Lactation & Breastfeeding

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EDITORIAL

Dear members and readers,

Record summer 2015: What causes hilarious feelings for holidaymakers is at the same time a huge problem for agriculture. In some parts of Central Europe it hasn't been that dry for 50 years.
Without precipitation the leaves are turning yellow as early as mid-August, the danger of forest fires is increasing, the harvest is poor and food prices are rising. Water as existential lifeline is in danger.
The same applies to mother's milk, the elixir of life. Quite a few new mothers without adequate information, counselling and support already fail after a few days to start breastfeeding successfully. Lactation subsides and expensive formula has to be fed.

Yet there are a few simple measures to support mothers throughout the world in achieving their aims in breastfeeding and thus protect both their own health and the health of their children.
These 10 steps to successful breastfeeding are the basis of the „Baby-friendly Hospital Initiative"(BFHI), which was founded 25 years ago. Implementing these simple, logical and scientifically founded steps should actually be common standard in any postnatal ward.
Another decisive factor for a successful breastfeeding relationship is the access to highly-qualified counselling and support by an IBCLC at an early stage.

IBCLCs closely cooperate with BFHI, they are an important part oft he support team, they teach colleagues, they initiate the establishment of breastfeeding standards, they introduce new scientific insights and above all they counsel and support families particularly in difficult situations of breastfeeding.
In our next issue of „Lactation & Breastfeeding" we are going to deal with these topics mentioned above and other interesting themes.

Andrea Hemmelmayr, IBCLC
President ELACTA

www.zinnhuetchen.com

Für einen entspannten Start in die Stillzeit

Gerade zu Beginn der Stillzeit kann es durch die ungewohnte Beanspruchung der Brustwarze zu Reizungen oder Entzündungen kommen. Der Kontakt mit Kleidungsstücken kann dieses Problem noch verstärken. Unsere Zinnhütchen schonen die Brustwarze und durch die feuchte Wundheilung in eigener Muttermilch wird der Heilungsprozess positiv beeinflusst.
Nicht umsonst gelten Zinnhütchen als altes Hebammen-Hausmittel.
Probieren Sie es aus!

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Letters to the editor
Dear readers! We want to know what you think. Please send your letters and comments to the following email address:
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Austrian Hospitals: Mother and Baby-Friendly for Their Employees?

In the health and social sector, breastfeeding and the promotion of breastfeeding are among the most cost-efficient and effective preventive measures. For that reason 16 Austrian hospitals are certified Baby-friendly by now. Others are already on their way and a lot of maternity clinics, neonatologies and pediatric wards are working on improving their breastfeeding counselling. However, does this „breastfeeding friendliness" also account for the employees of these hospitals?

Andrea Hemmelmayr, DGKS, IBCLC

Photo: Barbara Kämmerer

Also health workers need training/consultation and support when it comes to the selection of pumps, the organization of pumping, storing and feeding breast milk.

87.3 % interrupt their career after having children (Statistic Austria). In 2010 12 % of the mothers went back to work within the first 12 months and 23 % within the first 24 months. However, over the last 5 years the tendency of going back to work earlier increased. This is mainly due to the massive extension of childcare facilities even for the tiniest tots and the possibility to earn - besides childcare supplements - up to 60 % of the last salary.

Because of this new trend in Austria the employers are only seldom prepared that their female employees demand their legally due breastfeeding periods as well as facilities for expressing and storing their milk. Besides, many women believe weaning naturally precedes going back to work.

All too often they have no idea that many effects of breastfeeding become even stronger in association to a longer breastfeeding duration. Positive effects for the child primarily include infection and allergy prevention as well as the protection against chronic and malignant diseases. The dose-depending efficacy of breastfeeding especially has a positive effect on the mother's health; i.a. for instance the reduction in risk of getting breast, uterus and ovarian cancer[1] by at least 25 % (depending on the number of pregnancies and lifetime duration of breastfeeding).

Thus, if breastfeeding rates would moderately increase Austria could save € 7.6 M. of healthcare expenditures, which would otherwise have to be additionally paid if the breastfeeding rate declines.[2]

Which effects can an employer expect if he/she takes baby- and mother-friendly measures?

- Early return of experienced employees and thus smaller staff recruitment and training costs.
- Breastfeeding mothers less frequently take child care leave[3] and
- breastfeeding reduces the mother's likelihood of illness.
- Family friendly structures support the employees' loyalty.

Main points of the legal basis:

- On her return the breastfeeding mother must inform her employer that she still breastfeeds.
- She is entitled to have breastfeeding periods during her working time, which must not be equalized to taking a break: (>4.5 working hours - 45 min, >8 working hours - 2 x 45 min or 1 x 90 min)
- For breastfeeding mothers the Austrian Maternity Protection Act includes employment prohibitions (e.g. night work, overtime, Sundays and public holidays, dangerous work,...)

[1] Collaborative Group on Hormonal Factors in Breast Cancer. 2002. "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." In: The Lancet, Vol. 360, No. 9328, 187-95 pp.

[2] Renfrew, Mary J. et al. 2012. „Preventing diseases and saving resources: the potential contribution of increasing breastfeedingrates in the UK." London: UNICEF UK.

[3] Cohen R, Mrtek MB & Mrtek RG. 1995. "Comparison of maternal absenteeism and infant illness rates among breast-feeding and formula-feeding women in two corporations." In: American Journal of Health Promotion, Vol. 10, No. 2, 148-153 pp.

These employment prohibitions are rather difficult to implement by hospital staff: Most hospital nurses and especially female physicians waive their rights set forth in the Maternity Protection Act. Especially working hours are mostly not family-friendly, however, many young mothers see night and weekend shifts as a good opportunity to let the father care for the child(ren) so that there is little need for third-party care. Many young mothers cannot do without the bonuses, duty rosta are more difficult to arrange and thus colleagues and supervisors often lack understanding. Even the concern of being transferred to another ward is perfectly understandable.

Mother- and baby-friendly workplace

By involving in-house IBCLCs at hospitals with maternity ward a baby-friendly policy might be established for the staff as well. Furthermore it is important to inform nurse manager and colleagues about the measures. Since they too benefit from an early return of skilled colleagues who breastfeed and less frequently make use of care leave.

Information: Provide counselling via in-house IBCLCs or in outpatient departments for breastfeeding during pregnancy or at any point during breastfeeding period. Free participation in the in-house breastfeeding preparatory course and written information about this possibility before start of maternity leave and after the return, which underlines a companie's family friendliness.

Time: Depending on the child's age and the mother's demand repeated pumping periods of about 20 min each might be necessary. These pumping periods are mostly easy to plan for the mother. Where applicable a child might be brought to the workplace for being breastfed.

Room: Mothers require privacy for breastfeeding. A lockable room equipped with table and seating option as well as access to electricity for the breast pump would be suitable. Multiple use, e.g. an office room, would be adequate. In the actual room or at least nearby a cleaning possibility for the hands and breast pumps should be available. Storage possibilities for breast milk (fridge, maybe cooling bag), pumps and the accessories are certainly easy to arrange.

BFHI and the Code - a Difficult Topic?

The Baby-friendly Hospital Initiative (BFHI) was launched by WHO and UNICEF in 1991 and was implemented in Germany since 1992; in 2000 it led to the foundation of the association to support WHO/UNICEF Baby-friendly Hospital Initiative. Author: Monika Jahnke

BDL is a member of this association and supports its objectives. More than 90 hospitals already gained the accreditation „Baby-friendly" and more than 40 are preparing for it in Germany.

This distinction is recognized and accepted in general public, meanwhile even paediatric clinics, pharmacies and doctor's surgeries aim for becoming Baby-friendly. A lot of improvements can since be recognized in breastfeeding promotion and bonding support. Consistent implementation of B.E.St. plays a key role in achieving this success. B.E.St. criteria also include abidance to the aforementioned Code.

Recognising the numerous positive aspects, nevertheless critical voices by the members come up that question individual decisions and therefore lead the executive board of the national association to deal with this topic and the competent institution. To be precise, it is about presenting advertising partners on websites of Baby-friendly initiative, although their product marketing in some cases does not conform to WHO Code any longer. This led to discussions during the congress „Hand in Hand" in Fulda, Germany. **"What about the Code compliance at BFHI Germany?"** Many of you are certainly aware of the content of the Code; for this reason only a short explanation of the most important criteria follows:

WHO Code of 1981 **aims** at regulating the **marketing** of breast milk substitutes, including bottles and teats. It is not about the products' manufacturing and usage. The Code applies to **all breast milk substitutes** offered for infants younger than six months. In addition it applies to products such as follow-up formula, tea, juice, and baby mash, in case they are used as breast milk substitutes. Furthermore it applies to **bottles** and **teats**. However, the Code doesn't include milk pumps and breastfeeding equipment.

Now, the question is: If contacts to advertising partners not abiding to the Code exist, how could agreements everyone would accept look like? For us, as the BDL, the Code's implementation is essential. That's why we directly after the member notification sprang into action and established contact to the executive board of Baby-friendly Initiative. We are fully aware of the importance of BFHI for breastfeeding promotion; at the same time the maintenance of the Code is highly essential.

Although there are no concrete results so far, we'd like to notify that the boards of Baby-friendly Initiative and of BDL will stay in contact in order to discuss the current situation and to find solutions for the future. The implementation of this balancing act is not easy, we'll stay on the ball and continue to report.

Monika Jahnke
first chairwoman of BDL

We Have Not Recertified – a Progress Report

Ten years of being a Baby-Friendly Hospital – ten years in which much has happened in our institution as well as in our environment. We accommodated ourselves to everything but, nevertheless, after ten years of being certified, it was suddenly over. What happened? Author: K.Meier, GKKP, IBCLC


Photo: iStock

Ten years ago; when we were certified for the first time, we were still a small, easily manageable maternity unit. After five years of certification, came the first upheaval: it was decided that the maternity unit of another hospital in the city should be relocated to our hospital. Two teams were thrown together, one of which had worked, up until then, according to BFHI guidelines and one of which had had, up to then, no experience with them. This move led to an increase in the birth rate in our hospital. The hurdles to continuing to work in a unified way and at a high level were tackled successfully, since we remained "baby friendly" for another five years. Right up to the present time, we work in an interdisciplinary way. Our team is comprised of midwives, postpartum and pediatric nurses as well as, currently, an IBCLC lactation consultant.

However, as we all know – unfortunately – many small hospitals today have scarcely any chance of survival. So that's what happened for the first time with a hospital in our region, which had only 400-450 births a year. They had to shut down their maternity unit, whereupon, our birth rate shot up even more. Furthermore, we got new personnel, partially from the hospital that was closed, which meant that they also had to be trained first. All of us who work in maternity know how much must be invested in order, in the best case, to be in the black. The financial situation and the insecurity about how it would all turn out was then, ultimately, the reason why the decision against recertifying was made. Over the course of this year in which we did not recertify, still another smaller maternity unit in the area closed, so that we were given a huge catchment area, including, furthermore, the only pediatric hospital.

When we did not recertify again, we still had an IBCLC lactation consultant in the hospital. Together with her, the team decided to continue working as before, despite the loss of our plaque. Amazingly this worked very well and, outside the hospital, the fact that we were no longer "baby friendly" got around only slowly or not at all. Up until now, three years later, there are still many people who think that we are still certified.

Unfortunately, a year after the non-recertification, our IBCLC lactation consultant left us for new tasks and challenges. This was clearly noticeable in our breastfeeding and supplementation rates. The level stayed steady for some months, but then a creeping change was noticed: the supplementation rate for the babies increased significantly, as did the way of supplementing, preferably with the bottle. However, what constantly increased was our birth rate. This and the loss of our "motivator" led to the situation that many people could sometimes scarcely manage the workload and the value of breastfeeding was disregarded more and more.

Almost a year later, a new and motivated IBCLC lactation consultant accepted the challenge of getting everything back on the right track. Meanwhile, we are a Perinatal Level 1 hospital, have around 2000 births a year and an affiliated pediatric hospital. It is not exactly taking a smooth


Photo: iStock

path that our IBCLC is treading.. A bumpy forest path with inclines and turnings that go back down into the valley, describes the path very aptly. One might think, that in a hospital that was once "baby-friendly", it would be easier, since the guidelines were once available and work was carried out in accordance with them, but humans are creatures of habit and when there is supposedly an easier way, then one happily chooses this way. We cannot reproach anyone here, for it is the same for all of us. There are a couple of colleagues in the team, who were always more skeptical and, for our IBCLC, this is, from time to time, a really hard nut to crack. However, there are also many in the team, who are happy that there is an IBCLC again and that she is taking the reins in her hand, clearing up work that has been left undone and seeing to it that the breastfeeding rate goes up again. Apart from the new appointment in breastfeeding counseling, there have also been changes at the management level. We have been given a new unit manager and also a new nursing service manager. Both of them are open and sympathetic about breastfeeding, which naturally makes the work of the IBCLC much easier.

After a short warm-up period, it was full steam ahead and the topic of breastfeeding was, once again, given significantly more weight in our hospital. Thus, I can report on the following positive changes: Our IBCLC was given one day a week in which she is made available only for breastfeeding counseling. Feedback from the patients shows that this is received very positively and is seen as an enrichment for our hospital.

Once a month, she offers a breastfeeding preparation evening for pregnant women on the premises of the hospital. Here, she has support with advertising in that she may distribute her flyer in the hospital and at delivery room evening, there is an announcement of the evening on the hospital homepage and a small article in the newspaper. In addition, she can use the rooms at no cost. The breastfeeding preparation evening is not a direct offering of the hospital itself, but both sides profit from each other, as do we colleagues on the unit if a woman has participated in the breastfeeding preparation evening. There is still a breastfeeding support group in our hospital which has long been a part of what we offer.

Furthermore, the hospital made financial means available so there could be qualified and competent continuing education to train the staff and bring everyone up to the same level of knowledge – which is generally known to provide quality assurance. Furthermore, the hospital approves generous attendance at external continuing education.

New staff, who also have the IBCLC qualification, will be hired and the hospital is making it possible for already-employed staff to complete the training for this. These are all good developments. It needs time and it only happens step by step, not in great leaps. Sometimes, we also have the feeling that we are taking one step forward and, shortly afterwards, two back, but that's how it is in life, sometimes. It is important not to give up and to have people in management positions who leave space for and strengthen them

We do not yet know where the road will ultimately lead, whether we will simply try to maintain a high standard without a certificate or whether the road will actually lead back to (re)certification as a Baby-Friendly Hospital. Time will tell.

Baby-friendly Hospital – Certification As a Profitable Process

More than 18 % of the births take place in Baby-friendly hospitals and birthing facilities. The number of certified hospitals increased more than tenfold to 90. Author: Stefanie Frank

Photo: Europäisches Institut für Stillen und Laktation

For several years now, German and Austrian birth figures are falling. For quite some time the fertility rate is only 1.4 %. In 2014 Germany occupied position 200 of 224 in global ranking; Austria was 201. Nowadays women systematically decide in which hospital they like to give birth to their child. Perinatal care by paediatricians in case of occurring difficulties often appears as one of the selection criteria. Intensive care - connected to the maternity hospital - increases the parents' sense of safety. Besides an increasing number of parents decides to have family-oriented birth assistance. Childbearing in a personal, intimate setting becomes more and more attractive. The birth of a child as a unique experience, which should consciously and respectfully be realised and accompanied.

In 1991 WHO and UNICEF launched the Baby-friendly Hospital Initiative (BFHI) and in 1992 it was implemented in Germany as well. In Germany the Initiative of WHO/UNICEF successfully established "Baby-friendly" as a quality certification. More than 18 % of the births take place in Baby-friendly hospitals and birthing facilities. Until today the number of certified hospitals increased more than tenfold to 90. The world's first paediatric clinic that was certified Baby-friendly is the Josephinchen in Berlin. In 2012 Ubbo-Emmius-Kinderklinik (paediatric clinic) in Aurich and in 2014 paediatric clinic of Städtisches Klinikum Solingen followed.

Baby-friendly hospitals put the **"Ten Steps to Successful Breastfeeding"** into practice. These ten steps form the basis of the **requirements catalogue** hospitals need to adhere to in order to gain certification. The hospitals can be recognized via the patented quality seal "Baby-friendly" as well as the award certificate with the Picasso drawing „Maternité".

In order to gain certification the whole hospital staff that works in maternity ward needs to receive training. Training covers 16 hours of theory and 3 hours of practice. The classes are based on the issues defined in a **catalogue of topics**. Focus, order, duration and learning objectives are determined by the hospital.[1]

For many years now the European Institute for Breastfeeding and Lactation offers training courses for hospitals. Already during days of classes a unique kind of team formation takes place. Often midwives, nurses, paediatric nurses, and even physicians share for the first time the same training course, which directly concerns and affects one's own working area. In the first place it is interesting to see at which points work fields differ – but above all, in which respect they overlap. These interfaces offer the best opportunities to change to a standardised baby and family friendly birth assistance. This prime goal leads to interdisciplinary cooperation that creates more appreciation for the other occupational category. In turn, mutual understanding results in an improved satisfaction of the employers. The working processes run more smoothly and interlock.

However, first of all there are obstacles to overcome. And strangely enough, every paediatric clinic has its own challenges. Some of them find it difficult to carry out bonding after caesarean section, others regard step 9 of the 10 steps ("Give no pacifiers or artificial nipples to breastfeeding infants") as particularly difficult to implement.

The road to baby-friendly hospital eventually presents itself as a process ending in standardised birth assistance. The satisfaction of the mothers increases due to constantly high quality of breastfeeding counselling and family friendly support. Focus of care lies on the child and its parents and their need for bonding and privacy.

But the accreditation is of advantage even for the staff. A lot of old frictions between the individual wards and even among colleagues may vanish. The readiness to follow a common approach strengthens the team spirit.

[1] www.babyfreundlich.org

Below you can find two experience reports after gaining certification.

St. Anna-Klinik, Bad Cannstatt

St. Anna-Klinik links its tradition of Christian family support with modern, safe and baby-friendly birth assistance in a comfortable atmosphere. It's already the 3rd generation of little Cannstatter inhabitants that is born in St. Anna-Klinik; nearly 1000 each year!

Bonding: Before achieving certification, we already considered skin contact after vaginal delivery as very important and worthy of support and in most cases it was put into practice. In the course of BFHI we improved this and made it even possible during operation of caesarean section. Having various disciplines like anaesthesiologists, surgical staff, and physicians working together appeared challenging: by providing information and conducting conversations across disciplines it was possible to convincingly demonstrate the meaningfulness of these changes. Regular further education was necessary to keep everyone equally informed.

Various concerns appeared: The child might fall from the operating table (anaesthesiologists), it might lose body heat (paediatrician), the midwife being present in the operating room but actually being needed in the delivery room.

By means of training the staff and informing everyone, including the mothers, we were able to convince and satisfy the mothers and parents. Adjustment problems of the infants decreased - since certification we could halve the rate of infants being transferred to the children's ward. Mothers are less stressed and notably more satisfied due to bonding and rooming-in.

Supplementary feeding: even before certification, supplementary feeding of glucose and water was not part of the routine. In the course of the certification (in preparation) supplementary feeding of formula (or sab simplex®...) could be reduced to medically indicated cases due to improved breastfeeding management, bonding right after delivery and breast massage for expressing colostrum. In the beginning there was friction with paediatrician and paediatric nurses about concerns regarding weight reduction as they weren't able to calm down nervous children and their parents.

As well as the gynaecologists, who liked to see the mothers have some rest by giving the infant supplementary food. By clarifying the topic to parents, staff and colleagues the situation improved throughout certification. We informed about rooming-in, skin-to-skin contact and babywearing as possibilities to calm the babies. Since being certified there are remarkably less crying babies in the hospital rooms.

No pacifiers or artificial nipples: Pacifiers could be banned rather quickly during certification, because the staff knew better and better how to calm down restless children – and how to pass this knowledge on to the mothers. In the beginning problems arose as mothers, who already had other children, took a pacifier along – in these cases we relied on consistent communication (i.a., how shall I explain to a mother with more than one child why we don't recommend using a pacifier, but that she might use it if she already breastfed two children – if there is another mother in an adjacent bed who has her first child and can overhear the whole conversation?)

The information of why and how the pacifier affects breastfeeding was learned and passed on to the new mothers by the staff; we again and again experienced communication problems.

The teamwork of the members of the various occupational categories significantly improved and the appreciation of the work of the maternity ward nurses increased. Making generalised recommendations was and is challenging but this challenge can repeatedly be overcome via ongoing training and education.

The mother's satisfaction is very high, especially if she has been informed about breastfeeding and bonding prior to delivery. This could be intensified since certification via the provision of information evenings and antenatal classes.

Besides we can tell that there is a demand of ongoing training and education in order to persistently highlight the importance of the ten steps, to keep on working on these and to debate problematic situations.

One of the major points is communication – among each other and with the women. Sometimes we face language difficulties – due to colleagues coming from different nations we currently recognise an improvement.

Dr. Gaby Kussmann

BARMHERZIGE BRÜDER
KONVENTHOSPITAL LINZ

Konventhospital der Barmherzigen Brüder, Linz

Konventhospital der Barmherzigen Brüder Linz received certification in May 2015. Each year our ward has 1700 deliveries. Our project period lasted for 2 years in which the already implemented measures were improved and some new points were realised.

Before we achieved certification, uninterrupted skin-to-skin contact of mother and child after delivery and rooming-in were already part of the ward's daily practice. Within the first 2 hours after delivery the mothers stay in delivery room. During this time the infant breastfeeds for the first time or – if the infant is too weak to suck – colostrum will be expressed. Not till then the infant is being weighed and measured.

Bonding after caesarean section is a new aspect implemented since certification period. This adjustment required interdisciplinary communication with the aneasthesiologists (why do we do that? What is it for? Which doubts are there? How and under what circumstances can bonding be carried out in the operating room?). Since it is part of daily and well-functioning routine that the baby is allowed to cuddle on its mother's breast, this measure is not being questioned and immediately accepted by new colleagues.

Step 6 required further interdisciplinary exchange. Our paediatric ward is co-managed by the paediatricians of the directly adjacent Krankenhaus der Barmherzigen Schwestern Linz. Here again, a lot of interdisciplinary exchange was needed until we reached satisfying solutions regarding weight limits and manner of supplementary feeding. The reorientation regarding the change from bottle feeding to supplementary feeding using feeding-tubes ›

or similar devices directly at the mother's breast, was a new experience for everyone and first of all needed to be proven as realisable.

Since start of certification period pacifiers don't exist any longer. Mothers are being informed about the negative impact of artificial nipples at the beginning of breastfeeding attempts; if they nevertheless insist on using pacifiers they need to get one by themselves.

Overall, during certification period we experienced a very intensive but at the same time team strengthening time, since everyone needed to act in concert and it was really nice to see how even sceptical colleagues were brought in.

Of course there are critical voices as well. Supplementary feeding during the first days until breast milk comes in appears unmistakeably to be subject of fierce debate. Here, personal individual experience again and again shows that a singular bottle feeding calms mother and baby and that exclusive breastfeeding for months is nevertheless possible. Especially during tense nights this topic is highly present to the nursing staff and argumentation sometimes appears rather difficult ("My first child achieved a bottle in the second night; after that it slept peacefully and I nevertheless exclusively breastfed for 6 months!").

After this short amount of time, the mother's satisfaction is rather difficult to assess. Good quality is at all times and at all places expected to be the norm. Unfortunately we again and again receive negative acknowledgement (compulsory breastfeeding, my child wasn't bottle fed, ...), that don't really convince the management that BFHI certification is something positive and quality improving!

Dr. Gudrun Böhm, IBCLC

Stefanie Frank
family-paediatric nurse, IBCLC
Lecturer for the European Institute for Breastfeeding & Lactation

The International Code of Marketing of Breastmilk Substitutes as a Guarantor for the Protection of Breastfeeding:

In 1981, the International Code of Marketing of Breast-Milk Substitutes was adopted by the WHO and all member states are urged to incorporate this minimum standard completely into their national laws. Andrea Hemmelmayr, DGKS, IBCLC

The goal of the Code is to ensure safe and appropriate nutrition for infants through...

- ... the protection and promotion of breastfeeding
- ... provision for proper use of appropriate breastmilk substitutes when these are necessary
- ... suitable marketing and distribution of infant feeding products

All products, which are offered as a substitute for mother's milk or promote the use of infant formula, fall within the scope of this Code. Among these are: infant formula (first milk and follow-on formula, hypoallergenic formula, anti-reflux formula, anti-colic formula, soy formula -, simply put, all milks marketed for infants), other milk products (i.e. milk porridge), teas, baby water, juices, complementary food products, bottles and teats). Based on the world-wide WHO health recommendations, these rules apply to all products which are intended for feeding infants before six months or still better up to the end of the second year of life.

The Code does not forbid the sale of the products mentioned, but imposes strict regulations for all promotional measures. The health care system in particular should NOT be used as an access road for advertising.

Is the Code outdated?

Every two years, the WHO Director General reports to the WHA (World Health Assembly), "on the status of the implementation of the Code". The WHA makes an effort to keep up with the newest developments even 34 years after the publication of the Code by publishing subsequent relevant resolutions and reports on it, notably in 1986, 1994, 1996, 2001, 2002, 2005, 2006, 2008, 2010, 2011, 2013 and 2014. There are only very few bodies of law, which are evaluated, reviewed and amended with such frequency.

Find IBCLCs in your country

http://www.elacta.eu/en/europakarte.html

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Ten Steps to Successful Breastfeeding

Every facility providing maternity services and care for 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 half an 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 breast milk**, unless medically indicated.
7›	**Practise rooming-in** - that is, 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.

Source: Protecting, Promoting and Supporting Breastfeeding: The Special Role of Maternity Services, a joint WHO/UNICEF statement published by the World Health Organization.

Breastfeeding with pleasure – IBCLCs can assist you


Foto: Karl Grabherr


Foto: Fischerlehner


Foto: Fischerlehner


Foto: Bogensperger

IBCLCs ...

- help mothers to develop skills and techniques so breastfeeding can go well, right from the start
- advise and provide support for mothers – from the pregnancy throughout the entire breastfeeding period and even beyond weaning
- support mothers with special challenges, after Cesarean section, with premature or ill babies, with multiples, with maternal illnesses, with the return to work
- help mother and baby with breastfeeding problems
- support women who decide to wean
- support women to achieve their own goals and experience breastfeeding positively
- contribute to the health of women and babies and lower health care costs.

Contact your IBCLC

Contact data

IBCLC

International Board Certified Lactation Consultants are the only internationally recognized specialists for breastfeeding and lactation with a medical background.

The decision to breastfeed or not breastfeed has short- and long-term effects on the health of the child and the mother. However, breastfeeding is not always easy and may possibly require professional, expert support.

Latest News on the ELACTA Congress in 2016:

The programme for the Elacta Congress 2016 in Athens is taking on concrete shape. From this autumn on you will receive information concerning the main programme and you will be able to register online on our homepage. Without giving away too much, we have succeeded in reducing the admission fees in comparison with the previous congresses despite highly-qualified speakers and interesting topics

You are invited to get actively involved in the congress in Athens:

Apart from international presenters in the main hall we offer the opportunity for participants of presenting and discussing their own knowledge and work on Friday, May 13th and thus get actively involved in the congress. Likewise you will be given the chance of a poster presentation. The language of the congress is English. Unfortunately it is not possible to offer simultaneous translation of the submitted lectures. The submission deadline is December 31st, 2015. The selection of the lectures will be completed until March 1st. The guidelines for the submission of abstracts can be found on our website www.elacta.eu.

The location of the Congress: Titania Hotel in the centre of Athens.

Titania Hotel is located on Panepistimiou Avenue, right in the heart of the historical and commercial centre of Athens, between Syntagma und Omonia, the major squares in Athens. The recently renovated hotel is setting a landmark in the tradition of hospitality. It is surrounded by the most important historical and cultural monuments (such as Acropolis, the Archeological Museum, the University of Athens, the National Library and the Parliament) as well as by modern shops and businesses. The location of the congress hotel offers the participants a variety of sights and entertainment possibilities in direct vicinity. Titania Hotel is easy to reach for both foreign visitor and Greek participants due to its direct Underground connection to the airport, port and train station.

Apart from the congress hotel you can find numerous accommodations in Athens in all price categories.

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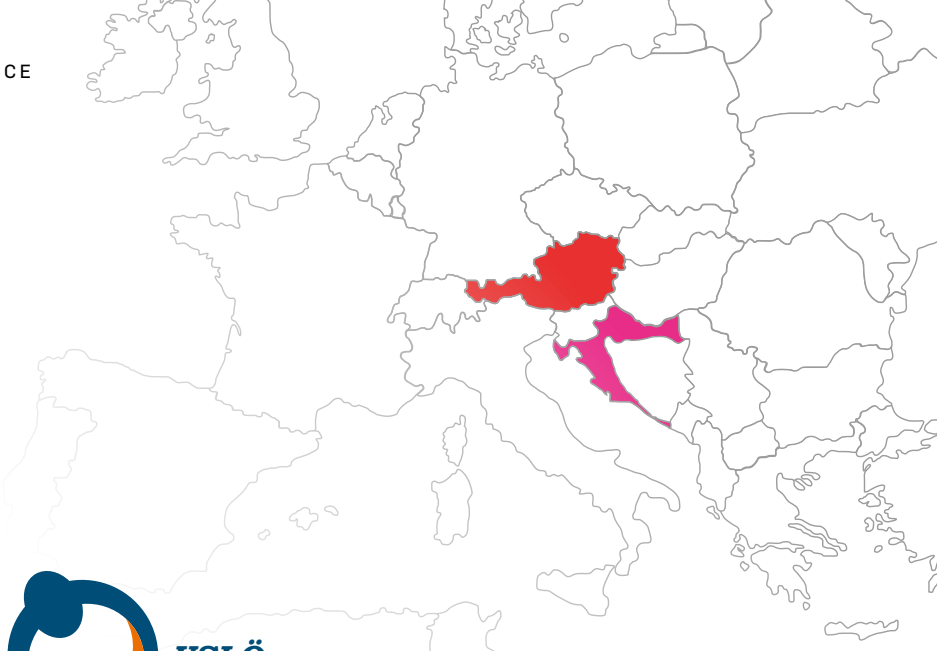


CROATIAN ASSOCIATION OF
LACTATION
CONSULTANTS

VSLÖ
Verband der Still- und
LaktationsberaterInnen
Österreichs IBCLC

News From VSLÖ (Austrian Association of Lactation Consultants (IBCLC)

This year the **Croatian Association of Lactation Consultants** will be organising its third, annual **'Croatian Breastfeeding Symposium'** which will be held on **1st October, 2015** at the Sisters of Mercy Hospital, Zagreb.

The topic of this year's Symposium is **'Breastfeeding- the basis of healthy habits'**. Our special guest will be **Gill Rapley**, from the UK, author of the popular book **'Baby-led weaning'**. Gill will be presenting the work from her recently completed doctoral thesis and will cover topics including 'What is Baby-led weaning?', 'Advantages of Baby-led weaning' and 'Practical aspects of Baby-led weaning'.

Other presentations will include: 'The role of breastfeeding in building a healthy microbiome', 'The role of volunteer breastfeeding counsellors on a postnatal ward', 'The World Breastfeeding Trends Initiative' and 'The challenges of on-line breastfeeding counselling'.

In the afternoon, three parallel workshops will be offered covering: 'The use of breastfeeding aids', 'Breastfeeding techniques' and 'Alternative baby-friendly feeding methods'. These workshops will be lead by experienced nurses/IBCLCs who will provide 'hands-on' opportunities for participants.

All morning sessions will be **simultaneously translated** into Croatian and English. For further information please contact Banana Kunina at banana.kunina@gmail.com.

KISS Task Force

Titular Professor, Dr. Daniela Karall, IBCLC is a new member of the KISS1 Task Force of the Austrian National Nutrition Commission (NEK). The recommendation for a permanent appointment was agreed to unanimously. The VSLÖ is very pleased that, thereby, a high level expert now represents the VSLÖ in this body of the Federal Health Ministry, which develops the official recommendations for Austria to improve the nutrition of pregnant and breastfeeding women and small children.

BFHI in Austria

The Austrian Network of Health-Promoting Hospitals and Health Care Facilities (ONGKG) is in charge of the Baby-Friendly Hospital Initiative in Austria. Currently there are 15 BFHI-certified hospitals in Austria. Newcomers are the Bregenz Regional Hospital and the Brothers of Charity Hospital in Linz. We congratulate them on their certification! Furthermore, the VSLÖ is pleased that Dr. Ingrid Zittera, IBCLC from Lienz and Iris Wagnsonner, M.A. Nutrition, Breastfeeding and Management Consultant from Linz are the new spokeswomen for BFHI Austria

World Breastfeeding Week 2015

The VSLÖ, together with the Austrian Midwives Committee, is developing and financing a poster and an information sheet for World Breastfeeding Week on the topic "When Maternity Leave is Over – Breastfeeding and Working – Together it Works!"

TRANSLATOR'S COMMENT (ELIZABETH HORMANN)
At the beginning of this year, the International Breastfeeding Journal (IBJ) published an article on BFHI in Austria by researchers on the Health Promotion Research team at the Ludwig Boltzmann Gesellschaft in Vienna: Wieczorek et al. International Breastfeeding Journal (2015) 10:3 DOI 10.1186/s13006-015-0030-0 "The bumpy road to implementing the Baby-Friendly Hospital Initiative in Austria: A qualitative study".

It can be downloaded at www.internationalbreastfeedingjournal.com/content/pdf/s13006-015-0030-0.pdf

[1] Kinder, Stillende, Schwangere (Children, Breastfeeding Mothers, Pregnant Women)

Breastfeeding And Childhood Leukemia Incidence: A Meta-analysis And Systematic Review

Amitay EL, Keinan-Boker L

Importance:
Childhood cancer is a leading cause of mortality among children and adolescents in the developed world and the incidence increases by 0.9 % each year. Leukemia accounts for about 30 % of all childhood cancer but its etiology is still mostly unknown.

Objective:
To conduct a meta-analysis of available scientific evidence on the association between breastfeeding and childhood leukemia.

Data Sources:
A thorough search for articles published between January 1960 and December 2014 researching the association between breastfeeding and childhood leukemia was conducted on PubMed, the Cochrane Library, and Scopus (performed in July and December 2014), supplemented by manual searches of reference lists.

Study Selection:
To be included in the meta-analyses, studies had to be case control; include breastfeeding as a measured exposure and leukemia as a measured outcome; include data on breastfeeding duration in months; and be published in a peer-reviewed journal with full text available in English.

Data Extraction and Synthesis:
The search identified 25 relevant studies, 18 of which met all inclusion criteria. No publication bias or heterogeneity among these 18 studies were detected. The quality of each study that met the inclusion criteria was assessed using the Newcastle-Ottawa Scale. Multiple meta-analyses were conducted using the random effect model on raw data in the StatsDirect statistical program.

Main Outcomes and Measures:
No or short duration of breastfeeding and the incidence of childhood leukemia.

Results:
The meta-analysis of all 18 studies indicated that compared with no or shorter breastfeeding, any breastfeeding for 6 months or longer was associated with a 19 % lower risk for childhood leukemia (odds ratio, 0.81; 95 % CI, 0.73-0.89). A separate meta-analysis of 15 studies indicated that ever breastfed compared with never breastfed was associated with an 11 % lower risk for childhood leukemia (odds ratio, 0.89; 95 % CI, 0.84-0.94), although the definition of never breastfed differed between studies. All meta-analyses of subgroups of the 18 studies showed similar associations. Based on current meta-analyses results, 14 % to 19 % of all childhood leukemia cases may be prevented by breastfeeding for 6 months or more.

Conclusions and Relevance:
Breastfeeding is a highly accessible, low-cost public health measure. This meta-analysis that included studies not featured in previous meta-analyses on the subject indicates that promoting breastfeeding for 6 months or more may help lower childhood leukemia incidence, in addition to its other health benefits for children and mothers.

SOURCE

› JAMA Pediatr. 2015 Jun 1;169(6):e151025. doi: 10.1001/jamapediatrics.2015.1025. Epub 2015 Jun 1.

KEY WORDS:

› Breastfeeding

› childhood leukemia

COMMENTS BY MÁRTA GUÒTH-GUMBERGER, IBCLC:
The increasing incidence of cancers in childhood is shocking. The meta-analysis comes to a clear conclusion on the protective effect of breastfeeding, although the definition of breastfeeding was not clear and no distinction between partial breastfeeding and exclusive breastfeeding was made. If exclusive breastfeeding were taken into account, the difference should be even more strongly pronounced.

The meta-analysis also makes a clear deduction and recommends breastfeeding promotion as a cost-effective preventive measure. The reality, however, is, on the one hand, that leukemia treatment is very expensive but, on the other hand, breastfeeding counseling by midwives is only covered to a limited degree by the health insurance. Counseling by an IBCLC is not covered. Continuing education for IBCLCs, as well as breastfeeding support groups, and the preparation for BFHI certification are also not supported financially.

It is also a reality that some pediatricians still tell mothers that breastfeeding has no more value after six months, and that full compliance with the WHO Code of Marketing of Breast-Milk Substitutes in not a national law in any German-speaking country.

Against this background, this article is an important contribution to the efforts for getting coverage of the costs of IBCLC counseling. It would be preferable if the formulation were that not-breastfeeding and, thereby, feeding with breast-milk substitutes, leads to a 14-19 % higher incidence of leukemia in childhood

Protective Effects of Breastfeeding Against Breast Cancer

What makes breastfeeding and its support important items even for oncologic sections.

Based on a lecture of Dr. Fedro Peccatori; Elke Cramer

Any woman should be informed about health effects of reproductive behavior, like breastfeeding, and decide, of course, autonomously."

Beside unchangeable risk factors for breast cancer, as gender, age, genetic risk factors, family and personal history of breast cancer, menstrual periods and dense breast tissue, there are the wellknown changeable ones: alcohol use, obesity, exercise and parity.

But there is one more factor, so far not adequately concerned: breastfeeding.

Fedro Peccatori, MD PhD from the division of Gynecologic Oncology at the European Institute of Oncology in Milan, Italy pointed out the protective effect of breastfeeding on the lifelong risk for breast cancer in his lecture at the BDL/EISL conference in Fulda on 24th of April 2015.

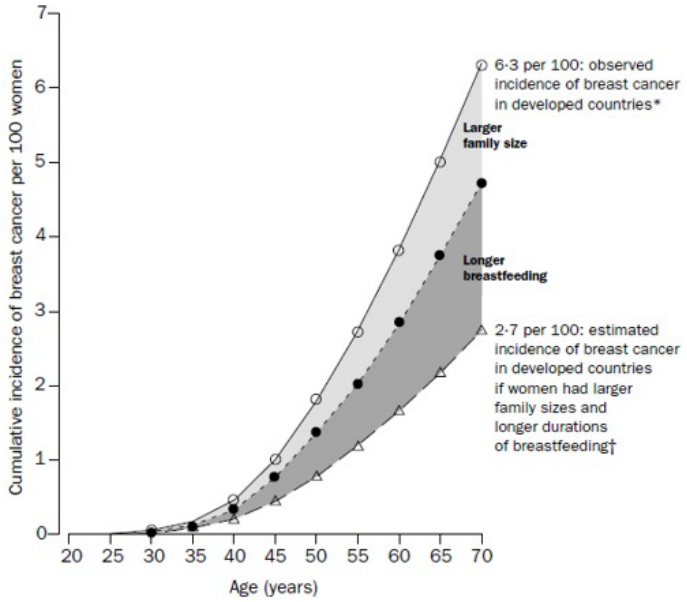
It is not easy to acquire big data about breastfeeding and cancer. Mainly because breastfeeding is not a yes or no. In many studies it is just ever or never, which only gives some hints but not the full figure. Besides the effect of breastfeeding is confounded by the effect of pregnancy. Of course you can have a pregnancy without breastfeeding, but usually you cannot breastfeed unless you have had a pregnancy. So the two effects come together and somehow they confound one another.

In the last fifteen years four meta-analysis of good quality were conducted. The first, published in 2000, is a meta-analysis of 23 case-control studies which includes about 26,000 cases affected by breast cancer and nearly 45,000 not affected controls. If we pool together all these studies, having ever breastfed gives an overall risk of 0.84, which means that women having breastfed have a 16 % less risk of getting breast cancer.

The interesting point which makes these data more robust is that the protection in terms of incidents increases according to the breastfeeding duration. Thus, if women breastfed for more than 12 months the risk was 0.72 - which means a risk reduction of 28 %.

The second study is a collaborative reanalysis of 47 epidemiological case-control studies with about 50,000 cases affected by breast cancer and almost 100,000 non-affected. The data were presented in the following way: How much is the reduction in terms of breast cancer incidents for every 12 months of breastfeeding? The relative risk of breast cancer decreased by 4.3 % for every year of breastfeeding in addition to a decrease of 7 % for each birth. And again there is the consistency: A longer lifetime duration of breastfeeding is associated with a higher protection.

Furthermore a simulation was conducted : What would happen if women changed their reproductive habits, so if they passed from 2.5 to 6.5 births and from 8.7 to 24 months of breastfeeding. As a consequence the incidence for breast cancer would drop from 6.3 % to 2.7 %. So there could be a huge impact from the change of habits.



*Cumulative incidence of breast cancer typical for women in developed countries around 1990;[1,4,52] †estimated incidence of breast cancer in developed countries if women had, on average, 6·5 births instead of 2·5, and if women breastfed each child, on average, for 24 months instead of a lifetime mean of 8·7 months; such values have been typical of developing and developed countries until recently.[53,54]

In the third meta-analysis they correlated the ER and PR status of breast cancer with pregnancy and breastfeeding. Breast cancer is not a single disease. In contrast there are many diseases because there are many disease presentations. But the determinant that really makes the difference is the expression of estrogen and progesterone receptor on breast cancer cells. And usually the ER and PRnegative breast cancer is the one more aggressive and the one to affect especially younger women. So it is important to see if pregnancy and breastfeeding change or protect differently these two different kinds of breast cancer. What was found from this meta-analysis published in 2006 is that while pregnancy protects much more against the ER-positive breast tumors, breastfeeding has a slight protection both against ER-positive and ER-negative tumors.

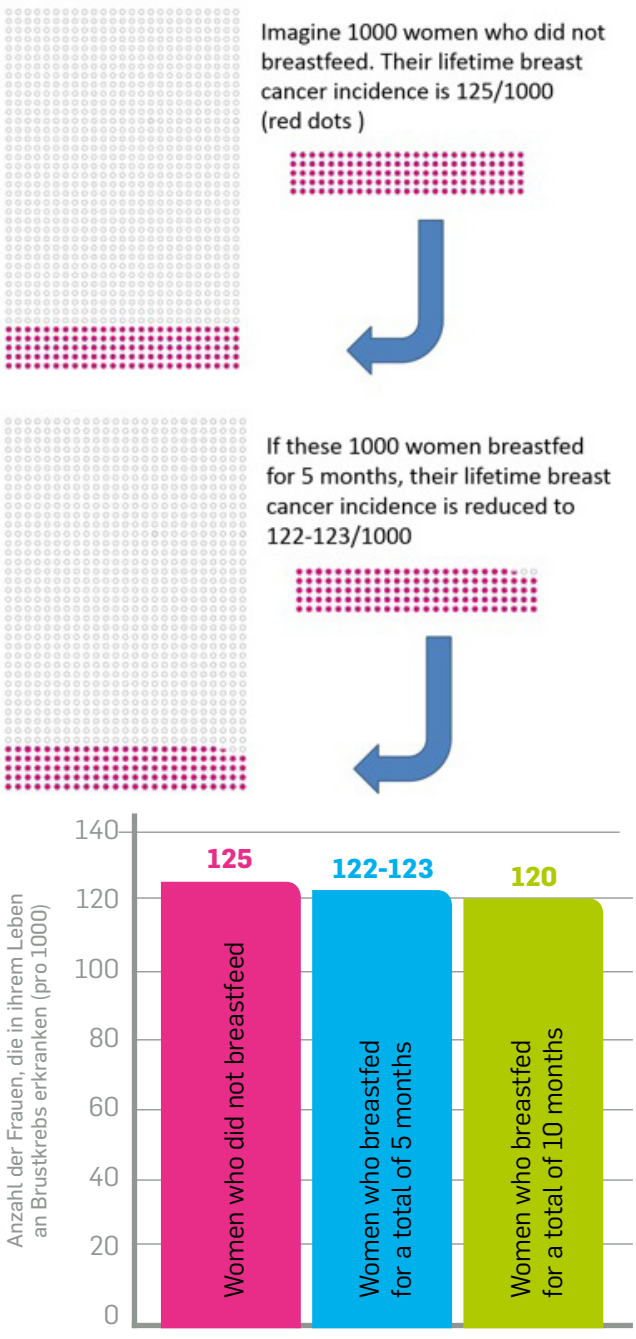
So it is important to notice that pregnancy and breastfeeding have probably different effects in terms of breast cancer protection: each birth reduced the risk of ER/PR-positive breast cancer by 11 % but breastfeeding reduced the relative risks of both ER/PR-positive and ER/PR-negative breast cancer by 5 % and 9 %.

The forth study is especially interesting because it looks at young women from 40 to 49. Breast cancer in these women is usually more advanced because there are no screening programs for young breast cancer women. Having ever breastfed was associated with a RR of 0.87 and again breastfeeding for more than twelve months was associated with a higher risk reduction 0.97 vs 0.85 (<12 months vs.12 months).

A study with Data from 2012 from the United States, Canada and Australia included about 4,000 women with breast cancer and nearly 3,000 population-based controls. The results indicated that having three or more children without breast feeding was as-

sociated with an increased risk for ER/PR-negative breast cancer (OR 1.57), however this association vanished if women breastfed (OR 0.93).

It may seem that the risk reduction for breast cancer by breastfeeding is just a small effect but if we think of the numbers of breast cancer patients this may make the difference:

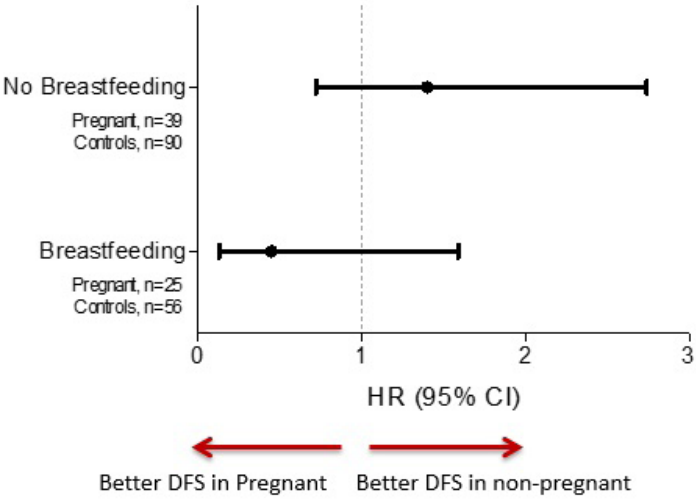


So 5 women out of 1000 would be spared in breast cancer appearance.

There are two special situations: The first one includes BRCA 1 and BRCA 2 mutation. As an example there is Angelina Jolie: She was very scared and worried about what she could do to reduce her risk. She had an amputation because she is a BRCA 1 mutation carrier, her mother died of ovarian cancer and her grandmother of breast cancer. These two gens are involved in DNA repair, are autosomally transmitted and are associated with a higher incidence of breast and ovarian cancer (70-80 % lifetime risk for breast cancer and 50 % life time risk for ovarian cancer).

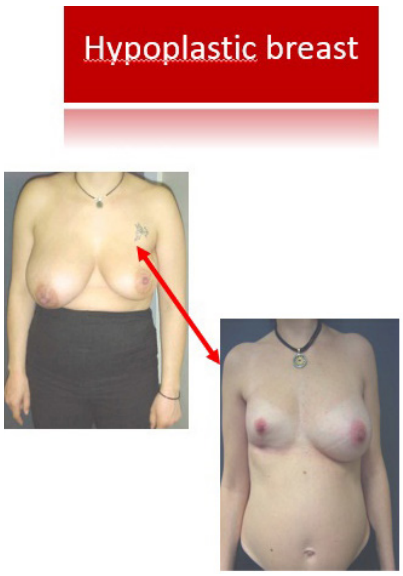
The good news is that for women with BRCA 1 mutation breastfeeding induces a significant reduction in breast cancer risk – OR 0.68 when breastfeeding for at least one year and almost 50 % for two or more years of breastfeeding. Thus counselling of these healthy women, not yet affected by cancer, should include that if they have children they should breastfeed them over a long period of time, as this is protective.

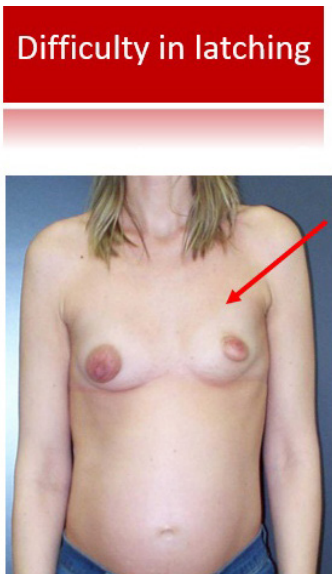
The second special situation includes breastfeeding after breast cancer. In 2013 Data were published about the effect of pregnancy after breast cancer and they showed that patients who breastfed after having had a pregnancy after breast cancer had a better prognosis. So apparently there is a protective effect of breastfeeding for these women who already suffered from breast cancer..



Concerning the feasibility of breastfeeding a study in 2010 looked at about 20 breast cancer survivors to know if they even considered the possibility of breastfeeding. And out of these 20 patients 10 attempted to breastfeed. Of these 10 who breastfed 4 had a just short period of breastfeeding, just within one month, 2 for mastitis and 2 for reduced milk production. Usually when there is a reduced milk production it is because the breast has not been stimulated in the right way and the woman has not been assisted in the right way. And of these 10 women 6 who breastfed for a long duration – 11 months of median duration – 5 of these 6 had a good breastfeeding counselling.

This shows the importance of early counselling for a successful breastfeeding, starting from the beginning just after delivery. Counselling is important for these patients because indeed they have problems. Even if they get conserving surgery like quadrantectomy the radiated breast does not produce milk, it remains hypoplastic during pregnancy and is probably fibrotic because of the radiation therapy the woman received. ›





Feasibility of breastfeeding from ipsilateral breast

Latching can be very difficult for a baby. And there are the uncertainties which were the main causes for women not to breastfeed. So, let us focus on the chances of a proper counselling.

There are many theories – not really one reason for the protective effect of breastfeeding. One possibility is that there is a differentiation of the breast tissue, pregnancy induces it but breastfeeding induces terminal differentiation. And this change is somehow protective.

The second reason is that prolonged breastfeeding is associated with amenorrhoea which means low estrogen levels. This is probably associated with lower levels of intramammary carcinogen levels.

And the last reason is that prolonged breastfeeding which is usually associated with "natural", not abrupt, weaning, is also associated with lower intramammary inflammation. And it is known that inflammation is another important risk factor for developing any kind of cancer including breast cancer.

So as a conclusion: by huge numbers of breast cancer even a slight reduction could have a significant impact on public health. Mothers should be at least informed about the breast cancer reduction due to breastfeeding and the risks of not breastfeeding should be minimized.

Especially in women harboring a BRCA 1 mutation prolonged breastfeeding significantly reduces breast cancer incidence: 32 % risk reduction for one year of breastfeeding and 49 % for two or more years.

Women – especially those with a high genetic breast cancer risk - should be informed about these facts in the hospital's oncologic section. This should be joined by a babyfriendly maternity ward, where these women receive a proper counselling for breastfeeding success during pregnancy and after birth.

Elke Cramer
Gynaecologist and IBCLC

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