs and then obviously I didn't know ... he was still hungry, and crying, not settling, so I put him on the bottle."*

...

*"He had to be put under the lights because he had jaundice, I couldn't see how much he was taking, and I think I was worried because I was worried that, with a bottle, obviously you can monitor what they're taking, but with breast I was just worried so I didn't."*

...

*"She started to puke up every time she was on the breast, proper vomiting, so I got scared, so I ... and she would choke as well on top of it, and I thought well how can breastfed babies choke on ... so I didn't know what was going on, so it scared me, and I just put her on the bottle."*

...

*"I've already got a two and a half year old and it was just too much sat there breastfeeding. She wants my attention. I couldn't do it all and he feeds every two hours. I was just knackered so I started combined feeding but then I just wanted to go back onto bottle because then my partner can help."*

Group 3 participants, tried breastfeeding but gave up

## Knowledge about breastfeeding

Most of the participants indicated that they knew that breastfeeding was beneficial for babies:

*"I think it just protects the baby against sort of the things that you're immune to ..."*

R4

*"I know they say that it's meant to give you more goodness and stuff, nutrients and stuff like that, and help your immune system and things like that."*

R6, partner

*"I know it's good for him ... the nutrients and I suppose it's natural isn't it, it's not sort of manmade materials that they're digesting. That's probably all I would know is, it's the nutrients."*

R7

*"It's like the first few weeks or month or something, it's like nutrients that are in breastfeeding, it's like better than what's in milk, like powdered milk."*

Group 2 participant, did not breastfeed

*"They reckon all your antibodies go into the baby, it's supposed to be good for the baby, and stuff like that."*

Group 3 participant, tried breastfeeding but gave up

*"When I was breastfeeding my little boy, they [other people] was like 'oh you shouldn't do that, they're prone to more colds and they're always ill, breastfed babies are always ill'; and I was like, 'no, it's the other way round, bottle fed babies are always ill'."*

Group 4 participant, breastfed successfully

However, there were mixed views about the long-term benefits of breastfeeding:

Interviewer: What about long term health benefits [of breastfeeding] for the baby?

*"No, I don't think so. When the children are older, when they are grown up, no."*

R3

*"It's better isn't it because of all the stuff ... because you're giving the baby natural antibodies from you, that you don't get from [formula] milk ... it [the effect] lasts forever I think."*

Group 1 participant, pregnant

Participants: *"That's meant to be the healthiest thing, breastfeeding."*

...

*"Yes, stronger immune system."*

...

Interviewer: How long do you think that effect might last?

Participant: *"I haven't got a clue."*

Group 2 participants, did not breastfeed

Participants: *"I thought it was the colostrum that set them up for life."*

...

*"Yes. ... That's what I thought, yes."*

...

*"That's the best milk; the richest milk isn't it, the colostrum."*

...

*"Yes, that's got all the goodness, yes."*

Interviewer: So you think that sort of sets them up for life then?

Participants: *"Their immune system.... Yes."*

Group 3 participants, tried breastfeeding but gave up

*"Well you've got a good healthy start haven't you, so probably helps you."*

...

*"If it gives them the head start and prevents them from getting stuff then surely that will benefit them in later life."*

Group 4 participants, breastfed successfully

A few of the women knew that breastfeeding was also beneficial for women, although one stated explicitly that this aspect was not nearly as important as the benefits for the baby:

*"Helps you get your figure back quickly, apparently."*

R4

*"I know it helps you with your uterus...makes it go back quicker. I don't know how true that is! That's all I know on that bit."*

R7

*"I was happy to know that it's going to burn a lot of calories ... I know about the benefits, treating the cancer, something like that, to me that's just a plus. The benefits to me was not the major reason. It was the baby, yes, it's best for the baby..."*

R8

*"It reduces your rate of getting breast cancer and breast cancer's in my family, that's another reason why I breastfeed as well, because my mother had breast cancer and so did my grandmother, so it's hereditary, and it actually can lower your chances of getting it and I don't think a lot of people know that."*

Group 1 participant, pregnant

*"Doesn't it make you less likely to get like cervical cancer or something?"*

Group 3 participant, tried breastfeeding but gave up

Some participants expressed scepticism about the benefits babies receive from breastfeeding, drawing on their personal experience in this regard:

*"I don't know really. I know they say breast is best, but sometimes ... she was bottle fed and you know she's fine; she doesn't very often get ill or things. She's learning quite well so she's advanced for her age I've been told."*

R2

*"I came away with eczema, asthma, basically I was allergic to every single thing that you could possibly imagine ... now whether that came from my mum, the milk or whatever else, I don't know, or whether it was generally me, my genetics, I don't know, but it [breastfeeding] didn't help me out one single bit."*

R6, partner



Participants gained knowledge about breastfeeding from a range of sources. Some participants preferred to access information on-line, while the timing and volume of NHS leaflets could be problematic:

*“I booked these NCT [classes], much to my partner’s disgust. Yes, that’s why I booked them because the NHS didn’t offer anything. It [the NHS class] was an hour or two hour class and I don’t know how I could cram in learning how to look after a baby in two hours... I learned loads and I recommend them [the NCT classes] to people...because I learnt things that I wouldn’t even know existed. ... You get a load of leaflets when you leave the hospital with all these breastfeeding support [details] and all this stuff. I had a flip through that and yes, but nothing stands out ... I was thinking about giving up and it had only been a couple of days and my nipples were sore and so I Googled it.”*

R3

*“I read through the baby book that we got ... I might have looked online a few times, but other than that, nothing else ... Mum’s Diary, yes I subscribe to them all [websites].”*

R4

*“You get given a load of leaflets, but the last thing you want to do is read it when you’ve just had a newborn, you know what I mean?”*

R7

*“When I go for information and stuff, I use babycentre.co.uk... I still go there for tips and stuff like that. I don’t go to any forums and read what other mums’ experiences are; I just really go for the expert advice. ... I think in terms of leaflets and the information, I think it’s good, like if you’re willing to listen, there’s plenty of it out there... [but] giving you a leaflet doesn’t mean you’re going to read it.”*

R8

R8 also spoke about some ‘official’ advice being unrealistic:

*“The problem I had was that they keep saying that all the government advice is, you know, first six months, just breastfeed and if the baby is hungry, just give more and that was really frustrating because with her she was about 4½ - 5 months and I had to feed her every hour and a half and then she would sit on the breast for half an hour...that’s when I was like, guideline or not, they don’t know what they’re talking about – just feed more often – how much more often can I feed her?”*

R8

## Influences

Individual participants reported traditions of both breastfeeding and bottle feeding within their own families:

<p><i>“My sister recently had a baby ... and she breastfed the whole way through because he was 9 weeks early.”</i></p> <p>Interviewer: What about your mother, aunts, grandmothers, how did they feed?</p> <p><i>“Bottle.”</i></p>	R1
<p>Interviewer: What about your family...?</p> <p><i>“I think they all bottle fed as well.”</i></p>	R2
<p><i>“My sister-in-law breastfeeds...I think everyone breastfed.”</i></p>	R3
<p>Interviewer: Is it something that the wider family always bottle feeds?</p> <p><i>“No ... she [R4] didn't like breast, [the] boys did.”</i></p> <p>R4's mother</p> <p><i>“I advised them to breastfeed...I breastfed all of mine. A lot of people did then.”</i></p> <p>R5, grandmother</p> <p><i>“I go back to when I was a baby, like nearly 40 years ago, my mum breastfed me...and I was massive ...the amount of weight I put on and stuff like that...”</i></p> <p>R6, partner</p> <p><i>“My mum breastfed with her youngest daughter and she lasted about three months...that was going back ten or eleven years ago now...”</i></p> <p>R7</p> <p><i>“I spoke to my mum as the mother of two, basically I spoke to her and told her that we're going to breastfeed and stuff, and she was like yes, that's what she did.”</i></p> <p>R8</p> <p><i>“Mum bottle fed. ... Yes. ... I was bottle fed as well.”</i></p> <p>Group 1 participants, pregnant</p>	

*My mum breastfed two, with me and my little brother I think it was, and my older brother and sister were bottle fed."*

...

*"My mum just bottle fed. ... "And mine." ... "That's how I was brought up, all my family."*

...

*"I think I was breastfed, I'm not sure."*

Group 2 participants, did not breastfeed

*"I was breastfed." ... "I was breastfed."*

...

*"I was breastfed because I'm a twin; I was premature, very premature."*

...

*"I'm not sure....I've got nobody to ask, I don't know."*

Group 3 participants, tried breastfeeding but gave up

*"I was bottle fed." ... "Breastfed." ... "I was breastfed."*

...

*"All of [partner's] family have been bottles. My sister breastfed for about a month and a half, but he was premature as well, for only two weeks though, but she only breastfed for about four weeks/six weeks and then went on to bottle because it was easy."*

Group 4 participants, breastfed successfully

Many of the women who had started breastfeeding reported that their partners generally supported their choice to do so:

*"He was very supportive about it."*

R4

*"Well I consulted with my husband, but we were on the same page so there was no real discussion."*

R8

Interviewer: What about your partner?

Participant: *"Yes, he's fine with it [breastfeeding] ... he doesn't mind."*

Interviewer: What do your partners think about you breastfeeding in public?

Participants: *"Oh my partner said that he's fine about it. Anyone says anything he'll tell them where to go. Basically he's protective. They'll just be protective."*

...

*"Yes...I think that's what mine would be like as well."*

Group 1 participants, pregnant

Interviewer: So your partners were happy about you breastfeeding?

Participants: "Yes."... "Yes."

...

*"My husband and I got into like a little routine. I'd go in and express, he'd come because obviously [I'd] be in there quite a while, swapping and changing and that to get enough. He'd rinse my pump out and then he'd do the little tags that you had to fill in, and then he'd put them in the fridge ... he was good as gold. He went out and got me nipple cream and he wasn't scared [to] ask at the counter for it, or anything."*

...

*"My other half don't care. He's like, if anyone's going to say anything to her, she's going to like stick up for herself."*

Group 4 participants, breastfed successfully

Interestingly, the women who had not breastfed also reported that their partners were generally supportive of breastfeeding, although not completely comfortable with it:

Interviewer: They [partners] wanted you to breastfeed?

Participants: "Yes."... "Yes."... *"I think most men want the mums to breastfeed, but then they get embarrassed."*

Group 2 participants, did not breastfeed

However, it was clear that the norm in the two areas was to bottle feed babies:

Interviewer: Of the women you know, your sort of age, how do they feed their babies?

*"They've all bottle fed. ... I've never seen anybody breastfeed around here. So I don't know whether they do it at home or not, but most people you just see them put a bottle in their mouths."*

R1

*"Majority bottle."*

R3

*"I haven't seen it [breastfeeding] at all."*

R5

*"I don't see it [breastfeeding] that much, don't see it a lot."*

R7

*"You see all the other mums bottle feeding..."*

R8

*"I don't really know anyone that's breastfed to be honest."*

Group 1 participant, pregnant

*"Bottle mainly."... "Mainly bottle."*

...

*"I think most people I know tend to start breastfeeding. Two or three weeks down the line they've changed to bottle."*

Group 2 participants, did not breastfeed

*"Bottle usually isn't it?"... "Bottle."... "Bottle."... "You don't see anyone breastfeeding do you?"*

...

*"Not really, no."*

Group 3 participants, tried breastfeeding but gave up

*"Generally they're formula first."... "Yes."... "I'd say that."*

Group 4 participants, breastfed successfully

**Practicalities**

Practical issues which affected whether women breastfed or bottle fed included convenience, particularly with respect to other people being able to feed their babies:

*"It's just easier to put a bottle in the bag...it's there for my mum or my partner, just to take him out for a bit."*

R2

*"Nowadays, I think they like the husbands to help out too, in the middle of the night, and the boyfriends. If they're breastfeeding, they can't do that."*

R5, grandmother

*"It's all you doing it [breastfeeding]; you don't get help with your partner ..."*

R7

*"If you are bottle fed, then my husband or whoever else with me in the car can just turn around and put a bottle in their mouth and we're all fine."*

R8

*"Someone else can do it." ... "Yes, exactly."*

...

*"If you're tired or ... not there, you can ..."*

...

*"You can just say, right, there's the bottle."*

...

*"Yes, with bottle feeding at least the father can bond with the child while feeding them then, because they can't exactly ... feed the child if you're breastfeeding."*

Group 2 participants, did not breastfeed

*"You can hand them over to the partner can't you, let them have a go."*

...

*"Yes, because I think most men do feel that. They're not involved."*

Group 3, tried breastfeeding but gave up

It was notable that these sentiments were even expressed by R8, who breastfed her baby for approximately six months. However, the ease of breastfeeding compared with bottle feeding was also mentioned, as well as the former's relative cheapness:

*"You've already got it on demand and you don't have to sterilise it ... it's there and it's sort of easy ... in the middle of the night, I literally just got her up and put her on my breast. I didn't have to go downstairs. I didn't have to check the bottles were done, or the milk's been made or the kettle's boiled, when it boiled and all that sort of stuff; and when I go out, I've just to take myself and my breasts. Not a bag full of bottles and milk and all sorts of stuff, and hot water; because you can't get hot water, places won't give you hot water because of the health and safety to heat up your bottle, so you need a little flask and all this jazz. When you've got a double pushchair with two children, you don't want a bag like that."*

R3

*"I personally think it comes down to money, doesn't it really now ... it's [breastfeeding's] free."*

R3

*"It's not cheap to bottle feed the kids and both me and my husband are full time employed so we don't get any of these grants, vouchers for baby food ... it wasn't a priority, but- it's really expensive if you just buy the milk all the time."*

R8

*"Sounds skanky but I thought a lot about the money that I'd save breastfeeding."*

...

*"Well, no, that's true."*

...

*"I mean it's free and like that was the biggest pro for me was, it's great for the baby [and] it's free."*

Group 3 participants, tried breastfeeding but gave up

*"I wanted her to have the milk, so it's free, it's convenient ..."*

Group 4 participant, breastfed successfully

## Barriers to breastfeeding

Some of the women taking part in the project reported that breastfeeding was very painful. This caused some to switch to bottle feeding, although others persevered:

*"It put me off, putting her on my breast...because it was so sore and she made me bleed as well. So I refuse to do that again."*

R1

*"I got very sore, my nipples got very sore and I remember thinking to myself, there's got to be something to help me with this because I was thinking about giving up and it had only been a couple of days and my nipples were sore."*

R3

*"She [daughter] did try for a week but I think it started to hurt her and that, but I used to say to her – you've just got to persevere for two or three weeks, then it'll be better, but no."*

R5, grandmother

*"I had some problems in the beginning with her because she didn't really know how to latch on and then my nipples were cracking and extremely painful, so I thought I would give it up, but the midwife came in the beginning, when the baby's like ten days old or something like that, the midwife kept coming, like every other day, and so I got some encouragement from the midwife."*

R8

*"I started, it hurt, I stopped."*

...

*"The more you breastfeed, your boobs stay harder for longer and they hurt. You knock them and they get squashed and then you've got the other kids accidentally elbowing you, punching you, and it just hurts, and once that milk's gone, it's a lot better, you know what I mean."*

Group 3 participants, tried breastfeeding but gave up

Some women also expressed anxiety about being not being sure how much milk a breastfed baby was getting:

*"I was always worried about if he was having enough ... you don't know how much they're drinking, you know."*

R7

*"You know what your baby's having."*

Group 2 participant, did not breastfeed

*"It's because I didn't know how much he was eating, like when I was feeding him, it was like he was non-stop hungry ... so I was doing both boobs and then obviously I didn't know ... he was still hungry, and crying, not settling, so I put him on the bottle."*

Group 3 participant, tried breastfeeding but gave up

A few women reported viewing breastfeeding as a rather alien, if not downright distasteful, activity. This included some of the women who had started breastfeeding:

*"It's the most unnatural thing ever putting your breast into a child's mouth at first."*

R3

*"I can remember quite clearly, a few weeks ago, two young girls that are pregnant at seventeen, 'oh I'm not breastfeeding, it's disgusting'."*

Group 1 participant, pregnant

*"I just think it's disgusting, having a baby clinging off [your breasts]."*

Group 2 participant, did not breastfeed

*"I must admit, when I was feeding my son, like breastfeeding ... I did come home thinking 'oh I feel a bit pervert-y'; I know you shouldn't...2"*

*"Yes, I know what you're saying. ... You feel a bit ..."*

...

*"I did feel a bit pervert-y when he started first doing it, I thought, no,' because I'm a mother feeding my baby'; but then you also think 'well he's sucking on my boob as well, that's a bit pervert'. It goes in your head. I don't know if anybody else thought that? It was just a bit weird."*

...

*"Yes, it felt a bit."*

Group 3 participants, tried breastfeeding but gave up



A major barrier to breastfeeding for some of the women appeared to be the embarrassment associated with feeding in public:

*“When I used to go out with my sister, I used to be embarrassed that she was doing it because people would look ... I'd feel embarrassed getting my breasts out in public.”*

R1

*“I'm kind of embarrassed to feed out in public as well.”*

R2

*“Funnily enough, my friend, when I went round to her house, and she's not very prudish or anything like that, but she drew the curtains so her husband couldn't see - he was sat in the garden... that made me feel a bit weird. My sister-in-law, she used to go upstairs...and my friend, she wouldn't breastfeed in front of her father-in-law. Ever.”*

R3

*“I wouldn't breastfeed in any public place...when the need arose, we were out of the house, I would just go back to the car and feed him...”*

R8

*“When I was breastfeeding my little man, I'd have visitors round, but then I'd feel obliged, for their own comfort, to go upstairs and do it because they're there. They would be –not me –they would be embarrassed and they would be put in a position, so I thought I'll go upstairs, and do it upstairs.”*

Group 3 participant, tried breastfeeding but gave up

However, it should be noted that problems with feeding in public did not prevent R3 or R8 from breastfeeding; in particular, R3 felt confident enough to breastfeed in public despite other people's embarrassment or disapproval. Some other women also said that they were happy about breastfeeding in public:

*“It didn't bother me. I think initially when you get your boob out, a little bit like – ooh - but once the child's on there, you can't see anything anyway. It didn't bother me. I got a few funny looks.”*

R3

*“In public I would do it anyway, I'm one of those people, you know, my baby's got to be fed, but unfortunately I didn't get to that stage to be able to do it.”*

R7

*“I wouldn't personally sit in the middle of the street ...See, I have, because mine starting screaming in the middle of the high street. I used to live in Chippenham and it was just like there's benches everywhere and I just thought, right, I've got a little towel, I'm going to sit on this bench, and I'm going to do this, because I'm not going to leave her to scream.”*

Group 3 participant, tried breastfeeding but gave up

*"My Dad actually stayed with me for the first week and I thought 'oh my God, I can't breastfeed in front of my Dad', and he just didn't look, he got on, carried on as normal, didn't mention it or anything like that ... I thought 'I can breastfeed in front of my Dad, that's actually quite a good feeling'; and same with my partner's Dad, he didn't like it, so I would just turn slightly away."*

...

*"See I don't do it in front of my in-laws. I go in the bedroom. I don't like it."*

...

*"Like, at first, I wouldn't not even in front of my partner ... and then gradually I got like my partner and my mother-in-law, and then like a few other people I did in front of like, slowly ... the one thing that worried me was about doing it in front of the kids [11–12 year-olds] ... then I had a chat with my mother-in-law about it, and she said well if anything it will teach them that it's a good thing, so [I] sort of ... braved up and did it really."*

Group 4 participants, breastfed successfully

There were different perceptions about how acceptable it was from an 'official' point of view to breastfeed in public:

*"Everywhere you go out now, like you go to the Outlet Village ... they've also got little feeding rooms, so you can sit in there and breastfeed in there if you feel a bit uneasy. In the town centre, there's feeding rooms in the Brunel Centre ... Debenhams have got one I think as well."*

R3

*"I can visualise a couple of them ['Breastfeeding Welcome Here' stickers], but I can't tell you the places where I saw them ... when I see them...I feel like OK, this is good."*

R8

*"There's laws now, there's an equality law, if somebody said to you when you were in a café, 'oh, can you not do that', they're breaking the law. They could get into trouble. You could sue them."*

...

*"Some cafes even actually have notices up saying 'breastfeed friendly'; just so you know you're alright in there and stuff, even though you're allowed to do it anywhere."*

Group 1 participants, pregnant

*"Women aren't allowed to breastfeed in a like real public place."*

...

*"Yes, you get people that are quite funny don't you."*

...

*"Yes, some people get offended by it, so you've got to have a certain place women can breastfeed."*

...

*"They're not allowed to just do it on the street."*

Group 2 participants, did not breastfeed

*"Nowadays you get pointed at. Sent to the toilet to feed your kid, it's just not right is it?"*

...

*"But even though it's changed, like people like look. Like even though they say it's more lenient they look at you like really weird for doing it."*

...

*"I mean I guarantee if one of us flopped ours out in McDonalds, do you know what I mean, it would be like, wow ..."*

Group 3 participants, tried breastfeeding but gave up

*"It's only now, when people are starting to really realise the benefits of breastfeeding, and the law has put in place that it's legal, you can feed your baby wherever you want."*

...

*"Yes, they can't kick you out of cafes or nothing like that can they?"*

...

*"There has been steps in the right direction over the last decade, but it's not there yet. It's going to take a long time to get it to where it needs to be, but a lot of people's mindsets aren't ... they're like, no, it's wrong, you shouldn't see women breastfeeding."*

Group 4 participants, breastfed successfully

Some women expressed the view that younger women were less comfortable about breastfeeding generally, sometimes because of being less confident about their bodies. It was also thought that younger women preferred bottle feeding, as it allowed them to revert to a 'freer' lifestyle:

*"I just think people in their twenties would rather put a bottle in it and off they go ... probably because of the social thing."*

R1

*"I think a lot of people in the area are young when they have children, and they're still quite insecure about their bodies and stuff like that, so I think maybe they feel like you know, don't want to [get] my boobs [out], don't want to feed my baby with them."*

R3

*"It's usually the younger mums ... 'my mum comes and looks after the child five days out of seven' and so on, those are the mums that I see that choose not to breastfeed, I think because they are just trying to keep the freeness."*

R8

*"I felt very looked down on anyway being pregnant at seventeen, so I didn't want to like be noticed to be breastfeeding as well, if that made sense."*

Group 1 participant, pregnant

*"I think a lot of the young people ... not wanting to breastfeed is because they say that they want to be able to have a drink."*

Group 3 participant, tried breastfeeding but gave up

For some women, who were aware of the benefits of breastfeeding their babies, but who were daunted by practical issues and/or problems associated with breastfeeding, the solution was to express their milk:

*"I breastfed [daughter] for a while but I didn't like it, so I bought a pump ... probably done about nine weeks with the pump ... just expressed it the whole time then, until it dried up, rather than putting her on me."*

R1

*"I bought a hand pump to see how that went and started trying to express and that helped because then my partner could feed her as well in the night and she could have more at night to help her go for a longer stretch."*

R3

*"I'm going to express for during the day, and just breastfeed at night, because obviously like partners and that, they can't have that bond with bottle feeding ... if the baby's constantly attached to the breast."*

Group 1 participant, pregnant

However, expressing milk proved too onerous for at least one woman:

*“I started off trying to breastfeed, but ... I had quite inverted nipples ... I went onto express every four hours and I lost, I think, about two weeks because it was obviously I had to express every four hours day and night and feed him as well with the bottle, and after two weeks I was just like knackered, so I went onto bottle feed him then.”*

R7

Expressing was also viewed as an expensive option by some of the women, particularly if they were eligible for vouchers to help with the cost of buying formula milk:

*“So it's easier to use your milk tokens to go and buy milk than what it is with your own money to go and buy a £100 breast pump.”*

Group 1 participant, pregnant

### Health professional support

Some of the pregnant women felt that they got good support from their midwives:

*“They [the midwives] are quite good actually aren't they?”... “Yes.”*

Group 1 participants, pregnant

R8 also reported having been helped by her midwife to establish breastfeeding in the early postnatal period:

*“I thought I would give it up, but the midwife came in the beginning, when the baby's like ten days old or something like that, the midwife kept coming, like every other day, and so I got some encouragement from the midwife.”*

R8

She also spoke about having had help while still in hospital from a volunteer:

*“I had problems in the beginning ... it was good because we were still in the hospital ... and there was a volunteer, an older lady, she was about seventy years old ... she was helping the new mums and helping breastfeeding and so on. So then she had like breastfeeding sessions with me, she was sort of helping me with her, she taught me what to do.”*

R8

One of the other women also related having received good support through a voluntary organisation:

*“There was a lady there called [name] who's one of the breastfeeding national ladies and she came and she showed all about the natural breastfeeding, how it's not about forcing them on to the boob and everything else, so that really reassured me.”*

Group4participant, breastfed successfully

Most participants did not feel that health professionals provided adequate support for breastfeeding mothers either at home or in the hospital:

*“At the hospital, when I had her, they just put her on me and then the next day sent me home, they didn't exactly show me how to do anything ... they [midwife and health visitor] just come really to check the health of the baby ... they just said ‘are you breastfeeding or bottle feeding?’ and they didn't really show me how to do it or anything.”*

R1

*“Well to be fair, I don't think she's [daughter] had much support at all, from any professionals ... because she was only young when she first started having the children ... she saw the midwife probably twice after she'd had a baby and that was it. The health visitor didn't come along until the baby was a year old ... she came out of hospital, she didn't have a clue. She's just a kid herself to be fair, she didn't have a clue and the professionals just let her get on with it and then wonder why she's pissed off ... I personally think it's disgusting the way she's just been left and not supported at all, especially being so young.”*

R5

*“I wish I had more support on the actual breastfeeding side of things, because I would have carried it on ... I had someone ring me up asking about breastfeeding but it was two weeks after he was born and that's when I'd given up, so it was a bit late ... they helped me at the hospital as much as they could, but he wasn't eating anything so we had to give him a bottle, but I wasn't offered anything like [an electric pump]... I had to literally feed him every three hours it was back then, and then another hour later I had to pump [using a hand pump] so it was quite difficult that way.”*

R7

*“He was born on the Thursday, she [the midwife] didn't come out till the Monday and then she come out the following week, and then the following week, and then it was every two weeks and then she come out once again, that was it.”*

...

*“You can ring them up in the morning but only between half nine and ten.”*

...

*“I know, it's crazy times isn't it?”*

...

*“There's no like continuous level of support. The minute that you are allegedly done and signed off, is the minute that that support stops.”*

...

*“My midwife was crap. She didn't tell me nothing. She was stupid. Like for my first baby, and I was only nineteen ... I hate her ... you'd think that she would have been good, but she didn't tell me nothing. Just like got me in, got me out, that was it.”*

Group 3 participants, tried breastfeeding but gave up

Lack of time seemed to be a contributing factor:

*“I was really upset about it ... I really wanted to breastfeed and the nurses or midwives on the ward were busy, they were always busy and they were like ‘I'll be back in a minute’ – and it'd be an hour and she'd be screaming for an hour, and oh my God, I just didn't know what to do, and then, you know, I had to ask ‘is it OK to just give her a bottle?’ – because I didn't have any bottles with me and I'd planned to breastfeed, so I didn't, you know, I didn't bring any of that sort of stuff. I didn't even know how to use the steriliser. I was like – my God, this wasn't the plan.”*

R3

*“I mean they do at the hospital, they just sort of say ‘yes, breast is best’, and you just get on with it, and if you're not quite sure what you're supposed to be doing ... she [health visitor] wasn't that good to be honest. As horrible as it sounds, they weren't, they just seemed too busy and too rushed. They came in, weighed baby and that was it, so they were here, what, five minutes, if that ... they just seemed so rushed.”*

R4

Unfortunately, when health professionals did offer support, it could be interpreted as authoritarian, or even bullying, behaviour:

*“When I was in hospital having [name] it was like forced upon me to breastfeed.”*

...

*“I was just going to say that.”*

...

*“You'd ask for a bottle and they, ‘no, no, no’, and then you've got to fill out a form, what breast they were on, how long they were on the breast, did it latch on. As soon as I gave birth to my boy I had a nurse come in and she said ‘put him on the breast’ and like I was in no state, you know what it's like after you've just given birth, like leave me alone, and she was there, she was grabbing my boobs ... as soon as I gave birth they were on my case, ‘breastfeed, breastfeed’. I had to practically beg for his first bottle because he wouldn't latch on and I had nothing there, because the milk hadn't come through, he was crying, he was crying, and they were saying ‘oh he needs a feed, he needs a feed, and then you'll have to give him breast’ – I don't want to give him breast, I haven't got nothing in there. What's the point of him sucking it if there's no milk there yet? ‘But you'll have to ...’”*

...

*“It's a bit overpowering...Yes, I think it is, yes.”*

...

*“When the health visitor comes, every time they come out, ‘how you feeling, you breastfeeding?’ – leave me alone.”*

...

*“I lied actually. I was like, ‘yes, still breastfeeding’ ... just so they didn't start ranting on.”*

...

*“And I think they make you feel guilty if you don't. It's like ‘well you should be doing it’.”*

...

*“I think I told my midwife that I was breastfeeding up until she was stopped coming round. I just had to hide the bottles all the time.”*

Group 3 participants, tried breastfeeding but gave up



Women also spoke about the type/amount of support they would have liked to receive:

*“So it would probably be nicer to get someone in to help you a bit more.”*

R1

Interviewer: What do you think will encourage mums to breastfeed?

*“A bit more help ... not two weeks after they’re born ... a hundred per cent, support. If I had more support I would have carried on breastfeeding ... definitely showing how different techniques [work], and things like that.”*

R7

*“I’m thinking more like interactive support; probably a person would be the best ... because it’s really hard in the beginning. So maybe someone to continue with that help and support ... I would probably listen to someone within my own age ... sometimes I feel they [other breastfeeding mothers] look so much older that I feel that if they would talk to me, I would take it like my mum’s nagging me or something.”*

R8

*“More support groups, maybe discussions about it for a breastfeeding group. I know you do have breastfeeding groups but probably there isn't enough because there's not enough funding to run those kind of programmes.”*

...

*“Maybe ... a drop-in breastfeeding [session] ... if you want to go on your own and you don't want to discuss it in front of others.”*

Group 1 participants, pregnant

Participant: *“No-one ever mentioned to me about taking breast milk and putting it in a bottle.”*

Interviewer: About expressing.

Participant: *“Yes.”*

...

Interviewer: Do you think that might have made a difference?

Participant: *“Yes ... seems so simple but, at the time, you just ... you don't think of it.”*

Interviewer: What do the rest of you feel about that, about actually expressing breast milk and feeding it by a bottle?

Participants: *“Even the thought of that just puts me off. Nothing appealing to it.”*

...

*“I don't know, I think I would do that actually.”*

...

*“Yes, because ... it's the best for the baby as well.”*

...

*"See I think you're on about like trying to get people to stop bottle feeding and breastfeeding. If they're still stuck to bottle feeding that I think that would be a better chance of getting them to breastfeed, putting it into a bottle."*

Interviewer: So you think there might be some mileage in discussing that with people.

Participant: *"Yes. ... I think you'll have more of a chance that way of getting them to breastfeed than just actually just breastfeeding."*

Group 2, did not breastfeed

*"Maybe they should make like a job to open up more jobs in Britain, around Britain, for people who are mums but aren't medically qualified, to be like sort of a support worker to go round people's houses and say right ..."*

...

*"A Booby Buddy!"*

...

*"Just be supportive, regardless of what path they choose."*

...

*"That's a really good idea."*

...

*"And other people would feel less uncomfortable because it's not a midwife or a doctor or ..."*

...

*"Yes."*

Group 3 participants, tried breastfeeding but gave up

*"You need a proper breastfeeding group. A bit like health visitors, breastfeeding specialists."*

...

*"Yes."*

...

*"Who go round and help people out, no matter what time of day. I know you've got the breastfeeding helpline as well."*

...

*"But then that's just over the phone isn't it, yes."*

...

*"Because when you're in hospital you ask your midwife, she's like 'oh ask your health visitor', you ask your health visitor and then it's 'oh ask your midwife', and it's like pillar to post."*

...

*“I think when you're in the hospital I think the midwife should like, when they come round to see you, make sure that you actually are really happy with what you're doing, before you go home, because I left the hospital, and I wasn't 100% happy with how we were getting on. It wasn't until the next midwife came out the next day that I got a bit more help.”*

Group 4 participants, breastfed successfully

Additional information about the type of support that women would like to receive was gleaned by Uscreates, during their process of asset mapping in the two communities. Five women contributed to this process, of whom three breastfed, one bottle fed, and one had personal experience of both methods of feeding. All these women would prefer face-to-face support in their own homes or in a community setting, although one said that telephone advice would also be acceptable. Some women would like to have one-to-one support; one expressed a wish to be in a group that met in someone's home. Content desired included emotional support, information and practical help/demonstration. Both professional and peer support were considered potentially helpful. The need for urgent overnight support was voiced by one woman.

## Appendix C: Health professionals'/managers' perceptions about breastfeeding

A purposive sample of six professionals/managers involved in services for mother and babies was interviewed after the interviews and focus groups had been held with the women. The sample was selected to include both managers and practitioners from the midwifery and health visiting services for Penhill and Pinehurst. The interview schedule was based on the findings from the data collected from the women. All the interviews were conducted on a one-to-one basis, with the exception of one interview held jointly with two managers from the health visiting service.

The interviews and focus groups were audio-recorded and transcribed verbatim. Data were analysed thematically. Findings are presented concerning two main areas, social issues and service issues. The six respondents are identified only by research numbers, that is, P1 to P6, in order to preserve their anonymity.

### Social issues

All the professionals were of the opinion that one of the main barriers to increasing the breastfeeding rate is that bottle feeding is the cultural norm in both areas. This is linked to strong family orientation within the community, where the influence of mothers and grandmothers has a significant effect on women's decisions about how to feed their babies, and on the social support they receive for their feeding choice:

*"I've asked 'Can you tell me are you going to breastfeed or formula feed?', and they say 'Formula'. I say 'What do you think about breastfeeding?', and I've had comments like 'It's disgusting'; also things like 'Well the baby won't sleep at night, you won't get them in a routine, my mother told me, you know, not to do it'. So my perception of it is, out there, is it's a culture, their culture. ... They're very strongly influenced by their mothers. In this area here you've got mother, granny, auntie, and they do see each other quite a lot, they live down the road, so for them to breastfeed would be absolutely alien to that culture of that family."*

P1

*"We've got family nurse partnerships here, based here, and they do work all around the borough, but what they're finding with the young girls they're working with, again, it's (breastfeeding)not promoted, it's not seen to be the thing to do, it's not cool."*

P2

*“One of the pitfalls I think is that people are coming from very large families and the families traditionally have bottle fed and so it seems to be that the children feel that that's the way they should be doing it as well.”*

P4

*“We've got areas of families that are quite closely linked to each other. We've got generations of women that have not breastfed, that are now grandparents to the next generation, so the positive reinforcement of breastfeeding isn't necessarily there, in the family network.”*

P5

*“They don't even think about breastfeeding because it's not – the normal way to feed a baby as they perceive it is bottle feeding. They're happy to do that. Why wouldn't they be, because they were bottle fed, and their brothers and sisters are bottle fed, their friends are bottle feeding, so therefore everyone else is okay, and they're doing it, and there's no problem with that, so there isn't the pull to make them, to challenge them and say actually, well, actually this might be a better way of doing it.”*

P6

One of the interviewees mentioned high levels of domestic abuse in the area as affecting feeding choices, linked to the perception of breasts having only a sexual function:

*“Well actually adding to that, another thing as well, this partner, we've got a high rate of domestic violence in this area... so for a man to let his girlfriend breastfeed and get her breasts out is, I think could be, a concern as well.”*

P1

The family-centric environment was also cited as a barrier to wider social engagement, in that many women in these areas restrict their social interaction to their families and one or two close friends. They are therefore unwilling to access groups where they might learn about breastfeeding, or observe other women breastfeeding:

*“There's a lot of families here that are all interlinked. You go to one, you know the sister, you know the cousin, you go in houses, and you can meet all these families, they're all interlinked. So they're not going to go to Sure Start, it's really hard to get them to go there, let alone ... they're not going to go to that.”*

P1

*“They're social amongst their family members and friends, but maybe aren't more sort of socially mobile, so they're not good at attending groups and accessing information.”*

P6

Penhill and Pinehurst both contain a large amount of social housing. So families from outside of these areas are also housed there:

*“Within this community, there are a lot of people who are isolated, so there are a lot of families who move in, young families who move in, they don't have family around them ... families that we visit here are quite isolated. They don't have granny down the road.”*

P3

*“There are obviously the families that have been there for a long time, but in all of these areas that we have in Swindon, as with everywhere else, you know, it's a case of that's where a lot of the sort of social housing is, and people have just been put there; and I suppose it's four walls and a roof and it's not – I would imagine it's quite a challenging area and environment to be living in, and therefore difficult then to socially make friends and things, if you don't have anyone else.”*

P6

It appears that the lack of wider social interaction on the part of the established residents may therefore also have an impact on the degree to which new families are socially isolated.

Wider social norms and practices, in both the local and national context, were also perceived to have an effect on breastfeeding rates:

*“We don't make breastfeeding public to them out there. It's very marketed isn't it, on the television, about formula feeding.”*

P1

*“If you go into Swindon, I don't think there are many places – there were a few that opened about a year ago, where you could go and feed your baby, now we've had a number of shops close and things like that, we're not terribly baby-friendly in the community. ... So if you've got a young family here who've taken the bus into town, and you can't feed your baby, and you're not confident to do it in the café, or it's not encouraged in the café, you're not going to do it are you.”*

P3

However, despite the perceptions of the strength of prevailing norms, some professionals did offer examples supporting the idea that there may be a degree of change slowly taking place:

*"I can remember a few years ago, going into somebody's house, and the wife would have been encouraged to go upstairs to breastfeed, but I've not seen that since I started in the community a year and a half ago, that's not happened at all. ... The ones that are breastfeeding, the partners are very much open and want to help with it, you know, and they're the ones that are sat next to the wives ready to help them support themselves and things like that."*

P4

*"I've had reports that some of the young mums [targeted through the family nurse programme] have since said 'Actually, you know, if I have another baby I would like to breastfeed for longer'; or 'I would like to breastfeed next time, as I didn't do it this time, and I think actually I would have liked to have done it'; and some of the young mums are going on and having more children and are breastfeeding and breastfeeding for longer, so I think it's having a longer term influence because it's challenging that cultural thing."*

P6

### Service issues

A key factor emerging from the data collected from the women was the perceived lack of timely and appropriate support. All the professionals interviewed were asked about this issue, and recognised it as a problem. Contributing factors were thought to include lack of resources in the wider health and social care context, particularly with regard to home visits in the first month after birth. Midwifery visits stop between 10 and 15 days after birth, and health visitors only start going into homes between 16 and 18 days after birth. So it is quite possible for women to have no routine support from healthcare professionals for up to a week during the time when breastfeeding is not yet properly established:

*"That's a real issue and it's been happening now probably for a couple of years that we've had a real issue around staffing within maternity services, but also within health visiting, and so you've kind of got the two extremes. You've got midwives who should be discharging at day 10 who may be discharging slightly earlier because of work capacity, and are offering fewer home visits, and you've got the health visitors who, again, are struggling with short staff and in their capacity will not be able to offer as many visits, so maybe only offering one visit, and having to prioritise those that they do follow-ups for. ... That first visit might come late, they might get a telephone call at sort of 10 days or two weeks, but they might not go in until day 16."*

P6

*“One of the things the staff have mentioned is that, because of some of the changes at the hospital, they think that [there is a] much quicker turnaround ... in terms of being able to access support, it could be that our shortage of staff has had an impact on that.”*

P2

*“I do think that women don't stay in hospital very long anymore because of the nature of the beast really, that bed stays are driven by healthy women going home early. ... We have to meet commissioning requirements, so we only visit on set days, unless there's a clinical indication. Breastfeeding support I think is something that probably is an area which we do need to work harder on ... it is harder to offer that support ... as a manager, I won't want to pay an on-call payment for somebody to go out.”*

P5

*“Talking to health visiting colleagues, they struggle with the fact that they can often only offer one visit to a mum to support them, you know, which is a primary visit, where they're doing umpteen other things as well.”*

P6

There also seemed to be a question about misplaced support for breastfeeding. One respondent thought that some women start breastfeeding in hospital because of a perception that healthcare professionals think they should do so, rather than because they actually want to breastfeed. Continued support for breastfeeding at home then becomes irrelevant:

*“In hospital, they seem to put the baby to the breast straight after delivery, and make it look as if, yes, we're going to breastfeed, but by the time they've come home, the actual reality of that's gone – I think they've already been out and bought their steriliser, their bottles, everything ready to bottle feed, and they think that people expect them to put the baby to the breast whilst they're in hospital and so they do, and they don't necessarily do it in a way that is effective.”*

P4

Lack of support was thought to be exacerbated by the difficulty of providing appropriate information to the women from Penhill and Pinehurst, in both the antenatal and postnatal periods, given their reluctance to interact outside their habitual social circles within their local area:



*“We alternated where we would do them (parent education classes), because what we found was, if we did parent education here in Penhill, we just didn't seem to get the people coming to it, whereas if we do it in another area, people from Penhill even come to it. ... Unfortunately, [the take-up] is not good at all, not good at all. We might have five couples and we run them every couple of months so that's very, very small.”*

P4

*“For a long time there was an outreach worker, she was trying to run a support group and people weren't coming to the group and I think that often comes back to the fact that people don't access groups. So if you were offering support, does it have to be on a one-to-one, does it have to be in somebody's home – because you won't get them to come to you.”*

P6

There was general consensus among the professionals that women having appropriate information early in pregnancy is important for promoting breastfeeding. However, keeping in communication with women during the antenatal period was reported as being sometimes problematic:

*“I have that problem, just with my clinic. I ran a clinic this morning and three people that were booked in didn't attend, so that is an ongoing problem within these two areas, both Penhill and Pinehurst. ... It just seems to be traditional again. I keep using that as an excuse, but I don't know [why], is the answer. I mean, I book their next appointment when I see them, and write it on the back of their notes, so they've got it, and then I'll phone them and say ‘Did you know you should have been here this morning?’ – ‘Oh, I forgot.”*

P4

Lack of resources had also impacted on some of the opportunities for women to access both antenatal education and postnatal support:

*“We used to do parent education classes that ran in the evenings, for example, and they might be two or three hours long, and now we're limited to doing an hour session during the day.”*

P4

*“Sure Start's set up in Penhill ... they had a breastfeeding maternity support worker in post. She's no longer there ... because the funding didn't continue for her post.”*

P5

Provision of information also appears to rely heavily on written literature, which one interviewee thought that women may not read:

*“We have across Swindon our Breastmates, breastfeeding support groups, and we have lots of contact numbers on there, you know, listing who you can contact locally for support, and nationally, and people don't seem to access it; but is that because they're not reading the literature? You know, are they getting the leaflet but not actually reading it? And is that because it's not being pointed out to them, or is it just kind of bundled in the discharge pack from the hospital and they're not reading it, they don't know it's there? Because I think there is plenty of support, but people perhaps have to look for it sometimes.”*

P6

It is obvious that, for successful promotion and support for breastfeeding, women need a coherent, integrated service. There were different opinions expressed about how well different healthcare professionals and support workers actually work together:

*“[The relationship between the midwives and health visitors has] changed because now we're geographical, we're corporate, so we could work for like ten different GP's, so you'd have ten different midwives ... communication is not as good as it was.”*

P1

*“There's a breastfeeding strategy group but also we've got maternity liaison pathway meetings. They're very good now, work going on around particular pathways, and the commissioner is the same, and the commissioner brings all the providers together, so the baby-friendly accreditation is being done as a joint activity [between the midwifery and health visiting services].”*

P2

*“I think from an actual service delivery perspective, [co-ordination of services] hasn't changed how we've worked. In fact, we've just launched the health visitor–midwife liaison pathway, which is across all of the areas, that's Wiltshire, as well as here. ... I think the clinicians' view very much is they're paid by the borough, but they are still health visitors and there's the clinical links that haven't changed, in fact, if anything, I would say we've strengthened them recently.”*

P5

*“Some Children's Centres are working fantastically well with health visiting teams, and are doing things together, programmes that work and things; but with some there is a lot of tension, and certainly quite a lot of tension around having Children's Centre staff trained as breastfeeding champions from the health visiting team. They don't seem very keen on that idea. ... I think it comes back to the fact that midwives and health visitors, you know, breastfeeding's a health sort of thing, it's their remit, and the idea that actually breastfeeding is wider than that, and it's a social experience – it's all about the mum and the family and actually putting them first – but they see breastfeeding still as quite a sort of more clinical thing I suppose; you know, if mum's got a breastfeeding problem, well she should be talking to the midwife, she should be talking to the health visitor ... [champions have] had sufficient training that they should be able to help with very straightforward first-line problems and signpost, but I think as soon as you mention the word 'breastfeeding champion' to a lot of the health visitors, it's, you know, sucking in air and don't really want to talk about it, don't like it, rolling the eyes, sort of thing ...”*

P6

One respondent reported still having to deal with women receiving conflicting advice. However, another felt that there is insufficient appreciation that women may need different advice at different stages when establishing breastfeeding:

*“I'd confused her so much with my information [which] was totally different to what she'd been given; she gave up [breastfeeding]. And she gave up then. And that's what she said to the health visitor 'I gave up because I was so confused'. Maybe it was an excuse. We don't know how accurate what she came out with was correct from hospital. But I still feel we (health visitors and midwives) are not saying the same thing, I still believe that.”*

P1

*“You need to remind them [women] 'Actually, what the midwife said when she came and saw you on day three, was probably the right information for then, but actually two weeks later things have changed, and actually you're being given different information'; so that's the reassurance that you haven't been given the wrong information, it's all about the timing of it, and that sometimes there isn't a right answer for things, actually for that particular mum, something different might work.”*

P6

When asked how they thought breastfeeding could be promoted in Penhill and Pinehurst, respondents spoke both about planned/ongoing initiatives, and those that they would like to see:

*“We have to get family support workers going round. We could use them at the Children’s Centre. ... When I worked in Reading, they used to give them mobile phone top-ups to get them to go to the antenatal classes. ... kind of a carrot to get them there. ... So then if we’ve got a family support worker going in, to tell them about the Children’s Centre, to talk about breastfeeding, that’s one bit of the drip. I go in, tell them about my role, breastfeeding, another drip. We get them to antenatal classes with a carrot, because you’re not going to get them there otherwise. We drip, drip away. Just constantly getting the message through.”*

P1

*“The health visitors have identified that the bit of the programme that they’d really like to get going in terms of evidence based pathways and a real change, is the pregnancy, the work around promoting a healthy pregnancy and looking at that sort of promotional health aspect and breastfeeding will be part of that ... getting to work with families at a much earlier point, particularly now with the evidence that that’s when people are really receptive to making changes, it’s an interview and programme that will be aimed at both parents ... I think we’d also want to have a look at young peoples’ attitudes because presumably that’s where some of the attitude around that’s not what breasts are for [comes from], and also the whole sort of issue around relationships ... where young women are telling us ‘No, I can’t do that, you know my partner doesn’t want me to, or doesn’t like it’; so really understanding ... we know there’s a huge amount of work to do to.”*

P3

*“I’m working quite closely with name who works for the NSPCC and at the moment they go in to the Sure Start Centre and do their pregnancy, birth and beyond sessions. I want to get in there as well and do breastfeeding in there ... we don’t know whether people will turn up, but if the service is there, and we call it a drop-in session perhaps, initially, then we’re going to get people turn up ... if you say, you know, it’s an open forum, come and have a cup of coffee, come and have a chat with the midwife, then you can talk about anything ... any other service in the area is great to jump on the back of because they already know a lot of the women in the area ...”*

P4

*"The NSPCC have got different pilot projects going on around the country, and in Swindon their pilot project is Pregnancy, Birth and Beyond. It's group work on parenting, coping mechanisms – we've got a midwife working there who does drug liaison work... We've got another ex-midwife who was a health visitor who was the smoking cessation midwife, nurse, she's now working there. So together, with social workers, with NSPCC, with support workers, they're delivering a package of pregnancy education and the birth education, but also looking at parenting and beyond. And that's a two year project and that will be evaluated. They're a year in pretty much. ... [They're targeting] groups with social deprivation, perhaps known parenting issues, and families that perhaps are identifying 'we've got vulnerabilities', but they're not fitting thresholds for intensive interventions from social care."*

P5

*"We've been trying to work with Children's Centres for a while now and they're part of our community baby friendly work anyway, but they're doing something called Payment by Results as a pilot in Swindon and breastfeeding they've identified as one of their target areas that they want to work on. So there are a series of meetings that have been happening recently, one I went to last week, within different areas of Swindon, different localities, to look at how children's centres can work with others to do more work around breastfeeding; partly because they'll obviously benefit from that, but it's also thinking like, well, can they offer a telephone support service? And we could get some of our peer supporters or the breastfeeding champions, so these are the staff that have had a couple of days breastfeeding training, from Children's Centres, to actually offer a telephone call to those mums that they know are breastfeeding; and then they can liaise with health visitors and say 'Actually, I've spoken to this mum, you know, things aren't going well, you know, could you actually go and see this mum earlier' – that sort of thing, so that's one of the things that we've suggested. ... That obviously relates directly to support. A lot of the other ideas that were coming out were more about antenatal information and things like that. But in terms of support, certainly that's what the Children's Centres are thinking of – you know, we can't help when we don't know who those mums are, so it's something about information sharing with the Children's Centres, from the midwives, and then can they offer that support, by telephone or home visits, that staff can't at the moment."*

P6

*"There's a Facebook page in Swindon for our Breastmates group ... when it came about, it was run by one of our breastfeeding counsellors ... I think it's going very well, and all the mums are there and I think that's often where they go at three o'clock in the morning ... and all the other breastfeeding mums are up at three o'clock in the morning, will respond, so people are gaining a lot of social support from that. But if that is a route that works, then we need to make it not just a sort of volunteer-led thing, but something more official, and then we can publicise it more, so that mums know about it. Because I would imagine a lot of the mums are using the social networking sites."*

P6

## Appendix D: First steps in co-creation process

Uscreates presentation to NHS Swindon November 2012

**uscreates**  
empowering society

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# Supporting an increase in breastfeeding in Penhill and Pinehurst

NHS Swindon

## Agenda

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- 1) Uscreates describes engagement activity
- 2) Uscreates shares insights into communities
- 3) Uscreates presents options for the project
- 4) Project team reviews, amends and prioritises continuing focus of project

## Co-creation: original aims

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- 1) To engage local people with the project and issue
- 2) To co-create ways to support mothers in breastfeeding
- 3) To empower local people to shape, develop and co-deliver interventions



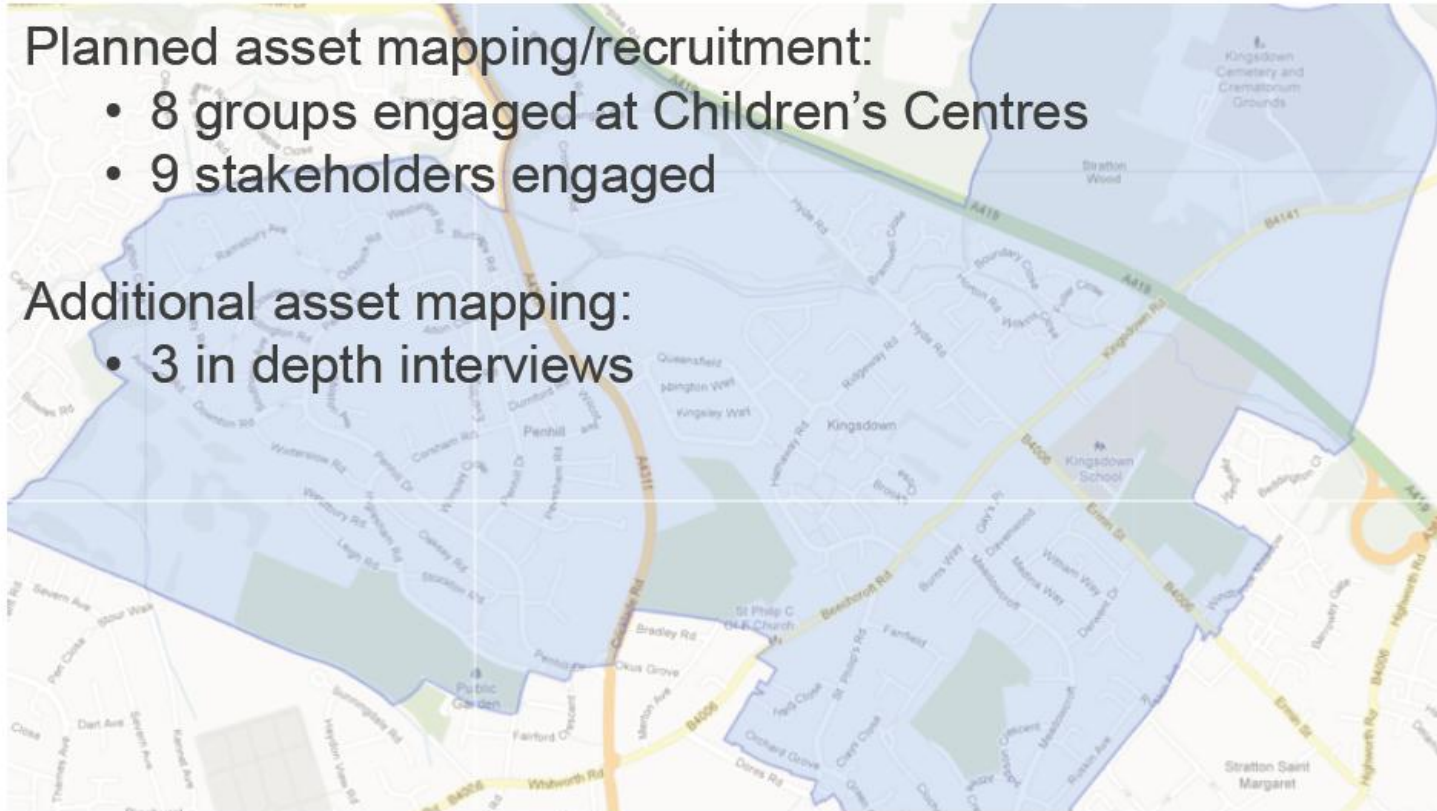
## Engagement activity to date

### Planned asset mapping/recruitment:

- 8 groups engaged at Children's Centres
- 9 stakeholders engaged

### Additional asset mapping:

- 3 in depth interviews



Asset mapping questions included:



- What do you like/dislike about area?
- Who do you respect in area?
- How would you describe to visitor from out of town?
- Why did you move to the area?
- Who do you see / talk to regularly locally?
- What is your favourite local place? Why?
- Who can you rely on to help out with a problem?
- If you could change one thing what would it be?

## Co-design events

### Aim:

- Share research insight
- Generate ideas and options
- Create ownership and confidence

### Plan

- Two events, one per ward
- Taxis, childcare and lunch
- 8 women confirmed & reminded

## You're invited

to help improve health of mothers and babies by increasing breastfeeding rates.

Uscreates is working with NHS Beithon and local women to support an increase in breastfeeding rates in Pentil and Pinehurst areas.

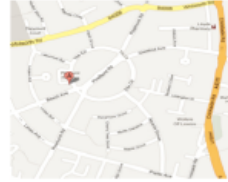
We would like to invite you to a collaborative design event where you will be part of a team generating ideas to increase the uptake of breastfeeding.

The project is all about getting local people and relevant community groups involved to contribute their ideas and creativity.


Uscreates will host the event with designers and researchers facilitating the afternoon. We hope that you can make it and look forward to seeing you there.

Help to make a difference  
RNVP: alan@uscreates.com

**Date: Tuesday 20th October.**  
**Time: 5pm - 8pm, refreshments afterwards.**  
**Location: Pinehurst Library, Pinehurst Community Centre, The Circle, Pinehurst, SK2 1QR**



### Ideas Workshop This Way



## Evaluation of co-design

### 1 woman attended.

Follow up calls revealed:

- Many seem to have forgotten
- Others put off by logistics
- Many prefer to do it at home

Discussion with stakeholders:

- A similar shared experience in terms of attendance/involvement



## The co-creation picture

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Collaborating with communities works well when they feel they have a stake in the area and project.

What we have understood so far describes two disengaged communities, one more than the other.

“Disengaged” may describe:

- Levels of involvement and participation in public society
- Levels of ‘neighbourliness’, ‘community spirit’ or interaction between members





## Community description

### Penhill

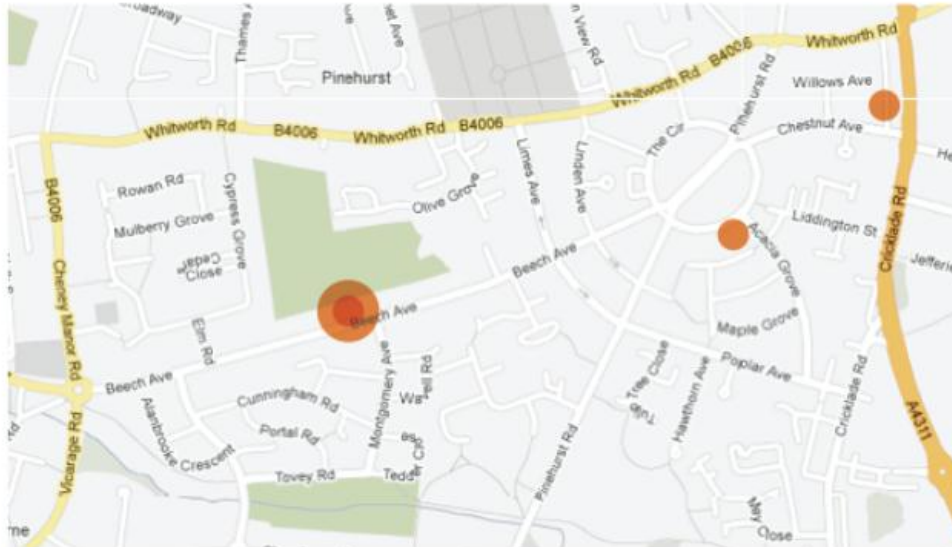
#### Community interaction - a mixed story





## Community description

### Pinehurst Assets



Mapped:

- Pinetrees community centre
- Children's Centre
- Swindon Academy
- Pinehurst Initiative

## Pinehurst Low involvement and low interaction

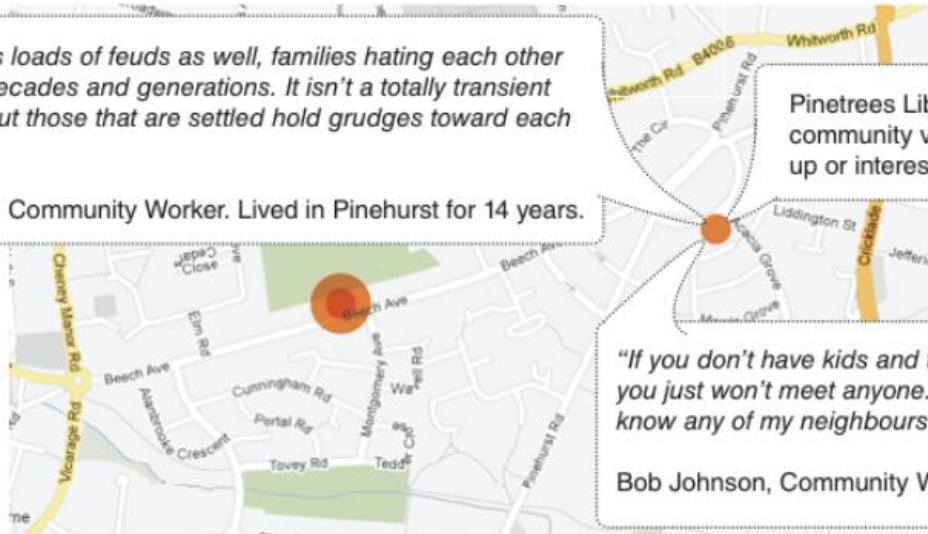
*"The area has loads of feuds as well, families hating each other going back decades and generations. It isn't a totally transient community, but those that are settled hold grudges toward each other."*

Bob Johnson, Community Worker. Lived in Pinehurst for 14 years.

Pinetrees Library - Planned handover to community volunteers in April but no take up or interest

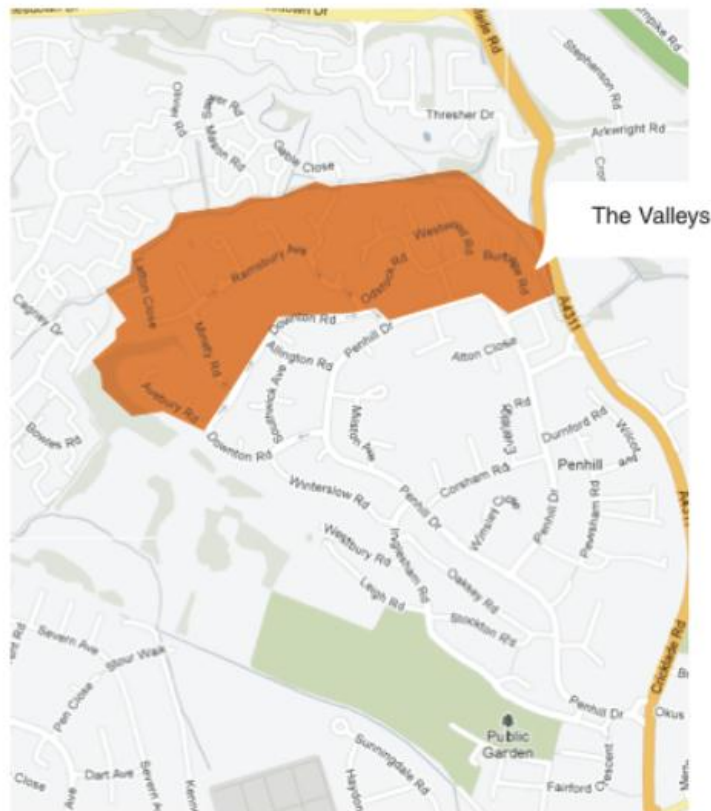
*"If you don't have kids and therefore meet people through school, you just won't meet anyone. Such low levels of interaction. I don't know any of my neighbours names."*

Bob Johnson, Community Worker. Lived in Pinehurst for 14 years.



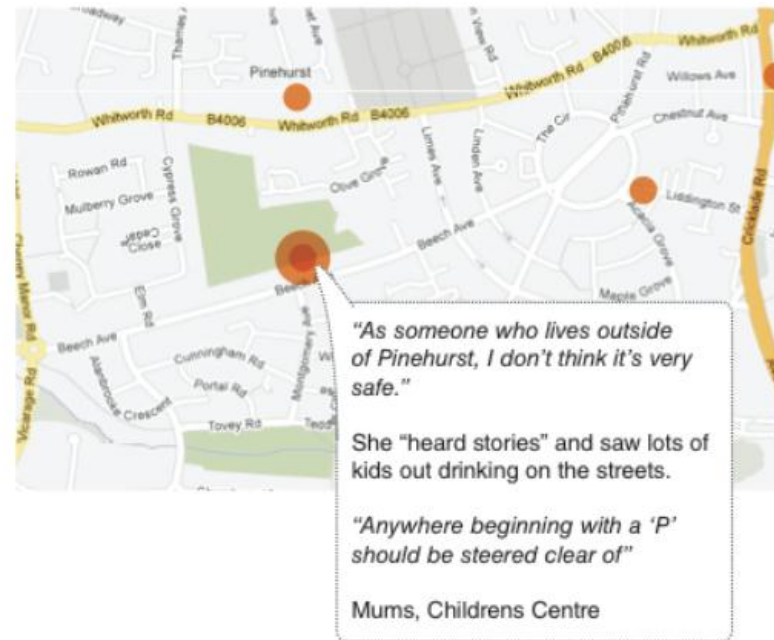
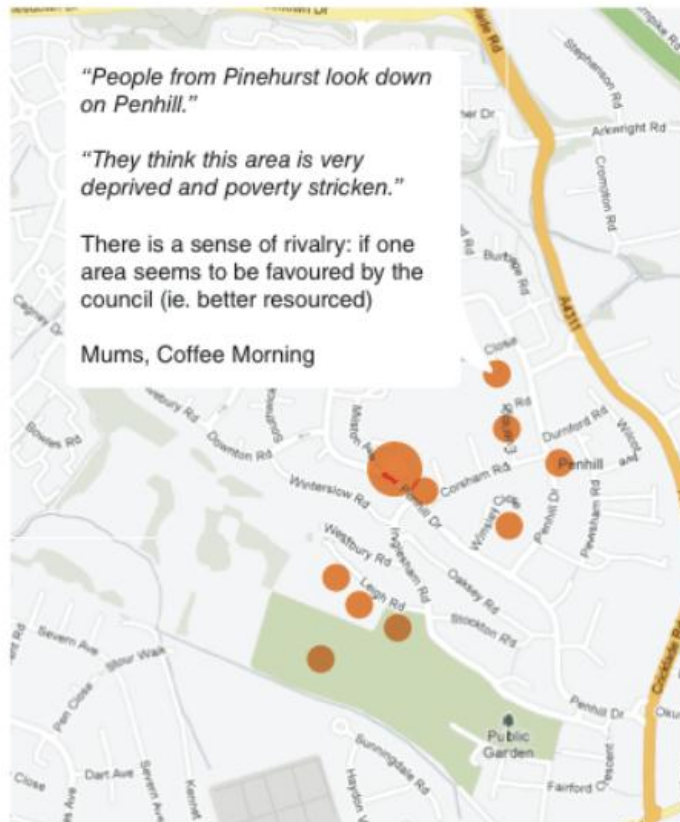
## Community description

### Penhill and Pinehurst Wards within wards



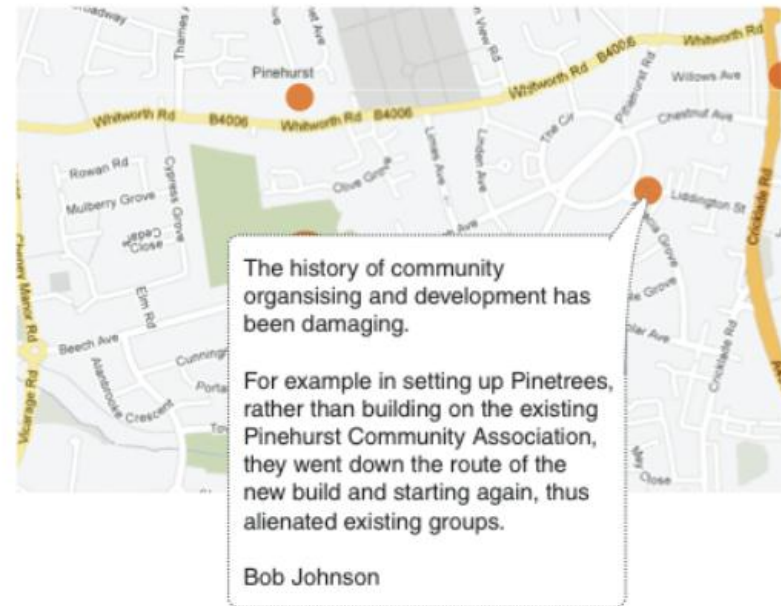
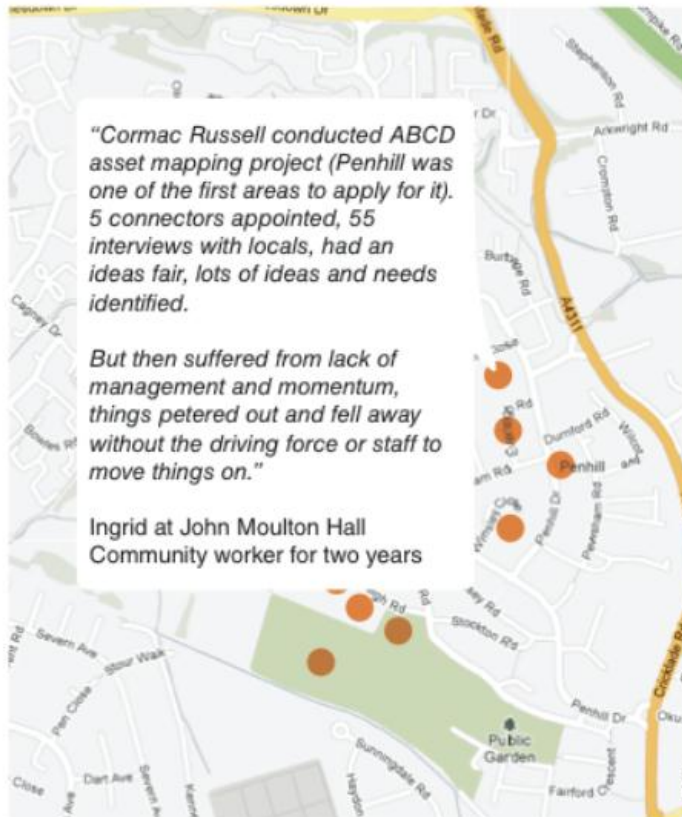
## Community description

### Penhill and Pinehurst Friction and outside perception



## Community description

### Penhill and Pinehurst Community development



## Possible reasons for low engagement

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The reasons people think these might be disengaged communities:

- Social housing – transient, no choice over area, culture of commitment?
- Crime levels – perception of unsafe streets
- Ownership over any common/shared spaces very low

## Community insights relevant to BF

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- What impact might low community involvement and interaction have on breastfeeding rates?
- No direct link is immediately obvious without additional insight
- It is relevant to co-implementing community led interventions
- Lack of support (practical/emotional) a key barrier to maintenance – higher community interaction may provide community based support
- What impact community interaction on social norms around breastfeeding?
- “It’s a very matriarchal society and mums say stuff like “not enough milk” and “not good quality milk” to daughters” - Health Visitor

## Next steps

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### **Immediate next steps.**

Several at home sessions with women in both wards arranged for next week.

Flexible opportunity to either:

- Idea generation and feedback on other's ideas
- Explore reasons behind low engagement further
- Involve partners/families informally



## Options going forward

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### Option 1 Uscreates-led:

- 1) Continue with focus on breastfeeding
- 2) Co-design ideas next week with individual women
- 3) Uscreates leads on decisions, development, implementation
- 4) Low levels of community involvement mean co-delivery unlikely
- 5) The intervention(s) may look like.....

## Option 1: Uscreates-led

### Service tweaks



### Online/Skype at home support



### Social media



### Branding and comms materials



## Options going forward

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Option 2 empower stakeholders to understand/increase involvement:

- 1) Shift focus to understanding reasons for low community interaction/involvement
- 2) Work closely with key stakeholders (community experts in Pinehurst and Penhill)
- 3) Train/empower them to carry out activity to understand community
- 4) Shadow them in their working day to identify possible improvements
- 5) Identify with them ways in which community involvement could be increased

## Appendix E: Community engagement insights

The following are some of the recurring themes that were reported/observed several times.

### **Penhill: a geographically distinct community**

- Penhill residents are a close knit community
- The area is more geographically isolated, without a main road passing through it, potentially creating more of a separate identity
- If you're outside doing gardening, everyone will say 'hello'
- Everyone knows everyone
- An example of community action: residents have raised £5,000 to save Chippenham Close Hall from closing down
- Social relationships may stem from the school (mums new to the area would meet other women when their children started attending the school)
- A reported lack of sustained engagement with community projects and initiatives by general population, perhaps due to a lack of a culture of commitment
- Several key and very committed volunteer groups and committees driving most changes, focusing community activity

### **Pinehurst: low inter-community interaction**

- Though geographically very close to Penhill, a very different social landscape
- Much less social and community integration and interaction between community members
- Less of a shared or common community identity
- Several reports of a lack of 'community spirit'
- Potential factors affecting community integration: transient communities in council housing, family living outside of area, not feeling safe
- Additionally far less in the way of community infrastructure and available buildings to organise around

### **Penhill vs. Pinehurst**

- Reported social barrier between the two areas
- At one point they considered establishing football teams from each area, but decided against it over concerns about rivalry
- Penhill residents report feeling that people from Pinehurst looked down on them, and that the perception of Penhill was that of deprivation and poverty
- Reports of migration from Penhill to Pinehurst to be closer to Swindon Academy on Beech Avenue
- Little mixing of the two wards – those that come from Penhill stay in Penhill and vice versa
- Some rivalry and competition between the areas, especially when one appeared to be receiving extra/special attention or services



### **Online community**

- Reports that much community activity and interaction happens digitally/online, either through Facebook or BBM, i.e., most of the Penhill community

### **Sense of community**

- Most from both areas felt there was little 'community spirit'
- Perceptions of pockets of crime in places – 'the Valleys', 'the Courts'
- Reasons for living in the areas included family, partner's job and council house allocation
- Mothers meet at friends' houses and at the Sure Start groups – there are few alternatives
- Factors encouraging community integration – knowing families with children of similar ages nearby, living in an area for longer, living in a 'safe' area

## Appendix F: Designer's pack

### Uscreates Brand Concepts



Breastmates  
Concept 1



Breastmates  
Concept 2

## Our Services:

### Group Support

Maybe you're new to breastfeeding and want to better prepare yourself? Perhaps you're already feeding and would like advice about how to make it easier for you and your baby?

Our trained peer supporters are all local breastfeeding mums and along with breastfeeding Counsellors and Champions, the groups are a great place to share tips, gain practical support and meet like minded women.

Each of our groups take place at Surestart Children's Centres. Text your NAME + GROUPSUPPORT to 07624 800500 for more info

### Home Support

Our friendly local breastfeeding Counsellors are available for home visits to women who would like breastfeeding support from the comfort of their own homes.

As our Counsellors work as volunteers and may not always be able to see you, please see your Midwife or Health Visitor if you need more urgent support.

Text your NAME + HOMESUPPORT to 07624 800500 for more info



### Telephone Support

There is a range of telephone support on offer, providing mother-to-mother help and advice over the phone at any time.

**La Leche League**  
0845 120 2918

**The National Breastfeeding Helpline**  
0300 100 0212

**National Childbirth Trust**  
8:00am-10:00pm on 0300 330 0771

### How to reach us:

Penhill SureStart Children's Centre  
Everleigh Road  
Penhill  
Swindon  
SN2 5HB

01793 705091

### Online Support

Our popular Swindon Breastmates Facebook group supports breastfeeding women from all over Swindon. Maybe you have a question only a mum could answer, or for those times when you aren't able to make it to one of our groups, just login and ask the community at:

[www.swindonbreastmates.co.uk/facebook](http://www.swindonbreastmates.co.uk/facebook)

Pinehurst SureStart Children's Centre  
Beech Avenue  
Pinehurst  
Swindon  
SN2 1JR

01793 514492





To: .....

**Breastfeeding, and need a bit of help?**

I'd like to invite you to join Breastmates, who give all sorts of support to local mums like you.

"Talking to other women who are breastfeeding or have breastfed can often be a great support. You can learn what to expect and what is or is not normal."



From: .....

## Our Services:

### 1. Group Support



Maybe you're new to breastfeeding and want to better prepare yourself? Perhaps you're already feeding and want help and advice about how to make it easier for you and your baby? Or you might just want to meet like-minded mums for a chat.

Our groups have been running in Swindon for x years (check with Bena), and have helped over x mums (check with Bena) to breastfeed. In January 2013, we're launching two exciting new groups in Pinehurst and Penhill and we'd love you to come along!

### 2. Home Support



We have trained breastfeeding experts called Counsellors, who are on hand to help women, both at groups and to visit mothers in the comfort of their own homes.

Our Counsellors are available to help during those difficult moments, offering a friendly face with personal and professional expertise.

If you need specific, practical support to better breastfeed your baby, simply register your details:

Text your NAME + HOMESUPPORT to 07424 800500

### 3. Telephone Support



La Leche League is your at home telephone support service. Offering friendly mother-to-mother support, the hotline can be used at any time of the day, from pregnancy through to weaning. La Leche accredited Leaders are mothers who have breastfed their own babies and know that when a mother needs a bit of help it can't wait until tomorrow.

Get in touch with La Leche League today:  
0845 120 2918  
[www.laleche.org.uk](http://www.laleche.org.uk)

### Facebook



Our popular Swindon Breastmates group supports breastfeeding women from all over Swindon. Maybe you have a question only a mother could answer, or for those times when you aren't able to make it to one of our groups, just login and ask the community at [www.swindonbreastmates.co.uk/](http://www.swindonbreastmates.co.uk/) facebook

For face to face peer support, visit one of our groups or for more immediate support, ring La Leche League.



Text your NAME and number of the support you want to 07624 800500

For more information visit [www.swindonbreastmates.co.uk/](http://www.swindonbreastmates.co.uk/)



Breastmates Concept 3



## Contact Us At:

Community midwives office  
9AM-5PM - 945000  
up to 28 days after birth  
0793 649000 - 17 or 602574

Community midwife Hood  
holder 07900 - 51000  
0793 649020

Great Western Hospital  
maternity Hood holder 24 hrs  
0793 649020

Health visiting team

SureStart breastfeeding  
support 9AM-5PM - 430000  
Monday to Friday  
0793 705090

Elwyn Race breastfeeding  
counsellor  
0793 878029

Sarah Lambert breastfeeding  
counsellor and pump hire  
0793 707600

For more information visit [www.swindonbreastmates.com](http://www.swindonbreastmates.com)

Penhill SureStart  
Children's Centre  
Everleigh Road  
Penhill  
Swindon  
SN2 5HD

0793 705091

By Bus from the Swindon Town Centre: From the Fleming Way Bus Station take the No.10 or No.17 bus. Get off at the stop in Penhill Drive just after Everleigh Road on the right hand side.

Pinehurst SureStart  
Children's Centre  
Beech Avenue  
Pinehurst  
Swindon  
SN2 1JR

0793 514492

By Bus: From Fleming Way Bus Station take the No. 10 or No. 11 bus. Continue until you reach Pinehurst road, get off at the traffic lights at poplar avenue and walk left towards beech avenue, on beech avenue, the children's centre is the 3rd turning on the left in the grounds of the Swindon Academy.





Breastmates  
Concept 4







# breastmates Brand Guidelines

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The *breastmates* brand has been co-designed with breastfeeding mums aged between 18 & 30 and key stakeholders from Great Western Hospitals NHS Trust. These guidelines aim to provide simple and clear guidance on applying the brand to various *breastmates* communications.

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## Concept/ Service

*Breastmates* is an existing peer-to-peer breastfeeding service aimed at mums and mums-to-be throughout Swindon. In partnership with Great Western Hospitals NHS Trust, two new *Breastmates* groups are being piloted with new branding and service tweaks. These service tweaks aim to provide mums and mums-to-be, who are, or are considering breastfeeding, with 4 different types of support. These types of support include: group, home, telephone and online.

The brand's concept has been developed in collaboration with breastfeeding mums and key stakeholders. The brand's name has been chosen for it's fun and accessible phrasing, whilst reflecting the service's peer-to-peer format. The visual aesthetic style has been chosen to enhance accessibility, and reflect the brand's friendly and welcoming tone of voice.

## Logo Variation



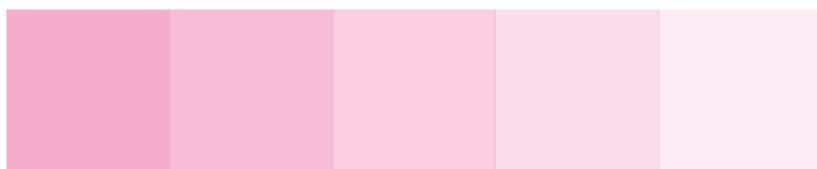
Above is the *breastmates* logo in both greyscale and colour variations. Where possible the logo should be applied in colour to enhance the brand's welcoming tone of voice. The logo should also be applied in a circular shape, but where size and proportions of marketing materials restrict this it can be applied without (as shown bottom right).

## Colour Palette



### Dark purple and tints

C 50 M 70 Y 0 K 0  
R 119 G 78 B 156  
Pantone 2583 C



### Pink and tints

C 0 M 40 Y 0 K 0  
R 239 G 154 B 195  
Pantone 203 C



### Black and Greyscale

C 0 M 0 Y 0 K 100  
R 0 G 0 B 0  
Pantone 426 C

The primary colour was chosen by mums during the co-design stages. It has been picked to help differentiate *breastmates* from breast cancer branding. Pale pink has been selected to compliment the purple, but should be used sparingly.

## Typefaces

Primary Brand Typeface: Sweetness Medium

ABCDEFGHIJKLMNOPQRSTUVWXYZ

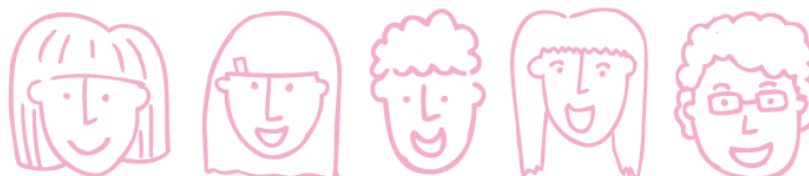
Secondary Brand Typeface: Gotham Rounded & Family

ABCDEFGHIJKLMNOPQRSTUVWXYZ

The *breastmate* brand uses two typefaces. The primary typeface was selected by mums during the co-design stages. It was selected to compliment the brand's illustrative and playful style whilst retaining legibility. The primary typeface should be applied to the logo and headers. The brand's secondary typeface has been chosen to compliment the primary typeface and should be used for body text.

## Illustrations

The brand uses illustrations to make it feel fun and accessible to mums. Feedback from the mums revealed that they liked the illustrations but noted that they should reflect the age and demographic of the target audience. Therefore any future illustrations created post brand launch, should remain fresh and youthful in style. Illustrations should always appear on a greyscale or coloured background. Where this isn't possible the illustrations should be outlines only, as shown below.







Photography is an important part of the *breastmates* brand. The mums consulted on the brand felt that photography should represent more than just breastfeeding. Images of mums breastfeeding should be avoided on primary marketing materials. Any photography selected should be warm in tone and represent 'real women' in a professional manner without feeling staged or clinical.

## Language

### Tagline:

The brand uses one central tagline:

“Support from other breastfeeding mums”

Where possible the tagline should remain unchanged and be used in partnership with the brand's logo in order to maintain consistency and encourage familiarity.

It has been written based on discussions with breastfeeding mums in the co-design stages and aims to identify that the service and support provided is from other mums that have experience of breastfeeding.

### Introductory text:

Any text which introduces the service should be both friendly and welcoming in tone, whilst also clearly stating the services that are provided by *breastmates*.

### Body text:

Mums felt that the language of the brand should be personal, welcoming and friendly. However it should still remain professional in tone, and avoid technical terminology where possible.

### Quotations:

When using quotations on marketing material they should be accompanied by a photo of the person who originally stated it. Any quotes used on *breastmates* marketing material should remain short in word count.

### Bullet points:

Bullet points are great to condense information into manageable chunks. The mums consulted liked bulletpoints being used as part of the *breastmates* brand.

## Poster

Great Western Hospitals **NHS**  
NHS Foundation Trust

**breastmatters**  
support from other breastfeeding mums

### Come and join breastmatters!

We'd like to invite you to come and join us and meet mums like you! breastmatters offers a range of services for breastfeeding mums, from groups to home visits and telephone and online support.

 <p><b>Group Support</b> Held at your local Children's Centre, our groups offer a range of practical support for all of our mums, from peer support from other local mums, through to professional advice and information from our Counsellors and Children's Centre Breastfeeding Champions.</p>	 <p><b>Home Support</b> We have trained breastfeeding experts called Counsellors, who are on hand to help women, both at groups and to visit mums in the comfort of their own homes. Our Counsellors are available to help during those difficult moments, offering a friendly face with personal and professional expertise.</p>	 <p><b>Telephone Support</b> There is a range of telephone support on offer, providing mum-to-mum help and advice over the phone at any time.</p>	 <p><b>Online Support</b> Our popular Swindon Breastmatters group supports breastfeeding women from all over Swindon. Maybe you have a question only a mum could answer, or for those times when you aren't able to make it to one of our groups, just login and ask the community at <a href="http://www.swindonbreastmatters.co.uk/facebook">www.swindonbreastmatters.co.uk/facebook</a></p>
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Text your NAME + GROUPSUPPORT to 07624 800500 for more info

Text your NAME + HOMESUPPORT to 07624 800500 for more info

La Leche League 0845 120 2918

The National Breastfeeding Helpline 0300 100 0212

National Childbirth Trust 8:00am-10:00pm on 0300 330 0771

For more info visit [www.swindonbreastmatters.co.uk](http://www.swindonbreastmatters.co.uk) or scan the QR code



## Invite

Great Western Hospitals **NHS**  
NHS Foundation Trust

**breastmatters**  
support from other breastfeeding mums

Welcome to breastmatters! We'd like to invite you to come and join us and meet mums like you! breastmatters offers a range of services for breastfeeding mums, from groups to home visits and telephone and online support.

## Badge



