

Exploring the politics and practices of breastfeeding

The WHO resolutions since the early 1980s reflect the complex array of psychological, political, social and economic factors associated with the desirable changes in breastfeeding policy and practice.

Contemporary examples exist in research, policy and practice, in different countries, which demonstrate continuation of the fundamental work carried out in the last two decades of the twentieth century.¹

INTRODUCTION

This chapter explores aspects of breastfeeding policy and practice, with particular emphasis on international codes of practice and other global policy statements that aim to influence and guide interest and action with regard to the protection, promotion and support of breastfeeding. International directives and statements are explored in the context of their impact on best practices in breastfeeding, at national and local levels.

DIFFERENT LEVELS OF POLITICAL INTEREST

International level

Political interest in breastfeeding at an international level is clearly in evidence from the 1980s onwards. Major organisations such as the World Health Organization (WHO), UNICEF and the World Health Assembly (WHA) played a key role in leading this international effort. This effort was sustained throughout the 1980s and early 1990s through a range of key meetings and the global dissemination of key policy statements and guidelines. The result was that a number of governments included the proactive promotion of breastfeeding as part of health policy.

National level

This international action was juxtaposed with a range of different national partnerships and practices designed to achieve change. The last three decades (1980–2010) have therefore demonstrated the potential benefits of collaborative professional, academic and research activities, which complemented the international effort. This collective effort with regard to breastfeeding in many countries, such as the UK and Australia, led to major new practice initiatives and the publication of seminal research work. Several robust and reliable systematic reviews have helped to consolidate the changes that have occurred over three decades.^{1–3} In addition, this concerted effort, supported by leading social and health organisations, has gently coerced governments, quasi-governmental organisations and other relevant bodies to engage with and support the breastfeeding debate.⁴

National examples exist in research, policy and practice in different countries. For example, in Hong Kong research studies demonstrate success in breastfeeding for 6 months or longer. In one study, a relatively small sample of 17 mothers revealed four themes as relevant to women's experiences:⁵

- 1 making the decision
- 2 maintaining family harmony
- 3 overcoming barriers
- 4 sustaining lactation.

Local level

As with international and national strategic policy, local policy and practice are strongly influenced by social, cultural, economic and political factors. The major practice change at local level is the top-down implementation of Baby-Friendly policies and practices in hospitals and in community healthcare facilities. Local political interest can also support bottom-up change, through many individualised examples of best practice. An example of this type of local interest can be found in the historical annuals of Dundee, in Scotland. This city has a long history of heavy (jute) and light (electronics) industry and of women contributing to the labour market. Records from the Dundee City Archives show that in 1906 the city established a special 'restaurant' for nursing mothers (mothers who were breastfeeding) where they could receive a 'nourishing' meal.⁶ It was concluded that the aim of this action was to keep nursing mothers working.

However, the contemporary challenge at all levels is summed up by the European Commission, which expressed concerns that despite the plethora of activity during the 1980s and 1990s, there remain significant difficulties in interpreting the available data, and that exclusivity and duration rates of breastfeeding in virtually every country worldwide, including EU countries, fall short of the recommended levels.⁷ In some EU countries, initiation rates are very low, but even in countries where these rates are relatively high, there is a significant fall during the first 6 months of breastfeeding, and the exclusive breastfeeding rate at 6 months is low throughout most of Europe.⁸ The last two decades therefore

appear to show a mixed picture of policy into action, and although awareness and commitment to breastfeeding are in evidence, the full impact of policy into practice has yet to be seen.

A major global challenge of the twenty-first century is that despite the mounting evidence that 'breast is best', breastfeeding is not the preferred choice of women, and breastfeeding rates remain relatively low worldwide, and are slow to rise. The reasons for this state of affairs are complex, they differ from one country to another, and they are strongly influenced by specific national and local factors. In the developed world, changing the attitudes of women is a necessity and remains a challenge, while in the developing world cause and effect can often be laid at the door of very basic issues, such as infection and illness in the mother, availability of clean water or, in some countries, scarcity of water.

INTERNATIONAL ACTIVITY: POLICY INTO PRACTICE, THE EARLY YEARS

The 33rd World Health Assembly

In October 1979 a four-day joint WHA and UNICEF meeting was held on 'Infant and Young Child Feeding.' This was attended by representatives of governments, the United Nations (UN), system and technical agencies, non-government organisations (NGOs) and the infant food industry, as well as by scientists working in this field. The main achievements and benefits of the 1979 meeting were threefold, namely to bring together a diverse mix of groups with a vested interest in breastfeeding, to ensure that breastfeeding was moved to the top of the global political agenda, and to raise awareness of the need for concerted action.

The 1979 WHA/UNICEF meeting agreed three key actions. First, it was agreed that there was an urgent need to review the existing legislation in different countries, with the specific purpose of better enabling and supporting women to breastfeed, especially working mothers. Secondly, it was recognised that strategies are required to strengthen the WHA's capacity to cooperate at the request of Member States in developing appropriate legislation. Thirdly, regular reporting to the WHA was agreed on the steps taken by the WHO to promote breastfeeding and to improve infant and young child feeding, as well as to evaluate the effects of all measures taken by the WHO and its Member States. This was to start from 1981 and to continue in even years thereafter.

An international marketing code (World Health Organization, 1981)

Two further major outcomes of the 1979 meeting were an agreement to develop an international code of conduct to guide countries on how infant formula should be promoted, supported and marketed, and a commitment from all countries to actively encourage and support breastfeeding. The following points represent the principal issues that all governments and other organisations attending the meeting agreed to for their respective countries:

- to address how breastfeeding can be encouraged and supported
- to promote and support appropriate weaning practices
- to strengthen education, training opportunities and methods of delivering appropriate information
- to promote the health and social status of women, so that women in turn are empowered in areas that relate to infant and young child feeding
- to implement appropriate marketing and distribution of breast milk substitutes
- to have in place a coherent food and nutrition policy that addresses the need for pregnant and lactating women to be adequately nourished.

The speed and direction of change moved the global community to produce the International Code of Marketing of Breast-Milk Substitutes, which contained a wide range of standards on the marketing of infant formula, and which aimed to curtail and address non-compliance. The Code was informed by previous international WHA resolutions, and was influenced by global concerns about the increase in infant mortality rates caused by the use of infant formula, especially in the developing world. The Code contained 10 provisions to guide the marketing of breast milk substitutes, as shown in Box 1.1.⁹

Box 1.1 Ten provisions of the International Code of Marketing of Breast-Milk Substitutes

- 1 No advertising of any of these products to the public.
- 2 No free samples to mothers.
- 3 No promotion of products in healthcare facilities, including no free supplies.
- 4 No company mothercraft nurses to advise mothers.
- 5 No gifts or personal samples to be given to health workers.
- 6 No words or pictures idealising artificial feeding, including pictures of infants, to be displayed on the labels of the products.
- 7 All information on artificial feeding, including the labels, should explain the benefits of breastfeeding, and the costs and hazards associated with artificial feeding.
- 8 Unsuitable products such as sweetened condensed milk should not be promoted for babies.
- 9 All products should be of a high quality.
- 10 Quality should take account of the climatic storage conditions of the country in which the products are used.

The 1981 Code aimed to control practices related to the international marketing of breast milk substitutes and thereby to protect all mothers and babies from inappropriate company practices in promoting breast milk substitutes.¹⁰ It aimed to ensure that women receive accurate information about breastfeeding,

but equally important, it aimed to ban the promotion of baby milks and other breast milk substitutes.

The Code was adopted and supported by law in many countries. Taylor found that in some countries the 1981 Code was given legal backing to increase compliance.¹¹ For example, in the 1980s the Hong Kong government prohibited advertisements of infant formula through the mass media.

Clear evidence of developments since the 1979 WHA/UNICEF meeting can be found in numerous policy statements from the early 1980s to the present day, from global organisations such as WHO and UNICEF. These statements demonstrate a clear commitment among powerful and influential organisations to the promotion, protection and support of breastfeeding. The key issues are covered in a number of WHA resolutions issued during the 1980s. These address infant nutrition and appropriate feeding practices for infants and young children, and include resolutions WHA33.32, WHA34.22, WHA35.26, WHA37.30, WHA39.28, WHA41.11, WHA43.3, WHA45.34, WHA46.7, WHA47.5 and WHA49.15. The WHA resolutions can be found at www.breastfeedingalberta.ca/resolutions.htm

The impact of the WHA resolutions

Responsibility for implementing the recommendations of the various WHA resolutions was recognised as needing to be shared between health services, health personnel, national governments and authorities, women's and other non-government organisations, the agencies of the UN and the infant food industry. These resolutions recognised that decisions about infant feeding made by a woman and her family raise a number of physical, social and emotional challenges. The global and national issues addressed in WHA resolutions during the 1980s and 1990s can be summarised as follows:

- the need for close consultation of all interested groups
- prompt action when required and on specifically targeted areas
- safe and adequate nutrition for infants and young children
- provision of adequate and relevant information
- active promotion of breastfeeding
- proper use of breast-milk substitutes
- attention to the education and training needs of healthcare professionals
- attention to policy and practice in relation to the adequate production, storage and distribution of breast-milk substitutes
- development of international quality standards
- promotion of the harmonious physical and psychosocial development of the child
- support for and encouragement of the use of local products in weaning
- a major review of advertising codes and legislation relating to the sales of baby foods
- adequate support for mothers who are working away from their homes during the lactation period

- intensification of activities in the field of health education, training and information about infant and young child feeding.

INTERNATIONAL ACTIVITY: POLICY INTO PRACTICE IN THE 1990s

Towards the end of the 1980s, policy guidelines moved closer to strategy implementation of best practice in breastfeeding at a local level, in the form of the Ten Steps identified as necessary to successful breastfeeding (*see* Box 1.2).¹² The Ten Steps confirmed the commitment of leading global health organisations to protecting, promoting and supporting breastfeeding, and aimed to guide maternity services in developing policy and practice in the key areas that support breastfeeding.

Box 1.2 Ten Steps to Successful Breastfeeding

- 1 Have a written breastfeeding policy that is routinely communicated to all healthcare staff.
- 2 Train all healthcare staff in the skills necessary to implement the breastfeeding policy.
- 3 Inform all pregnant women about the benefits and management of breastfeeding.
- 4 Help mothers to initiate breastfeeding soon after birth.
- 5 Show mothers how to breastfeed and how to maintain lactation even if they are separated from their babies.
- 6 Give newborn infants no food or drink other than breast milk, unless medically indicated.
- 7 Practise rooming in, allowing mothers and infants to remain together 24 hours a day.
- 8 Encourage breastfeeding on demand.
- 9 Give no artificial teats or dummies to breastfeeding infants.
- 10 Foster the establishment of breastfeeding support groups, and refer mothers to them on discharge from the hospital or clinic.

The Innocenti Declaration (1990)

The Ten Steps acted as a trigger to actions in other countries that were designed to protect, promote and support breastfeeding. The Innocenti Declaration was produced and adopted by participants at the Spedale degli Innocenti in Italy, in 1990. (The Spedale degli Innocenti or 'Hospital of the Innocents' is a children's orphanage in Florence that is dedicated to supporting and protecting poor children.)

The Innocenti document upholds the uniqueness of the breastfeeding process, and outlines the required changes and operational targets that governments should aim to achieve in order to protect, promote and support breastfeeding. It has been influential in reinforcing the need for professional and government

involvement in the promotion of breastfeeding, in creating opportunities to breastfeed and in assisting women to breastfeed successfully. The operational recommendations of the Innocenti Declaration are listed in Box 1.3.

Box 1.3 Recommendations of the Innocenti Declaration

- Appoint a national breastfeeding coordinator and establish a multisectoral national breastfeeding committee.
- Ensure that all facilities that provide maternity services fully practise all of the Ten Steps to Successful Breastfeeding as set out by the WHO/UNICEF document *Protecting, Promoting and Supporting Breastfeeding: the special role of the maternity services*.
- Take action to give effect to the principles and aims of all Articles of the International Code of Marketing of Breast-Milk Substitutes (1981).
- Enable imaginative legislation to protect the breastfeeding rights of working women and establish means for its enforcement.
- Support national situation analysis and surveys and the development of national goals and targets for action.
- Encourage and support national authorities in planning, implementing, monitoring and evaluating their breastfeeding policies.

The Innocenti Declaration constituted an important international policy statement on breastfeeding. It aimed to change attitudes towards breastfeeding practice worldwide, and was adopted by participating governments and WHO/UNICEF policy makers. It is considered to be a pivotal force in influencing breastfeeding on a global scale.

The Baby-Friendly Hospital Initiative (1991)

The baby-friendly concept evolved into a second strategy, which was supported globally, that aimed to further reinforce the best practices in breastfeeding initiated in the Ten Steps. The idea of hospitals that were managed and operated according to baby-friendly standards and criteria was launched at the International Paediatric Association Conference in Ankara in 1991, and was established in 1992, to take forward the Innocenti Declaration and the Ten Steps.¹³

The Seven Point Plan

The success of the Baby-Friendly Initiative in hospitals was demonstrated by its extension from hospital to community practice. Fundamental to the Baby-Friendly Initiative in the community is the *Seven Point Plan for Sustaining Breastfeeding in the Community*. The Seven Point Plan was the outcome of a widespread consultation with healthcare professionals, service providers and users, and it reflects the consensus as to what constitutes best practice in community health services. It is outlined in Box 1.4.

Box 1.4 The Seven Point Plan

- 1 Have in place a written breastfeeding policy that is routinely communicated to all healthcare staff.
- 2 Train all staff involved in the care of mothers and babies in the skills necessary to implement the policy.
- 3 Inform all antenatal women about the benefits and management of breastfeeding.
- 4 Support mothers to initiate and sustain breastfeeding.
- 5 Encourage exclusive and continued breastfeeding, with appropriately timed introduction of complementary foods.
- 6 Provide a welcoming atmosphere for breastfeeding families.
- 7 Promote cooperation between healthcare staff, breastfeeding support groups and the local community.

The Seven Points were subsequently revised in 2008.¹⁴ The revision document can be accessed at www.babyfriendly.org.uk/pdfs/The_Seven_Point_Plan_September_2008.pdf

Healthcare professionals in the UK expected, required and received government support for the changes in policy and practice relating to the initiation of baby-friendly practices.¹⁵ The widespread adoption of the Baby-Friendly Initiative, the Ten Steps and the Seven Point Plan in the UK and other countries is an excellent example of what can be achieved through cooperation at international, national and local levels where professionals, supported by global health organisations and their governments, take the lead in key policy areas that require change.

Examples of Baby-Friendly Initiative and Seven Point Plan developments can be found at the following Canadian and Australian websites:

- Breastfeeding Committee for Canada: www.breastfeedingcanada.ca/html/webdoc43.html
- Australian College of Midwives: <http://acmi.naqtechnology.com.au/Portals/8/position%20statements/DRAFT%20Position%20Statement%20on%20Infant%20Feeding.pdf>.

The Seven Point Plan and the Ten Steps complement each other. They represent a giant step forward in terms of supporting and sustaining breastfeeding. Their implementation goes a long way towards ensuring that women are well informed about infant feeding choices, and that professional practice in hospital and community healthcare meets a quality standard of care for all women. Together they provide a framework that supports best practice, guides the development of care standards and, importantly, facilitates the continuous development of policy and practice.

A professional account of a journey to establish the Baby-Friendly Initiative

in Ontario, Canada, can be found at www.beststart.org/events/detail/bsannual-conf07/presentations/preconf/P1_5.pdf

INTERNATIONAL ACTIVITY: POLICY INTO PRACTICE FROM 2000

The developments of the 1980s and 1990s continually sustained and reinforced the international consensus that breastfeeding was the best option for infants, especially for the first 6 months of life. By the early 2000s, more than 15 000 hospitals around the world had been officially designated as baby-friendly, and many countries have developed national action plans and policies to support the global recognition and value of breastfeeding.¹⁶

North America

Practice was supported in the USA through the breastfeeding policy 'Blueprint for Action.'¹⁷ This included an action plan related to supporting breastfeeding based on education, training, awareness, support and research. The Blueprint document contains key recommendations for improvements in baby-friendly practices in the hospital setting, in the workplace, in the support of families and communities and in research. These elements form a formidable and strong formula that supports breastfeeding.

The USA also replaced a previous statement published in 1997 with a new policy statement in February 2005 by the American Academy of Pediatrics (AAP) on 'Breastfeeding and the Use of Human Milk.'¹⁸ The 2005 document contains a wide range of reference sources, which reflect the growing body of knowledge on the benefits of breastfeeding and clinical management. It also includes issues relevant to high-risk infants, recommendations on the role of the healthcare professional, and a statement on research.

Europe

In Europe a similar approach to the Blueprint in the USA was adopted, with representation from the European Union (EU) members. This EU project for the promotion of breastfeeding in Europe published the document *Protection, Promotion and Support of Breastfeeding in Europe: a blueprint for action*.¹⁹ This provides a model for regional and national planning, with recommendations for action.

The 54th World Health Assembly (2001)

Two important agenda areas for the new century brought forward by the 54th WHA were exclusive breastfeeding and the International Code of Marketing of Breast-Milk Substitutes. At the 2001 Assembly there was global consensus on the need for exclusive breastfeeding, and because this is considered by the WHO to be a crucial public health issue, it is kept continually under review.²⁰ The Assembly considered the optimal duration of exclusive breastfeeding under the Global Strategy for Infant and Young Child Feeding. This Assembly also marked

the 20th anniversary of the adoption of the International Code of Marketing of Breast-Milk Substitutes. Resolution 54.2 considered past WHA resolutions on infant nutrition and appropriate feeding practices for infants and young children, and reinforced resolutions on the International Code's fundamental role of protecting, promoting and supporting breastfeeding. This meeting also gave due consideration to the need for international and national commitment to support for working women to breastfeed.

The practical value of research

The 2001 Assembly also debated the availability of scientific research on the balance of risk of HIV transmission through breastfeeding. The need for further research associated with the nutrition of infants of HIV-positive mothers was recognised. Based on existing evidence, it was agreed that when replacement feeding is safe, affordable and sustainable, HIV-positive women should be advised not to breastfeed. In addition, exclusive breastfeeding is recommended during the first months of life, and decisions to use formula feeding should be free from commercial influences. More information about the WHO recommendations on HIV and breastfeeding can be found online at <http://whqlibdoc.who.int/hq/2003/9241591226.pdf>.

Concerns were also raised at the Assembly that policy decisions (and, by implication, practice) continue to be hampered by lack of conclusive, global research evidence.²¹ Although the criticisms relating to research are timely and fair, it is also important to recognise that research in the areas related to baby-friendliness has achieved a great deal in bridging the divide between research and practice.

Two major recommendations were proposed to guide consistency between policy, practice and research. First, exclusive breastfeeding should continue for 6 months, with the introduction of complementary foods following this 6-month period, alongside continued breastfeeding. Secondly, more attention to the nutritional status of pregnant and lactating mothers and to the prevalence of deficiencies of micronutrients such as iron, zinc, and vitamin A was needed.

Consensus was reached that the main purpose of research should be to inform practice. The priority research areas recommended by the Assembly included a comparison of exclusive breastfeeding/predominant breastfeeding and partial breastfeeding for 4 to 6 months based on the following outcomes:²²

- proportion of infants with growth faltering and malnutrition at 6 and 12 months
- micronutrient status
- diarrhoeal morbidity
- neuromotor development
- changes in weight in mothers
- lactational amenorrhoea in mothers
- clarification of the range (globally) of biological and social factors that mitigate against exclusive breastfeeding to 6 months, in order to identify barriers and design appropriate and effective interventions.

Infant and young child feeding

The momentum of change was given a further boost in the early 2000s with the publication of the *WHO Global Strategy for Infant and Young Child Feeding*. This strategy document aimed to raise awareness around the world of the way in which feeding choices and practices for babies and young children affect their health and well-being. Furthermore, as a global public health recommendation, the WHO declared for the first time that during the first 6 months of life babies should be exclusively breastfed in order to attain the best possible health, growth and development.²³

The 61st World Health Assembly (2008)

The work of the WHA to protect and support women with regard to breastfeeding continues through a range of documents and resolutions aimed at guiding policy and practice. At the 61st WHA, resolution 61.15, agenda item 11.7, in considering the Global Immunisation Strategy, made reference to the importance of breastfeeding for the development of the baby's immune system. This new resolution WHA 61.15 urged Member States to '... strengthen efforts to protect, promote and support early and effective breastfeeding, in order to boost the development of infants' overall immune system (p. 2).²⁴

WHERE WILL THE FUTURE CHALLENGES COME FROM?

Various key documents, codes and guidelines from the WHA, the WHO and other leading international organisations and groups provide a strong foundation for policy and practice in the future, in both the developed and the developing worlds. Sustained effort by governments and industry, as well as by the professions, to gain a global level of commitment to exclusive breastfeeding for the first 6 months of an infant's life and restrict the marketing of formula is now well established policy and practice in many countries.

Unfortunately, the codes and guidelines are not applied uniformly throughout the world, and in many countries they are still simply ignored. At the end of the 1990s the *British Medical Journal (BMJ)* reported that in nearly all of the 31 countries surveyed there was non-compliance with the WHO code from the main producers of infant formula and other breast-milk substitutes.²⁵ This conclusion was supported by research evidence from the Interagency Group on Breastfeeding Monitoring of UNICEF, which also found violations of the code in Bangladesh, Poland, South Africa and Thailand.²⁶

In addition, the leading organisations and agencies spearheading this movement do not have legal power to enforce the codes or guidelines. On the one hand, progress seems to be dependent on the degree of beneficence within governments to support this important healthcare change, while on the other hand, progress is held to ransom by governments that are uncaring or, worse still, malevolent towards women and infants. Undoubtedly, future challenges will be inextricably linked with political, economic and ethical considerations.

In countries where the threat of adulteration is negligible, other unethical marketing practices have been observed. These include inducements to health professionals to recommend formula feeding bottles, and free trial supplies of milk substitutes to mothers.

As recent events have testified, the threat of catastrophic consequences caused by adulteration during the manufacturing and production processes of formula milk remains very real. In April 2004 the Chinese authorities arrested 22 manufacturers of baby milk and closed three factories because they had sold fake products, which had caused more than 12 infant deaths and hundreds of cases of malnourishment. Some of the products had only 6% of the required nutritional value, and some were found to contain no more nutrient value than water. Many infants suffered from a range of conditions associated with under-nourishment and severe malnutrition, which resulted not only in suffering but also in chronic, long-term conditions.²⁷ China is not the only culprit. In late 2004 the German company Humana Milchunion also paid out approximately \$20 000 000 to Israeli families whose children had suffered major neurological damage due to feeding with thiamine-deficient formula.²⁸

In September 2008, history repeated itself. Infant milk formula produced in China and distributed within China, Bangladesh, Burundi, Myanmar, Gabon and Yemen was found to contain lethal doses of melamine, an industrial chemical used in plastic. In September 2008 the Ministry of Health of China confirmed that the adulteration had caused the death of three babies, and over 6240 infants were found to have kidney stones, a very rare condition in infants. Apparently the General Administration of Quality Supervision, Inspection and Quarantine (GAQSIQ) in China, which is responsible for checking milk and related merchandise, had been aware of the illegal use of melamine for a long time and was unable to prevent this recent catastrophe.²⁹ At least 22 dairy manufacturers across the country were found to have melamine in some of their products, with levels ranging from 0.09 mg/kg to 2.56 mg/kg.³⁰

Siegel-Itzkovich, commenting on the adulteration of formula in 2004, stated that although the problem remained a contemporary one, the evidence suggests that governments and the legal profession are waking up to the scale of the problem and its relevance to the health of infants.³¹ Sadly, this is not the case. The 2008 episode in China demonstrates that ruthless individuals are willing, and more importantly able, to break both the letter and the spirit of the WHO 1981 code. Rather than waking up to the scale of the problem, as Siegel-Itzkovich suggests, some governments appear to be sleeping on the job of monitoring production to the rigorous standards set out in the Code. Governments therefore need to be more aware that unscrupulous producers of formula milk are undeterred and are willing to risk severe penalties, endangering the lives of vulnerable infants, for the sake of high profit margins. Governments and the healthcare professions thus have good cause to remain concerned and vigilant about the ability of the Code to regulate the quality of formula milk production and distribution worldwide.

For those manufacturers of infant formula who scrupulously observe product quality standards, profit margins continue to drive aggressive marketing techniques and the over-promotion of products. Ironically, in the developing world mothers and mothers-to-be, who are already poor, are encouraged to pay for food for their baby or babies, when it could be supplied by their own body, without cost. According to Dykes, the cost of formula can often use up to 30% of a family's income in the developing world, and can have an impact on the calorie intake of the rest of the family.³² Mothers who abandon breastfeeding become the captive market of the formula companies, and the effects go beyond the mother and her family. The costs associated with introducing formula feeding are not just those of the formula milk itself, but also include items such as bottles,

TABLE 1.1 Percentage of infants breastfed immediately postpartum compared with the percentage exclusively breastfed at 6 months

<i>Country</i>	<i>Early postpartum (%)</i>	<i>Exclusively at 6 months (%)</i>
USA	74	12
UK	76	3
Canada	87	16

TABLE 1.2 Percentage of infants breastfed exclusively at 6 months

<i>Country</i>	<i>Exclusively at 6 months (%)</i>
China	51
Chile	63
Cuba	41
Egypt	38
India	46
Kenya	13
Malawi	56
Mexico	38
Nigeria	17
South Africa	7
Thailand	5
Turkey	21
Zimbabwe	22

teats and sterilising equipment, as well as increased healthcare costs associated with additional hospitalisation, problems of dehydration and contraception.³³

For various reasons the percentage of infants who are breastfeeding exclusively remains a cause for concern, and is an area that needs to be addressed in the future. Tables 1.1 and 1.2 demonstrate the variations from one country to another with regard to exclusive breastfeeding at 6 months. The interpretation of data and comparative data analysis are hampered by the lack of availability of reliable data and the lack of systematic methods for collecting data. Tables 1.1 and 1.2 are based on information from the following sources:

- UNICEF: www.unicef.org/infobycountry/index.html
- UK Infant Feeding Survey 2005: www.ic.nhs.uk/statistics-and-data-collections/health-and-lifestyles-related-surveys/infant-feeding-survey/infant-feeding-survey-2005
- US Centers for Disease Control and Prevention (CDC): www.cdc.gov/breastfeeding/data/NIS_data/
- Canadian Perinatal Health Report 2008: www.phac-aspc.gc.ca/publicat/2008/cphr-rspc/index-eng.php.

It is suggested that the healthcare budgets in developed countries could be substantially reduced if approximately three-quarters of women in a country breastfeed, and the majority of this number breastfeed for 6 months. It has been estimated that a minimum of \$3.6 billion would be saved if breastfeeding was to be increased from current levels (64% in hospital, and 29% at 6 months) to those recommended by the US Surgeon General (75% and 50%, respectively). This figure is likely to be an underestimate of the total savings, because it represents cost savings from the treatment of only three childhood illnesses (otitis media, gastroenteritis and necrotising enterocolitis).³⁴

CONCLUSION

It is clear that protecting, promoting and supporting mothers with regard to initiation and continuation of breastfeeding remains an international policy priority, which is strongly linked to the continuous development of national and local practices in breastfeeding, and the growth of research related to breastfeeding. Over a generation, considerable and concerted effort has gone into producing and implementing policies and practices associated with the Baby-Friendly Initiative and other landmark initiatives such as the Ten Steps and the Seven Point Plan. This effort has provided a firm foundation for future action in the twenty-first century.

This first chapter identifies that the extent to which women and families are informed and supported with regard to breastfeeding, and how well breastfeeding interests are promoted and protected and 'best practice' is facilitated, are dependent on the interpretation and implementation of policy and practice at the local level. Effective local policy and practice therefore reflect the ethical and

professional values, principles and standards that operate in a specific region or healthcare facility. In addition, professionals with a role in supporting and promoting breastfeeding cannot escape the accompanying political challenges and the degree to which political awareness is beneficial for influencing and implementing change.

Inevitably, women are at the centre of breastfeeding activity and should be protected and supported in making informed choices about the type of infant feeding that they wish to adopt. This creates different challenges for healthcare professionals and governments across the globe, starting from the basic principle that women and young children have a fundamental human right to protection and benevolent policy making by governments, including protection and support for breastfeeding. The above conclusions are illustrated in Figure 1.1.

For professionals, the challenges are undeniably many and complex, and are often linked to expertise in listening, information management and information giving. For example, it has been reported that some professionals may be fearful about asking women outright to state their intentions with regard to infant feeding, because of concerns that once a woman has stated her intention to use formula, the door to further information and discussion about breastfeeding will be partially or completely closed.³⁵ However, there is a growing body of guidelines, research evidence and systematic reviews on breastfeeding, which can be used by healthcare professionals to inform and support women who are making decisions about infant feeding. Fortunately, the professional effort today to support, protect and promote breastfeeding continues with the same high level of intensity that has been demonstrated since the early 1980s.

The website of the National Conference of State Legislatures in the USA (www.ncsl.org/programs/health/breast50.htm) provides information about the

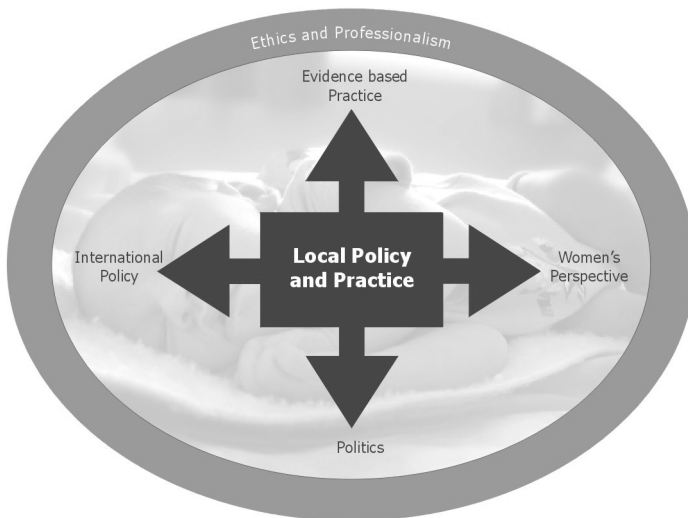


FIGURE 1.1: Local policy and practice.

legal issues to which various US states have committed, in relation to supporting breastfeeding. In 2009, the National Conference of State Legislatures also stated its aim of increasing the percentage of women who breastfeed during the postpartum period to 75% by 2010.³⁶

In this age of readily available information from online sources, popular sites such as YouTube demonstrate en masse the force of public opinion for breastfeeding. In 2009, a YouTube video (which can be viewed at www.birthactivist.com/2009/03/hong-kong-government-tackles-public-breastfeeding) drew public attention to the issue of breastfeeding in public in Hong Kong, and the lack of provision of adequate facilities for mothers to breastfeed outside the home.

EXAMPLE OF A POLITICAL CHALLENGE

A large number of community staff were interested in and committed to the implementation of the UNICEF Community Baby-Friendly Initiative. A formal approach to gain approval by the organisation can be a useful and productive approach to influence and negotiate change.

Using a strategy paper to address the challenge

The paper provided as an example can be used as a template to initiate change at the highest levels when recommending particular strategies or initiatives, which will benefit service users, in this case pregnant women and new mothers. There may also be a need to overcome opinion-based decisions by providing clear evidence for change.

The first reference point for those involved in this change activity was the *Ten Steps to Successful Breastfeeding*, to provide a framework for further discussion about building evidence to support their recommendations. It would also be used in the implementation of evidence-based practice, which is sensitive to the needs of women and is recommended in both national and local policy documents.

The example paper can be used to provide insight for senior managers, leaders and stakeholders. Such papers can be used to explore and highlight the ethical and political issues that are relevant to those who manage and fund services.

A strategy paper for implementing the WHO/UNICEF Community Baby-Friendly Initiative in xxx

1 Purpose of the report

The xxx Committee are asked to support in principle and provide key professional leadership for this initiative in their health/medical centres. Details of the process and implication are included in this report.

2 Recommendations

The xxx Committee approves the future development of the Hospital Baby-Friendly Initiative/Community Baby-Friendly Initiative with xxx Hospital or a cluster of interested general practices in each xxx area/community.

3 Executive summary

Breastfeeding is a public health priority throughout xxx. The WHO/UNICEF Baby-Friendly Hospital Initiative has successfully been implemented in xxx and is currently being progressed in xxx Hospital. Babies born in Baby-Friendly Accredited Hospitals in xxx are 28% more likely to be exclusively breastfeeding at 7 days and have significant improvements in breastfeeding rates over time. The Community Baby-Friendly Initiative has the potential to support the duration of breastfeeding for this increasing number of mothers choosing to breastfeed in xxx. The Community Baby-Friendly Initiative involves the implementation of evidence-based practice standards for the care of pregnant and postnatal women, as supported in the breastfeeding policy for xxx. The implementation of the practice standards leads to a prestigious nationally recognised quality award in recognition of the significant contribution to supporting breastfeeding in general practice populations.

The xxx clinical standards for maternity services published in xxx ask healthcare providers to provide evidence that the maternity service adheres to the principles of, or is working towards, the UNICEF/WHO Baby-Friendly status, which includes primary care services. Xxx will be assessed in xxx for evidence of these standards being progressed in all areas of xxx.

4 Financial implications

There is a small programme budget allocation to develop resources required for implementation. Training will be provided by members of the xxx Strategy Group, and negotiation will take place to release staff via the practice-based protected learning time or by appropriately trained practice staff (e.g. health visitors). It is anticipated that the cost of an external assessment by UNICEF would be met by xxx.

5 Risk assessment

The health benefits for mothers and infants are globally recognised. All continued progress would contribute towards the national health targets for breastfeeding. A full risk assessment has been performed and coded as red, which indicates that it is unlikely that improvement in breastfeeding initiation and continuation rates will take place unless there is a concentrated focus involving both hospital and community.

6 Implications for health

The national target is for more than xxx% of mothers still to be breastfeeding their baby at 6 weeks of age by xxx. Data provided from various sources indicate that continuation levels at 6–8 weeks have increased very slightly in xxx from x% to x% since xxx. It therefore seems highly unlikely that, if current trends continue, the national and local targets will be met by xxx, and further action must be taken.

There is significant and reliable evidence that breastfeeding has important advantages for both the infant and the mother. The xxx Infant Feeding Study indicated in 1990 that breastfeeding rates were highest in social groups I to III, with no exclusive breastfeeding taking place in social class V. Almost

20 years later the xxx Strategy for xxx identified that this trend continued into the early 2000s, with breastfeeding rates on discharge from hospital ranging from x% in the most disadvantaged areas to x% in the more affluent areas of xxx. There is clear evidence that the health of children is improved regardless of social class groups if they have been breastfed, with recommendations to target breastfeeding interventions in low-income groups as part of the xxx Strategy. Protective benefits for the infant include reduced risk of gastrointestinal infection, respiratory infections, necrotising enterocolitis, urinary tract infections, otitis media, allergic disease (eczema, asthma and wheezing) and insulin-dependent diabetes mellitus. Women who breastfeed are at lower risk of breast cancer, ovarian cancer and hip fractures. Increasing rates will improve long-term health for mothers and their infants. Where the Community Baby-Friendly Initiative is implemented there is a reduced rate of consultation with GPs about common childhood illnesses.

7 Timetable for implementation and Lead Officer

Approval will enable xxx Hospital *or* interested GP practices/medical centres to participate in the implementation of the Community Baby-Friendly Initiative. The xxx Directorate will support a baseline audit of current practice, and this will inform the development of an action plan, including a timetable for commencing in spring xxx. Further information about the process is included in Section 9.

8 Consultation

In xxx a paper was presented and considered by the conference members who supported the recommendations for implementation of the Community Baby-Friendly Initiative in principle. Discussions then took place with the general managers of the xxx areas, who asked for detailed information about the work required for this initiative in order for the xxx committee to approve this proposal.

Discussions have also taken place with a range of healthcare professionals throughout xxx. The initiative is supported in principle by the community nurses, managers and health visitors in xxx.

9 Background

Despite considerable commitment to working towards the promotion, protection and support of breastfeeding locally, breastfeeding rates at 6–8 weeks have remained static since xxx in xxx. In xxx a strategy group collectively decided to review the strategic focus of breastfeeding interventions. As a result, there will be a concentrated focus on the services offered to women during pregnancy and the first 6 weeks of the postnatal period. Interventions that support this include the Baby-Friendly Hospital Initiative, the Community Baby-Friendly Initiative, a new breastfeeding training programme for midwives, health visitors and public health nurses, and various research projects.

The UK Baby-Friendly Hospital Initiative was launched in 1994. This was based on the *WHO/UNICEF Joint Declaration on the Promotion, Protection and Support of Breastfeeding: the role of the maternity services*. This led to the

subsequent publication of the *Ten Steps to Successful Breastfeeding* in the hospital setting. Four years later, in 1998, the *Seven Point Plan for the Protection, Promotion and Support of Breastfeeding in Community Health Care Settings* was published by WHO/UNICEF. This complements and overlaps with the *Ten Steps* to provide agreed practice standards for pregnant and breastfeeding women, known as the Community Baby-Friendly Initiative.

The Community Baby-Friendly Initiative involves the adoption of breastfeeding policy, appropriate training of staff, supporting information giving to women during pregnancy and the initiation and duration of breastfeeding, providing a welcoming atmosphere to breastfeeding women on GP premises, and appropriate handover of care between health professionals. This involves community midwives, health visitors and general practitioners working in collaboration to achieve these practice standards. Compliance with the International Code of Marketing of Breast-Milk Substitutes is required, including withdrawal of the sale of infant formula in healthcare premises and the advertising of infant formula. Implementation of the Community Baby-Friendly Initiative would complement the strategic objectives in xxx. These standards lead to a nationally recognised quality award in recognition of the significant contribution to supporting breastfeeding in GP practice populations.

10 What will be required by participating practices/medical centres?

The vast majority of this initiative's work involves predominantly midwives, community midwives, health visitors and public health nurses. The greatest challenge will be the release of staff to receive necessary training appropriate to their role. This will be negotiated as part of the practice-based protected learning time for the cluster group.

- An integrated xxx policy has been ratified and approved and would need to be adopted by the participating general practices.
- With regard to training, it is anticipated that with the exception of midwives, health visitors and public health nurses, this will be provided with approval in the practice-based protected learning time. Time frames are indicated below. Relevant resources for management of breastfeeding complications would be supplied in each consulting room. Records of training will be held in each practice and by facilitators.
- Midwives, health visitors and public health nurses are required to assist women in making an informed infant feeding choice that is appropriate to their circumstances, and to ensure that they are fully supported in this decision. GPs would be required to support this process, ensuring that the information given is consistent.
- Support of women is predominantly the responsibility of midwives, health visitors and public health nurses. Where complications of breastfeeding occur, the GP is required to manage or refer the case as appropriate. Practice nurses and reception/administration staff are required to be knowledgeable about the policy, and may be required

<i>Objective</i>	<i>Lead officer</i>	<i>Staff group</i>	<i>Implementation</i>	<i>Completion</i>
Training	<Insert>	Practice managers General practitioners Practice nurse Reception/administration	2 hours 1 hour 1 hour 1 hour	<Insert>
Breastfeeding education	<Insert>	Midwives Health visitors Public health nurses	18 hours	<Insert>

to refer women to appropriate support. A postnatal checklist will be developed to assist community midwives and health visitors with regard to sharing of information.

- Encouragement of exclusive and continued breastfeeding, with appropriately timed introduction of complementary foods, is predominantly the responsibility of midwives and health visitors, but may occasionally involve GPs.
- A welcoming atmosphere should be created (display of policy, posters and information in the facility, reception/administration staff knowledgeable about policy and support of breastfeeding women) on the premises.
- With regard to breastfeeding groups, GPs, midwives, health visitors and reception/administration staff should know where to refer breastfeeding women.

<Insert similar information about local requirements for hospital criteria.>

FURTHER READING

The Ten Steps

Read about the Ten Steps and some global success stories about their implementation (www.unicef.org/programme/breastfeeding/baby.htm).

The Baby-Friendly website provides information on each of the Ten Steps, and outlines clearly for each one the associated standard, how the standard is assessed in practice, and how the standard can be assessed for compliance (www.babyfriendly.org.uk/page.asp?page=60).

The Innocenti Declaration

This substantial document was published in celebration of 15 years of the Innocenti Declaration on promoting, protecting and supporting breastfeeding (www.unicef.org/nutrition/files/Innocenti_plus15_BreastfeedingReport.pdf).

The International Code of Marketing of Breast-Milk Substitutes

This website provide a useful synopsis of the WHO code (www.babymilkaction.org/regs/thecode.html).

UNICEF also provides information about the Code. (www.unicef.org/programme/breastfeeding/code.htm).

The International Baby Food Action Network (IBFAN) is a further source of information on the code, including information on the systematic undermining of breastfeeding (www.ibfan.org/issue-international_code.html).

The Baby-Friendly Initiative

UNICEF has published a guide to implementing the Baby-Friendly best practice standards for breastfeeding in maternity and community healthcare facilities.

An implementation guide for both the Ten Steps and the Seven Point Plan has been prepared by the UNICEF UK Baby-Friendly Initiative (www.babyfriendly.org.uk). This site contains best practice standards for the support of breastfeeding (evidence, resources, training, statistics, guidance, leaflets for parents and strategies).

World Health Organization information on breastfeeding

In 2003, the WHO published their *Global Strategy for Infant and Young Child Feeding*. A summary and link to the full document are available (at www.who.int/entity/child_adolescent_health/topics/prevention_care/child/nutrition/global).

This is a large document (157 pages) that is useful for teams of key policy makers, non-government organisations and managers of healthcare services. The document incorporates a tool (which can be found at www.who.int/child_adolescent_health/documents/9241562544/en/index.html) that is designed to assess the strengths and weaknesses of policies and programmes for protecting,

promoting and supporting optimal feeding practices in their local setting, and to determine where improvements may be needed to meet the aims and objectives of the *Global Strategy for Infant and Young Child Feeding*.

Centers for Disease Control and Prevention

The US Centers for Disease Control and Prevention (CDC) website has an area devoted to breastfeeding, which incorporates a range of useful resources and publications (www.cdc.gov/breastfeeding).

News items

The recall of contaminated formula milk in China was a major international news story in 2008. Some analyses of this news story can be found on the following websites:

- www.timesonline.co.uk/tol/news/world/asia/article4790866.ece
- www.cnn.com/2008/WORLD/asiapcf/09/16/china.tainted.formula/index.html
- www.telegraph.co.uk/news/worldnews/asia/china/2827362/Baby-formula-recall-in-China-after-infant-death.html

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