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Baumslag, Naomi

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INSTITUTIONAL BARRIERS TO BREAST FEEDING

Naomi Baumslag MD MPH.

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BARRIERS TO BREAST FEEDING

To begin with let me stress that breast feeding is more than the provision of human milk - it is intricably interwoven with child care. It requires the interaction between mother and infant, closeness, touching, hearing, feeling. It is an active dynamic process involving the materno-infant dyad a closeness that has been established during gestation. Not only does breast feeding involve maternal commitment but commitment from health professionals and government.

Many programs in developing countries as well as so called developed countries, are attempting to reverse the downward trend and decreased duration of breast feeding. Some of these efforts have been listed recently in an article by Winnicoff and Bauer, 1980. Whilst they urge that the obstetrician can make the difference I want to urge that the barriers to breast feeding be ascertained in each setting first. Health professionals have been accusedof ignorance and indolence,while profit inthe infant feeding arena has been cited as counter productive to the publics health especially in developing countries.

Several barriers have to be considered.

(1) Health care is disease orientated and not health promotive

(2) Women are regarded as "appendages" or "bags of nutrients"

(3) Men make decisions for women

(4) Mixed messages - no consensus

(5) Health professionals don't practice what they preach

(6) There is no limit to profit at the expenses of public health

1. HEALTH CARE IS DISEASE ORIENTED AND NOT HEALTH PROMOTIVE

Our preoccupation with technology and devices for the sick have extended to include the well majority. Using technology inappropriately is costly and undermines the mother's confidence to breast feed.

a) Training Health Professionals

The teaching hospitals have a critical effect on the type of manpower programs, knowledge and experience of health professionals. The orientation of the health system and teaching curriculum needs to be redefined to provide students with a core of knowledge based on teaching and practical experience.

Training for mothers should be provided in schools, antenatal and maternity clinics with follow up at home.

b) Facilities Should Help not Hinder

They should be adapted to suit the materno-infant dyad and not health professionals and should be the location where breast feeding is promoted.

1) Ante Natal breast feeding education

Standard rigid lectures should be avoided and mothers should be educated or informed in discussion groups. No samples of formula bottles or displays of formula feeding should be permitted on the premises. Literature should be carefully screened or developed by the health department or hospital and should be consistent throughout. Inconsistencies or contradictions can only lead to confusion so time spent on this choice is profitable.

2) Maternities, health centers, hospitals

This area is critical and is where the most cost effective imprint can be made.

- Early materno infant contact increases the duration and success of breast feeding and should be implemented as soon as possible even in Caesarean Section patients. It also helps uterine contraction,

Prolonged observation periods, unnecessary surgery and absence of rooming-in prevent this essential contact.

- Rooming in

  Should be provided for healthy newborns round the clock. Building of over elaborate nurseries for the sick encourages cot occupancy because there is a tendency to also keep well infants in the nursery between feeds and at night. Bottle formula feeding occurs . . in this type of situation and this mitigates against breast feeding. Infants normally get 1/3 of their daily requirements at night and the idea that infants will be smothered by the mother at night are totally unfounded. There also is an odd unfounded notion that colostrun is not of value and the infant should be given milk or sugar water till lactation is established

- Facts, fallacies and fallacious rituals

  Should be detected and the health professionals educated to eradicate ridiculous practices e.g. scrubbing breasts with soap or even detergents. This practice

causes fissures or breast abscesses. Furthermore animal studies reveal odor of sebum is important and that washed breasts are rejected by newborn animals. Prelacteal feeds and supplementary sugar water feeds or even formula are also detrimental to breast feeding. There is no need to give a newborn water (breast milk has lots!); or sugar water feeds for 12 hours to rule out rare gastro-intestinal pathology or prevent hypoglycemia; test weighing inhibits the let down reflex; giving an infant a bottle which involves a different sucking mechanism is confusing. Breast feeding is not like artifical feeding! Scheduled feeding should be avoided. Nor do mothers have to eat enough for two persons or drink lots of water to lactate! There is no scientific evidence to corroborate this.

- Breast milk should be used wherever possible even for ill or low birth weight infants even if it has to be expressed and tube fed; mothers should be involved as much as possible. This is the place to educate mothers, not in lecture rooms.

- o Subsidized formula should not be sold nor samples provided. Dr. Clavanno in the Philippines drastically reduced infant mortality and morbidity in her hospital by prohibiting the use of formula.
- o Formula companies offer programs, free formula for multiple births and donations to nurseries. The use of these products must be critically evaluated.
- o Many mothers say that bottle feeding is a consequence of being sick - that when either the mother or the infant is sick the hospital won't admit the infant or the mother with the infant. It is clear that rooming in facilities for the dyad are important unless the illness is a contageous disease. Arrangements should be made for mothers with hospitalized infants (low birth weight, ill infants). For illness requiring long stays, a suitable breast pump should be available for expression if needed.

c) Attitudes - Reinforce Positive

Health professionals should be encouraged to have positive attitudes to breast feeding. They

also should realize that lots they can be learnt from mothers whom they should support not supplant.

Isolation of the Mother from Health Care

After delivery most programs do not provide follow up services. Home visits to new mothers should be compulsory with provisions for support and/or a functioning referral system. Hospital staff should be given feed back. The newborn baby and new mother should be integrated in the health system. This is an important six week period.

2. WOMEN ARE REGARDED AS "APPENDAGES" OR "BAGS OF NUTRIENTS"

Little effort is made to ascertain the needs, interests, concerns, health and nutritional status let alone the rights of women. Unless help for mothers is recognized as critical to care and help from mothers as agents for change, is understood, little will be achieved in health education and behavior modification. In Mozambique e.g. when mothers stay with their sick infants in hospitals the receive full pay from their employers. But this type of setting is the exception rather than the rule. In most hospitals infants are accommodated and the mother is sent home or, as in Hariari hospital Zimbabwe, to a nearby

hostel . making it impossible for the mother to feed her infant at night!

Day care centers are often not available for working mothers and lactation breaks are not provided. Maternity leave and lactation leave are not provided, even for federal of government employees in developed countries such as the USA. The period is referred to as one of "incapacition" and women have to take a combination of vacation and sick leave to cover this period. Women can lose their job if they look after sick children — often insummountable barriers to breast feed exist. Unless greater efforts are made to combat this type of narrow thinking, bottle propping formula feeding centers will mushroom.

3. MEN MAKE DECISIONS FOR WOMEN AND WOMEN ARE POWERLESS

Delegations to international meetings of importance to women e.g. WHO, UNICEF continue to be dominated by males even in areas where women undoubtedly have expertise such as breast feeding and child care. Other decision making bodies on maternal and child health involving policy, programs, and funding should include concerned knowledgable women to represent women's interests. If women are not available this shortcoming should be recognized and suitable candidates should be trained and made available!

4. MIXED MESSAGES _ NO CONSENSUS

a) Within the health system mothers are told different ways to feed and different times to introduce solids. Conflicting information may even be supplied in the same clinics by different health professionals.

b) Mothers may be told that there is not much difference between formula and breast milk and they are allowed to choose.

c) In at least one Africa country, a particular government department promotes breast feeding while another department promotes the sale of formula and milk powder for bottle feeding. This is the case in western Kenya and elsewhere. Where the conflict is recognized ministries should be urged to get together and decide whether profit or public health is to be compromised. This is a decision that has to be faced currently in Mozambique where one formula company Nestles would like to build a factory. The Ministry of Commerce has been exploring, the ministry of health has made its oppostion clear. A consortium has been formed and a decision based on input from all parties concerned will have to be made.

d) Societal norms are changing and the breast has become a profitable sex symbol instead of an organ of feeding.

5. HEALTH PROFESSIONALS DON"T PRACTICE WHAT THEY PREACH

a) International agencies and "developed countries" such as the U.S. which do not have paid maternity leave for pregnant and lactating workers are only too ready to suggest this practice is suitable for developing countries. In Kenya recently one UNICEF staff member who breast fed her 10-month old infant at night and in the morning, after and before work, arranged to take the infant and a caretaker at her own expense with her to a workshop. The Regional staff director objected and she had to battle for her rights to breast feed in spite of the advertised intentions and policy guidelines of UNICEF.

b) Women employed in health services often have to leave their infants at home with a child-caretaker and provide bottles with formula (the later may be supplied free of charge by a formula detail man). The neighborhood sees the example the staff nurse set while she lectures to the

clinic patients on the advantages of breast feeding.

Facilities and time for lactating women to feed should be designed. Work should not be an excuse for bottle feeding.

c) Health facilities especially maternities, give formula in bottles to infants, they provide space for displays of bottles, and nipples. They even teach bottle feeding and formula preparation to mothers who intend to or are breast feeding!

d) Subsidized milk powder and samples are provided in clinics and maternities. This adds legitimacy to the products.

I have only listed a few instances. I am sure that you all know many more examples of how we say one thing and yet do another.

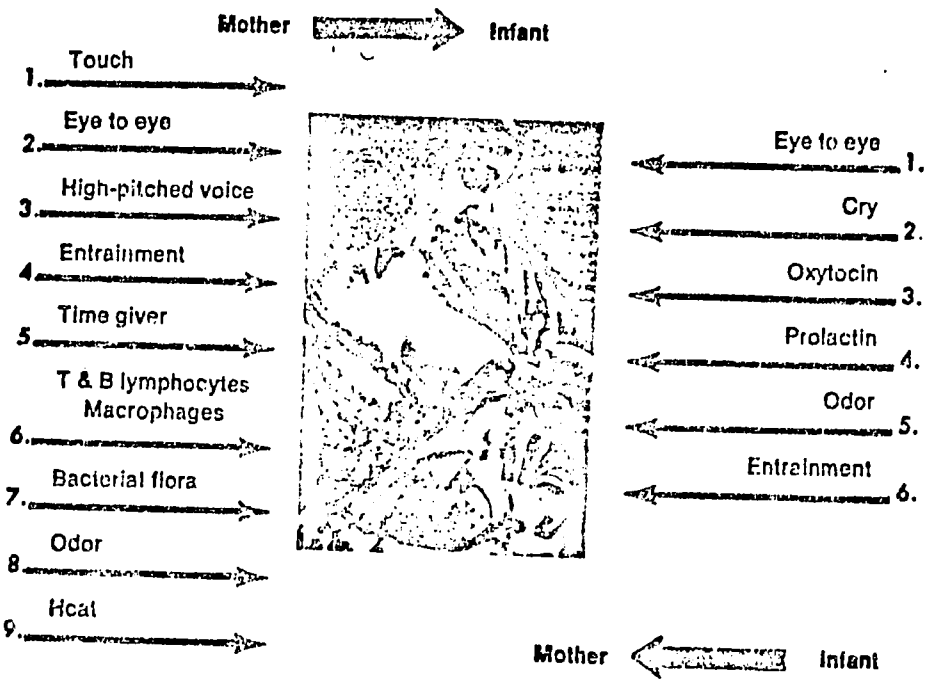
6. PROFIT VERSUS PUBLIC HEALTH

Breast milk is a natural resource of great national importance especially in countries where living conditions render bottle feeding of formula expensive and hazardous to health. Even in the U.S. studies show that allergy, otitis media and hospitalizations are increased in formula fed infants resulting in unnecessary medical care and costs.

If countries were to replace human breast milk with formula for all infants up to 12 months the national debt would be astronomical. Only a few people profit from the sale of formula; many countries should follow the example of Popua New Genae where health became the overriding consideration.

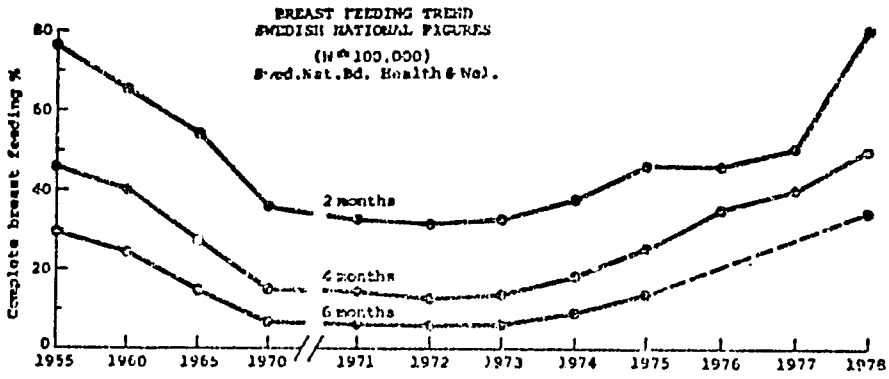
FIGURE 1

BREAST-FEEDING: A GUIDE FOR THE MEDICAL PROFESSION



Mother-to-infant and infant-to-mother interactions that can occur simultaneously in first days of life. (From Klaus, M. H., and Kennell, J. H.: Maternal-infant bonding, the impact of early separation or loss on family development, St. Louis, 1976, The C. V. Mosby Co.)

FIGURE 2



(Figures for '76, '77 and '78 from a representative sample by Semper Inc.)

The upturn in the proportion of mothers successfully breast feeding in Sweden is particularly encouraging. These are figures for the whole country.

FIGURE 3

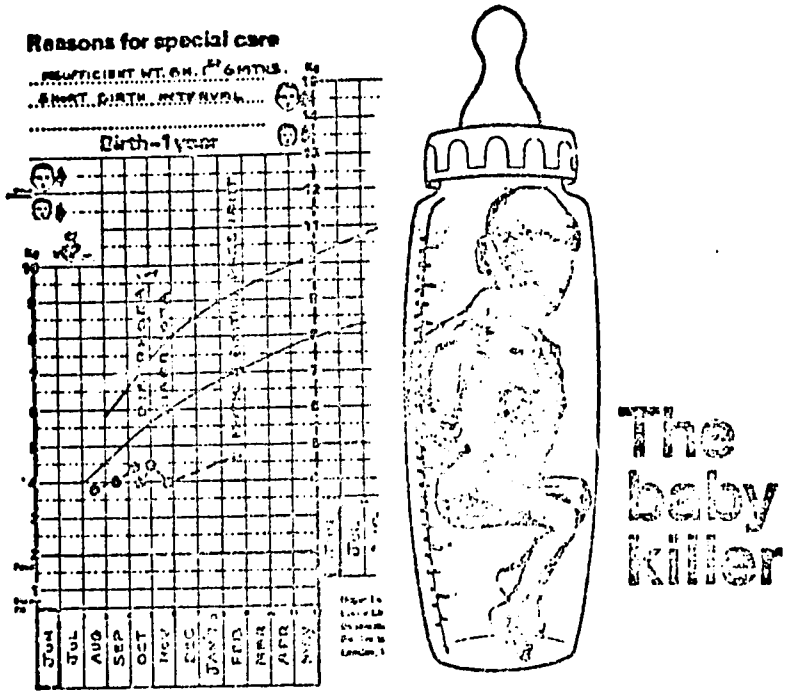


FIG 8.9 The results of bottle feeding on the weight curve of the first child of a bank clerk in Papua, New Guinea, who insisted that his wife should bottle feed, although she wanted to breast feed. So many families lack the knowledge, the water, the fuel, the time or the finance to make use of this technology. A detailed understanding of the national and social dangers of advertisement and high pressure sales techniques has resulted in the government of Papua, New Guinea leading other countries in the control of formula feeding.

FIGURE 4

- 'PRACTICAL PROGRAMMES'

PUERPERAL PRACTICES INTERFERING WITH LACTATION VIA THE PROLACTIN AND LET-DOWN REFLEXES (MODIFIED FROM HAIRE 1973)

Practice	Effect on lactation (via maternal reflexes)
Delaying first breastfeed	
Sedated newborn (excess maternal anaesthesia)	
Supplying prelacteal and complementary feeds	Limitation of suckling
Regular, limited feeds (4 hours) (with no limited night feeds)	prolactin secretion
Mother and infant separated ('nurseries')	
Uninformed, confused mother	
Tired mother (no food or drink in labour)	
Routine episiotomy (pain)	
Weighing before and after (test feeds)	Anxiety and intere-
Restricting visitors	ference with let-
Unsympathetic or ambivalent health staff ('anti-doula' effect')	down reflex
Lack of privacy	

FIGURE 5

POSSIBLE MODIFICATIONS IN HEALTH SERVICES DESIGNED

Health Service	Modifications
Prenatal Care	Information on breastfeeding (preferably from breastfeeding mothers). Breast preparation. Maternal diet. Emotional preparation for labour.
Puerperal Care	Avoid maternal fatigue/anxiety/pain (eg. allow to eat in early labour; avoid unnecessary episiotomy; husband permitted during delivery; relatives and visitors allowed; privacy and relaxed atmosphere; organization of day with breastfeeding in mind). Separate mother and newborn as little as possible. Stimulate lactation (eg. no prelacteal feeds; first breastfeeding as soon as possible; avoid unnecessary maternal anaesthesia; permissive schedule; rooming-in). Lactation 'consultants' (advisers - preferably women who have breastfed). Adequate 'lying-in' period. In hot weather, extra water by dropper on spoon.
Premature Unit	Use of expressed breast milk (preferably fresh). Contact between mother and baby with earliest return to direct breastfeeding.
Children's Wards	Accommodation in hospital (or nearby) for mothers of breastfed babies.
Home Visiting	Encourage, motivate, support.
Health Centre	Supplementary food distribution (eg. formula and weaning foods) according to defined, locally relevant policy.
General	Supportive atmosphere from all shifts. Avoid promotion of unwanted commercial infant foods (eg. samples, posters, calendars, brochures, etc.) Adopt minimal bottle feeding policy and practical health education concerning biological breastfeeding.

FOR ILLUSTRATIONS OF PROLACTIN REFLEX AND LET-DOWN REFLEX SEE "HOW BREASTFEEDING REALLY WORKS" BY DERRICK B. JELLIFFE AND E.F. PATRICE JELLIFFE, PAGES 6 AND 7 RESPECTIVELY.