Quintessence Foundation

Winter 2003

Why should you take part in the Quintessence Breastfeeding Challenge? A community perspective from 2002

by Wendy Robb, BSN IBCLC

In Duncan, British Columbia, we have a lot of fun with the Breastfeeding Challenge. It is such a wonderful way to celebrate World Breastfeeding Week:

- ✓ It captures the imagination of the media. We get great front page coverage in our local paper. This year we even had a lovely picture of an aboriginal mom actually showing a little areola- how is that for normalizing breastfeeding!

- ✓ It is a fun social event. We have lots of food and door prizes all donated. We get donations of self care items and fun items for kids from local businesses and also donations from Medela, Hollister and Avent. This year we had 30 door prizes for 46 women: almost everyone went home with something plus their certificate and pen.

- ✓ Women nurse longer just so they can participate. We start talking about the Challenge in the summer and several women have said that they will continue nursing just so they can attend the challenge. Today I saw a client at breastfeeding clinic with a 3 month old infant. They are struggling with a candida infection. They participated in this year's challenge and won the Medela foot stool as a door prize. Mom spoke about how much she loves it, and how she would like to be able to attend next year. The Breastfeeding Challenge experience will help her persevere with this struggle.

- ✓ Another interesting thing we encountered this year was the public perception that the challenge had been running for several years. In 12 short months it has become a tradition.

In 2001, we had almost twice the number of nursing moms that we had this year. Last year the Challenge was held at the community centre while the Parent's Unite garage sale was happening. The garage sale is a popular event where parents of young children can find great bargains in used clothing and baby gear. It is a natural combination: parents of young children and a breastfeeding challenge. In 2002, the garage sale was held Thanksgiving weekend and we were in a school gym because we could not get space at the community centre. What we learned, of course, is that location is everything. We are already negotiating with the community centre for the 2003 Challenge. We have requested they hold the garage sale October 4th.

This year- because of our location, we had fewer women attend that have more serious life challenges: issues of poverty, lack of power. This to me is the key part of breastfeeding: the empowerment women receive from successfully nursing their infant. The Breastfeeding Challenge honours the strength of women. For women with more challenges this can be a very powerful process. One woman proudly displayed her certificate on the wall of her apartment.

We three breastfeeding advocates of the Cowichan Valley, are looking forward to continuing this tradition every October.

Check out our Quintessence Foundation Website: www.babyfriendly.ca

Breastfeeding, breasts and donor milk banking in 2003: Countering attitudes in the media

Here we are twelve years after the launch of the UNICEF Baby-Friendly Hospital Initiative with many of us still struggling to make changes and maintain changes within our hospitals and communities. Overwhelmingly, health professionals state "breast is best," multitudes of studies substantiate the benefits of breastfeeding to mothers, children and society, the benefits of human milk and the beneficial composition of human milk. Yet achieving best practice remains a struggle. Finances and lack of time due to job overload contribute to the struggle. As we continue to work hard to promote, support and protect breastfeeding I wonder why breastfeeding as a health issue fails to rate higher in our society's list of priorities.

This last month provided several reminders of how our culture views breastfeeding, human milk and breasts in 2003. Understanding these everyday events in our lives and in the media suggests opportunities for changing our cultural view of breastfeeding.

Scenario one: A woman attending a multiples prenatal class asks about the benefits of breastfeeding. My response outlines the benefits to both mothers and children. The expectant mother's second question is about the "benefits" of formula feeding. Surprised to hear that there are no advantages of formula for children she began to give examples of the "benefits" including increased weight gain and the ability to distance yourself from the your child. Her comments indicate that this well educated woman clearly believes that formula is superior to human milk.

Scenario two: In response to a media request a hospital interview is set up in a room normally used for parent education. On the bulletin board are posters, many promoting breastfeeding and the use of human milk. One poster from Brazil pictures a side view of a woman's naked breast with a bottle of expressed milk held under the breast. The caption states, "To you its milk, to the baby its life." The poster contains additional messages encouraging donation to the local milk bank. It is worth noting that Brazil has over 150 milk banks and has the most successful breastfeeding promotion program in the world. The two media people look at the poster and one of them, a twenty something woman, looking taken back, states, "Wow. It's a breast." The cameraman quickly adds, "Well, we won't have that on camera." As organization of the interview continues the woman says, wrinkling up her nose in distaste, " I'll never look at milk the same way again."

Scenario three: A full page ad for "fragrances" appears in a national Canadian paper just prior to Valentine's Day. Featured is a picture of two young models (he clutching her) with her bikini top displaying a side view of her naked breast.

Scenario four: The Canadian papers report in some detail the case in Florida involving the female dentist who ran down her husband with her car in response to finding him at a hotel with a lover. It is also reported that she had planned to have breast enlargement in order to fix up the relationship but had not had time before the murder took place.

The common thread running through all four scenarios is attitude. The first scenario highlights the effectiveness of formula marketing pervasive in our culture. Health professionals play a significant role in formula marketing. This is evident from the common themes present in formula advertising over the last 100 years. These themes are physician endorsement and best nutrition coupled with cultural beliefs in the importance of independence and breasts as sexual objects. These beliefs enshrine formula as the "normal method" of infant feeding. Knowing the benefits of breastfeeding does not in and of itself enable women to breastfeed. As Bentovim put it " breastfeeding is a systematic product of many interacting (physical, psychologic and sociologic) factors rather than the product of individual behaviour only." Beyond knowledge, women benefit from support and awareness of our cultural beliefs and attitudes.

Scenarios two through four reflect cultural attitudes to breasts as sexual objects overriding the normalcy of providing human milk for human infants. Breasts are viewed so completely as sexual objects that all female breasts should be covered except in a sexual context. Form is worshipped over function - the normal variation of breast shapes is felt to best be corrected through the surgical implantation of foreign material on a woman's chest. Rather than accepting variation as normal, culturally we endorse the surgical alteration of normal breasts even though it may prevent normal function.

Those of us who are promoting, protecting and supporting breastfeeding are also immersed in this culture. Can we really make a difference, particularly on breastfeeding duration rates? Can we achieve a 75% initiation rate with at least 75% still exclusively breastfeeding for about 6 months, nationally? Current recommendations are for exclusive breastfeeding for about six months with breast

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milk to remain in the diet for two years and beyond. Current Canadian data suggest that Canadian initiation rates have improved over the last few decades. The same cannot be said of duration rates. It is the minority of Canadian children who receive human milk after six months. Very few receive human milk for two years and beyond.

Mothers want the best for their children and yet many, in the face of multiple barriers, wean their children prematurely. Research indicates the multitude of factors that influence the duration of breastfeeding comes down to attitudes and beliefs about the act of breastfeeding. Is this situation hopeless?

Not in the least. More women initiate breastfeeding. To impact duration rates a host of changes need to take place including changing cultural attitudes about breasts and breastfeeding. If we change attitudes to breasts with function being emphasized rather than form – this would have major ramifications on everything from women's self esteem to morbidity and mortality rates among young children. This type of change takes constant ongoing effort in many sectors of health and society.

Consider smoking. Many of us can remember (or have heard about) when smoking was accepted anywhere and at anytime. For example, it was the custom in the fifties for a hostess to put out cigarettes for her guests even if she lived in a non-smoking household. Consider how far we have come - today we have advertisements on TV pointing out that only 17% of adults living in BC smoke and "smoker's rights" are severely diminished. Smokers are viewed as needing support rather than being role models to be emulated. A major factor in bringing about this cultural change occurred both in print and audio visual media. Hollywood movies no longer routinely show actors smoking throughout movies.

Helping women succeed with their breastfeeding goals involves more than problem solving on the front lines. Most of us feel somewhat overwhelmed at times with the types of "problems" presented at the beginning of this article. It is helpful to step back and look at the bigger picture. To really help women we have to take on the "bigger picture" – the culture that presents so many problems and barriers for breastfeeding women. Formula feeding is heavily promoted by proprietary companies and by some health professionals. Lacking the same financial resources, it is important to use the resources available – the media being a valuable resource. Unusual events attract media attention. The Breastfeeding Challenge 2003 presents such an opportunity. Make your contribution to promoting protecting and supporting breastfeeding and affecting cultural attitudes - take part and spread the word!

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Quintessence Breastfeeding Challenge 2003

October 4, 2003, is the big day. Eleven a.m. is the time. This year's Breastfeeding Challenge will involve sites from Canada and the US so now is the time to get involved. The competitions are for the most women breastfeeding in one province/state/territory and Canada versus the US. The final numbers are worked out as a percentage of the area's birth rates so all areas and both countries have a good chance of being declared the winners.

This event can only be successful with your help. We need as many sites as possible. To be a site you need to register with Quintessence Foundation. Sites vary widely with some involving large numbers and others involving two or three mothers and breastfeeding children. It is a wonderful way to celebrate/acknowledge World Breastfeeding Week. In Canada, World Breastfeeding Week is celebrated during the first week of October but parts of the US celebrate in August. No matter, the Breastfeeding Challenge is open to anyone who wishes to sign up and follow the simple rules. Every mother and baby counts towards the total number for a province/territory/state and for the national total for each country. In this way there is more collaboration than competition!

To get involved, look up our website at www.babyfriendly.ca. The registration information, rules, flyers and more will get you off to a good start. The initial information will be available on-line by March 1, 2003. This information is being translated into French. We are also looking for volunteers to translate into other languages, particularly Spanish. Let us know if translation is among your skills. Please register with as early as possible even if it is just a name, general location and contact number.

World Breastfeeding Week: Celebrated in British Columbia October 1st to 7th 2003

The theme for this year is ***Breastfeeding in a Globalized World.***

Check out the WABA and Infact websites for further information.

Results from Breastfeeding Challenge 2002

Winner:

Yukon with a rating of 6.59% of women breastfeeding at one time.

Honourable mention

First Runner up:
Newfoundland & Labrador: with a rating of 2.00%

British Columbia was the province/territory with the most sites: 23 sites and a rating of 1.1%

Largest single site in Canada:
was Victoria, BC with 74 participants.

A total of 816 women took part at 47 sites across Canada.

Congratulations to all!

The History of infant feeding: Part II

The last edition (Fall 2003) of the newsletter has "The History of Infant Feeding: Part 1" covering the early history of breastfeeding and wet nursing up to the late part of the 19th century.

In the 19th century, medical management of feeding in America gained strength with the publication of seven pediatric texts between 1825 and 1850. As Golden (1997) describes, "What distinguished analyses of infant feeding in medical textbooks from those found in popular guides was not their science but rather their belief in medical authority". These texts provided a long list of reasons supporting the need for wet nurses and defined the nursery as a medical domain. These texts endorsed the need for physicians to provide medical guidance on child rearing including the selection of wet nurses (Golden).

Ideal wet nurses were expected to be very healthy and produce a good supply of milk (Acton, 1993). Wet nurses, like the donors to current milk banks, were screened with the health of the wet nurses own child being used as an indicator of the quality of her milk (Wickes, 1953). At a Paris hospital in the late 1800's, the number of feeds per wet nurse was reduced from fifty to thirty-four in order to promote the best outcomes for the lowest cost (Wickes). A reference written in 1917 quotes the average daily yield for a wet nurse as 38.5 ounces a day (Chown, 1928).

Unfortunately, many of the wet nurses were carriers of diseases such as tuberculosis and other infections (Grant, 1968). By the 16th century syphilis became a problem for wet nurses, either because they passed syphilis on to the baby they nursed or developed syphilis from contact with an ill baby. It remained a problem until the 20th century (Fildes, 1988). Other problems included neglect of the infant, inability to pay the wet nurse, alienation of the infant's affections, and concern about the quality of the milk.

Wet nurses were still regularly used in some countries until the 1940's (Fildes, 1988). In France and Russia they were employed in foundling homes (Wickes, 1953). The Moscow Foundling home employed 5,017 wet nurses in 1914 (Fildes). In the early part of the 20th century, the Royal Victoria Montreal Maternity Hospital employed wet nurses to feed premature infants. The arrangement was discontinued due to the cost of maintaining wet nurses and problems with availability of milk at all times (Barret & Hiscox, 1939). In 1917, both New York and Boston had directories of wet nurses (Abt, 1917). In Detroit, women who had stillbirths were encouraged to register as wet nurses and were paid seven dollars a week plus room and board (Hoobler, 1917). One physician of the time stated, "Every hospital with an infant's ward should have at least two wet nurses" (Hoobler). At this time, the term "wet nurse" was used to refer to women who breastfed other women's babies and those who expressed milk for the same purpose (Fildes). Wet nursing was considered very important in order to provide human milk for premature infants. Human milk was clearly valued in the early part of the 20th century and wet nursing forms the basis upon which donor milk banking was built. Wet nursing or professional breastfeeding was the initial form of donor milk banking to provide human milk to non-biological children. The drive to replace human milk interrupted the natural progression from wet nursing to donor milk banking.

Replacing human milk

When families could not afford to pay a wet nurse, they had to rely on either another woman's generosity or feed their babies animal milks such as cow, goat, camel, llama, sheep, donkey, water buffalo, or canine milk. Donkey milk was felt by some to be closest to human milk and could be purchased until the 1950's in England for ill babies (Grant, 1968). Over the centuries many alternatives substances were tried including various mixtures containing honey, clarified butter, broths, pap, wine, water, sherry, rice water, flour, beer, bread, sugar, meat juices, tea, dirt, and gin (Griffiths,1980; Jefferson, 1954; Powers, 1935; Wood,1955). Attempts at replacing human milk with other substances often proved fatal.

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By the beginning of the 20th century improved sanitation, knowledge of infant nutrition and decreased epidemics resulted in limited success with artificial feeding using modified animal milks (Baker, 1914; Blackman, 1977; Jefferson, 1954). The perceived importance of human milk diminished although as one physician described, "It is difficult to overcome a prejudice in favour of breast milk" (Tow, 1996, p.49). Many artificial feeding products or formulas were developed and sold in the late 19th and early 20th century. The first proprietary infant food, Liebig's "perfect" infant food, came on the market in the 1860s. Other companies, including Nestle, also began marketing infant feeding products throughout Europe, Australia and the Americas (Apple, 1986; Wood, 1955). As the advertising of artificial feeding products escalated, artificial feeding products began replacing human milk as the feeding method of choice (Apple; Stevenson, 1949).

Between 1900 and 1950, artificial feeding products replaced human milk as the normal method of infant feeding (Apple, 1994). This shift was facilitated by cultural changes in the first half of the 20th century including the changing role of physicians, increased medicalization of birth and increased technology (Apple, 1997). In addition, the establishment of pediatrics as a medical specialty and the increasing influence of science led to the shift from breastfeeding either mother's own or donor milk through wet nursing or milk banking to physician directed bottle feeding (Apple, 1997).

Part of the success of these new infant feeding products hinged on the marketers' use of medical patronage to sell their products. Around 1910, the proprietary companies started to realize the potential benefits of developing a closer partnership with the medical community (Apple, 1980). This resulted in products being produced without instructions on the cans (Apple). Mothers were encouraged to visit their physicians for guidance and the companies supplied instruction sheets directly to physicians (Apple).

By 1932, the American Medical Association (AMA) published specific advertising guidelines for infant foods. These stated that "every infant…should be under the supervision of the physician who is experienced and skilled in the care and feeding of infants" (Apple, 1980, p. 413). These guidelines restricted the companies from publishing instructions on the cans of artificial feeding products. By following the guidelines companies had their products endorsed with a Seal of Approval by the AMA, were permitted to participate in AMA meetings and advertise in the AMA journal (Apple, 1986). This relationship between proprietary companies and the medical community proved to be financially advantageous to both parties. Companies experienced increased demand for their products and physicians, through control of infant feeding, increased demand for their services. Marketing through the health care system continued throughout the years including most health care journals such as the Canadian Nurse. An example is a 1936 Gerber advertisement stating: "Thanks to you nurse, more mothers voted for me than for all the others combined" (Canadian Nurse, March 1936, p. 20).

Part lll will appear in our next newsletter.

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Education on your doorstep!

Making a Difference: an 18 hour course for health professionals

We are pleased to announce a new 18 hour course (based on the WHO/ UNICEF 18 Hour Course, 1993). *Making a Difference* is available across Canada as of February, 2003. Quintessence Foundation is promoting this course in an effort to support best practice. The two facilitators, Marianne Brophy and Kathy Venter, both IBCLCs, have a combined 26 years of international and Canadian Baby-Friendly Initiative (BFI) teaching and assessing experience. The course covers the basics of breastfeeding and includes a practicum session with mothers and babies and comprehensive coverage of the BFI 10 Steps Practice Outcome Indicators. Once the Practice Outcome Indicators for the BFI 7 Point Plan for the Community Health Services are available from the Breastfeeding Committee for Canada, they will be included as well.

In an effort to provide education at the lowest possible cost a variety of prices are offered depending on how much "in kind" services the sponsoring agency wishes to provide for the course. The cost is about $115/ student and up depending on the agency's involvement. Quintessence Foundation charges no fees, nor benefits financially in any way for providing the administrative and accounting services for this course. In addition, every time the course is offered, Quintessence Foundation will make a donation to the Vancouver Milk Bank. Promote best practice, support the Milk Bank, inquire about *Making a Difference* and make your own difference!

On-line education

The Baby-Friendly Initiative includes an emphasis on education for staff and physicians. This can be an expensive challenge with fiscal restraint, shift workers, and availability of speakers providing significant barriers. BC Women's Educational Services has developed a two-part breastfeeding on-line course to meet the needs of front line nurses in particular. Colour pictures and video clips enhance learning. This course offers the benefits of 24 hour availability, interactive learning, charts that can be printed off the computer, sections can be repeated by the learner as needed and costs are kept to a minimum.

There are two parts:

Level A Breastfeeding Course: A Clinical Introduction

Level B: Breastfeeding Course: Putting Theory into Practice.

Level A is an interactive course covering basic information related to factors affecting the breastfeeding relationship. Level B (under development) involves actual application of material learned in Level A to clinical situations. The course development involved the collaboration of two experienced nurse/ lactation consultant educators, a computer expert and professional photographers. Further information is available from Peter Choi at 604-875-2424 local 6388.

Update on Donor Milk Banking

In 1994, milk banks in the United States and Canada dispensed 162,950 ounces (HMBANA, 1995). In 1999, American/ Canadian banks dispensed 322,700 ounces and by 2001 the amount rose to 478,252 ounces (HMBANA, 2001). The growing demand throughout the world is reflected in increasing requests for donor milk throughout North America. In the United States, two more banks are in the process of opening bringing the number of American banks to seven. What about Canada? We have one donor milk bank at the Children's and Women's Health Centre of British Columbia.

The C & W Milk Bank has instituted a processing fee of $2/ounce to partially recover costs of processing. There is no charge for the milk itself. The cost of screening and processing donor milk is very labour intensive and expensive. In order to keep the milk bank functioning the processing fee has been applied as of February 4, 2003. There is no charge for milk used for children in hospital. The fee only applies to children in the community whose parents otherwise would be paying for formula.
To date, Quintessence Foundation has donated $25,000 to the C & W Milk Bank. We would encourage individuals to consider making a donation in order to enable the Milk Bank to thrive. We would also like to see regional banks established across Canada in order to meet the needs of Canadian infants. The establishment of regional banks is more fiscally sound than the one BC milk bank shipping donor and recipient milk across Canada.

What's New in Milk Banking?

Mexico: a contact in Mexico reports there are three milk banks functioning there.
Australia: a group is in the process of establishing a milk bank.
United States: a bank has opened in Delaware
Africa: there are now two banks in South Africa, both going by a name that roughly translated means "I have a Destiny."
If you would like to know where there are milk banks in North America, look up the HMBANA website at www.hmbana.org.

Save this date!
June 13th, 2003

Catch the Spirit
A workshop on the
Canadian BFI Practice
Outcome *Indicators*

10:00 am to 4:00 pm
at the Chan Centre at

BC Women's site

Cost $25.00 Lunch included.

Contact number: 604-875-2282

Registration forms available from wwwbabyfriendly.ca and attached to this newsletter.

This six hour workshop will include a review of both the BFI 10 Steps Practice Outcome Indicators for use in hospitals and the Practice Outcome Indicators for the BFI 7 Point Plan for Community Health Services. The three presenters Marianne Brophy, Marina Green and Frances Jones have experience working with the indicators and assessments. This workshop would be helpful to anyone interested in the Baby-Friendly Initiative and the provision of excellence of care in maternal-child health.

Ban on Use of Breast Milk

Recently, the media carried a story about breast milk that was being used in meals served in a restaurant in Changsha, capital of the southern Hunan province in China. The dishes were offered to reporters in January (one perch and one abalone dish) and by the next day 12 dishes were on the menu with donated milk from six women who were referred to as "nutritionists." The Hunan Ministry of Health informed the restaurant that breast milk cannot be sold as merchandise or traded for profit. The reason: "Selling breast milk is unethical because it deprives babies of their right to be breastfed by their mothers." (The Straits Times, 2003).

Wah Wong Memorial Lecture: Sleep like a baby: what does that really mean?

With James McKenna

The first Wah Wong Memorial lecture on June 7th, 2002, featured the topic of infant sleep. Dr James McKenna, Professor of Anthropology at the University of Notre Dame and Director of the Mother-Baby Behaviour Sleep Centre discussed where and how babies should sleep. His definition of co-sleeping included sleeping in the same bed or room as your child. He began by making the point babies do not need to be "trained to sleep." Dr McKenna highlighted how sleep training has been popularized in response to current ideas about "sleep disorders." The concept of sleep disorders which he described as "cultural disorders" have arisen over the last one hundred years. Co-sleeping leads to independent children but co-sleeping has been deemed culturally abnormal in North America. Patterns of sleep are influenced by cultural values of individualism and autonomy, influence of religious beliefs, and the rise of child care experts. Solitary infant sleep, which goes against biology, is viewed as normal. "There is no such thing as a baby, there is a baby and someone" (D. Winnicott). Dr McKenna refuted the idea that co-sleeping results in increased mortalilty and emphasized the need for careful examination of the evidence. Many deaths outside of a crib do not have the cause of death clearly defined. "Until better data are available to determine the impact of infant sleeping location on overall infant health, we should focus our recommendations on evidence-based information about sleep position and environment" (O'Hara, M. et al in press Pediatrics).

Dr McKenna acknowledged that safety during co-sleeping includes a firm mattress with no pillows or duvets covering the baby. Other factors increasing risk include parental obesity, smoking, drug or alcohol ingestion, poverty, prone infant sleeping position, over bundling and infant prematurity. Co-sleeping provides benefits as it enhances breastfeeding, encourages increased arousals and responses between mother and child (beneficial in decreasing risk of SIDS). Dr McKenna ended his session with questions from the audience and encouraged parents to feel comfortable in making the decisions for themselves regarding sleep arrangements.

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Formula: not as safe as often assumed

Soy formula: The UK Food Standards Agency has produced a detailed report about concerns regarding soy formula. It concludes by recommending that soy formula only be used when "clinically" indicated. The report reviews concerns regarding the effects of phytoestrogens on sexual development, thyroid function, and immune function. The report is found online at http:www.foodstandards.gov.uk/multimedia/webpage/phytoreportworddocs
Apparently consideration is being given in Britain to having soy formula available only on prescription. James Meikle writes in an article called, "Move to curb soy formula milk sales" in The Guardian (Feb 8, 2003):

> The (scientific) advisors say there "is clear evidence" of potential risk from using the products and no evidence that the products confer any benefit. There is no medical need for it either, they say, since other therapies could be prescribed for infants allergic to cow's milk protein.

Yes, and those therapies include, of course, breastfeeding and using human milk!

Powdered formulas: In the fall of 2002, Health Canada issued a warning regarding powdered formula. Contamination of powdered formula with E. sakazakii leading to infections and death in young children was reported. E. sakazakii can lead to neonatal meningitis, sepsis and necrotizing enterocolitis. Newborns with severe infections diagnosed with E. Sakazakii have a 40-80% chance of mortality. Meningitis from this type of infection may lead to cerebral abscess or infarction with cyst formation and severe neurological impairment.

The Health Canada warning indicates that powered infant formulas are not commercially sterile products. Therefore:

> Health Canada recommends that formula products be selected based on nutritional and medical needs. Whenever possible, an alternative to powdered formulas, such as ready-to-feed and concentrated liquid formulas, should be chosen in the NICU setting and for immunocompromised infants.

Since a healthy term baby became ill prior to hospital discharge and suffered permanent neurological sequelae as a result of an E. saskazakii infection, health providers and parents should be cautious in using powdered formula. Health Canada provides suggestions about preparing powdered formulas to help control or minimize the risk especially for situations in hospital where specialty powdered formulas are the choice. Just think – donor milk from a milk bank is only dispensed if sterile. Maybe the answer comes with greater availability of donor milk?

Further information is available on formula on the Health Canada website.

What's New in Research

Kramer, M.S, Kakuma, R. (2003). Optimal duration of exclusive breastfeeding (Cochrane Review). In *Cochrane Library, Issue* 1, 2003. Oxford: Update Software.
Twenty independent studies from both developing and developed countries met the criteria. The primary goal of the review was to assess the effects on child health, growth, and development and on maternal health of exclusive breastfeeding for six months versus exclusive breastfeeding for three to four months with mixed feeding thereafter through six months. Infants who were exclusively breastfed for six months experience less morbidity from gastrointestinal infection with no growth deficits. Recommends exclusive breastfeeding for six months.

Armstrong, J. Reilly, J. (2002) Breastfeeding and lowering the risk of childhood obesity. *Lancet, 359, 2003-2004*.
This study involved 52,394 Scottish children (39-42 months) and found those who were formula fed had a significant higher rate of obesity. Breastfeeding is associated with a reduction in childhood obesity risk.

Mikiel-Kostyra, K., Mazur, J., Boltruszko, I. (2002). Effect of early skin-to-skin contact after delivery on duration of breastfeeding: a prospective cohort study. *Acta Paed* 91, 12, 1301-1206.
The authors concluded that skin-to-skin contact lasting longer than 20 minutes after birth increases the duration of exclusive breastfeeding.

Ruoweii, L., Ogdenn, C., Ballew, C., Gillespie, C., Grummer-Strawn, L. (2002). Prevalence of exclusive breastfeeding among US infants: the third national health and nutrition examination survey. (Phas ll, 1991-1994). *American Journal of Public Health*, 92, 7, 1107-1110.
The results indicated that 47% of the children were exclusively breastfed at 7 days postpartum, 32% at 2 months, 19% at 4 months and 10% at 6 months whereas the proportion of children still being breastfed at these months was 52%, 40%, 29% and 22% respectively.

Fewtrell, M., Morley, R., Abbott, R., Singhal, A., Isaacs, E., Stephenson, T., MacFadyen, U., Lucas, A. (2002). Double-blind randomized trial of long-chain polyunsaturated fatty acid supplementation in formula fed to preterm infants. *Pediatrics*, 110, 1, 73-82.
This study examined the hypothesis that adding LC-PUFAs to preterm formula during the first weeks of life should confer long-term neurodevelopmental advantage. The results indicated no significant differences in developmental scores between randomized groups for those who did and did not receive the LC-PUFA formula. Breastfed infants had significantly higher developmental scores at 9 and 18 months than both formula groups. Further follow-up on these study groups is planned to consider effects at a later age.

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Weimer, J.P. (2001). *The economic benefit of breastfeeding*. Economic Research service. Food Assistance and Nutrition Research Report Number 13. USDA.
This excellent article provides an overview of studies supporting the economic benefits of breastfeeding. It concludes that a minimum of $US 3.6 billion would be saved in health care costs if breastfeeding rates increased from current levels (64% in hospital, 29% at 6 months) to those recommended by the US Surgeon General (75% and 50%).This includes the costs for treatment of only three childhood illnesses – otitis media, gastroenteritis and necrotizing enterocolitis. Although the report presents American data it provides evidence in an area where little evidence has existed.

Resources

1. The Ontario Breastfeeding Committee Newsletter
   Contact: Kventer@cogeco.ca
   Phone: 905-331-7922

2. UK UNICEF Baby-Friendly Initiative Newsletter available for downloading at www.babyfriendly.org.uk

3. Leon-Cava, N., Lutter, C., Ross, J., Martin, L. (2002) Quantifying the Benefits of Breastfeeding: A Summary of the Evidence. Washington, DC, PAHO. Reference number HPN/66/2.
   This booklet is available online at www.linkagesproject.org/. The entire booklet is 168 pages but parts can also be downloaded or a print copy ordered.

   A Child's view: A participant in the Breastfeeding Challenge 2002 was explaining to her older (verbal) son what was about to happen: "All these babies and toddlers are going to nurse at the same time." Her son's incredulous response was, "All off you, mommy?"

QF Contact information

If you would like to get this newsletter or make suggestions please check our website: www.babyfriendly.ca

Write to us at:

Quintessence Foundation,
Suite 501-4438 West 10th Ave.,
Vancouver, B.C. V6R 4R8

Check out the back page for information on the:
Catch the Spirit
A workshop on the
Canadian BFI Practice
Outcome *Indicators*

Funding

Funding for Quintessence comes from charitable donations. The Foundation abides by the principles of the International Code of Marketing of Breast Milk Substitutes and will not accept funding from any sources who do not support the Code. To make a donation please send a cheque to our listed address and a tax receipt for donations over ten dollars will be provided.

If you would like to receive this newsletter please fill in the following information. We would also like to receive information or suggestions for future newsletters.

Our newsletter can be downloaded from our website. If you have received this by mail and have computer access please let us know and we will notify you when we publish a newsletter. **We would prefer to e-mail our newsletter where possible.** If you have suggestions please email or send us a note.

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Quintessence Foundation
Suite 501- 4438 West 10th Ave,
Vancouver, BC, V6R 4R8
Charitable number: 89941 1425 RR00001

Catch the Spirit

A workshop on the Canadian Baby-Friendly Initiative (BFI) Practice Outcome Indicators For both hospital and community health care professionals

Quintessence Foundation

This six hour workshop includes a review of both the BFI 10 Steps Practice Outcome Indicators for use in hospitals and the Practice Outcome Indicators for the BFI 7 Point Plan for Community Health Services. These documents have been developed through the Breastfeeding Committee for Canada and provide guidance to health professionals about the specifics of the BFI assessment process in Canada. Agencies working toward having a BFI assessment will need to be familiar with the information provided at this workshop.

The three presenters have experience working with the indicators and assessments. All three presenters also have extensive experience working with breastfeeding families. This workshop would be helpful to anyone interested in the Baby-Friendly Initiative and the provision of excellence of care in maternal-child health.

Cost: $25.00 (includes lunch)

Place: Chan Centre for Family Health Education at the Children's and Women's Health Center of B.C. (the Chan Centre is on the hospital grounds)

Address: 28th & Oak Street, Vancouver

Date: June 13, 2003

Time: 10:00 am to 4:00 pm

Presenters: Marianne Brophy, B.Com. IBCLC, Marina Green, RN, MSN, IBCLC
Frances Jones RN, MSN IBCLC

For further information contact: 604-875-2282

Registration form: (***please print legibly***)

Name: _____

Position: _____

Agency Affiliation: _____

Contact information: Address:_____

_____Postal Code:_____

Phone: _____ Email: _____

Mail with cheque made out to Quintessence Foundation to:

Quintessence Foundation, Suite 501- 4438 West 10th Ave., Vancouver, B.C. V6R 4R8

Bring a team from your hospital/community and learn about the indicators.

IBCLC Cerps applied for

Check out the Quintessence Foundation website at www.babyfriendly.ca