BREAST-FEEDING WEEK

Ten Steps to Successful Breastfeeding
A joint WHO/Unicef Statement (1989)

Every facility providing maternity services and care for new-born infants should:

1. Have a written breastfeeding policy that is routinely communicated to all health-care staff.
2. Train all health-care staff in the 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 breastfeed and how to maintain lactation even if they are separated from their infants.
6. Give new-born infants no food or drink other than breast milk unless *medically* indicated.
7. Practice rooming-in - allow mothers and infants to stay together - 24 hours a day.
8. Encourage breastfeeding on demand.
9. Give no artificial teats or pacifiers (also called dummies and soothers) to breastfeeding infants.
10. Foster the establishment of breastfeeding support groups and refer mothers to them on discharge from hospital or clinic.

Janssen's Involvement in Breastfeeding week

Janssen Pharmaceutica SA has sponsored a public awareness campaign to promote the health benefits of breastfeeding.

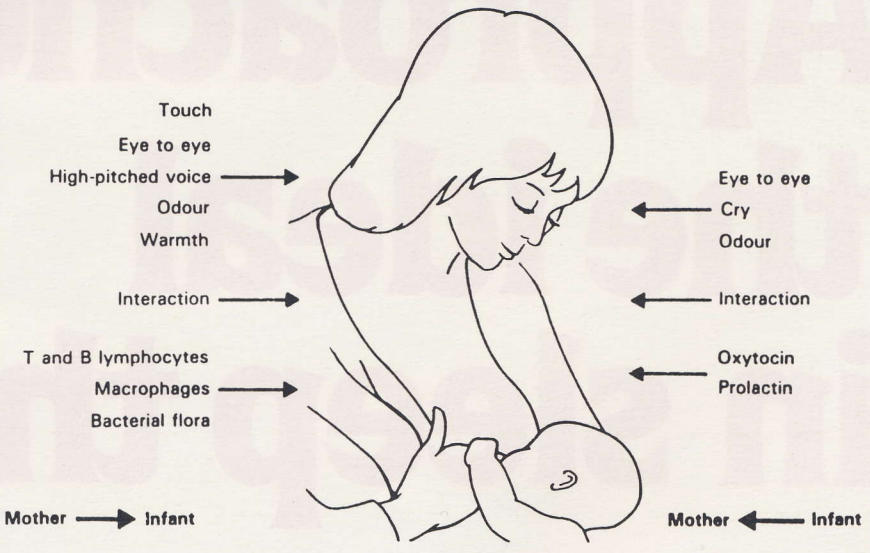
This sponsorship has been designed primarily to further the aims of the steering committee for National Breastfeeding Week.

Motivation behind this sponsorship, as described by Dr Matt Haus, Director of Medical Research, Janssen Research Foundation, when announcing the project, is as follows:

"The company has a committed responsibility to the developing communities, now and into the future. We have always seen ourselves as having a mandate to put expertise, information and resources back into the communities we serve. In this sense, prevention of disease is one of our primary objectives, and not only therapeutics.

"In both infantile gastroenteritis and allergic disease both critical issues to be addressed in this third world country, Janssen has a very strong franchise and mandate. Breastfeeding in infancy is one of the most important mechanisms by which we can prevent gastroenteritis and other acute infections in infancy."

Fig. 152 Suckling has advantages to the mother and child



Recent research has revealed, and still is revealing, the many advantages to the mother who suckles and the infant who is suckled.

Fig 152 and Fig 156: From: Marley and Lovel. My Name is today. An illustrated discussion of child health, society and poverty in less developed countries. London: MacMillan Publishers.

Consensus Statement

Breastfeeding as a family planning method*

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This report was contributed by Family Health International. The full conference report is available from Kathy Kennedy, Family Health International, PO Box 13950, RTP Branch, Durham, NC 27709 USA.

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Although the benefits of breastfeeding for infant health are universally recognised, many people are sceptical about the use of breastfeeding as a family planning method. An international group of scientists gathered in August, 1988, at the Bellagio Study and Conference Centre, Italy, with the support of the Rockefeller Foundation, Family Health International, and the WHO Special Programme of Research, Development and Research Training in Human Reproduction. This group came to consensus about the conditions under which breastfeeding can be used as a safe and effective method of family planning. It recommended that lactational amenorrhoea should be regarded as an appropriate method of fertility regulation for many women, and that this strategy should be incorporated into family planning programmes and presented as one element of informed choice, particularly when other family planning methods are not readily available or desired.

Two alternative strategies were proposed to take advantage of the period of lactational infertility: breastfeeding can be used either as a birth spacing method in its own right, especially when there are no alternatives available or if a couple chooses not to use other family planning methods; or it can be used as a means to delay the introduction of other family planning methods. Where there are difficulties with family planning availability, acceptability, or continuation (especially during breastfeeding), exploitation of the natural infertility of breastfeeding followed by use of another family planning method (rather than the simultaneous employment of both) may serve to maximise the interbirth interval.

The consensus was that the maximum birth spacing effect of breastfeeding is achieved when a mother "fully" or nearly fully breastfeeds and remains amenorrhoeic (bleeding before the 56th postpartum day being ignored). When these two conditions are fulfilled, breastfeeding provides more than 98% protection from pregnancy in the first six months. At six months, or if menses return or if breastfeeding ceases to be full or nearly full before the sixth month, the risk of pregnancy increases. As soon as one of these events occurs, consideration must be given to adoption of other means of family planning if a high degree of protection is desired or needed.

Full or nearly full breastfeeding is associated with longer periods of lactational amenorrhoea and infertility than partial breastfeeding. Suckling frequency and the duration of the longest period of no suckling activity have sometimes been used as measures of the amount of breastfeeding. However, these variables may be hard to define and implement as part of a set of general recommendations.

Women who wish to or need to rely on the birth spacing effect of breastfeeding should delay for as long as possible the introduction of other regular feedings to the infant's diet, but without jeopardising infant growth and development. When additional foods need to be introduced (usually between the fourth and sixth month postpartum), women should be encouraged to continue breastfeeding frequently (day and night) if they wish to maintain a milk supply.

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It is hypothesised that, if additional foods are introduced into the baby's diet gradually over an extended period, continued breastfeeding may still exert a substantial antifertility effect for a year or more. The key here is that breastfeeding is not reduced and other foods do not replace breastfeeding. This seems to be the breastfeeding pattern in many settings with long durations of lactational amenorrhoea. Local operational definitions of "full breastfeeding" must be used and evaluated.

In general, lactational infertility decreases with time. After the sixth month postpartum, when breastfeeding will probably cease to be full or nearly full, it is increasingly likely that fertility will precede the first vaginal bleed. On the other hand, the period of lactational infertility is longer in populations where the natural duration of lactation is very long; and this may be dependent, at least in part, on the pattern of feeding and supplementation. Pregnancy rates associated with lactational amenorrhoea after the sixth postpartum month, although low, have not been quantified precisely by time postpartum or breastfeeding pattern. Demographic survey data suggest that the risk of pregnancy among lactating amenorrhoeic women in developing countries is not

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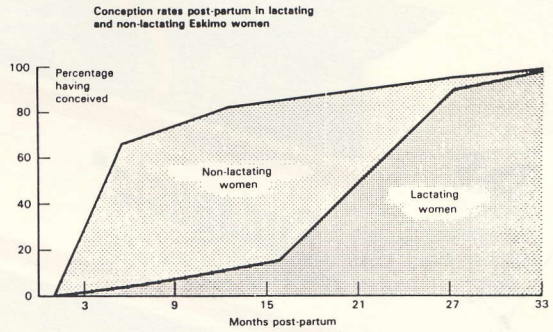
greater than 10% after six months, and in many such settings lactational amenorrhoea may last up to a year or more.

Guidelines specific to a particular country or population for use of breastfeeding as a postpartum family planning method can be developed from this consensus statement. The general guidelines can be adapted according to local infant feeding practices and the average duration of amenorrhoea.

Fig. 156 Suckling and conception



Suckling delays the birth of more infants in our world than all contraceptive measures.

Infant Feeding

Colic, "overfeeding", and symptoms of lactose malabsorption in the breast-fed baby; a possible artifact of feed management?

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Summary

Curtailing the time for which a baby feeds at the first breast, in order to encourage intake from the second breast, may maximise milk production by the mother. With escalation of this situation a point may be reached at which the infant, because of the constraint of his stomach capacity, is unable to consume sufficient calories at a feed, since foremilk is lower in calories than hindmilk. The result will be symptoms of hunger (crying, fretfulness) and maybe even failure to thrive. The low fat content of the diet may cause rapid gastric emptying. This in turn may lead to lactose reaching the small bowel in concentrations that may tax the infant's lactase potential, with resulting diarrhoea. A simple change in breastfeeding patterns may alleviate some instances of undernutrition or diarrhoea.

Case-Report

The following case-history shows how a combination of symptoms was alleviated by a simple change in feeding policy.

A 15-week-old breast feeding infant (girl) was referred to us for failure-to-thrive; she had gained only 2 oz in 3 weeks. She had had "explosive" passage of green watery stools since she was 12 weeks old. She had 9-12 feeds per 24 h. She was fretful and seemed dissatisfied after feeds despite her mother's "plentiful" milk supply; she cried persistently (was colicky) and was not sleeping at night.

The mother was being helped by a breast-feeding counsellor, who was satisfied that most aspects of management were being correctly followed - the baby was well attached on the breast, and was having frequent feeds of unrestricted length. The mother was offering both breasts, changing sides after 10 minutes on the first breast. We advised her to finish feeding from the first breast before attempting to offer the second breast. The effect was immediate and striking. The baby came off the breast without crying after the first "whole-breast" feed; she slept through the night for the first time on the second night of this new regimen; the stools became normal; and the baby started gaining weight. The baby continued to thrive thereafter while being exclusively breast-fed.