

Chapter Four

History of Breastfeeding

Objectives

Identify three reasons breastfeeding was phased out of maternal infant care in the last century in America.

Describe the terms used for breastfeeding and complementary feeding.

Describe one way in which the maternalists' objectives harmed the practice of breastfeeding.

State the aim of the WHO/UNICEF Global Strategy for Infant and Young Child Feeding.

List all 10 statements of the WHO International Code of Conduct for the Marketing of Breastmilk Substitutes.

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Suggested Reading

- Still Selling Out Mother and Babies, Marsha Walker found at www.naba-breastfeeding.org/resources.htm
- CDC Breastfeeding Report Card 2014 found at www.cdc.gov/breastfeeding/pdf/2014breastfeedingreportcard.pdf
- Milk, Money and Madness by Naomi Baumslag and Dia Michels
- A Look at Breastfeeding: Past, Present and Future by Nancy Wight, MD, FAAP, IBCLC

Historical Look at Breastfeeding

Introduction

Breastfeeding is the defining property of mammals. Breastfeeding advocate Chris Mulford wrote, "Mammals are successful because, unlike birds, they are not limited to breeding only where they can find food nearby for their babies. Mammal mothers make their babies' food themselves, and the babies control production by the amount of milk they drink. I believe it is essential to protect this collaborative bodily link between a human adult and her young." (Mulford, 2009)

Through most of human history, breastmilk was the only available food for infants, and breastfeeding was inseparable from baby care. If a mother died or was unable to breastfeed, another family or community member would nurse the baby, just as they would care for all of the baby's needs. In some cultures, sisters or other women with close relationships would nurse each other's babies (known as cross-nursing) in order to sustain their family, just as a modern woman might swap babysitting time with a friend, or rock and diaper a niece so her sister could nap. If the family had the funds necessary, a "wet-nurse" might be hired to care for and breastfeed the baby, a practice mentioned in ancient Egyptian and Biblical texts. Whether done for pay, familial love and nurturing, or community sustainability, breastfeeding was part and parcel of taking care of another woman's baby. These practices allowed babies to survive maternal absence, illness, or death, and helped societies cope with epidemics, famine, war, and natural disasters.

Industrialization and Urbanization

The industrial revolution and subsequent urbanization of western society meant that women were increasingly separated from their infants for factory work or other labor far from home, and also separated from their extended families. Wet nursing reached its height of popularity in the 18th and 19th century, partly due to these changes. European wet nursing in the 18th and 19th century involved sending infants from their homes in the city to wet nurses in the countryside. For wealthy women it was a status symbol, and for those women working in factories or doing manual labor, it was the only viable feeding alternative, as artificial feeding was considered dangerous and too costly.

Country wet nurses did not always breastfeed their charges, and instead often used dry nursing techniques. Dry nursing involved feeding the baby pap or panada, a mixture of grains, bread or flour with broth, water, or butter. Dry nursing resulted in the deaths of thousands of infants, and gradually wet nursing went out of favor as a dangerous method of feeding an infant. Wet nursing was found to be the dangerous culprit instead of the true problem – dry nursing.

Thus, the only alternative was artificial milk. Originally, each doctor had their own formula, which was written out on a prescription pad specifying the ingredients that the mother would obtain and mix herself at home. Later, companies began to brand specific recipes and manufacture them for sale, and the name “formula” stuck. In the late 1800s to early 1900s, Thomas Morgan Rotch and other entrepreneurs espoused the benefits of their own “formulas” for infants as an alternative to breastmilk. During this time, there was such an emphasis on all things scientific that the public began to see formula as scientifically superior to breastmilk. These artificial milk formulas were only offered through physicians, and thus began the relationship between formula companies and the medical profession.

Healthcare was changing and adopting new technologies in other ways as well. In the early 1900s, birth was being transitioned from the home with midwifery attendance to the hospital, overseen by nurses and doctors, who were enthusiastic about the new options for anesthesia and instrument-assisted delivery. Many women were highly medicated and unable to breastfeed for many days postpartum as their bodies recovered from the drugs and traumatic deliveries, including high forceps birth. It was also standard practice to not feed infants for twenty-four hours in the nursery and then use artificial milk formulas. When mothers finally got home with their infants, sometimes two weeks after delivery, their milk supply was diminished and their babies often had developed a preference for the bottle nipple.

Impact of Maternalists on Breastfeeding: 20th Century Public Health; Mixed Motives, Mixed Messages

The late 1800s and early 1900s also brought new attention and advocacy to public health concerns, largely due to the Maternalist and eugenics movements. These philosophies were promoted as ways to address a host of health problems, many related to poverty and urbanization. Factory workers often lived in squalid conditions, were exposed to unsafe working conditions, and had inadequate food. Infant and maternal mortality were high. Many workers were immigrants, and racist views tainted almost all efforts to alleviate these problems.

This is context in which the Maternalist movement began - a variety of women's groups, fronted by religious and social organizations, which became very active in political and social networking. Their concerns included, "Problems of consumption - such as the need for pure milk and Clean meat . . . [and] the need to clean up the urban environment (Skocpol, 1992)." The Maternalist effort started in a grassroots setting spreading to what was then known as Women's Clubs. A sampling of these clubs grew to include the National Congress of Mothers (1897), General Federation of Women's Clubs (1890), the National Consumers' League (1899), and the National Women's Trade Union League (1903) (Larsen, 2007).

Maternalists, responding to the growth of manufacturing and increasingly common exploitation of factory workers, were also largely responsible for legislation regarding "Women's hour laws, minimum wage laws, Mothers' pensions, the establish[ment] of the Children's Bureau and the passing of the Sheppard-Towner Act (Larsen, 2007)." The Sheppard-Towner Act, approved in 1921, established the Children's Bureau which administered the "Federal Act for the Promotion of Welfare and Hygiene of Maternity and Infancy", the first major maternal & child public health initiative in the US. The Sheppard-Towner Act made "public health nurses the mainstay of the program...[they] were the ones who gave hygienic advice, who encouraged breast-feeding, who gave routine care to expectant mothers, and who instructed the midwives (Skocpol, 1992)."

For women in the lower class, factory work was a mainstay for economic security. This return to work did not allow for breastfeeding and as such the only alternative was cow's milk or cow's milk formulas (Wolf, 2003). In the late 1880s many women switched from breastfeeding their babies to offering their newborns straight cow's milk and cow's milk formula. The terrible result of the switch from breastfeeding to cow's milk in infants was known as "summer complaint," the diarrhea epidemics caused by copious bacteria found in warm and improperly handled cow milk, and "winter complaint" the acute upper and lower respiratory disease

common to bottle fed babies (Semba, 1999). Babies were also fed out of unsafe bottles known as “tube bottles” which were impossible to keep clean and bacteria free (Semba, 1999). The Maternalist campaign that stemmed from this tragedy “urged mothers to breastfeed or to avoid feeding their babies spoiled, unadulterated cow’s milk that pervaded US cities.” (Wolf, 2003) During this time period, breastfeeding was seen as an important means of keeping babies alive.

Simultaneously, the Maternalists also campaigned for better sanitation of cow’s milk.

Ultimately this campaign would prove more successful than their breastfeeding promotion, perhaps in part because others also took up the dairy cause. Between 1911 and 1913, several scientists and pediatricians went on a health campaign to encourage children and women to drink cow’s milk. Cow’s milk was believed to have “vital amines,” later known as vitamins, the most significant thought to be vitamin A (Semba, 1999). Cow’s milk was declared essential for growth, believed to contain high levels of “vitamine” A and “vitamine” B. Cow’s milk actually does not have high levels of these vitamins, but at the time it was regarded as a reliable source. In 1926, *Milk the Indispensable Food* was written by Maternalist Dorothy Reed Medelsohn. In this document she stated that milk is a complete food and can be used as the sole nutrition of an infant to “sustain life and allow growth” (p. 4), something that is now known to be positively untrue. While cow’s milk formula with specific additives and modifications can be a medical alternative to breastfeeding, cow’s milk alone is not an adequate substitute for the complete nutrition of a human infant. In this document, milk was touted as a important fuel, a protective food, necessary for the pregnant and nursing mother. This document was an example of how quickly the Maternalists switched their focus from encouragement of breastfeeding and food purity issues, to the encouragement of cow’s milk formulas.

A related philosophy of that era was eugenics. This movement is now remembered for its racism, hostility to the disabled, and promotion of sterilization for “defective” individuals. At the time, though, eugenics (a term from the Greek for “good beginning”) encompassed a variety of ideas about how to produce healthy babies. Scientific understanding of genetics was in its infancy, and DNA had not yet been discovered. “Genetic” at the time meant inborn, not necessarily hereditary. Many practices that were then described and promoted as eugenic, such as good nutrition and regular exercise during pregnancy, actually had nothing to do with genes and would now be seen simply as common-sense preventive health. Other “eugenic” concerns included labor and economic conditions. A 1914 treatise titled “Science of Eugenics” proclaimed that “care of the body means proper food, proper housing conditions, and sufficient clothing . . . as well as enough leisure time to warrant a reasonable amount of exercise and relaxation. Depriv[ing] ... women workers of these fundamental rights can only lead to their

own destruction and the ultimate weakening of the race. [Science of Eugenics, 1914, Eugenics Health Foundation Inc., USA]

Eugenics advocates generally promoted breastfeeding. One text stated "...more physicians are proving the importance of maternal nursing . . . Every effort should be made to give the baby that which is his birthright." [Science of Eugenics, 1914, Eugenics Health Foundation Inc., USA] However, this message was undermined by the concurrent emphasis on scheduling: "The baby should be nursed first at 6am, and then at three hour intervals to 6pm; the night hours are 10pm and 2am, though they may be somewhat elastic."

Maternalists were also enthusiastic about scheduling. A strong component of the Maternalist agenda was to encourage a woman to run her home in a moral, chaste, and compassionate way, so her family would be healthier. A clean and organized home was the necessary epicenter of health and morality. This emphasis on cleanliness and order sparked a significant rise in home cleaning technology, and also a passion for scheduling babies. Good mothering was considered to be scheduled mothering. Breastfeeding was only to occur during certain hours of the day, often with 4 hours between feedings, and not at all during the nighttime hours. This drastically affected mothers' milk supply and did not allow those babies to thrive on their mother's own milk. Formula was seen as coming to the rescue.

Class and race prejudice also fed the decline of breastfeeding. Well-off women could take pride in providing the latest nutritional technology for their babies, while looking down on poorer women who could not afford formula. Breastfeeding was increasingly seen as a behavior of the uneducated and primitive, while formula was for the civilized and conscientious mother.

Maternalists and eugenics advocates together promoted a vision of a healthy society achieved through policy, technology, and individual virtue. These early public health movements recognized the need for breastfeeding and set out to promote it, but ultimately also contributed to its near disappearance from American culture. Breastfeeding rates in America saw a deleterious decline from these and many other sociological, technological, and political reasons. Jan Riordan reports in *Breastfeeding and Human Lactation*, 5th Ed., that breastfeeding rates went from 38% in 1946 to 21% in 1956 and reached a low of 18% in 1966.

History of Formula Marketing and the WHO Code

In the 1960s and 70s, aggressive formula promotion in developing countries led to widespread abandonment of breastfeeding. Formula was promoted as the modern, healthy, western way to

feed. Hospitals, doctors, and healthcare professionals were enlisted to distribute formula samples and promote their use. Nurses - or actors dressed as nurses - were hired to give public demonstrations of formula preparation, further promoting the impression that commercial formula was the medically preferred way. Mothers with little education, little money, and no access to clean water were given free samples of formula - just enough to last until their own milk dried up, making them dependent on a continued supply of formula. Their babies (now lacking the immune protection of breastmilk) were fed formula mixed with disease-infested water. Few parents were literate enough to read the instructions, and therefore unable to correctly prepare the formula. Because the formula was too expensive for most families, often it was deliberately over-diluted to make it last longer. The direct result was vast numbers of infant deaths from malnutrition and infectious disease. In response to this disaster, the World Health Organization in 1981 adopted the resolution now known as the WHO Code - formally the International Code of Marketing of Breastmilk Substitutes. The WHO code declared that certain types of advertising/promotion of infant formula are unethical, cause harm to infants, and should be legally restricted in member countries.

The Code in Historical and Political Context

The specific history of the Code began in the 1970s when these marketing practices, and the resulting infant deaths, finally made headlines across the world. During this period of time, many concerns were voiced at United Nations meetings urging action to be taken against formula companies, particularly Nestlé, then the world's largest manufacturer of formula. A UK-based charity named War on Want published a booklet in 1974 called *The Baby Killer*, which documented the marketing strategies of formula companies and the horrific results. The 1975 documentary, *Bottle Babies*, was also released around this same time, offering the world graphic images of malnourished and often starving formula fed infants and graveyards filled with treasured formula cans at the gravesite (as the most valued possession) (Baumslag, 1995). Public outrage grew, and grassroots efforts multiplied, including INFACT, IBFAN, and Infant Formula Action Coalition, which initiated an international boycott of Nestlé.

Policy makers in the West were also shocked into action. Edward Kennedy of the United States Congress, who was the chairman on the Subcommittee on Health and Scientific Research, launched an investigation in 1978 on the use and promotion of infant formula. At a public congressional hearing, physicians, aid workers, and infant health experts testified to the unethical and misleading marketing practices of the formula companies and their impact on mothers and babies. Executives from Nestlé, Bristol-Meyers, and American Home Products testified also; all acknowledged promoting formula in developing countries, all acknowledged

the damage being done, but all denied any corporate responsibility for the unsafe feeding practices that killed babies, and all declined to take any action to change their marketing practices. Senator Kennedy declared, "Can a product which requires clean water, good sanitation, adequate family income and a literate parent to follow printed instructions be properly and safely used in areas where water is contaminated, sewage runs in the streets, poverty is severe, and illiteracy is high?" These hearings led to the formation of the International Baby Food Action Network, a cooperation of NGOs; to a widespread boycott of Nestlé products; and to the convening of a 1979 meeting by WHO/UNICEF to discuss formula marketing.

At this meeting key representatives were in attendance; namely government leaders, industry leaders, UN agencies, and NGOs. The conclusion of this meeting called for an international code addressing marketing of formula. Representatives from six NGOs founded IBFAN, the International Baby Food Action Network, to be corporate watchdogs for formula and baby food companies. Over the next year, four drafts of the Code were written.

Initially, the US was a leader in drafting an international code of ethics to restrict formula marketing practices. At the inception of the Code drafting, the Carter administration developed an "Interagency Task Force" on the Code and was considered to be pro-Code. But when the code was ultimately adopted by the World Health Assembly in 1981, the US cast the only vote against; the new Reagan administration had ordered the opposition, fearing that it might lead to other restrictions on American corporations (Walker, 2001). Avoiding any acceptance of international law or WHO authority was the top priority, and the issue of infant feeding was a casualty.

Formula companies Nestlé and Bristol-Meyers pursued a strategy of publicly stating their support for the Code, while simultaneously working within the drafting system to weaken it, and lobbying the US government to reject it. Due to the lobbying from formula companies, the United States placed pressure on the WHA to downgrade the Code from a regulation to a resolution. The regulation would have made the Code an International Law; instead the resolution relied on each nation to implement the Code - or not.

In 1981 at the World Health Assembly, the International Code for Marketing of Breastmilk Substitutes was introduced with much opposition from the United States. 118 countries voted for adoption of the Code, three countries abstained, and one vote was cast against adoption. The United States was the only vote against the Code's adoption at that time and the vote was cast by a reluctant Dr. John Bryant under orders from the State Department (Baumslag, 1995).

The US has continued to balk at any legally binding agreement, while promoting some aspects of the Code. In the US, the availability of clean water and antibiotics substantially mitigate the consequences of formula feeding, so domestic Code enforcement has not been seen as a life and death issue by American policy makers. Since 1991, the United States has quietly supported all additional Resolutions of the Code (though it has not voted), as the WHA requires a review of the Code every two years. By abstaining from voting, the United States avoids controversy at the WHA and does not have to officially support the Code through legislation. The Code has since been given status as an international standard through the 1991 and 2005 Innocenti Declarations, and also by the Convention on the Rights of the Child, the largest international treaty in history. UNICEF reports that the only two nations which have not ratified the Convention are Somalia and the United States. The US currently stands alone as the one modern democracy that has not found a way to reconcile its financial, political, and philosophical concerns with commitment to these worldwide public health standards.

Requirements of the Code

The WHO code does NOT restrict the manufacture, sale, or use of formula. It is ONLY about marketing. Banned practices include: free samples of formula given to mothers or hospitals; misleading labels or promotional info suggesting that formula is healthier than breastmilk; marketing to or through healthcare workers that creates conflict of interest; and other types of direct advertising that inaccurately idealizes bottle feeding. The Code applies also to advertising of baby bottles, teats, and foods promoted for babies.

The ten specific principles listed by the Code are:

1. No direct advertising of breastmilk substitutes to the public, such as TV commercials.
2. No free samples given to mothers.
3. No marketing of formula in hospitals, including free samples or logo-bearing gifts.
4. No company representatives acting as advisors to mothers.
5. No gifts given to healthcare providers.
6. No pictures of babies on labels.
7. Information given to healthcare workers about the products must be factual.
8. Information given to parents must not misrepresent the health benefits of breastmilk, or the risks of artificial feeding.

9. Foods not meant for infants must not be promoted for infant feeding.
10. Labels must meet standards of accuracy.

All of these restrictions were adopted in response to specific marketing practices that were commonplace at the time; most continue in less blatant forms today.

Current Status of the Code

Most nations (other than the US) have legislation to enforce the Code, but violations still occur, particularly in developing countries. All major formula brand manufacturers claim to be Code compliant. According to the watchdog group IBFAN, none are.

Formula makers often get around the law and promote their brands by associating their logo with general infant health, and even breastfeeding promotion. Similac sponsors the website kidsgrowth.com, Enfamil is one sponsor of WebMD, and in India, Nestlé has issued “World Breastfeeding Week” materials adorned with their logo.

Disasters such as earthquakes and floods often are exploited as brand-building opportunities by formula companies. UNICEF, WHO, and the Red Cross have warned against formula donations, because widespread indiscriminate distribution of formula, particularly powdered formula, results in more infant deaths, not fewer. Combined with myths about stress and lactation, formula distribution undermines breastfeeding right when it is most needed. The major international relief agencies have increasingly used special tent sites for new mothers to provide a protected space for mothers to breastfeed their babies and receive nutritional support, information about breastfeeding, and help with breastfeeding problems or relactation. Still, donations of free formula are common and rarely questioned during emergencies.

Formula Promotion in The United States and Canada

Direct marketing, marketing through healthcare facilities, and free samples to mothers are still legal and common practices in the US. Some of these are traditional advertising. One can find ads for all of the products covered in the Code in parenting magazines, on television advertising, in hospital settings (such as on lanyards, sticky pads, pens), and by direct mail advertising. 1989 saw the first US television commercial ad for infant formula, and since that time this has been an extremely effective means of targeting mothers (Greer, 1991).

Additionally, sample cans of infant formula are sent to mothers for filling out surveys on the web and for entering baby contests.

More sophisticated marketing - which is not readily identifiable as formula promotion - is becoming more common. The most recent type of direct marketing to new mothers is the formula company website that is designed to look like a mother's advice website. Similac has a website called StrongMoms™ (Similac, 2008). This website's tag line is "Everything we do is inspired by moms." On the website, mothers can find an interactive hospital packing list, a month by month guide for mom and baby, an online discussion forum, an email newsletter, and a "Breastfeeding is best" PDF. Glowing mothers and babies abound, along with cute graphics and eye-popping cute images. The Nestlé website is called Start Healthy Stay Healthy resource center (Nestlé, 2008). Companies are also turning to social media. Mothers who are not identified as company representatives agree to promote a company's brand, often in exchange for free products.

Hospital-based giveaways are another major component of formula marketing. Formula companies give free bags of formula to new mothers who breastfeed and who bottle feed at the hospital (USGAO, 2006). Many hospital bassinets bear stickers with a formula logo and a warning never to change formulas without asking a pediatrician. The implication is that if you feed your baby this brand of formula (either provided for free to the hospital, or directly to the mother in a "gift" bag) once, you must stick with this brand indefinitely, unless you get specific approval from a doctor. The value of the brand loyalty created by this practice is obvious. Brand loyalty has been found to be up to 95% effective when begun at the hospital, according to Walker in *Still Selling Out Mothers and Babies* (Walker, 2007).

Research has demonstrated that mothers who receive free formula in the hospital are more likely to abandon breastfeeding. Moreover, these "free" samples aren't free - the cost is paid by formula feeding parents, in the form of inflated prices. Parents could avoid part of this cost by purchasing unbranded (generic) formula, with exactly the same ingredients, but are often afraid to do so, thanks to the "don't switch formula" warning in the hospital. While the hospital gift bag issue is often portrayed as breastfeeding activists vs. bottlefeeding parents, in fact bottlefeeding parents are also losing. By contrast, in countries where no formula marketing is permitted, parents who need or want to use formula can receive unbiased feeding information from hospitals and doctors, and can purchase formula far more affordably. This underscores how the formula giveaways benefit only the manufacturers.

A grassroots organization called BanTheBags.org out of Massachusetts created a support organization to encourage hospitals to remove infant formula bag freebies in 2008. They have met with much success. In fact, as of August 2014, more than 850 hospitals across the United States had banned the bags; nearly 26% of all US hospitals. The alternative is offering mothers

research-based support packets that comply with the Code. This has been shown to increase both exclusive and partial duration of breastfeeding (Donnelly, 2000; Eastham, 2005). Ban The Bags has created a toolkit for hospitals wanting to ban formula sponsored gift bags from their facilities, <http://banthebags.org/wp-content/uploads/2012/09/ToolKit-revision-10-11-12.pdf>.

Another avenue that formula companies have used effectively for marketing is the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC). WIC is a public health nutrition program under the jurisdiction of the US Department of Agriculture (USDA). WIC is for low-income pregnant and postpartum women, infants, and children up to age 5 who are at nutritional risk. The program was first piloted as a supplemental food program in 1972, and by 1974 WIC was operating in 45 states. In 1975, WIC was established as a permanent program by legislation. This USDA program is meant to improve the nutritional status of low income families by providing healthy food and education about healthy eating. For babies under a year old, WIC offers infant formula as part of the food package. Formula companies have competed aggressively to be vendors for WIC, not only to secure WIC itself as a reliable customer, but to generate brand loyalty among WIC families. Putting the WIC logo - widely recognized and associated with health - on formula cans is a powerful health-by-association advertising tactic. While WIC families are by definition low income, many end up putting a large fraction of their scarce wages, or food stamps, towards formula, making them attractive customers.

Breastfeeding rates among low income families have consistently been lower than the US average for decades, and concerns have developed that the WIC program itself was inadvertently encouraging formula feeding by providing formula to mothers who might otherwise breastfeed, by allowing use of the WIC logo, and by implicitly sanctioning formula feeding. A 2006 report from the GAO concluded that these concerns were well-founded. WIC leadership has increasingly recognized that the WIC mission of good nutrition in the early years requires an active commitment to supporting breastfeeding, and has made a variety of policy changes (in some states) such as:

- Not having supermarket-style product displays of formula
- Not allowing formula companies to use the WIC logo on their packaging
- Not putting formula in food packages unless a mother has already stated she is not breastfeeding (breastfeeding mothers are given extra food for themselves instead)
- Having lactation consultants or counselors on staff to work with mothers

- Publicizing the availability of free breastfeeding help at WIC clinics

Numerous studies show that WIC is effective and helps:

- Reduce premature births
- Reduce low and very low birth-weight babies
- Reduce fetal and infant deaths
- Reduce the incidence of low-iron anemia
- Increase access to prenatal care earlier in pregnancy
- Increase pregnant women's consumption of key nutrients such as iron, protein, calcium, and Vitamins A and C
- Increase immunization rates
- Improve diet quality
- Increase access to regular health care

Tennessee was the first state to implement the infant formula rebate program in 1986. In 1989, WIC instituted a bidding procedure to procure the infant formula. The bidding is very competitive since studies show how WIC drastically impacts the formula market. Some articles suggest that the WIC program purchases up to 60% of the formula manufactured in the US.

Although there is a huge concentration on infant formula and the WIC program is often touted as a formula program, WIC is striving to change its image and earn a reputation of a breastfeeding organization. Breastfeeding moms can stay on the program for one year, where non-breastfeeding moms are taken off the program at six months. Breastfeeding moms also receive a food packet that consists of about twice as much food. Pumps are made available to breastfeeding moms. A manual pump is easily obtainable, as is an electric pump (with a few qualifying markers).

WIC has also implemented the highly successful peer program which capitalizes on each ethnicity reaching those who they relate to best. Breastfeeding rates have increased exponentially in areas conducting peer support.

Each state and county has their own variations of the policies, but overall WIC is working to promote breastfeeding and reduce formula consumption. Since every client must attend educational meetings, they are in a great place of influence.

References:

- http://www.ers.usda.gov/amber-waves/2011-september/infant-formula-market.aspx#.VGgvt_nF98E
- www.nwica.org

Infant formula companies also use physician's offices and medical associations as a means of advertising to mothers. They offer feeding education packets, coupons, and reply cards for free cases of formula to physician's offices (Howard, 2000). When women see all of these offers and samples at their healthcare provider's place of business, the message is that formula is not only safe but recommended. Moreover, the health advice parents receive may be compromised.

Formula companies often underwrite the cost of staff training, conferences, or the publication of educational materials. As noted in Walker's *Still Selling Out Mothers and Babies*, the American Academy of Pediatrics (AAP) accepts large donations from formula companies, a form of industry sponsorship (Walker, 2007). The Honor Roll of Giving, a list of corporate sponsors for the AAP, as of 2014 included Abbott Nutrition, Mead Johnson Nutrition and Nestlé Nutrition, all having donated more than \$750,000 to the organization (AAP Website, 2014). While the generic "Breast is Best" message is always prominent in conferences and literature, specific information about the risks of formula feeding is eliminated in order to avoid jeopardizing the funding. This leaves the healthcare providers themselves with biased information. When women make the decision on how to feed their baby by the third trimester, well before they consider breastfeeding or childbirth classes, this message, both explicit and implicit, that formula is safe and healthy is one that has a significant impact which can be seen in decreased breastfeeding rates. (Winikoff, 1980; Howard, 2000 and Howard 1993).

The Baby Friendly Hospital Initiative is a WHO/UNICEF backed effort to ensure that healthcare providers offer effective breastfeeding support and unbiased information to both breastfeeding and formula-feeding parents. Baby-Friendly designated hospitals volunteer to forgo formula sampling to new moms, along with following ten steps that support breastfeeding for the new mom and baby dyad (BFHI USA, 2014).

The United States has 300 Baby-Friendly Hospitals in 47 states as of November 2015 (BFHI USA, 2015). This number continues to climb on a weekly basis. One can find the current statistical

data for BFHI hospitals in the US at www.babyfriendlyusa.org and in Canada at www.breastfeedingcanada.ca. The Healthy People 2020 guidelines call for 8.1% of all hospitals in US to support BabyFriendly practices.

Breastfeeding and Complementary Feeding Terms and Definitions

EXCLUSIVE BREASTFEEDING: the infant takes only breast milk and no additional food, water, or other fluids with the exception of medicines and vitamin or mineral drops.

PARTIAL BREASTFEEDING or MIXED FEEDING: the infant is given some breast feeds and some artificial feeds, either milk or cereal, or other food or water.

BOTTLE-FEEDING: the infant is feeding from a bottle, regardless of its contents, including expressed breast milk.

ARTIFICIAL FEEDING: the infant is given breastmilk substitutes and is not breastfeeding at all.

REPLACEMENT FEEDING: the process of feeding a child of an HIV-positive mother, who is not receiving any breastmilk, with a diet that provides all the nutrients the child needs.

COMPLEMENTARY FEEDING: the process of giving an infant food in addition to breast milk or infant formula, when either becomes insufficient to satisfy the infant's nutritional requirements.

Healthy People 2020 Goals

Sadly, neither the Healthy People Goals of 2000 were met for the United States, nor were all of the 2010 goals. In 2000, only 64% of all women initiated breastfeeding, when goal was set for 75% and no group of women met the goal for 50% duration to six months in 2000. Happily, we can report that many states met some of the the 2010 markers. The latest breastfeeding report card can be accessed at the following link:

http://www.cdc.gov/breastfeeding/data/report_card.htm

The 2010 goals were:

- 75% breastfeeding initiation (1998 64%), met this goal in 2010
- 50% breastfeeding duration until 6 months of age (1998 29%), at 43% in 2010

- 25% breastfeeding duration until 12 months of age (1998 16%), at 22.4% in 2010
- 60% EBB at 3 months (2002 43%), at 33% in 2010
- 25% EBB at 6 months (2002 13%), at 13.3% in 2010

The 2020 goals are as follows:

<http://healthypeople.gov/2020/topicsobjectives2020/objectiveslist.aspx?topicid=26>

- Increase rate of ever breastfed infants to 81.9%
- Increase rate of exclusive breastfeeding at 3 months to 46.2%
- Increase rate of breastfeeding at 6 months to 60.6%
- Increase rate of exclusive breastfeeding at 6 months to 25.5%
- Increase rate of breastfeeding at 12 months to 34.1%
- Increase number of Baby Friendly Hospitals to 8.1%
- Increase workplace accommodation to 38% (currently 25%, though workplace accommodation is now mandated by the US Healthcare Reform bill)
- Reduce in-hospital supplementation to 14.2% (currently 24.2%)

To find initiatives for Canada, please visit www.infactcanada.org or www.breastfeedingcanada.ca.

Maternity Care Practices and Breastfeeding, mPINC

(Direct excerpt from the CDC website; <http://www.cdc.gov/breastfeeding/data/mpinc/maternity-care-practices.htm>)

In the US, nearly all infants are born in a hospital or free-standing birth center. Their stay is typically very short, but events during this time have lasting effects. Many of the experiences of mothers and newborns in the hospital affect breastfeeding. In most cases, these experiences reflect routine practices at the facility level, and patients rarely request care different from that offered them by health professionals. Experiences with breastfeeding in the first hours and days of life significantly influence an infant's later feedings. Due to its inextricable relationship with

the birth experience, breastfeeding must be established during the maternity hospital stay, not postponed until the infant goes home.

A Cochrane review found that institutional changes in maternity care practices effectively increases breastfeeding initiation and duration rates. Birth facilities that have achieved designation as part of the World Health Organization/UNICEF Baby-Friendly Hospital Initiative (BFHI) typically experience an increase in breastfeeding rates. In addition, DiGirolamo et al. found a relationship between the number of Baby-Friendly steps (included in the Ten Steps to Successful Breastfeeding of BFHI) in place at a birth facility and a mother's breastfeeding success. The authors found that mothers experiencing none of the Ten Steps to Successful Breastfeeding required for BFHI designation during their stay were eight times as likely to stop breastfeeding before 6 weeks as those experiencing six steps.

Supportive Hospital Practices

Birth facility policies and practices that create a supportive environment for breastfeeding begin prenatally and continue through discharge, and include:

Skin-to-skin contact – Doctors and midwives place newborns skin-to-skin with their mothers immediately after birth, with no bedding or clothing between them, allowing enough uninterrupted time (at least 30 minutes) for mother and baby to start breastfeeding well.

Teaching about breastfeeding – Hospital staff teach mothers and babies how to breastfeed and to recognize and respond to important feeding cues.

Early and frequent breastfeeding – Hospital staff help mothers and babies start breastfeeding as soon as possible after birth, with many opportunities to practice throughout the hospital stay. Pacifiers are saved for medical procedures.

Exclusive breastfeeding – Hospital staff only disrupt breastfeeding with supplementary feedings in cases of rare medical complications.

Rooming-in – Hospital staff encourage mothers and babies to room together and teach families the benefits of this kind of close contact, including better quality and quantity of sleep for both and more opportunities to practice breastfeeding.

Active follow-up after discharge – Hospital staff schedule in-person breastfeeding follow-up visits for mothers and babies after they go home to check-up on breastfeeding, help resolve any feeding problems, and connect families to community breastfeeding resources.

To look up a state's most recent report, see <http://www.cdc.gov/breastfeeding/data/mpinc/reports.htm>.

Surgeon General's Call to Action for Breastfeeding Support

In March 2011, the Surgeon General posted a Call to Action for Breastfeeding Support in the United States. It is available at www.surgeongeneral.gov. It stated:

- Communities should expand and improve programs that provide mother-to-mother support and peer counseling.
- Health care systems should ensure that maternity care practices provide education and counseling on breastfeeding.
- Hospitals should become more "baby-friendly," by taking steps like those recommended by the UNICEF/WHO's Baby-Friendly Hospital Initiative.
- Clinicians should ensure that they are trained to properly care for breastfeeding mothers and babies. They should promote breastfeeding to their pregnant patients and make sure that mothers receive the best advice on how to breastfeed.
- Employers should work toward establishing paid maternity leave and high-quality lactation support programs.
- Employers should expand the use of programs that allow nursing mothers to have their babies close by so they can feed them during the day. They should also provide women with break times and private space to express breast milk.
- Families should give mothers the support and encouragement they need to breastfeed.

Obstacles

- Lack of experience by family members
- Not enough opportunities to communities with breastfeeding mothers
- Lack of up to date instruction for health care workers
- Difficult hospital practices
- Lack of work accommodation

Health Care Community

- Encourage BabyFriendly Hospital Initiative
- Provide education to health care providers
- Ensure access to IBCLCs

The Affordable Care Act in the United States

With the passage of the Affordable Care Act (ACA) women now can receive coverage for lactation services through their insurance provider. While the time has come for these services to be seen as preventative and supportive care, the Affordable Care Act unfortunately did not make enough specifications on exactly what should be covered. The law states that “Payers must cover, at no cost to the patient, ‘comprehensive lactation support and counseling, by a trained provider during pregnancy and/or in the postpartum period, and costs for renting breastfeeding equipment.” Here is a link to the verbiage on the HRSA website: <http://www.hrsa.gov/womensguidelines/>

What exactly does this mean? What does comprehensive lactation support mean? Who qualifies as trained providers? Why only cover rental of breastfeeding equipment? When was the last time you heard of a mother renting a nipple shield or a Supplemental Nursing System? Must all insurance companies pay for these mysterious covered services? I have been attending webinars and state health department meetings and what I have gleaned from all of the discussion is that the resolution for understanding and interpreting the ACA in terms of lactation is still in its infancy.

Let’s start with who has to pay for these services. The Affordable Care Act generally covers commercial insurance contracts. Whether Medicaid covers these services or not is basically up to the state. They have to elect to cover USPSF (US Preventative Services Task Force) preventative services. If they have decided to do so, then lactation coverage should be a part of that. Military services are also exempt from the recommendations in the ACA. Every insurance company also gets to decide how they interpret the ACA language. Many states have decided to create guidelines for insurance payers to use for interpretation on the ACA. The United States Breastfeeding Committee and the National Breastfeeding Center have created a Model Policy: Payer Coverage of Breastfeeding Support and Counseling Services, Pumps and Supplies. Most states have not adopted this “model policy”. Here is a link to that model policy: <http://www.usbreastfeeding.org/Portals/0/Publications/Model-Policy-Payer-Coverage-Breastfeeding-Support.pdf>

For insurance payers, the language in the ACA has created significant confusion. There are no clear directives about exactly what services are to be covered, at what rates, or even who should be providing these services. Most of the payers are also unfamiliar with the needs of lactating woman and do not have a grasp on what types of lactation equipment is needed in different circumstances. For example, if a woman has baby that she is exclusively expressing her milk for, she requires the use of a hospital grade breast pump, NOT a double-sided electric consumer pump. Furthermore, payers do not have a clear understanding of the circumstances in which a woman requires lactation services and when.

Here are some of the challenges that mothers have been encountering:

- When mothers call their insurance companies to find out how they can access their breast pumps they get the following responses:
 - They must get their pump (of the insurance company's choice) through a Durable Medical Goods Supply. These pumps often take weeks to be delivered. This is a problem twofold. One: it may be an inappropriate pump for the mother's situation. Two: They may not get the pump in time for their needs.
 - They have to purchase the pump and submit a receipt. They may or may not receive full reimbursement.
 - They are simply mailed a breast pump from their insurance company. It may be an ineffective hand pump or an inexpensive double electric.

Side note: There have also been known cases of insurance fraud. Women requesting pumps and then selling them on EBay and Craig's List in their unopened packaging.

Another challenge mentioned above is determining who is considered a trained provider. Commercial payers must insure that the professionals they pay are credentialed and follow certain rules and regulations. For most insurers this means that they will only cover licensed care providers or create standards for non-licensed professionals. Most insurance companies choose to reimburse (at least at highest rates if at all) their own credentialed professionals or in network providers. These providers must have their qualifications evaluated, meet certain criteria, confirm that they meet professional conduct and competence, and have their training, certification, and licensure reviewed. The challenge (and also the opportunity) with this is that many lactation support providers are not licensed.

The International Board Certified Lactation Consultant is an internationally certified professional but not required to get licensure to practice in the 50 states. Many states have been considering licensure for IBCLCs; however at this stage it is not mandatory. The Certified Lactation Educator™ is also a certified but not a licensed professional. Many insurance companies have decided to work their way around this by simply contracting with RN/IBCLCs only for all services (RN's do have licensure).

However, there are other professionals who are trained and certified to teach breastfeeding classes and run support groups, such as CAPPA's CLE®. This could mean that professionals like CLE®s could finally receive reimbursement for their services. Just as doula services are starting to become eligible for reimbursement, this is the perfect opportunity to start inquiring and talking to commercial payers about reimbursement for breastfeeding education services provided by CLE®s. As the ACA dissemination is in its infancy, now is the time for all breastfeeding professionals to make their voices heard and talk to the insurance companies and state health departments who are making suggested guidelines.

The following information includes what families need to know at this stage. All pregnant women should call their insurance provider early in pregnancy and find out what services are covered for lactation. They want to ask how to access a breast pump and what type of pump is covered. They want to find out if they cover breastfeeding classes and support groups and if there are specific ones they have to access. They also want to find out what type of lactation consulting services and which specific providers they can use. Many IBCLCs, if not in-network with the family's insurance plan, will ask for payment in advance and then offer to give a superbill so that the family can submit for reimbursement. They should also request that their breastfeeding classes and support groups that are run by CLE®s be covered.

As a lactation professional, it is important to encourage families to communicate early on with their insurance companies. Get actively involved in your state breastfeeding coalitions and work with your state health department to ensure that access to lactation services is reasonable and includes support professionals who are certified for those services. Finally, let mothers know that services are covered and be proactive in gaining access to these services.

While the ACA provides far from perfect lactation support, it is a step in the right direction in recognizing the fact that lactation support is PRIMARY preventative healthcare. It is also an amazing opportunity for CAPPA members and professionals to have their voices heard. Commercial payers are ready to listen and they need guidance. It is time to build some bridges and make your voices heard!

Breastmilk Substitutes

Breastmilk not only has all the nutrients a baby needs, but also all of the immunological factors necessary to strengthen a baby's immune system. There is no need for formula, unless it is recommended by a doctor or IBCLC for medically indicated reasons. Remember, the more a woman nurses the more milk she makes. In addition, if the baby gets full from formula or water, he will nurse less and the mother's breasts won't be stimulated to make as much milk. This can become a no win situation very quickly.

The first choice for infant feeding is always a baby being breastfed at the breast. The World Health Organization (WHO) states: "The second choice is the mother's own milk expressed and given to the infant in some way. The third choice is the milk of another human mother. The fourth and last choice is artificial baby milk."

The American Academy of Pediatrics endorses exclusive breastfeeding for six months and then breastfeeding twelve months and beyond. The WHO recommends breastfeeding for at least two years.

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Self-Test Questions

Terms Match

Match the following definitions with their appropriate breastfeeding term (terms may only be used once):

TERMS: Exclusive Breastfeeding, Partial Breastfeeding, Bottle Feeding, Artificial Feeding, Complementary Feeding

1. An 8 month old baby nurses several times a day and has two feedings of mashed vegetables and fruits
2. A 2 month old baby never receives formula or water, only nurses and receives daily vitamin drops
3. An infant receives nothing but his own mother's pumped breastmilk
4. A 3 month old infant receives nothing but formula
5. A 4 month old breastfeeds throughout the day and is given a small amount of rice cereal at family meal time

Additional Questions:

In your own words, describe why breastfeeding initially fell out of favor in the 19th century.

Describe hospital delivery and newborn procedures in the early 1900s as they relate to breastfeeding.

Describe who the maternalists were and how they impacted breastfeeding in the United States.