ENCYCLOPEDIA
on Early Childhood
Development

Programs to Protect, Support and Promote Breastfeeding

Ted Greiner, PhD

Associate Professor, International Child Health, Uppsala University, Sweden

March 2008, 2e éd.

Introduction

The importance of breastfeeding is widely acknowledged and referred to in several other papers in the Encyclopedia on Early Childhood Development. Dewey (Nutrition: Facilitating improved nutrition for pregnant and lactating women, and children 0-5 years of age) cites some of the best literature on the relationship between breastfeeding and maternal and child health, including the available evidence for the impact of breastfeeding on child development.[1]

The impact of breastfeeding on early childhood development is being increasingly recognized. For example, the United Nations Children's Fund, UNICEF, includes breastfeeding under the broader department dealing with Early Child Development. The World Health Organization (WHO) defines optimal breastfeeding as exclusive breastfeeding for six months, followed by continued breastfeeding with appropriate complementary feeding up to and beyond two years of age.

Subject

©2008-2026 ABILIO | BREASTFEEDING

How can breastfeeding best be protected, supported and promoted? These are complex concepts and the steps required to implement them are even more complex. In theory,[2] the establishment of systems to protect existing breastfeeding practice deserves priority, from both the human rights and economic perspectives. Second, priority should go to providing the social, economic, work-place, nutritional, lactation-management and "moral" support women need to meet their breastfeeding objectives. Only once such mechanisms are in place is it rational and defensible to "promote" breastfeeding to help convince women to increase the duration and intensity of their breastfeeding.

Of course, this is viewing "promotion" from a narrow perspective. Information on both the benefits and the successful practice of breastfeeding should always be provided as each generation of new mothers comes of age and requires such information. Indeed, this is obligatory in countries that have ratified the International Convention on the Rights of the Child.[3] There is also increasing agreement that such information should actually not take as its point of departure artificial feeding as the norm, and thus should provide health workers and mothers not with a "breast is best" message, but with objective evidence of the harm and risks inherent in feeding infants less than optimally. (It should be pointed out that such evidence is far from complete, especially regarding breastfeeding in economically well-off circumstances for periods longer than a year or in such circumstances, exclusively for more than four months.)

Problems

Though a traditional practice everywhere, and nearly universal for long periods of time in low-income countries (and, for shorter periods, in most of Scandinavia and parts of Canada (SPC)), breastfeeding in the modern world is not automatic. Many ideas and practices associated with modern life seem to work against it. Thus continuing efforts to protect, support and promote breastfeeding may be required, at least until it becomes the social norm.

Research Context and Recent Research Results

The concept of exclusive breastfeeding is new and the practice (giving breast milk and nothing else, not even water, to an infant from birth until six months of age) is not traditional anywhere. The theory and first experimental evidence that breastfed infants did not need additional water were first described by Almroth in 1978.[4] After several studies confirmed this theory, the WHO produced an update in 1997 warning health-care professionals not to give breastfed infants

water and teas. Based on a systematic review,[5] the WHO also recommended six months of exclusive breastfeeding. Thus, there has been little time to research the health implications of longer periods of exclusive breastfeeding (rare almost everywhere except for SPC), nor the methods of promoting and supporting this practice beyond the early weeks of life.

Best Practices

Protection

Probably the first “code of marketing” to protect breastfeeding from commercial forces was promulgated in the United States;[6] unfortunately, it is not respected by North American formula manufacturers who do not market other products through medical professions. The International Code of Marketing of Breast-Milk Substitutes[7] and later relevant World Health Assembly Resolutions continue to be the backbone of efforts to protect breastfeeding throughout most of the world, in spite of continued milk company promotional activities.[8] This unique Code is the basis for comprehensive marketing laws in more than 20 countries and less comprehensive laws in over twice that many. Due to the bad publicity they risk, most international companies abstain from consumer advertising in most other countries as well.

As for other products, marketing activities of commercial infant foods would not be undertaken if they did not lead to rising sales. Proving their impact has been difficult and few studies have even been attempted. Women’s recollection of having heard advertisements (controlling statistically for levels of brand familiarity, among other things) was associated with a shorter period of exclusive/predominant breastfeeding in St. Vincent.[9] The use of commercial discharge packs in the U.S. has also been associated with shorter periods of exclusive/predominant breastfeeding.[10]

It is by definition impossible to evaluate the impact of ongoing worldwide efforts to monitor and uphold the Code by the WHO, UNICEF and NGO networks, particularly the International Baby Food Action Network (IBFAN) and the World Alliance for Breastfeeding Action and its core partners.

Support

At the broadest level, women need the support of society as a whole, acceptance for breastfeeding as being a social norm, a part of life and a normal extension of the reproductive

process after pregnancy. This kind of social norm was lost in most of the wealthier countries of the world, but has now been restored in SPC. Much of the rest of Europe and North America is currently making efforts to promote the restoration of their earlier breastfeeding cultures. However, without some of the support measures described below, success seems unlikely.

While it is “natural,” breastfeeding is not instinctive on the part of the mother. Though several breastfeeding behaviours are instinctive for infants, a small proportion of infants or mothers get part of it wrong without help. A body of evidence has been built up for how best breastfeeding counselling and “lactation management” should take place, and several international courses (including one available from WHO[11]) and an international program for certification (International Board of Lactation Consultant Examiners[12]) have been established.

Every health facility should have staff members or consultants available who possess the requisite lactation management knowledge and skills. Such knowledge and skills are not included in the basic training of any health professionals, although midwifery training in some countries may come close.

Furthermore, health facilities where birthing takes place should adopt WHO and UNICEF’s “Ten Steps to Successful Breastfeeding” as part of the International Baby-Friendly Hospital Initiative. The changes required in hospital practice are well documented scientifically, particularly the importance of early initiation of breastfeeding, avoidance of unnecessary supplementation with glucose and other substances, and rooming in (babies sleeping with their mothers rather than in a “nursery”).[13]

The International Labour Organisation (ILO) has passed three Maternity Protection Conventions, the latest, Convention 183 of 2000, with Recommendation 195.[14] Only nine countries have ratified it so far (mid-2004).[14] A long period of paid leave (R195 recommends 18 weeks but SPC offer much longer periods) is no doubt the best way to give working women the opportunity for exclusive breastfeeding. Offering child care and breast milk expressing facilities at the workplace is another. The problem remains especially acute throughout the world for women working in the informal sector, who often have no maternity protection whatsoever and can even lose their jobs when pregnant.

Many studies have shown that various other kinds of support from the baby’s father, family and friends are crucial in helping women achieve optimal breastfeeding patterns.[15] In addition,

exclusive breastfeeding cannot be achieved in most countries without addressing the widespread myths that lead to the pressure placed on mothers[16] to follow various non-exclusive patterns of feeding that are normative all over the world.[17]

Seen as a whole, it is equally impossible to evaluate the impact of providing the many forms of support women need to achieve optimal breastfeeding patterns. Indeed, very few if any intentional national-level efforts have attempted to be comprehensive, with the possible exception of Brazil, which has, for more than 20 years, implemented a comprehensive range of efforts with undoubted impact on its breastfeeding rates – though much still remains to be done even there.[18,19,20]

Promotion

Evaluations have been performed of many ways of promoting breastfeeding, ranging from the provision of a simple brochure or verbal message to breastfeed, to integrated health-systems and community-based approaches. A review of 23 experimental and 31 quasi-experimental studies concluded that the most effective approaches to promoting breastfeeding through the health-care system were fairly comprehensive, combining prenatal group discussions with postnatal home visits.[21] Pugin et al[22] found that adding to several other interventions "prenatal group educational sessions emphasizing the skills necessary to initiate and maintain breastfeeding past the neonatal period" led to a significantly higher number of women still breastfeeding at six months.

A recent review for the U.K. National Health Service[23] examined evidence from two high-quality systematic reviews regarding interventions proven to increase the initiation of breastfeeding (and thus relevant mainly to areas where initiation is low). The review concluded that comprehensive approaches, both within and outside the health-care sector, were most likely to be effective, including use of the mass media and of peer counsellors.

It is difficult to "tease out" exactly which aspects of complex promotional programs have had an impact and which have not. De Oliveira et al.[21] found that "Small-scale short interventions, brief breastfeeding messages given amongst other topics and isolated use of printed matter all showed no effect. Most strategies with no or brief face-to-face interaction failed to produce significant results."

Peer counselling is the intervention that has attracted the most attention in recent years, perhaps in response to a few trials that have achieved dramatic impacts on exclusive breastfeeding rates in some developing countries.[24,25,26] In industrialized countries, outcomes of peer counsellor evaluations have been more mixed, as have reports from unpublished trials in developing countries. More research is needed to determine which characteristics of peer counsellors and of programs using them are most associated with Program success.

Conclusions

Optimal breastfeeding behaviours, although associated with enormous health benefits, especially in developing countries,[27] are demanding for mothers to implement and complex to promote programmatically. It seems unlikely that simplistic approaches that address only one aspect would be effective. Efforts need to address protection, support and promotion issues, both within the health-care sector and in the community as a whole.

Comprehensive advice to policy-makers on policies and programs for achieving optimal infant feeding has been provided by WHO in the recently approved Global Strategy on Infant and Young Child Feeding.[28] Among other things, countries are advised to establish intersectoral breastfeeding committees and appoint a coordinator. Both resources and responsibility need to be allocated before the protection, support and promotion of breastfeeding can succeed.

References

1. Dewey KG. Facilitating improved nutrition for pregnant and lactating women, and children 0-5 years of age. Commenting: Black, Reifsnider, and Devaney. In: Tremblay RE, Boivin M, Peters RDeV, eds. *Encyclopedia on Early Childhood Development* [online]. Montreal, Quebec: Centre of Excellence for Early Childhood Development and Strategic Knowledge Cluster on Early Child Development; 2003:1-6. Available at: http://www.child-encyclopedia.com/documents/DeweyANGxp.pdf. Accessed October 12, 2004.
2. Greiner T. Infant and young child nutrition: a historic review from a communication perspective. In: Koniz-Booher P, ed. *Proceedings of an international conference on communication strategies to support infant and young child nutrition, July 13-14, 1992, Washington, D.C.*. Ithaca, NY: Cornell University, Program in International Nutrition; 1993:7-15.
3. UNICEF. United Nations General Assembly. International Convention on the Rights of the Child. Available at: http://www.unicef.org/crc/. Accessed October 29, 2007.
4. Almroth SG. Water requirements of breast-fed infants in a hot climate. *American Journal of Clinical Nutrition* 1978;31(7):1154-1157.
5. Kramer MS, Kakuma R. *The optimal duration of exclusive breastfeeding: a systematic review*. Geneva, Switzerland: World Health Organization, Department of Nutrition for Health and Development, Department of Child and Adolescent Health and Development; 2002. Available at: http://www.who.int/nutrition/publications/optimal_duration_of_exc_bfeeding_review_eng.pdf. Accessed October 29, 2007.
6. AMA. Committee on Foods. Advertising guidelines. *JAMA - Journal of the American Medical Association* 1932;99:391.

©2008-2026 ABILIO | BREASTFEEDING

7. WHO. *International Code of Marketing of Breast-milk Substitutes*. Geneva, Switzerland: World Health Organization; 1981. Available at: http://www.who.int/nutrition/publications/code_english.pdf. Accessed October 29, 2007.
8. Aguayo VM, Ross JS, Kanon S, Ouedraogo AN. Monitoring compliance with the International Code of Marketing of Breastmilk Substitutes in west Africa: multisite cross sectional survey in Togo and Burkina Faso. *BMJ - British Medical Journal* 2003;326(7381):127.
9. Greiner T, Latham MC. The influence of infant food advertising on infant feeding practices in St. Vincent. *International Journal of Health Services* 1982;12(1):53-75.
10. Donnelly A, Snowden HM, Renfrew MJ, Woolridge MW. Commercial hospital discharge packs for breastfeeding women. *Cochrane Database of Systematic Reviews* 2004;3.
11. World Health Organization. *Breastfeeding counselling: a training course*. Geneva, Switzerland: World Health Organization; 1993. Available at: http://www.who.int/child-adolescent-health/publications/NUTRITION/BFC.htm. Accessed October 12, 2004.
12. International Board of Lactation Consultant Examiners Web site. Available at: http://www.iblce.org/. Accessed October 12, 2004.
13. World Health Organization, Division of Child Health and Development. *Evidence for the ten steps to successful breastfeeding*. Geneva, Switzerland: World Health Organization; 1998. Available at: http://www.who.int/child-adolescent-health/publications/NUTRITION/WHO_CHD_98.9.htm. Accessed October 12, 2004.
14. International Labour Organisation. C183 Maternity Protection Convention, 2000. Available at: http://www.ilo.org/ilolex/cgi-lex/convde.pl?C183. Accessed October 12, 2004.
15. Kessler LA, Gielen AC, Diener-West M, Paige DM. The effect of a woman's significant other on her breastfeeding decision. *Journal of Human Lactation* 1995;11(2):103-109.
16. Cohen RJ, Brown KH, Rivera LL, Dewey KG. Promoting exclusive breastfeeding for 4-6 months in Honduras: attitudes of mothers and barriers to compliance. *Journal of Human Lactation* 1999;15(1):9-18.
17. Haggerty PA, Rutstein SO. *Breastfeeding and complementary infant feeding, and the postpartum effects of breastfeeding*. Calverton, Md: Macro International Inc.; 1999.
18. de Oliveira Brady S. Protecting breastfeeding: Brazil's story. *Practising Midwife* 2003;6(10):14-16.
19. de Oliveira MIC, Camacho LAB, Tedstone AE. A method for the evaluation of primary health care units' practice in the promotion, protection, and support of breastfeeding: results from the state of Rio de Janeiro, Brazil. *Journal of Human Lactation* 2003;19(4):365-373.
20. Rea MF. [A review of breastfeeding in Brazil and how the country has reached ten months' breastfeeding duration] [Portuguese]. *Cadernos de Saude Publica* 2003;19(Suppl 1):S37-S45.
21. de Oliveira MI, Camacho LA, Tedstone AE. Extending breastfeeding duration through primary care: a systematic review of prenatal and postnatal interventions. *Journal of Human Lactation* 2001;17(4):326-343.
22. Pugin E, Valdes V, Labbok MH, Perez A, Aravena R. Does prenatal breastfeeding skills group education increase the effectiveness of a comprehensive breastfeeding promotion program? *Journal of Human Lactation* 1996;12(1):15-19.
23. Protheroe L, Dyson L, Renfrew MJ, Bull J, Mulvihill C. *The effectiveness of public health interventions to promote the initiation of breastfeeding: Evidence briefing*. London, England: NHS Health Development Agency; 2003. Available at: http://www.nice.org.uk/page.aspx?o=502579. Accessed October 29, 2007.
24. Morrow AL, Guerrero ML, Shults J, Calva JJ, Lutter C, Bravo J, Ruiz-Palacios G, Morrow RC, Butterfoss FD. Efficacy of home-based peer counselling to promote exclusive breastfeeding: a randomised controlled trial. *Lancet* 1999;353(9160):1226-1231.

25. Haider R, Ashworth A, Kabir I, Huttly SR. Effect of community-based peer counsellors on exclusive breastfeeding practices in Dhaka, Bangladesh: a randomised controlled trial. *Lancet* 2000;356(9242):1643-1647.

26. Bhandari N, Bahl R, Mazumdar S, Martines J, Black RE, Bhan MK, Infant Feeding Study Group. Effect of community-based promotion of exclusive breastfeeding on diarrhoeal illness and growth: a cluster randomised controlled trial. *Lancet* 2003;361(9367):1418-1423.

27. Jones G, Steketee RW, Black RE, Bhutta ZA, Morris SS, Bellagio Child Survival Study Group. How many child deaths can we prevent this year? *Lancet* 2003;362(9377):65-71.

28. World Health Organization. *Global strategy for infant and young child feeding.* Geneva, Switzerland: World Health Organization; 2003. Available at: http://www.who.int/entity/nutrition/publications/gs_infant_feeding_text_eng.pdf. Accessed October 29, 2007.

©2008-2026 ABILIO | BREASTFEEDING