Breastfeeding is Obesity Prevention

AUT Centre for Midwifery and Women's Health Research - La Leche League - Women's Health Action

getting it right from the start!

Background

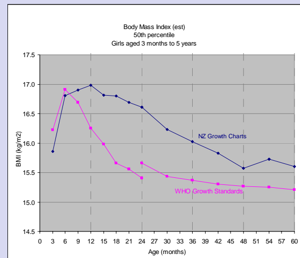
This poster highlights the key messages presented in submissions to the Parliamentary Health Select Committee Inquiry into Obesity and Type 2 Diabetes by community based breastfeeding advocates and academic researchers.

Child Growth Standards

"The standards will be an effective tool for detecting obesity. They allow for earlier diagnosis of excessive weight gain. In fact, the current obesity epidemic in many countries would have been detected earlier had this new standard been available 20 years ago"
(*WHO Advisory July 2006:* http://www.who.int/childgrowth).

The World Health Organisation's Growth Standards are based on well-nourished breastfed children as the normative growth model. The New Zealand Growth Charts are based on historical growth measurements of NZ babies and children, many of which were not breastfed at all, and most not beyond the early weeks or months. The New Zealand growth measure is therefore based on mainly artificially fed babies and toddlers.

Graph: WHO Growth Standard Measure Compared to NZ Growth Standard Measure



Graph Notes

The estimate of BMI implied by the NZ Growth Charts is calculated from the height and weight charts published in *Well Child Tamariki Ora Health Book.* (Ministry of Health, 2005)

The WHO Growth Standards graph reflects a vertical change at 2 years as a result of the measurement tool changing from prone length to standing length. (http://www.who.int/childgrowth)

The graph indicates that according to WHO standards, beyond six months of age, babies and children should be leaner than the comparable growth standards used in New Zealand. It is not uncommon for healthcare providers and parents to express concern about the 'slow' rate of growth of healthy breastfed babies who are in fact growing normally according to the WHO Standard. This often results in inappropriate interventions such as supplementary formula feeds, increased solids and other liquids, and a reduction in breastfeeding. This can set infants and toddlers on a track to obesity.

Three possible reasons why breastfeeding helps obesity prevention…

Breastfed babies learn hunger and full feelings and regulate their own caloric intake from 'physiological signalling'*.

Formula fed babies are not exposed to 'physiological signalling' as the fat concentration in formula remains constant throughout the feeding episode. Among formula-fed babies it is generally the caretaker and not the infant who controls the child's caloric intake.

Breastfed infants have a leptin profile that may favour adequate appetite regulation and less fat deposition. They gain less weight than formula-fed infants during the first year of life.

Formula-fed babies have higher insulin levels circulating in their blood stream as a result of the higher protein content in infant formula, which in turn may stimulate a higher deposition of fat stores.

Breastmilk is flavoured by the variety of foods the mother eats.

It is possible that breastmilk influences the development of a taste receptor profile that fosters a preference for lower energy diets later on in life. Formula always tastes the same.

**'physiological signalling' is related to the changing density of breastmilk from 'fore milk' to 'hind milk' which signals to the infant the end of a feed.*
IBFAN (2004) Editorial: Breastfeeding, Childhood Obesity and the Prevention of Chronic Diseases. *Breastfeeding - Briefs No 38.*

Definition of Optimal Feeding

Exclusive breastfeeding from birth for six months.

Exclusive breastfeeding is defined as nothing else by mouth except breastmilk and prescribed medication.

Solid food introduction from six months while continuing breastfeeding for two years or beyond.

Solids should be given using nutrient-rich family foods prepared to the appropriate consistency.

World Health Organisation (2003) Global Strategy for Infant and Young Child Feeding
World Health Organisation (2004) Global Strategy for Diet, Physical Activity and Health
http://www.waba.org.my/wbw/wbw05/actionfolder.pdf

Policy Recommendations

Adopt the WHO Child Growth Standards as a matter of priority, replacing the flawed growth charts currently in use.

Ensure all government sector policy and practice come into line with recommendations from the *World Health Organisation (WHO) Global Strategy for Infant and Young Child Feeding* and *The Innocenti Declaration 2005.*

Legislate the International Code of Marketing of Breastmilk Substitutes and relevant World Health Assembly Resolutions (WHA) in order to improve sustained breastfeeding rates.

Increase paid maternity leave to a minimum of six months. Adopt legislation which ensures flexibility of hours and conditions on the return to work. Legislate International Labour Organisation (ILO) recommendations for paid breastfeeding breaks.

Increase funding to community-based organisations that provide mother-to-mother breastfeeding support, education, information, advocacy and promotion.

AUT Centre for Midwifery and Women's Health Research, La Leche League, Women's Health Action & IFANZ - submissions to the Health Select Committee Enquiry into Obesity and Type 2 Diabetes.

Further References:

AUT Centre for Midwifery and Women's Health Research, La Leche League, Women's Health Action & IFANZ - submissions to the Health Select Committee Enquiry into Obesity and Type 2 Diabetes.

Picture used with permission of the Office on Women's Health, U.S. Department of Health and Human Services - www.4women.govt/breastfeeding