

Submission to Doctors in Training Workforce Roundtable
La Leche League New Zealand

May 2005

Thank you for the opportunity to provide input into the Doctors in Training Workforce Roundtable. La Leche League is an international non-governmental, non profit organization whose mission is to provide breastfeeding support and information via mother to mother networks. LLL operates in 66 countries with a workforce of more than 7200 volunteers.

Executive Summary

In this submission LLLNZ will comment specifically on the ways in which the training of NZ doctors could address the importance of protecting, supporting and promoting breastfeeding with reference to the following key points:

1. Preservation of the breastfeeding relationship as a primary health objective when planning and implementing treatment or care
2. The implications of cultural attitudes toward breastfeeding.
3. The implications of conflicting advice for breastfeeding
4. The importance and prevalence of breastfeeding beyond six months
5. The interdependent relationship of the breastfeeding dyad
6. The risks of artificial feeding
7. The influence of market forces on breastfeeding rates

1. Preservation of the breastfeeding relationship as a primary health objective when planning and initiating treatment or care

The World Health Organisation (WHO) (2002)ⁱ recommends **that all infants be exclusively breastfed for six months, followed by continued breastfeeding with the addition of appropriate complementary foods to two years and beyond.** This target is not yet met in New Zealand.

New Zealand breastfeeding statistics show:

Exclusive and fully breastfeeding at six wks 50% (Target 74%)

Exclusive and fully breastfeeding at three months 37% (Target 57%)

Exclusive and fully breastfeeding at six months 10% (Target 21%)ⁱⁱ

As a consequence optimal health outcomes, both short and long term, are not yet being achieved for children and their mothers.

Medical practitioners play a key role in ensuring that women who are breastfeeding (or planning to breastfeed) receive accurate and up to date information consistent with the WHO and NZ Ministry of Health (MoH) guidelines. In our opinion they are also

responsible for protecting the breastfeeding relationship by avoiding any action that could trigger the premature cessation of breastfeeding.

It is our experience that the burden of proof often lies with the mother to convince the doctor that it is appropriate for her to continue breastfeeding rather than the other way round. (see Code of Health and Disability Services Consumers' Rights ⁱⁱⁱ)

Supportive actions include:

- Choosing medications which are compatible with breastfeeding
- Choosing treatment and timing of treatment to minimise impact on the breastfeeding relationship
- Helping a mother to initiate and maintain lactation in the event of unavoidable separation of the mother and baby or where a treatment that is compatible with breastfeeding is not available
- Acting in a way that encourages and empowers the mother to continue breastfeeding
- Developing contacts with other health professionals and lay/volunteer counsellors knowledgeable about breastfeeding management to enhance personal knowledge and skills or in difficult cases to refer mothers to for expert help

Note: Breastfeeding to two years and beyond is a specific strategy in the prevention of breast and ovarian cancer ^{iv}.

2. The implications of cultural attitudes toward breastfeeding.

The MoH (2002)^v states that New Zealand is best defined as a bottle-feeding culture. Current practices reflect a collective attitude that breastfeeding is an option rather than a primary health necessity, that it can only be done successfully by a small number of women and that there are no continuing benefits after six months.

Supportive actions include:

- doctors acknowledging that their own personal experience and attitudes and cultural background may result in barriers to their patients successfully breastfeeding.
- medical practitioners consistently providing information that reflects international best practice.
- the integration of breastfeeding into all relevant aspects of doctors' training curricula
- active promotion, protection and support of breastfeeding
- recognition of the health implications of breastfeeding across the lifespan

3. The implications of conflicting advice for breastfeeding

Many women cite conflicting advice as a major reason for breastfeeding difficulties. Accurate and consistent information is vital for the maintenance of sustainable breastfeeding practices.

The urgent push for all maternity facilities to become accredited WHO/Unicef Baby Friendly Hospitals reflects the need to:

- Increase breastfeeding initiation and duration
- Decrease the incidence of conflicting advice about breastfeeding
- Ensure that all health care workers and allied staff who have contact with breastfeeding mothers provide consistent and accurate information via policy development, training of personnel (including doctors working within the facility) and implementation of practices that are consistent and supportive of breastfeeding.

The forthcoming Baby Friendly Community Initiative will enable community health organizations such as group practices of doctors to become accredited as Baby Friendly.

4. The importance and prevalence of breastfeeding beyond six months

It is estimated that less than 1% of two year old children in New Zealand are still breastfed. This is significantly less than WHO recommendations.

A mother may or may not disclose that she is breastfeeding, especially if her child is aged 12 months or more and/or she is breastfeeding two children of different ages and she is worried about people's reactions. It is common during the taking of a history for a doctor to enquire if a woman is pregnant, but not if she is breastfeeding, especially if her last birth was more than 12 months ago.

Supportive actions include:

- Routinely asking non-judgementally about breastfeeding practices to foster open communication between the doctor and patient and to reinforce that breastfeeding into the second year and beyond is a desirable behaviour.
- Taking into account the need for treatments to be compatible with breastfeeding for the duration of breastfeeding wherever possible

5. The interdependent relationship of the breastfeeding dyad

It is internationally recognised that the breastfeeding mother and child form an inseparable biological and social unit. This concept is most recently supported in particular by the *WHO Global Strategy on Infant and Young Child Feeding* (WHO 2003) and *The Right to Breastfeed* New Zealand Human Rights Commission (2005)^{vi}.

The implications of this are that any treatment of either partner of the breastfeeding pair will always have effects for the other partner, and that treatment protocols should take this interdependence into account.

6. The risks of artificial feeding

The risks of not breastfeeding and of using artificial milk are high for the infant:

Greater incidence and severity of infectious diseases including:

- Bacterial meningitis
- Bacteraemia
- Diarrhoea
- Respiratory Tract Infection
- Necrotizing Enterocolitis
- Otitis Media (and sequelae)
- Urinary Tract Infection
- Late Onset Sepsis in Pre-term Infants
- Increased Post Neonatal Infant Mortality
- Increased risk of allergy and atopic disease

Some studies also suggest:

- Increased rates of SIDS
- Increase in IDDM (Type 1) and NIDDM (Type 2)
- Increase in Lymphoma and Leukaemia
- Increase in Hodgkins Disease
- Increased rates of Overweight and Obesity
- Increased incidence of Hypercholesterolaemia
- Increased incidence of Asthma

Risks to the mother of not breastfeeding and of using artificial milk:

- Increased risk of breast and ovarian cancers
- Increased risk of post menopausal hip fractures and osteoporosis
- Increased post partum bleeding
- Less rapid uterine involution
- Increased menstrual blood loss
- Closer child spacing (due to absence of lactational amenorrhoea)
- Depression and mental health problems ^{vii}

Risks to the family of not breastfeeding and of using artificial milk:

- The incidence of poverty is increased
- Increased barriers to improving economic and educational outcomes
- Interference with work and income producing activities
- Increased stress due to incidence and severity of illnesses
- Long term social and economic costs associated with sequelae of illness
- Increased incidence of poor mental health outcomes
- Increased incidence of family violence ^{viii}

7. The influence of market forces on breastfeeding rates

The *WHO Code of Marketing of Breast Milk Substitutes* (1981) ^{ix} highlights the direct influence of the marketing of artificial baby milk on breastfeeding initiation and

duration. Doctors' training curricula content needs to highlight the subtle undermining of healthy practices by commercial forces.

Conclusion

1. Medical practitioners directly influence breastfeeding outcomes.
2. A single comment or treatment recommendation can result in a cascade of events leading to an undermining of a mothers ability to optimally feed and nurture her child.
3. There is a need for the training of doctors to include education regarding the long term effects of not exclusively breastfeeding for at least six months, or the premature cessation of continued breastfeeding thereafter.
4. A mother will make a fully informed choice for herself or her breastfeeding child if the doctor is aware of her breastfeeding status.
5. La Leche League New Zealand would be happy to provide further assistance to the Workforce Roundtable.

Yours sincerely

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Appendices

Appendix 1.

Resources available to medical practitioners / doctors in training

American Academy of Pediatrics. *Policy Statement: Breastfeeding and the use of human milk.* *Pediatrics* 2005; 115:2 496-506

<http://aappolicy.aappublications.org/cgi/content/abstract/pediatrics;115/2/496>

American Society of Anaesthetists: *Pre-operative fasting guidelines and the use of pharmacologic agents to reduce the risk of pulmonary aspiration: Application to healthy patients undergoing elective procedures*

<http://www.asahq.org/publicationsAndServices/NPO.pdf>

Baby Friendly Hospital Initiative

<http://www.babyfriendly.org.nz/>

<http://www.unicef.org/programme/breastfeeding/baby.htm>

Hale TW. *Medications and Mothers Milk*, Texas, USA: Pharmasoft Publishing, 2004

La Leche League New Zealand

<http://www.lalecheleague.org/LLLNZ>

New Zealand Lactation Consultants Association

<http://www.lactcon.org.nz/>

World Health Organisation *Code of Marketing Breast Milk Substitutes*, 1981

www.who.int/nut/documents/code_english.PDF

Appendix 2.

Breast cancer and breastfeeding: collaborative reanalysis of individual data from 47 epidemiological studies in 30 countries, including 50302 women with breast cancer and 96973 women without the disease.

Collaborative Group on Hormonal Factors in Breast Cancer.

Lancet 2002; 360: 187-95 (20 July)

SUMMARY

BACKGROUND: Although childbearing is known to protect against breast cancer, whether or not breastfeeding contributes to this protective effect is unclear.

METHODS: Individual data from 47 epidemiological studies in 30 countries that included information on breastfeeding patterns and other aspects of childbearing were collected, checked, and analysed centrally, for 50302 women with invasive breast cancer and 96973 controls. Estimates of the relative risk for breast cancer associated with breastfeeding in parous women were obtained after stratification by fine divisions of age, parity, and women's ages when their first child was born, as well as by study and menopausal status.

FINDINGS: Women with breast cancer had, on average, fewer births than did controls (2.2 vs 2.6). Furthermore, fewer parous women with cancer than parous controls had ever breastfed (71% vs 79%), and their average lifetime duration of breastfeeding was shorter (9.8 vs 15.6 months). The relative risk of breast cancer decreased by 4.3% (95% CI 2.9-5.8; $p < 0.0001$) for every 12 months of breastfeeding in addition to a decrease of 7.0% (5.0-9.0; $p < 0.0001$) for each birth. The size of the decline in the relative risk of breast cancer associated with breastfeeding did not differ significantly for women in developed and developing countries, and did not vary significantly by age, menopausal status, ethnic origin, the number of births a woman had, her age when her first child was born, or any of nine other personal characteristics examined. It is estimated that the cumulative incidence of breast cancer in developed countries would be reduced by more than half, from 6.3 to 2.7 per 100 women by age 70, if women had the average number of births and lifetime duration of breastfeeding that had been prevalent in developing countries until recently. Breastfeeding could account for almost two-thirds of this estimated reduction in breast cancer incidence.

INTERPRETATION: The longer women breast feed the more they are protected against breast cancer. The lack of or short lifetime duration of breastfeeding typical of women in developed countries makes a major contribution to the high incidence of breast cancer in these countries.

Appendix 3.

**LLLI Center for Breastfeeding Information
Journal Abstract of the Month for February 2005**

BREASTFEEDING AND THE USE OF HUMAN MILK

Author : American Academy of Pediatrics (AAP) Section on Breastfeeding
Pediatrics 2005 February; 115(2):496-506

This 2005 Policy Statement by the Section on Breastfeeding of the AAP replaces the 1997 statement. Because considerable advances have occurred since 1997 in the scientific knowledge of the benefits and management of breastfeeding, this new statement was issued. It lists many known and new benefits of breastfeeding to the infant, mother and community; and it gives recommendations to guide health care professionals in assisting mothers with initiation and maintenance of breastfeeding.

The Need

Human milk is species-specific, and all substitute feeding preparations differ markedly from it, making human milk uniquely superior for infant feeding. Exclusive breastfeeding is the reference or normative model against which all alternative feeding methods must be measured with regard to growth, health, development and all other short- and long-term outcomes.

Summary

In addition to the long list of child and mother benefits that are referenced in the article, it also states that these benefits include the potential for decreased annual health care costs of \$3.6 billion in the United States.

New information is introduced about reduced HIV transmission, with exclusive breastfeeding for the first 3-6 months after birth, from a study in Africa.

Breastfeeding is not contraindicated by mothers who have been exposed to low-level environmental chemical agents. Some previous contraindications are lifted.

Health care professionals should recommend breastfeeding education for both parents.

Skin-to-skin contact is to be encouraged.

Because certain maternal medications can alter the baby's alertness and some babies may need assistance with latch-on, doctors may want to minimize or modify the course of these drugs.

Pacifiers are best avoided during the initiation of breastfeeding.

Babies should be seen by knowledgeable, experienced health care professionals at 3-5 days and at 2-3 weeks, as this is a critical period.

Breastfeeding during painful procedures provides analgesia to infants.

There is no upper limit to the duration of breastfeeding and no evidence of psychological or developmental harm from breastfeeding into the third year of life or longer.

Mother and baby should sleep in proximity to each other to facilitate easier breastfeeding.

When mother or baby is hospitalized, every effort should be made to maintain breastfeeding.

Health care professionals are encouraged to become knowledgeable and skilled in the physiology and current clinical management of breastfeeding, and to encourage the development of breastfeeding and lactation curricula in medical schools.

Adoptive mothers should be counselled about induced lactation.

Health care professionals are encouraged to work collaboratively with the obstetric and dental communities, and to work actively toward eliminating hospital policies that discourage breastfeeding such as infant formula discharge packs.

Health care professionals should be familiar with local breastfeeding resources such as lay support groups.

Employers should be encouraged to provide appropriate facilities to breastfeeding mothers.

The courts should be encouraged to ensure continued breastfeeding in separation and custody proceedings and continue legislation to support the nursing mother.

Health care professionals should enthusiastically promote, support and protect breastfeeding because breastfeeding ensures the best possible health outcomes.

Summarised by La Leche League International, February 2005

This article is available at:

<http://aappolicy.aappublications.org/cgi/content/abstract/pediatrics;115/2/496>

References

- ⁱ World Health Organisation *Global Strategy on Infant and Young Child Feeding* WHO, 2003
- ⁱⁱ Royal New Zealand Plunket Society Breastfeeding Statistics, 2004
- ⁱⁱⁱ The Health and Disability Commissioner: *Code of Health and Disability Services Consumers' Rights*
<http://www.hdc.org.nz/index.php>
- ^{iv} Collaborative Group on Hormonal Factors in Breast Cancer. Breast cancer and breastfeeding: collaborative reanalysis of individual data from 47 epidemiological studies in 30 countries including 50302 women with breast cancer and 96973 women without the disease. *Lancet* 2002; 360: 187-95, (July 20)
- ^v New Zealand Ministry of Health *Breastfeeding: A Guide for Action* Ministry of Health, 2002
- ^{vi} New Zealand Human Rights Commission. *The Right to Breastfeed*. 2005
- ^{vii} American Academy of Pediatrics *Policy Statement on Breastfeeding and the Use of Human Milk*. *Pediatrics* 2005; 115:2 (February 2)
- ^{viii} Office of the Commissioner for Children, Submission to *The Right to Breastfeed* November 2004
<http://www.hrc.co.nz/>
- ^{ix} World Health Organisation *Code of Marketing of Breast Milk Substitutes*, WHO, 1981