

Baby Friendly News

UNICEF UK Baby Friendly Initiative

Issue 30

February 2010

In this issue: 2009 Conference round-up
Research round-up

Starts page 2

See page 10

New Year, New Challenges

At the Baby Friendly Initiative 2008 conference, Programme Director Sue Ashmore declared that it had been a "good year for breastfeeding". When she took to the platform to open the 2009 conference 12 months later, the unspoken question was whether she'd be as confident to make the same pronouncement this year. And, broadly, the answer was yes.

There is plenty of cause for optimism. Another £3 million has been allocated to 30 PCTs in England to support them in improving breastfeeding rates, on top of the £4 million allocated in 2008. Scotland is in the second year of a three-year programme to improve maternal and infant nutrition. A total of 87 facilities have taken a further step towards Baby Friendly accreditation, with the University of Bolton becoming the first health visiting course to gain a Certificate of Commitment.

But there was no avoiding the elephant in the room. The impact of the recession is being felt throughout the health services and, "We are looking at a very uncertain future," Sue admitted.



Nonetheless there are also new steps being taken to make the job of implementing the Baby Friendly Initiative standards that much easier for those responsible.

Key developments include:

Developing a breastfeeding strategy:

The guide is designed to be used in a practical manner and to provide a path to developing a strategy locally.

"We've written it in English" joked Sue, when highlighting it in her talk.

Commissioning local breastfeeding support services:

This new guide from DH is designed to be used with the Strategy Guide. As Sue put it: "If you're a commissioner, if you know who your commissioner is, if you think you could find out who your commissioner is, get this document."

Cost benefit research: We are in the process of commissioning a university to do a cost benefit study into breastfeeding as a whole, similar to the Australian study which calculated breastfeeding was worth AUS\$30 billion to their economy. Imagine what the British figure could be!

Care pathways: The redevelopment of the website is taking place during 2010, incorporating a new system of care pathways to act as guides through the best care practice for mothers at each stage of their pregnancy and that can be applied at various levels from midwife to strategic lead.

Providing help to accredited units:

Units that have been accredited as Baby Friendly for a long time face a very particular set of challenges in maintaining these standards and Baby Friendly will be developing some extra support in 2010.

Neonatal units: Baby Friendly will also be developing a new set of standards specifically for NICUs and will commence initial work on this in the latter half of 2010.



Education, advice and audit to improve
NHS support for breastfeeding

www.babyfriendly.org.uk

unicef 

The effect of breastfeeding on obesity

Peter Bundred doesn't believe in soft openings: "Obesity is probably the greatest danger to the health of children in this country that we will face in the 21st century." His talk, on whether breastfeeding can help alleviate this crisis, a riveting opening to the conference.

The growing awareness of the problem of obesity is evidenced from Professor Bundred's statistic that between 1948 and 1965, Medline published 298 articles on obesity, then published 7,000 in 2007 alone.

A number of studies have shown that breastfed infants are less likely to become obese. It is established that sub-optimal nutrition during the foetal period and the first year of life profoundly affects the way the child grows and has a major influence on the subsequent development of diseases such as hypertension, diabetes and heart disease in early adult life. As Professor Bundred notes, "the first few weeks of life are a key programming window for the prevention of obesity."

And the key influence on obesity: "Fast growth across the centiles in the early days is associated with a much greater

risk of obesity." Infant formula, with a protein content around 70 per cent greater than breastmilk, increases insulin levels and encourages this faster rate of initial growth.

Initially, breastfed children have a short period of physiological weight loss before they begin to gain weight. In general they have a different growth trajectory to formula-fed infants and it is this growth pattern which probably protects them from gaining excess weight.

Professor Bundred then spoke about the large cohort study he conducted in the Wirral, which examined 16,500 births in 1990. The research showed that children born to mothers from the lowest fifth of the socio-economic spectrum had a significantly lower birth weight than children born to mothers from the highest fifth of the spectrum.

Children with lower birth weight tend to have an increased rate of weight gain as they go through a period of "catch-up" growth. Breastfeeding can temper the rate of growth, but poorer mothers also tend to be formula feeders. This

perpetuates a generational inheritance of poverty and ill health. "Children who were rapid weight gainers were much less likely to have a normal BMI at three, and much more likely to be overweight and three times more likely to be obese and five times more likely to be very obese."

Babies with large birth weights would also be at risk, "Children who were large for gestation age were less likely to have a normal BMI at the age of three, more likely to be overweight and more likely to be obese and twice as likely to be very obese. Its an almost linear relationship."

Heavier children are often born to heavier mothers and another cohort study carried out between 1997 and 2003 on women booking at the Wirral antenatal clinic showed that women booking in 2003 were 3kg heavier than women booking in 1997.

Professor Bundred concluded, "Optimum nutrition during early life is the most significant intervention we can make, with exclusive breastfeeding for four months at least."

Weighing babies and supporting breastfeeding

Magda Sachs makes one thing clear at the start of her talk, "This is not a training session... we'd probably need a smaller group..."

You can understand why people might hope it was though. The new growth charts are a comprehensive amendment to the UK 1990 growth charts, and Dr Sachs, as one of the members of the group who put the new charts together, would be one of the best people to explain them.

The old World Health Organization (WHO) charts, "based on American formula-fed babies in the 1970s," had been questioned for some time as people around the world noticed that babies were not meeting the charts. Since they were based on the faster growth patterns of formula and

mixed-fed babies, they tended to undermine breastfeeding by making parents anxious that their children were not growing quickly enough.

In 2006 the WHO launched growth standards based on sampling conducted in six countries from relatively privileged infants (within reason: "not diplomat's children" points out Dr Sachs) who were exclusively breastfed for at least four months, and whose mothers did not smoke. The aim was nothing less than to describe optimal growth. "A huge ambition," admits Dr Sachs.

SACN (Scientific Advisory Committee on Nutrition) examined the application of these standards to the UK, and the Department of Health decided to adopt the WHO standards for infants in England

aged two weeks to four years.

The new growth charts are unique to this country as they combine UK and WHO data. Relating the new charts back to Peter Bundred's talk, Dr Sachs pointed out how the early weeks of the new chart are underneath the old UK lines, then after a few weeks go above. As for training, Dr Sachs pointed out that educational materials are available online, providing information on new features, and also general training in the use of growth charts and growth monitoring.

Dr Sachs concluded that she hoped that growth monitoring will become more appropriate, parents understand what's going on and breastfeeding growth is imprinted as the normal pattern.

One more time...

The Chair Lorna Hartwell put it best when she asked who had their lives changed by *The Politics of Breastfeeding* and a forest of hands shot up. She added that she was delighted to have one more chance to hear from the author before she retired. Without further ado, Gabrielle Palmer took to the podium. "It's lovely to be here," she began, then gestured to the audience, "Although I thought I'd be there, enjoying myself." After scheduled speaker Mark Cregan was taken ill at the last minute, Gabrielle graciously stepped in to talk about the politics of breastfeeding and bring a global perspective to the issue.

She reminded her audience, "The formula market is worth \$20 billion globally and the companies are very keen to protect it." Quoting from an industry paper that identified rising breastfeeding rates as a threat to sale, she linked this to the growth of the 'follow-on' milks market and other examples where, "they're inventing new milks to sell to us and they're rubbish." Gabrielle linked back to Sue Ashmore's talk on UNICEF's work across the world

and described how the separation of mother and child and the lack of respect shown to the business of motherhood worked against breastfeeding and parenting in general.

"Please bring back from retirement"

One common cause of a baby not being able to access milk is when the mother has died, "and this is far too common." Malawi has 14 maternal deaths a day – many of which could be avoided if good basic public health services, like having a midwife, were available. But the midwives aren't paid very well and many go abroad to work. Gabrielle highlighted the dilemma that a lot of the improvements in women's conditions in the western world had been achieved through the labour of poor women from overseas. One shocking statistic: 1.5 million children are left behind in the Phillipines by mothers going to work overseas.

She highlighted the need for governments to implement agreements like the UN Convention on the Rights of the Child, but explained that the pressure on individuals working in governments and inter-governmental organisations from formula companies was immense. She highlighted some examples she had encountered during her career with WHO.

Delegates were left in no doubt as to the absurdity of the way formula companies benefited from subsidies for the dairy industry when formula has an 80 per cent profit margin.

Gabrielle concluded, "I'm a natural pessimist, but there are great forces at work and that's what changes society." She described a recent webchat she participated in on Mumsnet and how she was overwhelmed by the passion she encountered: "There's lots of oxytocin pulsating away."

A standing ovation followed, not just for an inspirational talk, but for an inspirational career.

Seven natural laws for nursing mothers

If you've flown several thousand miles to give a talk, you may as well make the most of the journey. Why not follow Kathy Kendall Tackett's example and give two?

Her first, coming just after lunch on the first day, concerned the simplest and yet most taxing question – why don't more women breastfeed? Kathy's argument is that it cannot be due to a lack of information, rather it can be due to too much information, coming amidst a conflicting social environment where bottle-feeding is the norm. The key is to help mothers cut through this and, "tap into strengths and abilities they already possess and that are built-in to the breastfeeding relationship."

This is where the Seven Laws come in. They provide, "a biological, mammalian framework independent of culture." Time constraints prevent Kathy from running

through each one as fully as the audience might have liked, but the picture she paints is fascinating:

Law 1 – Babies are hardwired to

breastfeed: This is backed by evidence that babies left in skin-to-skin contact exhibit inborn behaviour similar to other mammals.

Law 2 – Mother's body is baby's natural habitat: Kathy illustrated this with several pertinent examples, including a study from South Africa that showed how the introduction of Kangaroo Mother Care led to a dramatic decrease in infant mortality.

Law 3 – Better feel and flow happen in the comfort zone: This reiterated the principles of positioning and attachment.

Law 4 – More breastfeeding at first means more milk later: Kathy reminded the audience that the perinatal period is a window of opportunity to impact on children's lives and that the first two weeks are particularly crucial for establishing breastfeeding and more

general patterns for the baby's life.

Law 5 – Every breastfeeding couple has its own rhythm: Kathy talks of how the natural pattern that a breastfeeding mother and child establish has been disrupted by practices such as scheduled feeding, supplements and dummy use.

Law 6 – More milk out equals more milk made: Quite simply, a reminder that drained breasts make milk faster and full breasts make milk more slowly!

Law 7 – Children wean naturally: The last point was in many ways the most interesting, citing historical examples that weaning took place after two years.

Kathy concluded with an inspirational story about a 16 year-old who gave birth in an attic during Hurricane Katrina, and nursed her baby with only her boyfriend for support despite having no intention to breastfeed originally. This was an exhilarating talk.

Supporting informed decision making

When the sound of a ukulele began to ring around the auditorium, it was clear this was going to be anything but a dry presentation from Jo Orgles and Janette Westman from the Baby Friendly Initiative.

The process of ensuring mothers are given, and absorb, the correct information about feeding their baby is a crucial part of the Baby Friendly Initiative standards. Both Jo and Janette, who have taken units through the accreditation process, are all too aware of this: "We know this is often an area where people fall down... both of us failed first time round, so perhaps we can learn from our mistakes."

The pair use the metaphor of being invited on a tropical holiday (with aforementioned

ukulele backing track) to explain how the information available can affect the decision the mother eventually makes. It hangs together surprisingly well, with the first point that although a tropical holiday may look good, how many people would feel confident saying yes straight away?

Similarly, mothers, with all the preconceptions and nerves that come with parenting may not be ready to embrace breastfeeding straight away. And if rushed into a decision, they might not make the right one. "If it's written in her notes 'decided to bottlefeed', it might not be raised again. With more information, the journey can become more attractive."

They continue, going through the various stages information can be given and also

how the information is given is very important if mothers are to be enabled to make choices and then to support them in those decisions, whatever they may be.

Asking open questions and facilitating a discussion, rather than asking for a decision, allows knowledge base and background to be established and appropriate responses given. They conclude by reiterating the point that if the mother is intending to breastfeed, "we need to make sure she is offered all the support she requires. All too often women are let down and they feel they failed their babies, when it's the system that failed."

Unlocking the power of social marketing

-Steven Johnson first apologises for not being his wife Helen – "she's much better looking" but, since he is the Creative Director of The Hub, the social marketing agency that came up with the 'Be A Star' campaign that has been used in some 20 PCTs to date, he's certainly not lacking in knowledge about how a social marketing campaign for breastfeeding takes shape.

Behaviour change is difficult, as Steven showed in an ice-breaker by getting delegates to take off their cardigans/jackets, then to try putting them back on with their opposite hands. The resulting confusion illustrated how changing behaviour is an inherently complex process, which is what social marketing is trying to do. Steven provided the definition, "Social marketing is a process that encourages behaviour change amongst a group to the benefit of society." It is different to normal marketing because, in Steven's words, it's about, "Changing lives and not just changing minds."

Devising a campaign has several stages, beginning with the *Scoping* stage where you look to understand the audience. This is followed by the *Development* phase – developing concepts and ideas – then

Implementation (doing it). After this comes *Evaluation* and *Follow-Up*, which measures the success of a project and what else needs to happen in order to maintain the campaign. Steven described the process as being in "perpetual beta" where everything was constantly open to amendment and improvement.

Steven then explained how this process related to the 'Be A Star' campaign. The campaign started in March 2008 in collaboration with Central Lancashire PCT, and was designed to increase initiation rates amongst white and mixed-race women of 16-25. The project managed a 13 per cent increase in initiation in six months and has won several awards.

During the scoping process they didn't just talk to the girls, but partners and families in the wider community as well. Largely, the audience were aware that breastfeeding was best but it wasn't aligned with current value sets within the target group, who thought "it's not for me"

The key goals were therefore to: make the desired behaviour more attractive, reposition it as something "we do" and make it easier to do by providing support.

The entire journey was mapped out in order to intervene at crucial points with positive messages. The communications element built on the cachet of celebrity that had been identified as a driver for the group, but used local women as accessible yet aspirational role models. The message that breastfeeding was "what we do" was emphasised with quotes from local girls emphasised in communication literature given out during the antenatal period. Materials were also developed for dads in the form of tabloid papers with information about supporting your partner, and alternative forms of bonding.

Steven noted that the research and partnership-building had also helped build cohesion and helped efficiency. The campaign inspires the audience – and as a by-product inspires staff in the areas.

In an encouraging conclusion, Steven said that one of the first stars became a volunteer peer supporter, then a paid peer supporter and has now started a midwifery degree. Sara from the Wirral, who was in the audience, had also become a volunteer peer supporter and this made for a heart-warming finish to the first day.

A new approach to postnatal depression

The second day of the conference began with another fascinating talk from Kathy Kendall-Tackett, this time about depression in new mothers. She started by explaining how, "The excitement in this field is palpable just now because so many things are changing in the way we see depression."

Kathy wrote her first book on depression in 1992, so has a clear perspective on the changes currently unfolding. She explained that traditionally we have talked about postnatal depression in terms of individual risk factors: stress, fatigue, sleep deprivation, pain, history of psychological trauma and history of affective disorder.

However, said Kathy, what research is revealing now is that all these factors increase the risk of one other condition: inflammation (that is inflammatory markers in the blood, controlled by the immune system). And it is increased inflammation that appears to increase the risk and severity of depression. This evidence leads to the significant conclusion that psychological factors can affect what happens in our immune system – a field of work known as psychoneuroimmunology.

"It is now well documented that what you think can actually alter the functioning of your immune system. This is a staggering



© UNICEF UK 2009

concept: that you can modify what happens to your body. This clearly affects how we are going to treat depression."

Inflammation affects pregnant women and new mothers in a distinct way. Molecules called pro-inflammatory cytokines are released by the body when it senses a threat. These molecules, which fight infections and heal wounds, are found in increased levels during the last trimester, as well as postnatally.

This, explained Kathy, is a perfectly understandable response if the cervix is to be open for several weeks; it is the body's way of rallying the troops to prepare for possible attack. However, if these pro-inflammatory agents are combined with other known stress factors, such as lack of sleep and pain, which often occur around the time of birth, the body can become overloaded and the risk of depression rises.

Now that we recognise the importance of inflammation in causing depression, we can directly treat it in order to alleviate depression. Breastfeeding plays an important part in this, because research has shown it reduces stress (and therefore inflammation) in the mother and enhances a positive mood. However, critically, if the mother is having difficulty breastfeeding, such as nipple pain, this can increase stress and therefore contribute to an increased risk of depression.

This, and the concern that sleep deprivation adds to stress, has led some health professionals to question whether breastfeeding is a good thing for an "at risk" mother, particularly at night. Kathy stressed how important it was, therefore, that breastfeeding experts are involved in discussions around the treatment of postnatal depression, in order to ensure that the protective effect of successful breastfeeding is fully understood.

The effects of Baby Friendly training on health visitors

Following straight on the heels of this talk was a very encouraging presentation of evidence around the effectiveness of Baby Friendly training on health visitors' breastfeeding attitudes, knowledge and confidence. The research was carried out, and presented, by Dr Jenny Ingram from the University of Bristol following BFI community training of staff in NHS Bristol during 2008.

All health visitors and nursery nurses working in community settings completed three days of training. Breastfeeding attitudes, knowledge and their confidence

in helping mothers to breastfeed were measured using a validated breastfeeding questionnaire and a self-efficacy tool. Questionnaires were given immediately before, one month after training, and again six months after. Statistically significant increases were seen in breastfeeding attitudes, knowledge and self-efficacy for both health visitors and nursery nurses after attending the course. These improvements were maintained six months later, and there were also increases in the appropriate management of some breastfeeding problems.

While details of the research cannot be included here prior to publication later this year, Jenny concluded that making the training mandatory across the whole Primary Care Trust has improved the consistency of advice and confidence of all health-care staff who help mothers with breastfeeding. These improvements have been translated into increased breastfeeding continuation rates at eight weeks – a very encouraging sign given the pressing need to improve dismally low continuity rates in the UK.

Kangaroo Neonatal Care

A highlight of the conference was the talk by Kerstin Hedberg, from the University Children's Hospital in Uppsala, Sweden on what is no less than a revolution in neonatal care. Care at the hospital is run along the principles of keeping families together 24-hours a day, with as much physical contact as possible, and breastfeeding ideally from birth.

Accommodation is required for parents to stay 24 hours a day. Uppsala hospital was reconstructed seven years ago to provide comfortable and practical living spaces for babies, their parents and families to spend sometimes prolonged periods of time, and to allow kangaroo mother care to be carried out. Kerstin explained that there are no such things as visiting hours because parents or a nominated substitute are continuously present. If a premature baby is stabilised and does not need incubation, the baby is placed straight away onto the mother's chest after birth (if not the mother then the father or another family member), with flexed arms and legs and head turned sideways, and more or less remains there for the next few weeks. When delegates heard there were no cots in the co-care rooms – because of the universal kangaroo care – there was initially complete silence in the conference hall followed by spontaneous applause, as delegates absorbed the impact of what they were hearing.

Kerstin demonstrated how a 28-week pre-term baby – and even younger – can remain in 24-hour kangaroo care using a tube top to hold the baby in place and give support to the head. "Here the baby gets warmth, breastmilk and love," said Kerstin, "In this position everything can be done except sleeping on your front and taking a shower. To breastfeed you slip the baby down a bit."

Even babies who need intensive care have a parent with them 24-hours a day, and at least some kangaroo care every day. Incubators have beds on either side of them for the parents, and partitions and subtle lighting allow the parents privacy. Nurses gradually teach parents how to carry out most medical procedure on their baby. "At Uppsala we are now experienced enough to know that parents are able to carry out nearly everything the nurses do, and they do it even better because they do it with love and they know their babies."

Much of Kerstin's work has addressed the widely held assumptions that neonatal infants are unable to breastfeed because of dysfunctional sucking ability. She carried out research on 15 babies born at between 26-31 weeks, and found evidence of obvious rooting, a lot of the breast inside the mouth and single sucks, from 29 weeks; staying fixed at the breast for 15 minutes and occasional repeated swallowing from 31 weeks; repeated long



bursts of sucking from 32 weeks. Breastfeeding initiation took place between 29-33 weeks and exclusive breastfeeding was achieved for 12 out of 15 of those babies. It took between 9 and 38 days after the first breastfeeding to establish exclusive breastfeeding.

As a result of allowing babies to suckle as soon as they can, and working with each mother and baby to develop a feeding routine, Kerstin said that babies in Uppsala are regularly discharged at 32 weeks exclusively breastfeeding, and this is common at 34 weeks. This uplifting talk clearly inspired many of the audience, who went away with Kerstin's words ringing in their ears: "The parent's chest is regarded as the optimum place for growth and care. The babies get the same hi-tech care and monitoring as anywhere else. The care is no different, only the place."

Why love is not enough: The Nurturing Programme

The final speaker of the day was Annette Mountford, Chief Executive of Family Links, an Oxford-based charity which runs the Nurturing Programme to help parents in the UK. After working as a health visitor for 13 years, Annette came across the Nurturing Programme in 1992 and was immediately impressed with its emphasis on feelings and emotions, which are at the heart of driving our behaviour.

Annette's engaging and entertaining talk reminded everyone how important a role health professionals play in providing support to parents during the antenatal

period, and in the early 0-3 years when a child's brain is developing for later life.

She reinforced that message that a warm and empathic parental style leads to the release of dopamine in the child's body, which aids healthy emotional development. On the contrary, cold and neglectful parenting releases high levels of adrenaline and cortisol into the brain, wiring it for a tendency towards depression and aggression in later life.

The Nurturing Programme, over a period of 10 weeks, covers topics such as

firmness, fairness, consistency and boundaries, all of which are essential for good parenting. More than 4,000 practitioners have been trained by Family Links, and recently courses have started running in prisons to provide support for some of the parents who are the hardest to reach. An antenatal course is being trialled.

Annette rounded off by calling for everyone to begin by nurturing themselves and replenish their stocks of well-being and self-esteem.

Turning training into improved practice

Julie Smee, midwife and senior professional officer for the Baby Friendly Initiative, gave a very practical talk on how to turn training into improved practice. As someone who has been Infant Feeding Co-ordinator in a Baby Friendly Hospital, Julie was able to address many of the frustrations and obstacles that can block the path to better breastfeeding practice.

But first she acknowledged the change taking place around breastfeeding "Finally, there is public recognition that it is a public health imperative to address our appallingly low breastfeeding rates. The importance of training is understood – to improve practice within the system in order to improve child and maternal health."

So why is it so difficult? Recognising that breastfeeding carries so much baggage, that we are creatures of habit who resist change, and that the change required is seen to take time and be an extra challenge, we need to find ways to win the support of staff as we work towards better practice, said Julie.

This requires a strategic and logical approach, and for this reason the Baby Friendly Initiative introduced the Staged Approach to accreditation. The three stages each cover different aspects of improving practice designed to be introduced in a logical process. It is easy to fall into the trap of seeing successful assessment of a single stage as the end point, but Julie emphasised how the stages need to be seen as fluid, merging components.

An agreed Action Plan is crucial to help your team do this. Check that good practice is being implemented along the way as staff are being trained, rather than waiting until the very end when training is complete. Always audit what has been done, ask for feedback, then present this data back to staff as a basis for discussion and to agree a plan to improve practice.

Julie spoke about the need for training to be robust, and to be delivered by a knowledgeable, effective teacher who can remove barriers and change long-standing attitudes. Julie also encouraged anyone

who is leading a process of change to attend the Project Management course. Amongst many other things, it contains help on management styles and influencing others – something that is essential if you want to change practice.

"Whatever type of manager we have, we need to pay close attention to tactics and nurture that relationship," advised Julie. "They need to understand the changes needed and give us help to overcome barriers. We need to be able to influence managers. Always feed back to your manager. Making her look good will go a long way to winning her support."

Finally, suggested Julie, ensure that staff are supported and have ownership over the targets set to improve breastfeeding. Be sensitive to how things may be difficult for staff, and give credit for small changes and improvements. And of course, be ready to celebrate the big milestones.

Breastfeeding support for women of Bangladeshi origin

Alison McFadden, research fellow and PhD student in the Mother and Infant Research Unit at the University of York presented findings from her doctoral study. Having worked as a midwife in Bristol, Malawi and Teeside, Alison had become very interested in breastfeeding practice of minority ethnic groups in the UK. She chose to focus on the Bangladeshi community because they have very high rates of breastfeeding initiation – more than 90 per cent – but by six months rates have dropped to those similar to white women. They also have the highest rates of socio-economic deprivation in the UK, so they are a group that could really benefit from breastfeeding support. Alison will be publishing a research summary for health practitioners, so this is a shorter overview.

The research looked at the views of the wider family, mothers, and practitioners. It was clear that this was a society where there was enthusiasm for breastfeeding,

awareness of the health benefits of breastmilk, some recognition that it is recommended in the Koran, and a perception that it is a tradition passed on through female kin.

One important message that Alison brought out of her findings is that Bangladeshi women, by and large, have similar experiences breastfeeding as the majority population, and so by improving care to women generally, we will be improving care for Bangladeshi women.

Notable culturally important differences are firstly in the family context of talking about breastfeeding, modesty issues around feeding, duties in the home and secondly in expectations of birth and the health service, including breastfeeding support services and peer support – none of which were utilised by any of the mothers in Alison's study.

In terms of changing our practice, Alison suggested we should not expect Bangladeshi women to initiate discussions around breastfeeding, and instead we should find sensitive ways of broaching the subject. Culturally sensitive training for practitioners would help demystify the difficulties around some home situations, and would also help staff understand what a woman's expectations after birth might be if she was in Bangladesh. More understanding of this would help staff provide sensitive care in the postnatal ward in the UK.

Finally, Bangladeshi women should themselves be involved in developing services. To facilitate this, Alison suggested that a practical step might be to employ some of them as bilingual advocacy workers who are trained in delivering breastfeeding support, which could take the pressure off official translators and also enable them to advocate for their peers.

The Convention on the Rights of the Child

As part of her talk, Sue Ashmore showed a presentation about the UN Convention on the Rights of the Child (CRC). November marked the 20th anniversary of the CRC and was highlighted with a series of events including a rally of 2,000 schoolchildren in Poole and the introduction of the Children's Rights Bill in the House of Lords.

The Convention is a major milestone in the effort to achieve a world fit for children. It has inspired changes in laws to better protect children, changed the way international organisations work, and helped to protect children during conflicts and natural disasters. One of these rights is the right to enjoyment of the highest attainable standard of health and to health-care facilities with specific obligations including providing knowledge of child health and nutrition, breastfeeding, hygiene and prevention of accidents. More than one million babies worldwide die every year because they are not breastfed effectively or because they are given other foods too early.

While great progress has been made on children's rights in the past 20 years, much remains to be done. As the champion of the Convention, UNICEF is making a

promise to help every child realise their rights. Every child has the right to a childhood, to be educated, to be healthy, to be treated fairly and to be heard.

Dan Seymour, Chief of UNICEF's Gender and Rights Unit, writes: "In every region of the world, we find numerous examples of the CRC's impact on law and practice. The CRC was the first international convention to be ratified by South Africa, leading to changes such as the prohibition of corporal punishment and development of a separate juvenile justice system. The Russian Federation also set up juvenile and family courts in response to the CRC, while Morocco established a National Institute to Monitor Children Rights. Finland took a number of new measures for children inspired by the Convention, such as a plan for early childhood education and care, a curriculum for the comprehensive school, quality recommendations for school health care, and an action plan against poverty and social exclusion.

This wide acceptance of the CRC can give the misleading impression that it is neither challenging nor new. Yet the very idea that children are the holders of rights is far from universally recognized. Too many

children are considered to be the property of adults, and are subjected to various forms of abuse and exploitation. That the world fails to respect the rights of its children – even to deny that children have rights – is clear in the alarming numbers of children who die of preventable causes, who do not attend school or attend a school that cannot offer them a decent education, who are left abandoned when their parents succumb to AIDS, or who are subjected to violence, exploitation and abuse against which they are unable to protect themselves.

We cannot claim that the Convention has achieved what needs to be achieved. Rather, it has provided all of us with an essential foundation to play our part in changing what needs to be changed. The Convention demands a revolution that places children at the heart of human development – not only because this offers a strong return on our investment (although it does) nor because the vulnerability of childhood calls upon our compassion (although it should), but rather for a more fundamental reason: because it is their right."

To find out more about the CRC, go to www.unicef.org/uk/crc

Sreynet is 10 years old. She has lived on the street all her life with her mother and stepsister in Cambodia. Most nights, when the rubbish truck arrives, the family scavenges for food and things to sell. During the day, Sreynet takes her sister to the park to beg.

When a child dies of hunger, lacks clean water, cannot go to school, is exploited or discriminated against, **this is wrong.**

Put it Right, which launches this week, is a major, five-year initiative by UNICEF UK to inspire unprecedented action to protect the rights of children everywhere – rights to a childhood, to be healthy, to be educated, to be treated fairly and to be heard.

All children have rights, yet millions are denied them every day. The global recession, climate change and HIV and AIDS are making this situation even worse. We're asking the UK public to help UNICEF put it right by supporting our initiative to protect and promote the rights of children.

Join us by going to www.unicef.org/uk/putitright and donating, taking our campaign action or fundraising.



© UNICEF UK/Bangladesh 09/Sue Parkhill

Denying child rights is wrong. Put it right.



UNICEF is urgently appealing for emergency assistance to aid the victims of a devastating earthquake that rocked the Caribbean nation of Haiti on 12 January.

Thousands of children have been killed or injured. Those who survived the disaster are now in temporary shelters, hospitals or on the streets. They have little access to food or water and are at increased risk of violence and abuse. So far, UNICEF supplies for 250,000 children have arrived and are being distributed. However, more funds are urgently needed to support UNICEF's ongoing recovery programmes throughout 2010 and into the future.

Please donate to UNICEF's Haiti Earthquake Children's Appeal today: www.unicef.org/uk/haiti



Lamonsia Laurent, 4, holds a bar of soap that she received during a distribution of newly arrived care packages for children, at the UNICEF-assisted Foye Zanmi Jezi orphanage, in the Lilavois neighbourhood of Port-au-Prince. © UNICEF/NYHQ2010-0151/Noorani

New awards!

Full accreditation

Caithness Maternity Unit

Stage 2

Countess of Chester Hospital

Middlesbrough PCT

Northumberland PCT

Leeds University

Airedale Hospital

Stage 1

Whiston Hospital

NHS Bath and North East

Somerset

Homerton Hospital

Stockton Children's Centres

Certificate of Commitment

Liverpool PCT

Great Western Hospital

Kettering Hospital

Bournemouth & Poole Community

Health Services

North Lincolnshire & Goole Hospitals

NHS Foundation Trust

Nottinghamshire Community Health

Frimley Park Hospital

Bournemouth University

Edge Hill University

University of West of Scotland –

Public Health Visiting Course

New course dates

Breastfeeding Management

Bristol: 26, 27 & 28 May 2010

Price: 1 to 4 places - £370 each; 5 or more places - £335 each.

Project Management

London: 13 & 14 May 2010

Price: £385 each

Auditing Practices to Support Breastfeeding

London: 23 February 2010

Price: £240 each

Train the Trainer

London: 26, 27 & 28 May 2010

Bristol: 16, 17 & 18 May 2010

Price: £650 each



Looking for an adrenalin-filled challenge? The sky's the limit with UNICEF UK's very first Skydive Day.

Experience the thrill of freefalling at speeds of over 120 mph, while raising vital funds for UNICEF's work in protecting and promoting child rights. Raise £395 sponsorship and you can jump for FREE. You can join our UNICEF Team at Cambridge airfield, or jump individually at 20 locations throughout the UK.

As a UNICEF UK skydiver, you'll be sent a fundraising pack and UNICEF T-shirt and receive support from a dedicated member of staff. To find out more information on how to take part go to www.unicef.org/uk/skydive or email fundraisinghelp@unicef.org.uk

Research round-up

Support for breastfeeding improves outcomes in younger mothers

A study carried out recently gives some insight into the factors associated with breastfeeding initiation and duration in young mothers. Increasing breastfeeding initiation and duration among this 'at risk' group is important for both infant and maternal health. A total of 138 mothers (≤ 24 years) recruited from local mother and infant groups, nurseries and online mother and infant forums completed a retrospective questionnaire between 6 and 24 months after the birth. In addition, 10 mothers who breastfed for at least six months completed a semi-structured interview. Breastfeeding for at least six months was positively associated with attending a breastfeeding support group, believing breastfeeding to be easy, being part of an environment where breastfeeding is the norm and being encouraged to breastfeed by others. The authors conclude that helping mothers to view breastfeeding as the norm, creating an environment where breastfeeding is accepted, providing professional and peer support, and encouraging the mother to continue breastfeeding are important steps in raising breastfeeding rates among younger mothers.

Brown A, Raynor P, Lee M (2009) *Young mothers who choose to breastfeed: the importance of being part of a supportive breast-feeding community*. *Midwifery*; October 2009

Epidural type and use showed no impact on breastfeeding success

A large study randomly allocated 1,054 primigravidas to receive standard bupivacaine epidural, combined spinal epidural or low dose infusion and in addition compared these with 351 matched primigravidas who did not elect to have epidural analgesia. Interviews were carried out following the birth and at 12 months a postal questionnaire was administered. The data was analysed to determine factors which independently predicted breastfeeding initiation and duration. A similar proportion of women in each epidural group initiated breastfeeding. Women with no epidural did not report a higher initiation rate relative to epidural groups, however significantly those in the latter group who did not elect for epidural analgesia but who received pethidine reported a lower initiation rate than those receiving epidural ($p = 0.002$). Epidural fentanyl dose and delivery mode were not predictive of breastfeeding outcome. Mean duration for breastfeeding was similar across epidural

groups. The authors argue that their data does not support an effect of epidural fentanyl on breastfeeding initiation.

Wilson MJA, Macarthur C, Cooper GM et al (2009) *Epidural analgesia and breastfeeding: a randomised controlled trial of epidural techniques with and without fentanyl and a non-epidural comparison group*. *Anaesthesia*; November 2009

Northern Ireland study demonstrates increased height amongst breastfed babies

A longitudinal study in Northern Ireland was conducted with one aim being to establish the association between breastfeeding and blood pressure, anthropometry and plasma lipid profile in both adolescence and young adulthood. Northern Ireland traditionally has the lowest breastfeeding prevalence in the UK. Schoolchildren were recruited aged 12 and 15 years who participated in a cross-sectional study of lifestyle and health, and were followed up as young adults aged 20-25 years. In this study, the researchers found no significant difference in height, weight, BMI, skinfold thickness measurements, blood pressure or plasma lipid profile in adolescents who had been breastfed compared with those who had not been breastfed. However, by the time these adolescents had reached adulthood, those who had been breastfed were significantly taller than those who had not been breastfed. The authors comment that given the known association of increased adult height with improved life expectancy, the results from this particular study support a beneficial effect of breastfeeding.

Holmes VA, Cardwell C, McKinley MC, et al (2009) *Association between breastfeeding and anthropometry and CVD risk factor status in adolescence and young adulthood: the Young Hearts Project, Northern Ireland*. *Public Health Nutrition*; 7:1-8

Study draws link between increased risk of SIDS and alcohol or drug use when co-sleeping

A study has been carried out over the last four years in the south west of England to investigate the factors associated with sudden infant death syndrome (SIDS) from birth to age two years, in particular looking at whether current advice has been followed, whether any new risk factors have

emerged and the specific circumstances when SIDS has occurred in a co-sleeping situation. The study, examining 80 SIDS infants and two control groups, one randomly selected and one of babies deemed to be at high risk of SIDS demonstrated that many of the deaths in a co-sleeping environment could be explained by a significant interaction between co-sleeping and recent parental use of alcohol or drugs (31 per cent vs 3 per cent random controls) and the increased proportion of SIDS infants who had co-slept on a sofa (17 per cent vs 1 per cent). Other factors included use of a pillow (21 per cent vs 3 per cent) and swaddling (24 per cent vs 6 per cent) and issues such as maternal smoking in pregnancy (60 per cent vs 14 per cent), preterm birth (26 per cent vs 5 per cent) and fair or poor health for the last sleep (28 per cent vs 6 per cent). Dummy use showed an unexpected decline among both the SIDS and control groups. The data regarding the length of time the dummy remained in the baby's mouth was limited, however no difference between the groups was noted which the authors suggest casts doubt on the idea that sucking a dummy affords protection.

With regard to the infant's sleeping environment, the authors conclude that the major influences on risk were from factors which would be amenable to change. Parents need to be advised never to put themselves in a situation where they might fall asleep with a young infant on a sofa and that they should never co-sleep with an infant in any environment if they have consumed alcohol or taken drugs.

[Blair PS, Sidebotham P, Evason-Coombe C et al \(2009\) *Hazardous co-sleeping environments and risk factors amenable to change: case-control study of SIDS in south west England*. *BMJ*; 339:b3666](#)

Breastfeeding reduces obesity in middle-aged mothers

A large UK study recruited 1 million middle aged women with an aim of examining the relationship between child-bearing and breastfeeding and subsequent body mass index (BMI). Data was collected by questionnaire which included information on personal and lifestyle characteristics, medical and reproductive history and breastfeeding, anthropometry, physical activity, and socio-demographic factors. A total of 980,474 women were included in the main analysis, 87 per cent of whom were parous, with 68 per cent having a history of ever breastfeeding. The mean lifetime duration of breastfeeding per child was 3.8 months. Mean BMI increased significantly with each birth from 25.8 for nullips to 28.1 for women with five or more births. Women who breastfed had significantly lower BMIs and this remained significant even after adjusting for confounding variables. The authors conclude that whilst BMI increased with increasing parity, this increase would be offset if women breastfed. They argue that the findings contribute to the

body of evidence that childbearing and breastfeeding have sustained long-term effects on the health status of women.

[Bobrow K, Quigley M, Green J et al \(2009\) *The Long Term Effects of Childbearing and Breastfeeding on Body Mass Index in Middle Aged Women: Results from the Million Women Study*. *J Epidemiol Community Health*; 63 \(Suppl_2\): 56](#)

Breastfeeding is associated with improved cognitive development

A large observational study was carried out in the UK to assess the relationship between breastfeeding and child cognitive development, and investigate whether this altered with prematurity. A total of 11,801 white singleton children were assessed according to their gestational age at birth; term (37-42 weeks, moderately preterm (33-36 weeks) and very preterm (28-32 weeks) and also according to breastfeeding status (ever vs never; and duration of any and exclusive breastfeeding). At age five the children were tested using a validated tool – the British Ability Scales (BAS) test. The researchers found that the mean BAS naming vocabulary score decreased with prematurity. After adjusting for confounders (including the baby's sex and birthweight; the mother's age, education, social class, smoking and alcohol in pregnancy, and whether this was her first child), ever breastfeeding was significantly associated with a higher mean BAS naming vocabulary score in children born at term with a stronger effect in children born moderately preterm or very preterm and this also increased with each additional month of breastfeeding. A similar effect of breastfeeding was observed when using other BAS tests such as pattern construction and picture similarities scales. The authors argue that these results, based on one of the largest observational studies of the effect of breastfeeding and child development, suggest that breastfeeding is associated with improved cognitive development, particularly in those born preterm.

[Quigley MA, Hockley C, Carson C et al \(2009\) *Breastfeeding is associated with improved child cognitive development: evidence from the UK Millennium Cohort Study*. *J Epidemiol Community Health*; 63\(Suppl_2\):8](#)

Breastfeeding provides optimum pain control during heel prick testing for neonates

A prospective study was conducted of 180 term newborn infants who were undergoing routine heel prick testing for neonatal screening of phenylketonuria and hypothyroidism. The babies were assigned to six groups: control (no pain relief); breastfeeding; non-nutritive sucking; holding by mother; oral glucose solution; or oral formula feeding. The

babies pain experience was analysed related to a validated scoring system - Neonatal Facial Coding System, duration of crying and autonomic variables obtained from analysis of heart rate variability before, during, and after heel prick test. The researchers found that infants with no pain control showed the highest pain scores compared with newborns to whom pain control was provided. Infants who breastfed showed the lowest increase in heart rate when compared with no pain relief (21 beats per minute vs 36), the lowest neonatal facial score (2.3 vs 7.1), lowest cry duration (5 vs 49), and lowest decrease in parasympathetic tone (-2 vs 1.2) and also when compared with the alternative interventions studied. Bottle feeding with infant formula also showed better effects than the other interventions, however was not as effective as breastfeeding. The authors conclude that any method of pain control is better than none. Feeding and in particular breastfeeding during heel prick testing were found to be the most effective methods of pain relief.

Weissman A, Aranovitch M, Blazer S et al (2009) *Heel-Lancing in Newborns: Behavioral and Spectral Analysis Assessment of Pain Control Methods*. PEDIATRICS (doi:10.1542/peds.2009-0598)

Breastfeeding may support earlier hospital discharge for moderately preterm infants

Moderately preterm infants (30-34 weeks) account for a large proportion of admissions and bed-days in neonatal units. A large study (2,388 infants) of the postmenstrual age (PMA) at hospital discharge and its relationship to perinatal risk factors and to organisation of care was carried out in Sweden. The researchers found that average PMA at discharge was 36.9 weeks. High (35 years) maternal age, multiple birth, small for gestational age, respiratory distress syndrome, infection, hypoglycaemia and hyperbilirubinaemia were significantly associated with higher PMA at discharge, but could only explain 13 per cent of the differences. Mean PMA at discharge differed by up to two weeks between hospitals. Infants treated at units without fixed discharge criteria had 4.7 days lower PMA at discharge and infants receiving domiciliary care had 9.8 days lower PMA at discharge. Breastfed infants also had lower PMA at discharge (mean 2.7 days lower) than those not breastfed, partly explained by lower morbidity in the breastfed infants and the researchers recommend that supporting the establishment of successful breast feeding in preterm infants should therefore be given high priority in neonatal care.

Altman M, Vanpee M, Cnattingius S et al (2009) *Moderately preterm infants and determinants of length of hospital stay*. Arch. Dis. Child. Fetal Neonatal Ed; 94: F414-F418

Association between drugs used in labour and lower breastfeeding rates

It is often supposed that breastfeeding rates may be adversely affected by drugs taken in labour. A large retrospective study was carried out in Wales to investigate associations between drugs routinely administered in labour and breastfeeding outcomes at 48 hours, in healthy women and infants. At 48 hours, 43.3 per cent of women were not breastfeeding. Statistical analysis confirmed previously reported associations of lower breastfeeding rates with epidural analgesia, intramuscular opioid analgesia and ergometrine. In addition it was found that oxytocin use, alone or in combination with ergometrine administered for prevention of postpartum haemorrhage (PPH), intravenous oxytocin and prostaglandins administered for induction of labour were all also associated with lower breastfeeding rates. The authors conclude that prospective studies on drugs used in labour are needed to investigate the potential associations between intrapartum medications and lower breastfeeding rates.

Jordan S, Emery S, Watkins A et al (2009) *Associations of drugs routinely given in labour with breastfeeding at 48 hours: analysis of the Cardiff Births Survey*. BJOG

Exclusive breastfeeding associated with better sleep

A study in Norway was carried out to assess the prevalence of, and risk factors for, postpartum maternal sleep problems and its associations with depression. In addition, the study aimed to identify any other factors independently associated with either condition. A total of 4,191 mothers completed a questionnaire seven weeks postpartum. Sleep was measured using a validated tool, the Pittsburgh Sleep Quality Index (PSQI), and depressive symptoms using the Edinburgh Postnatal Depression Scale (EPDS). The prevalence of sleep problems was 57.7 per cent, and the prevalence of depression was 16.5 per cent. Mothers reported an average of 6.5 hours sleep. Factors associated with poor sleep quality were depression, previous sleep problems, being primiparous, not exclusively breastfeeding, or having a younger or male infant. Poor sleep was associated with depression independently of other risk factors.

Dorheim SK, Bondevik GT, Eberhard-Gran M et al (2009) *Sleep and depression in postpartum women: a population-based study*. Sleep; 32: 847-55.

Further evidence of the positive impact of breastfeeding on the incidence of pre-menopausal breast cancer and epithelial ovarian cancer

Several studies have found associations between breastfeeding and reduced risk of pre-menopausal breast cancer. However the results are inconsistent, and data from large prospective cohort studies are lacking. Such a large study was carried out in the USA (1) using data from 60,075 parous women participating in a prospective cohort study. Women who had ever breastfed were less likely to suffer premenopausal breast cancer compared with women who had never breastfed and this association was modified by family history of breast cancer. The authors conclude that a history of having breastfed was inversely associated with incidence of breast cancer among women with a family history of breast cancer.

Several studies have found associations between breastfeeding and reduced ovarian cancer rates, however inconsistencies have been noted, particularly related to breastfeeding duration and to the type of ovarian cancer. An Australia-wide population-based case-control study (2) of epithelial ovarian cancer between 2001 and 2005 (1,092 cases and 1,288 controls) looked at parous women and their responses to a reproductive/lifestyle questionnaire. The researchers found a strong association between total duration of breastfeeding (all episodes) and reduced ovarian cancer occurrence, with protection increasing per month of breastfeeding. They conclude that a long total duration of breastfeeding appears to be associated with a substantial reduction in the overall risk of ovarian cancer but that this may vary according to histological subtype.

(1) Stuebe AM, Willett WC, Michels KB (2009) *Lactation and incidence of premenopausal breast cancer: a longitudinal study*. *Intern Med*; 169: 1364-71.

(2) Jordan S, Siskind V, Green AC et al (2009) *Breastfeeding and risk of epithelial ovarian cancer*. *Cancer Causes Control*.

Lactation reduces incidence of metabolic syndrome among women of reproductive age

A study was carried out in the US to prospectively assess the association between lactation duration and the incidence of the metabolic syndrome among women of reproductive age. A total of 1,399 women aged 18–30 years were recruited as part of the Coronary Artery Risk Development in Young Adults (CARDIA) Study, an ongoing multicenter prospective observational cohort study conducted in the US. The women were nulliparous and free of the metabolic syndrome at baseline stage of the study in

1985-6 and before subsequent pregnancies. They were re-examined 7, 10, 15 and/or 20 years after the baseline. Standard criteria were used to identify metabolic syndrome. The researchers found that among 704 parous women there were 120 metabolic syndrome incidences. Increased lactation duration was associated with lower crude metabolic syndrome incidence rates from 0–1 month to >9 months ($P < 0.001$). When this data was fully adjusted for preconception measurements, BMI, and socio-demographic and lifestyle traits risk reductions associated with longer lactation were stronger among GDM than non-GDM groups. They conclude that longer duration of lactation is associated with lower incidence of the metabolic syndrome years after weaning and that lactation may have persistent favorable effects on women's cardiometabolic health.

Gunderson EP, Jacobs DR, Chiang V et al (2010) *Duration of Lactation and Incidence of the Metabolic Syndrome in Women of Reproductive Age According to Gestational Diabetes Mellitus Status: A 20-Year Prospective Study in CARDIA (Coronary Artery Risk Development in Young Adults) Diabetes*; 59 : 2 495-504