The importance of recognising the social and political context surrounding infant feeding

Response to the SACN consultation: Draft feeding in the first year of life

Ruth Stirton[1]

[1] *Sussex Law School, University of Sussex,* r.stirton@sussex.ac.uk

Introduction

I am a Lecturer in Healthcare Law at the University of Sussex. I am working on infant feeding policy, and currently researching the impact that policy has on the lives of individual people. I am asking women in the UK to write about their experiences of infant feeding. The project is called My Infant Feeding Journey, and further details can be found at the project's facebook page: www.facebook.com/myinfantfeedingjourney and the project website: http://www.sussex.ac.uk/law/-research/groups/slish/researchprojects. This submission draws on a preliminary assessment of the themes raised in the 45 stories that I have received to date, detailed analysis of five stories and the wider literature in this area.

This submission is in response to the recommendations in paragraphs 533-534 of the *Draft Feeding in the First Year of Life Report*:

> 533. The evidence reviewed for this report strengthens current guidance to breastfeed exclusively for around the first six months of the infant's life and to continue breastfeeding throughout the first year. This makes an important contribution to infant and maternal health.
> 534. Greater focus should be given to reducing attrition rates and supporting women who make the informed choice to breastfeed for as long as possible, given the rapid decline in the proportion of women breastfeeding over the first few weeks of an infant's life. Increasing the proportion of women who continue to breastfeed or express breast milk beyond six months of age would yield additional health benefits.

This submission focuses on the implications of policy making in this area. Work by Lisa Smyth explores the impact on women of target-driven health-promotion messages. She shows that:

> ...breastfeeding promotion itself has become an important part of these wider contexts, in ways which can produce resentment, prolonged ill health, depression and anxiety, and consequently damage rather than enhance the relationship between mother and baby.[1]

The SACN terms of reference were to consider the scientific evidence underpinning recommendations around infant and young child feeding, and "to make recommendations for policy...". Given the complex social and political context in this field, it is fundamental to rely on a broad understanding of "science" which includes the social sciences. Making effective policy recommendations presupposes an understanding of the mechanisms of behaviour change. These mechanisms are well understood in

[1] L Smyth, "The social politics of breastfeeding: Norms, situations and policy implications" (2012) 6 Ethics and Social Welfare 182-194, 192

the social sciences.[2] Sam Sieber's work explores the counterproductive effects that occur when policy interventions fail to take into account the environment in which they take place.

The simple conclusion that the science supports exclusive breastfeeding, therefore the policy recommendation is to "reduce attrition rates" fails to take into account the impact on women of the policy itself. It fails to take into account the possibility that women stop breastfeeding, at least in part, *because* of the policy's "target-driven"[3] approach. This was shown to be a specific problem in relation to infant feeding in Smyth's work, and in work by Elizabeth Murphy in 2004[4] and Ellie Lee in 2007[5].

If the aim of the SACN is to make recommendations that will result in more women in the UK breastfeeding, then it is important that those recommendations will help women to initiate and continue breastfeeding. The recommendations must go beyond the assumption that women will respond to being told that science says they must breastfeed their babies. The recommendations must be informed by social science research on behaviour modification, and must recognise and deal sensitively with the complex social and political context surround infant feeding choices.

In the following, I highlight some of my respondents' experiences of the rhetoric around infant feeding and the support system available to them. Quotes are taken from stories from participants in My Infant Feeding Journey. Names have been changed where participants have requested anonymity.

1 "Attrition rates" and the rhetoric of infant feeding

The rhetoric surrounding infant feeding is highly problematic. Words which may appear objective to non-mothers can have a negative impact on individual women, and may further trigger a great deal of hurt and resentment, and potentially mental health issues.[6] In this case, the use of the phrase "attrition rates" carries significant negative connotations and squarely places the blame on the mother for stopping breastfeeding. It implies that it is the mother's responsibility to continue to breastfeed, and that she has failed when she stops breastfeeding and changes to another method of infant feeding.

There are particular problems with the "breast is best" rhetoric. This is not restricted to the specific phrase. It is applicable to all the phrasing which implies that breast is best. Whether intended by the author or not, this particular phraseology causes feelings of being judged in mothers who were not able to breastfeed. This further compounds the feelings of guilt and shame about their experiences, which also stay with some women for very long periods of time. At the least intrusive, Kirsty explained that:

> I have never felt able to tell anyone that actually I didn't want to breast feed — society, the media, family, friends and professionals all support breast is best meaning my concerns made me ashamed.

The problem for Kirsty was that the "breast is best" rhetoric meant she felt unable to discuss her concerns with midwives antenatally. These concerns were also in the context of difficulties conceiving and ultimately a complex and traumatic birth. At the very least she would have been better prepared for the experience of breastfeeding if she had been able to work through her concerns before she was thrust into the reality of establishing feeding after an emergency c-section with a baby in SCBU.

Both Paula and Megan highlight a different problem of the "breast is best" rhetoric:

> It seems to me that it is utterly absurd and frankly CRUEL to put women under SO much pressure to breastfeed ("Breast is best. Breast is best.") and then to effectively withdraw all support from them when they try to. Midwives just aren't expert enough in

[2] S Sieber, *Fatal Remedies: The Ironies of Social Intervention* (1981, Springer); P Grabosky, "Counterproductive Regulation" (1995) 23 International Journal of the Sociology of Law 347-369

[3] Smyth, p182

[4] E Murphy, "Anticipatory Accounts" (2004) 27 Symbolic Interaction 129-154

[5] E Lee, "Health, Morality, and Infant Feeding: British mothers' experiences of formula use in the early weeks" (2007) 29 Sociology of Health and Illness 1075-1090

[6] For a detailed discussion of the impact of language, see F Woollard and L Porter, "Breastfeeding and defeasible duties to benefit" (2017) 43 Journal of Medical Ethics 515-518. See also work by L Smyth, above.

many cases. And if the mothers fail? Well, we're repeatedly told by the media that you only have yourself to blame if your child develops allergies, obesity, low intelligence and even leukaemia. [Paula]

There seems to be a huge discrepancy between the emphasis on breastfeeding within both antenatal and postnatal provision, as an actually morally valuable 'decision', versus the lack of the actual level of personalised, free support within the NHS, that is in fact required to enable so many of those who want to breastfeed to do so. The gap between these two things seems to transform by default into blame, ultimately, on the mother – who has 'decided' to formula feed (morally reprehensible); who has 'failed' to work hard enough to get the breast established (lazy, selfish). [Megan]

This problem is not only limited to the rhetoric. There is a feedback circle from the rhetoric heard antenatally to the experiences of support after birth. The majority of my respondents wanted to breastfeed. They were motivated to breastfeed. But when the crunch time came, in the "post-natal fug" [Kirsty] many were not able to access the support necessary to help them establish and continue their breastfeeding journey. The problem with telling women that "breast is best" is that this is perceived to be pressuring them to breastfeed (whether intended to or not), and it is coupled with an inadequate support system which sets them up to fail.

2 The problem of support

Every one of my respondents had difficulties at at early stage in their infant feeding journey. This included women who had breastfed before, and women who had a relatively uncomplicated breastfeeding journey. Everyone initiated breastfeeding, and they asked for help to deal with latching difficulties, or pain, or cracked nipples, for example. What followed in most cases was a confusing mess of different advice from different people with varying success. In some cases, the mother received the right support from the right person at the right time. This transformed her feeding experience from one of pain to one of joy. Megan's experience is telling:

It was towards the end of the first week post birth, and in the midst of all this, that I saw a wonderful community midwife who was giving us one of the standard post-partum home visit check-ups (I remember him particularly because he was the only male midwife I saw) who recommended that I try and get an appointment with one of his colleagues who ran supporting sessions on breastfeeding, 1-2-1, at a children's centre which was around a 20 minute bus ride away.

He gave me her number, and I left a message. She phoned me back a day or so later and gave me an appointment for a few days hence. I am fairly sure my daughter was about two weeks old at that first appointment. The midwife sat with me and my partner for nearly an hour, in a consulting room upstairs at the children's centre, where she held her regular clinic, and we worked on the latch. She told me my baby's palate was quite deep, and pointed out that my breasts naturally pointed slightly outwards – which none of the many other midwives I'd had fleeting support from had had the time or, I think, the specific training to spot. Both of these features required, she suggested, a particular shift in the angle I should hold the baby at, and in the technique for latching her on. She gave me practical advice on what foods to eat to boost milk supply – a bowl of pasta every day, she said, for rapidly absorbed carbs, and fenugreek supplements (tested in the US apparently though not proven through UK based research as yet). She told me to express on both breasts in between every feed, to stimulate the milk production further, and enable me to take a break from breast feeding when nipples were sore, when I could use the expressed milk instead if I wanted to.

My partner and I refer to this midwife now as an 'angel' (and we are both fundamentally atheists, but if ever we met one, she was it). She saw us for about an hour at a time, every other day, for two weeks. During this period, I figured out the latch. My milk supply shot

> up. I was still mix feeding – but there appeared to be no issue with nipple confusion, after all the horror stories I had imbibed in previous months. I was reducing the amount of formula we were using, and the number of feeds that were on the bottle, and getting the breast feeding established.
> After two weeks she signed us off, and from that point on our feeding experience was pretty great.

Once she was able to find it, Megan received good support from someone who was properly trained, and was able to spend time working with Megan and giving personalised support. This 'angel' saved Megan's breastfeeding journey. Other women did not get this experience. Instead, they were seen by a series of health professionals who were not able to offer advice beyond "well the latch looks fine, keep going" [Paula]. Some women report comments and practices by health professionals that directly damaged their feeding relationships.

> They kept me and him overnight, back on the ward where he'd been born where the midwives came in to 'observe' us feeding (not great for oxytocin) and would say things like "how you must feel ... being back here two weeks later ... I can't imagine how bad you must feel". [Paula]

> On the second night the health care assistant queried the fact I was trying to breast feed at all given that Toby was now five days old and I hadn't managed it, she also stated that she had two other mothers to help during the night so could not be long. [Kirsty]

These negative comments from health professionals are not limited to the newborn phase:

> At his one year check I was told that he was malnourished because he was having too much milk and not enough food — he wasn't but for a while I would sit feeding him in the night with tears streaming down my face because I thought I was doing to wrong thing by the professionals but I knew I was doing the right thing for my baby. [Kirsty]

The power that health professionals have in relation to infant feeding in tremendous. Issues surrounding feeding stay with women for a long time. Kirsty's son is around 3 now, and:

> I went to the Dr last week to ask for blood tests for excessive tiredness and aching in my bones – she asked if I had breast fed, I simply said no and she then proceeded to tell me how good breast feeding is and that it helps the body recover from pregnancy. I'm pretty sure that ship has sailed but thanks for making me feel like a failure again!

The issue around support is that it must be done sensitively. Women are often extremely fragile after giving birth, they are not properly prepared for the experience of breastfeeding, and those that want to breastfeed have to fight for the support they need to help them. Doing all of this during the immediate post-natal phase makes it particularly challenging. As Kirsty's story also shows, there is a danger that women who do not want to breastfeed feel unable to discuss this with healthcare professionals because of the way that breastfeeding is talked about in healthcare practice. It is essential that women feel able to have calm, dispassionate conversations with healthcare professionals about their infant feeding choices, without the fear of judgement.

This submission so far gives a rather bleak picture of infant feeding experiences in the UK context. Of course it is not awful and bleak for every woman. There are many examples of women who went through horrendous difficulties, and came out the other side. There are also stories from women who had relatively straightforward experiences of establishing breastfeeding. Paula writes:

> I fed my daughter to 15 months. From about 6 months on it became a dreamy, gorgeous experience. Tired? Hungry? Sad? Bump her head? Whatever - my magical boobs could cure it! It had been worth the very literal blood, sweat and tears.

It is important therefore that we do not ignore the joy that mothers experience, but it is essential to recognise that many women do not reach the joyful phase because they are unsupported during the "blood, sweat and tears" around establishing breastfeeding. This lack of support is a policy decision in its own right, and it has a devastating impact on mothers and babies in the UK.

Conclusion and additional recommendations

Making policy recommendations in this area is a complex and sensitive business. The adherence to the "target-driven health-promotion"[7] approach is damaging to the ultimate goal of providing that mothers and babies are looked after in the way that most enhances their wellbeing. The impact of the current social and political context of infant feeding in the UK may make it difficult to convincingly argue that exclusive breastfeeding is best for the mother and baby, notwithstanding the scientific evidence in favour of exclusive breastfeeding. This is an uncomfortable point to make. If the SACN want to make recommendations that will increase the numbers of babies being breastfed in the UK, then the recommendations must move beyond the target-driven approach. They must be grounded in the extensive social science research on changing behaviour and take into account the social and political context in which women are being told to breastfeed.

I have two recommendations for the final report into this area, which I think will strengthen the overall tenor of the conclusions.

1. Include a statement that the social and political context around infant feeding in the UK has a dramatic impact on women's experiences in this area. This evidence was not explicitly considered by the SACN, but that future recommendations must use a broader concept of science and take this literature into account.

2. Make a recommendation directly to Public Health England, and the Department of Health that a wide ranging enquiry should be made into women's experiences of infant feeding policy in the UK, and that the terms of reference for that enquiry include making recommendations for new policy, which should be informed by the huge social science literature on regulating human behaviour.

[7] Smyth, above