Lactation & Breastfeeding

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EDITORIAL

Dear members, dear readers,

the legislative term of the ELACTA Board is drawing towards a close. Question are arising what has been done, what has been achieved and what remains to be done in the remaining half year, what has to be postponed to the next period. Needless to say that a fresh breeze is always needed. In this sense please heed our "Call for Board Members" and get in touch with the national organisation of your home country or with the ELACTA Board in case you are interested.

In the last few months Europe has been emotionally touched by the refugee crisis above all. Just at the right time our issue 2/2015 was dealing with this topic. A special treat was and has been our hand-drawn handout, which we are able to offer in 17 languages (situation October 2015). We are striving to improve it and are looking forward to receiving translations for additional languages. Please visit our website www.elacta.eu. Under the menu item "magazinel" you will find under the subitem "downloads" next to all the other useful handouts this practical aid.

Apart from that you can find information and possibilities for registration for the ELACTA/GALAXIAS Breastfeeding Congress 2016 in Athens.

ELACTA is a transnational, interesting and exciting network, that´s why we have succeeded in addition to our last issue with the stress on BFHI, in raising and contrasting the situation of BFHI in 11 different European countries. Only by looking at this list the variety of breastfeeding support in Europe becomes evident, but also how important it would be to embed and coordinate breastfeeding as a kind of health prevention more effectively in the EU.

This issue deals with immensely controversial topics in breastfeeding support – we are already looking forward to the discussions like e.g.:

› A professorship in mother´s milk research in medicine will surely provide us with the latest pieces of information in the years to come. The professorship is financed by a private foundation. Even though the foundation trustee Michael Larsson strengthens that the university has full freedom of research as well as academic freedom a potential conflict in interests cannot be denied.

› Nipple shields – an every-day aid. Dr. Beate Pietschnig is examining the question whether nipple shields can have an impact on the duration of breastfeeding.

› Sharing breastmilk: regarded by some as a retrograde step into times long past. Is there a way of ensuring this actual community of women and mothers´ solidarity is solid enough, so that more children whose mothers can either not supply them sufficiently with breast milk or not all, can be fed with breast milk.

› Breastfeeding support in medical practice – three German female gynaecologists are providing information as to how the expectations of young mothers can hardly be fulfilled in daily practice.

I wish you a thrilling read

Andrea Hemmelmayr, IBCLC
President of ELACTA

IMPRINT

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Dear readers! We want to know what you think. Please send your letters and comments to the following email address:
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Contents

Obstacles in doctor's breastfeeding support:

Just individually perceived or real?

Elke Cramer, IBCLC, Dr. med. Alexandra Glaß, IBCLC und Jeanette Vocht, IBCLC

Regarding the situation of the patient during consultation hour of her gynaecologist wishing to breastfeed or having breastfeeding difficulties, data that have been collected by BDL in cooperation with University Osnabrück (research topic Maternal and Child Health in 2010) accounted for the starting point: There is a discrepancy between the woman's wish of being advised - 48.5 % of the respondents consider breastfeeding consultation in the gynaecologist's practice as important - and the reality: Only 18.3 % of the female respondents stated in the poll that they actually received breastfeeding counselling.

According to the BDL survey 60 % of the women who didn't receive advise would have wished for it. Apparently they don't take the initiative and ask for advice. Thus they don't signal that there is an existing demand and the gynaecologist might reason that the pregnant or breastfeeding patient is already sufficiently informed. If the gynaecologist instead actively offers to talk by asking open questions and revealing particular needs, the short amount of time during consultation hour could be used in an optimal way: specific information could be given and solution strategies could be offered: Whereas the employed patient probably worries about compatibility of breastfeeding and employment, the patient having her second child has maybe made negative experiences during the preceding breastfeeding period.

2004 American data showed that 39 % of the mothers regarded their gynaecologist's advice as important, whereas only 8 % of the gynaecologists were conscious of this influence. Whereas 91 % of the gynaecologists stated that they always ask the mothers if they want to carry on breastfeeding after getting back to work, only 55 % of the mothers confirmed that this topic was discussed.[1]

There is obviously a problem of communication between gynaecologist and the mother(-to-be) and even more: This affects breastfeeding behaviour. Data from 2003 show that six weeks after delivery, 70 % of the mothers breastfed who believed their gynaecologist recommends breastfeeding. Of those women who believed their gynaecologist doesn't have a preference, only 54 % breastfed. Which indicators does a woman use to guess which preference her gynaecologist has, if the gynaecologist doesn't actively talk about breastfeeding? One clue gives the AAFP's (American Academy of Family Physicians) position paper on support for breastfeeding in 2014, because as "general practitioner for women" the gynaecologist reaches mothers as well as in many cases the grandmothers(-to-be): In this paper the US American general practitioners are called on establishing a breastfeeding friendly atmosphere in their practice; texts and pictures should illustrate breastfeeding as the natural and best nutrition for babies.

What reasons are there for gynaecologists in Germany not to meet the existing demand of their patients?

First of all gynaecologists experience a conflict: Their medical service before, during and after pregnancy is limited to the

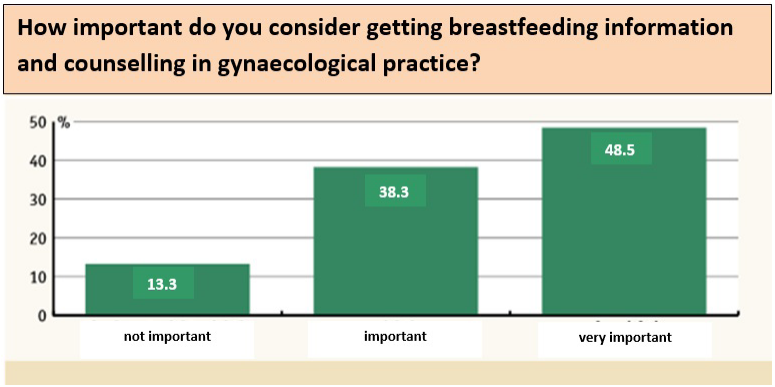

Fig. 1: Nearly half of those surveyed regarded breastfeeding counselling in gyneaecological practice as very important.

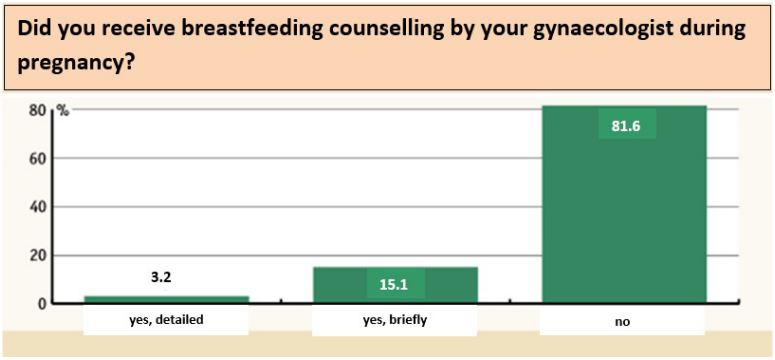

Fig. 2: Only a few women stated that they received breastfeeding counselling in gynaecological practice.

Source: Frauenarzt 52 (2011) Nr. 9 Stillberatung als wichtiger Teil der Schwangerenvorsorge, B. Borrmann, E. Cramer, M. Steffens

[1] Mothers' and Clinicians' Perspectives on Breastfeeding Counselling During Routine Preventive Visits, Taveras et al. Pediatrics Vol. 113 No- 5 May 2004

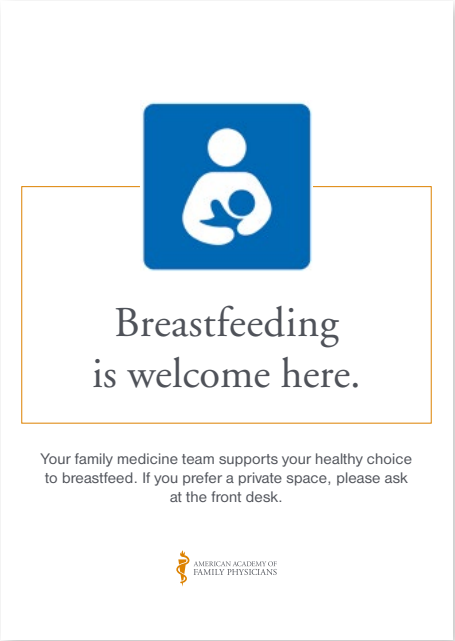

Fig. 3:
Waiting room poster of the AAFP

breast's pathology and is hardly able to strengthen the mother's confidence in her own body.

In gynaecological practice this can particularly be observed in the following situations:

We *are aware* that it is important to inform the mothers about breastfeeding before and during pregnancy. *In reality* no conversation about breastfeeding is scheduled during check-up and it wouldn't be reimbursed. During puerperal examination, 6-8 weeks post-partum, breastfeeding counselling is often too late; at this time many mothers already fed supplementary formula or weaned, often due to lack of support.

We *know* that breastfeeding counselling takes time. *In reality*, if there is pressure of time in practice, every patient needs to be dealt with in only 10 minutes in order to work economically. As a general rule health insurance companies quarterly pay a flat rate; multiple attendances of one patient are not "profitable". A good and in-depth consultation is for the most part "unsalaried".

Basic and advanced trainings cost time, which is not adequately reimbursed in the specialist's accounting system - the same applies to the professional counselling of women wishing to breastfeed or having difficulties with breastfeeding. There is no billing code for breastfeeding in the doctor's scale of medical fees. Below 20 € the gynaecologist is able to bill all visits of the same patient in the same trimester on the account of the health insurance company (billing numbers 08211 and 08220 as surcharge to the gynaecologist's basic service). The additional number 01770 for caring for the pregnant woman during one trimester can only be charged by one statutory health insurance physician; even if more than one physician take part in the attendance, either in case of an emergency, by proxy, or because of supplementary or aftertreatment. If this number can also be charged in the subsequent trimester after delivery for breastfeeding difficulties, mastitis or involution problems, the reimbursement of nearly 100 € can only be charged by the first physician in legally permissible period. There is legally bond duty to check the account data for plausibility and to take recourse against the second billing physician. In order to be paid at all, the second doctor therefore would have to let the counselled patient sign a statement that she would pay him in case of recourse. Health system in Germany offers quarterly at most 120 € for a comprehensive counselling of patients who would like to breastfeed by a specially trained physician; that means there is no financial incentive for gynaecologists to study further and specialise in lactation medicine. Furthermore, expert advice - both in advance and for concrete breastfeeding hindrances - costs time, which is not possible to take during daily consultation hours and almost non-existing reimbursement.

It is a balancing act between knowledge and reality, but we can find reasonable compromise:

During cancer check-up we can - in line with the scheduled examination of the breast and instruction of self-examination - inform the women about construction and function of the breast and inform them about the breast changes that take place during pregnancy and lactation period respectively.

In line with the three ultrasound examinations we can involve the father, who is often present, and try to bring up breastfeeding issues, e.g. if we observe the child sucking its thumb or swallowing.

Prenatal it is possible to send the pregnant woman to maternity hospital, using billing number 01780. Firstly for planning of the birth with risk factors (history of sectio, macrosomia, breech presentation, gemini...) including examination and ultrasound, but as well to antenatal talk without ultrasound if there are no risk factors. When we refer our patients to hospital we can sensitise the pregnant women to enquire routines in maternity ward and post-natal unit and to check their breastfeeding friendliness.

In hospital we have similar areas of conflict as well:

Some of the women coming for delivery didn't attend antenatal classes and are not informed about the procedure in maternity ward and post-natal unit.

It is helpful to broach the course of events already during pregnancy while visiting the maternity ward, during information evenings or in-patient stay by specially trained midwives, nurses and physicians; in practice there is not enough time.

In maternity ward, the doctor's contribution to support breastfeeding and bonding is little; it is usually limited to encouraging interest and not interrupting intimacy.

In antenatal unit we *know* that during ward round doctor's explanations and suggestions regarding breastfeeding can considerably contribute to the acceptance and implementation of the nurses' and midwives' suggestions.

In reality there is not much time during ward round ("healthy women and healthy children").

The only compromise we can currently find is to accept that doctor's breastfeeding counselling at post-natal unit is mostly "unsalaried".

We were happy about meanwhile getting a procedure code for the comprehensive breastfeeding counselling in line with the "delivery case", which can be ›

› encoded if the woman receives two or more hours of counselling (whoever does the counselling: 9-500.0). In reality this code, even if it is encoded and is being passed to health insurance companies, doesn't change flat-rate payments (statistics) nor does it change reimbursement of hospital stay.
Here again the only possible compromise: Breastfeeding counselling via various professional groups in post-natal units is for the most part "unsalaried".

Examples from practice: Which additional obstacles does the gynaecologist face, if she is nevertheless willing and able to do breastfeeding counselling?

How do these obstacles present in daily practice? Two examples from daily practice shall illustrate this issue:

› Off-label use exemplified by Domperidone

› Treatment of breast thrush using Fluconazole

Most of us know of the use of Domperidone to increase breast milk supply; again and again women come into practice and ask for a prescription. Often they looked for information on the internet in advance. While reading the PIL (patient information leaflet) of Domperidone we stumble upon "Domperidone is used [...] to treat nausea and vomitting".

Thus Domperidone is not approved for being used to increase milk supply, which means this usage is off-label.

"Off-label use" is the use of pharmaceutical drugs for an *unapproved* indication.

Off-label use is thus not the "ordinary" drug prescription:

› It can't be prescribed on a public health service prescription, but the patient receives a private prescription and needs to pay on her own, since the costs for a drug can only be reimbursed by health insurance companies if the drug is approved for the present indication. Source: G-BA 1/15

› Liability is still a matter for the physician. The prescribing physician is liable for medical accuracy and possible side effects. It is recommended to do off-label use only on the basis of valid guidelines, recommendations or widely recognised scientific literature. The patient needs to be well-informed. The kind of information needs to meet certain requirements.

› Off-label prescription is only permitted if the disease is severe (life-threatening or strongly affecting life quality) and no other therapy is available (i.e. no label use is available or was already tested but didn't work).

› Due to data situation there is legitimate hope that a therapy might succeed.[4]

Is it severe to have too little breast milk? The woman for sure perceives it as being severe, but in our society there are enough possibilities to give a child (additionally) formula. It could be argued that the off-label use of Domperidone is not indicated as it is not life-threatening to the child. A lack of milk definitely restricts life quality of mother and child. But how should a practitioner know if all necessary measures have already been taken without success (if he is at all familiar with those measures)? With the aforementioned 10 minutes each patient, a comprehensive survey of breastfeeding history, control of sucking behaviour and control of the infant's oral anatomy, is just impossible even for a gynaecologist being IBCLC certified. But Domperidone can't be efficient if the baby has a short frenulum of tongue or breastfeeding management is poor - it is always just *one* component in treatment of hypogalactia or failure to thrive, which can only be successful if a comprehensive counselling and improvement of breastfeeding management takes place.

In summary, the correct off-label use of Domperidone to treat hypogalactia and failure to thrive is quite often indicated and enough data exists. During normal practice routine it is hardly possible to determine and document this.

Besides since 2014 a "Rote-Hand-Brief" [The "Rote Hand Brief" is an instrument of information that is used in medical expert groups for important information concerning newly identified, significant risks concerning the use and administration of pharmaceutical drugs and measures for their minimisation] for Domperidone exists, that says (excerpts):

› "The risk-benefit ratio only remains positive with the indication "symptom relief with nausea and vomiting"

› "The duration of administration should take one week at maximum."

› "Risk of severe cardiac events in connection with the use of Domperidone."

› "Dosage suggestion: 10mg up to 3x/d"[5] (usual dosage suggestion for increasing milk supply, see box). A negative attitude towards this is probably inevitable of a gynaecologist lacking breastfeeding knowledge. And even for the gynaecologist with breastfeeding knowledge there is a lot to consider.

DOMPERIDONE DOSAGE RECOMMENDATION FOR INCREASING MILK SUPPLY

Embryotox:
30mg/d for 1-2 weeks
Source: embryotox.de

ABM:
10-20mg 3-4x/d for 3-8 weeks
Source: ABM Protocol # 9

Dr. Jack Newman:
Usual dosage: 30mg 3x/d for 3-8 weeks, longer if necessary. Occasionally 4x40mg.
Source: breastfeedinginc.ca

Completely different but equally demanding: the second example:

Treatment of breast thrush with Fluconazole

Differential diagnosis, as is known, is quite complex. What causes the pain? Poor drinking technique, vasospasms? In this case, too, a comprehensive medical history, checking of breastfeeding management and surveillance of a complete breastfeeding procedure, from latching on to releasing, is actually essential.

And even if the physician finally accepts the diagnosis thrush - recommended therapy of thrush mastitis ("initial dose from 200-400mg Fluconazole, followed by daily 100-200mg Fluconazole for several days or several weeks, until some days after being free of symptoms") costs far more than 100€, in this case on a public health service prescription for the patient and in times of regimented budgets highly unprofitable for the gynaecologist.

These are only two examples from practice, a lot more exist. As is known, a lot of physicians lack knowledge regarding lactation and breastfeeding. But even those physicians who have knowledge in this field, face obstacles when they want to treat the patient in the way she definitely is entitled to and at the same time work economically.

Possible approaches to solve the described dilemma of doctor's breastfeeding counselling in clinic and practice might be:

- To strengthen gynaecologists by offering made-to-measure further training and appropriate information material.
- To strengthen confidence of the patients by optimising verbal and non-verbal communication.
- To strengthen networks in order to ideally use the resources of all professional groups for the good of mother and child.

However, we can draw hope from news reports like the following from 13th October 2015: The recent prevention act in Germany allows to extend the legally consolidated preventive examinations during pregnancy and in the first year of life by additionally offering preventive consultation.

SOURCES

- [1] Mothers' and Clinicians' Perspectives on Breastfeeding Counseling During Routine Preventive Visits, Taveras et al. Pediatrics Vol. 113 No- 5 May 2004
- [2] Do perceived attitudes of physicians and hospital staff affect breastfeeding decisions? Di Girolamo AM et al Birth 2003 Jun, 30 (2):94-100
- [3] G-BA 1/15
- [4] Frauenheilkunde up2date, 1/2010, Off-label-use: Konflikt zwischen medizinischer Notwendigkeit und Rechtssprechung.
- [5] Rote Hand Brief 20.August 2014
- [6] www.gesund-ins-leben.de/Fachtagung-Fruehkindliche-Praevention

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First Professorship for Mother's Milk Research in Medicine

Much is known about the health benefits of mother's milk. By contrast, little is known about the background and connections. The world-wide first professorship for mother's milk research in Zurich should help fill in the research gaps. Author: Christine Brennan, Managing Director of "Breastfeeding Promotion Switzerland", www.stillfoerderung.ch

It is no longer a secret that mother's milk is healthful. Countless studies from all over the world show the health benefits of breastfeeding for both the infants and their mothers. Thus, breastfeeding promotes the baby's good growth and development and influences the development of immune function positively, which is also particularly important for premature infants. Exclusive breastfeeding in the first four to six months[1] reduces the number of infections in infancy by 40 to 70 % and lowers hospital admissions of infants in the first year of life by more than 50 %. For example, breastfeeding reduces the risk of lower respiratory infections in infants by more than 70 %. Other illnesses, which occur less frequently among breastfed babies, are middle-ear infections and gastrointestinal infections. Furthermore there are indications that, later on, breastfed children develop allergies, obesity and diabetes less often. It also seems proven that breastfeeding mothers return to their normal weight more quickly postpartum and have a lower risk of breast cancer later in life.

High Complexity of Mother's Milk

The question about the causes and backgrounds of these positive effects entails more secrets than just the question about the health benefits of mother's milk. Thus, in 2012, the National Breastfeeding Commission of the German Federal Institute for Risk Assessment (BfR) noted in an official statement that it is not simply one component or one factor in the mother's milk that influences the infant's health, but rather the interaction of components, which mutually complement each other. According to the Breastfeeding Commission, mother's milk contains, among other things, countless immunologically active substances which *cannot* be in industrially produced infant formula because they are shaped by the mother's immune system. This high complexity and variability in the composition of the mother's milk makes it difficult to understand why and under what conditions, mother's milk has these effects and through which factors can influence these effects.

Previous Study Result Do Not Eliminate Controversies.

What we know today about mother's milk rests primarily on observational studies. These do give us information about more or less immediate effects, however only in a limited way about long-term effects and little about the causes and more complex interrelationships.

Thus there remains considerable room for interpretations and speculations and, thereby, for controversies. Other influence factors could, in some circumstances, be more decisive than those that are observed. The old controversy about the effects of breastfeeding on intelligence, which has recently flared up again, provides an example. According to one thesis, breastfed children are more intelligent and have higher incomes in adulthood than non-breastfed children, due primarily to the long-chain saturated fatty acids in mother's milk. Many studies have researched this. Some of them found evidence for the thesis and others did not. Time and time again, there has been criticism that some of these (studies) ignore the influence of the parents or the environment. The higher IQ of the persons observed could, for instance, also be due to better upbringing or heredity. However, this objection is not applicable to the long-term study of a cohort of Brazilian children born in 1982, published in *The Lancet Global Health* in the spring of 2015. This showed that, at the age of 30, subjects who had been breastfed for 12 months or longer had an IQ of almost 4 points more than their non-breastfed counterparts. According to the authors of the report, the breastfeeding rate at that time was not dependent on the social class of the mothers. The study caused a great stir but, due to its uniqueness was not sufficient to quell skepticism.

The Professorship Enables Research for 25 Years

This example shows: Together with the basic research on the mechanism of action of mother's milk, it is also important to test the results found in observational studies through long-term studies. In addition, like the aforementioned IQ study, this must rule out support for the children over a period of many years and the possibility of other influencing factors. However there is a lack of such research projects. Worldwide, it is estimated that only about 300 researchers are dealing exclusively or primarily with mother's milk.

That should change now with this worldwide first professorship for mother's milk research in medicine. It will be established at the University of Zurich and take up its work in the middle of 2016. This is made possible through a donation of 20 million Swiss Francs by the "Larsson-Rosenquist-Foundation".[2] This non-profit organization founded in 2013 by Olle Larsson Holding, a family enterprise, better known under the company name "Medela" with its seat in Zug, Switzerland, presents itself on its website as "the only foundation worldwide which is devoted primarily to the promotion and support of breastfeeding and mother's milk feeding." Thereby, it works together with leading universities with the goal of expanding the number of professorship chairs for mother's milk research. This first one will now be established in Zurich and a second will follow almost simultaneously at the University of Western Australia in Perth. In accordance with the wishes of the donor, the two chairs are to work together: While in Australia, research on the biological, biochemical and immunological composition of mother's milk will be paramount, in Zurich, primarily the

[1] The international WHO/UNICEF standard is six months of exclusive breastfeeding

[2] www.larsson-rosenquist.org/en/home.html

mode of action of the mother's milk as well as the lasting influence of breastfeeding on the psycho-emotional and cognitive development of infants and children, will be studied. Above all, the effects of mother's milk on health and life in adulthood will be the focus in Zurich. According to those responsible, the money should be sufficient for at least 25 years. The independence of the chairs from their financier will, however, be maintained. The foundation will have no voice in allocating the professorial chair and no influence on future research projects.

Support for the Expert Community

The experts need solid scientific bases for their recommendations and their professional action in the context of supporting mother and child. From the perspective of the experts, the founding of these chairs should be very welcome and the goals pursued should be supported. In this way, the topics of mother's milk and lactation should, in the future, flow into the curriculum of medical specialists, in accordance with the wishes of the donors. For those interested in this, specific additional education should be offered. It is to be hoped that, with the establishment of mother's milk research as a university research discipline, the profession of lactation consultant will become better known and the topic of breastfeeding will have a higher status in the medical environment.

COMMENTARY BY ANDREA HEMMELMAYR, PRESIDENT OF ELACTA:

Medela is a company that has consciously been neglecting the international code of Marketing of Breast-milk Substitutes. The administrative president of Medela, Michael Larsson, who is at the same time foundation trustee of the Larsson-Rosenquist foundation, points out that the university has full freedom of research and academic freedom as well. Nonetheless there is reason to fear that Medela is going to use the results in research as measures of advertising and scientists will be influenced conscioulsy or unconsciously by the financial benefits of a firm that pursues commercial aims.

Sharing breastmilk

Donors' breast milk - a forgotten and underestimated alternative to formula Author: Tanja Müller, Translation: Annika Cramer

Foto: iStock

I gave birth to three children. The first was a caesarean section, the second naturally delivered - however, too early (spent nine days on intensive care unit and two weeks in the nursery section) - and my third child died in my arms one hour after delivery. Due to these births I made different experiences with having too little or too much breast milk. My desire to receive milk for my baby from another mother or to pass my own surplus on to other babies remained unquenched. I wanted to avoid using formula. So I started to investigate and quickly learned that a lot of other mothers share my desire.

Early in 2013 I went to work: I wanted to establish a platform for mothers with the desire to give or receive breast milk and thus be able to find each other. I wanted it to be professional and first of all safe. I wanted to instruct the mothers right from the beginning and guide them. Before the breast milk sharing platform started, German mothers exchanged milk via various internet platforms: using small advertisements on Quoka or Ebay, in online forums, facebook groups and US American sharing platforms - they did it invisible, without instructions and often just in English. In Germany the question if milk of milk banks or that of private donors is better does not arise for mothers of healthy children. Milk of milk banks is not available for them. All of the 14 German milk banks give their milk only to premature infants of their own intensive care unit, sell it to other hospitals or pass it on to enterprises for study purposes. Healthy babies who are staying at home are no high-risk patients of an intensive care unit. Making the same demands regarding their nourishment is implausible. Other criteria need to apply and other paths need to be trod. ›

On 28th January 2014 the German breast milk sharing platform went on-line as a charitable project - the first of its kind in Germany. Thereby the mothers' desire became visible and debatable for the first time. So far (status 24th August 2015) 1817 user registered, 303 mothers placed an offer or request, and 783 times mothers were being contacted due to their message. The user figures of platforms worldwide increase continuously. In 2014 worldwide more than 56,000 users were active at HM4HB (Human Milk for Human Babies) alone - and this figure doesn't even include the figures of the big platforms like Only The Breast or Eats On Feets. This is a global movement of mothers, that pushes itself onto the market, and it reveals a primal urge of all those mothers.

A decision of general principle

Sharing breast milk on a private scale - either via a platform or not - shows similarities to the free choice of the birthplace. This is also about the mothers' decision-making authority and about what generally is considered as standard nutrition for infants. An interesting fact: For years the World Health Organisation (WHO) argues for donor's breast milk as being preferred to formula, but until today didn't take steps to practically realise a possibility for all infants. The basic questions are:

- Is artificially manufactured formula a better alternative than breast milk of another woman, or is it worthwhile breaking the taboo of donated milk?
- Should donated milk solely be handled by healthcare personnel? Or is it also possible for mothers to share their milk in a safe way by being professionally assisted?

A reasonable addition

The private breast milk exchange is no competition to milk banks, but instead to formula and thus faces a financially strong lobby. It is a reasonable addition with regard to milk banks. Besides the private breast milk exchange is no renunciation of breastfeeding - quite the contrary. Medical studies even prove that breastfeeding success is more difficult to achieve if formula is given to the baby early in hospital, even if the mother is highly motivated to breastfeed. The breast milk exchange among mothers enhances breastfeeding due to appreciation of human milk in general and due to the role model effect professionals and hospital staff have for parents. This was impressively proven in Brazil where 214 milk banks and additional 145 breast milk collection points were built. This contributed to a breastfeeding rate of over 50 % exclusive breastfeeding in the first 6 months in Brazil despite its high rate of caesarean section. The population started to develop a consciousness of the value of donated milk. This can be seen in a high decrease of mortality and an improvement of babies' health, as well as in a decrease of costs in health care system.

Involving medical professionals and hospitals

Private sharing of breast milk at home should be accompanied by qualified personnel. Not meant as a compulsory institution taking over the whole process as it is the case with intensive care patients, but as an accompanying instrument. The mothers can be advised and assisted by midwives, lactation consultants, paediatric nurses and physicians. In Germany this network of professionals is already implemented, at least in comparison to other countries. That should be utilized.

Sharing between already familiar mothers (e.g. in an extended family or between neighbours, friends etc.) is for sure best. The breast milk sharing platform may or may not be helpful. The Internet is for sure the biggest fear-factor. However, today it is definitely part of human private life and safety can be possible of course. Mothers who don't dare ask other women for their milk on the street or in toddler groups, meet each other here. It is important, however, that these mothers get to know each other very well, since anonymity should be avoided at all costs.

It is hardly realisable to hand this process on to the hospitals to manage it on their own. On one hand it would be impossible to ban the mothers from sharing their milk on a private scale, since they would do it instead unseen which might bring up dangerous situations. On the other hand the preparation of the milk, as done by the milk banks today in Germany, is too extensive and costly for babies who are not struggling for their life on intensive care units. Without further financing, like involving health insurances and modernising milk banks with regard to breast milk for mature and healthy infants, the supply for all babies will not be possible. The involvement of maternity clinics is nevertheless important and should be conducted at the same time.

Foto: iStock

How the milk sharing platform works

The exchange platform is meant for mothers who are interested in personal contacts. Mothers and babies are brought together locally. Mothers with milk surplus place an offer and mothers who have a demand can contact them. To place an offer the mothers need to pay a small amount in order to make sure that only real people interfere. Real data like the real name, address and bank details are entered. There is no anonymity. More than 90 % of the mothers look for each other using the search via postal code, meet each other after the first contact and receive the milk directly from the offeror in person. On the website of the sharing platform every mother gets all important information for sharing breast milk in a safe way, written in German. Furthermore the actual likelihood of the possible risks is being explained. How do I express milk with pumps? How do I freeze it? How do I defrost the milk? How do I behave hygienically accurate? Mothers are advised to visit and interrogate the donors at home: What does her pump look like? What freezer does she have? How does she treat her own child? Do the kitchen and the equipment look neat? It is also explained, which questions are important for the donor, for example: Is she vaccinated against hepatitis B? Did she copy the results of her blood test during her pregnancy (for example the HIV test) at her doctor and are they directly available? All these questions are going to be explained. At the milk exchange platform I daily observe how serious mothers take their responsibility regarding control of milk and donor, since they are aware that there is no other authority to check. Some even close a written contract or have the donor's answers counter-signed.

Mothers who feel unsure even find a step-by-step instruction on pasteurisation at home on the platform. All relevant germs and bacteria are inactivated or killed during this process. Even after being boiled to a sterile liquid, the milk is better than formula. The sharing platform cooperates with the institute for milk testing (IFM), a bacteriological laboratory that tests the milk on a random basis according to DIN. This shows the high professionalism of the sharing platform. Here every buyer can test the milk for germs or being diluted with water, formula or cow's milk. The platform doesn't recommend distribution. Is it nevertheless wanted, the platform offers a detailed instruction and a partner company.

Blessing or curse, or just applying double standards

In contrast to the many documented health damages due to infant formula, there is no documented case of health damage due to donated breast milk world wide - despite high usage numbers of private milk sharing. This is one reason why the warnings of the public authorities are no longer heard by mothers. On the other hand it seems to be ignored that according to WHO, day by day children get sick due to formula feeding, even in industrial countries like Germany. Again and again germs, toxic substances or wrong mixtures are found in formula. Regarding private milk sharing, it seems that just the bare imagination of a possible health damage is enough to completely decline it. Precaution and attention are important in the case of donated milk as well because meanwhile financially strong economic interests appeared. The private exchange of donated milk is not wished in economic terms because no one but mothers and babies make profit.

In Germany breastfeeding is supported on a huge scale by government funds as well as marketing and advertising campaigns - an important aspect that needs continually to be first priority. However, we should take a further step and offer donated milk as a natural alternative to formula. Since the combination of these measures - supporting breastfeeding and the donation of breast milk - promises an improvement regarding breast milk feeding and our babies' health.

Tanja Müller had been working as a marketing manager for a medium-sized company for years. Then she became a mother. Her children and her new role changed her life and in mid-2013 she became self-employed. Today she is the business manager of MIMARA, a non-profit entrepreneurial company, whose first project has been the mother´s milk exchange. Mrs Müller is promoting mother´s milk donation instead of formula, in our birth clinics and from mother to mother.

ILCA

ILCA is the International Lactation Consultant Association and provides a worldwide network of Lactation Professionals. Their recently renewed vision is: "World health transformed through breastfeeding and skilled lactation care". Author: Karin Tiktak

Ilca was founded in the USA in 1985 by a concerned group of LLL volunteers. LLLI initiated the development of the profile of a lactation consultant, because there was a need of professional lactation care in the time frame when breastfeeding figures approached rock bottom. After several big transformational steps the National Health Agency required an independent organization beside the certifying body which was part of LLLI. The well known Linda Smith stood at the cradle of ILCA together with colleagues throughout the world to form the first board of directors.

Now, summer 2015, ILCA has 6047 members from out of 95 countries. For membership it is not obligatory to be an IBCLC. For your knowledge, there are about 27000 IBCLC's worldwide.

The daily business of ILCA is leaded by their Board of Directors. Decalie Brown, from Australia, is the 21st president now. After her legislation period in 2016 Michele Griswold from USA, will take over her tasks. The Board works together and under supervision of the ILCA Staff, with Dick Padlo as the executive director. There are a lot of volunteers working for ILCA in different committees.

To give an impression of their work you will find the following overview of the activities:

ILCA provides a conference each year. The Annual General Meeting is part of it. 2015 it was held in Washington DC. The committee of this year's conference consists of 12 members.

In 2014 the preparations were made for the Global Outreach program to collaborate with 17 more organizations who support and advocate for lactation care. This was crowned by a partners meeting at the ILCA conference in Washington DC , this summer. All new partners shaked hands and shared their experiences. This facilitates networking among lactation professionals and strengthens the work in our field and advances our profession. ILCA has close connections with the global organizations IBCLE, LLLI, WHO, IBFAN, WABA and UNICEF.

ILCA provides the Journal of Human Lactation with evidence based scientific research articles. There is a research committee for this work. Out of all the articles of each year, the best research and the best article are selected. ILCA produces a lot of forms and articles and provides webinars. They have an online webshop for their books and translations of forms and papers in different languages. A weekly newsletter is sent to the members online, called the ILCA alert. They have an online database for searching a lactation consultant: "FALC, find a lactation consultant." When you are member of ILCA try to find yourself in the data base. For members they have a speakerslist too.

Besides you can become an ILCA fellow by doing extraordinary volunteer work. Every year a scholarship is given to a new ambitious student, who can apply for this special "give-away".

July 2015, ELACTA has signed the agreement of partnership with ILCA. This is a worthful starting point to build firm bridges in order to collaborate for reaching our goals in promotion, protection and support of breastfeeding and improvement of maternal and infant health outcomes worldwide.

For ELACTA it is a big chance to outreach to global working organizations and strengthens our position in the World. It is empowering ELACTA too by taking part in a lot more global activities and getting into contact with a lot more lactation consultants. We can learn from each other!

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Alliance

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Nipple shield

Read the following information carefully before using a nipple shield. In order to immediately eliminate the causes for breastfeeding difficulties, fast and competent consultancy* should be top priority. For improving the situation over the long term it is mostly sufficient to control and improve latching, breastfeeding position, breastfeeding frequency etc. Nipple shields shall only be used when comprehensive and competent consultation has been taken place; as a result the underlying causes are unlikely to remain hidden or become even worse and no additional problems occur.


Foto: Karl Grabherr

Why using a nipple shield? What has to be taken into account when using a nipple shield?

Made of thin, soft silicone the shields have a more or less stable shade, that stimulates a sucking reflex in the child's mouth. Thus a child that didn't suck or couldn't draw up the nipple properly until that moment, might spontaneously begin to actively suck. A positive, quite desirable effect. However, the child might not be able to train and learn to suck on it's mothers breast. Besides the shield interrupts skin-to-skin contact. Thus the sensitive nerve endings of the nipples are stimulated insufficiently and feedback mechanism gets disturbed. Let-down reflex might thus be delayed, perhaps milk supply decreases, especially if the child latches incorrect or the use of nipple shields covers underlying problems.

Sore or hurting nipples are common cause for using nipple shields. As a general rule applies: First of all it is essential to identify and eliminate the causes. There might be no necessity of using this equipment afterwards.

Selection of the right size:

Nipple shields are available in various sizes. On one hand the shield needs to be short and small; if it is too big, the baby cannot adequately draw up the mother's nipple and may only suck the shaft of the shield. On the other hand it needs to be big enough in order to allow the nipple to extend adequately without hurting or obstructing the nipple. As big as necessary, but as small as possible.

Using the nipple shield

When sitting the shield on the nipple make sure the nipple is sucked into the shield even before the child latches on. For this purpose slightly moisten the nipple shield using warm water; before placement roll back the brim and sit the shield on the nipple while stretching it. Place the opening of the shield on the side

*IBCLCs are specialists regarding breastfeeding and lactation in every issue.

of the nipple where baby's nose has direct contact to the mother's skin.

Make sure your baby's mouth is opened wide and latches correctly. The baby's jaws must close on the breast, not out on the shaft of the nipple shield, having as much breast tissue as possible in it's mouth.

To notice potential problems in time, weight control should take place; expressing milk might be helpful as well.

After each use the nipple shields need to be washed in soapy water and rinsed afterwards. Boil once daily. With sick or premature infants, the clinic possibly recommends boiling after each use. After drying, keep the shields in a clean box.

Weaning off from the nipple shield.

Use the shield as long as necessary and as short as possible.

Weaning begins with the correct selection of size and a correct latch. When it's hunger is already nearly satisfied, some babies can while being fed directly change from shield to nipple, as the nipple at that point is already extended through sucking. Thus some babies have no difficulties in changing from shield to nipple. For others it might be necessary to notice the first signs of hunger and preferably put them to the breast while being half asleep. And yet others will need this equipment for a longer period of time. From time to time you should try again; it's worth the effort.

Slightly moisten the nipple shield using warm water; before placement roll back the brim and sit the shield on the nipple while stretching it.

Particularly if you are breastfeeding with a nipple shield, the correct latch-on is crucial for being successful.

Use the shield as long as necessary and as short as possible.

IBCLC

International Board Certified Lactation Consultants are the only internationally approved breastfeeding and lactation specialists having a medical background.

The decision to breastfeed or not to breastfeed has short- and long-term impact on the health of child and mother. However, breastfeeding sometimes turns out to be difficult and perhaps professional, competent assistance is needed.

Contact your IBCLC

Summary ILCA Conference

Washington 21-26 July 2015 by Karin Tiktak (ELACTA board)

Meeting of the ILCA partners

ELACTA gave me the opportunity of visiting the ILCA conference this year. I had already had several contacts within ILCA, about their Global Outreach programme. We, ELACTA, had just signed the agreement about partnership!

It was a special trip: by plane to the United States. It took lots of preparations and patience to get there. I stayed in an apartment in Georgetown. To me Georgetown is the best district in the city. From there I travelled to the Marriot hotel every day , the luxurious venue for this huge conference. ILCA celebrated its 30th anniversary, which started with a real American Parade of Flags in the enormous Ballroom Hall. I proudly presented the new ELACTA flag. Then the rush of presentations started, in different halls and rooms.

ILCA has about 6,000 members and 1,000 of them attended this conference. From Europe there were only 6 women and one man. The Danish man was from one of the exhibition companies. The exhibition hall was extremely large. Elacta had a very big table and I stood there displaying our upcoming conference in Athens. I was shocked when I became aware I had only the German cards with me ! Luckily the save the date text was in English.

I attended very interesting workshops and presentations. Dr. Howard Chiltond talked about the unsettled baby and told the audience about reasons for crying as well as about solutions and warned us about lots of books about sleeping problems which were not suitable for young babies. Catharina Watson talked about tongue kinematics, Chessa Lutter about NET code and WHO policies, Kerstin Moberg about Oxytocin and a lot lot more.

On Wednesday afternoon we had the Partners Meeting, together with the ILCA Board. The big global organizations, like WHO, IBFAN, WABA, LLLI, and IBCLE gave their presentations and after that we celebrated the fact that 17 organizations, among them ELACTA, had joined the club of ILCA Partners, by taking photographs and having a chat with each other. A great opportunity of getting involved in the projects and fields of work of other global organizations. It gave me lots of inspiration.

After several interesting presentations on Thursday I decided to take a sightseeing tour through Washington to see all the nice memorials, impressive buildings and the White House. I had dinner in a lovely little French bar in Georgetown.

On Friday I had again an exhausting day of presentations and chatting with several IBCLCs during lunch (American: French fries, salad and coke!! Even the lactation consultants from the US found it disgusting!). I hurried through the exhibition hall, to establish contacts for a possible exhibition in Greece and to get some new ideas. I posted my facebook updates, presented Elacta at my stand, ›

and now and then, I scurried to a different hall for a cup of coffee.

I had planned to give the Elacta presentation and had organized a European meeting in advance. As it turned out in the end there were only 5 participants in a hall which could hold 200 people : LCGB fromUK (2), ALCI from Ireland, Slovenia and myself. It was sad but we had a bit of a chat about WBTi, IBCLE and so on. Despite the fact that we had such nice conversations with LCGB and ALCI, they still haven´t subscribed for membership of Elacta yet. I encouraged them to extend our collaboration in the future, in order to to welcome them as members of Elacta at last.

A special part of the program was the Annual General Meeting. To me that was very instructive. It was typically American with all the cherishes and applause. It gave me a lot of insights about ILCA, and about their structure with a Board of Directors and the ILCA Staff. Also the president Decalie Brown held her own "about the president" presentation. That was really nice. After Donna Geddes, I left the venue to catch my plane home. Time to digest all my experiences and impressions and to report to my Boardmembers.

The ELACTA / GALAXIAS Congress in Athens is nearing:

13 and 14 May 2016 in Athens/Greece; pre-conference: 12 May 2016

Lactation counselling needs both, the theoretical aspect, i.e. scientific facts and considerations, as well as the practical approach, i.e. practical advice, guidance and exchange of counselling experience. To meet this need, we are organizing a very practically oriented pre-congress with various workshops where small groups can work intensively on different topics for three hours.

The range of topics is as diverse as the nationality of outstanding speakers. The core theme is "Breastfeeding - An ancient art in a modern world". Amongst others, the congress will discuss topics such as: Stone Age babies and mothers in a modern world; the physiological continuum - labour, childbirth and breastfeeding; epigenetics and breastfeeding; family-centred care for premature babies; the support of infantile competencies; anterior and posterior lingual frenulum; scientific papers and articles and how to read and interpret them correctly; modern mothers and social media; breastfeeding in emergencies; Reflux, GERD and breastfeeding; thyroid function in nursing women; long breastfed children; start of complimentary food for infants; allergies; the legal frameworks for lactation counselling.

Internationally renowned speakers such as Katherina Genna Watson,

Eveline Kirkilionis, Michel Odent, Andreja Terkauc Golob, Elizabeth Hormann, Carlos Gonzales and many more will enrich and contribute to this congress.

Participants can also actively contribute by sharing their knowledge and experience with others through poster- or brief oral presentations (Parallel Session)

More detailed information about the workshops, the presentations, the speakers, submission of abstracts, the venue or the possibility of translations can be found on our website: www.elacta.eu

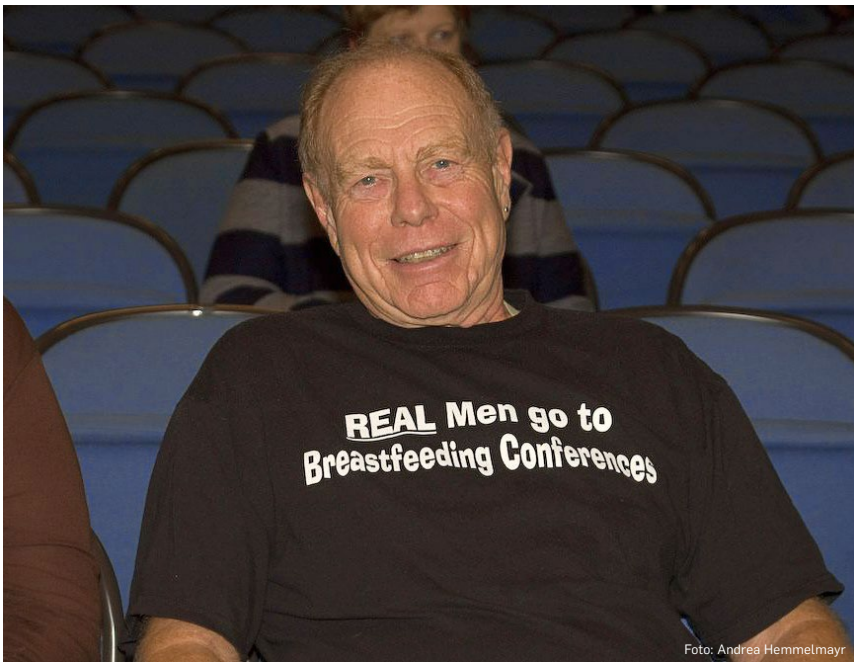


Foto: Andrea Hemmelmayr

Institut pre podporu dojčenia (IPD)

IPD - Institute for Breastfeeding Support was founded in 2014 as an association to support and unite healthcare personnel in the field of breastfeeding. IPD works according to the recommendations of ELACTA and the guidelines of the international examination IBLCE.

IPD arranges courses in collaboration with the Slovakian Paediatric Society and the Slovak Committee for UNICEF. It offers further training in the field of breastfeeding in accordance to the guidelines of WHO and UNICEF. Besides it participates actively in awarding the BFH certification, is partner of IBFAN and represents Slovakia in the institution ELACTA.

The aim of IPD is to support the qualification of healthcare personnel in the field of breastfeeding as based on the latest science and research findings. IPD aims to make room for continuous qualification and enhancing knowledge about breastfeeding.

IPD's vision is to professionally train healthcare personnel in accordance with the criteria of Lactation Consultants IBCLC, which correspond to the standards of the international examination IBLCE. IPD shall function as an umbrella organisation for breastfeeding consultants and IBCLCs in Slovakia. As a further step the arrangement of national and central-European congresses is planned.

IPD arranges courses, lectures and brush up courses.

Our Website www.institutdojcenia.sk offers information on our profession, our courses, breastfeeding congresses, newsletter and the latest research findings.

INŠTITÚT PRE PODPORU DOJČENIA
THE INSTITUTE FOR BREASTFEEDING SUPPORT

elacta
European Lactation Consultants Alliance

CALL FOR NEW BOARD MEMBERS!

- Are you searching for some challenge in your work as lactation consultant?
- Do you like boardwork?
- Are you flexible and do you have some extra spare time?
- Do you like organizing a big European event?
- Do you have experience with specific tasks like finances, accounting or webmastering, secretary work, working in projects or redactional work?
- Are you communicative, in spoken and written English?
- Do you like to work in a team of sparkling, ambitious women and eager to discover Europe?
- Then the Board of Elacta invites you to apply for the Board 2016-2018!

We offer you:

- Flexible working hours from the comfort of your home
- About 8 hours per week investment in ELACTA work
- 3 times yearly a boardmeeting of 3 days in a European city
- The possibility to attend conferences abroad
- Work in diverse taskgroups
- A step into a big network of lactation consultants

Please note the following application procedure:

1. Get in contact with your membership organization to ask permission to apply.
2. Fill in the application form
3. When you have additional questions, please feel free to contact us.
4. Send the form to office@elacta.eu, to Mirjam Pot, secretary, before 31st March 2015.

Looking forward to your application

BFHI in Europe

The Netherlands:
Information provided by Karin Tiktak (ELACTA Board)
Total number of maternity wards:
more than 1,000 instititutions. In the Netherlands not only hospitals with maternity wards can be accredited but also midwifery practices, child-parent care institutions and the so called "Centres for Babycare at Home" ("kraamzorg").
Number of those accredited by BFHI:
278 of these institutions (about 25 %)
Coordinator of BFHI in the Netherlands:
"Zorg voor Borstvoeding", www.zorgvoorborstvoeding.nl

South Tyrol
Information provided by VSLS
Total number of maternity wards:
In South Tyrol there are 6 hospitals with delivery room and adjacent maternity ward
Number of those accredited by BFHI: 4
Additional baby-friendly initiatives:
none
Coordinator of BFHI in South Tyrol:
UNICEF Italia with its reviewers is responsible for the certification as BFHI

Greatest challenge:
› The greatest challenge for the implementation of guidelines of BFHI are basically the attitudes and the motivation of the institution. The actual costs and the very high standards for perpetual recertification are burdensome. The constant change of personnel entails additional training expense. The requirements imposed by UNICEF Italia are on the one hand justifiably high one the other hand they represent a major obstacle and involve high organisational effort for the successful implementation.

Greece:
Information provided by GALAXIS
Total number of maternity wards: 146 private and public hospitals with birth wards
Number of those accredited by BFHI: 4
Additional baby-friendly initiatives:
› There is a pilot project in one of the intensive care units in Greece implementing the guidelines of BF.
› Apart from that there is a movement for baby-friendly pharmacies. Two pharmacist have undergone the IBCLCE Exam this year.
› The Ministry of Health and some municipalities are planning to create areas for breastfeeding in airports, ports, town halls and shopping malls etc.
› There are Health Centres for mothers and children either affilliated with hospitals or working independently.
Coordinator of BFHI in Greece: 2 organisations:
› The Institute of Child Health – Greece Department of Developmental Medicine Ioanna Adoniadou 2107701557 Messogion 38-40, 11527 Athens, Greece, alkyoni.thilasmos@ich.gr
› Panagioula (Yioyla) Mexi Bourna, MD, IBCLC, President of GALAXIS, the Hellenic IBCLCs Association Sinopis 4, Drosia 14572, Greece ymexi@hotmail.com

Greatest challenge:
› Everone in Greece believes that breastfeeding is the best nutrion for the baby but...
› For what period of time? (controversial points of view on duration)
› How can a mother achieve her aims? (Education of mothers)
› Who can help? (Education of Health Professionals)
› Development of a BF culture is a big challenge

Germany:
Information provided by BDL
Total number of maternity wards: more than 700
Number of those accredited by BFHI: 90 (situation spring 2015)
Additional baby-friendly initiatives:
› baby-friendly neonatal units
› baby-friendly pharmacies
Coordinator of BFHI in Germany: "Initiative Babyfreundlich"

Slovakia
Information provided by IPD (Institut pre podporu dojcenia)
Total number of maternity wards: ?
Number of those accredited by BFHI:
at the moment 28-30, some have to recertify in the nearer future, which has to be done every three years.
Additional baby-friendly initiatives:
those hospitals with a neonatological intensive care units (NICU) are striving to receive an acknowledgement plaque. At the moment the breastfeeding work groups and the Institute for the Promotion of Breastfeeding are developing a "baby- and family-friendly" concept for NICU.
Coordinator of BFHI in Slovakia:
Since 2014 the Slovak Committee has been implementing for UNICEF the initiative "baby-friendly hospital" in cooperation with the Slovak Pedriatric Association. In order to coordinate all the activities a task force has been called into existence which works closely together with the Institute for Breastfeeding (IPD). The programme is only marginally supported by the Ministry of Health.

Croatia
Information provided by CALC and by the National BFHI Project Team
Total number of maternity wards:
32, 31 are public and one is private, annual births: 39,939 (situation 2013)
Number of those accredited by BFHI:30
Additional initiatives:
Neo-BFHI, Babyfriendly regions (towns, districts, primary health care practices, breastfeeding groups)
Coordinator of BFHI in Croatia:
UNICEF Croatia and the Ministry of Health

Greatest challenge:
› Maintenance of BFHI standards und implementation of the codex in primary health care.

Denmark:
Information provided by DACLC
Total number of maternity wards: 24
Number of those accredited by BFHI:
There are no BFHI hospitals in Denmark any more. The institution for BFHI accreditation was shut down in 2009, after that it has been impossible to be accredited. A few years ago there were 2 BFHI hospitals in Denmark.
Additional baby-friendly initiatives:
There are no further BF initiatives, but the Danish breastfeeding rates are luckily very high. In Denmark the recommendations of WHO and Unicef as well as the 10 steps are generally followed.

Greatest challenge:
› As there are no BF-initiatives in the country it is no longer a big topic nowadays. There are local initiatives throughout the country that support breastfeeding. Nearly all women who give birth in Denmark, start breastfeeding after birth. In 2012 80 % were still breastfeeding after 4 weeks, after 4 months there were only 60 % and after 6 months the numbers had decreased to 12 % of the mothers. In Denmark there are 249 IBCLCs.

Austria:
Information provided by Ingrid Zittera, sectional spokeswoman of BFHI
Total number of maternity wards:
78 (situation 2013)
Number of those accredited by BFHI:
15 BFHI (situation July 2015)
Additional Baby-friendly initiatives:
unknown
Coordinator of BFHI in Austria:
Austrian network of health-promoting hospitals and health facilities (ONGKG)

Greatest challenge:
› According to a survey BFHI seems to represent a big challenge for health professions as habitual working processes and structures have to be modified. The introductory phase as well as the implementation phase are perceived as impediments by hospitals not accredited by BFHI.
"The bumpy road to implementing tue Baby-friendly Hospital Initiative in Austria: a qualitative study by Wieczorek et al. International Breastfeeding Journal (2015) 10:3 DOI 10.1186/s13006-015-0030-0 to be found at www.internationalbreastfeedingjournal.com/content/10/1/3

France:
Information provided by Juanita Jauer Steichen (ELACTA Board)
Total number of maternity wards:
335 (situation June 2015) with 832,000 births annually
Number of those accredited by BFHI: 24 BFHI (situation June 2015) with 36,200 births annually. 5 % of births are given in BFHI hospitals
Coordinator of BFHI in France:
IHAB France

Poland
Information provided by PALC
Total number of maternity wards:
440 hospitals
Number of those accredited by BFHI: 94
Coordinator of BFHI in Poland:
since 1992 it has been organised by the "Committee for Popularization of Breastfeeding" (NGOs)

Greatest challenge in Poland:
› in 2012 a very important document was passed in Poland "The new standards of perinatal care". It is a legal regulation by the Ministry of Health for all health professionals who take care of mothers and children in the perinatal period. This document implements 6 of 10 steps of the BFHI strategy (except step 1, 2, 9 and 10). This is a huge success because for the first time national legislation is concerned with education of mothers during pregnancy and supporting them. Unfortunately the last reviews show that this regulation has not really been implemented in practice. A survey in 2014 (after a mothers´ event "For a better birth") among 4,000 women shows that after a physiological birth only 24 % of the mothers experience "skin-to-skin contact". 6 % of the mothers were not able to make this experience at all. 28 % did not get any support with breastfeeding at the start and for this reason 11 % of the women stopped breastfeeding altogether while still in hospital. (http;//serwisy.gazetaprawna.pl/zdrowie/artykuly/892640,na-porodowkach-prawo-nie-obowiazuje.html) Summarizing the situation one would have to say that things have improved over the last ten years but there´s still a lot of work to do particularly to make the new standards more popular among women and health professionals and to implement them in the daily routines of hospitals.

Italy:
Information provided by AICPAM
Total number of maternity wards: 521 (situation December 2015)
Number of those accredited by BFHI: 23
Additional baby-friendly initiatives:
› there are 6 baby-friendly regions in Italy

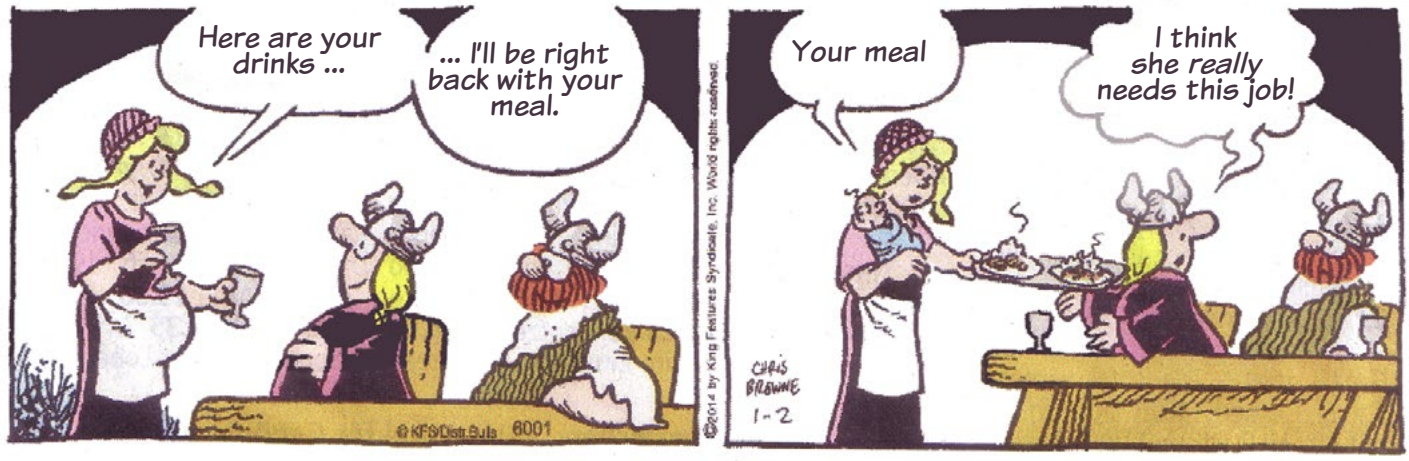
Romania
Information provided by Pro Mama
Total number of maternity wards:
204 (situation 2012)
Number of those accredited by BFHI:
31 (situation 2012)
Additional Baby-friendly initiatives:
none
Coordinator of BFHI in Romania:
Until 2013 BFHI had been organised by UNICEF. Since 2013 it has been coordinated by an ONG "Hands Across Romania" on which there is unfortunately no current information to be obtained. Even from the MInistry of Health there is no information concerning BFHI which is kept current. The latest data date back to the years 2012 and were collected by UNICEF.

Greatest challenge:
› Many BFH have only partly implemented the 10 steps:
› Initial breastfeeding within the first hour after giving birth is often not put into practice (6.8 hours) and skin-to skin contact with self-latching of the baby (breastcrawl) is rare. Separating mother and baby in the first hour for examinations and bathing, Cesarean and epidural anaesthesia are quite common.
› Supplementary bottle-feeding which is not indicated for a breast-fed baby (limited time of staff and shortage of staff)
› Some hospitals only offer rooming-in in some wards or separate mother and child during the night and for examinations
› No constant support of the breastfeeding team due to personnel shortage
› members of the staff do not agree with the 10 steps or the education and the training of the personnel is inadequate
› there is a lack of breastfeeding support groups
› neglection of the International Codex about marketing of breastmilk substitutes

Recent family politics

Establishment of uniform regulations on maternity leave throughout Europe failed Author: Jeanette Vocht, translation: Eva Bogensberger

HÄGAR THE TERRIBLE



Last month, the implementation of at least 20 weeks maternity leave as a standardized rule in the European Union - an attempt of EU Commission - failed. The proposal included that the mothers should have been gone for at least six out of twenty weeks after delivery. For the first time even fathers should have get the right to take leave for two weeks after the birth of their child. These norms should have applied for adopted children under the age of twelve as well.

Due to additional financial strain for employers, especially the economic side opposes against these plans. It is said that even the German Ministry of Family Affairs rejected to extend maternity leave on the ground that the situation won't improve for the persons concerned.

Numerous German politicians commented in a similar way, hinting on the exemplary German system of maternity leave and parental benefits, which is not affordable in other countries.

Thus, regulation of maternity leave and of maternity benefits stays in charge of every EU country individually. As especially the latter one is not granted in every state, a lot of European mothers can't afford staying at home several weeks before and after delivery.

Whereas German mothers get voluntary maternity leave lasting six weeks before delivery and compulsory maternity leave of eight weeks after delivery on full pay, as well as both parents can receive parents' money during the first year post partum, a lot of parents in other European countries for financial reasons can't afford being released from work in order to spend physiological puerperium in familiar surroundings, let alone care for their child in it's first year by themselves.

In the short term this might be profitable; in the long run ignoring puerperium and establishment of initial attachment will cause adverse health effects which in turn will affect productivity of employees. Very much in the spirit of free trade agreement, labour rights are being ignored (without Europe-wide regulation their removal will be easier) without considering or respecting long-term consequences.

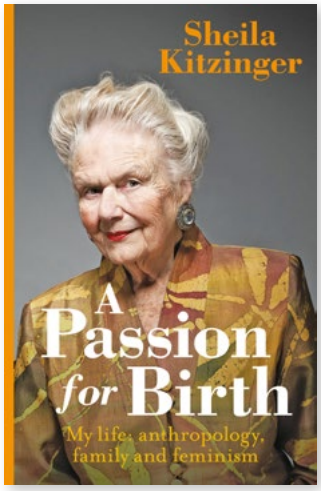
From our perspective, this is a sad development of our days.

Sharp-tongued caricatured: Will we one day experience a situation, likely the one Haegar and Helga (in cartoon above) experience during their dinner, in times of industrial revolution before the introduction of social reform?!?!?!

Jeanette Vocht
Gynaecologist, IBCLC
BDL board member

Sheila Kitzinger – A Passion for Birth

My Life. Anthropology, Family and Feminism. Author: Elizabeth Hormann, IBCLC



SHEILA KITZINGER – A PASSION FOR BIRTH:

My Life. Anthropology, Family and Feminism.

London: Pinter & Martin Ltd., 2015

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The title of this memoire gives only a hint of who Sheila Kitzinger was, what she accomplished in her long life and the impact she had on generations of women around the world over a career that spanned more than half a century.

By the time I met her in1969 at a day-long workshop in Boston, she was already well known in Europe for her first book, The Experience of Childbirth (1962) and her pioneering research in Jamaica on "women's lives, values and relationships" (1964). She quickly became an icon in the USA as well.

Sheila challenged the practices of the time, urging a paradigm shift from clock-watching, "ritual interventions", routine drugs, technology, physiologically unsound and humiliating positioning for birth ("spread-eagled and harpooned" (p. 179) and rising Cesarean rates to a system in which a woman's autonomy would be a given throughout the pregnancy and birth cycle, continuity of care would be assured and interventions limited to those absolutely necessary for her well-being and that of her baby.

Her question – "Is pregnancy an illness of which a woman must be "cured" by an obstetrician? Or is it part of a developmental process in which a couple grow to be parents and the family welcomes a new member" is as relevant today as it was when she first posed it in the 1970s. The "ritual interventions" of that time have been replaced by new, high-tech, often ritual interventions.

Some changes which came about in the heyday of the "natural childbirth" and breastfeeding revolution have remained standard – even during the present revival of interventionism and renewed enthusiasm for routine technology. Fathers and other birth partners are "allowed" to be present – even for Cesarean deliveries. Birthing pools are available in many hospitals and women may have more choice about positions for labor and delivery – unless monitors and Cesarean deliveries (about a third of all births in Germany) intervene." Bonding time" is still common - if not always immediately after the birth and uninterrupted – as is rooming-in. Breastfeeding rates remain higher than they were 40 years ago. Nevertheless, in light of the roll-back of the fundamental changes made in the latter part of the 20th Century, a new birthing and mothering revolution may be overdue.

A significant novelty in Sheila's work was placing pregnancy, birth and breastfeeding squarely in a feminist context at a time when many feminist thinkers were not focusing on it. She was invited to travel the world to share her work not only with parents and those who accompanied them – from traditional birth attendants to midwives in hospital settings and private practice to obstetricians - and beyond. One of the most moving – and timely – sections of this book is Chapter 15 – "When There is no Birthplace" in which she looks at the treatment and options for pregnant women under occupation, in war, as refugees and asylum seekers and in prison.

With Sheila's death in April 2015, an extraordinary guiding light for women of all ages and at all stages of their lives was extinguished. Fortunately for us, our daughters and granddaughters, she left behind a body of work (including more than 30 books) that will continue to inspire and encourage women to take bold steps to empower themselves to refashion both their personal lives and the wider world in which we all live.

Does the Use of Nipple Shields Influence Breastfeeding Duration?

Analysis of the Austrian study "Infant Feeding Today, 2006"

Dr. Beate Pietschnig for "Österreichische Stillkommission des Obersten Sanitätsrates", (2004–2010); translation: Elizabeth Hormann, IBCLC

ABSTRACT:

Background
Nipple shields are frequently recommended at the beginning of breastfeeding to help mothers with sore nipples and with nipples with anomalies. Nipple shields are intended to enable mothers to breastfeed, although the data is very contradictory. The goal of the study was to examine the effects of nipple shields on breastfeeding duration.

Material and Methods
Data on the use of nipple shields in correlation to breastfeeding duration and the infant´s weight gain was collected and analyzed in the context of the study "Infant Feeding Today – 2006"

719 mothers of 728 children from all over Austria were qinterviewed three, six and 12 months after birth. 25 % of the 719 mothers were given a nipple shield postpartum, 52.7 % of them due to painful nipples.

Results
Infants who were breastfed with nipple shields at the beginning showed significantly shorter times of exclusive and partial breastfeeding. The weight gain patterns of the children did not show any significant differences.

Conclusion
The results show that nipple shields negatively influence the duration of breastfeeding. Thus, the uncriticial and unsupported use of nipple shields is not recommended.

Keywords:
› breastfeeding
› breastfeeding counselling
› nipple shields
› breastfeeding duration

Exclusive breastfeeding for approximately the first six months of the infant's life is nationally and internationally recommended.[1, 5, 8, 9, 22], as breastfeeding is amongst the most effective health-promoting measures in the health care system [3]

The use of nipple shields is recommended for treatment or prevention of pain and sore nipples and to ease attachment. Especially in anatomical variations (such as inverted or flat nipples) , nipple shields can enable breastfeeding at all On the other hand, nipple shields can lead to breastfeeding problems.

Breastfeeding counsellors report that mothers are often given nipple shields in the first few days in hospital unreflected and without detailed information. In the related literature, there is little and very contradictory information on the benefits and risks of nipple shields. Although there are absolute (inverted nipples) and relative indications (i.e. flat nipples and, sometimes, premature babies) for the use of nipple shields, practice shows that nipple shields are also often recommended without specific indications. Consequences of the (unreflected) use of nipple shields include earlier supplementation and weaning of the baby.

To evaluatethe outcome of early nipple shield use, the survey "Infant feeding Today 2006", was conducted to evaluate the use of nipple shields in the initial days of life. The survey was conducted on behalf of the Austrian Federal Ministry of Health and the Austrian Breastfeeding Committee,

Methods

In the Austrian study, "Infant Feeding 2006", two topics were evaluated : the structure of in – hospital care in the ob-

stetrical units, , and the nutrion of infants during the first year of life. [6]

All 100 obstetrical units in Austria were asked to take part in the prospective survey. The structure of in-hospital care was determined from the questionnaires answered by the obstetrical units. According to WHO, there were, 12 BFHI units, in Austria, until September 2011. These units care for the mothers in accordance with the Ten Steps to Successful Breastfeeding (WHO/UNICEF 1989) and omit advertising as demanded in the International Code of Marketing of Breast-Milk Substitutes (WHO/UNICEF 1981).

According to the demographic data, representative mothers from Austria were to be recruited from all obstetrical units, via private-practice and after home births via the midwives. Ultimately, around 700 mothers (they are representative of about 1 % of the births in Austria) were enrolled in the study. They wereinterviewed on breastfeeding management and the feeding of their babies prospectively and longitudinally during the first year of life.

Mothers were recruited post partum in the obstetrical department, and written consent was obtained. Structured telephone interviews were conducted when the babies were three, six and 12 months old. Apart from demographic data (such as age and education of the mothers, parity, smoking) and data on the birth (such as multiples, the duration of the pregnancy, the type of birth, weight, length, head circumference and Apgar score, peripartum complications in the mother and the baby and transfers to neonatal units), infant nutrition during the first days (breastfeeding, additional feeding and the use of nipple shields) in the first days was evaluated

In every interview mothers were asked whether the baby was fully or partially breastfed at that given time, whether a nipple shield was currently being used and whether breastmilk subsitutes and/or complementary food was offered. The date of the last weight check as well as the weight of the infant were recorded so that weight gains could also be calculated.

The data was evaluated employing SPSS 16. Statistical analyses used were non-parametric and parametric group comparisions and the Log-Rank (Mantel-Cox) test. The aplan-Meier technique was used to evaluate the influence of the nipple shields on breastfeeding duration. To evaluate the growth data, the daily increments of the weight data provided by the mothers were calculated and compared in both groups.

Results

In the years 2004-2005 about 1000 mothers were recruited for the study from 84 obstetrical units 719 mothers were included in the study according to geographical distribution. The data of their 728 children (9 sets of twins) were evaluated. 36 mothers (5.7 %) had premature babies born between the 31+0 and the 36+6 week of pregnancy. The other children were mature newborns.

All 12 BFHI certified obstetrical units [19] in Austria recruited mothers so that the data of 125 women (17.3 % of the mothers) was evaluated from BFHI hospitals.

171 of the 710 (25.8 %) mothers had breastfed their babies (174 babies) with a nipple shield during their stay at the obstetrical unit. 491 of the mothers (68.7 %) had not used a nipple shield and for 62 mothers there was no information available.

See table 1: The Use of Nipple Shields

The evaluation of the daily weight gain of the 728 babies did not show any significant difference during the first half year in babies fed with or without nipple shields (with nipple shields 30.1 +/- 11.3 g/daily vs without nipple shields 30.4 +/- 13.2 g/daily; not significant).

However, a significant difference was found in the duration of exclusive breastfeeding (Figure 1) and the total duration of breastfeeding (Figure 2), to the benefit of those babies who were breastfed without a nipple shield. The Kaplan-Meier charts show the longer exclusive and partial breastfeeding duration of children without nipple shields over the course of time. ($p < 0.05$)

See chart 1: The Use of Nipple Shields and the Duration of Exclusive Breastfeeding and chart 2: The Use of Nipple Shields and the Total Duration of Breastfeeding

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Table 1:
Nipple shield use during the first week of life, infants dismissed breastfed

	Standard obstetrical unit N=554 N(%)	BFHI obstetrical unit N=112 N(%)	P-value
Nipple shield used	144 (26 %)	31 (28 %)	n. s.
No nipple shield used	410 (74 %)	81 (72 %)	n. s.

Chart 1: The Use of Nipple Shields and the Duration of Exclusive Breastfeeding

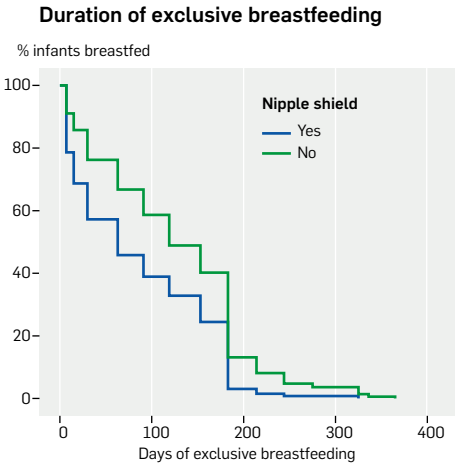


Chart 2: The Use of Nipple Shields and the Total Duration of Breastfeeding

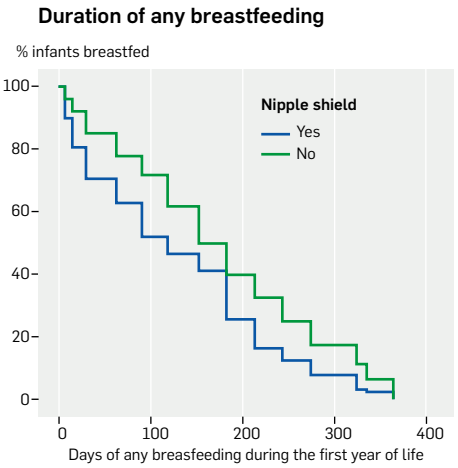


Table 2:
Duration of breatfeeding and use of nipple shields at the obstetrical unit, infants dismissed breastfed

	Nipple shield used N=131	No nipple shield used N=358	p-value
Exclusive breastfeeding, days Mean ± SD	86.7 ± 75,0	126.2 ± 83.2	P=0,0002
Exclusive breastfeeding, days Median (5. - 95. Percentile)	63 (7 – 183)	119 (7 -365)	P<0.0001
	Nipple shield used N=129	No nipple shield used N=329	
Any breastfeeding, days Mean ± SD	131.4 ± 101.7	176 ± 107.3	P=0,0003
Any breastfeeding, days Median (5. - 95. Perzentile)	119 (7 – 365)	153 (15 – 365)	P=0.050

Exclusive breastfeeding: mother´s milk exclusively
Any breastfeeding: time until termination of breastfeeding (incl. solids and/or formula)

› Table 2: Breastfeeding Duration with and without non-parametric Test

The most frequent justifications for the use of a nipple shield were pain at latch-on and easier attachment (Table 3). This justification was given by 336 mothers, 25 (7 %) of whom breastfed with nipple shields, at the baby´s age of three months.

Table: 3 Reasons for Using the Nipple Shield

In the analysis of factors influencing the use of nipple shields, the multivariance analysis showed that parity had a highly significant influence

(p< 0.001) and the mother's age had a significant influence, with p= 0.038. All the other factors evaluated, such as smoking, Cesarean Section, week of pregnancy, multiples, ethnicity and education, had no significant influence on the use of nipple shields. Interestingly, giving birth in a BFHI hospital also showed no significant influence on the use of a nipple shield.

Breastfeeding problems were frequent in our study group: Altogether, 342 mothers (47.5 %) reported breastfeeding problems during the first three months. Of these, 174 mothers (50.8 %) were worried about too little milk production. 55 of the mothers with breastfeeding problems in the first three months (16.2 %) reported problems with their nipples. Half of the the mothers affected by breastfeeding problems in the first three months supplemented or had already weaned before the third month.

Discussion

The data of this prospective survey confirms the experience that infants who had started breastfeeding with a nipple shield in the hospital during the first week of life, were breastfed for a significantly shorter time exclusively or partially than babies who were breastfed without a nipple shield. in the obstetrical unit.

Nipple shields are contoured shields with a silicon or (infrequently) latex teat, which is placed over the nipple before breastfeeding. The shield is often cut out or is very soft in order to improve the contact to the mother. However the teat is harder than the bare nipple. In the USA, these nipple shields are called "ultrathin".

The nipple shield is mostly used to reduce pain or for anatomical problems of the nipple as well as with engorgement during the first days. It can contribute to making breastfeeding possible.[11,16, 17] However, it is often recommended without providing any further information or support. In this study, to our surprise nipple shields were used in BFHI hospitals as often as they were used in standard obsetrical units. It can be assumed that the influence of the nipple shield on breastfeeding is underestimated in BFHI hospitals or is insufficiently known, but here the number of mothers is still limited.

Mostly the obstetrical unit is not informed about the further course of breastfeeding, problems with breastfeeding. Therefore, insufficient weight gain cannot be recognized as mothers are discharged early.

Inverted nipples are considered an obligatory indication for nipple shields. However, since inverted nipples are rare (ca 1 %) [18], the fact that 25 % of mothers are given nipple shields cannot be explained. .

Above all, parity and, to a lesser extent, the mother's age could be seen as the most important influencing factors for using nipple shields. Younger primiparae show more frequent use of nipple shields.

In our study, no difference in the course of weight gain of the children could be determined. However, additional formula was fed significantly earlier and babies were weaned significantly earlier if nipple shields were used. The higher incidence of early supplementation for children being breastfed with a nipple shield indicated that these children received too little milk with exclusive breastfeeding and were, therefore, given infant formula.

Due to the study design of a survey, the amount of supplementary formula fed could not be evaluated. The only question posed was whether the children were exclusively or partially breastfed. The study did not evaluate whether professional lactaion consultation was obtained at any time.

Table 3 :
Reasons for the use of nipple shields

	Number of answers given N=172 % (n)
Sore nipples	49,4 % (85)
Flat nipples, easier latch-on	11,6 % (20)
Inverted nipples	10,5 % (18)
Other reasons given by the mothers for the use of nipple shields	28,5 % (49)

Explanatory paradigms for the negative effects of the nipple shield:

› The teat of the nipple shield almost completely fills the newborn's mouth. The palate is immdiately touched by the nipple shield. Ttouching the hard palate of a healthy, alert, full-term infant triggers the sucking reflex. Therefore babies sucking on a nipple shield begin sucking motions immediately and give the impression of effective breastfeeding.

› The nipple shield hampers the baby's direct contact with the areola and thus minimizes direct stimulation of the breast, thereby reducing the neuro-hormonal feedback via the pituitary gland. As a result of the the reduced release of prolactin, the amount of milk can be reduced. [14]

› During the first few weeks, the milk ejection reflex (controlled by oxytocin) leads to a prompt flow of milk and fills the nipple shield. However, the milk transfer can be significantly impaired.[11]

› Insufficient emptying of the breast can also contribute to engorgement occurring more frequentliy.[11, 18].

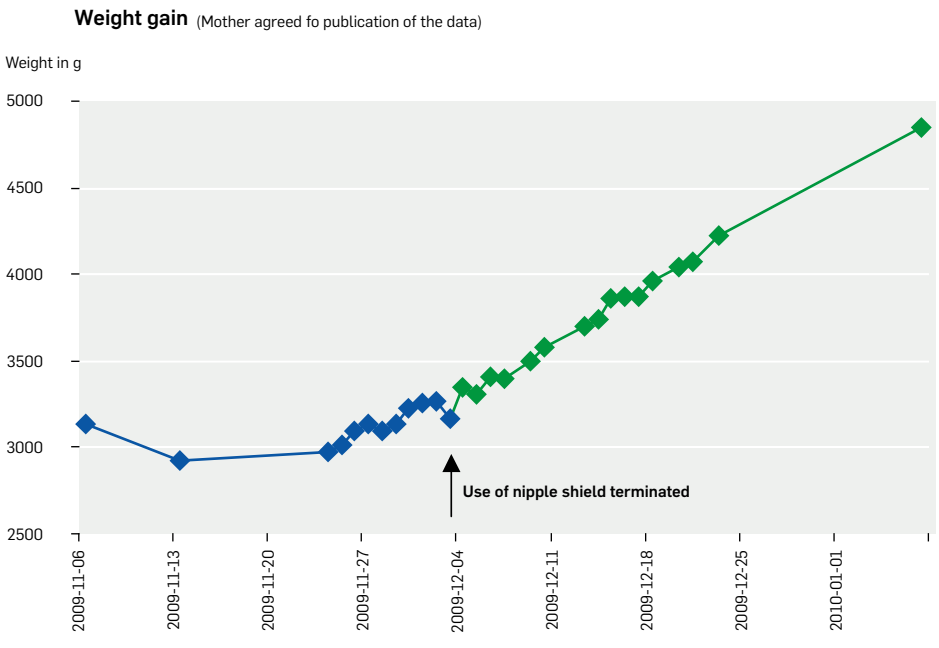
The warm, damp milieu under the nipple shield poses another possible problem: especially with already sore nipples , as fungal and bacterial growth appears to be enhanced according to clinical observations.

› Due to the infant's insufficient milk intake, the baby is breastfed very frequently and for very long periods, but the weight gain is inadequate, a very common effect. Very frequently, supplementary feeding is promptly recommended without searching for the cause.

› If breastfeeding without the nipple shield can be restored, excessive catch-up growth is often seen, even without supplementation.[12]

Chart 3 shows the weight gain of a baby after the elimination of the nipple shield.

Chart 3:
Weight gain after cessation of nipple shield use



Contradictory experiences with the use of nipple shields are discussed in the literature:

Paula Meier[15] describes very good experiences with nipple shields in extremely small premature infants on the NICU. With excessive milk production, milk transfer could be increased on average from 3.9 ml to 18.4 mil. These optimally supported mothers of small prematures, however, are not comparable to our collective.

Chertok [7] reported successful use of the nipple shield for two months with full-term babies for appropriate indications. Brigham [4] also reported good experience with the use of ultrathin nipple shields within the framework of counseling in the Breastfeeding Clinic, but advises that the nipple shield should only be used for for the shortest period of time possible.

Powers[17] surveyed 202 breastfeeding mothers using nipple shields, who reported their personal positive experiences with them. The duration of use of the nipple shield varied between 1 day and 15 months.

On the contrary, there are publications discouraging the use of nipple shields:

In a clinical study, planned to examine the influence of nipple shields on the amount of milk that could be expressed by pumping, Auerbach[2] reported significantly reduced milk volume if pumping was done through a nipple shield.

In a Polish paper, Mikiel-Kostyra[16] noted that the use of nipple shields often caused nipple confusion

Guóth- Gumberger[11] mentions that some babies cannot cope with the different sucking patterns needed - with and without nipple shields - and sometimes also with bottle teats and refuse to suck from the bare breast. This is called nipple confusion.

Wilson-Clay[21] clearly describes the controversies regarding the use of silicon nipple shields which, on the one hand, have contributed to making breastfeeding possible and, on the other hand, have shown indications that earlier weaning may be associated with their use.

In the guidlines of the International Lactation Consultant Association (ILCA)[13] it is noted that the use of nipple shields can lead to sucking difficulties and reduced milk production and, thus, their use should be avoided until any negative influence on breastfeeding can be ruled out.

In a recent literature review, McKeechnie et al.[14] point out that the literature on nipple shields is sparse and is often ›

only of limited use. It can be assumed from some studies that the use of nipple shields could lead to a reduced excretion of the hormones oxytocin and prolactin. Many studies show that with the use of nipple shields there is a shorter exclusive and partial breastfeeding period and frequently, a reduced milk transfer. Overall, the authors strongly advise against regarding nipple shields as safe and free of risk with respect to breastfeeding, weight gain and milk production.

When mothers are given nipple shields, it is important that they are fully informed about the advantages and limitations of the nipple shield and that good support is provided.

In her book "The Course of Weight Gain and Breastfeeding", Márta Guóth-Gumberger goes into depth about the possible significan reduction of weight gain, its course compared to the WHO centiles and the potential risk for the baby resulting from use of the nipple shield [12]

On the homepages of VSLÖ and EISL there is instruction (in German only) on the use of nipple shields with the warning never to use them without counselling, to use them as infrequently as possible and to provide sufficient support to the mothers. [20]

Conclusion

In order to be able to evaluate the use of nipple shields with good supervision, further studies on the feeding patterns of the babies, on the hormone levels with and without nipple shields, as well as on milk transfer and the consequences of using nipple shields, are urgently needed.

If nipple shields are inevitable, mothers should be well informed and supported and the use of the nipple shield should be kept as brief as possible. When nipple shields are used, it is necessary to offer the mothers further information, counselling and support (i.e. through IBCLCs, www.stillen.at, www.stillen.de), so as to prevent poor growth, followed by early supplementation and weaning.

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