



Breastfeeding and Introducing Solid Foods

Consumer Insight Summary



Prepared by COI Strategic Consultancy on behalf of the Department of Health

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1. INTRODUCTION

This report is a summary of consumer insight research carried out into breastfeeding and the introduction of solid foods by the Department of Health (DH), strategic health authorities (SHAs) and primary care trusts (PCTs) in England. It is designed to pool knowledge of the barriers to and insights into breastfeeding, and insights into the introduction of solid foods, along with recommended interventions where appropriate. It draws on a range of consumer insight research reports supplemented by key academic papers. A full list of source information is listed in section 7; however, the key source documents are as follows:

- Baby And Toddler Nutrition, Define for COI and DH, 2008
- Baby And Toddler Nutrition – Key ethnic minority communities, Ethnic Dimension for COI and DH, 2008
- Qualitative research to explore reactions to DVD about breastfeeding, Cragg Ross Dawson, 2008

The report covers parents of children aged 0–2 years, with a particular focus on mothers aged under 25 from lower socio-economic groups, and on mothers from ethnic minority communities.

It is intended for use by healthcare and marketing professionals to inform both service delivery and communications in SHA and PCT settings.





2. BACKGROUND

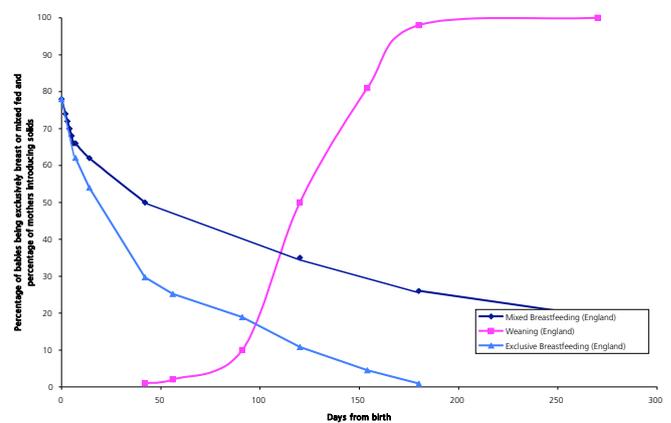
The World Health Organization (WHO) recommends that infants are fed exclusively on breastmilk until the age of 6 months and then breastfed alongside food for as long as the mother and baby are happy. Evidence suggests that as well as providing all the energy and nutrients that the child needs in its first few months of life, breastmilk promotes sensory and cognitive development. It leads to slower, healthier weight gain, reducing the chance of later obesity. It provides greater protection from infectious and chronic disease. Babies breastfed for a minimum of 6 months are less likely to experience colic, constipation, sickness/vomiting, diarrhoea, chest infections and thrush. Breastfeeding has also been shown to reduce the risk of ovarian and breast cancer in mothers.

Breastfeeding rates in England remain amongst the lowest in Europe. Initiation rates (defined as the child being put to the breast at least once) are around 78%, but within one week the number exclusively breastfeeding drops to 46%, and by 6 weeks it is down to 22%. At 6 months, only 26% of mothers are breastfeeding, with barely 1% doing so exclusively.¹

DH guidelines support the WHO recommendation that the introduction of solid foods should begin around 6 months. Only around 2% of mothers follow this guideline, although between 2000 and 2005 there was a trend towards solid foods being introduced later. Mothers from lower socio-economic groups are more likely to introduce solid foods earlier.^{1,24}

Breastfeeding fallout and rates for the introduction of solid foods in the first 300 days from birth are illustrated in figure 1.

FIG 1. BREASTFEEDING FALLOUT AND RATES FOR THE INTRODUCTION OF SOLID FOODS



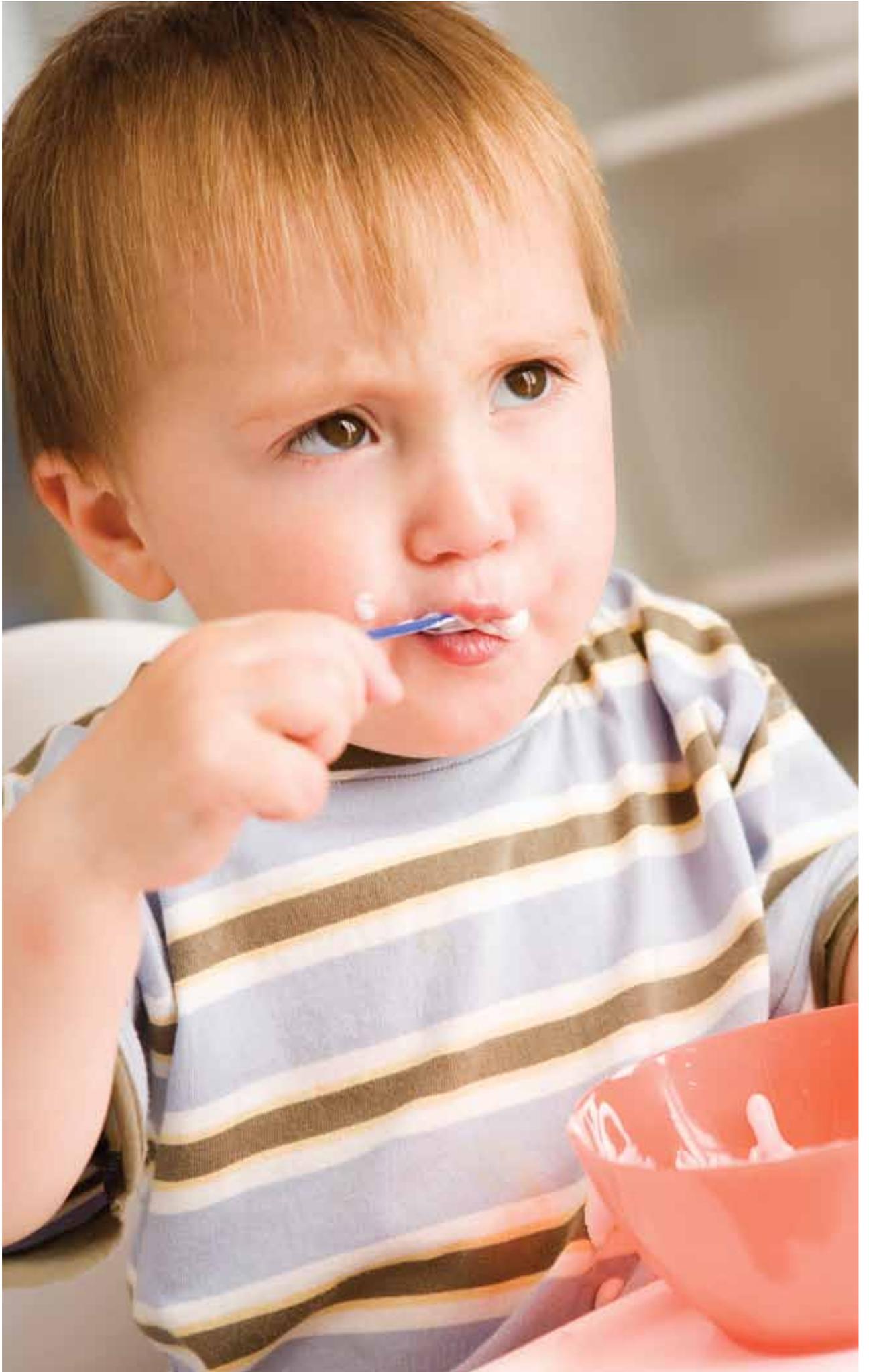
Source: Infant Feeding Survey 2005

DH has issued a Public Service Agreement target of achieving the highest possible prevalence of breastfeeding at 6–8 weeks by 2011. Government policy, underpinned by National Institute for Health and Clinical Excellence (NICE) guidance, promotes the adoption of the United Nations Children’s Fund’s (Unicef’s) Baby Friendly Initiative (www.babyfriendly.org.uk) as the best evidence-based intervention to raise levels of breastfeeding.

DH is supporting the implementation of the initiative by funding hospitals to start the accreditation process of becoming Baby Friendly, with the aim of raising breastfeeding rates within each PCT’s area, through comprehensive training and co-ordination of breastfeeding activities in hospitals and community settings.³⁴

New UK–WHO growth charts from birth to 4 years have been introduced using the WHO growth standards based on breastfed children. The charts provide standards on “how all children should grow”. They should be used for all infants, however they are fed, and for all ethnic groups.





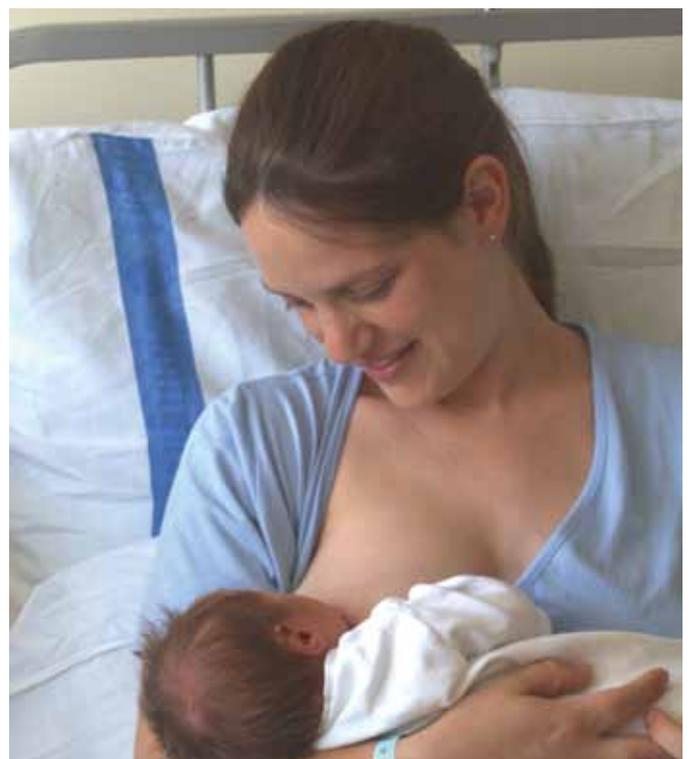
3. MARKETING STRATEGY

The Change4Life marketing campaign was launched in England in January 2009 as part of the “Healthy Weight, Healthy Lives” cross-government strategy. As its name suggests, Change4Life is an initiative designed to encourage healthy diets and physical activity in an era of increased availability of unhealthy foods and sedentary lifestyles. Its aim is to reduce the preventable diseases and illnesses associated with obesity. It encourages parents to take responsibility for ensuring that their children eat more healthily and take regular exercise. It is a long-term campaign, targeting families with children aged 0–11 with a clear rationale for focusing on parents at the start of a child’s life. The aim is to encourage them to adopt healthy habits from the beginning, when they are more likely to be receptive to receiving information on child health and wellbeing. For this reason Start4Life seeks to influence parental behaviours in the first year of a child’s life by focusing on pregnant mothers and parents of babies under 2 years.⁴

Exclusive breastfeeding drops off significantly during the first week after birth, and the Change4Life Marketing Strategy identifies this as a key time to influence women and to change the trend.³⁴

It is essential to educate and build awareness in mothers, and those who support them, so that they are equipped (both psychologically and socially) to maintain exclusive breastfeeding through the first week – and beyond. Marketing communications, along with policy and service interventions such as the provision of breastfeeding peer support, have a central role to play in increasing the duration of breastfeeding.

DH currently disseminates information for consumers about breastfeeding and the introduction of solid foods through the www.breastfeeding.nhs.uk website, the NHS Choices website, the National Breastfeeding Helpline, the “From Bump To Breastfeeding” DVD and a range of literature available within PCTs and hospitals.





4. BREASTFEEDING INSIGHTS

Early decisions

Many women make the decision on feeding, consciously or not, in the first few weeks after learning of their pregnancy, and some before becoming pregnant at all.¹² Evidence suggests that many mothers carry their stated feeding intentions before the birth through to actual feeding behaviour.^{1,12}

Cultural and family norms play strongly into this decision; if bottle feeding is common practice in the family or amongst friends then this is likely to be reflected in the woman's decision.^{29,30} Most mothers are aware of the reported benefits of breastfeeding (84%¹). In qualitative research conducted in 2007, all mothers in the sample were familiar with the "breast is best" message.³⁵ Although they were hazy on the details, they saw the benefits as primarily to do with the health of the baby. This translates into a willingness to 'give it a go'^{36,38} (see "emotional factors affecting breastfeeding", below). However there is frequent scepticism about these benefits in the context of lifestyle expectations and knowledge in society/local culture today.^{4,35,37}

"It can't be that bad; my family's been bottle fed, and they're OK.

16–19, First pregnancy, Birmingham⁴

This is particularly common amongst younger mothers from lower socio-economic groups, who may lack breastfeeding 'role models'.¹¹

The Infant Feeding Survey shows initiation to be lower for second and subsequent babies than with first time mothers, although duration of breastfeeding is longer.¹ However, there is some suggestion from qualitative research that second time mothers may be more willing to breastfeed the second time around; they know they can cope with child-rearing and that they can revert to the bottle if there are difficulties.⁴

"I think I'd be more likely to do it if I had another child later on – I don't feel like doing it at this age and with my first child."

16–19, First pregnancy, Birmingham⁴

Equally, mothers from families where breastfeeding is the norm are much more likely to do so themselves. The attitude that breastfeeding is the norm is more common in older mothers from higher socio-economic groups.^{1,3}

The breastfeeding culture

The lack of a breastfeeding culture is frequently cited as one of the most significant contributory barriers to a woman's decision to breastfeed.¹⁹ Health professionals note that the subject of breastfeeding does not feature in the national curriculum, and is not taught in schools.¹⁹ In addition, formula milk continues to be advertised on television. All of these contribute to the fact that, for many communities, it is bottle feeding, rather than breastfeeding, that is the norm.

A positive breastfeeding culture most commonly begins with the support and approval of family and peers.^{29,30} However, encouragement to move to formula rather than breastfeed can come from a range of different influencers, including: mothers and grandmothers,¹⁰ who were bottle-fed themselves; partners, who fear that breastfeeding excludes them from contact and care of their infant or who may see breasts as solely sexual objects;^{19,20} and friends and peers, who may be bottle feeding their own babies and may exert a conscious or unconscious pressure to do the same.³⁸ There is evidence of a 'give it a go' breastfeeding culture, whereby women who intend to breastfeed have strong expectations that they will encounter difficulties, thereby preparing themselves for failure.³⁸

Mothers feel that society still holds a negative attitude towards breastfeeding in public. Many sense disapproval from restaurant and cafe owners, adding to a feeling of embarrassment.^{26,4} A lack of suitable facilities is one of the reasons given by mothers when asked what had discouraged them from breastfeeding in public.¹

Practical/physical issues that act as a deterrent to breastfeeding

It is the practical and physical issues with breastfeeding that emerge most quickly. The most common^{1,3} are:

- Difficulties with the baby suckling effectively, or apparently rejecting the breast.
- Mothers not being aware that colostrum is sufficient for babies in the first few days before their milk 'comes in' around days 2–4. As a result, they perceive early

milk to be insufficient, which can challenge expectations that breastfeeding is 'natural'.^{10,12}

- Uncertainty over controlling consumption; mothers are frequently concerned that the baby may not be getting enough milk.
- The belief that pain and soreness of breasts or nipples is inevitable or will get better over time without help. Often due to either a lack of skilled support, or reluctance to access it, pain remains unresolved and mothers tend to persevere for long periods leading to dissatisfaction with the breastfeeding experience and/or cessation.³⁸

The difficulties that many parents experience in preparing for and facing parenthood are particularly marked in the first few days and weeks. Giving birth can be exhausting, as can becoming a new mother, however a woman chooses to feed her baby. The current culture of infant formula and bottle feeding can be seen as a coping strategy to alleviate feelings of confusion and stress.³⁸ Parents may set out with a plan for a regular feeding pattern with the expectation that it will ensure that babies sleep through the night. However, in practice such plans may not materialise and mothers feel sleep deprived¹⁹ and are not able to 'return to normal'. Many families expect to get back to normal activity quickly, but find that this is impossible. For a struggling mother, the perception of formula feeding as less physically demanding seems to offer the possibility of finding more energy for other activities.^{20,36}

“I was going to try it, but when I had the baby, because I didn’t have the energy, I gave him a bottle. My boyfriend wanted me to try it. I don’t know what it was, I just didn’t have the energy. My Auntie breastfed and I’m really close to her but I just never did it.”

Mother, bottle feeder²⁰

- Because breastfeeding is the sole responsibility of the mother, some mothers feared their partner would feel left out if they breastfed. For others, the main concern was to be able to share the practicalities of feeding to reduce tiredness.

Having a baby is going to be so much hard work, especially to start with, so it would take a bit of pressure off me to bottle feed; everyone can help out.”

16–19, 1st pregnancy, Newcastle⁴

- In some cases, mothers may feel that the baby is gaining insufficient weight according to their ‘red book’³⁶ (Personal Child Health Record) reinforced by misconceptions that breastmilk alone is insufficient nourishment. This may also be compounded by uncertainties over how much breastmilk the baby is actually getting.³⁶ These negative experiences tend to override the knowledge that ‘breast is best’,²¹ especially amongst parents who, as we have seen, may be sceptical about the real value of the benefits in the first place.
- For mothers from lower socio-economic groups who qualify for Healthy Start vouchers there is not seen to be any financial incentive not to bottle feed – although they can exchange their vouchers for food, most (83%) exchange them for infant formula.^{1,40}
- Lack of support and help is a major issue. Research indicates that up to one third of breastfeeding mothers experience problems in the first few weeks.¹ Those who did not receive some kind of help and support were

likely to have stopped within two weeks. This issue is described in more detail in the “help and support” section below.

- At 4–6 months after birth, the need to return to work becomes a significant issue in continuing breastfeeding,¹ although it can emerge as early as 2–3 months after birth. Only a small proportion of mothers report facilities at work for breastfeeding or expressing milk, generally associated with a workplace crèche. Unsurprisingly, the evidence suggests that mothers are more likely to combine breastfeeding with work where these facilities are available, and are also more likely to be breastfeeding at 5 or 6 months. However, between 2000 and 2005, the number of mothers mentioning returning to work as a factor in giving up breastfeeding had declined. This is consistent with longer maternity leave entitlement and suggests increasing support from employers.¹
- Medical problems mothers may encounter include tongue tie, thrush, mastitis, milk intolerance or colic. If misdiagnosed, or not properly or successfully treated, then these are sometimes quoted by mothers as a reason to discontinue breastfeeding.³⁶

All of these factors are interconnected. Evidence suggests that if one aspect of breastfeeding ‘goes wrong’, then other reasons often emerge as part of a cumulative effect on the mother’s decision-making, and any underlying pessimism felt antenatally will be borne out.^{13,38}

Emotional factors affecting breastfeeding

Although the factors affecting breastfeeding are interconnected and overlapping,¹³ it is quite usual for many mothers to either anticipate or experience emotional concerns about breastfeeding, generally associated with loss of identity, guilt and lack of confidence. There is clear evidence to show that mothers with higher

self-esteem and a more positive attitude are more likely to continue breastfeeding.¹³ Research also reveals a number of observations that enable us to understand the concerns of less confident mothers:

- In the initial stages of motherhood the pressure to breastfeed as “the best thing for your baby” can result in a fear of failure.²⁰ Mothers feel an obligation to start to breastfeed, but have little expectation of continuing for anything other than a short space of time.⁴ Some may agree to it just to avoid the pressure.³⁶

They say breast is best, so just trying is doing the best for your baby. So long as you try it, you've done your bit.”

Mum, 24, C2DE³⁶

- Despite acknowledgement that it is gradually becoming more publicly acceptable, mothers may still be embarrassed about breastfeeding in public, especially if they don't know the techniques to avoid exposing themselves.^{4,20} They may feel awkward about breastfeeding at home in front of male family members or relatives.⁴
- Some women are simply squeamish about the mechanics of breastfeeding.²⁰

Many mothers worry about the loss of personal identity, especially sexual identity, resulting from the constant focus on the child.³ Research suggests that this is a common experience and, whilst not always strong enough to result in a mother discontinuing breastfeeding, it provides an added stress. Mothers may feel a number of sentiments:

- They may resent being ‘tied’ to the baby, and feel that breastfeeding is a barrier to their social activities. For many, this is as simple as going out with friends;

for some it will include a desire to resume drinking,⁴ smoking or drug-taking.^{11,19}

- There is a natural desire to want to regain their figure and lose weight they may have gained during pregnancy.³ (Some mothers are unaware that breastfeeding can help with this.)
- They may also feel that the act of breastfeeding itself makes them less attractive,³⁵ and some worry that breastfeeding will ruin their breasts.⁴
- In addition, mothers with other children in the family may feel guilty about the amount of focus on the newborn infant, and see giving up breastfeeding as a means of freeing up more time for the rest of the family.¹¹

Help and support

Research has shown that if a mother feels supported and encouraged to continue breastfeeding by all of her family and health professionals then she is considerably more likely (as much as 37 times more according to one study¹⁷) still to be breastfeeding at 6 weeks.¹⁷ Analysis of a range of studies shows that skilled breastfeeding support, at all stages from pregnancy to postnatal care in the community, can enhance breastfeeding duration. This support can be effective when provided by either peers or professionals¹⁷ but a combined approach is strongest, starting in pregnancy, with peer support in hospital and with contact starting 48 hours after hospital discharge (or home birth).¹⁸

Qualitative evidence suggests that the lack of a supportive environment is the primary factor in a decision not to breastfeed amongst younger mothers from lower socio-demographic groups.⁴ It is this group who, in the absence of role

models or peers, depend most on professional services. The consensus that emerges from research amongst both mothers and health professionals is that these services are delivered inconsistently. The main observations are:

- During pregnancy, the regular appointments, check-ups and antenatal classes give mothers-to-be a wide range of advice and opportunities to ask questions. Studies show that the quality of this advice can vary greatly, with some, even amongst health professionals, based on outdated information.^{3,5} In addition, mothers have to contend with much conflicting information from sources as diverse as friends and relatives, the press, advertising and the internet.
- In the immediate aftermath of birth, mothers can feel overwhelmed and isolated, and they are focused on simply getting through each day.¹⁶ Advice tends to come from midwives or nurses, but support at this stage can be erratic, due to resource pressures in maternity wards and in the community.¹⁹ Health professionals may have little time to develop a relationship with the mother at a time when reassurance and help can be critical to establishing breastfeeding successfully.^{3,5}
- Some mothers are discharged early from hospital without a supervised first feed.³ Often a visit from the midwife or health visitor comes too late.³
- A common feeling amongst mothers is that they are 'left to fend for themselves' after early support. In the opinion of many health professionals, postnatal visits are not seen as a priority, and health visitors may visit only 'targeted' families, leaving mothers to take the initiative to visit a GP or health clinic.³ A fear of revealing their perceived failure to breastfeed may lead to some mothers being reluctant to seek help.^{12,14,15}

- For many mothers it is about understanding the experience of breastfeeding – the ups and the downs – rather than just the benefits. In research, many cite NCT classes as doing this better than equivalent NHS classes.³⁶

Postnatal support networks and services are highly valued, but sometimes seen as not catering, or suitable, for everyone.³ In research conducted for Wandsworth PCT,³⁶ breastfeeding counsellors proved to be very popular. Peer supporters and midwives could suffer from the comparison, and be seen as a 'second choice'.

Young mums' groups met with considerable approval, whilst breastfeeding cafes evoked a mixed response. Most who had attended were positive, but others were more sceptical about the idea.

"It's just too breasty! I don't want to go and meet other Mums just to talk about breastfeeding."

Mum, Wandsworth³⁶

Parents tend to be focused on the immediate, and may be short on memory, patience and attention span.³ The timing of information is therefore critical, and needs to be measured – mothers frequently claim to feel 'bombarded' at discharge from hospital.³⁶

In summary, research suggests that the more support and help that is made available, the better, but it is critical that the right information is provided at the right time, and that where possible the wider body of influencers should be targeted, not just the mother.

Ethnic minority mothers

There is only a limited amount of research available on which to call for breastfeeding insights specific to mothers from ethnic minorities. Outlined below is the main evidence available. (There is considerably more information, albeit from one primary source, on the introduction of solid foods in ethnic minority families. This information is contained in section 5, "Introduction of solid foods".)

- Women from black and minority ethnic cultures are more likely than white women to initiate breastfeeding. Over 90% of mothers who classified themselves as Asian, Black, or Chinese or other ethnic origin initially breastfed compared with 74% of white mothers.¹
- Qualitative research from 2008 also supports this finding that a high proportion of ethnic minority mothers breastfeed, many until their babies are at least 3 months old.⁹ This seems to be explained either by the fact that it was the norm in the mother's country of origin (where the mother was born abroad), or by the knowledge of government guidelines. A small minority had moved from breast to formula milk when the baby was 4–6 weeks old.
- A 2003 study indicated that South Asian mothers were more likely than white mothers to have received their advice from other family members, with very few attending antenatal classes where breastfeeding was discussed.²⁷ Most South Asian mothers reported that they received plenty of practical and emotional support from their families. Grandmothers in particular tended to be very supportive of breastfeeding mothers.²⁷
- A particular reluctance amongst South Asian mothers to breastfeed in public is an important barrier to exclusive breastfeeding.⁹
- Black mothers, African or Caribbean, tend to have the highest breastfeeding rates of all, with 87% still breastfeeding at 6 weeks.¹
- Evidence also suggests that length of residency in the UK can have a detrimental effect on breastfeeding behaviour. For every additional 5 years living in the UK, immigrant mothers from ethnic minorities were 5% less likely to breastfeed for at least 4 months.³⁹

Younger first time mothers

Whilst they share many of the common barriers to breastfeeding with other mothers, younger first time mothers tend to be the most resistant to breastfeeding. For one thing they are much more likely to come from a bottle feeding culture, with some claiming never to have seen a baby being breastfed.³⁵ Other issues stem in part from a lack of confidence, and in part from a desire to maintain as much of their prenatal lifestyle as possible.^{4,19} These include:

- a lack of peers, or other positive role models;
- a desire to allow their partner and other family members to assist with feeding;
- wanting to maintain their freedom to leave the house and enjoy themselves;
- concern about sagging breasts making them less sexually attractive;
- fear that breastfeeding will be difficult and painful, and that they are likely to get it wrong;
- squeamishness;
- embarrassment about breastfeeding in public, or in front of male family members.

“I think less people breastfeed now. The choice is there and obviously the easiest option is to make the bottle.”

16–19, DE, Birmingham³⁵

These issues tend to be particularly prevalent in younger mothers from lower socio-economic groups, and those with low educational attainment.⁴

For many very young mothers, problems that they may be facing or feeling as individuals are further compounded by parenthood:³⁶

- They are concerned about being stigmatised, intimidated or patronised by authority figures.
- Lack of money is a real barrier to many activities, such as getting around.
- They may feel that they have nowhere to go.

“You need to realise that having a baby is not the most important thing in their (teenage mothers) lives. Usually they’ve got so many other pressing issues.”

Health Visitor, Wandsworth³⁶

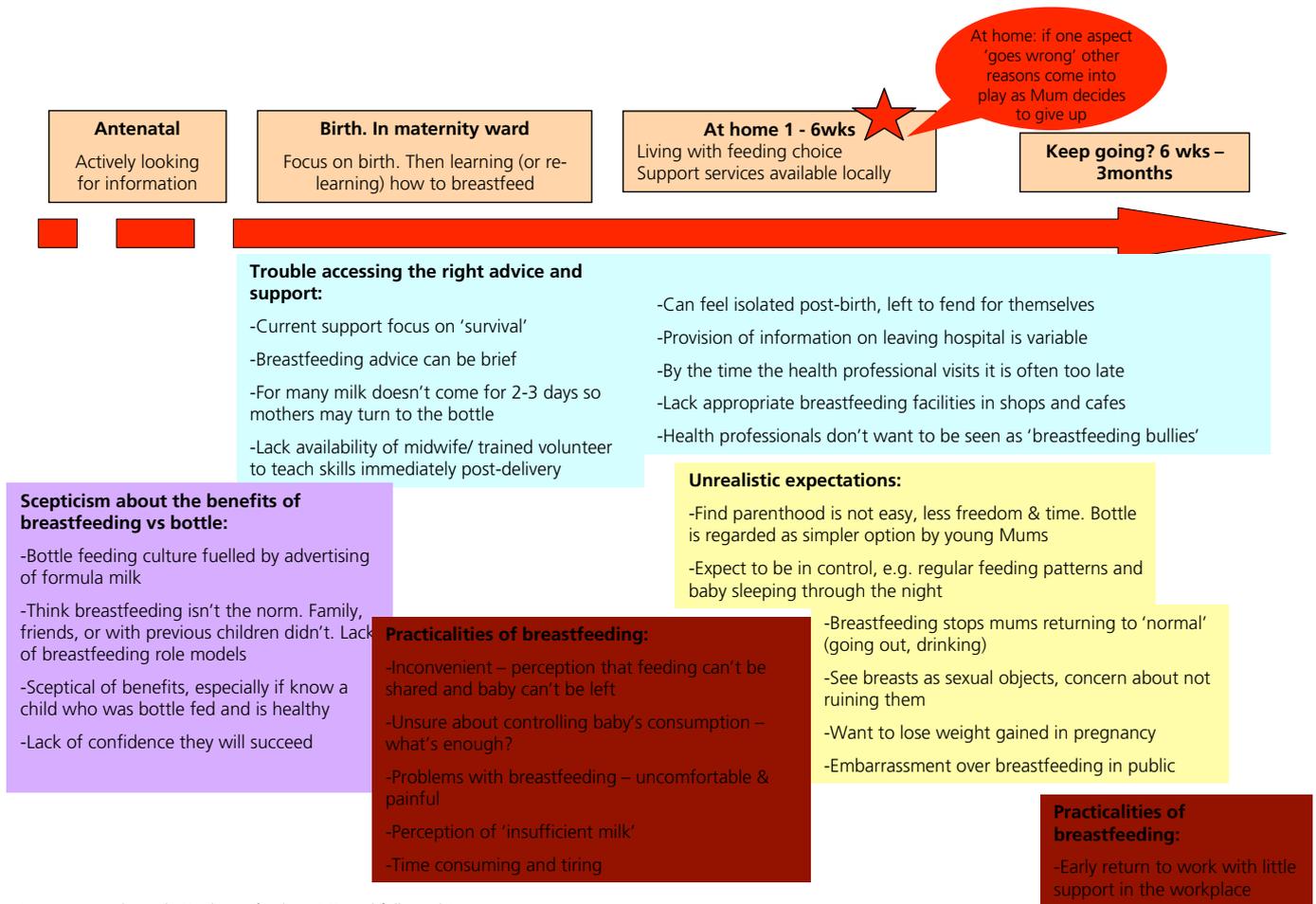
Breastfeeding summary

We have seen that almost all mothers are aware of the “breast is best” message, but much less sure about why, beyond a vague understanding that it is good for the baby’s health. Getting across the facts behind the slogan may well help to encourage some mothers to favour breastfeeding, and increase their commitment to continuing with it. An empathetic approach, designed to help mothers understand the experience, rather than just the benefits, of breastfeeding, is likely to meet with greater approval from mothers, and greater success. We can also see that first time mothers rapidly find themselves unprepared for the ups and downs of parenthood. Common refrains are that “I wish I had asked before” and that “I didn’t know what to ask”, suggesting that more advice given earlier would have been welcomed by many mothers, even if not used straight away. It is clear that few mothers experience problem-free breastfeeding. As well as the range of practical and medical problems, coming to terms with the social and emotional pressures that parenthood in general, and breastfeeding in particular, bring, is difficult for many mothers. The continuation of breastfeeding in the face of these problems depends on a combination of the commitment of the mother and the speed and value of the help and support they receive. Of all the actions that could be taken to increase breastfeeding continuation, the one most likely to yield positive results is to ensure that mothers, especially unconfident, younger mothers, feel supported, empathised with, able to ask for help and aware of where they can find it.



Insights and barriers to breastfeeding are summarised in figure 2, below.

FIG 2. SUMMARY OF BARRIERS TO BREASTFEEDING



Source: 'Wandsworth PCT breastfeeding' COI and full insight report



5. INTRODUCING SOLID FOODS

In this section we concentrate on exploring the various influences and levels of understanding around the replacement of milk (either breastmilk or infant formula) with solid foods, from 3 months to around 8 months. This is the period of feeding 'first food', which most mothers would regard as what is meant by 'weaning' or the introduction of solid foods.⁷

Initiation

For the majority of mothers, the introduction of solid foods begins according to the needs – perceived or otherwise – of the child, rather than following the guideline. These 'triggers' may include the following:

- *Hunger* is probably the most common reason for initiation. Parents will look for signs that they feel indicate that milk on its own is insufficient. In practice this can be almost any sign of discomfort, such as continual crying and regurgitation of milk. Sleeplessness, either at night or during a normal daytime nap, will also often be perceived as hunger.^{7,21}
- *Energy needs*. As the baby begins to move around or is "strong enough to roll" then the perception is that energy, over and above that which milk can provide, is required.
- *Baby size*. The size of the infant may also come into play – larger babies are seen to need more energy to live, and smaller babies seen to need more to grow.⁷ Boys are sometimes perceived as needing more energy than girls.⁷
- *Stimulation*. The baby may appear to show interest in food, such as watching its parents eat, dribbling,

chewing or grabbing at food; or it may appear to be going off milk – drinking less, showing less interest.

- *Previous experience*. Mothers who have weaned a previous infant early are extremely unlikely to change behaviour with a subsequent child.⁷

Although mostly observed by the parents directly, the trigger signals can also be interpreted by influencers such as relatives or health professionals. This is discussed below. Improvements in the baby's behaviour – such as stopping crying or sleeping better – will tend to be seen as validation for the change to the feeding regime.⁷

Early introduction of solid food

In addition to the physical signs exhibited by the infant, many parents see other benefits to introducing solids earlier rather than later. The first group of benefits can be described as 'emotional', and include the following:

- Being a 'good Mum', willing to do things first. Making food or providing food to an infant is, for some mothers, an assertion of their own value and role.⁷
- *Something new*. A milestone for the baby, the next phase and the beginning of the end of breastfeeding, with which the mother may well have become bored.⁷
- *Involving others*. Particularly for breastfeeding mothers, who are keen to share the burden of feeding with partners and relatives, and distance themselves from the baby.⁷

There are also felt to be practical benefits:

- The sooner feeding begins, the more time there is to 'get it right'. For first time mothers in particular, there is no pressure if feeding doesn't immediately go well.⁷
- Younger babies are regarded as easier to feed than older babies, less easily distracted and less likely to make a mess, and at a better age for the development of good eating manners.⁷

They need the nutrition of food by 6 months, so you can't start then as it takes time to get into it."

Mum 34, B, Twickenham⁷

The 6 month threshold

Research indicates clearly that most mothers are aware of the recommendation that babies should be exclusively milk fed for around 6 months.^{7,8} However, there is also a high degree of awareness of the previous guidelines of 4 and 3 months, and there are a number of reasons that mothers cite that militate against adhering to the 6 month guideline.

- There is little understanding of why the guideline is 6 months. Issues such as the development of the infant's digestive system, and the higher risk of allergies and infections, are not widely understood, even by many health professionals.^{3,7} The perception is that the guideline is 'adaptable'.
- Health professionals view it as an ideal and in practice focus on preventing the very early introduction of solid foods. Few of them promote the 6 month guideline vigorously, balancing it against the need to retain a trusted relationship with the parent.⁷

- The food labels themselves indicate the appropriate age as "from 4 months". The baby aisle of the supermarket operates a powerful influence and commercial and branded items appear to offer the simplest route through the minefield of early parenting, with parents gravitating towards the leaflets and baby products for food instruction.⁷

They wouldn't be allowed to put 4 months on a jar if you can't feed it to a baby."
19 year old mother, E, 9 months old boy, London⁷

- Parents are unaware of any negative effects experienced by friends, relatives or peers who have introduced solids earlier than 6 months.⁷

A minority of parents introduce solid foods at 6 months or later. This may be because they understand the reasons for the guidelines, or simply trust the professional advice given either by the NHS or their health visitor. In most cases, they are confident in their ability to manage the baby's behaviour with milk alone. For some, there may be an emotional desire to 'keep baby as baby' (the opposite of the desire to reach the solid food milestone as early as possible).⁷

The role of influencers

Parents, especially first time parents, are continually seeking advice and information. In the case of family members who have experienced parenthood themselves, this advice invariably works towards the earlier introduction of solids, based on their own experience from a time when the introduction of solid foods at 3–4 months was the norm. In many cases they will interpret actions from the baby as denoting a need for solid foods when the parents may

not have done so. Grandmothers in particular frequently exert a strong influence over parents.⁷

“My Mum said to me, “You were weaned at 10 weeks so I don’t know what they’re talking about; you should be giving her food by now” (16 weeks).”

Mother, 32, B, Twickenham⁷

Health visitors are also cited as commonly suggesting the introduction of solid foods before 6 months, a fact acknowledged by many health visitors themselves.

Six months is not realistic for every family; they won’t listen if you say that.”

Health visitor, Herts⁷

Healthy eating

Research indicates that most mothers are broadly aware of the foods to be wary of when introducing solids, such as salt, sugar, undercooked eggs and nuts. They are also conscious of the need to gradually introduce a variety of foods, as well as natural fresh foods. However, mothers can struggle to implement this in practice.⁷

- The longer-term health consideration will inevitably lose out to the shorter-term need to get the baby to eat, even when parents know they need to be persistent.
- Babies who consistently dominate their own eating patterns are seen as ‘fussy’ eaters, and they will often be fed preferred foods, have their meals served separately, or be bribed with treats.
- In many families, the child’s food is modelled on the adults’ food, who may not themselves eat healthily.

Introduction of solid foods in ethnic minority families

Mothers from ethnic minority families share many of the same influences on their decision-making as the mainstream audience. There is broad awareness of the 6 month threshold and a similar lack of understanding of the reasons why. However, cultural issues also emerge, principally around the timing of the introduction of first foods, the type of foods introduced, and the strong role of family influencers. Health visitors frequently feel that they lack adequate resources to deal with many of the issues that arise in ethnic minority communities.⁹

In a qualitative study from 2008⁹ the majority of ethnic minority mothers had introduced foods early, from as soon as 2 months. This was largely for the same reasons as the mainstream audience – a perceived hunger signal from the baby – but cultural issues were also an influencing factor.

- Some mothers from all ethnic groups thickened breastmilk or formula milk for babies over 2 months old. Black African and Black Caribbean mothers generally used cornmeal, maize and the commercial cereal Cerelac (remembered as a common food in their country of origin). South Asian mothers were often adding rusks or semolina. This was in response to a general belief that milk alone was insufficiently satisfying, often prompted by grandparents.

He just wouldn’t settle down after a feed, so Mum told me to put some cornmeal in his milk. He completely settled down after that and didn’t wake up during the night.”

Black Caribbean mother, Birmingham

- Mothers were keen to introduce cultural foods as soon as possible. These are seen as healthier – they were fresh and home cooked – but also necessary to develop a taste and palate for cultural foods.⁹

“In our culture we give our food from day one. You want them to get used to your food.”

Black Caribbean mother, London⁹

- The belief in the importance of a ‘big baby’ remains strong within traditional South Asian and Black communities, especially amongst grandparents.⁹ Big babies are considered to be healthy and strong, and in need of more nourishment but this can also lead to overfeeding, for example with no reduction in milk as solids are introduced.⁹

“My mother-in-law tried to give the baby milk after his food. She just didn’t understand that he doesn’t need that much food.”

Pakistani mother, Bradford⁹

Health visitors see this as a continuing problem.

That attitude that big babies are healthy babies, this is really hard to shift.”

Health visitor, Birmingham⁹

The research also pointed to significant differences between ethnic groups.

- Bangladeshi, Pakistani and Indian mothers would commonly hand feed, even when the baby was capable of grasping and feeding themselves. Reasons behind this included the fact that some ethnic foods, such as roti and daal, are not easy for a baby to pick up. It was also seen as a means of controlling feeding, sometimes resulting in overfeeding. There is an emotional dimension to hand feeding. Grandmothers

in particular see it as a demonstration of their love for their grandchildren.⁹ Many mothers use commercial foods initially, believing them to be of high quality and, to a degree, a sign of status. They were also more likely to feed sweeter foods, as part of the belief that babies need calories to grow.

- Black African and Black Caribbean mothers more usually begin with savoury foods, such as stews and soups. Many Black mothers were keen to introduce ‘hard’ foods, such as plantains and yams, as soon as they could.⁹

Healthy eating presents many of the same problems for ethnic minority mothers as it does for mainstream mothers. Although broadly aware of the elements of a healthy infant diet, there are several barriers to putting these into practice:

- Mothers often lacked specific knowledge, such as what foods were appropriate for specific stages, and didn’t always understand why some foods needed to be avoided.⁹
- In the most traditional households, it was frequently impossible to prevent the overfeeding of male children by family members.⁹ Although more common in South Asian households, it also applied to some Black African and Black Caribbean mothers.

“My mother-in-law is obsessed with food. She wants to feed the baby every time she cries. She doesn’t understand that the baby could cry for another reason. She just wants to stuff the baby.”

Indian mother, London⁹

- A lack of confidence in deciding what is the right food could result in the baby being given foods which are known to be safe and which the child has eaten before, leading to a more limited diet.⁹

- As for the mainstream audience, infants' diets were sometimes modelled on inappropriate adult food, including processed foods, spicy foods and takeaways.⁹

The research emphasised the central role of female family members:

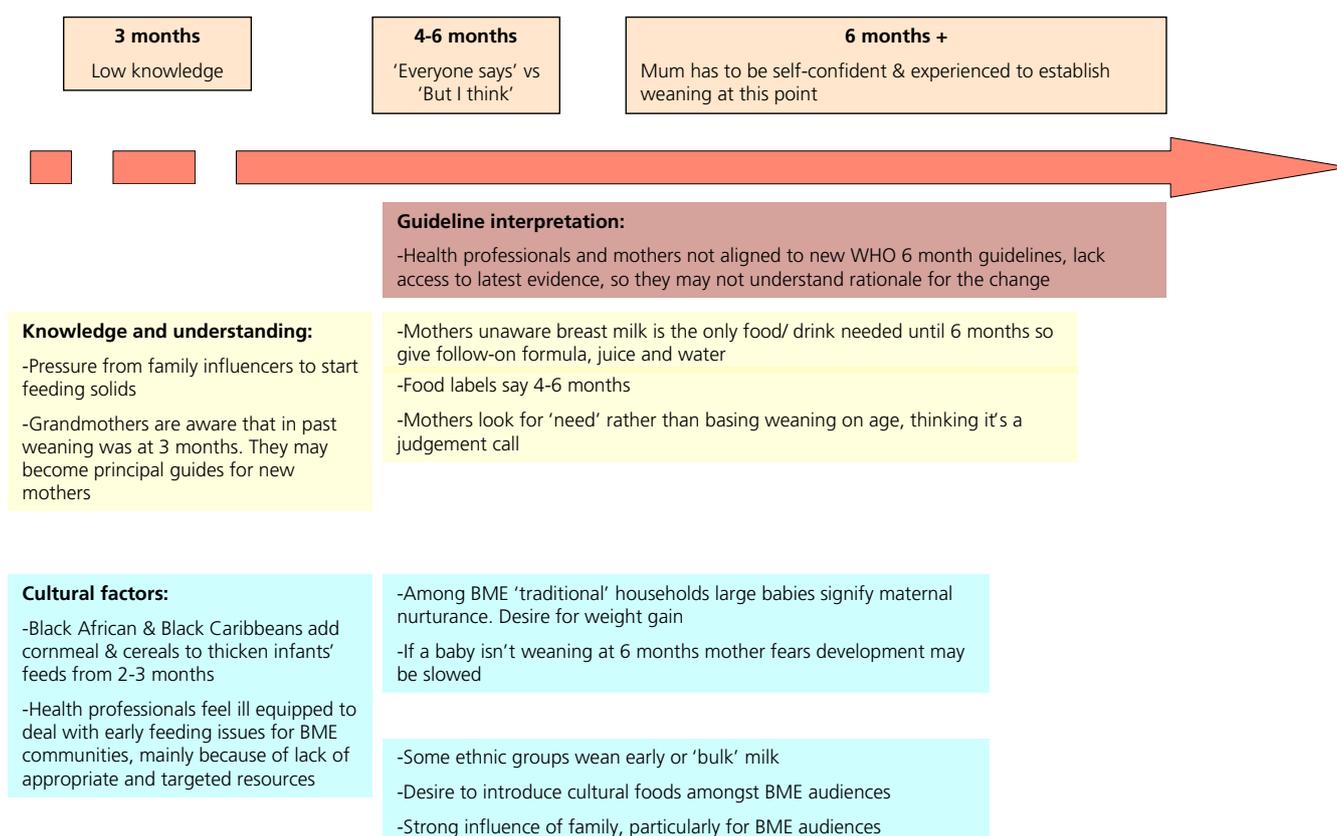
- Amongst Bangladeshi and Pakistani mothers, their mothers-in-law tended to be the primary source of information and advice, whereas for Black African women, it tended to be their own mothers. Mothers were sometimes targeted by health professionals, and those who attended baby clinics and weaning sessions appeared to be open to help and advice, and interested in improving their babies' diets, in spite of pressure from older female family members to follow different practices.

Introduction of solid foods – summary

As we have seen, mothers gather their information on introducing solid foods from a variety of sources. Currently this information is inconsistent. In the face of apparently conflicting advice and information cues from sources such as peers, relatives, the supermarket and health professionals, parents tend to see the introduction of solid foods at 6 months as 'delayed weaning', and only the most confident of mothers are likely to adhere to it. However, the desire for clear and concise information *and* explanation represents an opportunity for authoritative communication that parents from both mainstream and ethnic minority audiences will welcome.

The factors encouraging early introduction of solid foods are summarised in figure 3, below.

FIG 3. INFLUENCES OF EARLY INTRODUCTION OF SOLID FOODS



Source: Define 'Revisiting early feeding research' for COI & DH, Nov 08



6. RECOMMENDATIONS AND INTERVENTIONS

Meeting policy targets requires that we:

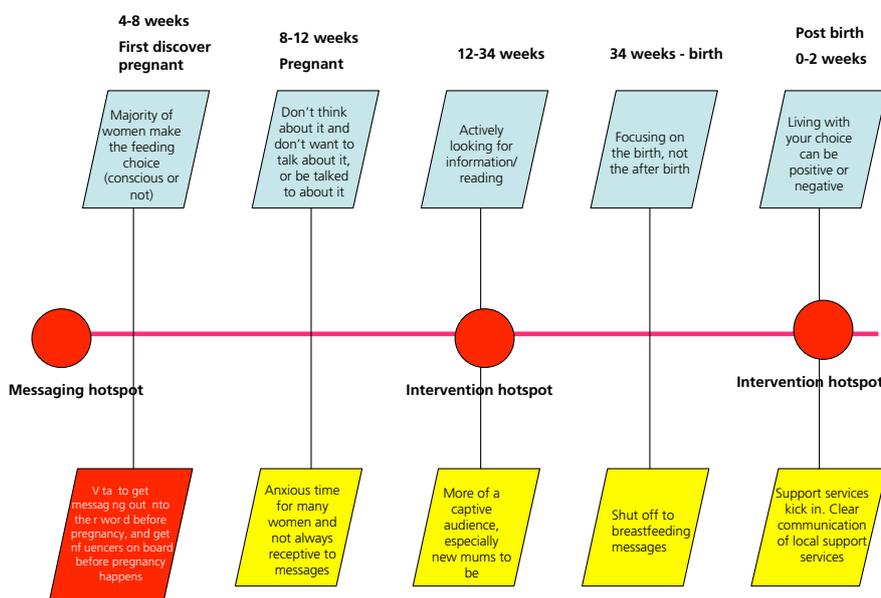
- create a mainstream view that breastfeeding is normal;
- sustain and support breastfeeding prevalence beyond the trial;
- ensure that the “solid foods are introduced around 6 months” message is communicated and explained clearly.

Some general conclusions and guiding principles can be drawn from the insights identified in this summary.

- There is a need to provide and tailor appropriate information for different stages of pregnancy. This is described in figure 4, below.
- Information alone is insufficient – personal support and advice from health professionals are required to ensure that knowledge is embedded and transformed into behaviour.

- Early influence is crucial, even during pre-pregnancy
- Ongoing support needs to continue from birth, with mothers able to access timely help and support easily.
- Fathers and other family influencers, especially grandmothers, are key audiences. They may be highly influential when targeting harder to reach mothers, especially mothers who are younger, of lower educational achievement, or disadvantaged.
- Healthcare professionals are central deliverers of information and guidance to parents-to-be and parents. Communications campaigns targeting healthcare professionals with consistent information will ensure that they understand and support the evidence and approach.
- Cohesive and imaginative communications, in which fathers, peers and professionals as well as mothers are targeted under a single promotional campaign, have been shown to deliver significant improvements in both breastfeeding initiation and continuation.^{14,15}

FIG 4. FEEDING DECISION TIMELINE



Source: Breastfeeding Research Insight, Great Yarmouth and Waveney, Corporate Culture, 2009.



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