Value for Money

nsmc
leading behaviour change

Breast is best for love or money: user guide

About The NSMC

We are The NSMC, the international centre of behaviour change expertise.

We're dedicated to making change happen that improves people's lives.

We do this by supporting organisations to design cost-effective programmes that help people adopt and sustain positive behaviours – those that improve their lives. Eating healthily, being more active and saving energy are just some of the positive changes we have helped our clients achieve.

As well as programme support and strategic advice, we also provide professionals with the skills and resources to design and deliver their own cost-effective behaviour change programmes.

Originally set up by the UK Government, we now have a global reach, applying social marketing skills, knowledge and experience from around the world to solve behavioural challenges.

Contents

Introduction

The NSMC has worked with leading health economists and NICE to develop a suite of online tools. These will help practitioners and commissioners to calculate the value for money of their social marketing and behaviour change programmes. The breastfeeding tool is one of those developed.

The tools have two important uses:

1. To help plan for proposed social marketing and behaviour change programmes by estimating the likelihood that they will provide value for money.

2. To evaluate whether social marketing and behaviour change interventions were value for money upon completion.

The tools go beyond costs to the NHS, to include wider societal costs.

Using the tool

These notes are intended to help users and provide links to the relevant evidence used to prepare the tool. You may also wish to refer to the *Glossary* and NICE Intervention Costing Guidelines available on The NSMC's website.

Most users may choose only to use the *Data Input* and *Results* pages, but advanced users can also make use of other pages to update the tool as further evidence becomes available.

This tool applies to social marketing and programmes to support behaviour change for mothers. This includes peer support, local media campaigns and targeted community action as recommended by NICE and UNICEF[1].

The tool is not intended to be applied to hospital-based interventions to promote higher breastfeeding initiation rates, but to community based interventions designed to encourage the continuation of breastfeeding to six to eight weeks and beyond.

It is also important to note at the outset that social marketing or other programmes in this field must recognise the needs of mothers who may be unable to continue to breastfeed for a variety of reasons. Undue pressure rather than empowerment would be counterproductive to the wellbeing of such mothers.

While there are guides to good practice in this field, some of which are listed in the final section of this guide, in preparing this tool the author was unable to find specific research evidence or clear consensus estimates on many aspects of the impact of breastfeeding. Full health impacts and cost implications for the NHS, the cost of not breastfeeding to mothers and the relative impact of initiation as compared to continuation of breastfeeding were unavailable.

In order to address this, the tool provides preliminary estimates of these factors in the hope that experts in the field will be able to adjust the tool as more evidence and clear consensus emerges. It is hoped that the work being undertaken at York University (due to report in June 2012), may improve these initial estimates.

In the meantime, the outcomes produced by this tool should be treated with caution and the data supporting the tool will need to be improved and updated as we learn more about the impacts of support for breastfeeding.

Data input

Completing the data input sheet

The following section provides details of what data should be included in each section of the tool, and also what evidence has been used in its development.

Intervention costs

The tool can be used to evaluate costs and outcomes over one year or over a shorter period. For longer term projects, it will allocate one-off planning and start-up costs over the lifetime of the intervention project.

Detailed advice on what costs should be included is provided in the NICE costing guidelines available on The NSMC website (www.thensmc.com/resources/vfm/guidelines).

It is important to note that while a health risk reduction may have lifetime impacts for mothers and children. This is reflected in the way health impacts are measured as risks generated or reduced by the continuation of breastfeeding over a six month period.

The tool does not forecast future behaviour nor does it discount future impacts. Below are further details of what should be included in each field.

1. In Table 1 please enter the:

a) Cost of planning and developing the intervention

The separation between intervention costs and NHS costs assumes that behaviour change support may be funded by a PCT, Clinical Commissioning Group or Local Authority separately from the provision of services such as Maternity and Health Visitor services.

Furthermore, aspects of the intervention might be funded by employers or give rise to costs to others. Throughout this analysis, all costs are mutually exclusive, so avoid any double-counting except for incentives, which are both a cost to the intervention and a negative cost (a payment) to mothers.

Development and capital costs will be spread over the life of the intervention. These should include costs relating to the design and application of a specific behaviour change project for targeted mothers. General needs assessment, such as a JSNA, should be excluded.

Research conducted during the scoping phase for the specific project, should be included.

b) Annual revenue costs per year of supporting the intervention

Annual revenue costs should include direct management and staff time. It should also include consumables such as leaflets, incentives (if applicable) and rent of facilities and equipment (if relevant).

Where the project, or elements of it, is contracted to private or voluntary sector providers, VAT should be excluded (because this is a transfer to government). All other costs relating to one year of full operation and management of the contract should be included.

"Avoid any double-counting except for incentives"

Full public sector staff costs and on-costs should be included but not unavoidable central overheads, e.g. management and premises costs that are not changed by the project.

2. In the field entitled 'What are the…' (Table 1), the following costs should be considered and included when relevant:

a) NHS set up costs including capital, training, and reorganisation
Capital or other one-off setup costs such as retraining and reorganising staff and services should be spread over the life of the project.

Setup costs may include staff time for Midwives or Health Visitors and other staff advising or conducting the development of the project.

b) NHS annual revenue costs per year
These costs may include Midwifery staff or Health Visitor time working with the behaviour change project, plus the additional costs generated by increased uptake of services (e.g. extra mothers seeking help).

The ongoing cost of midwifery support for mothers, as recommended by the Baby Friendly Initiative, should not be included as this is a part of the basic service level required.

The cost of premises and/or equipment should be included only if they are specific to the project and would otherwise not be required; or if they are in such high demand that other valuable activities must be curtailed.

3. Over how many years should development and training costs be spread?
Capital costs and project development costs will be spread over the life of the intervention. You need to select the number of years that the intervention will benefit from the setup costs.

4. Add in any other public sector costs, if relevant:

a) Project development and capital expenditure
If the intervention requires input by other public sector providers such as social workers, community support workers or teachers, set up costs for their training may be relevant. However, it is important to consider only additional costs above those already incurred by services in the normal course of their work and training.

b) Annual revenue costs per year
Annual costs to other public sector services should be included here. It is important to consider only additional costs above those already incurred by such services in the normal course of their work.

5. Charges, costs or incentive payments to clients (if relevant)
If mothers pay for items or services, the aggregate annual cost should be recorded as a social cost rather than a project cost.

Payments to mothers as incentives or subsidies should be included as both an element of project cost and as a payment to clients. The aggregate level of all incentives or subsidies for a year should be entered as a negative number.

6. Employer costs (if relevant)

a) Project development and capital expenditure
If employers (or other partners such as supermarkets or food producers) contribute to the cost of an intervention, this should be recorded as a social cost and this should reduce the public sector intervention costs.

In this box, enter any capital or start up costs to employers.

b) Annual revenue costs per year
Annual costs to employers should be entered here if relevant.

Table 2: Clients and Outcomes
Enter information on the number and characteristics of clients and outcomes planned or achieved. The tool can be used to assess planned interventions or to evaluate current projects.

1) Enter the total number of mothers contacted per year
These should be mothers who have initiated breast-feeding and need support and encouragement to continue to six weeks and beyond. This should include all mothers contacted, not just those who continued breastfeeding to six weeks.

The number of contacts and outcomes may include indirect (community multiplier) contacts i.e. other mothers whose behaviour is changed only if evidence is available.

2) Percentage of mothers who achieved the behaviour change target
This is your target for the intervention or a record of the level of breastfeeding actually achieved amongst the mothers contacted. It should be higher than the expected level generated by the age and education of the mothers targeted (and any adjustment you make). Otherwise, the intervention will be shown as having a negative effect.

3) Percentage of mothers in the most disadvantaged 20% or in a specially disadvantaged group
This provides a measure of the extent to which the intervention is targeted at disadvantaged groups. If there is no bias towards disadvantage, 20 per cent of respondents would be expected to be in this category. Disadvantage may be measured by the Index of Multiple Deprivation (IMD) scores (see Glossary) or other ways determined locally.

4) Behaviour Indicator for success in encouraging breastfeeding
This is the indicator for the target you are trying to achieve. Enter the name of the indicator you are using e.g. breastfeeding at six to eight weeks.

5) Typical Age of mothers targeted
The typical age of mothers and level of education data are used to generate the expected level of breastfeeding at six weeks. This is based on the National Infant Feeding Survey of 2005.

6) Select the typical age of mothers targeted and numbers completed their full time education
These data are used to generate the expected level of breastfeeding at initiation. They use formulae reflecting how the expected breastfeeding initiation and continuation rates vary with the age and education level of mothers.

These formulae may be improved as behaviour changes and better evidence becomes available. They are based on the evidence of the National Infant Feeding Survey of 2005 and can be viewed at the Impacts page.

If you do not have age and education data for the mothers targeted or if you have not targeted the intervention in this way (e.g. if you are targeting mothers from a specific ethnic minority), you may need to refer to the NIFS or generate your own specific baseline survey data of a comparable group of mothers. This will allow you to generate an estimate of the number of mothers who would be breastfeeding at six weeks without the intervention.

To enter the value you find, simply chose central values for age and education here and then adjust to the value you find from the survey in the adjustment box at question 8 below.

7) Expected level of breastfeeding at 6-8 weeks given age and education of targeted mothers
This is the percentage of mothers contacted who would be expected to continue breastfeeding to six weeks given their typical age and level of education you identified. You can adjust this if there are special circumstances that justify this or if you have specific survey data. This figure will change as you adjust it and a warning note will be generated if the target rate for your intervention is below the level that would have been expected without intervention (as this would generate a nonsense negative impact).

The calculation of the expected level of breastfeeding at initiation (six weeks and six months), is based on the figures reported in the Infant Feeding Survey of 2005[2]. Survey results for the UK showed a clear association between the age and education of mothers and prevalence of breastfeeding such that, for mothers:

- Age under 20: at birth 55 per cent, at six weeks 14 per cent and at six months seven per cent
- Age 20 to 24: at birth 66 per cent, at six weeks 31 per cent and at six months 12 per cent
- Age 25 to 29: at birth 76 per cent, at six weeks 47 per cent and at six months 31per cent
- Age 30+: at birth 84 per cent, at six weeks 60 per cent and at six months 36 per cent
- Educated up to 16: at birth 61 per cent, at six weeks 27 per cent and at six months 12 per cent
- Educated up to 18: at birth 73 per cent, at six weeks 42 per cent and at six months 20 per cent
- Educated beyond 18: at birth 90 per cent, at six weeks 68 per cent and at six months 27 per cent
- UK average: at birth 76 per cent, at six weeks 48 per cent and at six months 25 per cent
- English average: at birth 78 per cent, at six weeks 50 per cent and at six months 26 per cent

To model this accurately would require an analysis of the combined effect of the two variables on breastfeeding (technically called the coefficient of multiple determination). It is possible to approximate to this, assuming that age predominates over education level so that only a third of the impact of education level is taken into account. For the purpose of this tool, the following approximation was used to generate expected breastfeeding rates (BF).

- BF at Initiation =78 -21 (if under 20) or -10 (if 20-24 or -0 (if 25-29) or +11 (if over 30) -5 (if educated to 16) -1 (if educated to 16-18) +4.7(if educated beyond 18)
- BF at 6 weeks=50 -34 (if under 20) or- 17 (if 20-24) or -1 (if 25-29) or +12 (if over 30) -7 (if educated to 16) -2 (if educated to 16-18) + 6.7 (if educated beyond 18)
- BF at 6 months=26 -18 (if under 20) or-13 (if 20-24) or +6 (if 25-29) or+11 (if over 30) -4.3 (if educated to 16) -1.7 (if educated to 16-18) +0.7 (if educated beyond 18)

"It will be important to demonstrate why the expected figure should be adjusted for the mothers you are targeting"

8) If there are reasons to expect higher or lower breastfeeding rates at 6-8 weeks add or subtract 1-10%

If you have survey data of breastfeeding rates before and after intervention, or if you are dealing with a target group of mothers with known different rates of take-up (lower or higher than indicated by national statistical analysis of their age and the age at which they completed education), you can adjust the figures by adding or subtracting from the expected rate by entering an adjustment here.

It will be important to demonstrate why the expected figure should be adjusted for the mothers you are targeting.

9) Which year's prices are you using?

The tool allows you to choose which year's prices you wish to work in (known as the base year for the analysis). Generally, this should be the first full year of the intervention for which you have outcome data.

You have to input costs in terms of that year's prices, so you may have to adjust for inflation between the year in which the intervention was planned and developed and the base year of the intervention. This is included to prevent the tool from becoming out of date.

10) Enter your weight for disadvantage if you wish to

This allows you to give an extra value to impacts on disadvantaged and hard-to-reach groups. A value between 0 and 100 per cent can be used (but enter zero if you do not wish to apply a weight) giving that percentage more value to interventions for disadvantaged people. The tool does this by simply adding an extra value to the percentage of clients in the most disadvantaged 20 per cent using IMD scores or in some other way you may define.

This means that, for example, if you chose a weight of 50 per cent and all the clients were in the most disadvantaged group, a value of the outcomes will be shown as 50 per cent more than the outcomes for a project which did not address disadvantaged

people. However, while this value is shown in the Results page it does not affect the main outcomes reported which are not weighted.

Giving an extra weight or 'utility value' to disadvantage is controversial. Department of Health policy is not to weight QALYs because everyone's health is equally valuable. However, it is arguable that addressing disadvantage is an important priority and thus of more value.

11) Enter the Reach of the intervention (optional)
The Reach of the project is a term used in the Health England Leading Prioritisation (HELP) scheme. If you want to apply their measure of the value placed on addressing equity and the priority of this project you may include a value here to represent the proportion of people who could be eligible for the intervention if it were extended nationwide.

There are about 450,000 new mothers and 605 births each year. This would be about one per cent of the population. A subgroup of mothers targeted (for example, young mothers) will be some proportion of one per cent (you do not need to be very precise).

12) Disadvantage Weight Generated by HELP
The results will also show the effect of weighting for disadvantage and a priority score from the HELP programme. This project surveyed the way 99 public health professionals prioritised projects it then developed a formula to model their values: (Utility) as a preference curve based on cost effectiveness (Cost per QALY, C), the reach of the project (what proportion of the population could benefit, R) and impact on disadvantage (percent of clients in most disadvantaged 20 per cent, D).

This tool derives a weight for disadvantage by substituting values from the current project in this formula. It is also replicates the utility score that would be given by the HELP formula.

$$Utility = e(-0.0000586x\ C + 0.0435987\ x\ R + 0.119895x\ D)$$

For a detailed explanation of this see: http://help.matrixknowledge.com.

You may choose to ignore these methods of weighting outcomes and treat disadvantage as a separate issue, as DH suggest. To do this you may wish to make use of the Health Inequalities Intervention toolkit available from the London Health Observatory at:
www.lho.org.uk/LHO_Topics/Analytic_Tools/HealthInequalitiesInterventionToolkit.aspx.

You may also wish to refer to the DH/DCFS guide to equity assessment in breastfeeding, *Commissioning local breastfeeding support services: Equity Impact Assessment* at
www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_106502.pdf.

Interpreting the results

The results page reports a wide range of outcome measures that were requested by various local and national users during the piloting of these tools.

You may decide that some of these are not relevant to your needs; it is up to you to choose which measures are most useful for your purposes. You need to take into account the decision-makers priorities and the strength of the available evidence which varies for different outcome measures.

Table 1: Net Local Public Sector Cost per Lifetime Health Gain

This table provides a range of outcome and value for money measures requested by users.

Sensitivity analysis

In general it is more reasonable to report a range of possible outcomes rather than just reporting a single central estimate. The sensitivity analysis shows a high and low value range arising from different assumptions about behaviour, the extent of persistence and the rate of health recovery (see *Glossary*).

Sensitivity analysis in this tool does not consider the uncertainty in underlying estimates of health gain and costs which are treated as consensus estimates. Users can also vary the input data and other factors to generate other sensitivity analyses and to examine 'what if?' questions.

Health impact

The estimate of the potential health risk gain from improved breastfeeding is taken from WHO estimate of the burden of disease for High Income European countries attributable to 'sub optimal breastfeeding' in 2004[3].

This estimate has been applied to estimates of total UK DALYs derive from Green and Miles (2007)[4] and adjusted by population for England. The value shown represents the estimated current value of the lifetime reduction in health risk arising from the project. It is important to note that the model estimates health impacts in terms of lifetime health risks.

It is not possible to provide a timescale for all resulting impacts on health or costs but because these factors are discounted to the base year, the equivalent health impact and cost burden can be estimated. Most of the health gain relates to immediate impacts on the health of the baby.

However, there are also lifetime risks to the child and the mother, captured by the Burden of Disease assessment. These risks are generated at the time of breastfeeding rather than as a result of continued behaviour thus there is no need to project long term behaviour or discount the benefits as they are already taken into account.

QALYs impacts

Quality Adjusted Life Years (QALYs) are the most commonly used measure of health gain in the UK.

Outcomes are reported in these terms by converting from Disability Life Years (DALYs) to Quality Adjusted Life Years (QALYs) using a conversion factor of 1/.705 appropriate for age five and duration of illness of six months. This is taken from Sassi (2006)[5]. While not perfect, this is the best available estimate. Further research could improve this conversion factor.

Net cost to the public sector
This is the summary of public sector costs per year shown in the Data page resulting from the costs you reported.

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This is the summary of public sector costs per year shown in the Data page resulting from the costs you reported.

Cost per QALY

This is derived by dividing QALY gain by public sector cost. This is shown as a central estimate and high and low values.

Cost Savings to the NHS

The NICE costing report Postnatal care: routine postnatal care of women and their babies from 2006 indicates that a ten per cent 'improvement in breastfeeding' would result in savings to the NHS of some £5.6 million in 2005/2006 prices or £6.4 million in 2007/2008 prices arising from reductions in Otitis Media, Gastroenteritis, Asthma and reduced costs to the NHS of formula and teats.

Breastfeeding is also considered to reduce other infections, reduce the likelihood of obesity and developmental problems for children. It is also seen to reduce ovarian and breast cancer risks for mothers.

These cost impacts were not considered so these estimates are likely to be conservative. For all these reasons, this tool can only provide a broad indications of potential cost impacts. Research is needed to improve these estimates and communicate them to local teams.

A ten per cent improvement would increase breastfeeding initiation and months of breastfeeding from the current level which is 78 per cent of the potential maximum for initiation and 34 per cent for continuation.

If it is assumed that initiation produces 25 per cent of cost savings and 75 per cent of savings arise from continuation, a ten per cent improvement would equate to 7.8x0.25%+3.4x0.75%= 4.5% of the potential costs arising from sub optimal breastfeeding in respect of Otitis Media, Gastroenteritis and Asthma. If this equates to £6.4 million savings, then the hypothetical full cost impact from these causes would be £6,400,00/0.045= £142,200,000.

The tool uses this as a baseline for estimating the impact of improving breastfeeding rates.

Value for money

The value for money can be estimated as a cost per health risk gain as a £ per QALY and as a cost net of NHS savings per QALY.

Cost savings per mother contacted
This is simply the estimate of NHS cost savings divided by the number of mothers contacted as entered in the Data input page.

Cost saving per additional mother who continues to breastfeed
This is cost savings to the NHS per additional mother who meets the six to eight week indicator. This is given as a range.

Total cost savings to mothers
This shows the cost savings to mothers of not needing to buy sterilisers and formula.

This depends upon the estimated cost of these items which depends on whether they simply delay purchasing equipment and simply save the cost of formula or do not use bottle feed at any stage. As this is very dependent on local circumstances, this estimate can be changed in the data input page.

Cost savings to mothers per mother contacted
This simply divides total savings to mothers by the number contacted.

Cost savings to mothers per additional mother who continues to breastfeed
This is the savings that a mother would make by continuing to breastfeed to six weeks.

Cost savings to mothers per mother contacted
This simply divides total estimated savings to mothers by the number of mothers contacted.

QALY per additional mother breastfeeding to 6 weeks
This is the health risk gain in QALYs for each mother achieving the six-week indicator target.

Odds ratio
This is a commonly used measure of the effectiveness of an intervention.

It is a measure of the probability of a mother achieving the target with the support of the intervention compared with her chances of achieving it without support. In other words, it measures how effective the intervention is in changing behaviour.

Table 2 a: Societal Impact in terms of the human value of QALY gains

The Human value
This table applies a social value to the improvement in health risks for mothers and babies gained as a result of the intervention. It can be regarded as the cost of pain and grief caused by death and illness.

In discussion with Robert Anderson, Economic Adviser to Department of Health in 2011, it has been pointed out that the Department of Health's official position is that a QALY can be valued at £60,000 as derived from Department of Transport willingness to pay survey of 1991/1992 (Highways Economics Note 1) in respect of fatal accidents updated to 2007 values. However, in practice, as NHS expenditure is limited, it is accepted that the marginal productivity of the NHS is four QALYs per £100,000 and for this reason a value of £25,000 can be applied.

While the Department of Health continue to refer to a survey carried out in 1991/1992 for the Department of Transport, it should be noted that this willingness to pay survey focused on traffic accident outcomes. These include early death, which has a particular emotional value.

Another estimate of the value of a QALY gain can be based on the upper estimate of the value placed on non-fatal injury derived from the same survey, which gives an estimate of £27,000. This is close to the figure used by the National Institute of Health and Clinical Excellence of £30,000. Thus for this purpose a value of £25,000 in 2007/2008 updated for inflation in incomes has been used, but this can be varied if required.

There is limited evidence to suggest that sub-optimal breastfeeding may be linked to increased risk of infant deaths[6]. However this is a complex issue with multiple causes and for this reason the tool does not include an estimate of deaths from this cause. This

could be done if there were expert consensus on this issue.

Weighting for Disadvantage, Your Weights
The tool permits you to add an extra value to the percentage of clients in the most disadvantaged 20 per cent using IMD scores or in some other way you may define. This is simply the result of applying the weight or extra value you selected to the percentage of targeted mothers who are disadvantaged.

Health England Leading Prioritisation (HELP) weighting and utility score
This applies the HELP formula for assessing the utility or priority of the intervention. To put this in context, you should consult the website introduced in the *Data Input* section of this guide.

Table 2b: Societal Impact: Net Impact on Stakeholders
This estimates the financial impact on the NHS and mothers in terms of savings. In this case, savings are not a particularly important goal for either mothers or the NHS as breastfeeding is primarily concerned with improving health and wellbeing.

Table 2c: Societal Impact: Social Return on Investment
The calculation of Social Return on Investment (SROI) does not take into consideration any weighting applied to QALYs as above.

SROI is calculated in two ways, as the net impact on all stakeholders divided by the total cost to stake-holders and as the value of the QALYs increased by the intervention valued at £25,000 in 2007.

For more details of the SROI approach, see the *Glossary* and related links from The NSMC website.

"The tool permits you to add an extra value to the percentage of clients in the most disadvantaged 20 per cent"

Other pages of the tool

The other pages of the tool can be explored by users but these are basically working sheets. All references have been referred to in the *Data input* and *Results* sections of this guide.

Impacts

The Impacts page of the tool provides a mechanism for comparing the expected rate of breastfeeding and the rate targeted or achieved as a result of the intervention. This uses the formulae explained at point 8 of the *Data Input* guide.

The *Impacts* page also provides high and low scenarios, varying the expected rate of breastfeeding to provide a range of results reflecting the uncertainty in these estimates. These data can be improved, but it is suggested that this is a task for advanced users.

National Data

The National Data page of the tool brings together relevant data as introduced elsewhere in this guide. It provides estimates of the health impacts of breastfeeding in terms of DALYs and QALYs.

While this page can be updated, again we suggest this should be done by advanced users to update the tool as further evidence becomes available.

Look Up Tables

This page provides details of the inflation factors used in the tool. It can be updated but again it is suggested that this should only be attempted by advanced users. Inflation estimates for NHS costs are taken from official projections. Costs to mothers are assumed to rise at four per cent per year.

Other sources of help and guidance

It is important to stress that this tool is intended to support evaluation alongside the application of qualitative guidance. It is not intended to replace or supplant any such guides.

- Commissioning local breastfeeding support services DH/ DCFS at www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_106497.pdf
- Commissioning local breastfeeding support services: Equity Impact Assessment www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_106502.pdf
- ChiMat Child and Maternal Health Observatory which includes a suite of on-line tools for presenting key data and indicators, undertaking needs assessment, capacity planning and more www.chimat.org.uk
- Dyson, L. Renfrew, M. McFadden, A. McCormick, F. Herbert G and Thomas J,2005 Promotion of breastfeeding initiation and duration: Evidence into practice briefing, NICE

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Any remaining errors and omissions remain the responsibility of the author.

References

1. NICE Promotion of Breastfeeding Initiation and Duration: Evidence into Practice Briefing of 2006 and the UNICEF Baby Friendly Initiative which stresses the importance of community support for breast-feeding to six months and sets out a seven point plan to support this, including a range of behaviour change actions. It also describes many advantages of continuation of breastfeeding

2. This showed that in England 78 per cent of mothers initiated breastfeeding, but breastfeeding prevalence fell to 62 per cent after two weeks, 50 per cent of mothers were breastfeeding at six weeks and 26 per cent were still breastfeeding at six months but in virtually all cases this was not exclusive (i.e. the babies were given other food)

3. Published in the report by Colin Mathers, Gretchen Stevens and Maya Mascarenhas of 2009 *Global Health Risks: mortality and burden on disease attributable to selected risk factors*

4. Green, S. and Miles, R. (2007) *The Burden of Disease and Illness in the UK* Oxford Healthcare Associates

5. See the U.S. Department of Health and Human Services, *The Surgeon General's Call to Action to Support Breastfeeding*. Washington, DC: U.S. Department of Health and Human Services, Office of the Surgeon General; 2011, table 1

6. Franco Sassi *Calculating QALYs, comparing QALY and DALY calculations* Health Policy and Planning. (2006) 21 (5): 402-408

Further support from The NSMC

Practical advice and support

If you need some fresh thinking to improve your results, we'll carry out an **expert review** of your current approach to behaviour change. Practical recommendations on how to plan, manage, implement and evaluate your projects will ensure you're able to make progress.

Need help taking a behaviour change approach forward? We can develop a **behaviour change strategy** for your organisation – ensuring you're better placed to deliver effective future programmes.

We'll **support you through developing and managing** your project, with **mentoring** offered as and when you need it. Using our 'learning by doing' approach, we bring our tried and tested behaviour change planning process to your behavioural challenge.

To help make your project happen, we can also **bring your stakeholders together** and secure their involvement in achieving your objectives.

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Implementing an effective behaviour change project

Whatever your behavioural challenge, our experts' unrivalled experience in **delivering behaviour change programmes** will ensure it is addressed cost-effectively. Our network of consultants and suppliers means the **best specialists** will take your project forward.

Training and resources

To give you and your team the skills you need to run your own behaviour change projects, we provide both **classroom and e-learning training courses**. Devised and delivered by expert professionals, they draw on real experience of what works.

To help ensure your staff have the right tools and support when they need them, our **online planning guide and toolbox** provides everything they need to plan and implement a behaviour change programme. Tried and tested by a range of professionals and organisations, we can develop specialised versions, tailored to meet your organisational needs.

Supporting your organisation to keep your audiences at the heart of everything you do

We'll help you **develop and conduct research** that will give you a firm foundation for a behaviour change intervention. Our experts will help ensure you get the most from your research budget.

Our **One Stop Shop** database of unpublished market research gives you the means to quickly get to grips with your audience and behavioural challenge. It will enable you to focus your research and make the best use of your resources.

If you're pushed for time, our **data synthesis** service will package up the most relevant research into your challenge held on the One Stop Shop for you.

Providing best practice in behaviour change

ShowCase is our **online case study database** of behaviour change initiatives. From smoking to active travel, young people to health professionals, it highlights honest learning and success from the real world on a wide range of issues and audiences.

You can follow the journey project teams took and find detailed information on the 'how' of delivering a behaviour change intervention. Capitalise on others' achievements and learn from their mistakes and barriers, without having to commission expensive research.

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We have specialist experience of e**valuating behaviour change programmes** of all kinds. We'll help you demonstrate the impact of your projects to your stakeholders and capture lessons to improve future work

We'll also help you put together an **evaluation plan** that will ensure you collect the right information to effectively measure success and avoid knowledge gaps from the outset

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