Issue 48
June 2013

Baby Friendly Hospital Initiative in Ireland

THE NEWSLETTER OF THE BABY FRIENDLY INITIATIVE IN IRELAND

BFHI LINK

The Baby Friendly Initiative in Ireland web site has lots of useful information
http://www.ihph.ie/babyfriendlyinitiative/

What do codes of professional ethics say about involvement with marketing and what is the role of service managers?
Read about it in the Code section on the Project Resources page

The 2012 Annual Report of the Baby Friendly Initiative is available on the home page

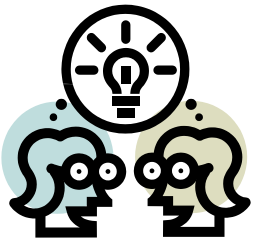
48 issues of *BFHI Link* each with a Parent Handout to download and share.

Is your hospital active? 2013 Action Plans are due

The Project Resources page has a section on Action Planning with Guidance Notes for competing the Action Plan Template, and an aid to reporting on actions.

If you need ideas for actions or assistance with developing your action plan and this help is not available within your hospital, contact the BFHI National Coordinator at bfhi@iol.ie

Share your outcomes from your Action Plans with other hospitals through BFHI Link.



Look inside this issue:

The Baby Friendly Initiative in Ireland is grant-aided by the Health Service Executive
BFHI Link is on-line at www.ihph.ie/babyfriendlyinitiative

Not Breastfeeding has Long-Term Economic Costs

Preventing disease and saving resources: the potential contribution of increasing breastfeeding rates in the UK

Commissioned by UNICEF UK and produced by a multi-university academic team including Dundee University, Oxford University, University of York, Brunel University, and St George's, University of London, as well as the National Childbirth Trust. Over 100 pages. The report is free to download from http://www.unicef.org.uk/Documents/Baby_Friendly/Research/Preventing_disease_saving_resources.pdf?epslanguage=en

Pressure on health services funding? Health inequalities?

Improving rates of breastfeeding initiation and continuation can provide on-going cost savings in the health service and reduce differences in health outcomes across all social groups.

Key Messages

- Low breastfeeding rates lead to increased incidence of illness and significant health cost.
- Investment in effective services to increase and sustain breastfeeding rates is likely to provide a return within a few years, possibly as little as one year.
- Investing in supporting breastfeeding will improve the quality of life for women and for children.

Strong evidence allowed economic models around five illnesses showing how moderate increases in breastfeeding would translate into cost savings for the NHS of about £40 million a year:

Over £17 million could be gained if 45% of babies breastfed exclusively for 4 months and 75% of babies in neonatal units were breastfeeding on discharge, each year there would be:

- 3,285 fewer babies hospitalised with gastroenteritis and 10,637 fewer GP consultations, saving more than £3.6 million
- 5,916 fewer babies hospitalised with respiratory illness, and 22,248 fewer GP consultations, saving around £6.7 million
- 21,045 fewer ear infection GP visits, saving £750,000
- 361 fewer cases of the potentially fatal disease NEC, saving more than £6 million

If half of those mothers who currently do not breastfeed were to do so for up to 18 months of their lifetime, for each annual cohort of first-time mothers there would be:

- 865 fewer cases of breast cancer with cost savings to the NHS of over £21 million
- Improved quality of life equating to more than £10 million (benefit to the individual)

There was good evidence, though not strong enough for full economic models for the effect of small increases in breastfeeding rates and three conditions:

- increase in IQ that could result in more than £278 million gains in economic productivity annually
- at least three fewer cases of Sudden Infant Death Syndrome annually, avoiding the loss of life and profound consequences for families and saving around £4.7 million in monetary costs.
- reduction in childhood obesity, which would save around £1.6million each year.

Research evidence was plausible or likely that increases in breastfeeding rates would reduce health care costs from diabetes (Type 2 for mothers and mainly Type 1 for children), cardiovascular disease, ovarian cancer, asthma, leukaemia, coeliac disease, and neonatal sepsis. Researchers identified a further 45 conditions where there is some evidence but further research is needed to confirm the cost effect of increasing breastfeeding rates.

What costs with Irish data?

Action needed

- Ensure health services are fit for purpose including policy, practice, health worker curriculum, and information for the public.
- Strengthen legislation to protect breastfeeding, implement the full International Code of Marketing.
- Support further research on the impact of breastfeeding on health and the burden of disease associated with low breastfeeding rates.

More on health economics related to breastfeeding: Bartick, MC; Stuebe, AM et al. Cost analysis of maternal disease associated with suboptimal breastfeeding. *Obstetrics & Gynecology* 2013 early on-line

Bartick M, Reinhold A. The burden of suboptimal breast-feeding in the United States: A pediatric cost analysis. *Pediatrics* 2010;125:e1048–e1056.

Mainstreaming the practices of the Baby Friendly Initiative -

some highlights from a recent ILCA webinar presented by Genevieve Becker, National BFHI Coordinator

What is the "main stream"?

- Human milk for human babies is normal. It is not a added benefit or an advantage above normal that a mother must *chose* to do.
- A mother keeping her baby close is normal. It is not an option that a staff member might offer to a mother.
- Care and support for a pregnant woman or new mother is normal. It is not a special request above normal care.

What is the evidenced based care?

- What is the evidence that feeding a baby anything other than human milk is low risk?
- What is the evidence that separating a mother and baby at birth is good care?
- Mammals feed their young with mother's milk and keep close to them. New mothers learn from experienced mothers. This has occurred for thousands of years.
- How did it come about that we are asked for the research evidence to prove that biological normality is safe and good practice?
- How did it come about that pregnant women are asked to *chose* to use the milk that their body naturally provides for their baby?

Do not ask: Why implement Baby Friendly practices?

Ask: Why are Baby Friendly practices <u>not</u> in place as the norm?

If there was a liability situation what evidence could be offered for practice that was not in accordance with internationally recognised best practice?

Are their benefits to breastfeeding or risks to not breastfeeding?

Consider the language used

- Diane Weissinger, an International Board Certified Lactation Consultant (IBCLC), New York www.normalfed.com
- Is breastfeeding really invisible, or did the health care system just choose not to notice it? *International Breastfeeding Journal* 2008, 3:13 Chris Mulford http:// www.internationalbreastfeedingjournal.com/content/3/1/13
- McNiel, M. E., Labbok, M. H. and Abrahams, S. W. (2010), What are the Risks Associated with Formula Feeding? A Re-Analysis and Review. Birth, 37: 50–58. http://onlinelibrary.wiley.com/doi/10.1111/j.1523-536X.2009.00378.x/full

The BFHI is Baby Focused

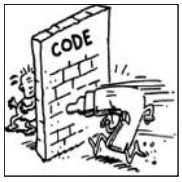
Not called the mother friendly initiative.

The baby is the most vulnerable person in the situation. If we don't speak for the baby, who will?

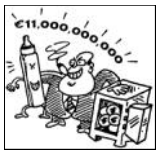
Not called the breastfeeding friendly initiative.

It is more than breastfeeding. It is relevant to all babies.

NEWS and RESOURCES



A guide for health workers to working within the International Code of Marketing of Breastmilk Substitutes is a new publication from UNICEF UK BFI. This free download provides information on how to recognise and reduce commercial influences on infant feeding and offers guidance on the interactions with industry including using their materials, attending study days and accepting gifts or research funding. http://comms.unicef.org.uk/t/911676/2214630/2693130/0/



Remember, marketing of bottles and teats are also covered by the International Code. A claim that a teat or a bottle is similar to breastfeeding is a breach of the Code. Follow-on formula are breast milk substitutes and health services should not be assisting in the marketing of these products.

I've had Kangaroo Care Today!

The idea for these chart stickers originated in the neonatal unit of the Royal Victoria Infirmary, Newcastle, UK to raise awareness of the importance of kangaroo care and help ensure infants received it every day. Stickers and a chart page from www.bliss.org/improving-care/kangaroo-care-stickers

Need a reference to show that the BFHI in Ireland has value?

Becker G. Does the Baby Friendly Hospital Initiative make a difference in Ireland? *National Institute of Health Sciences Research Bulletin* 6:4, 43, 2013. Download the research article from www.hse.ie/go/nihs

Evidence of the long term effects of breastfeeding review, updated 2013 Horta & Victora, WHO

Sixty new publications were identified for this update of the 2007 systematic review and meta-analysis. Long-term outcomes reviewed were: blood pressure, type-2 diabetes, serum cholesterol, overweight and obesity, and intellectual performance. The 74-pages describe the methods, results and conclusions of this updated review. Free to download from http://www.who.int/maternal_child_adolescent/documents/breastfeeding_long_term_effects/en/index.html

New and Revised Clinical Protocols from the Academy of Breastfeeding Medicine

#25: Recommendations for Pre-procedural Fasting for the Breastfed Infant: "NPO" Guidelines

#15: Analgesia and Anesthesia for the Breastfeeding Mother, Revised 2012

#14:Breastfeeding-Friendly Physician's Office: Optimizing Care for Infants and Children, Revised 2013

Free from http://www.bfmed.org/Resources/Protocols.aspx

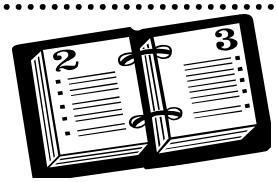
Can a c-section be "natural"?

Immediate and sustained skin to skin contact for mother and baby can assist in feeling more natural when there is a scheduled c-section. *Read:* Smith J, Plaat F, Fisk N. The natural caesarean: a woman-centred technique. BJOG 2008;115:1037–1042. http://onlinelibrary.wiley.com/doi/10.1111/j.1471-0528.2008.01777.x/full *Watch:* You Tube http://www.youtube.com/watch?v=m5RIcaK98Yg

BFHI Link is written by Genevieve Becker, National Co-ordinator of BFHI, and reviewed by members of the BFHI National Committee.

We welcome your news and suggestions.

Contact the BFHI Co-ordinator, email: bfhi@iol.ie
Web site: www.ihph.ie/babyfriendlyinitiative



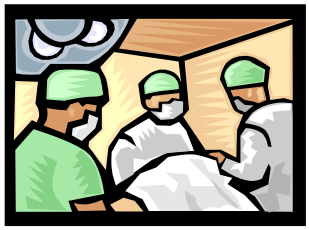
Diary

World Breastfeeding Week.
Aug 1-7 *Breastfeeding Support: close to mothers.* www.worldbreastfeedingweek.org

Oct 1-7 ***National Breastfeeding Week***

Oct 4 - 5 ***Association of Lactation Consultants in Ireland, Annual Conference*** Dublin. *Creating realistic breastfeeding expectations.* www.alcireland.ie

Breastfeeding after a planned c-section



Breastfeeding works after c-sections too!

Early contact: Most hospitals now provide immediate and sustained skin to skin contact for mother and baby after a c-section if there are no health problems. This contact keeps baby warm and helps to steady breathing and blood pressure for you both. Talk to your birth partner about the importance of this early contact so they know to ask if it does not occur as routine.

First feed: During this skin to skin contact time in theatre and in the recovery area your baby may show signs of wanting to go to the breast. This early suckling provides colostrum to nourish your baby and develop baby's immune system.

Pain relief: Medications are available suitable for breastfeeding. Ask for pain relief as needed so you are comfortable moving about and can relax to feed your baby.

Position: Side lying is a useful position after a c-section. Have support behind your back such as the bed rail or pillows. A pillow or a rolled up towel under your tummy and between you knees can reduce strain also. Baby lies facing mother chest to chest, start with nose level with nipple and then chin to breast with a wide open mouth.

Only mother's milk: You make colostrum for the first days in small amounts because your baby's tummy is very small. Your baby feeds often to get these small amounts and this helps more milk to come and in larger amounts. Unless your baby has a medical condition, your milk is all that is needed.

Baby near: When baby is near you can see the early feeding signs and get ready to feed without the stress of a crying baby. The short frequent feeds of the first few days are also easier when baby is near.

Ask for help: You may need help to lift the baby and to get in and out of bed if the bed is high. Ask the midwife or physiotherapist to show you ways to move comfortably. Arrange for some help at home to avoid lifting anything heavy and to get some rest each day. A c-section is surgery and you need time to recover.

What if? A long labour and an emergency c-section may leave you or baby not able to have contact immediately. When you and baby are stable you can have skin to skin contact and start breastfeeding. If baby is not able to feed, start hand expressing your milk as soon as possible, ideally within the first 2 - 4 hours.

Get information before birth: Mother support counsellors, lactation consultants, midwives, and nurses are all used to assisting mothers with breastfeeding after a c-section. If you are expecting a c-section find your local supports before the birth so you know who they are if you need them after the birth.

This is general information. Discuss your specific needs with your midwife or doctor.