

Breastfeeding Position Paper
A position paper originally adopted at the
1993 OPHA Annual General Meeting

Revised July 2007

Code: 2007-03 (PP) / 2007-03 (RES) / *Status:* Active

Submitted by the OPHA Breastfeeding Workgroup

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OPHA Breastfeeding Position Paper (Revised 2007) Executive Summary

The original OPHA Breastfeeding Position Paper was adopted in 1993. Since that time, extensive research has added to the body of knowledge regarding the crucial role of breastmilk and breastfeeding in achieving optimal health outcomes, as well as the impact of implementing evidence-informed strategies on breastfeeding initiation and duration rates.

There have been numerous related World Health Assembly (WHA) resolutions since 1981, when the WHO/UNICEF introduced the International Code of Marketing of Breast Milk Substitutes (the Code). The aim of the Code, and the subsequent resolutions, is to contribute to the provision of safe and adequate nutrition for infants. The Code protects breastfeeding and ensures the proper use of breastmilk substitutes, through informed decision making and appropriate marketing and distribution.

In 2002, the Breastfeeding Committee for Canada released *The Baby-Friendly Initiative in Community Health Services: A Canadian Implementation Guide*. This implementation guide builds on the principles of the Baby-Friendly Hospital Initiative, a global campaign of the WHO/UNICEF, and is the primary Canadian resource to implement breastfeeding best practices in community health services. The best practices are outlined in the Seven Point Plan for the Protection, Promotion and Support of Breastfeeding in Community Health Services. These Seven Steps complement the Ten Steps to Successful Breastfeeding, which outline best practices for hospitals and maternity facilities. The guide provides concrete strategies for a population health approach, examines the determinants of health, and expands on the guiding principles of The Seven Steps, including informed decision making, to direct our approach in public health.

In 2003, the Registered Nurses Association of Ontario (RNAO) released the *Breastfeeding Best Practice Guidelines for Nurses*. This comprehensive document provides referenced information on breastfeeding as a basis for evidence-informed nursing practice in all care settings, including public health.

In 2004, Health Canada revised their infant feeding recommendations to reflect the global public health recommendation that infants should be exclusively breastfed for the first six months of life, with the introduction of nutritionally adequate and safe complementary foods thereafter, and continued breastfeeding for up to two years and beyond.

In 2006, the World Health Assembly (WHA) endorsed the *Global Strategy for Infant and Young Child Feeding* (WHO/UNICEF, 2003), and urged member states to renew their commitment to implementation of the Code and to the revitalization of the Baby-Friendly Initiative.

In 2007, the Ministry of Health introduced new Ontario Public Health Standards. Although the new standards do not fully reflect breastfeeding best practice recommendations, opportunity still exists to influence the development of protocols which will guide and support public health practitioners in implementing evidence-informed breastfeeding strategies.

The Breastfeeding Promotion Workgroup has revised the Breastfeeding Position Paper to reflect new research, resources and recommendations related to breastfeeding. The workgroup seeks OPHA's endorsement of this Position Paper, and their support as the workgroup endeavors to

implement proposed strategies for improving health outcomes through the protection, promotion and support of breastfeeding in Ontario.

It is the position of the Ontario Public Health Association:

- that breast milk is the normal, species-specific, exclusive food source for human infants during the first six months of life, and that continued breastfeeding is recommended for up to two years and beyond, with the introduction of nutrient-rich complementary foods at six months, with particular attention to iron. (Exclusive breastfeeding is based on the WHO definition and refers to the practice of feeding only breast milk, including expressed breast milk, and allows the baby to receive vitamins, minerals or medicine. Water, breast milk substitutes, other liquids and solid foods are excluded.)
- that breastfeeding has a mediating effect on the determinants of health, reducing health inequities among population groups
- that the protection, promotion and support of breastfeeding must be recognized as an indispensable population health strategy
- that breastfeeding best practice is represented in the guiding principles and recommendations of the WHO/UNICEF Baby-Friendly Initiative (BFI), which includes informed decision making and evidence-based and best practice (see Appendix A).

Additionally, as part of this position, the OPHA:

- supports the development and implementation of a provincial breastfeeding strategy to improve breastfeeding rates
- endorses the WHO/UNICEF International Code of Marketing of Breast Milk Substitutes (*see Appendix A*), the WHO/UNICEF statement on Protecting, Promoting and Supporting Breastfeeding, the WHO/UNICEF Baby Friendly Initiative (*see Appendix A*) and recognizes the WHO/UNICEF Global Strategy for Infant and Young Child Feeding (WHO, 2003).

Rationale for the Position Statement:

Breastfeeding is one of the most important contributors to infant health. Breastfeeding provides a range of benefits related to infant growth, immunity, and development. Breastfeeding also improves maternal health and confers economic benefits to the family, health care system, and workplace (Satcher D, 2000). Additionally, breastfeeding is ecologically sound, thus protecting the environment, and ensures food security for infants and young children in the event of emergencies or disasters. The health and well-being of infants, mothers, families, communities and society is enhanced by breastfeeding.

Epidemiological evidence shows that exclusive breastfeeding for the first six months has both short and long term advantages for infants and mothers (RNAO, 2003). In spite of these benefits, optimal breastfeeding initiation and duration rates have not been achieved in Ontario or Canada. The Canadian Perinatal Health Survey showed that 85% of mothers in Canada initiated breastfeeding in 2003, as compared with 75% in 1994-95; however, only 47% were

breastfeeding at six months, and only 19 % were breastfeeding exclusively for at least six months (PHAC, 2003). These rates are well below the recommendations of Health Canada and the Canadian Paediatric Society and will have both short and long term effects on health care as less than optimal numbers of mothers and babies will receive the full immunological, nutritional, hypoallergenic, and psychological benefits of breastfeeding.

A woman's decision to breastfeed is influenced by a variety of demographic, personal and societal factors, including socio-economic status, attendance at prenatal classes, attitudes and beliefs toward breastfeeding, identity and body image issues, lifestyle issues (such as smoking), comfort with breastfeeding in public and the influence of others such as family, friends, and health care professionals. Educational level, a previous successful breastfeeding experience, hospital practices, social network (including peer and professional support), and return to work or school are all factors which affect the initiation and duration of breastfeeding. Research shows the majority of women make their decision to breastfeed before pregnancy or during the first trimester (PHAC, 2003).

The rate at which women initiate and continue breastfeeding will only be increased if there are positive societal attitudes toward breastfeeding and increased community support to help women address their individual barriers to breastfeeding.

Breastfeeding and the Determinants of Health

The *key determinants of health* are those factors which have the most predictive effect on health outcomes for populations of people. Breastfeeding has been referred to as “a natural safety net” because of its mediating effect on the determinants of health. Breastfeeding helps reduce health inequities among population groups, as follows:

Income and Social Status

Income and social status are considered the most influential determinants of health status. The many benefits of breastfeeding help to offset the negative impacts that poverty imposes on children and their families. More of the family's income is available for other needs because infant nutrition is supplied at a low cost to the family.

Social Support Networks

Breastfeeding thrives with and also inspires social support networks. When group and peer supports for breastfeeding are improved, access to additional social supports for women is facilitated, thus benefiting other aspects of her health. Breastfeeding peer supports have been identified as effective mediating links between mothers in the community and health care professionals, which may be particularly beneficial for socially disadvantaged breastfeeding mothers (Dennis, 2002).

Education

A child's education is impacted by early childhood development and intelligence factors. These are directly correlated to the grade levels a child ultimately attains. Breastfeeding affects cognitive development (Angelsen, 2001). This is particularly true for preterm and small-for-gestational-age infants ((Lucas et al, 1992; Rao et al, 2002; Slykerman et al, 2005).

The population health strategies of the Baby-Friendly Initiative affect breastfeeding initiation and duration rates across all sectors of the population, including women at risk of not breastfeeding or at risk of not succeeding at breastfeeding. This helps to reduce the significance of the mother's educational level as a predictive factor for her breastfeeding success.

Employment / Working Conditions

Better policies for breastfeeding can improve work environments and help to foster less stressful work environments for women and their families. Policies which incorporate provisions for pumping or feeding at the workplace, allow women to have more control over their work environment and the health of their children. Because breastfeeding prevents early childhood illness, workplace stress related to arranging care for ill children is reduced. The results of several studies have shown that providing a lactation program in the workplace saves companies money by decreasing absenteeism and increasing employee job satisfaction (Wyatt, 2002).

Social Environments

Human rights policy as it relates to breastfeeding in public is an example of a community providing social stability and acceptance for women, as well as a recognition of diversity. In turn, increased breastfeeding rates can improve the overall health of the community.

Physical Environments

Breastfeeding is an ecologically sound natural resource. It is a resource which can be crucial to the health of children during natural disasters and states of emergency when clean water is not available or when access to food is threatened or impaired. Breastfeeding does not contribute to environmental waste.

Personal Health Practices and Coping Skills

Because family poverty issues are ameliorated by breastfeeding, the potential effects of early socioeconomic hardship on later risks to health are lessened. It is also true that the activity of breastfeeding creates the capacity to rely on personal resources instead of depending on outside wealth and consumer products as a resource. In short, breastfeeding makes a mother feel capable. This message resonates with a mother herself but also to her other observing children, conveying to them that, "I can sustain my child this way and contribute to our family". Breastfeeding helps a mother cope in a family crisis by providing an available food source. Many women will make healthier choices, such as quitting smoking or improving their nutrition, because they are breastfeeding.

Healthy Child Development

The effect of breastfeeding on attachment, nutrition and prevention of early childhood diseases, including obesity, is evident in the research. This decisively translates into a healthier early childhood development process. It is also not influenced by wealth, thus relieving another key determinant of health.

Biology and Genetic Endowment

Breastfeeding can ameliorate disease processes and potentials as in the case of early childhood diabetes and allergy conditions (Fewtrell, 2004). Breastfeeding helps protect women against diseases such as pre-menopausal breast cancer and ovarian cancer. (Tung et al, 2005; Zhang et al, 2004).

Health Services

Though health services and access to them can determine health, when breastfeeding is prevalent in populations families are less reliant on access to medical services for early childhood illnesses. This is because the need for medical intervention for common early childhood diseases is reduced. Medical and health care costs are reduced due to a healthier population. The Baby-Friendly Initiative is an evidence-based approach to maternity and community care which ensures that families receive the information, education and support they need to make informed decisions about infant feeding.

Gender

Measures to address gender inequality and gender bias within and beyond the health system will improve population health. Breastfeeding women become more self-reliant and valued as providers of nutrition for their families, increasing their perceived status. When public policy is congruent with this societal value, there are more public provisions for breastfeeding women, and more personal recognition for this status. Breastfeeding helps protect women from diseases such as pre-menopausal breast cancer, and can also provide natural child spacing.

Culture

Many women experience breastfeeding as the cultural norm in their country of origin, only to discover when they move to “developed” countries that breastfeeding is not the norm. Best practices in health environments can improve this by normalizing breastfeeding, thus shaping societal perceptions and attitudes.

Epidemiological Evidence to Support Breastfeeding

The Canadian Paediatric Society recommends exclusive breastfeeding for healthy term infants for the first six months, with continued breastfeeding to 2 years and beyond, as does Health Canada in their recommendations regarding Exclusive Breastfeeding Duration. (Health Canada, Office of Nutrition Policy and Promotion, 2004).

The advantages of breastfeeding in terms of nutrition, immunity and the psycho-physiologic interaction between mother and infant have been well documented (RNAO, 2003). Breast milk contains an abundance of factors that are active against infection. Since the infant’s immune system is not fully mature until about 2 years of age, the transfer of these factors from human milk provides a distinct advantage that infants fed formula do not experience (Satcher D, 2000).

A review of the literature related to the epidemiological advantages of breastfeeding concluded that not only does breastfeeding offer well understood protection against gastrointestinal infections but it also offers significant reductions in other types of infections in young children including pneumonia, otitis media, bacteraemia, meningitis and urinary tract infections. Breastfeeding may also protect against atopic disease, allergies and asthma.

Breastfed infants, compared with formula-fed infants, produce enhanced immune responses to polio, tetanus, diphtheria, and H. influenzae immunizations, and to respiratory syncytial virus infection (RSV), a common infant respiratory infection. Human milk contains anti-inflammatory factors and other factors that regulate the response of the immune system against infection. There

is also evidence that breastfeeding results in earlier development of the infant immune system (Satcher D, 2000).

Until recently, the prevailing opinion was that the benefits of breastfeeding were limited to infancy. Studies are showing an association between artificial feeding and immune system disorders as well as a range of chronic diseases in late childhood and adulthood (Fewtrell, 2004).

Trends in Breastfeeding

Breastfeeding rates have changed dramatically in Canada over the last 50 years. From all-time lows in the late 1950s and early 1960s, recent years have seen an increase in the number of women breastfeeding at the time of hospital discharge. However, many women discontinue breastfeeding shortly after leaving hospital. Furthermore, as stated previously, the current duration rates are well below the recommendations of Health Canada and the Canadian Paediatric Society.

During the 1970s, the World Health Organization recognized that breastfeeding rates were declining and formula feeding rates were increasing. Scientific research indicated that children who were not breastfed had increased diarrhea, respiratory illness, ear infections, childhood diabetes and malnutrition. It was identified that the breastfeeding rates were being impacted by the aggressive marketing approaches of the infant formula industry. In 1981, during the 34th World Health Assembly, the World Health Organization approved and adopted a code of marketing conduct. Canada endorsed the measures described in the WHO/UNICEF International Code of Marketing of Breast Milk Substitutes (WHO Code),¹ but opted to take a voluntary approach rather than legislating compliance. The formula industry participated in the process and pledged to cooperate in the interest of health, however, violations of the WHO Code continue.

Because of concerns of non-compliance with the WHO Code, the Canadian Food Inspection Agency wrote a letter to the formula industry in January 2007 saying that comparing infant formula to breast milk, including comparisons of the levels of a nutrient in infant formula to the levels of the same nutrient in breast milk, is contrary to the message embodied in the WHO Code. While the Code has not been incorporated into Canadian domestic legislation, the infant formula industry is encouraged not to make a reference to breast milk on a label or advertising of infant formula, other than a statement regarding the superiority of breastfeeding or that breast milk is the optimal method of feeding infants.

Knowledge of the WHO Code is essential in order to protect the public from misinformation about infant feeding methods so that informed decisions can be made about infant feeding.

¹ International Code of Marketing of Breastmilk Substitutes (see Appendix A for a summary of the *Code*)

Influences on Infant Feeding Decisions

While the basic prerequisites to the initiation of breastfeeding are the motivation to breastfeed, the belief that breastfeeding is convenient and the belief that breast milk is the best food for infants, there are numerous social and psychological factors influencing the choices women make regarding how they approach the breastfeeding experience and how long they continue to breastfeed (RNAO, 2003; Sheehan, Watt, Krueger, Sword, 2006).

Attitudes toward breastfeeding and the degree of commitment to them have been established long before a woman's admission to the hospital and will reflect her family, culture and more general public attitudes about infant feeding choices (Sheehan, Watt, Krueger, Sword, 2006). Research findings show a positive association between higher socio-economic status, and higher education and breastfeeding, with maternal educational level being the strongest factor related to breastfeeding duration in both Canada and the United States. Studies have also found a positive correlation between maternal age and breastfeeding duration.

In general, the social network was found to be more influential than health care providers in affecting the choice of infant feeding method and the duration of breastfeeding (RNAO, 2003; Nutrition Committee, CPS 1988). A mother considering breastfeeding her infant may be discouraged both verbally and non-verbally by family, friends, and health care professionals. Moreover, numerous studies indicate that information and recommendations from health care professionals regarding breastfeeding are often inconsistent, inaccurate, and/or inadequate. Conflicting advice offered by professionals is a concern frequently cited by breastfeeding mothers. Consistent, evidenced-based practices and policies, such as those found in the Baby-Friendly Initiative, can be an important determinant of breastfeeding initiation, exclusivity and duration.

Deterrants to Breastfeeding

In traditional societies, childbearing and nursing women have been surrounded by a support system of women in the extended family who themselves have borne and breastfed infants. In Canadian society a young woman can be faced with the task of feeding her newborn without ever having seen a baby breastfeed, and without the traditional supports of their own mother (-in-law), sisters or friends who have breastfed.

Although there are many factors contributing to the support of breastfeeding, there are also factors that deter initiation and/or duration of breastfeeding. Negative attitudes towards breastfeeding and socio-cultural factors can deter women from initiating and/or continuing breastfeeding. Perceived inadequate milk supply was found to be a major factor affecting breastfeeding duration, as it was the main reason women stopped breastfeeding within the first four weeks following hospital discharge (Sheehan, Watt, Krueger, Sword, 2006). Difficulty with breastfeeding techniques, sore nipples, fatigue and perceived restriction of activities are other factors which commonly influence breastfeeding duration. Mother's expected return to work was one of the top three reasons they did not breastfeed (Arora, McJunkin, Wehrer, Kuhn 2000). Additionally, among women who did breastfeed, studies have shown that the sooner a woman returns to work, the earlier she stops breastfeeding (Wyatt, 2002).

Dennis identified the women least likely to breastfeed included the young, the poor, those belonging to an ethnic minority, the lonely and unsupported, and those without maternity leave requiring attendance at a full-time job or school (Dennis, 2002).

Any attempt to identify the factors affecting the initiation and duration of breastfeeding must consider the complex social and psychological factors mediating the breastfeeding experience.

Breastfeeding: Protecting, Promoting, Supporting

Decisions regarding breastfeeding are usually made prior to pregnancy, or during the first trimester of pregnancy. Education of mothers, families (especially fathers), and health care professionals regarding the benefits of breastfeeding, the risks related to using artificial baby milk, as well as how to overcome potential barriers to breastfeeding success, would have a positive impact on the number of mothers choosing to breastfeed (Arora, McJunkin, Wehrer, Kuhn 2000). Strategies designed to address these issues before pregnancy and during the first trimester would enable truly informed decisions to be made regarding infant feeding.

Encouraging breastfeeding requires an approach that addresses not only the attitudes and beliefs of women but also the practices of providers. Sheehan (2006) advises that institutional and community providers both have a significant role to play if the goal of exclusive breastfeeding for six months is to be achieved. The Baby-Friendly Initiative is an effective means of protecting, promoting and supporting breastfeeding in both hospitals and community health settings because of the evidenced-based educational component for service providers within it. Additionally, the Baby-Friendly Initiative fosters continuity of care between hospital, community health services and other community resources, a strategy that helps improve breastfeeding duration.

Conclusion

The OPHA is in a position to protect, promote and support breastfeeding through endorsement of this Position Paper, and a commitment to implement the proposed resolution.

Breastfeeding Resolution

WHEREAS the mission of the OPHA is to provide leadership on issues affecting the public's health and to strengthen the impact of people who are active in public and community health throughout Ontario, and,

WHEREAS breastfeeding is a population health strategy that must be protected, supported and promoted to optimize the health of our entire population, and,

WHEREAS it is the position of the OPHA:

- that breast milk is the normal, species-specific, exclusive food source for human infants during the first six months of life, and that continued breastfeeding is recommended for up to two years and beyond, with the introduction of nutrient-rich complementary foods at six months, with particular attention to iron. (Exclusive breastfeeding is based on the WHO definition and refers to the practice of feeding only breast milk, including expressed breast milk, and allows the baby to receive vitamins, minerals or medicine. Water, breast milk substitutes, other liquids and solid foods are excluded.)
- that breastfeeding has a mediating effect on the determinants of health, reducing health inequities among population groups.
- that the protection, promotion and support of breastfeeding must be recognized as an indispensable population health strategy
- that breastfeeding best practice is represented in the guiding principles and recommendations of the Baby-Friendly Initiative, which includes informed decision making, and evidence-based and best practice (see Appendix A).

THEREFORE BE IT RESOLVED THAT:

The OPHA adopt this revised position paper

The OPHA support a provincial strategy that would include establishing breastfeeding targets, data collection, and allocation of human resources and funding to implement and sustain the strategy.

The OPHA support the implementation of the standardized breastfeeding curriculum for health care professionals developed by the OPHA Breastfeeding Workgroup.

The OPHA support the inclusion of appropriate breastfeeding information in the Ontario Ministry of Education curricula.

The OPHA support the collaboration and partnership with professional associations and organizations to increase the protection, promotion and support of breastfeeding.

The OPHA support and facilitate communication with other OPHA workgroups to enable collaboration and partnership to address shared goals.

Implementation Strategy

This resolution will be implemented by the OPHA Breastfeeding Promotion Workgroup, with the cooperation of the OPHA Board of Directors and Executive, where appropriate and required.

Copies of the position paper and accompanying resolution will be sent to the Acting Chief Medical Officer of Health for Ontario; and the Ontario Ministers of Education, Health and Long-Term Care, Children and Youth Services, and Health Promotion; the Public Health Agency of Canada, and the Office of Nutrition Policy & Promotion, Health Canada.

Copies of the position paper and accompanying resolution will be sent to alPHa, AOHC, RNAO, Breastfeeding Committee for Canada and Ontario Breastfeeding Committee with a request to work together on advocating for the measures identified in the resolution.

Copies of the position paper and accompanying resolution will be sent to all public health units in Ontario.

Copies of the position paper and accompanying resolution will be sent to other OPHA workgroups identified as having shared goals.

Develop strategy, in collaboration and partnership with other professional associations and organizations, for lobbying the appropriate provincial ministries regarding the establishment of breastfeeding targets and data collection methods.

Develop strategy for further dissemination of the breastfeeding curriculum (*Breastfeeding Modules for integration into Undergraduate Health Professional Curricula*, January 2004)

References

- Angelsen NK, Vik T, Jacobsen G, Bakketeig LS (2001). *Breastfeeding and cognitive development at age 1 and 5 years*. Arch Dis Child 2001; 85: 183-88.
- Arora S, McJunkin C, Wehrer J, Kuhn P (2000). *Major Factors Influencing Breastfeeding Rates: Mother's Perception of Father's Attitude and Milk Supply*. Pediatrics, vol. 106 No. 5. (Retrieved October 27, 2006, from www.pediatrics.org).
- Barron SP, Lane HW, Hannan TE, Struemaker B, Williams, JC (1988). *Factors influencing duration of breastfeeding among low income women*. Journal of the American Dietetic Association, 88, 1557-1561.
- Breastfeeding Committee for Canada (2002). *The Baby Friendly™ Initiative in Community Health Services: A Canadian Implementation Guide*. Toronto: Author.
- Breastfeeding Committee for Canada (2006). *Breastfeeding Definitions and Data Collection Periods*. (Retrieved January 9, 2006, from <http://www.breastfeedingcanada.ca>)
- Canadian Paediatric Society, Dieticians of Canada, Health Canada (2005). *Nutrition for Healthy Term Infants*. Health Canada.
- Dennis CL, Hodnett E, Gallop R, Chalmers B (2002). *The effect of peer support on breastfeeding duration among primiparous women: a randomized controlled trial*. CMAJ. 2002; 166:21-28.
- Earle S (2002). *Factors affecting the initiation of breastfeeding: implications for breastfeeding promotion*. Health Promot Int: 2002;17:205-214.
- Fewtrell MS (2004). *The long-term benefits of having been breast-fed*. Current Paediatrics, London, UK.
- Harder T, Bergmann R, Kallischnigg G, Plagemann A. *Duration of Breastfeeding and Risk of Overweight: A Meta-Analysis*. American Journal of Epidemiology: 2005;162:397-403.
- Public Health Agency of Canada (2003). *Canadian Perinatal Health Report*. Ottawa: Minister of Public Works and Government Services Canada. Cat. No. H49-142/2003E.
- Rao MR, Hediger ML, Levine RJ, Naficy AB, Vik T. *Effect of breastfeeding on cognitive development of infants born small for gestational age*. Acta Paediatr 2002;91:267-74.
- Registered Nurses Association of Ontario (2003). *Breastfeeding Best Practices Guidelines for Nurses*. Author.
- Public Health Agency of Canada (2003). *Make Every Mother and Child Count: Report on Maternal and Child Health in Canada*, p. 5. (Retrieved October 2006, from http://www.phac-aspc.gc.ca/rhs-ssg/pdf/whd_05epi_e.pdf).
- Satcher D; Centers for Disease Control, Atlanta. *HHS blue print for action on breastfeeding*. [cited 2006, April 03]. Available from: <http://www.cdc.gov/breastfeeding/pdf/bluprntbk2.pdf>
- Sheehan D, Watt S, Krueger P, Sword W (2006). *The Impact of a New Universal Postpartum Program on Breastfeeding Outcomes*. Journal of Human Lactation. 2006; 22 (4).

Slykerman RF, Thompson JMD, Becroft DMO, Robinson E, Pryor JE, Clark PM, Wild CJ, Mitchell EA. *Breastfeeding and intelligence of preschool children*. *Acta Paediatrica*, 2005; 94: 832-837.

Tung K, Wilkens L, Wu A H, McDuffie K, Nomura A MY, Kolonel LN, Terada, KY, Goodman MT. *Effect of Anovulation Factors on Pre- and Postmenopausal Ovarian Cancer Risk: Revisiting the Incessant Ovulation Hypothesis*. *Am J Epidemiolog*: 161(4):321-329, February 15, 2005.

Wyatt SN (2002). *Challenges of the Working Breastfeeding Mother: Workplace Solutions*. *AAOHN Journal*, February 02, vol. 50, No. 2.

WHO/UNICEF, 1989. *Protecting, promoting and supporting breastfeeding: The special role of maternity services. A joint WHO/UNICEF statement*. Geneva, Switzerland.

WHO/UNICEF, 2003. *Global Strategy for Infant and Young Child Feeding*. Geneva, Switzerland.

Yeung DL, Pennell MD, Leung M, Hall J (1981). *Breastfeeding: Prevalence and influencing factors*. *Canadian Journal of Public Health*, 72, 323-329.

Zhang M, Xie X, Lee AH, Binns CW. *Prolonged lactation reduces ovarian cancer risk in Chinese women*. *European Journal of Cancer Prevention* 2004, 13:499-502.

APPENDIX A

The Baby-Friendly Initiative

The *Baby-Friendly Initiative* is an evidence-based and globally endorsed set of standards outlined in the WHO/UNICEF Ten Steps to Successful Breastfeeding, the WHO/UNICEF International Code of Marketing of Breastmilk Substitutes and, the Breastfeeding Committee for Canada's Seven-Point Plan for Community Health Services (a summary of these standards follows).

The Baby-Friendly Initiative recognizes that implementing best practices in health services is crucial to the success of programs that protect, promote and support breastfeeding in all sectors of our community – hospitals, schools, the workplace, community agencies and the community-at-large, and encourages hospitals and community health settings to work toward full Baby Friendly designation

International Code of Marketing of Breastmilk Substitutes *World Health Organization (WHO), Geneva, Switzerland, 1981*

Summary of the Code includes these ten important provisions:

1. No advertising of products under the scope of the Code to the public.
2. No free samples to mothers.
3. No promotion of products in health care facilities, including the distribution of free or low-cost supplies.
4. No company representatives to advise mothers.
5. No gifts or personal samples to health workers.
6. No words or pictures idealizing artificial feeding, including pictures of infants, on the labels of the products.
7. Information to health workers should be scientific and factual.
8. All information on artificial feeding, including the labels, should explain the benefits of breastfeeding and all costs and hazards associated with artificial feeding.
9. Unsuitable products such as sweetened condensed milk should not be promoted for babies.
10. All products should be of a high quality and take account of the climatic and storage conditions of the country where they are used.

The Baby-Friendly Initiative in Canada – A Summary

www.breastfeedingcanada.ca

The Ten Steps to Successful Breastfeeding

A Joint WHO/UNICEF Statement, Geneva, Switzerland, 1989

Every facility or agency providing maternity services and care of newborn infants should:

1. Have a written breastfeeding policy that is routinely communicated to all health care staff.
2. Train all health care staff in skills necessary to implement this policy.
3. Inform all pregnant women about the benefits and management of breastfeeding.
4. Help mothers initiate breastfeeding within a half-hour of birth.
5. Show mothers how to breastfeed and how to maintain lactation even if they should be separated from their infants.
6. Give newborn infants no food or drink other than breastmilk, unless medically indicated.
7. Practice rooming-in - allow mothers and infants to remain together 24 hours a day.
8. Encourage breastfeeding on demand.
9. Give no artificial teats or pacifiers (also called dummies or soothers) to breastfeeding infants.
10. Foster the establishment of breastfeeding support groups and refer mothers to them on discharge from the hospital or clinic.

The Seven Point Plan for the Protection, Promotion and Support of Breastfeeding in Community Health Services

Adapted with permission from: UNICEF UK Baby Friendly Initiative, 1999

1. Have a written breastfeeding policy that is routinely communicated to all staff and volunteers.
2. Train all health care providers in the knowledge and skills necessary to implement the breastfeeding policy.
3. Inform pregnant women and their families about the benefits and management of breastfeeding.
4. Support mothers to establish and maintain exclusive breastfeeding to six months.
5. Encourage sustained breastfeeding beyond six months with appropriate introduction of complementary foods.
6. Provide a welcoming atmosphere for breastfeeding families.
7. Promote collaboration between health care providers, breastfeeding support groups and the local community.

Regarding Resolutions, Position Papers, and Motions:

Status: Policy statements (resolutions, position papers, and motions) are categorized as:

Active, if:

1. The activities outlined in the policy statement's implementation plan have not yet been completed,
2. The policy statement addresses an issue that is currently relevant to public health in Ontario.

Archived, if:

1. The activities outlined in the policy statement's implementation plan have been completed, or
2. The policy statement addresses an issue that is not currently relevant to public health in Ontario or is not based upon the most current evidence. The statement remains the position of the OPHA until a new statement is adopted that effectively reverses or essentially negates all or major elements of an earlier statement. In this instance, the former supercedes the latter.

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