

Lactation & Breastfeeding

Magazine of the European Lactation Consultants Alliance • www.elacta.eu • ISSN 1614-807x

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European
Lactation Consultants
Alliance



EDITORIAL

Dear members, dear colleagues,

At first, I would like to wish everyone a very happy 2019!

This past year, the team of the magazine has made big steps forward. We welcome a new member of our editorial team, Julia Glantschnig, who will deal with the subscriptions.

In the publication of this issue you will read about the successful conference organized by VSLÖ and EISL in Vienna. A very fruitful meeting of the ELACTA Board and the Editorial Team took place. In this issue you will find the reports.

In my editorial, I will briefly share the subjects of the issue with you. You will find a marvellous interview with Elizabeth Hormann, the first IBCLC in Europe! Additionally, Petra Schwaiger has written a detailed report about her experience in setting up her practice as an IBCLC. For our brand new IBCLCs a useful contribution!

Natalie Grois has written a handout about sore nipples and treatment of the different wounds, which will be very helpful for the daily practice of an IBCLC. Jack Newman has contributed an interesting article on jaundiced babies.

The cluster randomized study about early discharge from hospital from Ingrid Nilsson illustrates the effects of a simple intervention plan on the outcome of breastfeeding. Eva Bogensperger-Hezel points out the importance of breastfeeding preparation during pregnancy. Information about breastfeeding should be given at least 9 months before giving birth.

During the last meeting of the Breastfeeding Council in my country I spoke to different health care workers in the field of lactation and I am fully convinced that we can play a major role by being ambassadors for the babies and their caregivers.

I wish you a pleasant time reading!

Kind regards,

Karin Tiktak
President ELACTA

IMPRINT

Company Information:
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Layout: Christoph Rossmeissl

Published quarterly at the end of March,
June, September and December

Deadlines: 15 January, 15 April, 15 July,
15 October

With its articles, Lactation and
Breastfeeding wants to go beyond expert
information about breastfeeding and
also stimulate discussion. Therefore, we
welcome your views. Please send Letters
to the Editor to the following email
address:
magazin@elacta.eu

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LETTER TO THE EDITOR, EDITION 2-2018, ARTICLE „BEIKOSTEMPFEHLUNGEN UND WIRTSCHAFTSINTERESSEN“

Complementary Feeding Recommendations and Business Interests



The author discusses the background and context of interest in which this recommendation is made. The author also discusses the background and context of interest in which this recommendation is made.

Dear Ms. Ziemer,
dear Editorial Team

I would like to thank you for your very informative and so carefully researched article “Complementary Feeding Recommendations and Business Interests” in *Lactation and Breastfeeding* 2/2018. It is certainly not just very valuable

for me when you illuminate the backgrounds of the entanglement of the infant formula manufacturers, lobbyists and sloppy reporting and decry the manipulation behind it. What remains after reading it are outrage and head-shaking over so much greed and irresponsibility.

I discuss the topic of “complementary feeding” over and over again in lectures in the region and I encounter it regularly as a lactation consultant in each of my breastfeeding groups. The women repeatedly report to me what you also observed in your small daughter: The babies know exactly when they are ready to eat and want to start with it. Why do the mothers often listen so little to the signals of their children and allow themselves to be guided by the glass-jar labels or apparent authorities and tendentious info-literature?

In my experience, among those giving false advice in my own environment are – unfortunately – many health care professionals, who are also “educated” and influenced by the glass-jar-fraction. All too often, they incorrectly understand the formulation “earliest at the beginning of the 5th month” as a directive that must be strictly adhered to.

If one recommends a later start with complementary foods to new mothers, one can even be confronted and attacked by an angry physician as happened to me recently

Your excellent article is a welcome basis for argumentation and help with this. One battles against the powerful alliances of glass-jar advocates but it is often a fight against windmills. Nevertheless, it is worth it.

I wish you and all those who know better, continued success with your educational work!

With kind regards,

Marlies Würzner, Lactation Consultant

Mothers' views on information provided to pregnant mothers on preparing for Breastfeeding

The WHO calls on health care providers to discuss the importance and management of breastfeeding with pregnant women in step 3 of its 10 steps to successful breastfeeding⁽¹⁾. But when is the right time to start discussions on preparing to breastfeed and where do women get information from? I discussed this question with about 15 mothers in breastfeeding support groups and also received written answers from them. All agreed that “breastfeeding preparation is a really important topic“. Author: Eva Bogensperger-Hezel, IBCLC

Many mothers do not expect the multitude of conflicting information given in the maternity ward or the variety of extremely intense feelings they experience in the first days after childbirth. The more their experience differs from their expectations in pregnancy, the more they are likely to be disappointed.

There are many reasons why the first days in the hospital do not go the way parents expect before their baby is born. Medical staff also often feel disappointed because they are not able to give mothers as much support as they need.

Four out of five mothers initiate breastfeeding⁽²⁾. If asked during pregnancy whether they would like to breastfeed, most mothers give an affirmative answer.

Where do parents get information from?

Many mothers expected to get information from their midwife or in childbirth preparation courses.

“The information I got there was very theoretical – in practice I couldn’t do anything with it“, was a comment I heard from many mothers. This begs the question what mothers perceive to be practical information.

Mothers reported that childbirth preparation courses run by midwives sometimes devote no time to breastfeeding or cover the topic of breastfeeding in one evening. Most mothers said that breastfeeding was touched upon or mentioned. The courses which mothers appreciated most were those in which some aspect of breastfeeding was discussed in every session.

Many women also sought helpful literature in bookshops and got hold of every self-help book on display. Often the books available were outdated, inappropriate or influenced by advertising. Several mothers were lucky enough to find the book “Stillen” by Márta Guóth-Gumberger and Elizabeth Hormann⁽³⁾ and found it highly recommendable and helpful.

One way to recommend good literature to mothers would be to create and display lists of good up-to-date books. Coordination between specialists (and volunteer breastfeeding counsellors) is a help here, as it prevents such lists from reflecting personal bias. Meeting in



Photo: © iStock.com/Wavebreakmedia

person can help, but there are also some useful forums on the internet that enable breastfeeding counsellors to network with each other.

Few mothers visited breastfeeding preparation courses. One reason for this is that they thought they would learn the most important things in childbirth preparation courses and receive instruction and support from the staff in the hospital. Some women had not heard of any breastfeeding preparation courses taking place.

It's not easy to find an answer to the question of how such courses can be advertised. When they are looking for a midwife to provide aftercare after the birth, most women visit the websites of midwives or midwifery centres. Thus, cooperation with a midwife or midwifery centre can be very helpful. A personal recommendation from a midwife or a friend is most effective.

Only one mother reported that her gynaecologist had raised the issue of breastfeeding with her.

This list can be expanded. One woman with type 1 diabetes was informed by her diabetologist of the positive impact of breastfeeding.

Practical information?

All women agreed that practical exercises on correct positioning and latching are particularly important. Wherever possible, information should be illustrated. Examples cited were a picture of a really wide-

open baby's mouth, different breastfeeding holds and positions, or videos of babies drinking effectively.

One breastfeeding mother pointed out, *"The message that I don't have to put up with severe pain when my baby is latched on, but that I should try to get a better latch, was very important to me. Nobody mentioned this in the hospital."* The real life experience of many young mothers was that their babies were "latched on" for them when they asked for help. *"I got the impression that it was a highly complex technical exercise, and I wondered how my baby and I would ever manage on our own."*

Even in times where the staff is overworked and no one has time for them, women who have realistic expectations before childbirth are better able to cope if they know about the importance of skin-to-skin contact not only as a means of calming babies, but also as a means of rousing sleepy babies. Some mothers had heard about babies' instinctive nursing behaviours and had wonderful experiences with intuitive breastfeeding due to skin-to-skin contact. *"Laid-back nursing was absolutely the best thing for me in the beginning!"* One of the most valuable means of supporting staff (especially when they are overworked) is to promote continuous or repeated skin-to-skin contact in the first few days. We all know about the advantages of bonding. Why don't we take advantage of them in the maternity ward?

Other topics for breastfeeding preparation courses:

The mothers in the groups mentioned topics such as:

- › Information about the value of colostrum and the possibility to express colostrum after the birth and feed the baby with it in a breastfeeding-friendly way if he or she is unwilling to suckle. *"When the nurses wanted to feed my baby with a bottle it was a great relief to have learned in pregnancy that this is an alternative. Being able to assert myself and get my own way made me proud of myself."*
- › *"Don't let yourself be persuaded unnecessarily to supplement – supplementing changes baby's intestinal flora."* – This statement appears rebellious, but for me it is a sign that women need more information to back a decision to supplement when it is necessary, and, even more important, they need to know about alternatives. These include how to express and feed their milk or colostrum, and what other means of soothing babies there are (e.g. skin-to-skin contact, carrying/babywearing, massage, swaddling)! One breastfeeding mother burst into tears when we talked about this, and said that she would have really appreciated hearing this information in pregnancy. Many women reported that supplementing with a bottle was proposed very early – and often portrayed as the only solution. In retrospect, they are often sad and angry with themselves or the hospital staff. Sometimes they use words like "failure".
- › The basics of milk production (*"... that the first day is very important and that I should wake my baby to breastfeed him if he sleeps too long", "... that you can't suddenly not have enough milk ..."*)
- › Some information on caesarean sections would be useful, although it is important not to focus too much on potential problems. (*"...to know that skin-to-skin contact and initiating breastfeeding right after birth are just as possible as after a normal birth, and that you can still breastfeed after taking painkillers, and that taking enough painkillers helps."*) IBCLCs and other breastfeeding counsellors can address this last comment by providing basic information on medications and breastfeeding. Many unnecessary restrictions on breastfeeding are still made in this connection.
- › Co-sleeping and its importance for bonding and getting to know the baby and for breastfeeding. ›

- › (Information on a safe sleep environment belongs here, as well as the practical advantage of not having to get up at night to breastfeed.)
- › Clusterfeeding (...that I can create a comfortable “breastfeeding station” where I can put everything I need while nursing – something to eat and drink, my mobile phone, the remote control, a book....)
- › Nutrition and diet while breastfeeding (“...the main thing is that I can actually eat anything”)
- › Some women wished they had heard that the recommendation to breastfeed exclusively is still correct and that breastfeeding should be continued after the introduction of complementary foods.
- › Contact addresses for potential breastfeeding problems (midwife, breastfeeding support groups, breastfeeding counsellors).
- › The importance of the baby’s father, his opinions and support.

Does everyone say something different?

Apparently differing or de facto contradictory information from hospital staff, especially with regard to positioning and supplementing, left many women feeling insecure in the postpartum period. Is there a way of empowering women so that they can cope with this?

“Build up women’s self-confidence before childbirth. Let them know that breastfeeding or looking after a baby generally works if you trust your intuition, that qualified counselling is available and where they can find it.”

This mother puts into words something that many mothers confirm. Lack of confidence in their own abilities was the most common reason why they preferred to trust an expert rather than their own gut feelings. In retrospect, many mothers had the feeling that they were “persuaded” to supplement.

Continuous support from one person is often lacking in the postpartum period. Women who were attended to by an IBCLC or nurse trained in breastfeeding management were much happier and described the form of care they received as more consistent, especially when this person was only responsible for breastfeeding questions (e.g. because as an IBCLC and breastfeeding specialist, she was allocated work time for breastfeeding counselling).

What empowers mothers (parents) to go their own way with confidence and to assert their opinions even in the delicate and emotional early days after childbirth?

As well as the information above, mothers have the following wishes:

- › Counsellors who radiate a sense of calm and security
- › Instructions and guidance from someone who is patient
- › Enough time to perceive and act on their own intuition
- › The statement that parents, especially the mother, know their baby best. (“Trust your own feelings, look at your baby, people caring for the mother should show trust in the mother’s intuition.”)

One woman said it would have been good to know “that despite a resolute manner and alleged knowledge, nurses and midwives often don’t know much about breastfeeding”.

Mothers often make statements like this to provide an explanation for why they didn’t “defend themselves”.

It is a challenge and an art to counsel and tend to a woman in such a way that she is actively involved in decisions and never gets the feeling afterwards that she was persuaded to do something without wanting or understanding it.

All mothers saw the breastfeeding group as a great form of support! In addition to breastfeeding-specific information, mothers find the chance to communicate (honestly) with each other very important. It is well worth visiting a breastfeeding group during pregnancy. Many mothers hardly had any contact with breastfeeding mothers before the birth of their first child. Mothers can support, empower, console and motivate each other. Sometimes the group leader has to make an effort to pick up and act on unspoken feelings such as “guilty conscience”, “comparing with each other” or “being inadequate”. When this succeeds, mothers in breastfeeding groups receive a priceless gift.

Not all breastfeeding problems can be addressed adequately in a breastfeeding group. Some mothers may also need individual counselling in the form of a home or practice visit. This type of counselling often complements midwifery care after birth. If mothers know about the different types of counselling on offer early enough, this will save them from a difficult and frustrating last-minute search (usually via the internet) when they are experiencing problems.

Finally, typical myths and old wives’ tales about breastfeeding should be addressed in pregnancy. This will enable parents to filter the different advice they receive in the intense and emotional early days and pick out the information that works for them and their babies!



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- › ^[1] World Health Organization; **Protecting, Promoting and Supporting Breastfeeding: The Special Role of Maternity Services**, a joint WHO/UNICEF statement 1989, 2018 revidiert: www.who.int/nutrition/bfhi/ten-steps/en
- › ^[2] Von der Lippe E., Brettschneider AK, Gutsche J., Poethko-Müller C., **Einflussfaktoren auf Verbreitung und Dauer des Stillens in Deutschland – Ergebnisse KIGGS-Studie – Erste Folgebefragung (KIGGS Welle 1)**, Bundesgesundheitsbl. 2014;57 (7): 849-859
- › ^[3] Guóth-Gumberger, Márta / Hormann, Elizabeth; **Stillen – Einfühlsame Begleitung durch alle Phasen der Stillzeit**; GRÄFE UND UNZER Verlag GmbH 2014



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Many years of experience as a nurse on the maternity ward.

An example of building a breastfeeding counselling Practice

How it all began. Author: Petra Schwaiger



Intuitive breastfeeding and skin contact are important elements in practice

The decision to take the training to become a lactation consultant, developed quickly after the birth of my second son. I worked half-time in a newborn unit, but also spent a lot of time with my children on the playground and met many other mothers.

Inevitably, at some point, the topic of breastfeeding came up. And mothers said: “I couldn’t breastfeed.” When I heard that, I often felt bad, but knew only too well that it was not the “fault” of the mothers that they could not breastfeed, but that the breastfeeding management in the hospitals was so poor that breastfeeding could not succeed. I experienced this daily on the job. Nevertheless, the feeling of failure and “not-being-able-to-“remained. Changing this was and is my motivation.

During my training in 2003 to become an IBCLC lactation consultant, I already

knew that I also wanted to work free-lance. I saw the great need. So, only six months after passing my exam in 2004, my own homepage went online and, alongside of my job in the hospital, I began to work on a free-lance basis, offering both home visits and telephone counselling. I worked this way between 2004 and 2015. Over this long period of time, the wish to open a practice of my own and “only” work free-lance grew greater and more concrete. Nevertheless, I wouldn’t have wanted to miss out on the long years, during which I was able to acquire experience from which I am now profiting. The fact that I was able to have experience with breastfeeding both on a newborn unit as well as on a newborn intensive care unit, as well as having worked as a study nurse in research, makes my work as a breastfeeding counsellor easier. Also my work as a head nurse and

breastfeeding coordinator and the further education on “Middle Management in the Health Care Sector” help me to organize well and with the daily planning and documentation of my counselling activity.

The start

In 2016, I decided to end my work in the hospital and to work primarily free-lance as a lactation consultant. I updated my homepage, designed flyers and business cards and established contacts with pediatricians, midwives and gynecologists.

I informed myself about taking out health insurance for self-employed persons, about possible pension contributions, the necessity for my own professional liability insurance, etc.

At first, I wanted primarily to offer home visits for acute breastfeeding problems.

Then, I searched every now and then >

for consulting rooms. But the rents for these are very high in Munich. Even then, I tried to network myself with other breastfeeding counsellors. For, possibly, I could also share practice rooms. At the beginning it was not possible to do it alone.

However, right from the beginning, it was also important to offer “my women” an easily accessible advisory service in the context of a breastfeeding meeting. Also, especially for the women who could not afford a second, possibly necessary home visit. *It is very important to be able not to refuse to counsel women for financial reasons.*

So, I undertook a search for a room, which I could use once a week for this. Here, I actually had good luck. I found a very lovely room right in the middle of the city center in Munich.

My time planning in the first year of my self-employment

In the first year (2017) of my self-employment, I offered home visits, infant care courses, complementary feeding seminars, as well as my breastfeeding meeting. As a benchmark, my goal was 5-10 consultations a week. This worked very well from the beginning without having to invest much in advertising. The breastfeeding support group also proved very popular. On average, between 6 and 12 women constantly participated. The number of home visits grew steadily and there were days in which I was underway with the car a lot because, as far as possible, I visited all the districts in Munich. Due to the fact that this takes up a lot of time, today I only offer home visits in certain districts. I have networked well with IBCLC colleagues so that I can make a referral to a colleague if necessary.

My time planning in the first year of my self-employment

	Monday	Tuesday	Wednesday	Thursday	Friday	Sa/Su
Tel. Consulting	8:00-9:00	8:00-9:00	8:00-9:00	8:00-9:00	8:00-9:00	
Office hours in the practice		10:00-16:00		10:00-16:00	10:00-16:00	As needed, in emergency
Time for home visits	9:30-16:00		14:00-16:00			
Breastfeeding meeting			10:30-12:00			
Breastfeeding lecture for parents in the hospital	1x a month					
Complementary feeding seminar in a pediatric practice	1x a month					

The practice room

At the beginning of 2018 we moved into a house in which it was possible to set up a practice room. For me, this had the advantage that the families could come to me and I no longer had to drive so much. Because we moved away from the inner city of Munich into a suburb, I was unsure at the beginning about whether the families would actually come to me in Deisenhofen.

I opened the practice in March 2018, about 10 days after we moved. And astonishingly, it really went/is going very well. Most women have no problem having to come to me in the practice, while I also accommodate the families by offering appointments on the weekend because the fathers are able to come then.

Setting up the practice room

Setting up my own consultation room was exciting and also a challenge since there are scarcely any models for this. Where do I put the desk, the sofa or the breastfeeding chair? Do I need a warming lamp, a scale, an extra chair for the father? Do I need to have diapers and disposal changing mats? Are there hygienic standards that I must observe?

I dealt with all of these questions.

And after a couple of weeks of running the practice, I rearranged things again, got better lamps and also, in fact, a scale, as well as diapers and (disposable) changing mats. Mostly the parents have all the things with them that they need for diapering but some young, nervous parents/mothers don't. So it is more relaxed for everyone if I have the basic supplies available. The warming lamp and the scale have also proven valuable.



Photo: © Petra Schwaiger

My weekly planning since March 2018

	Monday	Tuesday	Wednesday	Thursday	Friday	Sa/Su
Tel. Consulting	8:00-9:00	8:00-9:00	8:00-9:00	8:00-9:00	8:00-9:00	
Time for home visits	10:00-16:00	10:00-16:00	14:00-16:00	10:00-16:00	10:00-16:00	As needed in an emergency
Breastfeeding Meeting			10:30-12:00			
Breastfeeding lecture for parents in the hospital	1x a month					
Complementary feeding seminar in a pediatric practice	1x a month					

Since March 2018, my weekly planning looks like this:

Normally, I always offer home visits on Mondays and, if needed, on Wednesday afternoon. On all other days, the families/women come to me in my practice. Mostly, I start at 10:00 a.m., also because this is most favorable for the families from a traffic perspective. On practice days, I counsel 2 to 6 families a day. A consultation in the practice takes about 60-90 minutes or, in exceptional cases, occasionally 120 min. If possible, I plan in at least 90 minutes. Thereby, there is no waiting time and I have sufficient time to document the individual consultations.

Communication and making appointments

Mothers reach me either via my landline telephone, at best during my telephone hours in the morning between 8:00 and 9:00 or through my homepage. During the day, while I am making home visits or have made appointments in the practice, the

mothers either cannot reach me at all or, in exceptional situations, only by telephone, but rather, via my homepage or email. Mothers with breastfeeding problems can send me a question through a contact form on my homepage. The email that it generates contains name, address as well as telephone number and the reason for the query. It is important that the telephone number be included in the email. This facilitates rapid contact by telephone and making an appointment. I make appointments by telephone or suggest possible appointments to the mothers by email. This procedure also functions well. Very rarely is an appointment cancelled or postponed. Mothers who are already in counselling, also use the contact form or email to make a telephone appointment if they have not reached me during the telephone time.

Generally speaking, I try not to communicate with the mothers or counsel them per WhatsApp. This is not always easy, but when I explain to the mothers that this is also for their own protection, they accept it gracefully. I also avoid communication via WhatsApp in order not to lose the overview and to ensure an orderly documentation.

Preparing the consultation

I put the data that I have received from mothers by email or during a brief preliminary talk by telephone (such as first and last name, address, telephone number, birth date of the baby, etc.) into my documentation system ahead of time. After the creation of a file for a new patient/client, I can generate and print a personalized case history sheet. The available data are already contained in this document. Further infor-

mation can be added by hand. A patient ID is also allocated on the personalized history sheet with which one can easily search for the patients/clients in the system or also in the register

If, before the actual consultation appointment, I already know that it is not, for instance, a consultation on insufficient weight gain or insufficient milk production nor about painful attachment to the breast, then I always try to ask about the data on weight ahead of time in order to be able to create a weight curve. Thereby, I work primarily with the program by Márta Guóth-Gumberger (LACTDOC).^[1] I can enter all the data into my documentation system and it will be automatically exported to the LACTDOC program. Personally, I have had good experience with this, with discussing the weight curve with the parents and, if they wish, I can print out a copy of the curve for them.

It is helpful for me to already know certain things before the actual consultation, i.e. about particular basic illnesses in the baby or the mother or problematic weight gain, etc. Therefore, it is worthwhile having a short telephone call beforehand if the request by the parents has come by email. Sometimes, however, this is not possible for time reasons. In the case history sheet there is also a page which the parents sign, that they agree to the consultation and the examination of themselves and their child and with the saving of their data.

¹ Guóth-Gumberger, Márta, LACTDOC: Program for Documentation and Weight Monitoring of Breastfed Babies <http://stillunterstuetzung.de/eng/pub.htm>

EXAMPLES FOR PUBLICITY:

- › Homepage and other online presence such as, i.e., Google Business or Facebook
- › Flyers
- › Business Cards
- › Advertising, i.e., in parents' magazines
- › Contact with the Women's Affairs Officer in the state/ region
- › Breastfeeding preparation courses in hospitals
- › Actions for World Breastfeeding Week with other IBCLCs

Home visit – practice visit

Anamnesis/case history

With home visits and consultations in the practice, I quickly moved to begin very systematically and to go through the case history form with the women. Often the parents/mothers had already written a very detailed email about how they were faring at that time. Nevertheless, it proved effective for me not to go into the email and the current situation directly, but to go through the case history form, step by step. Frequently, I receive a completely different picture than I would have, had I only noted key points in an unstructured way. For this reason, I combine a kind of checklist (i.e. type of birth, illnesses of the mother, etc.) with an open discussion, i.e. about the experience of the birth.

The standardized anamnesis, with the help of a checklist, is characterized by closed questions or by pre-defined answers. This is why I combine the closed questions with the possibility of formulating the questions myself. The advantage here lies in objectifiable data that I can update later in my documentation system or put in directly during the consultation, if the women come to me in the practice. For this, I also use appropriate assessment instruments, such as pain-scale or pain-score.

Observing a breastfeed

Sometimes it happens that the baby already wants to breastfeed during the discussion of the case history. That obviously always takes precedence. I ask the mothers to position the baby as they would do if they were alone. Thereby, I can easily recognize where there is potential for improvement or possible underlying mistakes. It is always surprising for me how little feeling or understanding there is among new mothers about what is really a comfortable breastfeeding position.

Examining the breast

I look very carefully at the breast and the mammillae before and after the breast-

feed. I have also had good experience with palpating the breast before and after the breastfeed. In order to be able to better judge the condition of the mammillae, I work with a special daylight lamp and sit on a small stool directly in front of the woman. In this way, I can best see what I want to see.

Examining the baby

The point during the consultation at which I look at the baby is very individual. In any case, I want to see into the mouth of the baby in order to make a judgment about the palate or a tongue tie or, for instance, to detect a white coating that could indicate thrush. Often, you can see well into the mouth if the baby cries briefly. I am generally very reserved about examining the mouth with my fingers. It is important to me to see the infant lying relaxed on the changing table. Mostly, this occurs shortly before or after the parents have diapered him. Thereby, I want to see whether the baby is relaxed when he is lying down and whether there is a possible difference between (the left and right) sides

The end of the consultation, time planning and further support

I plan 60-90 minutes for a home visit or a visit to the practice so that there is sufficient time to actually observe an entire breastfeed and, afterwards, there is still some time left to reflect on what was seen and discuss possible individual solutions. What I recommend or what was discussed, I summarize in key points in writing for the mother and go through them point by point so as to address any questions immediately.

After the consultation, mothers are given a cell phone number under which they can easily reach me in an emergency or with urgent questions or I mention my telephone consultation hours again.

I always ask the mothers for feedback after a few days, either by email or by telephone.

It sometimes happens that I set a follow-up appointment with the parents im-

mediately after the consultation. However, in about 75% of the cases, one consultation and 1-2 telephone calls are sufficient.

Invoicing

At the end of the consultation – that is, as a rule, about 6-9 weeks after the first interview when all further questions have been clarified or after I have received feedback from the patients - all families receive a detailed invoice with an invoice number and all the relevant data (date of the consultation(s), reason for the consultation(s), etc.) by post, which, in some cases, they can submit to the health insurance. The invoices generate themselves with a touch of the button from the data that I have put in during or after the consultation,

Weekly breastfeeding meeting

After a consultation, the women happily come to follow-up care in my weekly breastfeeding meeting. At the beginning, I had doubts about whether this offer would really be taken up. But after a year-and-a-half, I can say that it has been very well received. It is good in many respects:

1. It is a low-threshold offer for women who are not yet sure whether they want to avail themselves of a breastfeeding consultation or first want to get to know the counsellor with no obligation.
2. It is an inexpensive offer for aftercare for women who have already had a home visit or individual consultation.
3. It is a good opportunity for women to get to know other women in similar situations.
4. As counsellor, I learn an amazing amount, i.e. about the effectiveness of individual counselling/work.

An example:

I took care of the patient at the beginning of the year. At the beginning, her baby needed intensive care and breastfeeding was not possible. When she was back home, she had continued to pump and to supplement with infant formula. Putting the baby to breast had not – or only seldom – worked.

During the time that her midwife was on vacation, I visited her at home twice. We practiced putting the baby to breast and discussed pump management. We tried to reduce the stressors and talked a lot about the first few days, which were particularly traumatic due to the separation and her feeling of helplessness. In between the two home visits, we telephoned three times. The main issue was the topic: "Will I manage this/will my milk be sufficient?" After the second home visit, I then heard nothing more for a while. At this point, the patient was nearly fully breastfeeding. Then about 4 weeks after the second home visit, she came to my breastfeeding meeting, exclusively breastfeeding and tremendously proud. I asked her what had helped her the most. She didn't have to think long about this and said the following to me: "What helped me the most was that you were always so optimistic. Once you said to me 'You will breastfeed this baby. It is a matter of time.' That calmed me down and gave me confidence."

During the home visits and telephone calls we spoke about so many things. What she could still do, how she could increase the amount of milk, etc. But these very simple words were what had helped this mother the most.

I myself couldn't remember having said this. But I learned a lot from this. Perhaps, without my breastfeeding group, I would not have gotten this information. And I am very thankful that through a foundation, I have the possibility to use a room so inexpensively.

Is everything breastfeeding counselling?

In the last few months or, actually, since I have had my practice room, it occurs to me more and more often that the part of my work that makes up the actual breastfeeding counselling, is becoming ever shorter. However, the women need a lot of time in order to tell what they experienced in the hospitals and how they fared there. How little time the staff had for her; that she was treated as undeserving and in an unfriendly way; that she was hurt by hastily said words there or someone was rude and

unkind to her baby or she and her concerns were not taken seriously. Everything was interconnected, the hurtfulness, the sore mamillae, the crying baby, the overload, too little time, the milk coming in, insufficient milk, no sleep, no recuperation, no time to eat, I never imagined it would be like this, and so on. All of this must be heard and requires consolation and understanding.

And I listen to all of this, all these stories and this dilemma becomes so clear. I know from my time in the hospital that most maternity nurses, pediatric nurses, midwives and physicians happily work with the women, are highly motivated and want to give their best and still it often does not succeed. No-one will consciously hustle the mothers at breakneck speed across the maternity unit or hurt them intentionally. I just don't believe that. But our current health care system and the nursing crisis allow no time for more than the bare essentials. And among others who must pay for it are our young families on the maternity units.

What is difficult – limits of counselling

It is Friday afternoon, a patient comes with very sore, infected, painful mamillae. Weaning is being considered. Here, I can give advice, practice putting the baby to breast if possible and, ultimately, I can also work with the laser, introduce sensible wound management with the breast-donut, etc. But here, still more is needed, i.e. *decoder tri or crème cordes*®. I know that if it is not better soon, the patient will perhaps give up because she cannot bear it anymore. And here, for me, as a breastfeeding counsellor, the big question is how I can organize things now – Friday afternoon – a prescription – and then find a physician who takes the problem seriously and will write an appropriate prescription. For a breastfeeding counsellor who self-employed, it is imperative to build up a network of physicians, who will support her, take her seriously and are also prepared to help in an unbureaucratic way (I mean, for instance, appointments at short notice on Friday afternoon).

And there are situations in which I, as a breastfeeding counsellor, come against real limits – in a post-partum depression, for instance. Here, I can deal with a possible breastfeeding problem, but it must be clear that in these cases, professional psychological help is necessary. Here, I work very closely with a mother-child psychotherapist. It works so well that the women can often connect at short notice. Or in another case: From birth on, the baby (the mother's 2nd child) had a laryngomalacia/ "soft larynx". Probably due to the many examinations of the baby's mouth, breastfeeding became increasingly difficult. Consequently, the baby had gained poorly and had, to some extent, refused food. There was no question of feeding from a bottle. As I counselled the mother for the first time, the baby already had a gastric tube, was two months old and had several hospital stays behind him. The mother was so worried about the baby's condition and, on top of that, had great anxiety that her milk production would decline. This is why she contacted me. A real vicious circle and a significant eating disorder had developed. Here too, it quickly became clear that I could certainly encourage the mother and could help her to maintain her milk supply. We also tried breastfeeding time and again with and without the gastric tube. However it was also quickly clear to me that, in this case, extensive professional help was needed and I also spoke about this openly. This mother had breastfed her first child without any problems and suffered a great deal that this time it did not succeed.

Conclusion

For almost 2 years now, I have now worked exclusively free-lance as an IBCLC lactation consultant. I still miss my work in the hospital, which I had loved so much. However, I have not, for a single day, regretted or questioned my decision to become self-employed. I have no employer. I organize my time as I wish. I can take as much time as I want. If it happens that a woman who has come to me very tired and did not have enough time to eat break- ▶

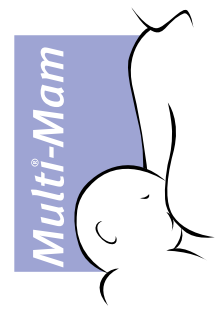
› fast, I can first make coffee for her before we begin with the actual consultation (here it is helpful if the breastfeeding consultant is also a barista). I can work on weekends when I want – or not. In the hospital, I did not have all this freedom and the time to really be there for a family.

But courage is also needed. For it can well happen that my appointment calendar for the coming week is almost empty on Friday afternoon. In breastfeeding counselling, the appointments are almost always made at short notice. Making appointments for breastfeeding counselling well in advance happens rather seldom. And one must be able to cope with this. It is much the same regarding the fact that the telephone rings constantly on Monday morning and that after two hours there are no more appointments free for the next three days and women who actually urgently need help must be refused. I am very thankful that I have, meanwhile, developed a network of very involved colleagues and that we help each other out and share ideas and learn from each other.

And I am also very thankful to my husband, Gerson Kurz, for helping me and supporting me in working in the way I want to – even on weekends or holidays. He programmed the documentation and invoicing programs, without which I cannot imagine how I would work.



Petra Schwaiger
Kinderkrankenschwester,
Still- und Laktationsberaterin IBCLC
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Caring properly for sore Mammillae

By **Natalie Groiss**



Photo: © Andrea Hemelmayr

Sore mammillae (nipples) are among the most common breastfeeding problems and, not infrequently, lead to premature weaning. Rapid successful healing protects against further problems, from wound infections up to breast infections, an abscess and premature weaning. To bring about rapid healing, it is important to first recognize the causes and to remedy them.

1 Looking for the causes and remedying them

It is best to look for a certified lactation consultant (IBCLC) to identify the causes and remedy them.

If sucking feels painful and/or the skin is damaged, mostly the mammilla is not lying in the baby's mouth correctly. The cause for this could be, among other things, an incorrect technique for putting the baby to breast, the milk coming in very strongly (ca. 3rd day after birth), a short tongue tie or lip tie or other anatomical features in the baby's mouth, insufficient elasticity or changed sucking behavior due to the use of an artificial nipple (pacifier, bottle, nipple shield)

Inadequate blood circulation, infection or skin disease on the mammillae, as well as incorrect handling of the milk pump and nipple shield, can also damage the sensitive skin of the mammillae.

Without effective elimination of the cause, even the best wound management is ineffective!

Cleaning the wound

After the breastfeed, the mammilla is treated:

2a

The mammilla is red or irritated, but not yet open

Don't forget to clean the breast as part of normal daily personal hygiene and also to wash your hands after using the toilet and after diapering the baby! After breastfeeding, the mother's milk can be allowed to dry on the mammillae. Mother's milk contains nurturing, protective and restorative ingredients. DON'T spread it on the mammillae with unclean fingers!

2b

The mammilla has a wound, with or without infection

Sore mammillae are potential entryways for germs and should, therefore, be cleaned after every breastfeeding with a 0.9% salt solution or with boiled, lukewarm water. In the hospital or with infected wounds, a wound disinfectant with an appropriate mucosa antiseptic follows the wound cleaning.



Photo: © Andrea Hemelmayr

Wound dressing

3a For wounds that are not infected

So that the wound does not dry out, scab over and be ripped open again at every feeding, moist wound healing can be ensured with an ointment dressing made of high quality wool fat (lanolin). Thus, wound healing can be hastened, the mother has less pain and there is less scarring. Thereby, the lanolin should be applied to the mammillae directly from the tube with clean, disinfected hands or on sterile swabs (from the pharmacy). The mammillae must be completely covered with a thick layer of lanolin. A mere thin application is not sufficient.

If there are still remnants of the ointment on the breast before breastfeeding, they can simply be wiped off with a clean swab without further cleaning.

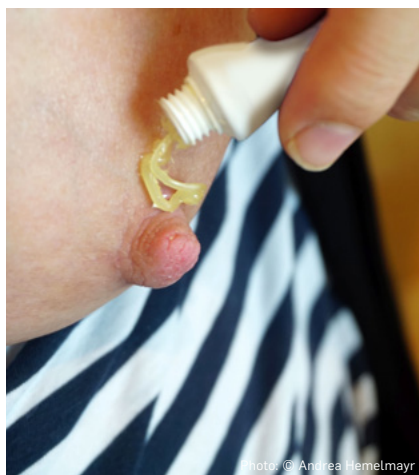


Photo: © Andrea Hemelmayr

3b For infected wounds

Infected mammillae must be treated with anti-bacterial, anti-mycotic and/or anti-inflammatory agents. Here, the diagnosis and therapy must lie in the hands of the medical professionals. Moist wound healing is not sufficient in such cases and can potentially worsen the situation!

4

Relief

In order for the mammillae to heal, they must remain supplied with sufficient blood. To ensure this, a "breast donut" (www.elacta.eu/wp-content/uploads/2017/04/Vien-na-Breastfeeding-Donut.pdf) (poor English translation) can help prevent pressure from the bra and other clothing.

Also, a switch to more frequent, but shorter breastfeeds with the support of a breast massage limits the sucking pressure by the newborn. Thereby, the

baby should be removed from the breast when the active sucking and swallowing declines and the baby begins non-nutritive sucking.

5

Pain therapy

Sensible pain therapy with breastfeeding-compatible pain killers can also hasten the wound healing and reduce follow-on problems.

Further Therapy Options:

6a

Laser therapy is an effective complement to the other therapies, hastens the wound healing and relieves pain.

6b

The principle of moist wound healing can also be ensured with **silver shields, hydrocolloid bandages or pre-prepared gel applications**. Competent breastfeeding counselling must assess whether such forms of therapy are appropriate and monitor the success of the therapy.



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- > <http://www.stillen-institut.com/de/wunde-mamillen.html> **German and French only**

FURTHER INFORMATION IN ENGLISH:

- > <https://www.ingentaconnect.com/content/springer/clac/2013/00000004/00000003/art00003?crawler=true> (Marsha Walker – Are there any cures for sore nipples? © 2013 United States Lactation Consultant Association)



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

The incorrectly called “Breastmilk Jaundice”

Why formula is not the answer. Author: Jack Newman, MD, FRCPC

So-called “breastmilk jaundice” is considered abnormal by many physicians, perhaps even the majority of physicians. Even those who understand that it is usually normal for babies of three or six weeks of age and even older, to have visually obvious jaundice, may, due to the general fear of jaundice, advise the mother to interrupt breastfeeding for 24 to 48 hours in order to “prove” that the problem is due to breastfeeding.

In fact, stopping breastfeeding and giving formula by bottle for even 24 to 48 hours can cause significant problems with breastfeeding at worst stopping the breastfeeding altogether for that baby.

It is typical of babies with “breastmilk jaundice” to be bursting with obvious good health: There is nothing in the baby’s story of concern, no physical findings of concern

and observation of the feeding shows a baby drinking very well at the breast. Interestingly, “breastmilk jaundice” might even be normal and good to have.

Why might jaundice be good?

Jaundice might be of benefit because bilirubin is an antioxidant, a powerful cytoprotectant and there is good evidence that bilirubin protects the body against oxidative stress (Baranano et al., 2002). A cytoprotectant protects cells from damage.

There is a fascinating association of higher than average levels of bilirubin in an inherited condition called Gilbert’s syndrome and a lower incidence of atherosclerosis, now believed to be an inflammatory disease (Sedlak & Snyder, 2004). This has been known for many years. Frequently, the jaundice is not really noticeable in such people, but with infection or stress, the bilirubin may rise. Maybe bilirubin is a bene-

ficial thing, rising to protect the individual when she or he has an infection of some sort.

Excluding liver disease

If there is any question whether the baby may have liver disease, a test for serum bilirubin – asking for both indirect and direct levels of bilirubin – should be done. It is usually easy enough to suspect liver disease causing jaundice. The baby’s urine is often brownish and the bowel movements are paler than usual, though this is not so easy to notice as a baby’s bowel movements are paler than an adult’s. The most common cause in a newborn baby is a condition called biliary atresia, where the ducts leading from the liver to the baby’s intestinal tract are blocked. On physical examination by a physician or nurse practitioner, the liver is usually enlarged and the spleen is also often enlarged as well. ➤

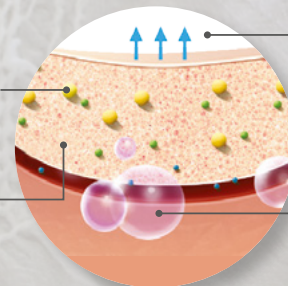
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Photo 1. Seven weeks old baby with obvious jaundice. He is breastfeeding exclusively, receiving lots of milk from the breast and gaining weight well. His urine is clear like water, and there is no evidence of liver disease.



Photo: © Jack Newman

your baby may be brain damaged”. What’s the message? Breastfeeding is dangerous. Many doctors will talk about “brain damage” if the mother is reluctant to stop breastfeeding, but even pushing the mother to stop breastfeeding is enough to plant the seed in the mother’s mind that breastfeeding is dangerous.

Giving the baby formula may result in breastfeeding difficulties: The common myth amongst many health professionals is that there is no problem with giving breastfed babies bottles. This myth can only come from the idea that breastfeeding and bottle feeding are the same. Of course, there is no lack of various companies flogging their bottles as “just like breastfeeding” but that’s marketing and just not true.

“The breastmilk makes your baby sick”

The concept “breastmilk jaundice” and interrupting breastfeeding also create the impression that breastmilk might be harmful for infants as demonstrated by the following example from a mother’s personal blog:

“My nipples looked like hamburger meat, yet I kept going. I wanted to succeed. Then his pediatrician told me he had breast milk jaundice. She gave me 3 cans of formula and told me to take him off breast milk for 3 days and feed him the formula instead. I was distraught. All I could think was “I have gone through all of this to breastfeed him and here I was poisoning him the entire time”. His jaundice cleared up in 2 days and I quit breastfeeding. I lost all control over my emotions in the parking lot of the doc’s office and called my husband to tell him I will never breastfeed again for as long as I live.”

The message the mother received from this simple exchange with the pediatrician was: “I have gone through all of this to breastfeed him and here I was *poisoning* him the entire time” – poisoning her baby with breastfeeding! Not surprisingly, she will not breastfeed any of her babies to come.

As mentioned already in this article, “breastmilk jaundice” is not only *not* bad for the baby, but it actually is probably good. But the concept of “breastmilk jaundice” and three cans of formula sealed the fate of this mother’s breastfeeding. Because of the poor latch, it is possible the baby actually

› **Case studies of babies with “breastmilk jaundice”**

Case study 1

The baby in this photo is seven weeks old. He was born slightly premature at 36 weeks gestation. He was exclusively breastfed in hospital and after. Here are his weights: At birth 2.87 kg, at 7 weeks – when I first saw him – 4.57 kg.

I did not worry the mother by saying that the jaundice was a problem. However, I did tell her that it was normal for many exclusively breastfed well gaining babies to be jaundiced so that if anyone did worry her about it she wouldn’t worry (interestingly, the mother had not noticed the jaundice).

I did not do any blood tests, but I did ask about the colour of the urine and I did examine the baby’s abdomen to make sure the baby did not have a big liver and spleen. The mother stated that the baby’s urine was clear as water. When I examined the baby, the baby’s liver and spleen were not enlarged.

I did not tell her to interrupt breastfeeding and I urged her to continue *exclusive* breastfeeding. I did help her overcome her sore nipples. That was easy, simply by helping her adjust how the baby was latching on.

Case study 2

Unlike the previous baby, this one month old baby’s mother was under pressure to stop breastfeeding both from the baby’s doctor and from the mother’s family. However, there was no reason to stop breastfeeding, even for one feeding, and no reason to give the baby formula either.

Why giving formula is detrimental

Giving the baby formula, even small amounts of formula, might be detrimental for breastfeeding. Expressing breastmilk is sometimes presented as something easy to do but it is not. Mothers may become painfully engorged despite pumping. Many babies do not respond well to formula. Additionally, there are babies who vomit formula, have diarrhea or constipation when on formula. Some, even by 3 weeks of age, will not drink from a bottle.

The advise to interrupt breastfeeding may undermine the mother’s confidence in breastfeeding and breastmilk:

Mothers get messages from public health departments, from magazines, from their doctors that “breast is best”. But when the baby has “breastmilk jaundice”, “you need to stop breastfeeding and give formula, or

was not getting enough milk and the problem wasn't "breastmilk jaundice" at all, but rather "not enough breastmilk jaundice".

Giving the mother three cans of formula is not help and not a gift, because this mother will now spend a lot of money in the next months to pay for that "gift". Who gains? The formula company, of course, because chances are the mother will then go on to buy the same brand of formula for the entire time the baby is formula fed. This way the pediatrician becomes a marketing agent for formula.

A second mother wrote in an email to me: "I think it is a bit odd that the doctors were really adamant about feeding him every 3 hours in the hospital and making sure he was nursing really well before we went home and now they think that is what is making him sick. I guess what I am emailing you for is to see if I can get a clearer explanation for this and for my child's affliction."

Maybe these doctors are more supportive than the pediatrician in the previous case. But the message the mother got from them is that breastmilk makes her baby "sick".

Regular tests may also jeopardize continuation of breastfeeding

Some mothers have stopped breastfeeding in order to stop the baby being stuck for blood every few days. And all one learns from the bilirubin done every few days is the level of bilirubin that day. This really is not very helpful in deciding what to do and may result in "oh, the bilirubin has gone up a little, I wonder what that means. To be sure, I will just recommend stopping breastfeeding."

Pediatricians and family doctors following up the baby don't usually have a bilimeter for transcutane measurements and ultimately even with a bilimeter, blood tests will end up being done as well to make the numbers more "precise" or get a direct bilirubin level. It may be indicated in some situations to do a direct bilirubin level. These tests make the parents worried and undermine their trust in breastfeeding. According to Kemper et al (1989) they may lead to the vulnerable child syndrome where the parents overprotect a child they feel is "vulnerable".

Regular tests are not necessary when liver disease has been ruled out and the

baby is healthy. There is no proof bilirubin alone causes brain damage, but diseases where higher bilirubin is a symptom may cause brain damage (Newman & Maisels, 1990 and 1992).

Conclusion

The relationship between jaundice and breastfeeding is largely misunderstood. In most people's minds, breastfeeding is blamed for causing jaundice and this erroneous notion results in too many babies being given formula as if formula were treatment for jaundice or as using formula helped with diagnosis. The same applies to interrupting breastfeeding which accomplishes nothing other than plant the seed in the parents' mind that breastfeeding is harmful to their baby, and not to mention the fact that using bottles may lead to the baby not going back to breastfeeding.



Jack Newman MD, FRCP



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RECOMMENDATION

Breastfeeding: Empowering Parents, Interactive version (English Edition) as Kindle version and Paperback by Jack Newman MD (Author)



NEWS from ELACTA Board

Board meeting Milan, September 21–22

Elacta Board met in Milan, hometown of Marica Bettinelli, one of the board members.

Our treasurer outlined the financial position and the rules for statement of expenses & the budget, which is approved. The Conference finances of Rotterdam are positively finished. We renewed the contract with our partner EISL.

An important part is the focus on our members. We have worked on the overview of all European countries and divided contact persons and associations visits. We discussed ways and means of attracting new organizations and how to find a solution when organizations fail to comply with their financial obligations.

The aspects of the activities of all task groups (TG) were discussed.

- › TG Conference: Milan is chosen to host ELACTA conference in 2020! As being in Milan the Board met with AICPAM. The Italian association was represented by the President Gerardo Chirichiello and Marina Astengo, past AICPAM President and a member of TG Conference who confirmed the support for the conference.
- › TG Magazine. We are strengthening the communication and exchange of information with the editorial team.
- › TG Recognition & Communication. We have formed a very enthusiastic group of IBCLCs, from Rumania, Italy, UK, Germany and the Netherlands. We have advisors from a lobby bureau, IBLCE and a lawyer from Rumania. The profession Profile from the Netherlands is translated and we can make steps to get parliaments better informed and the IBCLC embedded in the health care system, all in order to work on recognition of the IBCLC.
- › TG Website & Social Media: more news, like magazine items, will be integrated on Facebook and website.
- › TG Core Values: The Board discussed organizational matters such as procedures and bylaws, to make the organization work more efficient. The Board approved the Strategic Plan.

CERPs international, held in Beld, Slovenia, from 30 May till 2 June 2019 is our next big member event. Information can be collected from Andrea Hemmelmayr and Alenka Benedik who are the organizers (a.hemmelmayr@gmx.at).

The next Board meeting will take place in Brussels in February, 2019.

Discharge of the ELACTA Board

Netherlands, September 16, 2018

As agreed during General Assembly, 18 May 2018 in Rotterdam, mandate was given to all member associations to vote for the postponed auditors report.

The Auditors received 18 out of 27 votes for the proposal to discharge president, treasurers, and board members of ELACTA and the magazine team of years 2016 and 2017.

- › 17 associations agreed
- › 1 association disagreed
- › 9 associations didn't respond.

Conclusion: Majority of the members has agreed on discharge of Heli Vanhatalo and Maja Recic, as treasurers, and the board members of ELACTA. The financial audit 2016–2017 is completed.

Kind regards,

The Auditors

Serena Debonnet
Myrte van Lonkhuijsen
Marga Wapenaar



**NEW AUDITING COMMITTEE
ELACTA 2018–2019**

Members:

- › Marga Wapenaar (Netherlands)
- › Myrte van Lonkhuijsen (Netherlands)
- › Serena Debonnet (Belgium)
- › Monika Jahnke (Germany)

Visiting the annual conference of the Irish association ALCI

At the end of September ELACTA Board Member Daiva Sniukaite-Adner had been visiting Association of Lactation Consultants of Ireland (ALCI) at its annual conference “Communication: Not Just Talking The Talk”. The aim of the visit was to present ELACTA organization and activities, to meet ALCI Council and members and to invite them to join ELACTA. Daiva made presentation for the audience of nearly 200 conference participants and had good possibility to discuss in person.

ALCI is organization with voluntary membership where the daily activities are organized by the Council – a group of the most active people with elected President Sue Jameson. The President and the Council were convinced that in the nearest meeting they would discuss joining ELACTA as already there was an interest from a group of members. ELACTA is looking forward to seeing ALCI in its community.



Photo: © ELACTA

ELACTA board member Daiva Sniukaite-Adner together with the ALCI Council at the Conference in Maynooth, Ireland. From left to right (standing) Fiona Rea, Áine O'Leary-McCarthy, Daiva Sniukaite-Adner (Board member ELACTA), Sue Jameson (President ALCI), Regina Keogh, Lorraine O'Hagan, sitting from left to right Caoimhe Whelan, Niamh Lohan, Ciara Butler.

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We look forward to hearing from you!

Contact: magazin@elacta.eu

Who is ELCA?

The Egyptian Lactation Consultant Association (ELCA) was founded in July 2004 as an official body, embracing the vision of breastfeeding support by Egyptian healthcare providers in the field of maternal and child health. The members of the association are International Board Certified Lactation Consultants (IBCLCs).



M.D. Amaal el Tawell one of board member of ELCA Coordinator of the 90 h course in Egypt society

Egyptian IBCLCs:

In Egypt, the exam has been held for the first time in 2002.

The association helped more than 400 health care providers to certify as IBCLC in a period of over 14 years.

Currently the number of IBCLCs in the country decreased due to the fact that less IBCLCs are recertifying.

A small number of Arabian IBCLCs attended the educational program in Egypt. Since 2016 the Egyptian education program is replicated in Saudi Arabia at a smaller scale.

ELCA is a member of the European association first in 2007 in VELB and then in 2017 in ELACTA. Interestingly, the name of ELACTA was voted by the majority in order to distinguish the European association from the Egyptian association.

The Egyptian IBCLCs have engaged in manifold activities for the promotion of breastfeeding.

Members of ELCA are working in different settings:

› **Healthcare Services**

The first IBCLCs established the first breastfeeding clinic in Egypt in the Center of Social and Preventive Medicine (CSPM) at Cairo University Hospital. Subsequently many other public and private clinics followed their example. The majority of IBCLCs work both in the private and public healthcare sectors.

› **Educational Work**

Over the last 15 years, the reputable pre-exam, as part of the education in the field of lactation and breastfeeding, has contributed to more than 500 Egyptian and Arabic health care providers obtaining the IBCLC accreditation.

› **Research Work**

› **Training Activities**

› **Scientific Activities**

› **Socio-Cultural Activities**

› **National Collaboration**

› **International Collaboration**

Difficulties

Services offered by IBCLCs are not included in the National health insurance system. The credential of the IBCLC only started to be recognized in the last 5 years.

Board of ELCA

The board of ELCA includes 9 members:

1. Head of society Dr. Mohamed Emad Salem (Professor of Pediatrics)
2. Prof. Dr. Ablaa El Alfy (Professor of Pediatrics, IBCLC)
3. Prof. Dr. Wael Lotfy (Professor of Pediatrics, IBCLC)
4. Dr. Khaled Aid (Pediatric Hematology Consultant, IBCLC)
5. Dr. Amal el Taweel (Consultant of Pediatrics, IBCLC)
6. Dr. Ghada Sayd Abd Maksood (Consultant of Pediatrics, IBCLC)
7. Prof. Dr. May Matter (Consultant of Child Health, IBCLC)
8. Prof. Dr. Gihan Fouad (Consultant of Pediatrics, IBCLC)
9. Mahmoud Yosry (Consultant of Pediatrics, IBCLC)

Romanian Lactation Consultant Association

History

In March 2013, IBCLC Day was first celebrated in Romania.

On this occasion, the IBCLCs present at the event suggested the idea of organizing ourselves into a professional association.

That is why, one year later, in January 2014, The Romanian Lactation Consultant Association (ACLR) was founded.

Mission and vision

ACLR is a non-profit organization with the main purpose of defending, promoting and representing the professional, economic and social rights and interests of its members in the spirit of free access to the practice of lactation consultant profession.

ACLR also aims to officially recognize the profession of lactation consultant in Romania and the introduction of this profession among the occupations practiced within the national economy (Romanian Classification of Occupations).

The association promotes human resource development and employment, access to and participation in continuing vocational training, representing and defending the interests of its members, both at the national as well as the international level. ACLR has been a member of ELACTA since 2017.

The association's mission is to improve specialized services for newborns, infants, babies and parents,

to improve the quality of life, to reduce the infant mortality and morbidity rates, to increase the access to professional lactation consultant support and to increase the breastfeeding rates in Romania.

Activities

The main activities the association organizes are:

- › Preparing, training and supporting future lactation consultants. The association has organized 5 editions of the 90-hour course of education in lactation. The members are involved in mentoring and preparing the future IBCLCs.

First photo: Mihaela Nita president and Ilinca Tudose-Tranulis vice-president



Members of association and parents at the conference dedicated to the World Breastfeeding Week 2017



Breastfeeding support group



Breastfeeding march "Lactation Matters"

- › Organizing courses, workshops, conferences (with CERPS or CME) to provide medical education to lactation consultants, doctors, nurses, midwives and other health professionals.
- › Offering educational programs for doctors, midwives and nurses.
- › Establishing volunteer programs in NICU and birth centers.
- › Organizing breastfeeding support groups, breastfeeding march.
- › Providing counseling activities for members, second opinion and professional guidance.

Members

The association has 15 members and we are growing, being in the process of getting new applications for membership.

The majority of the members are IBCLCs. The other members are health professionals who participated in the 90-hour training course and are planning to get their certification.

The president of the association is Mihaela Nita, the vice-president is Ilinca Tudose-Tranulis and the secretary is Loredana Isbasoiu-Gafu.

ACLR is a small association compared to the other European associations.

Still, taking into account the fact that the first IBCLC exam held in Romania was in 2011, the emergence of new IBCLCs, the enthusiasm, the willingness to change the standards of care/protocols and so on can make us optimistic about our future in the country as a profession but also as a professional association.

Growth factor: Breastfeeding

Possibilities for empowerment in breastfeeding counselling Author: Elisabeth Dittmann, Midwife



Photo: © iStock.com/Demkat

The discussion about breastfeeding often deals with the effects, which relate to the physical and psychological health of a mother-baby pair. Thereby, the talk is about the prevention or minimization of risks, of higher or lower rates, particular constituents and biochemical processes. It is a medical perspective that is shown here and which is, no doubt, justified. However, if one assumes that motherhood is not an illness, but the achievement of a new stage in life and that, along with the baby, a mother is also born, it becomes clear that the task to be mastered is more complex. The process of personal growth also deserves careful attention as do all other processes because the positive mastering of the trans-

formation from “woman” to “mother” also represents an important health resource. But how can these strengthening experiences be described and measured, on the one hand and, on the other hand, be supported with the mother and baby?^[3]

Maternal self-efficacy expectation

It is well-documented by scientific studies that mothers, who perceive themselves as competent, have a more warm-hearted, engaged style of raising children and are significantly more responsive to their children.^[1] Apparently, the trust in one’s own ability to shape her own life and relationships changes the ability to act in general. The Canadian psychologist, Alfred Bandura, started, from the 1970s, to study these

connections. He developed the concept of self-efficacy expectation (SEE) that describes which expectations a person has in relation to her abilities to master a certain situation. It turned out that this expectation has a clear influence on the actual success. This means that people who were confident of their possibilities for influencing a certain and possibly also difficult life situation, were, in fact, more capable of changing this to their advantage.^[1]

Thereby, Bandura differentiates between expectations that are dependent on consequences (i.e. “If my baby feeds a lot, he will gain weight well”) and expectations of competency depending on a person (i.e. “I feel that I am capable of putting my baby to the breast by myself as needed, so that he gains well”). This difference is important

because only expectations, which depend on a person, have an influence on the general self-efficacy expectation. Summarized and somewhat simplified, one can also say that people have better chances to master a challenge if they are well-prepared and confident and, when they succeed in attributing this success to their competency, they can, in consequence, assert themselves more successfully in other areas of life. Challenges thus become so-called “mastery experiences”. Nowhere else is this motto – “Nothing succeeds like success” more valid than here.

Significance for breastfeeding counselling

From my perspective, this offers great opportunities related to the field of breastfeeding counselling:

- › Good preparation for breastfeeding has a great influence on breastfeeding success
- › Mothers who, up until then, seldom or in significant situations (Cesarean Section, trauma, violence, lack of opportunities) have not had the experience of being able to shape their lives to their advantage, receive from a successful breastfeeding relationship a strengthening of their general self-efficacy expectations and, thereby, the best conditions for improving their general life circumstances.
- › Mother/child relationships become more loving, they gaze more at each other and profit – also after weaning – from this “mastery-experience”. Even newborn babies have the daily experience of self-efficacy with on-demand breastfeeding every day. They can change their life circumstances to their advantage on their own accord and with their own means without outside help as is the case, for example, with the “breast crawl” (person-related competency expectation): Nutrition, closeness, stimulation, attention, calming, bonding ... and, thus, they have the best chances not only to have their current needs met exactly, but also to master their later life with a high self-efficacy expectation.

Also, the connection between the quality of bonding, depression, breastfeeding, and self-efficacy expectation has already been well studied and clearly shows that mothers with a higher self-efficacy expectation are better positioned in all of the areas mentioned. ^[2,7,8,10,11,13,18,19,21,23]

Sources of self-efficacy expectation

Bandura names four significant sources which can be ranked according to the strength of their influence on the self-efficacy expectation:

- › Results of action in shaping one’s own success or lack thereof
- › Vicarious experiences through observation of behavioral models
- › Verbal persuasion (outside evaluation or self-instruction) and
- › Perceiving of one’s own stimulation of feelings

Here too, there are clear indications for practice: Successes, which the mothers and children can clearly ascribe to their own competency, are the strongest source for self-efficacy (1). For breastfeeding counselling, this could, for example, mean placing the focus more strongly on preparation for breastfeeding in order to transform the testing situation “first breastfeeding/ breastfeeding start” into a “mastery-experience. Included in this is providing women with correct information during the pregnancy, instructing them in practical things even before birth (breast massage, hand expression, breastfeeding positions, signs of a good “latch-on” etc.,...) but also, as difficult as it sometimes may be, to only guide verbally in order to leave the success to the mother and child. As the second strongest source, Bandura cites learning through observation (2). Pregnant women attending a breastfeeding support group, if possible, to consciously take a close look when a baby is breastfed or repeated viewing of high quality filmed sequences on putting the baby to breast, could be a helpful substitute for experiences of this sort, which, in earlier times, women in traditional multi-generational families had quite incidentally and naturally

Linguistic convictions, such as encouragement by others or by oneself, play a further important role (3). Probably breastfeeding counsellors are challenged the most in this area – that is, less “hands-on” and more attentive, respectful and empowering communication. Even during the pregnancy, practiced mantras could be useful in helping mothers and fathers to more easily master difficult situations, such as, for instance, putting a frantic newborn to the breast with self-instruction. The ability to perceive, name and lovingly accept the arousal of feelings in challenging situations, is the fourth area, which has an influence on the self-efficacy expectation (4). The challenge consists in the pounding heart, the trembling, sweating hands, the hot flashes, but also the dripping milk as something not indicative of incompetence, but rather an indication of great inner engagement. Here too, this offers breastfeeding counsellors a great opportunity to do a great deal for parents and children with a few intelligent and respectful words

The Canadian scientist, Cindy-Lee Dennis^[24], has developed an instrument, based on Bandura’s results, to measure maternal self-efficacy expectation related to breastfeeding (breastfeeding-self-efficacy expectation, BF-SEE), that is used to evaluate the efficacy of varying counselling approaches. Thereby, she and her team were able to demonstrate that mothers who had prepared themselves for the breastfeeding period during pregnancy by watching videos of breastfeeding women or received recognition and praise from their partners or their own mothers were able to achieve significantly higher breastfeeding-self-efficacy expectation values. ^[15]

This breastfeeding-self-efficacy expectation is, in turn, decisive for the breastfeeding duration, as an Iranian study documented. There, nulliparous women, who wanted to breastfeed, twice received two hours of information and training at two-day intervals, while the control group only received the regular pregnancy care. Also, the intervention group had the possibility at any point in the study to ask a professional for help with difficulties

or problems that related to breastfeeding. The breastfeeding-efficacy expectation of the mothers at the time of the birth was nearly equal, however it increased significantly in the intervention group after one month. Six months after the birth, 73.3% of the intervention group were still breastfeeding, while in the control group without intervention it was only 26.6%.^[9] A relative study in Japan confirmed this statement.^[17]

Empowerment

An increase in the self-efficacy expectation, as already mentioned, is then achieved if people can attribute successes to themselves. To achieve this, a special approach in counseling is needed. One possible approach is so-called empowerment. The most striking feature of empowerment is the disengagement from the focus on deficiencies. This perspective has, above all, an eye on the things that are considered to be problems, building blocks or handicaps of people. Very quickly individuals become people with this or that emotional, physical or social limitation. Through a concentration on the deficits in a person's life, a phenomenon that is known as "learned helplessness" is created.^[4,5] Professional helpers perceive things as problematic in accordance with their personal pool of experience (for example the course of the weight gain of a newborn in the first few days) and formulate this in a language that emphasizes deficits ("Mrs. M, you see that your baby is not feeding well from the breast. Again he has not gained weight") and, thereby, create a situation in which the woman must take on the role as a passive-needy person in order to benefit from the help of the active-competent helping person. One needs to behave in a needy way in order to get help. In this case, the helping person herself may perhaps have success – when, for instance, the baby has received significantly more milk according to a test weighing after the mother has received a textbook butterfly-like breast massage and the baby has been put to the breast "correctly, for the first time". Feelings of uncertainty,

incompetence and helplessness arise in the mother, above all and especially when this procedure is repeated and she has a limited self-efficacy expectation. (As a reminder, people with a limited self-efficacy expectation frequently attribute failure to themselves, while success is attributed to the circumstances.)

With this situation, it becomes clear that good breastfeeding counselling always and foremost must have the goal of giving women the kind of help that makes it possible for them to master the sometimes difficult process of producing milk and breastfeeding from their own strength and along the percentiles of their own growth curves. At the same time, however, the high demands on the breastfeeding counsellor are clear. It is exactly those mothers who resist a top-down consultation whom we often experience as difficult. Also, in reality, there are definitely situations which require directive statements, pragmatic management or drawing a clear line. However, these situations probably arise when mothers can no longer exercise their ability to advocate for themselves and their interests because they have been "disfranchised" through the mechanism of "learned helplessness: Mothers who – for whatever reasons – have been denied the "world cultural heritage of breastfeeding knowledge", mothers whose children have been withheld on (sometimes questionable) organizational or medical grounds, mothers and babies who have not been given the opportunity for re-bonding, etc.

Helpful relationships, which carry the aspect of learned helplessness, lead, in the long run, to ever more deeply buried personal resources and ever stronger delegation of personal responsibility to others or to the system. This form of resignation is a particular challenge in counseling activity. Helping women searching for motives to conquer this resignation does not, by a long shot, always succeed. What is tragic is that just those mothers and babies, who, due to their background or their life circumstances are not afforded much opportunity for participation, often have a long career

with helping institutions behind or ahead of them. Thus, learned helplessness is potentially passed along through the generations. Maternal depression, for instance, which is broadly known to be particularly strongly connected with a low breastfeeding-self-efficacy expectation, leads to strongly limited interaction with the baby. In their early months, these children have the experience that they cannot or can only slightly influence the interactional behavior of the mother in a positive way. Thereby, the child's self-efficacy expectation is also lacking. This process taking place (or also a not-taking place process) could be the basis for a higher probability for later depressive disturbances in the sense of the concept of learned helplessness.^[11]

Breastfeeding is not the privilege of well-situated, informed and organized women. Breastfeeding is the right of every individual mother and every individual child. Across all (social) classes, mothers and parents have a strong will, through the birth of a child, to improve their life circumstances. This initial momentum should be used, because underprivileged mother-baby constellations profit the most from the enabling of breastfeeding.



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50 years ago, she dove into the Breastfeeding World – and today, she’s still Swimming

Interview with Elizabeth Hormann



Photo: © Elizabeth Hormann

You were an LLL Leader for many years. How you came to take the IBLCE exam is, naturally, also interesting.

I became an LLL Leader in 1968 (50 years ago!). I was leading groups in the US until we moved to Germany in 1986. The next year, I started an LLL group in Bonn and the year afterwards in Cologne. Those groups are still running (with new Leaders).

The IBCLC exam was not on my “to do” list but a good friend and co-Leader in LLL persuaded me to go with her to New York to take it the second year that it was given. It was sheer luck that I was able to do it. I

had talked to Joanne Scott – who was the driving force behind the exam – but hadn’t actually registered to take it. She was a bit surprised when I turned up but, thankfully in those early days, there was enough flexibility to allow “walk-ins” to take it anyway. Less than a month later we made our already-planned move to Germany. It was another three months before I got the results and suddenly I was an IBCLC – as it happened, the only one in Europe until the next year when lactation consultancy began to plant itself firmly on the European continent.

The work with WHO and UNICEF was also a stroke of luck. The same friend who

got me to go to New York, moved to Kenya shortly after I moved to Germany. She asked me to join her on a teaching trip to Ethiopia in 1988, the next year it was Zimbabwe and the year after that Mauritius. By the early 1990s, Baby-Friendly was just about to be launched and WHO asked me to take part in the first training of assessors in Egypt. I continued that work throughout Europe and the Middle East for 20 years.

Breastfeeding counselling has been something like your “life’s work”. Do you also see it this way?

I am surprised that breastfeeding is still so central to my professional life and to me personally. I continued working with the assessment process for BFHI Germany – in all its facets from evaluating check lists supplied by the hospitals through pre-assessment visits, assessments and re-assessments until about 7 years ago and continued teaching in the EISL courses until about two years ago. I am still publishing articles in both English and German journals and translating German articles in the ELACTA magazine (L&S) for the English online version (L&B).

What changes have you seen in the “breastfeeding scene” since then?

The breastfeeding “scene” has several facets. The experience “on the ground” for **breastfeeding mothers** and their babies has changed a great deal – mostly for the better – over the last several decades. In 1964, when my first baby was born in the USA, less than 25% of American mothers even began breastfeeding and that figure went down to 22% by the early 1970s. Today, more than 80% of mothers in the US initiate breastfeeding. Growing up in a culture where bottle-feeding was the norm, I might well have missed out on breastfeeding altogether but for a couple of crucial factors. When I was 5, I accidentally walked

into the office of my school's head teacher while she was breastfeeding her baby. I'd never seen anyone breastfeed – and didn't even have a name for it – but I knew right then that I would feed my babies that way. My children's German father was the second crucial factor. He told me (incorrectly as it turned out) that “all German babies are breastfed for 18 months” so his children would also be breastfed that long. He supported that in practice and provided a buffer in our neighborhood where one neighbor commented “Breastfeeding? Didn't that go out with the hoop skirt?”

The rise or resurgence of skilled **breastfeeding counselors** – whether **voluntary** (LLL and AFS in Germany along with other NGOs around the world) or **professional** (IBCLCs, midwives and other health care professionals with extensive knowledge about breastfeeding) – focuses, first and foremost, on helping mothers to acquire the necessary skills and confidence to breastfeed. And that is as it should be. The mother-to-mother model of providing this support is still one of the most effective ways of creating an environment in which breastfeeding is the norm. When this model is firmly grounded in up-to-date breastfeeding science and good communication skills, this may be all that many women need to sort out the questions and day-to-day problems that arise. This is all the more the case when it takes place in the setting of a breastfeeding support group in which mothers learn from each other and from watching the more experienced mothers. Even as a young LLL Leader, I noticed that successful breastfeeding can also positively influence a mother in other areas of life – without having words such as “higher self-efficacy” for this. Over and over, I experienced mothers who, during breastfeeding or after the breastfeeding period, found the self-confidence to do things for which they had earlier lacked the courage. Sometimes



Photo: © Elizabeth Hormann

they even moved their lives in a whole new direction. Our profession as IBCLCs grew out of the mother-to-mother movement. Originally conceived as a way of recognizing the knowledge and skills acquired over the years of counseling in the context of voluntary breastfeeding support groups, this has changed significantly as more and more health care professionals have acquired certification as IBCLCs. Today many of those certified in the early years, who introduced the profession in their geographical regions and trained others – both health care professionals and those with other backgrounds – would no longer be admitted to the exam. I find that very regrettable – not just because that would have affected many of the pioneers who took the exam in the early years, established training programs in their countries and beyond and encouraged those with a professional background in health care to get involved – but also because it discourages skilled voluntary breastfeeding counselors from attempting to acquire certification as IBCLCs.

When I was a young mother, many **health care professionals** in the Western world had very little – if any – knowledge about or experience with breastfeeding.

Introducing solids at 6 weeks was routine and, as new parents, we went along with this with our first daughter only to discover that she did not react well to this timetable and that my milk supply decreased. Fortunately, our local childbirth education group had a breastfeeding counsellor who got us back on track. When our second daughter was born, I already knew about exclusive breastfeeding for six months and shocked her pediatrician by telling him of my intention. “**My** babies” he said must all be on solids by three months.” I pointed out that she was actually **my** baby and that even at that time there was evidence to support 6 months exclusive breastfeeding. Eventually he admitted that he had never seen an exclusively breastfed baby over 3 months and, somewhat reluctantly, agreed to see how it worked. By the time our third daughter rejected all offerings of solids until 9 months, the pediatrician simply assured us that she was developing well and would get interested in other foods on her own timetable. Later on, a hospital administrator told me that the medical school in our city used to have only one lecture on breastfeeding for student doctors titled “**Breastfeeding and other Breast Abnormalities**”. I couldn't confirm that but it seemed plausible.

Nowadays, there are a great many opportunities for **breastfeeding education** both for health care professionals and for aspiring IBCLCs and those already certified. All of these groups are exposed to more up-to-date information on the **normal course of breastfeeding**, on **breastfeeding science**, **breastfeeding policy** and the **politics of breastfeeding**. Nevertheless, there continue to be forces that undermine the recommendations for and the implementation of best practice – both from the baby food industry and among the medical/scientific community (some members of which accept industry financing for >

their research). When WHO/UNICEF issued a statement in January 2011 recommending 6 months exclusive breastfeeding as the norm world-wide the ink was scarcely dry on this document before there was a simultaneous, coordinated outcry from some segments of the European medical/scientific community urging a return to 4 to 6 months. Reframing this as between “the beginning of the 5th month and the beginning of the 7th month” creates an optical illusion of a more expansive range, but the reality on the ground remains the same (4 to 6 months). WHO and UNICEF issued a number of documents during their decade-and-a-half of studying the question of the **optimal duration of exclusive breastfeeding** in both developing and industrialized countries. Two recent articles update the state of knowledge about exclusive breastfeeding:

- › <https://kellymom.com/ages/older-infant/delay-solids/>
- › <https://scienceofmom.com/2015/05/14/starting-solids-4-months-6-months-or-somewhere-in-between>

What breastfeeding problems have you most often encountered and have the women or their problems really changed?”

Because I specialized early in relactation/induced lactation, I have had a good bit of experience in responding to questions and supporting mothers in these situations. But I also counselled mothers in the usual breastfeeding situations through La Leche League and as an IBCLC for many years. Very often the same questions arise in every generation of mothers – **how often to breastfeed, when to start complementary feeding, sleeping through the night, when to stop breastfeeding.** And just when you think that these questions have been definitively answered, some “new”/old practice re-emerges in the hands of someone with a title promising peaceful nights if you just “encourage” the baby to sleep through by ignoring his/her need to feed during the night (sometimes kindly by rocking him or walking around with him until he falls asleep again, sometimes by letting/making him cry it out) or you are promised a cheerful compliant child if you teach him who is boss (**you!**) even if it is

difficult to listen to his sobs until he gives up. My parents were told to feed me every four hours during the day but to skip the 2 a.m. feeding once we were out of the hospital (after 2 weeks). They obeyed the “experts” but my mother reported standing at my door weeping until I stopped crying and “learned” to sleep through the night. This practice has re-emerged several times in the course of my career.

Within the topical area of induced lactation, I have had experience in the last 35 years with several families whose children were born to surrogates. This seems to work out best when the surrogate-mother is a close relative – the designated mother’s own mother or sister, for instance. With commercial surrogacy, there are more pitfalls possible – both for the woman carrying the baby and for the family intending to parent him. One thing that has disturbed me about surrogacy in general is that there is little recognition of the reality that, for the baby, this is essentially an adoption. He spends 9 months getting to know the voice and movements that the pregnant woman makes and then, after birth, there is a completely different mother holding him in her arms and caring for him. We know from the work on babies who came into their adoptive families early in life that these babies mostly bond fairly quickly with their adoptive parents, but this doesn’t necessarily happen immediately – on either side. With the increase in commercial surrogacy, the surrogate-mother is often at a great disadvantage so much so that many developing countries have outlawed the practice. In the United States, surrogates frequently have to give up their rights to the baby during pregnancy even if they are carrying a baby whose genetic material is half theirs. Because of the way that birth certificates are issued in the US, there is no written documentation that a baby was **not** born to the designated mother. I have talked with several families whose babies were born in the US whose birth certificates carry only the names of those identified as their parents. They return to European countries where surrogacy is not permitted and they sometimes feel it necessary to conceal the role of surrogacy in building their families. Breastfeeding can also be an issue and here is where I have gotten involved (with mixed

feelings) – both before and after the babies are born.

One new topic has come about with the increase in woman-woman partnerships. Very often they want to share the breastfeeding, which is understandable, but can be difficult in practice. In counselling them, I suggest that the mother who has given birth should first get her milk supply established so the baby is exclusively breastfed. There are several ways for the other mother to be involved with the baby including some breastfeeding. If she has prepared by inducing lactation during her partner’s pregnancy, she might want to do some comfort nursing even in the early stages. The important thing to keep in mind is the well-being of the baby, which ideally includes exclusive breastfeeding by the mother who gave birth, and bonding with both mothers as s/he would in any other two-parent family. In some families I know, the partners each have a child (or children).

„Has your profession influenced you within your family and do you also see your knowledge as an enrichment to your family sphere? (In the editorial team, for example, we often speak about experiencing this).”

Yes, to a considerable extent. My sister – 13 years younger than I am – became an aunt when she was 10 and observed me breastfeeding all five of my children for anything from 1 year to 4-1/2 years. When she started having children, she basically did the same thing even though she worked full-time with all six of them. Two of my children did not have children themselves. One daughter breastfed her only child for about 8 months, the other daughter has 4 children and her breastfeeding patterns were similar to my sister’s and mine. My son’s little boy was not breastfed nor was my 2 year old great-grandson whose father is my grandson. In talking with my contemporaries who have grandchildren, they also report more breastfeeding among their daughters than among their daughters-in-law. I wish that breastfeeding were integrated into biology classes or sex education instruction for both girls and boys in school.

CERPs International

30 May–2 June 2019 in Bled, Slovenia



Photo: © Annamartha/pixelio.de

Treat yourself to this unforgettable experience!

CERPs international is a very special training offer from ELACTA – the European Lactation Consultants Alliance – for ELACTA members. An opportunity to get to know colleagues from around the world and share knowledge and experiences. Furthermore, the afternoons offer the possibility to get acquainted with the wonderful venue of Bled in the Julian Alps.

The participants design the program – for a contribution from their side, the participant fee is reduced by about € 20.00 (case study) - € 40.00 (workshop or lecture). Experience shows that about 10-12 CERPs can be earned during the training. The plan is to have a room available for German-language lectures and another one for English-language lectures.

Leisure Time: In the afternoons, we will enjoy excursions to natural, cultural and culinary sites. The hotel is only 5 minutes away by foot from Lake Bled. Depending on the weather, we are planning different tours: A visit to Bled Castle and to the island of Vintgar Gorge. For all who like to get up early to enjoy peace and unspoiled Nature, there is an unparalleled opportunity to reach the grandiose hills above Lake Bled on forest trails and **admire the unforgettable view of the Lake!** Naturally,

we will also sample local treats, among them a slice of the famous Bled Crème Cake and the Slovenian national specialty, potica, a sweet yeast bread with a walnut and date filling. (www.bled.si/en/)

Cost:

The participant fee is 150€. Because the number of participants is limited, please register quickly. Attention! The hotel is in great demand!

Your registration is **only valid after paying** the registration fee.

Rooms and prices:

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Voices and photo from the last CERPs-International Event in Salzburg:

Janette Timmermans (NL):

“I know that I speak in the name of all who attended CERPs International when I say that we enjoyed a fantastic and fun time. We laughed with each other and found friends for life.”

Sandra Gattiker (CH):

“CERPs International is worthwhile in every respect – not only for collecting CERPs – I would participate in it again in an instant!”



Photo: © Andrea Hemmelmayr

How do we support mothers to breastfeed effectively after early post-partum Discharge?

A cluster randomized study. Author: Ingrid MS Nilsson



Photo: © Andrea Hemmelmayr

In Western countries, the length of hospitalization following birth has decreased over the past 50 years and today, the average length of stay is 2-3 days. The postnatal period is a time of major physiological, psychological and social changes for the mother and infant, with implications for their health and well-being. Breastfeeding makes an important contribution to public health. However, initiation of breastfeeding is challenging, as the mother and infant have to become familiar with it, while the milk production increases and the infant adapts to the outside world. Many mothers who leave hospitals in the early postpartum are concerned about establishing breastfeeding. A Danish study found that more than half of the mothers who stop

breastfeeding within four months following birth do it in the first five weeks. This underscores that the early period following birth is crucial for breastfeeding success.

Ineffective breastfeeding in the early postnatal period has implications for the mother as well as the infant, such as delayed milk production, lack of maternal confidence and security and increased infant morbidity, such as dehydration, jaundice and excessive weight loss. This might result in enhanced use of the health care system including re-admission of the newborn. The literature on the consequences of early discharge on breastfeeding effectiveness and duration is inconclusive.

Health care professionals provide new mothers with breastfeeding knowledge and psychosocial support. The literature forms

the basis of the health care professionals' evidence-based knowledge on how to support new mothers. However, recent knowledge doesn't take into account that the majority of mothers today are discharged early postnatally. We therefore need more knowledge about how health care professionals can support mothers to breastfeed effectively during a short postnatal hospital stay. The aim of this study was to test whether a midwife/nurse-provided program, focusing on enhancing breastfeeding self-efficacy and supporting the mothers' milk production and the infants' metabolic adaptation in an early discharge setting would influence maternal breastfeeding self-efficacy, exclusive breastfeeding at one week, one month and six months postpartum, and infant re-admission due to nutritional problems, compared to a reference group of mothers who were supported as usual.

Births and breastfeeding in Denmark

Almost all women (98%) deliver at hospitals in Denmark, even though there has been an increase in home births in recent years. During the previous 10 years, hospital stays have been shortened and, today, 33% are discharged within 12 hours postpartum. After discharge, the new families are offered visits during the first year by a health visitor, who has a nursing education supplemented by a year-and-half of further education.

Denmark has a strong tradition for breastfeeding and 97-98% of all mothers initiate breastfeeding after delivery. However, approximately 20% of mothers stop breastfeeding within the first month and only 55% are still exclusively breastfeeding when the infant is four months old. At six months after birth, only 16% of mothers breastfeed exclusively. In 2008, the Baby-Friendly Hospital Initiative was closed down due to lack of funding. Since then, breastfeeding counselling in the 23 birth facilities in Denmark rests on a national evidence-based breastfeeding book.

Development and description of the intervention

Intervention Mapping^[1] was used as the systematic method to develop, implement and evaluate this intervention. This method ensures the development of a breastfeeding program which takes into account both evidence-based knowledge on breastfeeding and theory-based knowledge on how to enhance maternal confidence in breastfeeding. The new program consisted of a breastfeeding program for parents and a related training program for health professionals. The development of the program was carried out in cooperation between practitioners from the intervention hospitals and the researcher to enhance ownership and ensure implementation at the intervention facilities. From March to May 2013, a total of 350 nurses and midwives participated in the 2-day interactive training program, which was supported by a written manual in Danish. The health care professionals initiated implementation of the program immediately after the training.

The objective of the parental breastfeeding program was to increase maternal breastfeeding self-efficacy and ensure effective breastfeeding that meets both the mother's and the infant's needs, while supporting maternal milk production and the metabolic adaptation of the infant.

In order to compensate for the short hospital stay, a simple program was implemented, which was easy to follow for the parents, who were discharged early postpartum. The program consisted of only four core elements:

1 Extended skin-to-skin contact as much as possible during the first three days, while the mother and father were awake.

2 Breastfeeding on demand defined as a minimum of eight times in 24 hours after day 2 postpartum, including identifying the infant's readiness cues for breastfeeding and signs of getting enough milk.

3 Good positioning of the mother/infant dyad, including introducing the parents to laid-back breastfeeding immediately after birth and focusing on the mother's experience of pain and relaxation as guidelines for positional changes.

4 Acknowledgment and explication of the mother and the father as equal parents with different roles in relation to breastfeeding.

The parents' breastfeeding self-efficacy was supported by communication based on Bandura's theory of self-efficacy and his four sources for increasing self-efficacy (mastery experiences, vicarious experiences, social persuasion and emotional arousal) and breastfeeding knowledge was tailored to the specific needs of the individual.

All mothers at the intervention facilities were orally introduced to the four core elements of the breastfeeding program during pregnancy. After delivery, they were supported according to the manual and a written pamphlet which was actively used during breastfeeding counseling. The parents were supposed to adhere to the program during the first 3 days while the infants went through the metabolic adaptation and the mother's milk production increased or until the first home visit by the health visitor 3–5 days postnatally. The parents received a follow-up telephone call 24 hours after discharge. Unless the mothers and infants had specific needs related to breastfeeding, the counselling only included the four core elements.

Evaluation

The nine birth facilities involved were randomly assigned to intervention or usual care (control group), which means that all mothers at each hospital were offered the same breastfeeding counselling. This cluster randomization was done instead of an individual randomization to prevent contamination, because the individual mothers from the intervention group might inform mothers from the control group about the intervention and, thereby, blur the results of the study. Details about the study design, measurement, and analysis of the data is found in a peer-reviewed research article in *Maternal & Child Nutrition*.

Results

Between April 2013 and August 2014, 2065 mothers were recruited at intervention and 1476 at control settings. Results show that fewer infants were re-admitted one week postnatally in the intervention (2.2%) compared to the control group (3.6%) (adjusted OR 0.55, 95% CI 0.37-0.81) and six months following birth, more infants were exclusively breastfed in the intervention group: 6.6% versus 5.1% in the control group (adjusted OR 1.36, 95% CI 1.02-1.81). Moreover, mothers in the intervention group compared to the control group were breastfeeding more frequently ($p < 0.001$), spent more hours in skin-to-skin contact with their infants ($p < 0.001$), the infants were less often treated for jaundice ($p = 0.003$) and there was more paternal involvement ($p = 0.037$). The intervention did not affect maternal self-efficacy. The lower re-admission rate in the intervention group could be explained by more skin-to-skin contact, which was associated with more frequent breastfeeding, which, in turn, was associated with less jaundice and re-admission. Hence, there was a physiological explanation for this result. ▶

¹ More about Intervention Mapping: <https://interventionmapping.com/>

Intervention group mothers reported that it was hard to breastfeed so often. However, they did it anyway. The control group mothers experienced more pain and rated pain as more severe. This might be explained by significantly fewer mothers using the laid-back position during breastfeeding, compared to the intervention group. The process assessment found that the intervention group mothers compared to the control group mothers more often reported having been instructed by health care professionals in skin-to-skin contact, frequent breastfeeding, altering breastfeeding position to reduce pain and the father's role.

Conclusion

In an early postnatal discharge setting, a hospital-based breastfeeding intervention can decrease re-admission of newborns due to nutritional problems within the first week postnatally, support the physiology of lactation and increase the prevalence of exclusive breastfeeding at six months. Frequent breastfeeding seemed to contribute to the decreased re-admission prevalence in the intervention group. However, more women in this group also experienced the more frequent breastfeeding as problematic. It might be important for health care professionals to discuss this parental ambivalence in order to encourage new parents to accommodate frequent breastfeeding.



Ingrid Nilsson

is a nurse, PhD and IBCLC and has worked with breastfeeding since 1987

Ingrid introduced the IBLCE exam in Denmark in 2004. Since then, she has been responsible for the preparation course for the IBLCE exam in Denmark and has educated approximately 650 health professionals. Ingrid was co-founder of the Danish Association of Certified Lactation Consultants (DACLC) in 2006 and president of the same from 2006-2013. She is an advisor on breastfeeding matters for the Danish Health Authorities.



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The risk of cataracts: the longer women breastfeed, the lower the risk of developing this Disease

by Ronald D. Gerste

Many positive influences on the child's health are attributed to breastfeeding and also – though this is less well documented – to that of the mother. A study of the data from a Korean health register on 3,821 women of at least 50 years of age, who had all borne children, showed: Participants who had breastfed their babies for comparatively long periods, less frequently developed a cortical cataract in old age. With this form of the “gray star”, the age-related clouding of the eye lense occurs in the periphery and mostly has a zig-zag shape. Other forms of cataract involve a clouding of the lens bowl and a clouding of the lens core.

The participants in the study of women were, on average, 62 years old and had breastfed an average of 2.8 children over a period of 46 months. 57% of the women had an age-related cataract. While there was no association between the breastfeeding time and the two other forms of cataract, the connection with the frequency of the cortical cataract was clearly and statistically significant. By comparison to women who had one child or had never breastfed, the risk of a cortical cataract by those who had breastfed between 4 and 12 children, had sunk to an odds ratio (OR) of 0.56 (95%- confidence interval [95%-KI] [0.35; 0.89]). By comparison to those who had breastfed for a total of 16 months or less, the OR for cortical cataract in women who had breastfed for 36-60 months was reduced by 0.63 [0.42; 0.90]. The risk with a breastfeeding time of 61-324 months was even lower: for this group the OR was only 0.53 [0.33; 0.83].

Conclusion: “This is a further study, which shows a positive effect of breastfeeding for the mother” said ophthalmologist, Dr. med Ulrich Thelen from Münster.

“However, it is only one of various manifestations of cataract, the prevalence of which could be significantly statistically reduced through breastfeeding. Why breastfeeding is not protective against sub-capsular cataract and is effective against core cataract remains unclear” Thelen commented. “The protective effect against cortical cataract may be an indirect one: According to many studies, breastfeeding women less often have diabetes mellitus and other metabolic illnesses. And it is exactly these illnesses that are associated more frequently with cortical cataracts.”



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An article by Dr. med. Ronald D. Gerste with the same name appeared in the *Deutschen Ärzteblatt*, 41/2018. We thank the author and the editor for permission to reprint!

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