Seminars in Fetal & Neonatal Medicine (2006) 11, 48–53

available at www.sciencedirect.com

SCIENCE DIRECT®

journal homepage: www.elsevier.com/locate/siny

Seminars in FETAL & NEONATAL MEDICINE

Protection, promotion and support of breastfeeding in low-income countries

Adriano Cattaneo [a,*], Sofia Quintero-Romero [b]

[a] Unit for Health Services Research and International Health, Istituto per l'Infanzia IRCCS Burlo Garofolo, Via dei Burlo 1, 34123 Trieste, Italy
[b] Freelance Consultant in Breastfeeding, Androna San Fortunato 8, 34136 Trieste, Italy

KEYWORDS
Breastfeeding;
Developing countries

Summary The rates of exclusive breastfeeding and the duration of breastfeeding fall short of what is recommended by the Global Strategy on Infant and Young Child Feeding worldwide. In low-income countries this is associated with a great excess of avoidable childhood death and disease. A higher degree of protection, promotion and support of breastfeeding has the potential to avert the death of about 1.3 million children per year and to prevent much of the associated individual and social sufferings. This paper presents some evidence about interventions that are effective to protect, promote and support breastfeeding in the health system and in the community. These interventions should not be implemented in isolation, but as part of an integrated and intersectoral programme, with a participatory approach that takes local cultural characteristics into account. Lack of political will is probably the most important factor associated with inadequate protection, promotion and support of breastfeeding.

Introduction

The Global Strategy on Infant and Young Child Feeding,[1] adopted by all the World Health Organization (WHO) member states at the 55th World Health Assembly (WHA) in May 2002, recommends, as a public health measure, that all infants be exclusively breastfed up to 6 months of age and that breastfeeding continue, with the progressive introduction of appropriate complementary foods, up to 2 years and beyond. This recommendation is universal, it applies to low- and high-income mothers and children, and to both healthy and sick, including preterm, infants, as reflected, for example, in the recent policy statement of the American Academy of Pediatrics.[2] Yet breastfeeding rates fall far short of these recommendations everywhere. Data from Europe,[3] the United States[4] and Australia[5] show that the initiation or the ever breastfeeding rate varies between 60% and 99%. Exclusive breastfeeding at 6 months, however, rarely goes beyond 20% and is usually below 10%, while only 10% to 20% of infants are still breastfed at 12 months. This is probably true in other high-income countries, where we can conclude that current rates are not only far below widely accepted recommendations, but also below national targets where they exist. It is clear that effective measures have to be taken in these countries if breastfeeding rates were to increase up to expected levels.[6–9]

* Corresponding author. Tel.: +39 40 322 0379; fax: +39 40 322 4702.
E-mail address: cattaneo@burlo.trieste.it (A. Cattaneo).

1744-165X/$ - see front matter © 2005 Elsevier Ltd. All rights reserved.
doi:10.1016/j.siny.2005.10.007

Things are worse in low-income countries. Not because of lower breastfeeding rates: these are in fact higher than those reported from high-income countries, with an average in 94 countries of 39% exclusive breastfeeding at 6 months, 86% continued breastfeeding at 6–11 months, and 68% in infants aged 12–23 months.[10] The problem is that even at this level of breastfeeding the negative effects of no breastfeeding are much worse than in high-income communities. Because of the increased risk of death associated with the lack of breastfeeding, especially for diarrhoea and acute respiratory infections,[11,12] it is estimated that 1.3 million deaths of children under 5 years, representing 13% of total age-specific mortality, could be prevented each year if 90% of infants were exclusively breastfed to 6 months.[13] More deaths could probably be averted with continued breastfeeding and appropriate complementary feeding after 6 months, though there are no data to make such an estimate. The deaths represent the tip of the iceberg: disease, malnutrition, suffering, admission to hospital, social and economic cost for families and communities add immensely to the death burden. There is plenty to be done in public health terms to increase the coverage of interventions to protect, promote and support breastfeeding,[14,15] with great care for equity so that the gap between the have and the have-not will not increase and will hopefully decrease.[16] But how do we protect, promote and support breastfeeding in low-income communities? This paper will discuss interventions that are available for this purpose and how to implement them.

Protection

The two main interventions to protect breastfeeding are the full implementation of: (1) the International Code of Marketing of Breastmilk Substitutes[17] and subsequent relevant Resolutions of the World Health Assembly,[c] and (2) the ILO Maternity Protection Convention.[18]

There is no doubt that the International Code is systematically infringed. A study carried out in 1996 in four countries (Bangladesh, Poland, South Africa and Thailand) showed that 8–50% of health facilities received and accepted free samples of milk formula; 2–18% of health workers received and accepted gifts from companies; in 15–56% of health facilities information that violated the International Code had been provided by companies and was available to staff.[19] Similar results were found in a more recent study carried out in Benin and Burkina Faso.[20] Unfortunately, there are no population-based controlled studies on the effectiveness of strict enforcement of the International Code on breastfeeding. There is, however, indirect evidence that strict measures in this sense may have a beneficial effect. In Brazil, the development of a national legislation based on the International Code and its enforcement are thought to have contributed to increasing breastfeeding rates.[21,22] Similar findings are reported from India, while countries with a weak legislation such as Kenya, Mexico and Bolivia show lower breastfeeding rates.[23] On a more specific scale, several studies have analysed the effects of commercial hospital discharge packs, some containing samples of breast-milk substitutes, some just printed promotional materials, on initiation and duration of breastfeeding; all these practices are clearly forbidden by the International Code. These studies conclude that commercial discharge packs have a detrimental effect on breastfeeding.[24–26] Countries should revise their current legislation to ensure that it is fully in line with all the provisions of the International Code; they should obviously enforce it, with adequate information to the public and to health professionals. These have a pivotal role in the protection of breastfeeding. They should learn about their duties under the International Code; they should avoid any conflict of interest with infant food companies in their clinical, public health, training and research activities; they should not accept to act as carriers of information and products from these companies to the public.

There is less evidence on the effect of legislation for the protection of breastfeeding among mothers in the workplace. A recent review suggested that labour market policies, combined with socio-cultural support, as applied in Sweden, are associated with higher breastfeeding rates compared with the policies of Ireland and the United States.[27] Another review of data from 18 industrialised countries shows that extending the number of weeks of job-protected paid leave to which new mothers are entitled has significant effects on decreasing infant mortalities; increased breastfeeding may be one of the underlying mechanisms of such an effect.[28] Unfortunately, there are no similar reports from low-income countries, but it is very likely that a combination of longer maternity leave, flexible working hours, part time, and workplace lactation breaks to either return home to breastfeed, to breastfeed in the workplace nursery, to have the child brought to work to breastfeed, or to facilitate the expression of breast milk, be effective practices for the protection of breastfeeding in the workplace, as shown by some reports from Brazil and Chile.[29–31] To increase the chances that their infants be breastfed at least as much and as long as term infants, the maternity leave benefits of the mothers of preterm infants should be increased by a number of weeks equal to those missing before term. Such a legal provision has been introduced in industrialised countries, and more recently has been proposed in Brazil[d] and Argentina[e].

Promotion

Promotion of breastfeeding depends heavily on global, national and local policies and recommendations, on their consistency and integration with other maternal and child health policies, on the extent to which they are known to health professionals and the public, and on their degree of implementation at various levels. Ideally, all policies and recommendations should be based on the WHO Global Strategy on Infant and Young Child Feeding.[1] In Europe, only few countries have developed such policies.[3] It is

[c] The International Code of Marketing of Breastmilk Substitutes and the subsequent relevant WHA Resolutions are jointly referred to in this document as the International Code.

[d] http://www.senado.gov.br/web/senador/luizpontes/lp_no_senado/projetos/PLS/2001/PLS190-01.htm.

[e] http://www.apaprem.org.ar/derechos/leidoprema.htm.