Protecting, Promoting and Supporting Breastfeeding

INFACT Canada/
IBFAN North America

Infant Feeding Action Coalition, 6 Trinity Square Toronto, ON M5G 1B1 tel: (416) 595-9819 fax: (416) 591-9355

Newsletter Spring 2009

Canada's Breastfeeding Rates: How are we doing?

Canada's breastfeeding rates need a periodic check-up and Canada's 2008 Perinatal Health Report[1] does just that. The good news is that overall, Canada's breastfeeding rates are increasing.

Published by the Public Health Agency of Canada, the report covers a number of perinatal health determinants and outcomes. It also gives us the most up-to-date look not only at Canada's breastfeeding rates but also at the behaviours, the environments both physical and social, and the health services that impact on infant feeding outcomes. The report used data from the Canadian Community Health Survey[2] (CCHS). In this survey, breastfeeding rates are defined as "the number of women who have given birth to a live born child and ever breastfed that child, expressed as a proportion of all the women who delivered a live born child."

Using Canada's infant feeding recommendations (based on the World Health Organization's recommendations of exclusive breastfeeding for the first six months of life and continued breastfeeding for up to two years and beyond) as the standard, both rates of initiation and duration of exclusivity show improvement.

Some Comparisons

The 1982 Health and Welfare Canada national survey, of 18,000 households, reported a national average for mothers initiating breastfeeding to be 69.4 per cent. Similar regional variations were reported, showing a low of 57.6 per cent for the Atlantic provinces and a high of 82.9 per cent in British Columbia. By six months, 75 per cent had discontinued breastfeeding with mothers from the Atlantic provinces and British Columbia discontinuing earlier while mothers in the Central parts of Canada breastfed for a longer duration.

The Province of Quebec has made substantial progress over the past decade. In the National Population Health Survey of 1996-97 (Health Canada, Statistics Canada and the Canadian Centre for Health Information, 1999), breastfeeding rates at birth were 60 per cent in Quebec as compared with 79 per cent for Canada overall,

placing Quebec, along with the Maritimes, at the lowest level among Canadian provinces.

Quebec and the Maritimes also have the shortest duration of breastfeeding: in Quebec, according to the 2000 Canadian Perinatal Health Report, 34.8 per cent of mothers who breastfed did so for less than three months (Statistics Canada, data from 1996-1997).

More recent data from the Longitudinal Study of Child Development in Quebec (ELDEQ 1998-2002) shows a recent improvement in the situation with close to three-quarters (72 per cent) of Quebec infants having been breastfed at birth. The study's data also show that 47 per cent were breastfed for at least three months and that 41 per cent were breastfed for at least four months. Other reports[3,4] note that numerous women are failing to reach the objectives they set for themselves in the area of breastfeeding duration. In a survey carried out in 1994 among first-time mothers in Quebec, only 41 per cent of women who breastfed reached their goal.

The Brome-Missisquoi region of Quebec, with Canada's first Baby-Friendly hospital, instituted a program which demonstrates the correlation between supportive policies and practices and breastfeeding outcomes. A formative assessment of the program showed a substantial increase in the rate of breastfeeding at the time of leaving the hospital, which rose from 47 per cent in 1994 to 80 per cent in 1997.

Results

- The rates of breastfeeding initiation have increased steadily during the five years of surveillance. In 2005, 87.0% of mothers who gave birth in the previous five years initiated breastfeeding, compared to 81.6% in 2000–2001
- Similarly, rates of exclusive breastfeeding for at least six months have increased. In 2005, 16.4% of infants were breastfed exclusively for six months compared to 14.2% in 2003 (Figure 2).
- Breastfeeding initiation rates varied by province with an increasing trend from east to west. In 2005, rates ranged from a low of 62.3% (95% CI: 54.9–69.8) in Newfoundland and Labrador to 98.8% (95% CI: 96.5–101.1) in the Yukon (Figure 1).

Are we there yet?

Simply put—no. Although we can feel pleased and confident about improved infant feeding practices, we remain far from reaching the more optimal levels found in countries such as Norway, considered a model for breastfeeding practices and policies. As a society we are increasingly realizing that breastfeeding is the normal way to feed infants and young children and we are gradually coming to understand the social and institutional supports needed to achieve this. However, we still don't fully accept breastfeeding as what it is—natural, normal, and instinctive. The recent, much publicized controversy over Facebook's withdrawal of photos of breastfeeding mothers and their babies demonstrates the discrimination that persists.

Improved supports

A number of interesting and positive social changes have taken place over the past decade to improve environments for mothers and children. Mothers are now more aware

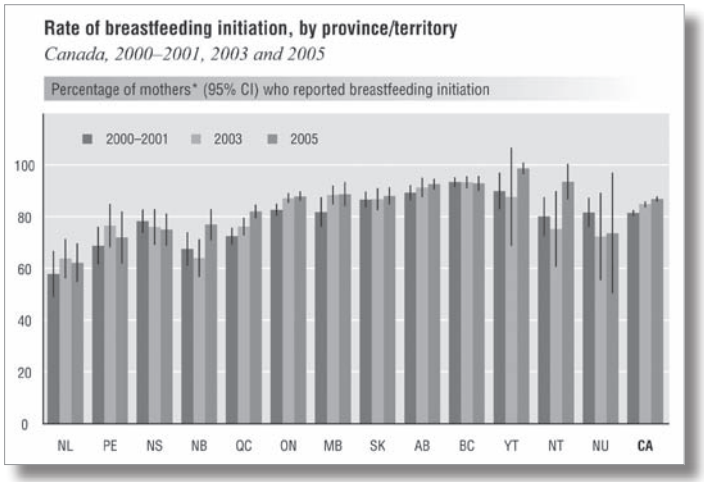


Figure 1: Rate of breastfeeding initiation, by province/territory

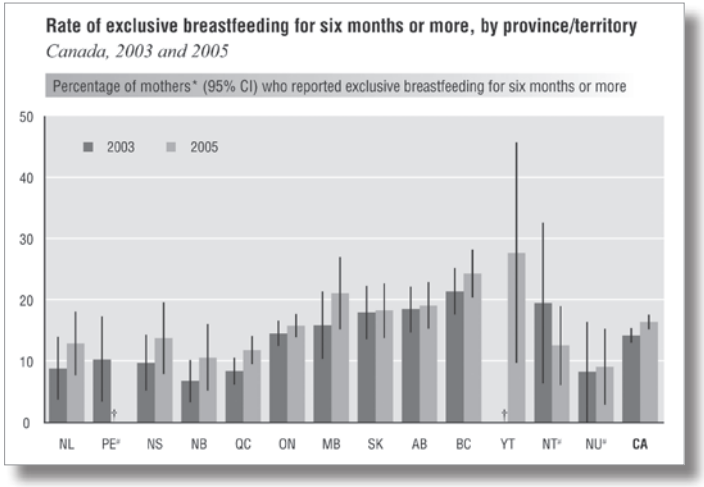


Figure 2: Rate of exclusive breastfeeding for six months or more, by province/territory

of their right to breastfeed and their babies' right to be breastfed. Discriminatory behaviour directed at mother-baby pairs breastfeeding in public spaces has been met with anger and activism. With demonstrations and boycotts against retailers and a volume of media attention, we are realizing that discrimination against breastfeeding women, apart from being illegal, is socially unacceptable, and rightly so. Canada's progress towards mother-baby friendly birthing through the implementation of the Baby-Friendly Hospital initiative has been criticized as being too slow. Even so, important positive changes in maternity delivery practices have taken place over the past decade. Rooming-in, early breastfeeding after birthing, elimination of infant formula discharge packs, improved staff training and post-discharge links with community mother-to-mother support groups all contribute to establishing the normalcy of breastfeeding.

In industrialized countries such as Norway where broad-based supportive social polices exist,[5] higher breastfeeding rates are also common. In Norway in the mid 1990s, the rate was 98 per cent at birth and 68 per cent at six months. More recently, the rates reported in Norway were 92 per cent at three months, 80 per cent at six months and 40 per cent at 12 months.

Maternity benefits for Canadian families are comparable to those of Scandinavian countries, with the majority of mothers receiving 50 weeks of paid

Steps of the Baby Friendly Hospital Initiative and questions asked about them in the MES[6]

Steps		%
Step 3: Inform all pregnant women about the benefits and management of breastfeeding	Given information about breastfeeding prenatally	92.3
Step 4: Help mothers initiate breastfeeding within a half-hour of birth.*	Baby held within 5 minutes of birth	71.9
	Baby first held skin-to-skin, i.e. when the baby was naked i.e. not wrapped, dressed or in a diaper, and held against the mother's skin	31.1
	Baby first put to the breast within 5 minutes of birth	21.9
	Baby first put to the breast between 6–30 minutes of birth	23.8
	Baby first put to the breast within 31 minutes–2 hours of birth	29.5
Step 5: Show mothers how to breastfeed, and how to maintain lactation even if they should be separated from their infants.	Healthcare provider offered to or helped mother to start breastfeeding	80.7
Step 6: Give newborn infants no food and drink other than breast milk, unless medically indicated.	Liquids such as water, juice or formula added within first week after birth	10.0
	Liquids such as water, juice or formula added within two weeks of birth	25.0
	Healthcare provider gave or offered to give mother free formula samples	35.8
Step 7: Practise rooming-in—allow mothers and infants to remain together—24 hours a day.	Baby rooming–in (in another room for 1 hour per day)	65.0
Step 8: Encourage breastfeeding on demand.	Fed whenever baby seemed hungry / demand feeding	49.8
	Fixed schedule feeding	17.7
	Mixed demand and schedule feeding	32.5
Step 9: Give no artificial teats or pacifiers (also called dummies or soothers) to breastfeeding infants.	Baby given a pacifier or soother within first week after birth	44.4
Step 10: Foster the establishment of breastfeeding support groups and refer mothers to them on discharge from the hospital or clinic.	Given information about community breastfeeding support resource	86.3

Note: No questions were asked about Step 1 (Have a written breastfeeding policy that is routinely communicated to all health care staff) and Step 2 (Train all health care staff in skills necessary to implement this policy) as these do not involve mothers directly.

* Step 4 refers to initiation of breastfeeding within one half-hour of birth. Initiation of breastfeeding is regarded as commencing with maternal-infant contact in the moments after birth, preferably skin-to-skin, followed by breastfeeding when the baby shows signs of readiness to feed, usually within t he first hour after birth.

maternity benefits. Thus far access criteria remain an obstacle for some women, especially those engaged in part-time, temporary or self-employed work. Yet these are the very employment situations that many women with family responsibilities face. Quebec remains the only province to date to recognize the varying demands placed on working women and the province has eased access restrictions. Throughout the country, the extension of Canada's maternity leave from six months to a full year in 2000 has allowed more mothers to return to work later and increased both the rates of exclusive and sustained breastfeeding. A study[7] conducted after this increase showed:

- mothers returned to work three to three and a half months later,
- breastfeeding duration increased by an average of one month,
- exclusive breastfeeding increased from 20 per cent to 28 per cent.

Recognition of mothers' and babies' right to breastfeed is a social construct in the continuum of supports which must be strengthened in order to mainstream breastfeeding. This includes both the right to breastfeed anytime, anywhere as well as the right to negotiate her breastfeeding needs in the workplace after completion of her maternity leave. These rights are increasingly understood, and consequently more women who are discriminated against are taking their complaints to their provincial or territorial Human Rights Commissions, as highlighted by recent media-profiled cases.[8,9]

Increasingly, major public health agencies, professional associations and even provinces have developed comprehensive breastfeeding policies. Cities like Toronto have incorporated practices based on breastfeeding rights, including accessible home visits for all mothers, adequate training of all health care workers, and breastfeeding-friendly workplace environments. Both Quebec and Nova Scotia are targeting their public health practices towards full provincial Baby-Friendly status. A recent Quebec study[4] concluded breastfeeding rates have increased significantly in the past five years and are comparable with those in the rest of Canada. Therefore initiatives to support breastfeeding mothers in the hospital and in the community have been successful.

Barriers still faced by Canada's mothers

Canada's Perinatal Health Report does not analyze the reasons for the increase in breastfeeding rates, nor the fact that breastfeeding rates remain far from optimal. Full realization of the WHO and Health Canada's recommendations for exclusive and sustained breastfeeding remain elusive. Health Canada's hands-off policy regarding the full implementation of the International Code of Marketing of Breastmilk Substitutes and the relevant WHA resolutions means that women continue to be pressured by virtually unregulated formula advertising. Pregnant women and new mothers are assaulted with free product samples, false health claims and persistent email campaigns stressing the virtues of artificial feeding. These are all intended to undermine public health efforts that support women's breastfeeding needs.

Canada's government must put both financial and policy support behind the many ongoing efforts across Canada towards breastfeeding-friendly structures. Recognition by governments that breastfeeding support is one of the most effect-

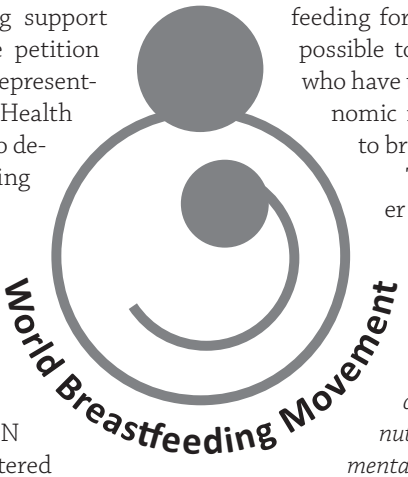
Continued on page 7

ONE MILLION breastfeeding campaign launched

INFACT Canada is proud to join with IBFAN Asia in their One Million Campaign, a global initiative to promote and support women's right to breastfeed. INFACT Canada's counterpart in the region is spearheading the drive to collect one million signatures on a petition demanding breastfeeding support from world leaders. The petition will be presented to UN representatives when the World Health Assembly meets in May to deliberate on infant feeding issues.

The campaign was officially launched on 9 February 2009 when the website **www.onemillioncampaign.org** went online. It is fitting that IBFAN Asia, which is headquartered in India, is at the head of this effort. India has long been at the forefront of combatting aggressive formula marketing and has enacted many provisions of the International Code into national law. Like many other countries however, breastfeeding rates are far from optimal and infants continue to suffer the consequences. One in 18 Indian children die in their first year of life.

The One Million Campaign focuses specifically on the need to create workplace environments that are breastfeeding-friendly. Having to return to work after birth is a primary reason why many women stop breastfeeding, especially in countries that provide working women with few, if any, maternity benefits. Marginalized and impoverished mothers often have little choice but to leave their babies at home when they leave for the workplace. The WHO's global recommendation of exclusive breastfeeding for six months will be impossible to achieve unless women who have to return to work for economic reasons have their right to breastfeed protected.



Graphic courtesy IBFAN Asia

The petition will deliver the following message to the representatives at the World Health Assembly :

"As citizens, we call for a stop to commercial interference in infant nutrition, the strict implementation of the International Code for Marketing of Breastmilk Substitutes and ensuring support for women to breastfeed. We urge you to create/implement legislation that restricts infant milk manufacturers from promoting their products as breastmilk substitutes/baby foods, to have a budgeted plan of action to promote and support women for optimal breastfeeding and to ensure breastfeeding friendly workplaces with adequate nursing breaks in the public and private sector so that working women are not forced to abandon breastfeeding."

To sign the petition, visit **http://www.onemillioncampaign.org**.

Continued from page 7: "Breastfeeding Rates"

ive and least costly public health interventions is yet to be realized.

References

1. Public Health Agency of Canada. **Canadian Perinatal Health Report, 2008 Edition,** Ottawa, 2008.
2. Statistics Canada. **Canadian Community Health Survey.** **http://www.statcan.gc.ca/cgi-bin/imdb/p2SV.pl?Function=getSurvey&SurvId=3226&SurvVer=0&InstaId=15282&InstaVer=4&SDDS=3226&lang=en&db=IMDB&dbg=f&adm=8&dis=2**. accessed March 16, 2009.
3. Gilbert D, Moisan J, Lepage MC, De Serres G. **(Breastfeeding and factors associated with younger and older mothers)** Can J Publ Health 87: 95-96, 1996.
4. Bell L, Lacombe M, Yergeau E, Moutquin JM, Tribble DS, Royer F, Garant MP. **The factors facilitating and constraining the continuation of breastfeeding in women in Estrie, Quebec**. Can J Publ Health 99: 212-215, 2008.
5. Heiberg EE, Helsing E. **Changes in breastfeeding practices in Norwegian maternity wards: national surveys 1973, 1982 and 1991.** Acta Paediatr. 84: 719-724, 1995.
6. Chalmers B, Dzakpasu, S, Heaman M, Kaczorowski J, **The Canadian Maternity Experiences Survey: An Overview of Findings.** J Obstet Gynaecol Can 30:217–228, 2008.
7. Baker M, Milligan K. **Maternal employment, breastfeeding and health.** Statistics Canada, April, 2007.
8. **Breastfeeding mums fill Vancouver H&M store.** CBC August 8, 2008.
9. **H&M breastfeeding incident sparks human rights protest.** CBC August 6, 2008.

World Breastfeeding Week 2009

World Breastfeeding Week is celebrated each year on October 1 to 7 in Canada. This year's WBW theme, created by the World Alliance for Breastfeeding Action, is **Breastfeeding: *A Vital Emergency Response … Are You Ready?*** This theme highlights the life-saving capacity of breastfeeding in emergency situations.

To develop this theme, INFACT Canada is using the slogan **Breastfeeding Saves Lives: *Protecting Infants Every Day and in Emergencies*** for our World Breastfeeding Week celebrations. This slogan affirms that breastfeeding is vital to infant health, and protects against mortality and morbidity. The immunological and nutritional properties of breastmilk are protective against serious threats to infant health under routine as well as extraordinary conditions. Premature or low-birth weight babies, as well as babies in crisis situations or situations of poverty, can especially benefit from being breastfed. The bottom line is that breastfeeding saves lives.

As usual, INFACT Canada will be marking the occasion with the production of our World Breastfeeding Week Action Kit, which contains original fact sheets, resources and posters to promote this year's theme. Fact sheet topics include: The International Code, Breastfeeding and Food Security, the Costs of Formula Feeding and Case Studies on Breastfeeding in Emergencies.

World Breastfeeding Week is celebrated October 1 to 7 in Canada. INFACT Canada's World Breastfeeding Week Action Kit will be available for purchase this June at **www.infactcanada.ca**.

Study confirms Nestlé Bear Brand labels dangerous

In the Winter 2006 edition of INFACT Canada's newsletter, we reported on Nestlé's use of misleading labels on products in Laos. Many products sold in South Asia, including coffee sweeteners, condensed milk, skimmed milk, and palm oil, are branded with a logo showing a cartoon mother bear cradling a baby bear in the breastfeeding position. This same logo appears on infant formula for children over six months. Doctors in Laos have reported that malnourished children have been arriving in hospitals after being fed exclusively on coffee sweeteners or condensed milk. Many parents mistakenly believe that any product with the mother and baby bear logo is suitable infant food. The result has been malnourishment and death among Laotian children.

The original Bear Brand logo from 1979 (left) appears to be a deliberate attempt to confuse parents into thinking Nestlé condensed milk is a baby food. The current, revised logo (right) is virtually the same.

Nestlé has allowed this situation to persist for years, despite calls from health officials and activists to change the way their products are labelled. In September of last year however, the British Medical Journal published a high profile study[1] confirming that Nestlé's labelling was causing deadly confusion in Laos. The researchers interviewed all 26 doctors who were working as paediatricians in the country at the time. Thirteen of them responded that parents "often" fed coffee creamer to their infants as a breastmilk substitute.

Researchers also interviewed nearly 1100 adults and only two percent of the respondents correctly identified the product as coffee creamer. Ninety-six per cent believed the can contained milk, and nearly half said either the product was good for infants or was a replacement for breastmilk. Nineteen per cent of adults reported giving the coffee creamer to their children, and said their main reasons for doing so were because they thought it complemented breastmilk, was good for infants, or because it was cheap.

Nestlé has argued that its labels are appropriate because they include a message that the product is "not... a breastmilk substitute," but the study's results show that the visual image of the mother bear and cub contradict the written message and parents continue to be misled. Laos does not have a high literacy rate, especially in rural areas, and it seems the visual message of the bear is much more effective than any warning. The warning is written in English and Thai, not Lao, or the local languages which are spoken in rural areas of the country.

In a letter to BMJ,[2] the head of Nestlé's dairy operations in the region said that the company stopped using the logo on its coffee creamer in February 2008. However it still appears on a variety of products that are dangerous if used as breastmilk substitutes, such as condensed milk.

> *It's taken over thirty years for Nestle to make even minor changes to its dangerous logo.*

Nestlé has said it is taking extraordinary measures to address this situation. The original Bear Brand logo, created in the 1970s, featured a mother bear bottle feeding a baby bear. Since then the company dropped the bottle, and are apparently now planning to remove the baby bear from the logo in the near future. As Dr. Leila Srour, a Lao physician wrote "Is this an extraordinary measure? Dropping a bottle and then a baby within 30 years?"[3] A much more appropriate step would be to have labels that correspond to the contents of the container, i.e. a picture of a coffee cup to denote a coffee creamer.

Laos already faces high levels of infant malnutrition, and these misleading labels only increase the risk to already vulnerable Laotian children. After years of paediatricians and activists speaking out against these labels, Nestlé can no longer claim ignorance. Their labelling practices are actively undermining the health of Laotian children and the company refuses to take definitive action. The continued use of the Bear Brand logo stands out as a particularly harmful offence among the company's ongoing litany of dangerous practices.

References

1. Barennes H, Andriatahina T, Latthaphasavang V, Anderson M, Srour LM, **"Misperceptions and misuse of Bear Brand coffee creamer as infant food: national cross sectional survey of consumers and paediatricians in Laos."** BMJ 2008;337;a1379 doi:10.1136/bmj.a1379.
2. BMJ, 2009; 338, p. 189.
3. Srour, Leila **"Will Nestlé's Bears Continue to Mislead Parents and Threaten Infants' Lives?"** British Medical Journal, March 3 2009, **www.bmj.com/cgi/eletters/337/sep09_2/a1379#207174.**

All hospitals in Oman to become baby-friendly

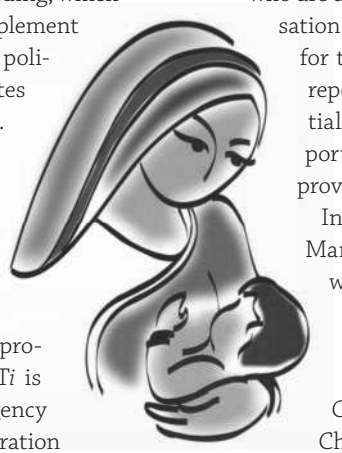
All private hospitals in the middle-eastern country of Oman will become baby-friendly accredited, according to a plan introduced by the ministry of health. In 1996, all government hospitals in the country were brought under the WHO/UNICEF's Baby Friendly Hospital Initiative, but only now is the initiative being made mandatory for private facilities as well. "The aim is to ensure breastfeeding and discourage the use of breast milk substitutes," Dr Sheikha Al Kharusi, coordinator of the Ministry of Health said.

Health officials at all levels will be responsible for instituting the BFHI, and the government will institute a training program for health workers. The exclusive breastfeeding rate in Oman is only 31 per cent, but Oman has been a regional leader in the efforts to promote breastfeeding.

India releases breastfeeding report as part of IBFAN global monitoring project

In December 2008, India released a report on the state of breastfeeding support in the country. The report was a milestone in a new international IBFAN project designed to evaluate national breastfeeding policies around the world. The World Breastfeeding Trends Initiative (WBT*i*) was launched last year, and seeks to follow up on the recommendations of the Global Strategy for Infant and Young Child Feeding, which urged member states to implement and evaluate comprehensive policies to raise breastfeeding rates and reduce child malnutrition.

The goal of WBT*i* is to produce an accurate picture of how breastfeeding support programs are operating in any given country, and to identify and bridge gaps in countries' breastfeeding programs and policies. The WBT*i* is funded by the Norwegian Agency for Development Cooperation (NORAD) and has been launched in 51 countries, with regional IBFAN groups training local representatives to conduct the mapping of IYC feeding programs in their own countries. The WBT*i* seeks to bring government agencies and civil society together to work towards better breastfeeding practices. While other countries have completed WBT*i* reports, India's is seen as a flagship project because of its status as one of the world's largest countries and a regional leader.



Graphic courtesy IBFAN Asia

The results of the India report are far from optimal. India received a colour ranking of Yellow, one step above the lowest ranking of Red. The report shows that the country has no defined policy to encourage breastfeeding, and no budget has been specifically set aside for any breastfeeding programs. It also highlighted that there are no policies for working women and women in emergency situations, who are at particular risk for early cessation of breastfeeding. As a pilot for the WBT*i* program, the India report demonstrates the potential for identifying gaps in support programs needed to improve breastfeeding rates.

In 2007, Prime Minister Manmohan Singh vowed to wipe out child malnutrition by ensuring all infants were optimally breastfed. The Prime Minister's National Council on India's Nutrition Challenges has been set up in order to achieve this goal. IBFAN's own representative on the council, Dr. Arun Gupta, is hoping that the India 2008 Report, while troubling, will be used as an effective tool to take action on infant nutrition issues.

Furthermore, as WBT*i* results come in from additional countries, IBFAN's capacity to target its programming and its advocacy will be greatly increased, strengthening efforts for breastfeeding and child survival programs at all levels.

Policy report recommends breastfeeding to reduce cancer risk

In February 2009, the World Cancer Research Fund and the American Institute for Cancer research released a policy report on cancer prevention. The document was put together by leading experts in the field of cancer research and public health and looks at the relationship between diet, exercise and cancer. Researchers conducted systematic literature reviews and made ten overarching policy recommendations based on the scientific evidence. This study went beyond the standard recommendation that mothers should breastfeed and babies should be breastfed, and outlined specific policies to be adopted by governments and in the workplace to ensure best breastfeeding practices.

Supportive Environments

Not only did the report highlight the relationship between cancer and breastfeeding, but it also looked at environmental factors that influence breastfeeding rates such as maternity leave, workplace policies and marketing of infant formula. The authors suggest that workplaces institute policies that support breastfeeding, such as having an area for mother's to pump and store their breastmilk, as well as providing access to a crèche (on site daycare). Implementing these policies would support working women to continue breastfeeding, thus decreasing the mother's chance of developing breast cancer, and reducing the infant's risk of becoming overweight or obese (and therefore reducing the risk of cancers associated with overweight and obesity).

The authors highlighted examples of countries that have put into effect laws and policies that promote breastfeeding in public. One such country was New Zealand, which passed a bill in 2008 that makes it mandatory for employers to provide breaks and facilities for mothers to express and store breastmilk. Non-compliant organizations may be subject to penalties (as of yet unspecified).

Report Recommendation: That *workplaces and institutions* encourage sustained breastfeeding with supportive environments and employment contracts, and access to childcare.

Advertising and Marketing

The report also discusses the impact of advertising and marketing of processed foods and beverages to children. The types of foods being aggressively advertised (sugary breakfast cereals, fast foods, soft drinks, confectionary and savoury snacks) and the success of these strategies is a strong indictment for taking action to curb such advertising. Looking specifically at the impact on breastfeeding, the report notes that since breastfeeding is not advertised, promotion of infant formula competes unfairly with breastmilk. Furthermore, while the WHO International Code of Marketing of Breastmilk Substitutes came into being in 1981, the document is not enforceable unless it is legislated by a country.

The authors suggest three possible strategies to change the current marketing environment: 1) Restrict or **prohibit advertising of unhealthy processed foods** to children, 2) Stricter **controls** on advertising

Continued on page 13

Bisphenol lingers much longer in infants, U of G study finds

Despite evidence, manufacturers, still determined to sell BPA bottles outside North America.

A new study from University of Guelph has shown that babies are particularly vulnerable to the build up of bisphenol A in their bodies. If exposed to the same amount of bisphenol A (also known as BPA), infants will retain the chemical at levels 11 times higher than adults, the study found. This seems to justify Canada's move to ban the use of the chemical in baby feeding bottles, a process that was initiated last year by Health Minister Tony Clement.

Photo courtesy treehugger.com

Canadian infants have been protected from BPA by a government ban. If bottle manufacturers have their way, infants in other countries may not be so lucky.

The study suggests that infants don't yet have the proper enzymes to break down and eliminate bisphenol from their systems, making them particularly vulnerable to the chemical.

BPA is also present in many plastics and the linings of food containers, leading to fears that pregnant women who ingest the chemical may be exposing their babies to health risks. Len Ritter, who conducted the Guelph study and is executive director of the Canadian Network of Toxicology Centres, said "I would advise a pregnant woman to try to reduce or entirely eliminate her exposure to bisphenol A."

The chemical has been linked to cancer, early onset of female sexual maturity, male fertility problems, and behavioural problems. It has been used commercially for more than 30 years, and for much of that time has been a prime component of baby bottles.

In the same week the study was released, the San Francisco Chronicle quoted a spokesperson for Philips, which makes Avent feeding bottles, as saying the company would no longer be selling bottles containing BPA in the United States because of "confusion" over the safety of the chemical. The company does plan to continue selling the bottles in other parts of the world however.

Philips' position on BPA seems to fly in the face of almost all research done on BPA. The Guelph study is only the latest of many to conclude that the chemical is harmful, particularly to infants. Despite the scientific consensus, the bottle manufacturer is pointing to "confusion" over the evidence, and has pledged to continue selling the toxic bottles in markets where the chemical has not yet been regulated.

In reaction to the Philips statement, the Malaysian organization, the Consumers Association of Penang (CAP) issued a statement warning that Asian markets might become a "dumping ground" for the dangerous chemical. The CAP is lobbying its government to immediately halt the sales of baby bottles containing BPA.

Reduction and regulation of chemicals in our environments is critical to safeguard the health of infants and children. What's more, the protection and support of breastfeeding to reduce the use of artificial feeding products is our best assurance against these chemical dangers harming children.

Continued from page 11: "Policy Report on Cancer "

and **marketing of infant formula** and weaning foods, 3) Promotion and **marketing of healthy ways of life**. The second strategy was deemed to have high potential impact as well as a high level of confidence in the data (the only strategy to receive a rating of 'high' in both areas). Examples of countries that have successfully implemented restrictions on infant formula include Iran, where infant formula is only available by prescription and Papua New Guinea, where there is a ban on advertising breastmilk substitutes as well as feeding bottles, cups, teats and pacifiers.

This report is the first of its kind to recommend implementing the Code as a measure to fight cancer.

Report Recommendations:

1. For *governments* to incorporate United Nations recommendations into law or appropriate public health and consumer protection rules ;
2. For *industry* to ensure that marketing and promotion of breastmilk substitutes and complementary foods follow the terms of UN codes and strategies on infant and young child feeding, which include the **International Code** and the **Global Strategy on Infant and Young Child Feeding**.

The Policy and Action for Cancer Prevention report provides a comprehensive analysis of the factors that affect the most common cancers, as well as the policies that can be implemented on various levels to prevent cancer. The fact that breastfeeding was included as an overarching recommendation is a testament to the important role it plays in developing healthy infants into adults. Having a report of this calibre recommend specific actions such as establishing workplace breastfeeding policies and legislating the International Code of Marketing of Breastmilk Substitutes is an important step for breastfeeding policy. In addition to the environmental and marketing sections, the report also includes information on how civil society and individual factors affect breastfeeding rates. While there were no specific recommendations that came out of this discussion, issues such as pre-natal education and peer-to-peer support groups were mentioned as ways that civil society can support best breastfeeding practices. This report represents a definitive statement from the greater scientific community calling for breastfeeding support at all levels of society.

To download the report in its entirety go to: **www.dietandcancerreport.org/**

Exclusive Breastfeeding

The research published on breastfeeding is extensive and varied. Studies have been produced on the immunological properties of breastmilk, the reduction in the risk of cancer and other chronic disease as well as overweight and obesity, to mention only a few. While this body of research has established a strong case for the importance of breastfeeding, many studies have failed to clearly define the term 'exclusive breastfeeding.'

Considering that the recommendation from the World Health Organization, Health Canada and the Canadian Pediatric Association is for exclusive breastfeeding for the first six months, we decided to look at articles published over the last two years that dealt specifically with exclusive breastfeeding. The following articles address factors that affect exclusive breastfeeding as well as outcomes achieved by exclusive breastfeeding.

Groleau, D and Cabral, IE. Reconfiguring insufficient breast milk as a sociosomatic problem: mothers of premature babies using the kangaroo method in Brazil. *Maternal and Child Nutrition* (2009), 5, pp. 10-24.

This was a qualitative study that followed mothers who gave birth to premature babies and were discharged from the hospital using the Kangaroo Mother Care Method. Mothers left the hospital breastfeeding exclusively, but stopped exclusive breastfeeding once they returned home due to concerns about insufficient breast milk (IBM). The authors of this study explored how mothers interpreted IBM within their social environment. Eleven mothers were included in the study, as well as people close to them, such as mothers, family members and neighbours, for a total sample size of 39. The researchers conducted home visits at one month, one-and-a-half months and two months post-discharge.

Researchers chose the Creative Sensitive Method (CSM) for data collection, as this allowed them to analyse a variety of qualitative data including drawings, theatrical performances, keywords and verbatim narratives. This methodology was deemed appropriate given that the study participants had low levels of education and a limited vocabulary to express their experiences verbally. The results indicate that while mothers initiated exclusive breastfeeding in-hospital, a variety of health system and social factors, as well as physiological and psychological factors rekindled their IBM problem when they returned home.

Mothers were faced with conflicting views from family members, neighbours and clinicians, many of whom suggested supplementing with formula to relieve insecurities about breast milk quality and quantity. The authors suggest that IBM is a socio-somatic problem that should be addressed by focussing on nursing care in homes and communities. Furthermore, health promotion activities should be provided to mothers, their families and neighbours and to outpatient clinicians so that mothers have access to continued support and are not subject to conflicting advice. Finally, the entire family should be involved in infant feeding throughout the Kangaroo Mother Care Method.

Nascimento Simon, VG, Pacheco de Souza, JM & Buongermino de Souza, S. Breastfeeding, complementary feeding, overweight and obesity in pre-school children. *Rev Saúde Pública* (2009), 43(1).

This study took place in Sao Paulo, Southeastern Brazil in 2004-2005. The cross-sectional design included 566 children (age two to six) enrolled in private schools. Researchers looked at the relationship between body mass index, specifically overweight and obesity, and breastfeeding. Other explanatory variables such as child and family socio-demographic characteristics, birth weight, parents' nutritional status, breastfeeding, complementary feeding and current feeding were also studied. Authors used simple and multiple logistic regression to analyze the relationship between explanatory variables and outcomes. Results indicate that exclusive breastfeeding for six months or more was protective against overweight and obesity (95% CI [0.38; 0.86]; OR = 0.57; p=0.02) as was breastfeeding for more than 24 months (95% CI [0.05; 0.37]; OR= 0.13; p=0.00). The researchers hypothesized that the protective effect of longer duration of breastfeeding on overweight and obesity may be due to a dose response relationship (i.e. the greater the amount of maternal milk fed at the beginning of life, the greater the protection against overweight and obesity). Further research would be required to test this hypothesis. The study concluded that breastfeeding has a protective effect against overweight and obesity during childhood regardless of child age, family income, nutritional status and parents' level of education.

Hasselman, MH, Werneck, GL, and da Silva, CVC. Symptoms of postpartum depression and early interruption of exclusive breastfeeding in the first two months of life. *Cad. Saúde Pública* (2008), 24 Sup 2:S341-S352.

This investigation into the relationship between early cessation of exclusive breastfeeding and postpartum depression included 429 children all 20 days of age or less from four primary health clinics in Rio de Janeiro, Brazil. The authors defined interruption of exclusive breastfeeding (the outcome), as the introduction of water, other types of liquids, milk, formula or any food. Postpartum depression was measured using the Edinburgh Post-Natal Depression Scale, which was applied face-to-face with cards. Children of mothers with postpartum depressive symptoms were at higher risk of early interruption of exclusive breastfeeding in the first and second months of follow-up (RR=1.46; 95% CI: 0.98-2.17 and RR=1.21; 95% CI: 1.02-1.45 respectively). For babies still exclusively breastfeeding at one month, only age and prematurity were risks factors for cessation of exclusive breastfeeding. Overall, the results indicate that mothers experiencing postpartum depression are at an increased risk of weaning their infants early (both within the first days of life and in the following two months) even when potential confounders are controlled. This study highlights the importance that maternal mental health has on successful exclusive breastfeeding.

CANADA BREASTFEEDS

Kitchener's biggest maternity hospital becomes baby-friendly

The Grand River Hospital in Kitchener, ON, has successfully achieved the Baby-Friendly designation. The hospital made the announcement on January 21, and becomes the third hospital in Ontario to become Baby-Friendly. This designation is important because Grand River Hospital is the regional centre for birthing services in the Kitchener-Waterloo area and 4100 mothers give birth there every year.

Canada now has a total of 26 BFI-designated facilities—ten hospitals, two birthing centres and 14 community health facilities. Québec by far leads the way with 15 BFHI facilities, and Ontario now has six.

Nursing mother told to cover up at children's hospital

In a bizarre incident at Halifax's only children's hospital, a nursing mother was asked by staff to cover up while breastfeeding her infant. Shannon Hardy was breastfeeding her son when a hospital worker approached her and told her to put a blanket over the child's head. A spokesperson for the Izaak Walton Killam Health Centre said that the hospital has a policy to promote breastfeeding but "Obviously somebody didn't get the message."

Fortunately Hardy is a trained doula and was not easily swayed. She and some friends returned to the hospital the next day to hold a nurse-in, but she stressed that her intention wasn't to be confrontational. The response from the hospital had been positive, she said. A spokesperson for IWK said the embarrassing event has shown that the health centre needs to boost breastfeeding knowledge among its staff.

Breastfeeding Roundtable Meeting: Toronto, ON, December 2008

In December 2008, Toronto Public Health hosted its second roundtable meeting on breastfeeding. Toronto's Medical Officer Dr. David McKeown presided over the meeting, which included representatives from hospitals, community health centres, universities, and public health, as well as non-governmental organizations such as La Leche League and INFACT Canada. After an update on current breastfeeding initiatives, the discussion turned to the need for a provincial breastfeeding strategy. Participants felt that it would be important for one ministry to take ownership of the strategy and that all key stakeholders be included in the development of this document. It was agreed that with Toronto Public Health releasing their Breastfeeding Report Card in the spring of 2009, this would be a good time to advocate for increased initiatives around breastfeeding. Finally, it was agreed upon that a provincial strategy must also include measures to control the marketing of infant formula. The next step is to compile key messages that participants would like to see in a provincial breastfeeding strategy.

Annual National Breastfeeding Conference 2009

Toronto, October 22, 23

The theme for this year's conference is Breastmilk: A Valuable Commodity. Topics will include milk banking, birthing medications and supporting breastfeeding from six to 24 months. For more information on conference location, speakers or registration, visit **www.breastfeedingconference.com**.

INFACT Québec gets new leader

INFACT Québec has a new coordinator. Carole Dobrich is a registered nurse and certified lactation consultant, and currently runs the Goldfarb Breastfeeding Program at the Sir Mortimer B. Davis – Jewish General Hospital in Montreal. For French breastfeeding information and resources, contact Carole at **aussiecan@videotron.ca**.

Two more countries ratify landmark maternity protection

The Netherlands and Latvia are the latest countries to ratify the International Labor Organization's Maternity Protection Convention. The convention, known as C183, was revised in 2000 to update the ILO's standards for protection for working women, which hadn't been revised since 1952. The latest convention seeks to provide protection for all employed women, including those in atypical (seasonal or part-time) work. It extends the minimum period of maternity leave from 12 to 14 weeks, and guarantees a woman the right to return to work at the same or equivalent position that she had before her maternity leave. Women are also guaranteed daily breaks in order to breastfeed. Seventeen countries have now ratified ILO C183.

The ratification of the Convention by these countries coincides with strong labour laws which were just passed in New Zealand. The new laws, which will come into effect later this year, require that employers provide employees with breaks and private areas to breastfeed or express breastmilk.

These laws and the ratification of ILO C183 recognize the obstacles faced by working breastfeeding mothers. The pressure to return to work after pregnancy is one of the biggest factors that leads to early cessation of breastfeeding and undermines women's ability to breastfeed their children for the first six months of life, as recommended by the WHO. That more and more countries are recognizing the connection between labour laws and infant health, and the fact that mothers have the right to breastfeed at work, is a positive trend.

The International Baby Food Action Network, represented in North America by INFACT Canada, is part of the Maternity Protection Coalition, which works around the world to advocate for better maternity protection in the workplace.

Babies who aren't breastfed are twice as likely to die of SIDS, study says

A study published in March[1] in the journal of the American Academy of Pediatrics has found that breastfeeding protects infants from Sudden Infant Death Syndrome (SIDS). SIDS is the leading cause of death for infants in developed countries, and yet the causes behind the syndrome are not fully understood. Past studies[2] have linked breastfeeding with SIDS prevention, and this research shows that infants who are formula-fed are twice as likely to die of SIDS than are breastfed infants. Any amount of breastfeeding was found to have a protective effect. As a result, the researchers recommend that all SIDS-prevention campaigns carry a message promoting breastfeeding. The study was a case-control design and included 333 cases of SIDS and 998 age-matched controls in Germany, from 1998 to 2001.

While previous research has documented the relationship between breastfeeding and low SIDS rates, there was speculation that this relationship may not be causal. The argument is made that parents who are more likely to breastfeed are also more likely to be of high socioeconomic status, and therefore statistically less likely to engage in behaviours which put infants at risk for SIDS, such as smoking or dangerous co-sleeping habits. In this study researchers adjusted the data to control for the effect of socioeconomic status and suggested a mechanism which could explain a causal relationship between breastfeeding and SIDS-prevention. Most infants who die of SIDS are between two and four months old. At this age, maternal acquired immunoglobulin G is low and the infant has not yet begun to produce large amounts of its own immunoglobulin. Breastmilk contains immunoglobulin and cytokines, which may help stave off infections which are believed to contribute to SIDS. It has also been shown that breastfed infants are more easily roused than formula-fed babies, another mechanism which could help prevent SIDS. Some SIDS deaths are attributed to inadvertent suffocation, and babies who are easily roused from sleep are less likely to suffocate.

After the age of four months, infants are at a lower risk for SIDS and the older they get, the more their risk declines. Because the risk is so low after six months of age, researchers recommend that all babies be breastfed for the first six months of life.

Current recommendations from the Canadian Paediatric Society do not take into account the impact that breastfeeding has on SIDS rates, nor do those of the American Academy of Pediatrics or the UK Department of Health. Because breastfeeding rates are low in economically deprived sectors of society, the researchers recommend "special programs" which encourage mothers with low socioeconomic status to breastfeed.

For the full study see: **http://pediatrics.aappublications.org/cgi/content/full/123/3/e406**

References

1. Vennemann MM, Bajanowski T, Jorch G, Mitchell EA, **Does Breastfeeding Reduce the Risk of Sudden Infant Death Syndrome**, Pediatrics Vol. 123, No. 3, March 2009, pp e406-e410.
2. Ip S, et al, **"Breastfeeding and maternal and infant health outcomes in developed countries,"** 2007 Apr;(153):1-186.

Breastfeeding Information Resource Centre

Coming soon: **INFACT Canada's 2009 World Breastfeeding Week Action Kit**

IBFAN 2009 Breastfeeding Calendar • $15

The IBFAN 2009 annual breastfeeding calendar is packed with twelve beautiful breastfeeding images from around the world.

Sleeping with Your Baby • $14.95

Looks at various ways to safely cosleep and the latest information on the scientific benefits of cosleeping.

Items from the 2008 World Breastfeeding Week Kit

"Risks of Formula Feeding" brochure • $2.50

An annotated bibliography documenting the risks of artificial feeding and the benefits of breastfeeding.

"Fine Dining" mini-poster • $2

8½ x 11" mini-poster "Fine Dining – Breastfeeding: Anytime, Anywhere" slogan, breastfeeding duo in restaurant.

"Cost of Formula" wheel • $3

Shows mothers how much they can save by breastfeeding.

"Mother Support" mini-poster • $2

Beautiful breastfeeding image with the slogan "Mother Support: Reclaiming our Breastfeeding Culture."

New!

The Politics of Breastfeeding 3rd ed. • $23.95

The latest edition of this classic book by Gabrielle Palmer is finally available. In this fully revised and updated edition, Palmer powerfully describes the damaging effects of infant formula marketing, and the political and social issues surrounding infant feeding. A must-read for breastfeeding advocates.