BREASTFEEDING (AND THE BABY-FRIENDLY HOSPITAL INITIATIVE): A DEVELOPMENT ISSUE

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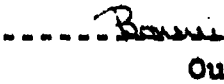

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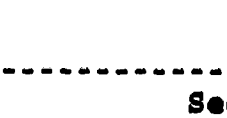

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Abstract:

It is safe to speculate that there are numerous underlying obstacles facing breastfeeding women today, not just in North America, but globally. Factors, such as the socio-economic status, support, education, and the role of the media are adding to this phenomena of an overwhelming baby-unfriendly society.

The purpose of this study is to examine how breastfeeding is a global development issue. Within this framework, the ecumenical dilemmas with regards to the breastfeeding vs. bottlefeeding controversy will be discussed.

Further, this study will examine breastfeeding as the focus of the Baby-Friendly Hospital Initiative, a new joint health initiative which was set up by Unicef and the World Health Organization, shortly after the World Summit for Children in 1990. Subsequently, this examination will seek to illustrate why the Baby-Friendly Hospital Initiative has been so successful in the developing countries (using in particular, the case of Manila, Philippines where the initiative had its early informal beginnings) and why the initiative, here in Canada, is lagging behind.

Finally, this study will summarize these problems and will suggest alternatives to these dilemmas.

Introduction:

According to Unicef and the World Health Organization, breastfeeding is now an endangered practice around the world, in both rich and poor countries. This has been shown by the following facts:[1]

1) There is a universal increase in feeding babies with infant formulas instead of breastmilk and a decline in breastfeeding, especially exclusive breastfeeding.
2) Too many hospitals, the source and symbols of modern medical practice, hinder breastfeeding through practises such as separating the newborn from the mother immediately after birth, and giving supplemental bottles of formula, soothers, etc.
3) Every year over one million infants die, and millions of other are impaired, because they are not breastfed.
4) Each year there seems to be more promotion of baby formula by companies in exchange for money.

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[1] UNICEF, 1992.

According to UNICEF, babies world wide are being born into unfriendly environments and are victims of widespread poverty, rapid urbanization and relentless marketing of breastmilk substitutes.

With the support from world leaders, health experts and non-governmental organizations (NGO's), the United Nations Children's Fund (UNICEF) and the World Health Organizations (WHO) have now launched the baby-friendly initiative to convince hospitals, health services and parents, that breastfeeding gives babies the best possible start in life.

Both UNICEF and WHO are well aware that most of the world's babies are born away from hospitals or maternity centers. They are also aware of the critical and pervasive effects of hospitals as the hub of national health systems. It is in hospitals where doctors, nurses and other health workers set the national standards and, where people should see how to protect, promote and support breastfeeding, not just in their homes, but in the communities as well.

With rapid urbanization in many countries, hospitals are also under increasing pressure to serve larger numbers of poorer and less educated people, who are the most vulnerable to the forces which inhibit breastfeeding. Also with urbanization, more babies are born in hospitals.

Experts in child nutrition, health and development are in agreement that breastfeeding is the most effective way to provide a baby with a caring environment and complete food. Yet most hospitals and maternity centers make it difficult for mothers to breastfeed, as many have become dependent on free or discounted infant formulas. The hospitals routinely separate mother and baby at birth and even before the mother has a chance to breastfeed, the infant is given formula or other liquids.

So, while scientific understanding of breastfeeding has advanced beyond health-care most of the world's health-care institutions lag behind in their support. Why?

Theoretical Framework:

The theoretical framework chosen for this study is (generally) from an overall feminist point of view, however, it tends to lean more towards the socialist feminist school of thought, as this framework allows for such determinants as class analysis and cultural relativism. When examining the Baby-Friendly Hospital Initiative, it was found that the following theories, (socialist, liberal, conservative, and radical feminism), were the underlying basis for the Initiative. It is interesting to note that most of the women that I have discussed the topics of breastfeeding and the Baby-Friendly Hospital Initiative with, do not "belong" to any one distinctive school of thought, but to several related and overlapping schools.

I believe at this point is necessary to explain socialist feminist theory as it relates to this study. As previously stated socialist feminism allows for such determinants as class analysis and cultural relativism.
In terms of class analysis and cultural relativism, breastfeeding can be accomplished in all societies and in all classes, therefore, breastfeeding and the Baby-Friendly Hospital Initiative, can be considered to be relative to all cultures and classes. Contrary to this, breastfeeding, is considered, however, to be middle class phenomena, and is

sometimes regarded as "repugnant" in some societies, judging from research conducted in this study. Breastfeeding for all intense purposes should be considered as a structural phenomena, one which allows for both mother and baby friendly societies. This in turn will allow for a healthier society.

Feminist groups and writers in North America have been slow to determine the breast-bottle controversy as a feminist issue. Although the National Organization of Women in the United States and the National Action Committee on the Status of Women in Canada both endorse the Nestle boycott, they did not develop the feminist potential of the breast-bottle controversy. It was not a "cause" that lent it itself to a single feminist perspective because women viewed the controversy - and infant feeding decision- as intensely personal and emotionally loaded matters. Opinions about breastfeeding run the spectrum from the extreme conservatism to radical feminism, and each position can be defended by reference to a broad appeal to what is best for women.

Socialist Feminist framework on Breastfeeding

Socialist feminists consider gender discrimination to be inseparable from class discrimination. But unlike Marxist feminist, who assume women will be liberated when class oppression ends, socialist feminists combine political economy

arguments with gender analysis. This perspective encourages a broader examination of institutions in class societies that oppress women and a more cultural relativistic examination of the experiences of different groups of women. This is in order to observe the interaction of class and gender relations in specific historical and cultural contexts and how they reinforce each other. These socialist feminist arguments are useful in connection with analyzing breastfeeding in developing countries.

Socialist feminist positions on the infant feeding controversy could probably place the conflict in the capitalist expansion market forces in the developing countries rather than in the context of sexual politics or the personal decision of individual mothers. However, breastfeeding is not included as part of socialist feminists' view of reproductive freedom.

The transformation of social conditions that socialist feminists envision would generally be beneficial to breastfeeding, even though this issue is not defined as a primary concern. The development of self-help clinics for women, the increasing pressure for the use of midwives, and the increasing opportunities for informed, prepared natural childbirths in North America assist breastfeeding since these conditions enable women to exercise more control over their

groups and create a new integrative feminist framework.

Liberal Feminist Framework on Breastfeeding

The early feminists who led the liberation movement of the sixties and seventies wanted to see opportunities increased for women in order for them to "catch up" with men and participate more fully in the mainstream of modern society. Their efforts to remove sexual discrimination included improving educational opportunities and legal rights for women and lobbying for equal pay for equal work. Liberal feminists, however, are less concerned with critiquing conservative (or radical feminist) positions than with ensuring that women have full access to the benefits, not just to North American women, but to women universally. The liberal school of thought describes liberation in terms of individual rights - rights to choose legal abortion, rights for children - that are often defined legally.

From the flip side of the liberal point of view, breastfeeding may well be viewed as restrictive and unappealing, tying an otherwise emancipated career woman to the restrictive roles of wife and mother. For these women, infant formula and bottlefeeding are part of the technological solution to the problem of making their reproductive and productive lives more compatible. In their view, bottle

feeding, child care centers, and maternity leaves allow women to compete more equitably with men.

North American women who choose to breastfeed might recognize existing discrimination against lactating mothers, object to the lack of facilities for nursing mothers to feed in comfort and privacy in the workplace or in any other public locations, and argue for more extended maternity leave with no subsequent loss of seniority. (Jagger, 1983:181)

The liberal position is most compatible with the promotional efforts of infant formula companies in the west. Artificial milk was developed in the 1920's and did not become popular in North America on a large scale until World War II, as this freed more women to work full time, and in place of men, for the war effort. Bottle feeding with new "improved" varieties of infant formula offered "liberation in a can" for working women. This was often the argument that used in the advertisements for the infant formula companies.

The liberal feminists therefore, defend both breastfeeding and bottlefeeding, and most importantly like the Baby-Friendly Hospital Initiative, are always in support of the right to choose.

Conservative Feminism Framework on Breastfeeding

Western feminists reject a conservative position that denies the oppression of women and accepts the proposition that human nature is determined by innate biology. However, the elements of conservative logic diffuse the discussion on breastfeeding and bottle feeding often through the semblance of a renewed maternal or domestic feminism. Stuart-Hagge interprets feminism as the need to pursue "self-actualization" and that historical maternal feminism and its logical continuation on the seventies and eighties stress the intrinsic moral superiority of women and motherhood as a sacred trust. [3]

The new conservative claim that the feminist movement denigrates housewives and mothers and seeks to destroy the family. Conservative reasoning underlies some infant feeding policies and programs, even when couched in more widely acceptable feminist rhetoric.

Conservative messages stem partly from the facts of women's reproductive capacity. Breastfeeding is seen as the natural continuation of pregnancy and birth. Conservatives, through their quest to make much of the "naturalness" of breastfeeding, may tend to increase the confusion of mothers

[3] Stuart-Hagge, 1981.

who encounter breastfeeding problems. In some parts of the world, "natural" breastfeeding involves nearly continuous body contact between mothers and infants, as if the infant is still a part of the mother and symbol identified with her (Simpson, 1980: 17-18). This conservative view fits in perfectly with one of the Ten-Steps in the Baby-Friendly Hospital Initiative which demands skin-to-skin contact as one of its prime objectives.

One particular viewpoint regarding the conservative framework is the question of bonding. Diane Eyer traces the historical roots of bonding, which she feels is the belief that physical contact between mother and infant shortly after birth forms the necessary (biologically determined) connection between the two that ensures the social and emotional adaption of the human species. Eyer, manages to de-construct scientific knowledge claims by revealing the importance of the cultural framework in which knowledge is produced.

In her book, Rossi argues that "the interconnections between sexuality and maternalism make good evolutionary sense". This angered feminist Eisenstein (1983:70), who interpreted her argument on biosocial parenting as reinforcing old conservative stereotypes based on biological determinism. She argued that feminists had gone too far in rejecting women's nurturing role: "The full weight of Western history

has inserted a wedge between sex and maternalism so successfully that women themselves and the scientists that have studied their bodies have seldom seen the innate connection between then" (1977:17). In her defense, Rossi argues that we need to know more than we do about bodily processes, including lactation.

Conservative logic prescribes that women can only be totally fulfilled through the processes of pregnancy, birth and lactation. It also suggests that a women's primary duty to stay home and care for the children. Should a woman have a problem either of these roles, the conservative point of view would find that there is something wrong with her.

These elements are reflected in one of the best and widely used manuals on breastfeeding, The Womanly Art of Breastfeeding, written and published by the La Leche League. This manual was first written in the 1950's is helpful and useful book to new nursing mothers. Its revisions, however, tend to make value judgements concerning women's duties and the naturalness of breastfeeding, with regard to making non-nursing mothers feel guilty about breastfeeding.

The publics need to meet conservative themes are also reflected in the literature and programs in which stress the need for modesty by keeping the breasts covered while

breastfeeding. This "modesty" allows breastfeeding from suffering the loss of sexual appeal that the breasts have, by making them sag, or to the fact that men may be even more attracted to the enlarged breasts of a lactating mother.

Another point is that some mothers may feel the need to obtain the approval and support of their husbands for breastfeeding. For example, I have spoken to women locally who have felt the need to gain permission from their husbands/partners to breastfeed, for fear that the husbands/partners would become resentful of the fact that the newborn would pull both physical and emotional attention away from them. Although these points in themselves may be practical suggestions for some women in some societies, it is important to recognize the conservative assumptions underlying them in order to more fully understand the emotional intensity of the infant formula controversy.

Finally, conservative motivation determines the shift in emphasis from mother's rights to infant's rights. The La Leche League and various movements that support more natural childbirth and mothering can become oppressive as they develop ideals and standards against which mothers judge themselves.

In a radical feminist discussion of breastfeeding, Evans notes that "many of the books about breastfeeding that are

available now are written by people who believe that a baby has a right to its mother's milk, no matter what her feelings on the alternatives are...if she shows revulsion at the idea of breastfeeding, she's told she's being selfish and lazy". [4]

Conservative views of modesty and sexuality may underlie women's decision to bottle feed, while tantamount conservative views on the subject see breastfeeding women's as natural heritage and duty as the reasoning underlying women's decision to breastfeed.

Radical Feminist Framework on Breastfeeding

A radical feminist position assumes that the oppression of women in all societies - socialist and capitalist - originates from their reproductive functions, which force them to become dependent on men. For some radical feminists, their political position requires them to separate themselves entirely from men by becoming lesbian. [5] Radical feminists assume the existence of universal patriarchy and the use of the most powerful rhetoric and ideology to fight it. Political lesbianism is partly an attempt to create a nonsexist environment for women - a "womanspace" where the symbols and

[4] Evans, 1980.

[5] Bloom, 1981.

constraints of patriarchy are removed. It is the radical feminists who have made the most visible attacks on symbols of patriarchy such as pornography, rape and sex-oriented tourism.

Radical feminists seek the fundamental restructuring of gender roles to allow both men and women to develop their full potential - freed of restrictive ideologies and practices. The flexibility they envision would include first, the right for women to choose whether they want to have children and second, if they do have children, the right to have more control over the total process of pregnancy, childbirth, and lactation. A key issue for the radical feminists is the loss of control over women's own bodies - in the form of anesthesized, uninformed births and other procedures that make it more difficult to establish lactation in the hospital. These procedures included binding the breasts, using drying substances to clean nipples, and the use of pills or injections to dry up the milk supply. This amounts to a "functional castration" of women who have "acquiesced to a combination of forces, medical and cultural, which have eventuated in the use of breast as the primary sex symbol and yardstick of feminine desirability, divorced from its nurturing function". [6] Bloom (1981; pp. 262) suggests that women "reclaim ownership and control over their bodies, allowing each woman to experience her breasts in a new

[6] Weichert, 1975.

perspective; not as playthings...but as an erogenous one where pleasure and function are inextricably intertwined".

Yet radical feminist assumptions have also been used to support the position that breastfeeding and infant feeding methods are issues that simply are not on the agenda for political action. If motherhood is the basis of women's oppression, then lactation, too is a part of the reproductive system oppressing women. But radical feminism produces contradictory arguments about motherhood.[7] These women fight for the right to refuse motherhood while at the same time explore the potential for lesbian mothers to experience pregnancy and lactation (through technological innovations such as artificial insemination) and embracing the concept of motherhood as the inspiration for feminist values and activities such as mother-goddess rituals. Their ahistorical and ethnocentric assumptions about universal patriarchy as the basis for the universal oppression of women make it difficult to apply western radical feminism to the analysis of women's issues in the third world, although their passion inspires many international women's groups.

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[7] Mahar, 1992.

Methodological Approach

For the purpose of this study, I have chosen several research methods.

First, a general analysis of why breastfeeding is a development issue, and second, an explanation of the Baby-Friendly Hospital Initiative, with particular reference to both the North (Canada) and the South (Manila, Philippines). The Philippines was the lead country in terms of the designated Baby-Friendly Hospitals. According to UNICEF, the Philippines presently has 136 designated Baby-Friendly Hospitals. China is currently leading the world with 207 Baby-Friendly Hospitals. [8]

Within this context an examination shall be conducted as to why Baguio General Hospital (where it all began in the Philippines) is so successful and, why Canada is lagging behind. One very important factor that will be will (generally) discussed is that of the support and education (and/or the lack thereof) given in the hospital and in the community to the mothers of newborn infants, in terms of the Ten-Steps (Baby-Friendly criteria) put forth by the UNICEF and the World Health Organization. Lack of support and education are probably the most crucial elements in the overall

[8] UNICEF, Progress of Nations, 1994

breastfeeding dilemma.

It is hoped that by examining the methods within the two different societies, a determination of the similarities which lead to the Baguio success. Other secondary data obtained from numerous sources assisted in answering the following questions in this study:

1) Why are there designated Baby-Friendly Hospitals in the Philippines and not one in Canada?
2) Why is the Philippines so successful?
3) Who controls the birthing process in terms of the structure of the health care system?
4) Why (or why not) is breastfeeding important in our society?
5) Why is breastfeeding considered to be a multinational economic force?
6) Why is breastfeeding a development question?
7) What are the cultural mores regarding breastfeeding? and how can we change them?

Merchant (1980), believes that the concepts deployed by international agencies for those in the south originate in Western industrial cultures, and are rooted in the particular relationship between science and industrial society which has obtained in the West over the last three centuries. The

science which aspires to subordinate 'nature' to industrial ends includes 'reproduction' and therefore women and sexuality as past of its field of action.

In much of literature (mostly medical, demographic and nutritional) dealing with the gestation, birth and rearing of children, reproduction is treated as subject to 'natural laws' rather than to human choices and cultural pressures. Cultural factors, such as the variable configurations of gender relations which determine women's work, conjugal or kinship roles, or the importance of reproduction as a political strategy are rarely discussed. It was also found that breastfeeding is treated in a social vacuum, as a 'biologically imperative' function of the 'biological dyad' formed by the mother and child.

Van Esterik (1988) points out that infant feeding, and the decisions regarding breastfeeding or bottle-feeding are generally acknowledged to be women's issues. However, she states that this does not mean that infant feeding has been the subject of feminist analysis. Breastfeeding, and by extension the option for artificial feeding, should be and can be a paradigmatic feminist issue for significant feminist reasons.

Lactation seems to have moved out of the consciousness of

western women. It is not a central concern of women's health clinics or reproductive rights groups, nor it is something likely to be brought up in meetings on women's pay equity. According to Van Esterik, it is "surprisingly" absent from contemporary feminist thought - much as if women no longer had breasts, or considered them to be optional equipment.

The marketing of breastmilk formulas have been blamed on "urbanization and modernization and new social values". (Berg, 1973). He continues to state that breastfeeding is often viewed as an old-fashioned or backward custom and, by some, as a vulgar peasant practice. He says that in most developing countries, the greater sophistication, the worse the lactation; the bottle has become a status symbol.

Latham (1975) also points to western influence, as "a belief develops that it is superior, chic, and sophisticated to bottle feed. Breastfeeding may come to be regarded as a 'primitive' practice whereas the bottle become a status symbol.

Vanessa Maher (1992) states that the visibility of breastfeeding as an issue, or the custom of breastfeeding avoidance, needs critical interpretation in cultural terms rather in the positivist terms of the medical model. She asserts that in the Industrial West, interpretation in

behavioral factors can also influence a woman's decision to initiate (and terminate) breastfeeding. The effects of urbanization, maternal education, and socio-economic status act through the intervening variables of sociocultural factors, health services, employment status of women, and availability of breastmilk substitutes.

James P. Grant, the Executive Director of the United Nations Children's Fund (UNICEF), upon receipt of the E.M. Christopherson Lectureship Award on International Child Health Care (1990), stated that the unmet health needs of children, both globally and nationally had recently been extensively publicized in the media. He declared that by infiltrating the media with news regarding child health care that the overall conditions of children did, in fact, improve.

CHAPTER 2:

The purpose of this chapter is to examine how breastfeeding is a multifaceted development question. Just as development is an interdisciplinary field, so too is breastfeeding. It can be seen as having a development perspective in the following areas:

a) breastfeeding as an environmental issue

b) breastfeeding as a means of contraception/family planning/and population control.

c) breastfeeding as a feminist issue

d) breastfeeding as an economic/renewable resource

e) breastfeeding as a labour issue

f) breastfeeding as a nutrition/medical issue

g) breastfeeding and the role of the media

A. Breastfeeding as an Environmental Issue:

Environmental awareness is presently considered to be fashionable and politically correct in industrialized nations. Dedicated people of all ages challenge accepted practices and encourage a sense of responsibility at the grass-roots level. In developing countries, however, women continue to be the primary environmental managers reflecting the intimate relationship which still exists between those who struggle to provide for their families and the natural environment on which they depend.

Unfortunately, most development initiatives fail to address the needs of women. Although they possess the knowledge to promote sustainable use, Third World women often have no choice but to exploit natural resources for survival.

The transition to cash crops and hybrid seeds has resulted in the loss of family plots and the indigenous crop base in much of the developing world. Poisoning and groundwater pollution are the consequences of extensive herbicides and pesticide use. Irrigation schemes further reduce water quality and availability, while the expansion of monoculture forests has effectively marginalized any traditions of forest protection. Costly commercial energy sources ensure a continued dependence of wood fuels and where these are scarce, rural families burn dung and crop residues, hastening the cycle of soil loss and infertility. Both rural and urban families ultimately pay the price. in Uganda, mango tree are cut down for firewood and charcoal production. [9]

Against the backdrop of environmental realities, the promotion and distribution of breastmilk substitutes is irresponsible and demonstrates a complete disregard for women's traditional knowledge. The North has exported many of our attitudes along with our health services. Women who are intent on improving their status are presented with modern Western prejudices which view breastfeeding as a constraint to their freedom. "The baby-bottle and packaged formulas share come of the same aura of modern science and technology as automobiles or television". [10]

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[9] Dankleman, p.77

[10] Allen and Unwin, 1989.

Mothers would strive to provide what they perceive as the best their children. But a dependence on breastmilk substitutes, encouraged by a sample from a clinic or "milk nurse", is fraught with difficulties and dangers in the developing world. It is impossible for families to secure a safe and increased supply of fuel and continuous supply of cash.

For example, "...to prepare feeds for a 3-month-old baby takes one lite of water per day, plus 2 litres of water to boil and prepare bottles and teats, plus one more to wash and rinse the bottles. Without this, contamination and serious disease is unavoidable."[11]

Another good example, I found was that "...to boil just one litre of this precious water requires 200 grams of equally valuable wood fuel". [12]

In economies where cash cropping and agro-forestry are already un-determining the traditional subsistence systems and placing an increased workload on women, mothers must venture still further into Western-style commercial sectors to earn hard currency for the purchase of bottles, teats and tinned or powered baby-milk.

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[11] Minchin, p.332.

[12] Palmer, 1990.

In Nigeria, the cost of artificially feeding a child for twelve months is 264% of the yearly legal minimum wage. That sum of money would purchase 158 kilograms of cassava - enough to provide a nutritious diet for both the lactating mother and the remainder of her family. [13]

The economic impact of breastmilk substitutes is also felt on the national level. Breastmilk is not taken into account in food production figures, economic calculations or national nutrition surveys, yet the cost of replacement is enormous. Health services struggle to meet the demand for public health centered and supplementary feeding programs, in response to the increase in infant malnutrition and illness.

"The value of breastmilk as commodity becomes staggering...In Kenya the established annual loss of breastmilk as a resource is $11.5 million (US) - equivalent to 2/3 the annual health budget for the entire country. Additionally, infant formula is usually imported thus draining further a poor nation's foreign exchange." [14]

Commercial infant feeding transforms a basic human right into a commodity beginning at birth. Breastmilk is a renewable resource, a living substance which is individualized

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[13] INFACT newsletter, winter 89/90.

[14] Campbell, 1982.

to the needs of the child and the micro-environment of the mother. Breastmilk substitutes, on the other hand, are non-renewable, standardized, quantified and inert. [15]

The international response to the realities of artificial feeding in developing countries has been subdued at best. The inclusion of breastfeeding components in development and aid projects within the health sector recognizes the true value of mothers' milk. However, any policies directed at promoting breastfeeding inevitably create pressures for environmental safeguards. There must be international recognition of the consequences of inappropriate technologies and imposed modernization.

The World Commission on Environment and Development argues that "the distribution of power and influence within a society lies at the heart of most environment and development challenges". [16]

The crisis of infant feeding is no exception. The issues affecting the lives and decisions of individual mothers must be addressed so that women might ultimately contribute to a sustainable environment for their children.

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[15] Van Esterik, p. 201.

[16] The World Commission on Environment and Development, 1987.

Several other positive aspects regarding breastfeeding and the environment: [17]

1) breastfeeding protects the environment in that it produces no waste.

2) Nursing mothers need only the smallest amount of extra energy often taken from body fat

3) Breastmilk needs no extra packaging. Breastmilk does not need to be imported or exported thus saving on fuel and other valuable (non-renewable) resources.

4) Most women do not menstruate when breastfeeding and therefore need fewer tampons, or other forms of feminine protection. This reduces the need for fibres, bleaching, packaging and disposal of these items. If a baby is strictly breastfed for six months and breastfeeding continues into the second year, the average mother will not menstruate for 14 months, thus saving a great deal of space in landfills.

5) Most artificial milk is based on cows milk. The dairy industry wastes land and resources as well as contributes

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[17] The following information was taken from personal notes gathered at the 4th Annual Breastfeeding Seminar, 04-06 June, Humber College, Toronto.

to the pollution of the environment. Such pollutants come in the form of methane gas caused from cow flatulence and excretion, and ammonia from cow pats and slurry tanks contributes to the problem of acid rain, attacking the leaves and acidifying the soil.

6) Another example is, fertilizers used to grow feed for dairy cows drain out the soil, pollute the rivers and groundwater. These fertilizers and animal sewage cause rivers to become overgrown with plants, eventually turning foul smelling and virtually lifeless.

7) Cows need around 10,000 square meters of pasture each. Wooded land is cleared for pasture, leading to deforestation, depletion and erosion of the soil, an increase in greenhouse gases and a reduction in animal and plant species. One kilogram of baby milk produced in Mexico, for example, costs 12.5 square meters of rainforest. In 1984, Ethiopia exported 10,000 tons of molasses to the United Kingdom, mainly for cattle feed. The molasses were likely to have been from deforested land which could have been used to feed local people.

8) Brazilian forests are cleared and burned to make way for soya plantations. Soya beans are used to feed cattle (and are also the base for some artificial milk). Soya

requires a high input of artificial fertilizers and irrigation.

Breastfeeding vs. Bottlefeeding: an Environmental Glance

BREASTFEEDING:	**BOTTLEFEEDING:**
1. Utilization of renewable resources, therefore no strain on ecosystem.	1. Utilization of renewable resources to produce and infant formula, therefore strain on ecosystem.
2. No production of solid wastes.	2. Production of solid wastes.
3. Lessened demand for fuel supplies.	3. Increased demand for fuel supplies.
4. Links between living conditions and infant morbidity and mortality are direct and can easily be made obvious to mothers.	4. Links between living conditions and infant morbidity and mortality are less direct and harder to demonstrate to mothers.
5. Pressure for clean water supply to improve women's health status.	5. Pressures for clean water to prepare adequate breastmilk substitutes.
6. Greater pressure to reduce dangers of radiation on environment.	6. Less pressure to reduce dangers of radiation in environment.
7. Greater pressure to reduce environmental pollutants.	7. Less pressure to reduce environmental pollutants.

B. Breastfeeding as a Means of Contraception/Family Planning/ and Population Control

Breastfeeding plays an important role in developing countries for many reasons. One example is because of the

relationship with overall child health and birth spacing. It is well known that breastfeeding has a significant impact on reducing mortality in infants. Aside from this major role, breastfeeding is equally important in controlling fertility in developing countries. Postpartum infertility associated with the practice of breastfeeding is a major determinant of spacing between births, with resulting reductions in overall fertility levels. This by its very nature leads to a healthier population.

For example, in West Africa (in particular New Guinea), a post-partum taboo on the mother having sexual intercourse may last for two or three years. Frequently, the post-partum taboo is closely associated with the breastfeeding period. Such a taboo enables the mother to dedicate her undivided attention to the infant, relieves her of the fear of a new pregnancy which would endanger the young child, and make it unnecessary for her to employ contraceptive measures (such as the pill which tends to inhibit lactation). A long period of breastfeeding reinforced by the postpartum taboo ensures a long interval between births. This is an advantage to both mother and child especially where resources are scarce and a woman's work burden is heavy.

An article recently published in <u>The Medical Post</u> by Diana Swift, discusses a recent lactation and hormonal study

conducted by Dr. Ronald Gray, from the school of public health at John Hopkins University provided convincing evidence that "amenorrheic women practising exclusive breastfeeding in the first six months after child birth can achieve protection equivalent to, or greater than that provided by IUDs and oral contraceptives." [18] The study, which drew women from the Philippines and Baltimore, was specifically designed to consider the link between protection levels and breastfeeding patterns. According to Dr. Gray " ...as long as breastfeeding provided about 70% of total nutrition and the mother gave the equivalent of ten, 10-minute feeds per day, then her risk was comparable to that of taking the pill."

Winikoff and Laukaran conducted a comparative study to investigate infant feeding practices and their determinants in four developing countries (Bangkok, Thailand; Bogota, Columbia; Nairobi, Kenya; Semarang, Indonesia).

The study documents changes in infant feeding that can be expected to have detrimental effects for child health and for child spacing. According to the study, bottle use appeared to interfere with breastfeeding in all cultures, but more dramatically in more "modernized" societies. Mothers resort to bottle use for a variety of reasons, but not usually as an attempt to wean. The health care system often provides the

[18] Swift, 1990.

first contact between mothers and bottle use, and health care providers frequently encourage the use of artificial feeding. Women who work away from home early in their infants' lives must often use bottlefeeding, but the percent of women affected is very small. Many more women use bottles and wean early than work away from home, and most artificially fed babies do not have mothers working outside of the home.

"In some situations, mothers apparently perceive the use of a bottle as beneficial for the baby and add it as a tonic or nutrient booster to breastmilk...formula here is perceived as providing specific health advantages for the young child. This attitude seemed to be most prevalent in Nairobi, with almost one-third (1/3) of all mothers citing this as the reasons bottles were used initially. This behaviour reflects the fact that over 86% of all Nairobi mothers felt that children would be healthier if they received infant formula in the first three months of life."[19]

Product advertising appeared to be a major source of information and the data indicated that "consumer awareness of this particular modern convenience was high in all places". Receiving samples from hospitals was not particularly high, however, mothers were more likely to receive samples when babies did not room-in with the mother.

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[19] Winikoff & Laukaran, 1989.

Three characteristics seem to create circumstances particularly conducive to the use of the artificial milk:[20]

1) high degree of sensitivity to the possibility of having insufficient milk (i.e. inability to nourish babies without addition of a supplement);

2) substantial awareness of the possibility of artificial milk, including knowledge of specific products marketed for this purpose;

3) exposure to use of such products (appears to occur through health services and the advice of health professionals).

C. Breastfeeding as a Gender Issue [21]

Breastfeeding is an important women's issue, human rights issue, and feminist issue, since breastfeeding empowers women and contributes to gender equality. Women who wish to breastfeed their babies but cannot - because of inadequate support from family or health workers, constraints in the workplace, or misinformation from the infant food industry -

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[20] Winikoff & Laukaran, 1989.

[21] Also see Theoretical Framework

in objectifying women's breasts through the media and advertising making it difficult for some women to breastfeed in public. When feeding bottles are used in public for fear of public exposure to breasts, or choosing bottle feeding because of fear that breastfeeding will alter the shape of their breasts, then women are being as sex objects.

Doris Anderson, a columnist with the Toronto Star, and author of The Unfinished Revolution - The State of Women in Twelve Countries, states "There is something sick about society where it is okay to expose a woman's breast to sell any male merchandise from hair cream to cars. But it's a scandal for a woman to publicly use her breast for its original function, to feed her baby". She also says that we here in North America can learn much from our Africa neighbours - women who breastfeed in public with dignity and no concern.

Women's fears about exposing their breasts are more than confirmed when North American women are arrested or asked to leave public places for breastfeeding openly. Thanks to the efforts of women activists, breastfeeding women are reclaiming their breasts as valued pasts of their bodies and refusing to be treated as sex objects.

The decision not to spend cash on breastmilk substitutes

is a rejection of a consumption pattern forcing women to rely on expensive, industrially produced food. As purchasers of infant formula, women devalue their own capabilities, and seek commercial solutions to infant feeding. The constant efforts of infant formula manufacturers to expand their markets for these products fuels the advertising campaigns directed to women as consumers.

Breastfeeding encourages women's self-reliance by increasing their confidence in their ability to meet the needs of their infants. Breastfeeding requires women to have confidence in themselves, and enough self-esteem to protect (or in some contexts, demand) their rights, including their right to breastfeed. Women with a positive self-image may be less likely to assume they do not have enough breastmilk, or that their breastmilk is of poor quality.

Breastfeeding focuses attention on the need to ensure equality in the distribution of food and other resources within the household. Since breastfeeding women's requirements are higher per unit weight than those adult men within the family unit, priority must be given to breastfeeding women in the distribution of food. In some societies, women may not receive enough food to ensure their own health and that of their children. Therefore, the health of both mother and children suffer.

Breastfeeding takes time, and as such it can take away from other household duties. This has been known to cause a certain bone of contention in some homes, whether it be in the North or the South. Therefore, within households, women often work together to share child-care responsibilities, thus eliminating the dissention that breastfeeding time may have caused. Other family members can play a useful role in assisting new mothers by providing advice on managing breastfeeding and helping with household tasks.

Internationally, women as individuals and as members of health and consumer organizations, have lobbied governments on behalf of breastfeeding and protested against the commercial interests that put profit over the well-being of mothers and infants. The campaigns against the promotion of infant formula mobilized women (and men) all over the world to join consumer groups and to rediscover for themselves how women in developed and developing countries face many similar problems. Coalitions between women (and men) in developed and developing countries on issues like breastfeeding are potential opportunities for empowering women and for identifying common constraints that limit women's power to care for their children. Men have an important role to play in changing conditions for women and changing their own attitudes towards breastfeeding and women's work.

Successful breastfeeding reduces women's dependence on medical professionals and discourages further use of medical professionals for infant feeding. The knowledge mothers and midwives have about infant care and feeding increases in value and importance.

When breastfeeding is highly valued, the social and physical costs of breastfeeding are more carefully considered. Women's bodies are finite, and cannot be over-burdened without causing suffering and loss of their productive and reproductive capabilities. Breastfeeding mothers need access to food, health care and a supportive environment.

In the sexual division of labour, infant care usually falls to women. It is women who have the capacity to provide food for their infants, ensuring, women's self-reliance and their infants' survival for the first few months of life. Women give birth and produce milk. If the work of breastfeeding is valued as productive work, not a woman's duty, then conditions for its successful integration with other activities must be arranged.

These arrangements include legislation to provide maternity leaves and nursing breaks, affordable child-care and other strategies developed by women workers. A woman-centered definition of work must take into consideration the importance of nurturing and caring, including breastfeeding.

D. Breastfeeding as an Renewable Economic Resource

Information from developing countries on breastfeeding trends is showing a decline in initiation as well as duration rates. This decline, occurring more rapidly in urban areas, is most evident in the "modernized" segment of Developing population. Cultural, social and economic alienation exacerbate the abandonment of the traditional practice of breastfeeding. The lure of free samples, modern images of well-to-do women, and thriving health babies in the infant formula promotional is a callous strategy targeted at women determined to do the "best" for their infants.

Conversely, the rate of breastfeeding is increasing in industrialized countries. However, this increase is much slower among economically and educationally disadvantaged women, for whom the duration rate is also shorter. [24]

The marketing of infant feeding products utilizes seductive imagery which portrays bottlefeeding as modern, progressive and benign, often bribing the health care system for implied endorsements. Infant formula companies have consistently engaged in marketing strategies that ignore the economic hardship and health threatening consequences to women and children while failing to acknowledge their impact on the

[24] Mahar, 1992.

infant feeding patterns of women who can least afford the consequences.

Over the continent of Africa, the statistics show that the percentage of minimum wage needed to artificially feed an infant ranges form 18% to 264%. In Argentina, the Asociacion de Ayuda de Materna NUNU reports the cost to be 40% of the minimum wage, during the first month, to 73% for the fourth month. CEFEMINA of Costa Rica reports the cost of formula feeding an infant to be 6% of the minimum wage, for the first month, and up to 34% for the fourth month.[25]

In Canada, surveys show that women with lower incomes are more likely to bottle feed than women with higher incomes. Infant mortality rates are also higher in communities where incomes and educational levels are low.[26]

Ironically, health professionals often play a role in discouraging breastfeeding. A study commissioned by Health and Welfare Canada and conducted at the Montreal General Hospital concluded that the distribution of infant formula samples caused a decrease in the duration of breastfeeding, especially in less educated mothers, first-time mothers and

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[25] INFACT Canada, 1991.

[26] Canadian Institute of Child Health, 1989.

mothers who had been ill after childbirth. [27]

The practice of giving out free samples is widespread. A random telephone survey of doctors' offices conducted by INFACT Canada in December of 1989 found that 70% of doctors with pediatric or family practices routinely give free samples of infant formula to new mothers! A 1988 survey found that 62% of the hospitals responding to the survey routinely give free samples to new mothers. [28]

The World Health Organization International Code of Marketing of Breast-milk Substitutes implicitly states that health workers should not give out free samples, and that information about the use of infant formula should include the financial implications of its use. Doctors omitting this information represent irresponsible disregard for physical and economic well-being of women and children.

The World Health Organization's International Code of Marketing of Breast-milk Substitutes was written to protect mothers and infants from pressures to bottlefeed generated by advertising and promotion. Canada voted in favor of the Code at the World Health assembly in 1981. However, the Code has not been implemented in Canada. Instead, Health and Welfare

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[27] Bergevin et al., 1983.

[28] INFACT Canada, 1983.

Canada has accepted self-regulating marketing guidelines drafted by the Canadian Infant Formula Association (CIFA). Health and Welfare Canada claims that CIFA's guidelines are practical and acceptable [and] reflect the spirit and the principles of the WHO International Code. [29] To the contrary, many advertising practices show a total disregard for the Code.

E. Breastfeeding as a labour issue

On a number of occasions since 1948 the World Health Assembly has urged the Organizations' Member States to enforce existing or adopt new, measures to promote and facilitate breastfeeding among employed women. In May 1992, the Health Assembly requested the Director-General to consider, in collaboration with the International Labour Organization (ILO), the options available in the health and other interested sectors for reinforcing the protection of women in the workplace in view of their maternal responsibilities. [30]

In a special message on the occasion of World Breastfeeding Week 1993, the theme of which was creating a

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[29] World Health Organization International Code of Marketing of Breastmilk Substitutes, 1991.

[30] Resolution WHA45.34

"mother-friendly" workplace, the Director-General emphasized the importance of alerting the social partners to advances in scientific knowledge, and practical understanding of breastfeeding's function in promoting human health and development, and to the implications for social policy. Maternity protection in the workplace - and specifically the promotion of breastfeeding - assume greater significance than the relatively limited functions of nutrition and child care originally appeared to suggest. As employers strive to contain costs, they should be careful to take into account the "value added" by social measures on behalf of women workers, such as adequate maternity leave, flexible working schedules, job-sharing, and child-care facilities at or near the workplace. These measures increase satisfaction and productivity, reduce turnover, absenteeism and tardiness, and improve loyalty and morale. And to the extent that they enhance opportunity for employers to reduce their health costs. Working outside the home and breastfeeding are compatible when a mother has the support of her family and employer. [31]

Maternal protection must be seen within the broader framework of a whole range of national policies and social

[31] WHO/ILO, 1993.

measures, and health and health legislation.[32] These include among others, legislation, policies and services for primary health care, including maternal and child health/family planning, and family support measures, and family planning, and involve governmental programmes, private services and social security schemes.[33]

New scientific evidence and socio-economic situations have again proved the benefits of breastfeeding, and have combined to compel further action for the development of measures to protect, and support maternity leaves. Recent research on the biological and psychological mother-child interactions of intra-uterine life, as well as in early infancy provide new information about how critical these stages are for child survival and health as well as subsequent adult well-being.[34]

From an overall health point of view, it is imperative that maternity leave should be long enough to cover at least this crucial period and should ideally extend until weaning is completed. Where this is not possible, legislation (by way of

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[32] International Labour Organization (ILO) Women at Work Number two, 1984.

[33] International Labour Organization (ILO), Women at Work, Number Two, 1984.

[34] International Labour Organization (ILO), Women at Work, Number Two, 1984.

the government) should ensure that day-care facilities in close geographical proximity be mandatory in all workplaces. Also a sufficient number of breastfeeding/nursing breaks should be provided within the contexts of the maternity legislation.

Recent economic and social changes have sometimes aggravated existing health problems and have brought new ones. The decline in the practice of breastfeeding in some developing countries is an important example.[35] The factors influencing the practice of breastfeeding are closely related to women's changing role and status. They included women's time and working conditions, job insecurity, their income, health, availability of family and social support, their knowledge about management of breastfeeding, advertising and promotion of breastmilk substitutes, and the availability of suitable day-care arrangements for their children.

Women are often afraid that it is not possible to successfully breastfeed and return to work outside the home, however, there are many ways to combine successful breastfeeding and working; including expressing and saving breastmilk for feeding times when mother and baby are separated - but there is also a lot of misinformation that

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[35] International Labour Organization (ILO), Women at Work, Number Two, 1984.

keeps women from trying.

One interesting fact is that women in industrialized countries who work outside the home are more likely to breastfeed than mothers who stay at home with their babies.

The International Labour Organization (ILO) outlines measures to protect breastfeeding mothers in the work force as early as 1919. In its 103 Convention, adopted in 1952, ILO revised its outline, setting the following minimum standards:

1) 12 weeks of maternity leave with cash benefits amounting to at least 66% of previous earnings;
2) two half-hour breastfeeding breaks during each working day:
3) prohibition of dismissal during maternity leave.

Many countries around the world have adopted these - or similar - standards through policy or legislation.

Mexico City Declaration on Population and Development:

This is an important International Labour Organization declaration as it emphasizes the importance of improving the status and conditions for women at work and in the community.

"...Improving the status of women and enhancing their role is an important goal in itself and will also influence family life and size in a positive way, Community support is essential to bring about the full integration and participation of women into all phases and functions of the development process. Institutional, economic and cultural barriers must be removed and broad and swift action must be taken to assist women in attaining full equality with men in the social, political and economic life of their communities. To achieve this goal, it is necessary for men and women to jointly share responsibilities in areas such as family life, child-caring and family planning. Governments should formulate and implement concrete policies which would enhance the status and role of women.

Unwanted high fertility adversely affects the health and welfare of individuals and families, especially among the poor, and seriously impedes social and economic progress in many countries. Women and children are the main victims of unregulated fertility. Too many, too close, too early and too late pregnancies are a major cause of maternal, infant and childhood mortality and morbidity...".[36]

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[36] Mexico Declaration on Population and Development, adopted by the International Conference on Population, Mexico City, 14 Aug. 1984.

Recent studies point to what is called a 'dose-response mechanism' - in other words, the longer a baby is breastfed, (in industrialized and non-industrialized countries) the better protected it will be.

Unicef and WHO have coined the term 'exclusive breastfeeding'. This means that a baby is given nothing other than breastmilk, not even water.

G. Breastfeeding and the role of the media

The last report to the Health Assembly briefly considered the health implications of direct advertising of infant formula to the general public.[38] It was recalled that, because of the hazards associated with using breast-milk substitutes, infant formula was no ordinary consumer product, but that, up to the age of four to six months, it should be treated more as a nutritional medicine that should be used with the advice and under the supervision of health workers. The report also noted that, even viewed from the perspective of fostering competition, direct advertising to mothers with infants in the first four to six months of life was simply inappropriate because of the following reasons:

1) advertising infant formula as a substitute for breast

[38] Document WHO/MCM/NUT/90.1, op.cit

milk competes unfairly with normal, healthy breastfeeding, which is not subject to advertising, yet which is the safest and lowest cost method of nourishing an infant;

2) advertising infant formula as a substitute for breastmilk favors uninformed decision-making, bypassing the necessary advice and supervision of the mother's physician or health worker.

In this respect, the report concluded that advertising of infant formula fails to achieve the objectives of ensuring the best quality at the lowest cost and creating an informed public, which are among the benefits assumed to be a result of direct advertising. It is very important to note that Nestle, I believe, manipulated it's public both in the developed and developing countries and obstructed all of the codes set forth in the Code of Marketing. Despite the world-wide on-again, off-again boycott of Nestle products, the company still has not yet learned to comply with the Code.[39] It is also important to point out that Nestle is not the only formula company guilty of this crime. Gerber also directly violates the Code (see Summary - # 1, 3, 4, 5, 6, and 8) in its advertisements for baby-formula. Therefore, it is safe to say that the practice of "technological transfers" from North to

[39] Please see Appendix for Summary of the Code of Marketing

South with regards to advertising and bottlefeeding is deadly.

The debate continues about the extent to which direct advertising of infant formula to the general public influences the prevalence and duration of breastfeeding. Choice of infant feeding mode is a highly complex process that is affected by multiple factors including cultural traditions, educational opportunities, accessibility of objective and consistent information, time available and perceived options. The World Health Organization has consistently stated that appropriate marketing and distribution of breastmilk substitutes is only one of the several important factors where protecting health practices in respect of infant and young child feeding is concerned.

One last note on advertising is that of the toy companies, and the method in which they promote infant dolls. It is still a fact that young girls role-play with infant dolls. Infant dolls come with bottles. It is here that the toy companies have to take responsibility for the ending the continuation of the bottle cycle. If girls are not exposed to bottles and their uses, it cannot (or at least, it should not) be mirrored in reality later on.

Chapter 3

The Baby-Friendly Hospital Initiative: What is it? [40]

The Baby-Friendly Hospital Initiative is a global campaign that gives health care providers a leading role in the promotion, protection and support of breastfeeding. BFHI also recognizes hospitals around the world that offer complete and accurate information about the benefits and management of breastfeeding. It also provides an incentive for other facilities to improve their practices.

The idea originated in 1990, 30 Governments and 10 international agencies developed a set of four goals for the year 1995 - called the Innocenti Declaration - that would restore women's rights to learn about and practice breastfeeding successfully. BFHI was designed to encourage hospitals to achieve the goals set forth in the Innocenti Declaration. A discussion of the Innocenti Declaration can be found further on in this chapter.

The BFHI tends to focus exclusively on hospitals because of this ironic fact: Most of the (mis)information that causes confusion and dissuades people from breastfeeding can be traced back to a health care facility or provider.

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[40] UNICEF, 1993.

By changing the knowledge, attitudes and practices of health care workers, BFHI goes right to the source of modern myths and misinformation, and replaces them with information, scientific facts and skills to promote breastfeeding.

Unicef and WHO in their efforts have made the "Ten Steps" non-negotiable because these 'Ten Steps' represent the best available knowledge on what makes breastfeeding succeed and were arrived at after long study and deliberation by a broad consensus of health and nutrition experts from around the world.

For this reason, WHO and UNICEF wish to encourage a review of how health service promote or hinder breastfeeding, so that policies, practices and routines that enhance its early initiation and establishment may be reinforced and those that interfere with it may be modified.

This is the secret behind the Baby-Friendly Hospital Initiative. WHO and UNICEF have designed a "check-list" (or assessment) for Baby-Friendly designation status which concentrates on the relatively brief period of prenatal, delivery and perinatal care provided in maternity wards and clinics, which is critical for the successful initiation and maintenance of breastfeeding. This is when interaction between health personnel and mothers is the closest and where health care routines have the greatest influence on mothers'

attitudes towards breastfeeding and perceptions about their ability to breastfeed. This check-list serves to illustrate the effectiveness of the promotion and implementation of breastfeeding by the facility.

The Baby-Friendly Hospital Initiative: The Ten-Steps to Success

The idea of baby-friendly hospitals is to focus on the needs of the mother and her new born. To become baby-friendly, hospitals and maternity centers must practice the ten step that were put forth by UNICEF-WHO.

The ten steps are as follows:[41]

1) Have a written breastfeeding policy that is routinely communicated to all health care staff.
2) Train all health care staff in skills necessary to implement this policy.
3) Inform all pregnant women about the benefits and management of breastfeeding.
4) Help mothers initiate breastfeeding within a half-hour of birth.
5) Show mothers how to breastfed, and how to maintain lactation even if they should be separated from their infants.

[41] UNICEF, 1993.

6) Give newborn infants no food or drink other than breastmilk, unless medically indicated.

7) Practice rooming-in - allow mothers and infants to remain together 24 hours a day.

8) Encourage breastfeeding on demand.

9) Give no artificial soothers or pacifiers to breastfeeding infants.

10) Foster the establishment of breastfeeding support groups and refer mothers to them on discharge from the hospital or clinic.

The experiences of many countries have shown over time that each of the 'Ten Steps' is an important element in achieving the goals of exclusive and sustained breastfeeding.

Unicef and WHO have specifically implied that there is something terribly wrong with giving free samples of infant formula to new mothers as they leave the hospital. This is because the public reasonably assumes that health care providers will give them the best possible care and advice; for new mothers, that means advising and helping them to breastfeed, not bottle-feed.

Free samples, on the other hand, are distributed solely to stimulate future sales of infant formula, and since that runs counter to breastfeeding, samples have no legitimate

place in health facilities.

A hospital that gets its infant formula free or at low cost from manufacturers or distributors cannot be designated baby-friendly.

Baby-friendly hospitals should purchase any infant formula they need, just as they purchase other foods and pharmaceutical items. They should recognize that accepting free and low-cost supplies of infant formula involves health care providers in a marketing activity designed specifically to decrease the overall number of breastfeeding babies and increase the number who use formula.

There are only a few exceptions when a baby-friendly hospital may accept free or low-cost supplies. Baby-friendly hospitals may accept subsidized or free supplies only for orphaned or abandoned children or for babies with certain, very rare metabolic disorders.

Hospitals can take the lead by refusing to accept free and low-cost infant formula supplies, and consumers can do their part by opting to use baby-friendly hospitals, (and to boycott any baby formula companies, ie. Nestle.)

Mothers can, however, choose to bottle-feed their own

babies in a baby-friendly hospital. Health care professionals in a baby-friendly hospital should make certain that women have all the facts and support required to make their decision. While health professionals would not agree that a mother who is able to nurse, but chooses to bottle-feed instead, has made the best personal choice decision, health workers in a baby-friendly hospital respect and support every woman's right to make this very important choice about her baby's health.

Unfortunately most health care professionals are not aware of the benefits and management of breastfeeding. Research has shown that very little attention has been given to the health and nutrition benefits or to the physiology of breastfeeding in modern medical and nursing schools. [42] As a result, many medical practitioners have inadequate or even wrong information about breastfeeding.

A recent study in the US measuring the knowledge of registered nurses about breastfeeding yielded an average score of 7.09 out of 14. Another study showed that half the staff members of a large New York City Hospital were inaccurately informed about certain biological properties of breastmilk and some of the arguments that keep women from breastfeeding.

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[42] This reference comes from personally speaking to nurses and other health professionals.

Innocenti Declaration: on the Protection, Promotion and Support of Breastfeeding. [43]

The Innocenti Declaration was produced and adopted by participants at the WHO/UNICEF policymakers' meeting on "Breastfeeding in the 1990's: A Global Initiative", co-sponsored by the United States Agency for International Development (U.S.A.I.D.) and the Swedish International Development Authority (SIDA), held at the Spedale degli Innocenti, Florence, Italy, on 30 July - 1 August 1990. The Declaration reflects the contents of the original background document for the meeting and the views expressed in group and plenary sessions.

The Declaration recognizes that breastfeeding is a unique process whereby it:

- provides ideal nutrition for infants and contributes to their health growth and development;
- reduces incidence and severity of infectious diseases, thereby lowering infant morbidity and mortality;
- contributes to women's health by reducing the risk of breast and ovarian cancer, and by increasing the spacing between pregnancies;

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[43] Innocenti Declaration, UNICEF Headquarters, New York, 1990.

- provides social and economic benefits to the family and the nation;
- provides most women with a sense of satisfaction when successfully carried out.

Recent research has found that these benefits increase with increased exclusiveness [44] of breastfeeding during the first six months of life, and is also increased by furthering the duration of breastfeeding with complementary food after the first year.

The Declaration declares the following: "as a global goal for optimal maternal and child health and nutrition, all women should be enabled to practise exclusive breastfeeding and all infants should be fed exclusively in breastmilk from 4-6 months of age. Thereafter, children should continue to be breastfed, while receiving appropriate and adequate complementary foods, for up to two years of age or beyond. This child-feeding ideal is to be achieved by creating an appropriate environment of awareness and support so that women can breastfeed in this manner."[45]

Attainment of the goal requires, in many countries, the

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[44] Exclusive breastfeeding means that no drink or food is given to the infant; the infant should feed frequently and for unrestricted periods.

[45] Innocenti Declaration, 1990.

reinforcement of a "breastfeeding culture" and its vigorous defence against incursions of a "bottle-feeding culture." This requires commitment and advocacy for social mobilization, utilizing to the full the prestige and authority of acknowledged leaders of society in all walks of life.

Efforts should be made to increase women's confidence in their ability to breastfeed. Such empowerment involves the removal of constraints and influences that manipulate perceptions and behaviour towards breastfeeding often by subtle and indirect means. This requires sensitivity, continued vigilance, and a responsive and comprehensive communications strategy involving all media and addressed to all levels of society. Furthermore, obstacles to breastfeeding within the health system, the workplace and the community must be eliminated.

Measures should be taken to ensure that women are adequately nourished for their optimal health and that of their families. Furthermore, ensuring that all women also have access to family planning information and services allows them to sustain breastfeeding and avoid shortened birth intervals that may compromise their health and nutritional status, and that is their children.

All governments should develop national breastfeeding

policies and set appropriate national targets for the 1990's. They should establish a national system for monitoring the attainment of their targets, and they should develop indicators such as the prevalence of exclusively breastfed infants at four months of age.

National authorities are further urged, according to UNICEF and WHO, to integrate their breastfeeding policies into their overall health and development policies. In so doing they should reinforce all actions that protect, promote and support breastfeeding within complementary programmes such as prenatal and perinatal care, nutrition, family planning services, and prevention and treatment of common maternal and childhood diseases. All health care staff should be trained in the skills necessary to implement these breastfeeding policies.

It is hoped that all governments will meet the following operational targets by the year 1995:[46]

- appointed a national breastfeeding coordinator of appropriate authority, and established a multisectoral national breastfeeding committee composed of representatives from relevant government departments, non-governmental organizations, and health professional

[46] UNICEF, 1991.

The prevalence and duration of breastfeeding have declined in many parts of the world for a variety of social, economic and cultural reasons. With the introduction of modern technologies and the adoption of new life-styles, the importance attached to this traditional practice has been noticeably reduced in many societies. However, health services are frequently unable to meet the all of the demands of the of new mothers, either by failing to support and encourage mothers to breastfeed or by introducing routines and procedures that interfere with the normal initiation and establishment of breastfeeding. Common examples of the latter are separating mothers from their infants at birth, giving infants glucose water by bottle and teat before lactation has been initiated, and routinely encouraging the use of breastmilk substitutes.

For breastfeeding to be successfully initiated and established, mothers need the active support, during pregnancy and following birth, not only of their families and communities but also of the entire health care system. Ideally, all health workers with whom expectant mothers come into contact will be committed to promoting breastfeeding, and will be able to provide appropriate information as well as demonstrate a thorough practical knowledge of breastfeeding management.

Too often, however, the reality is quite different; health personnel may have insufficient knowledge about breastfeeding and little experience in providing appropriate support for mothers, and may be unaware of the main factors that determine whether or not mothers breastfeed and for how long. Their training has frequently oriented them more towards bottlefeeding, as a "modern technology" that can be taught and supervised, than towards preparing mothers for successful breastfeeding, which they may regard as old-fashioned and no longer warranting particular attention. Not surprisingly, they may also be ignorant of the negative impact that accepted hospital routines and procedures (often established on grounds of efficiency or resource constraints, or for supposed scientific reasons) can have on the successful initiation and establishment of breastfeeding. Impediments to breastfeeding initiation range from the physical layout of maternity wards and hospitals and the organization of their services to the multitudes of doctors, nurses. administrators, and other staff.

The World Health Organization (WHO) and the United Nations Childrens' Fund (UNICEF) believe that, of the many factors that affect the normal initiation and establishment of breastfeeding, health care practices, particularly those related to the care of mothers and newborn infants, stand out as one of the most promising means of increasing the

prevalence and duration of breastfeeding. Reasons for this include the predisposition of health care workers to promote health enhancing behaviour, the very nature and function of health care facilities, and the fact that, apart from good will, few additional resources are required to maintain or introduce appropriate routines and procedures.

The International Code of Marketing of Breastmilk Substitutes:

There now exists an International Code of Marketing of Breastmilk Substitutes. In simplest terms, the International Code (adopted by 118 countries in 1981) and the resolutions that followed it were drawn up when governments recognized that unrestricted advertising and marketing of a product that competes with breastfeeding poses a real danger to infants and children. The Code defines the international community's limits on how, when, and where, the marketing of breastmilk substitutes can be conducted.[48]

Governments have important roles to play in support of BFHI that can increase the incidence and duration of breastfeeding and so improve the health of populations. They can act to prohibit all companies from supplying hospitals with free and low-cost breastmilk substitutes; pass legislations that supports the rights of wage-earning women to

[48] World Health Organization, 1991.

breastfeed; appoint a breastfeeding committee at the national level; and take an active role in the BFHI authority that officially designates hospitals as baby-friendly.

Wherever governments of developed and developing countries have acted to ban distribution of free and low-cost infant formula to maternity facilities and hospitals, IFM pledges that its member companies would comply with those orders. To date, the governments in all but three developing countries either do not have the problem of free and low-cost supplies, or have enacted bans to end their distribution.

UNICEF field offices are working with countries to assist in establishing monitoring and enforcement systems to ascertain whether manufacturers and distributors are in compliance with government measures.

IFM has stated that it will abide by each government's official measures to regulate marketing practices; members have pledged not to interfere with UNICEF and WHO efforts to end supplies of free and low-cost infant formula to health facilities in industrial countries by June 1994.

Summary of the Code of Marketing

1. No advertising of infant formula, pacifiers or feeding

bottles to the public.

2. No free formula to parents unless supplies can continue for 4-6 months.
3. No promotion of infant feeding products (e.g by notepads, booklets, posters, displays) in health care facilities.
4. No formula company representatives to advise mothers.
5. No words or pictures idealizing artificial feeding, including pictures of infants, on the labels of the products.
6. All information on artificial infant feeding, including the labels, should explain the benefits of breastfeeding, and the costs and hazards associated with artificial feeding.
7. Unsuitable products, such as sweetened condensed milk and evaporated milk, should not be promoted for babies.
8. No gifts or personal samples should be given to health workers.
9. Information to health workers should be scientific and factual.
10. There should be disclosure of grants from formula companies for research or travel. [49]

Recently, companies that manufacturer artificial milk (ie. Gerber, Johnsons & Johnsons) are covering their legal

[49] World Health Organization, International Code of Marketing of Breast-milk Substitutes. Geneva, 1993.

basis in terms of advertising. Since the time of the world-wide Nestle boycott and the International Code of Marketing setting of standards, companies have to be very careful as to how they advertise their products. For example, one Gerber television commercial begins something like "...although we know that breast is best, if you can't from you, then it should come from Gerber".[50]

Philippine Model of Success

The Baby-Friendly Hospital Initiative had its earliest, informal beginnings at the Baguio General Hospital and Medical Center, (Manila, Philippines) between 1975-1978, under the guiding hand of Dr. Natividad Reclucio-Clavano, Chief of Paediatrics. Dr. Clavano followed closely the consequences on child population at the hospital and it was from this study that she determined that the hospital and its practices (with newborn infants) needed changing.

It was though Dr. David Morley, head of the Tropical Child Health Unit of the Institute of Child Health, University of London and his colleagues that brought the breast vs. bottle controversy to the attention of Dr. Clavano as they were deeply concerned about the health problems of children in

[50] Authers note: this may not be the exact wording of the commercial.

the developing countries.[51] According to Dr. Clavano, "they made me see that babies belong with their mothers, not in the nursery, and deserve to given their mother's milk, not commercial formula". [52] [53]

After spending time travelling throughout Africa and Asia, where she discovered the extent of the problem of infant malnutrition, Dr. Clavano went back to Baguio General Hospital and tried a series of administrative changes in order to correct the damage that was being done.

The first step was to convince the hospital administrators that breastfeeding is practical and economical. Then the nursery staff had to be re-oriented in the mechanics of implementing breastfeeding and rooming-in. According to Dr. Clavano the "biggest challenge came from the nurses and physicians who gave birth at the hospital and wanted to bottlefeed their babies". [54]

The next step was to forbid the promotion of infant formula within the hospital. Dr. Clavano and her staff

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[51] Clavano, 1981.

[52] Clavano, 1981.

[53] Personal correspondence, March 1994.

[54] Personal correspondence, March, 1994.

stopped giving babies the starter dose of infant formula, and stopped accepting the gifts of posters and samples to the hospital.

One the most important changes in hospital procedures in the this "experiment" came from the shift of time it took for the mothers to be reunited with their child (for the first time and for the first feeding) soon after birth. Initially the babies were brought to their mothers within eight hours after birth. After a few months, the time was reduced to six hours, then four, then two and finally, to 30 minutes. Immediate post-partum contact and suckling has been documented to be advantageous for the mother and child. [55]

The results of this study showed that breastfeeding babies (on demand) reduced vomiting, diarrhoea, fungal infections[56] and gained weight more rapidly than bottle-fed babies. The successes of this study gained the elimination of all bottlefeeding and the use of infant formula from Baguio General Hospital as of July, 1978.[57]

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[55] Davis, 1978.

[56] Miller, 1976.

[57] Please refer to appendix 1 for "formula" for success.

Why the BFHI is not working in North America - particularly Canada

Neither Canada or the United States of America currently have any hospitals which have been designated as "baby-friendly".

No government, at any level - be it municipal, provincial or federal, in Canada has taken the initiative to actively support the Baby-Friendly Hospital Initiative and as a result there is no "authority" at any level to promote the program and undertake responsibility for assessment and designation of hospitals as outlined in the Baby-Friendly Hospital Initiative manuals.

The second fact is that almost all Canadian hospitals continue to provide free or low-cost supplies of infant formula to new mothers, which clearly disqualifies them from attaining baby-friendly status.

Another reason for the lack of the Baby-Friendly Hospital Initiative in Canada is that some of the "Ten Steps" are not universally agreed upon among health professionals. As an example, the Canadian Paediatric Society has concerns over

step number 6 [58] as some of their members believe strongly in giving babies water between feeds. As well, some Registered Nurses Associations are on record as being uncomfortable with the "lack of choice" offered to new mothers if nurses are expected to strongly promote breastfeeding.

World Breastfeeding Week:

The first week of August has recently been designated as the World Breastfeeding Week. The purpose of this week is not only to celebrate the anniversary of the Innocenti Declaration, but also it offers an opportunity for people world wide to join together in celebration and action for breastfeeding. WBW also enables people to evaluate the progress being made towards the protection, promotion and support of breastfeeding annually.

Last year, (1993) a new highlight of the breastfeeding debate was presented, that of breastfeeding mothers in the workplace. James P. Grant, UNICEF's Executive Director, stated that "support for the recognition of mother-friendly work places will promote and protect the rights of wage-earning women everywhere to simultaneously fulfil their roles

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[58] Number Six of the "Ten Steps to Success - The Baby-Friendly Hospital Initiative" states "give newborn infants no food or drink other than breastmilk unless medically indicated".

as productive and reproductive members of society without sacrificing or compromising either the rewards of employment or the well-being of their children".

This year the theme for World Breastfeeding Week was "Protect Breastfeeding: At Home, At Work and in the Community". Again, the theme sought to provide nursing mothers with a comforting message that breastfeeding is acceptable anywhere, anytime. The objectives this year were as follows:

1) to increase community and professional awareness of and Canada's commitment to the International Code of Marketing of Breast-milk Substitutes;
2) to increase community and professional awareness of strategies which support and protect breastfeeding and;
3) to promote positive attitudes and actions to foster a breastfeeding friendly environment.

It is hoped that by the year 2000 that there won't be a need to have World Breastfeeding Week, as breastfeeding will be celebrated, practised and encouraged throughout the entire year, not just a week.

Is Canada Baby-Friendly?

The following are observations and statistics gathered at the 4th Annual Breastfeeding Seminar, held at Humber College, 04-06 June, 1994.

"The breast is best" may be the policy of the World Health Organization and UNICEF, but Canadian hospitals are not doing enough to encourage new mothers to breastfeed their babies.[59] A joint report by the WHO and UNICEF says giving food or drink to breast-fed babies under four months is usually unnecessary and may make the baby more vulnerable to diarrhoea and disease.

Cheryl Levitt (Sir Mortimor Dais Jewish Hospital in Montreal) and Louise Hanvey, (a nurse and researcher based in Ottawa) recently completed a study (1993) which was the first comprehensive look at breastfeeding trends in Canada. The study consisted of a survey called, Routine Care in Canadian Maternity Units, [60] which involved 523 hospitals in Canada responding to questions about infant feeding.

Their finding were disturbing and alarming. More than 80% of hospitals that responded to the survey have exclusive

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[59] The London Free Press, 1994.

[60] See Appendix 1

contracts with formula companies, and barely three-quarters of new mothers are nursing their babies when they leave hospital.

Determining the policies of hospitals may help explain why more mothers are not breastfeeding their babies when they go home, she said. According to Levitt, "one of the biggest blocks or problems to encouraging women to breastfeed lies in the health beliefs, attitudes and policies". [61]

Breastfeeding advocates have long criticized Canadian hospitals that receive millions of dollars from formula companies to distribute samples. The Canadian Paediatric Society recommends breastfeeding for up to a year. But in Canada, fewer that 20% of mothers continue to breastfeed for even six months. [62]

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[61] National seminars notes, 1994.

[62] INFACT Canada, 1994.

nine months. [64]

According to the Canadian Institute of Child Health, women with lower incomes are more likely to bottle-feed their children than women with higher incomes; and infant mortality rates are higher for the low-income group. It was also noted that women from high income groups tend also to lean towards bottle-feeding. This would support the notion that breastfeeding is a middle-class phenomena.

Where do we go from here?

First and foremost, women realize two points: 1) that lactation is a process, just as pregnancy and childbirth are and 2) breastfeeding is empowering. Breastfeeding must then become a conscious discourse, where it can be redefined and reinterpreted from a feminist perspective.

Breastfeeding requires structural changes in all societies that will improve the position and condition of women. The empowering key to success is education. It is through these changes in the status quo that will, hopefully, enable breastfeeding mothers and (all) women a chance to gain

[64] INFACT Canada, Newsletter, Fall 1989.

power and to control her own body - this in turn, will challenge medical hegemony resulting in both a mother and baby-friendly society.

APPENDIX 1

Hospital facilities recommended for a successful breastfeeding program - Manila, Philippines.

To implement a breastfeeding program, a hospital should provide adequate facilities for both mother and child.

These should include the following:

Obstetric ward: No special room is needed for the newborns. They are brought to where the mothers are confined after delivery.

Breastfeeding room: This is a small room where a mother who is confined to a general ward can come to breastfeed every two or three hours, accompanied by a nursing attendant or student nurse.

Private room: In these rooms for paying mothers, babies are roomed-in with or without bassinets.

Mini milk bank: Expressed breast milk that will not be used immediately is stored in an ordinary refrigerator. Milk is collected daily from selected donors to ensure a continuous supply.

Mother and child room: In the case of Baguio General Hospital and Medical Center, a portion of the nursery was converted into a four-bed room, where a mother, after her discharge from the obstetric ward, can stay with her baby if it has been admitted because of illness, feeding problems, or need for observation. No mother is discharged before her baby in order to prevent the disruption of lactation, breastfeeding, and the early development of the mother-child bond.

APPENDIX 2

ROUTINE CARE STUDY [65]

- findings of the Levitt/Hanvey Canadian Hospitals Study.

- 73.6 per cent of new mothers were breastfeeding when discharged from hospital.
- 46 per cent of hospitals said breast-fed babies were given liquid other than mother's milk at least once.
- 14 per cent of hospitals have lactation consultants to support nursing mothers.
- 58.4 per cent of hospitals have written policies on breastfeeding.
- 81.9 percent of hospitals have exclusive contracts with formula companies.
- 24 per cent of hospitals routinely distribute formula samples.

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[65] These statistics were taken from my notes which I gathered at the 4th Annual National Breastfeeding Seminar, Toronto, June, 1994.

APPENDIX 3

Historical Overview of Breastfeeding Support [66]

The following is a chronological overview of breastfeeding support.

1939) Dr. Cecily William's famous speech "Milk and Murder" to the Singapore Rotary Club, focused on the negative promotion of unsuitable infant feeding practices and forced the international community to pay attention to breastfeeding.

Since 1939, progress has been made; international events, documents, programs and initiatives have attempted to make breastfeeding policies an important issue all over the world.

1956) Formulation of La Leche League International (LLLI). A Mother-to-Mother support organization which has become the International Authority on Breastfeeding.

1960) Dr. Derrick and Patricia Jelliffe called attention to breastfeeding's crucial role in child survival.

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[66] From personal notes taken at the 4th National Breastfeeding Seminar. 04-06, June 1994 - Humber College, Toronto.

1979) UNICEF and WHO sponsored a meeting on Infant and Young Child Feeding in Geneva. From this meeting came a document recommending an International Code of Marketing Breastmilk Substitutes. At this same meeting in Geneva, six non-governmental organizations formed the International Baby Food Action Network (IBFAN)

1983) LLLI initiated a Lactation Consultant Department with a vision for the development of a new health care professional.

1985) International Board of Lactation Consultant Examiners (IBLCE) offered the first international exam which offered a certificate for Lactation Consultants. Also, the formation of the International Lactation Consultant Association.

1988) UNICEF workshop "Breastfeeding: Passport to Life" - this placed breastfeeding in the middle of the international public health agenda.

1989) WHO, UNICEF and UNESCO produced three documents important for global breastfeeding: 1) Protecting, Promoting and Supporting Breastfeeding - The Special Role of Maternity Services; 2) Facts for

Life - A Communication Challenge; 3) Convention of the Rights of the Child

1980 - ▸) Ongoing promotion from Health Canada

1987) CIFA - Canadian Infant Formula Association, the corporate's response to the WHO Code recommendations - Canadian Government accepted the industry's answer, a self-regulated code of practice, rather than enacting legislation. Nooe: CIFA was disbanded in 1994.

1986) Formation of Canadian Lactation Consultant Association.

1991) National Expert Working Committee on Breastfeeding established by Health Canada. Membership composed of 25-30 representatives from national organizations which are involved with breastfeeding. Initial focus is the Promotion of Breastfeeding as a Lifestyle Norm in Canada.

1993) Canadian Institute of Child Health - production of a document entitled, "Promoting Breastfeeding: A Role for the Dietitian?Nutritionist".

1994) The Canadian Dietetic Association, The Canadian Pediatric Association and Family Health Unit of Health Canada are revising the Infant Feeding Statement to be released this year. Also, the Canadian Nurses' Association and the Canadian Medical Association have endorsed the joint WHO Statement on Breastfeeding and WHO Code of Marketing Breast-milk Substitutes.

APPENDIX 4

A National (Canadian) Historical Overview on Breastfeeding Support

1922) The book Canadian Mother and Child actively encouraged breastfeeding.

1961) First La Leche League Leaders in Canada, eventually formed La Leche League in Canada as an affiliate of LLLI.

1979) Formation of INFACT Canada - IBFAN North America.

1979) Health and Welfare Canada, Canadian Pediatric Association and La Leche League Canada actively collaborated in a significant promotional program for breastfeeding. Posters, etc. of educational materials on breastfeeding were distributed to all hospitals, health clinics and physicians' offices.

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Committees

- Grace Maternity Hospital Breastfeeding Support Committee.
- Education for Development - UNICEF Nova Scotia.

Personal Correspondences

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1) UNICEF Canada

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