



Breastfeeding Update

“Good health begins with breastfeeding.”

BREASTFEEDING & FAMILY FOODS: LOVING & HEALTHY

Amy Trendel MPH, RD, CLE

Parents get advice about feeding their babies from many different sources including family, friends, physicians, WIC (Women, Infants & Children Supplemental Nutrition Program) staff, baby food companies, and the internet. Unfortunately, much of the information they receive is conflicting, anecdotal, and does not meet current recommendations. Sorting out that information to make informed decisions about how, when, and what to feed their babies poses challenges to parents who simply want to do what is best for their child.

The American Academy of Pediatrics advises that healthy, full-term breastfed babies need nothing (no supplemental formula, water, juice, cereal, other solid foods) other than mother's milk during the first 6 months of life. Furthermore, the AAP encourages breastfeeding for “at least the first year of life and beyond for as long as mutually desired by infant and mother” (1).

Why not introduce solids before 6 months?

Exclusive breastfeeding is sufficient to meet the nutritional needs of most babies until they reach 6 months of age as well as to support optimal growth and development. Many parents and providers are unaware of the risks of introducing other foods (and drinks) to breastfed babies before 6 months, which include:

- Increased risk of developing allergies, eczema, asthma (2), and heart disease (3)
- Babies receive less breastmilk which means that:
 - Overall nutrient intake is lowered because the foods given are less nutritious than breastmilk.
 - Babies receive less of the protective factors unique to mothers' milk.
 - Breastmilk production will be reduced.

- Increased risk and severity of diarrhea and other infections because of greater exposure to pathogens and decreased protection from breastmilk (4,5)
- Because a young baby's digestive system is immature, he may not be able to digest other foods as well, which may result in spitting up, constipation, or diarrhea.

At 6 months of age babies need other foods in addition to breastmilk to meet their nutritional needs. They begin to require more iron and zinc than breastmilk alone can provide. Around this same time, babies also become developmentally able to eat soft and semi-solid food when they can sit up, hold their heads steady, and move food around in their mouths.

How to “Feed Lovingly” (6)

Starting older babies on other foods to complement breastmilk provides opportunities for the development of hand-eye coordination, motor skills, and communication skills. To “feed lovingly” parents should respond to their child's signs of hunger and feeding abilities. Parents and care givers can make feeding a time for learning and love by feeding slowly and patiently, helping and encouraging children to eat without force feeding, experimenting with different foods, and minimizing distractions.

The consistency and texture of the foods, how they are fed, and the amounts offered need to change as children grow and learn how to move food around in their mouths, to chew, to hold foods and a spoon and eventually to feed themselves. In

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BREASTFEEDING & FAMILY FOODS: LOVING & HEALTHY

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the beginning, the aim is simply to encourage babies to experiment with the new experience of having food in their mouths. Parents and care givers should get the baby's permission before putting anything in his mouth and let him decide how fast and how much to eat. It doesn't matter if on some days he spits out his food or seems to play with it rather than eat it because he will be getting most of his nutrition from breastmilk. Emphasizing the quality of feedings rather than getting food into the baby helps make feeding fun for parent and baby. If a baby refuses a particular food, she should be encouraged to try it again another day. She may need as many as 5 or 10 or even 15 exposures to a new food before liking it (7).

Babies' stomachs are still relatively small, so it's important they receive nutrient dense foods. The WIC program recommends iron-fortified infant rice cereal as the first food introduced because it is a good source of iron and unlikely to cause allergies.

Importance of breastfeeding past 6 months old

Our culture leads many moms to think weaning should occur at a young age. However, breastfeeding continues to be important for children's nutrition, development and care long after the first 6 months of life. Breastmilk contains more calories and nutrients per ounce than most other foods and is easy to digest. It is also contains factors that help with the absorption of nutrients. Additionally, breastmilk continues to provide protection against illness and reduce the severity

of those that occur. Some protection is provided even if breastfeeding declines to a few times per day. Breastfeeding also helps recovery from illness. Sick babies often do not feel like eating foods, but usually want to breastfeed, which helps keep them hydrated and nourished. The special emotional nurturing provided by breastfeeding continues well beyond 6 months. Continued breastfeeding along with responsive feeding as described above is part of a caring transition from exclusive breastfeeding to eating family foods.

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1. American Academy of Pediatrics. Policy Statement, Section on Breastfeeding: Breastfeeding and the Use of Human Milk. *Pediatrics* 2005; 115(2): 496-506.
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5. Increasing Rates of Exclusive Breastfeeding, background paper prepared for the WHO/ UNICEF Technical Consultation on Infant and Young Child Feeding. WHO Geneva 13-17 March.
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7. Satter, Ellyn. *Child of Mine: Feeding with Love and Good Sense*. Bell Publishing Company, Palo Alto, CA, 2000.

SAVE THE DATE

August 5, 2005

San Diego, California, USA

To Clip or Not to Clip: Ankyloglossia & the Breastfed Infant.

Children's Hospital Grand Rounds, 0800-0900, Cafeteria Conference Rooms A,B,C. Sponsored by CHHC.

Speakers: Dr. James Murphy & Dr. Seth Pransky

For more information contact Nancy Wight MD at 858-939-4175.

August 6, 2005

San Diego, California, USA

Breastfeeding the Older Child: A Mini-Seminar for Physicians & Other Health Care Providers.

Children's Hospital Medical Office Bldg, 8:00-12:30

Sponsored by CHHC in cooperation with the SDCBC

Contact: Gigi Campbell at (858) 939-4175 or

Email: gigi.campbell@sharp.com

September 20, 2005

Foster City, California, USA

Promoting Breastfeeding through Education & Evidence-Based Care.

San Mateo Perinatal Council, Foster City Library, Wind Room.

Contact by telephone (650) 573-2955 or

Email: smperinatal@yahoo.com

October 7-9, 2005

Sacramento, California, USA

Essential Pieces: Continuing Education Lactation Conference 2005

Sponsored by La Leche League of Northern California and Hawaii

Contact by telephone (916) 781-9871 or

Email: LLLconference@yahoo.com

October 17-18, 2005

Alexandria, Virginia, USA

Human Milk Banking - A Global Perspective on Best Practices

Sponsored by the Human Milk Banking Association of North American

Email: aprather@olsonmgmt.com

October 23-24, 2005

Denver, Colorado, USA

Taking Breastfeeding to New Heights: The 5th Annual Health Team

Members Meeting at the 10th Annual International Meeting of the

Academy of Breastfeeding Medicine

Sponsored by the Academy of Breastfeeding Medicine

Program and registration information will be posted at www.bfmed.org.

For more information, call (877) 836-9947 or Email: jymeek@orhs.org

BOOK REVIEW

Improving Nutrition for Very Low Birth Weight Infants: Toolkits I (2004) & II (2005)

Nancy E. Wight MD, IBCLC, FABM, FAAP

The concept of collaboration among institutions for the purpose of improving overall quality of care is a key component of successful and efficient change in health care. Building on the existing VON (Vermont-Oxford Network) framework, the California Association of Neonatologists (CAN), in association with multiple public and private partners developed the California Perinatal Quality Care Collaborative (CPQCC) to foster benchmark performance by all of the NICUs in California. The three arms of the CPQCC are the Data Center, the Perinatal Quality Improvement Panel (PQIP) and the Research Unit.¹

PQIP regional opinion leaders identify NICU care practices that have the potential for improvement. Practice recommendations are presented in a stand-alone quality improvement “toolkit” and a multidisciplinary quality improvement workshop designed to “jump-start” unit teams. Participants are sent exercises before the workshop that are designed to assess current practice and create “cognitive dissonance” as a force for change. Past quality improvement (QI) initiatives have targeted antenatal steroid use, surfactant use, consistent mechanical ventilation, abandonment of postnatal steroid use, prevention of early-onset sepsis, and prevention of nosocomial infection.

I had the privilege of working on “Nutritional Support of the Very Low Birth Weight Infant: Parts I (2004) & II (2005)”, which encompass multiple best practice recommendations with extensive reference lists, assessment tools, and multiple, practical appendices.^{2,3}

Part I was designed to help the NICU care team assess current nutritional practices and outcomes, and to promote and support breastmilk for VLBW infants as part of optimal nutritional management. Part 2 includes best practices in parenteral and enteral nutrition, plus additional attention to continued support for breastfeeding in the NICU and post-discharge. As an extra bonus, Toolkit II includes discussions and appendices on current nutritional “hot topics” such as misadministration of human milk and cytomegalovirus in human milk for extremely preterm infants. Both Toolkits are currently available as a free downloads (~150 pages each) on the CPQCC site (www.cpqcc.org).

Lactation consultants, NICU nurses and anyone interested in optimal nutrition for NICU patients should review these Toolkits. Neonatal nutrition and the use of breastmilk and breastfeeding in the NICU are extensively addressed, using current research and honestly noting where research support is lacking. A recent expert panel report, presented as a supplement to the May 2005 Issue of the Journal of Perinatology⁴, confirmed many of the best practices elucidated in the Toolkits.

1. Wirtschafter DD, & Powers RJ (2004). Organizing regional perinatal quality improvement: Global considerations and local implementation. *NeoReviews*, 5(2), e50-59.
2. CPQCC/PQIP: Nutritional Support of the Very Low Birth Weight Infant: Part I, <http://www.cpqcc.org/NutritionToolkit.html>
3. CPQCC/PQIP: Nutritional Support of the Very Low Birth Weight Infant: Part II, <http://www.cpqcc.org/NutritionIIToolkit.htm>
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In summary, if a pregnancy is not high risk and there is no uterine bleeding, no history of premature delivery, and good weight gain, the pregnant mother can breastfeed without jeopardizing the pregnancy or her health. The infant and older child who are tandem feeding usually do well as long as the mother is well nourished and the older child has access to good complementary nutrition. The emotional and physical aspects of tandem nursing on the mother are more variable. I agree with Hilary Flower if there is not a high risk situation: “Weigh things carefully. Tune into your body. Be brave. Be honest. And trust yourself to make the most appropriate plan for the health and well-being for your family.”

References:

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Reduced Breast Milk Intake and Growth During Early Infancy. *Pediatrics*. 2002;109(4):e56.

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Additional Reading:

Lawrence RA, Lawrence RM, Breastfeeding, A guide for the Medical Profession. 6th Ed. St. Louis: Mosby 2005. 754-757.

SDCBC 2005 MEMBERSHIP DRIVE

Your continued support is needed! Become a member.

If you are interested in becoming a member or renewing your membership for 2005, please visit our website at www.breastfeeding.org or contact our office for more information at (858) 966-5981 or email sdcbc@breastfeeding.org.

What is the San Diego County Breastfeeding Coalition? The San Diego County Breastfeeding Coalition is a non-profit association whose mission is to promote and support breastfeeding through education and outreach in our community. We work with many community partners in various ways to increase breastfeeding initiation and duration rates, thereby improving the health of our community.

SDCBC Membership Levels

Sponsor - \$100 (*Business/Organization/Professional*)

Contributing Member - \$50 (*Individual*)

Friends of the Coalition - any amount under \$50

What are the benefits of being a San Diego County Breastfeeding Coalition Member? As a full member of the San Diego County Breastfeeding Coalition you will:

- Network with a growing body of people dedicated to the promotion and support of breastfeeding,
- Have access to lactation professionals and the most up-to-date breastfeeding resources,
- Receive a free supply of Breastfeeding Resource Guides in English and Spanish,
- Receive a discount for Coalition sponsored education programs,
- Have a home page or link, as appropriate, on the SDCBC's website: www.breastfeeding.org,
- Be listed, with a Sponsor membership, as appropriate, in the "Breastfeeding Resource Guide" without a fee.

- Receive free CME credits for Coalition meeting education programs

You can show your support of the San Diego County Breastfeeding Coalition by:

- Making a monetary contribution to support coalition activities.
- Donating your time by serving on a committee:

Advocacy/Political Action	Community Outreach
Fundraising	Grant Research
Membership	Professional Outreach
Research and Evaluation	Volunteer Coordination
- Attending Coalition meetings and providing your expertise and experience.

NEW! CMEs for Coalition Meetings! The SDCBC is pleased to announce that CMEs (and therefore nursing continuing education credits) are available for the first hour of each general Coalition meeting. Children's Hospital is the generous sponsor for these CMEs. CMEs will be FREE to Coalition members and representatives of organizational Coalition members. A minimal fee of \$10.00 for 1 hour of CME credit will be charged for those who are not SDCBC members who wish CME credit. The first hour of each general Coalition meeting (3-4 pm) will be devoted to education, and the second hour to Coalition business, planning and networking.

Interested in what we do? Attend one of our General Coalition Meetings! General Coalition Meetings are held on the 2nd Thursday of each odd-numbered month at Sharp Mary Birch Hospital for Women, 3003 Health Center Drive, San Diego, in the Grace Benbough Room, located on the 2nd floor, 3:00 – 5:00 pm. Please call (858) 541-4185 or visit our website for directions (www.breastfeeding.org).

BREASTFEEDING FRIENDLY WORKPLACE AWARD

The San Diego County Breastfeeding Coalition is pleased to announce that it will be presenting its 2005 Breastfeeding Friendly Workplace Award in concert with other California counties on **August 24, 2005**. This annual award is presented in celebration of World Breastfeeding Week (August 1-7) to one or more businesses that demonstrate significant commitment to supporting their own breastfeeding employees. Past recipients include: Solar Turbines (2004), UCSD Healthcare (2003), Naval Hospital, Camp Pendleton (2002), The City of Escondido, Kyocera, The San Diego Spirit (2001), Aetna US Healthcare (2000), Qualcomm, People's Organic Foods Market (1999),

SeaWorld (1998), Naval Medical Center San Diego (1997), and Hewlett-Packard (1996).

If your company is contributing to the health of San Diego County by providing employees with time and facilities to express milk at work, we would like to acknowledge your accomplishments. **Please complete our on-line application at www.breastfeeding.org by July 30, 2005 to nominate your employer for the Breastfeeding Friendly Workplace Award.** We will gladly provide a mail-in application at your request. For further information, please contact SDCBC President, **Eve Moeran RN, IBCLC** at milkmade@cox.net.

COMMUNITY SPOTLIGHT

California WIC: Supporting Breastfeeding and Family Foods: Loving and Healthier

Michele Y. van Eyken, MPH, RD

Deputy Chief of Nutrition Programs

California WIC Supplemental Nutrition Program

WIC Services Reach a Majority of California Infants

WIC Services Reach a Majority of California Infants

The WIC Program (Women, Infants and Children Supplemental Nutrition Program) has promoted the health of low to moderate income families (enrolled in Medi-Cal or Food Stamps and/or income less than \$35,798 for a family of four) throughout the United States for over 30 years by providing nutrition education, supplemental food, referrals for needed services and promotion of regular health care. Nationally, the program reaches over 7.5 million pregnant, breastfeeding, and post-partum women and children under age five who have nutrition and health-related risks.

In California, over 1.3 million participants monthly attend classes and counseling support for healthy family meals, active lifestyles, breastfeeding, as well as other topics; and afterward receive their monthly "checks" for nutritious foods that are high in protein, Vitamin C and/or iron. The specific nutritious foods provided to participants include peanut butter, beans, milk, cheese, eggs, iron-fortified cereal, juices, and iron-fortified infant formula for infants not breastfed. In 1999, 62 percent of all infants born in California participated in WIC, giving WIC the potential to influence a significant number of parents on the feeding options for their young children.

Private, non-profit health organizations and local health departments operate 82 local WIC programs in over 640 offices located in all 58 California counties. Staff serve immigrants from around the world in up to twenty-five languages, as families work and adapt to American foods, health care and way of life, as well as teen mothers, college students, newly unemployed parents of young children and others.

WIC Support for Breastfeeding

Since its inception in 1972, the WIC program has included breastfeeding women as a category for program eligibility and has provided a food package to meet their nutritional needs. However, it was discouraging to note in the 1998 Maternal and Infant Health Survey that, compared with the breastfeeding initiation rates of income-eligible non-participants, the initiation rates of WIC participants were lower only among those who did not receive breastfeeding advice (1). A more recent study has found a positive association between WIC participation and breastfeeding initiation but no effect on duration (2). More recently, Congress has allocated specific funds for WIC programs to develop and implement

breastfeeding peer counseling programs, given the evidence this model works to increase breastfeeding initiation, duration and exclusivity rates (3).

Following a review of the WIC food packages in 1988, a special food package for exclusively breastfeeding women was introduced as an incentive to encourage mothers to breastfeed. Still, in 2002, just 41.7 percent of California women who initiated breastfeeding in the hospital were fully or partially breastfeeding six months later, according to the Maternal and Infant Health Assessment in 2003. Similar assessments of WIC mothers indicate that breastfeeding initiation and duration rates for WIC participants continue to lag behind the national average, despite a significant increase in WIC breastfeeding rates since 1990. (4) As other researchers have noted, "the WIC program faces a difficult challenge in encouraging low-income mothers to breastfeed while also providing formula." (2).

Institute of Medicine Study & Recommendations on the WIC Food Package

Faced with mounting pressure from the WIC and health communities to revise the content of the WIC food packages, and given the rising concern about obesity in the American population and the realization that the WIC food package no longer meets the health needs of its target population, the U.S. Department of Agriculture (USDA) commissioned a study of the issue from the Institute of Medicine (IOM) in 2003. The report of the committee was released in April of this year (5) and by law, USDA must publish final regulations on revised food package regulations no later than October 2006.

The committee's research concluded, "WIC participants need at least as much, if not more, breastfeeding advice and support than higher-income women." In addition, the current enhanced food package for exclusively breastfeeding women is not attractive enough compared to packages for partially breastfeeding mother and infant. The committee, therefore, recommended a comprehensive approach that involves:

- Enhanced food packages-including an double the amount of eggs, cheese and baby fruits and vegetables and the addition of baby meats for infants over six months-for the fully breastfeeding mother and her infant;
- Reduced maximum amount of formula provided to partially breastfed infants as well as to formula-fed infants 6 months and older;
- A policy change of not routinely providing formula in the first month of life to breastfed infants;
- A policy change of not providing complementary foods before 6 months of age; and
- Provision of breastfeeding counseling to breastfeeding mothers who request formula in the first month postpartum.

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ASK THE EXPERT: TANDEM NURSING

Eyla Boies MD, FAAP



Eyla Boies joined the UC San Diego Pediatric Faculty Practice in 1992. She devotes her time at UCSD to teaching residents and students, conducting clinical research on clinical breastfeeding related issues, and seeing patients. She is a member of the Academy of Breastfeeding Medicine, and the Section on Breastfeeding of the American Academy of Pediatrics, and sits on the board of the San Diego Breastfeeding Coalition.

Question: I have heard the term “tandem nursing” used for breastfeeding more than one infant. What, exactly, is it?

Answer: Tandem nursing refers to breastfeeding a new baby while continuing to breastfeed an older child, usually a toddler. Tandem nursing may occur when a lactating mother of a toddler or young child adopts or becomes the primary caregiver (e.g. foster mother) of an infant and elects to breastfeed both children. More commonly, a mother conceives while lactating and continues to breastfeed throughout pregnancy and after delivery breastfeeds the older child in addition to the new infant.

Many women around the world who have breastfed during pregnancy and tandem nursed after delivery have done so without informing their health care providers. Their failure to share this information stems partly from the belief that they would be admonished to wean the older child when intuitively she feels she should breastfeed both. I believe providers of health to expectant mothers, mothers of young children, and infants will encounter these question more commonly in the future as the goals of the AAP and WHO to breastfeed for at least one or two years or longer are realized.

Many questions come up when considering this situation. Is it safe for the pregnant mother to breastfeed? Will the infant get enough breastmilk after delivery if he/she has to compete with the older child? What effect will the additional demand of breastfeeding a toddler, in addition to a newborn, have on the mother emotionally as well as physically? What if one child is sick, can they both still breastfeed?

In response to the question, “Is it safe for pregnant women to breastfeed?” the answer is generally yes if the mother is well nourished and the pregnancy is not at high risk of premature labor. There have been theoretical concerns that stimulation of the breast during suckling could initiate uterine contractions and delivery through the release of oxytocin. Experience has shown that the uterus is not sensitive to oxytocin until term and thus in the uncomplicated pregnancy breastfeeding does not increase the risk of fetal loss. The fetus also appears to do well in a healthy well-nourished breastfeeding

mother whose pregnancy is not high risk as documented in studies from Peru¹ and San Diego². A study from rural India, however, documented lower birth weight in mothers who were poorly nourish and breastfeeding.³

In response to the second question about the possible limitation of milk supply available to the newborn, the answer is usually this not a problem in the well-nourished mother. Most mothers report ample breastmilk supply and the more common problem is over supply of milk⁴. One study in India documented faltering growth in the older child in pregnant and malnourished mother³. However, weaning the older child of a pregnant mother when adequate nutrition is in short supply is not without risk as was demonstrated in a study from Bhutan where an abruptly weaned children had a greater risk of developing diarrhea, stunted growth and illness⁵. After delivery of the new infant a mother will produce colostrum providing the all important immunologic boost to the newborn. The toddler may notice the difference and reject that milk.

The answer to the third question regarding the effect of tandem nursing on the mother physically and emotionally is more variable. There is evidence that short birth intervals, that is conceiving within six months of a previous pregnancy, places the subsequent pregnancy at high risk⁶. Physically most mothers report increased fatigue and many experience nipple pain with nursing during pregnancy. In two studies of women who became pregnant while nursing 57% and 69% weaned during the pregnancy^{2,7}. Half of the weanings were mother led and usually due to nipple/breast pain; the other half were child led weanings. Milk supply frequently diminishes during pregnancy and it may change in flavor. These factors likely promote child led weaning. Some mothers feel tandem nursing is absolutely the right thing to do for both children and others have very negative feelings much to their own surprise. Besides extreme fatigue, some women report resentment toward one of their children or a sensation of being “touched out” by both children and partner. Almost all mothers who successfully tandem nurse recommend protected down time for self-care. [Adventures in Tandem Nursing](#) by Hilary Flower is an excellent resource for parents and clinicians. She not only covers the limited literature on the topic, she enlisted the comments of 200 mothers around the world who tandem nursed their children. I highly recommend this book for anyone interested in this subject.

The answer to the fourth question, can both children nurse if one is sick, is usually yes. For common colds exposure usually occurs before symptoms are apparent and usually occurs whether breastfeeding or not. However in the case of a toddler with cold sores otherwise known as herpes on the lip (HSV I), the toddler should **not** breastfeed until the cold sores have completely healed. Herpes infections in the first months of life can be devastating and even fatal. If one child has thrush and the other does not, it would be wise to allot one breast to each child if feasible.

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USDA, as part of the public administrative process for generating regulations, will put the IOM committee's recommendations out for public comment and will use these comments to formulate the final rules.

World Breastfeeding Week 2005

Celebrate World Breastfeeding Week this year by promoting exclusive breastfeeding and raising awareness of the risks and costs of introducing other foods to breastfed babies before six months.:

- Exclusive breastfeeding is sufficient to support optimal growth and development for approximately the first six months of life;
- Breastfeeding should be continued for at least the first year of life and beyond for as long as mutually desired by mother and child;
- Complementary foods rich in iron should be introduced gradually beginning around 6 months of life; earlier introduction in general does not increase total caloric intake...[but] only substitutes foods that lack the protective components of human milk; (6).
- Initial breastfeeding protects against obesity later in life (7).
- Early exposure of formula feeding and rapid growth in infancy are risk factors for diabetes in children (8).

Celebrate World Breastfeeding Week throughout the year and in 2006 by working with WIC programs to improve the WIC food package in a way that supports breastfeeding.

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POLITICS, ADVOCACY & LEGISLATION

SB 600: HEALTHY CALIFORNIANS BIOMONITORING PROGRAM

Nancy Wight MD, IBCLC, FABM, FAAP

After much deliberation, the San Diego County Breastfeeding Coalition endorsed Senate Bill 600 (Ortiz & Perata), the Healthy Californians Biomonitoring Program, which seeks to establish a statewide community-based monitoring program using biospecimens such as urine, blood and breastmilk. The resulting data can be used to improve public health by identifying communities disproportionately affected by chemical exposures; assessing the effectiveness of current legislative regulations; creating a base for prioritizing regulatory action, and improving support for breastfeeding as a means of ameliorating the harmful effects of the chemicals found.

The greatest risk from exposure to harmful chemicals is the period in utero, but toxic chemicals have been found in both artificial infant formulas and human milk. **The presence of chemicals in breastmilk is NOT a reason to stop breastfeeding.** Infants fed artificial milks are at higher risk for poor outcomes as they are not

only exposed to toxic chemicals, but lack the myriad of protective factors found in human milk, including anti-inflammatory agents, anti-oxidants, direct anti-infective factors, immunomodulators, hormones, growth factors and multiple other bioactive factors.

Breastmilk, and the other biospecimens, can yield valuable information regarding the kinds and quantities of chemicals found in all our bodies. SB 600 addresses the use of breastmilk for biomonitoring with care, so that women are not deterred from breastfeeding, through coordination with the Maternal, Child & Adolescent Branch of the Department of Health Services, an advisory panel including a breastfeeding advocate, and coordination with other organizations to develop Biomonitoring materials, protocols, training programs and public education materials.

As breastfeeding advocates and educators we should stand together with environmental health proponents to promote breastfeeding while demanding the elimination of harmful chemicals that are contaminating California's children. We should clearly make the case that breastfeeding has even more advantages in our polluted environment.

Breastfeeding Update

“Extended Breastfeeding & Other Foods”

SDCBC's Newsletter for July 2005
Volume 5, Issue 2



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“Good health begins with breastfeeding.”

SEE THIS NEWSLETTER ON THE WEB AT
www.breastfeeding.org

RESEARCH CORNER

The relationship between maternal smoking and breastfeeding duration after adjustment for maternal feeding intention. Donath SM, Amir LH, ALSPAC Study Team. *Acta Paediatr* 2004; 93:1514-18.

Previous studies have shown that women who smoke are less likely to breastfeed and that smoking is associated with a shorter duration of breastfeeding. Research has also shown that prenatal infant feeding intention is a strong predictor of breastfeeding duration. Is the earlier weaning by mothers who smoke a physiologic effect of smoking on breastfeeding, or do these smoking mothers intend to breastfeed less often and for a shorter period of time?

Over 14,000 women expecting to give birth 1992-4 were recruited for the Avon Longitudinal Study of Parents and Childhood (ALSPAC) in 3 Bristol-based health clinics of Avon, U.K, with complete data available for 11,111 women. Main outcome measures included maternal infant feeding intention at 32 weeks of pregnancy, intention for the first week, intention for the rest of the first month and intention in months 2 to 4. Maternal smoking was defined as any smoking reported at any time during pregnancy. Data on initiation and

duration of breastfeeding were based on a questionnaire at 6 months postpartum, supplemented by data from a 15-mo questionnaire if necessary.

RESULTS: Smoking mothers were younger and less educated than nonsmoking mothers. Women who smoked during pregnancy had an adjusted odds ratio of 1.5 (95% CI: 1.3-1.7) of not breastfeeding at 6 months compared to non-smokers (adjusting for maternal age, education and intention). Survival analysis of duration of breastfeeding in the first 6 months postpartum found that women who intended to breastfeed for less than 1 month were 78% more likely to stop at any given time than women planning to breastfeed for at least 4 mo, while smokers were 17% more likely to stop breastfeeding than non-smokers. This smaller difference (17%) could be due to the physical effects of smoking, or to unidentified confounders.

CONCLUSION: Although women who smoke are less likely to breastfeed their infants than are non-smoking women, it appears that this is largely due to lower motivation to breastfeed rather than a physiological effect of smoking on their milk supply.

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