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Promotion, protection and support of breastfeeding in Norway

By

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Written Declaration

I declare that I completed the submitted work individually and only used the mentioned sources and literature. Concurrently, I give my permission for this diploma/bachelor thesis to be used for study purposes.

In Prague 1st of April 2010 Ellen Wang Ræstad

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INTRODUCTION

Norway has the last 40 years had a dramatic increase in breastfeeding women.

In 1968, only 5% of Norwegian mothers breastfed their babies at 9 months. Today, in 2010, 98% of neonates receive breastmilk at 3 months, and 80% at 9 months! These numbers reveal that Norway has the highest prevalence of breastfeeding of the developed countries. Over the past 40 years the percentage of women who breastfeed has been high and steady, and the duration of breastfeeding has been long.

85-90% of Norwegian children still receive breastmilk after the age of 3 months. The incidence of breastfeeding beyond the age of 1 year is still increasing. [9]

There is a big interest around the world, asking: ”What did Norway do??”

This question is the basis of my thesis.

What did Norway do to increase the number of breastfeeding woman with 85%? How come Norway is so much better than the neighbouring Scandinavian countries concerning breastfeeding?

Under the supervision of Dr. Dagmar Schneidrová, at the Institute of Child and Youth Health of the 3rd Faculty of Medicine of Charles University in Prague and Dr. Gro Nylander at Rikshospitalet in Oslo I have searched this topic.

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ADVANTAGES OF BREASTFEEDING

Breast milk provides the optimal nutrition for infants and offers health benefits as well as immunity from infections. Maternal benefits of breastfeeding can include more rapid return of postpartum uterine tone and postpartum weight loss, delay of ovulation, and decreased risk of breast, ovarian, and endometrial cancers. [12]

Feelings about mother's milk, widespread in Norway today:

"It should be as rare to feed animal milk to human newborns as it is to feed human milk to animals: It can be done, but should only be used occasionally" .

Fat: especially long chain fatty acids are important. This is very important for the brain development as well as for the rest of the body.

Sugars and other carbohydrates. Milk sugar and lactose being the most important ones for nutrition.

Proteins and enzymes (cow milk contains too much protein for a baby!)

Iron and other minerals

Water, salts and calcium

Vitamins (supplements of vitamin D and C is normal)

Enough **fluid,** even for warm days

Breast milk also contain important factors preventing diseases:

- antibodies against bacteria and virus
- white blood cells

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- proteins binding inappropriate free iron
- factors promoting growth of beneficial bacteria in the gut
- interferons for viral protection

Breastfed children are at decreased risk to develop:

- dangerous general infections during infancy
- diarrhea and other disorders of the gut
- respiratory disorders, e.g. influenza, RSV, bronchitis, pneumonia etc.
- urinary tract infections
- eczema and other allergies
- hypersensitivity to cowmilk products
- diabetes mellitus
- bowel disorders in adulthood.

Norwegian women produce, 10,000 tons of breastmilk each year. (2,5 litre per Norwegian each year) . [12]

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Weightgain:

Breastfed children grow and gain weight rapidly when the breastfeeding is well established during the first month. The milk from the mother helps to develop and mature the child intestines. This makes the transition from getting nutrients via the umbilical cord to feeding via the mouth more smooth and comfortable. Breastmilk is easily digested and the nutrients are absorbed very quickly. This is one of the reasons that brestfed babies need feeding more often than bottle fed babies.

After approximately 3 months of age however, breastfed children tend to be slimmer than children fed on formulas. World Health Organization (WHO) developed growth charts showing the "gold standard" for fully breastfed children – thus not to compare them with children fed in any other ways. The reason for this is that many neonates are diagnosed wrongly as underweight, and many who are overweight are registered too late. [10 and 1]

See text number 5 in appendix with description of breastfeeding after birth.

EPIDEMIOLOGY

Norway is a leading country in promotion, protection and support of breastfeeding, and has since 1968 increased the prevalence of breastfeeding mothers from less than 5% to more than 90% today.

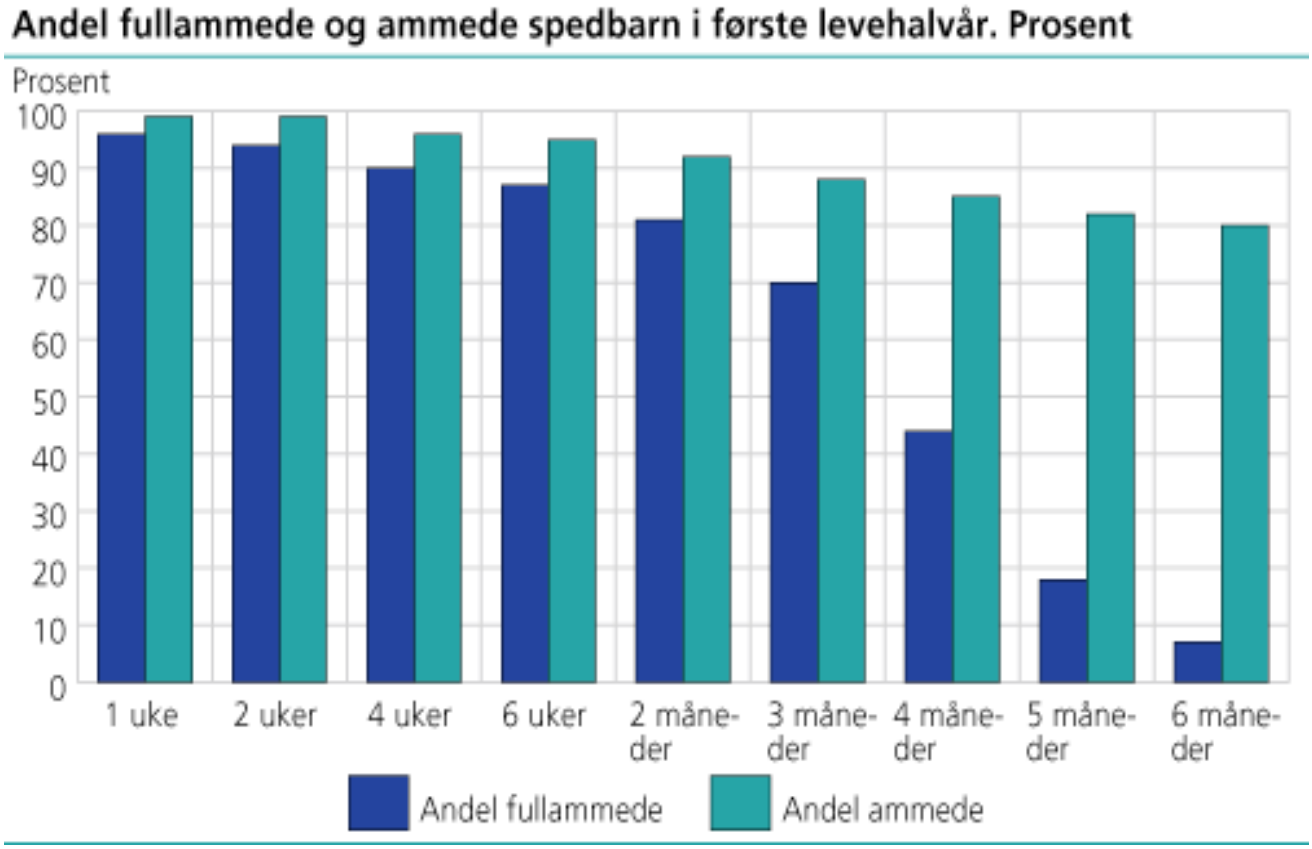
4 out of 5 Norwegian babies still receive breastmilk at age of 6 months. Only 1% of Norwegian babies have never been breastfed. Most infants are being fed according to the recommendations concerning nutrition. 70% of the infants don't get anything else but milk from their mother the first 3 months of life, 79% get introduced to solid food at age of 4 months or later, and 80% get vitamin D supplements. 80% still receive breastmilk when they are 6 months old.

The period of exclusive breastfeeding is for many mothers shorter than recommended. At the age of 4 months 44% of Norwegian infants receive only breastmilk. It is recommended to give only breastmilk up to the age of 6 months as long as the mother and the baby are satisfied with that.

At age of 6 months 90% of Norwegian infants get porridge and 63% eat solid food for dinner. Of those who do not get breastfed when they are half a year old, receive breastmilk substitutes as recommended rather than cow milk to drink.

The incidence of breastfed babies are equal between boys and girls. On the other hand there are differences in number of breastfeeding women according to their age, education, smoking habits, number of children, living conditions and the birth weight. Incidence of breastfeeding increase with mothers age, education and number of children.

In a research done by the Norwegian Statistics in 1998, 80% of the questioned women got useful information about breastfeeding from the hospital. Together with different brochures and consultations, family and friends were also important sources of information. About 50% requested more information. This included especially more information concerning termination of breastfeeding, introduction of solid food, how to make homemade food for infants and information about allergies and food intolerance. [14]



The table shows percentage of infants receiving breastmilk together with substitutes (green) and percentage of fully breastfed infants (blue) during the first year of living.

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The promotion of breastfeeding is one of the most effective ways to improve the health of children. It has also beneficial effects for mothers, families, the community, the health and social system, the environment, and the society in general.

There are numerous initiatives at local, regional, national and international level that promote breastfeeding. In the following chapters I will describe some of these.

WHO GUIDELINES

World Health Organization (WHO) has recommendations concerning breastfeeding worldwide. They state that:

“Breastfeeding is one of the most effective ways to ensure child health and survival. A lack of exclusive breastfeeding during the first six months of life contributes to over a million avoidable child deaths each year.

Globally less than 40% of infants under six months of age are exclusively breastfed. Adequate breastfeeding support for mothers and families could save many young lives.

WHO actively promotes breastfeeding as the best source of nourishment for infants and young children. This fact file explores the many benefits of the practice, and how robust help for mothers can increase breastfeeding worldwide.”

WHO has put up 10 facts about breastfeeding:[16]

1) WHO recommends

WHO strongly recommends exclusive breastfeeding for the first six months of life. At six months, other foods should complement breastfeeding for up to two years or more. In addition:

- breastfeeding should begin within an hour of birth;

- breastfeeding should be "on demand", as often as the child wants day and night; and
- bottles or pacifiers should be avoided.

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2) Health benefits for infants

Breast milk is the ideal food for newborns and infants. It gives infants all the nutrients they need for healthy development. It is safe and contains antibodies that help protect infants from common childhood illnesses - such as diarrhea and pneumonia, the two primary causes of child mortality worldwide. Breast milk is readily available and affordable, which helps to ensure that infants get adequate sustenance.

3) Benefits for mothers

Breastfeeding also benefits mothers. The practice when done exclusively often induces a lack of menstruation, which is a natural (though not fail-safe) method of birth control. It reduces risks of breast and ovarian cancer later in life, helps women return to their pre-pregnancy weight faster, and lowers rates of obesity.

4) Long-term benefits for children

Beyond the immediate benefits for children, breastfeeding contributes to a lifetime of good health. Adults who were breastfed as babies often have lower blood pressure and lower cholesterol, as well as lower rates of overweight, obesity and type-2 diabetes. There is evidence that people who were breastfed perform better in intelligence tests.

5) Why not infant formula?

Infant formula does not contain the antibodies found in breast milk and is linked to some risks, such as water-borne diseases that arise from mixing powdered formula with unsafe water (many families lack access to clean water). Malnutrition can result from over-diluting formula to "stretch" supplies. Further, frequent feedings maintain the breast milk supply. If formula is used but becomes unavailable, a return to breastfeeding may not be an option due to diminished breast milk production.

6) HIV and breastfeeding

For HIV-positive mothers, WHO recommends exclusive breastfeeding for the first six months unless replacement feeding is:

- acceptable (socially welcome)
- feasible (facilities and help are available to prepare formula)
- affordable (formula can be purchased for six months)
- sustainable (feeding can be sustained for six months)
- safe (formula is prepared with safe water and in hygienic conditions).

7) Regulating breast-milk substitutes

The International Code of Marketing of Breast-milk Substitutes was adopted in 1981. It calls for:

- all formula labels and information to state the benefits of breastfeeding and the health risks of breast-milk substitutes;
- no promotion of breast-milk substitutes;
- no free samples of breast-milk substitutes to be given to pregnant women, mothers or their families; and
- no distribution of free or subsidized breast-milk substitutes to health workers or facilities.

8) Support for mothers is essential

Breastfeeding has to be learned and many women encounter difficulties at the beginning. Nipple pain, and fear that there is not enough milk to sustain

the baby are common. Health facilities that support breastfeeding - by making trained breastfeeding counsellors available to new mothers - encourage higher rates of the practice. To provide this support and improve care for mothers and newborns, there are now more than 20 000 "Baby-friendly" facilities in 152 countries thanks to a WHO-UNICEF BFH initiative.

9) Work and breastfeeding

WHO recommends that a new mother should have at least 16 weeks of absence from work after delivery, to be able to rest and breastfeed her child. Many mothers who go back to work abandon exclusive breastfeeding before the recommended six months because they do not have sufficient time, or an adequate place to breastfeed or express and store their milk at work. Mothers need access to a safe, clean and private place in or near their workplaces to continue the practice.

10) The next step: phasing in new foods

To meet the growing needs of babies at six months of age, complementary foods should be introduced as they continue to breastfeed. Foods for the baby can be specially prepared or modified from family meals. WHO notes that:

-breastfeeding should not be decreased when starting complementary feeding;

- complementary foods should be given with a spoon or cup, not in a bottle;

- foods should be clean, safe and locally available;

- ample time is needed for young children to learn to eat solid foods.

Norwegian representative of the international Red Cross organization at a Maternity School in Bangladesh 1975.

EUROPEAN UNION BLUEPRINT FOR ACTION

The Blueprint for Action was developed by a group of breastfeeding experts representing all EU and associated countries. Within the group of national respondents to the project most of the key relevant health and allied professional bodies and stakeholder groups were represented, including mothers. Before developing the Blueprint, the group analyzed the current situation (prevailing breastfeeding rates and practices) in all the participant countries. The group then undertook a thorough review of breastfeeding interventions, together with an analysis of the research evidence supporting them, in order to identify the gaps between what is done and what should be done. The draft Blueprint was then submitted for

consideration and review by a larger group of stakeholders, identified as having a specific relevant role and expertise in their respective countries.

The Blueprint is a model plan that outlines the actions a national or regional plan should contain and implement if effective protection, promotion and support of breastfeeding are to be achieved. Underpinning all stages of the action plan is the need for policy, planning, management and financing; for information, education and communication; for pre- and in-service training; and for evaluation and monitoring. The Blueprint incorporates specific interventions and sets of interventions; most of the recommended interventions have been previously graded by level of evidence. The Blueprint also includes interventions, which, though not based on research evidence of effectiveness, public health experts consider as essential contributions to the effective implementation of an action plan.

The protection, promotion and support of breastfeeding are a public health priority throughout Europe. Low rates and early cessation of breastfeeding have important adverse health and social implications for women, children, the community and the environment, result in greater expenditure on national health care provision, and increase inequalities in health.

The Global Strategy on Infant and Young Child Feeding, adopted by all WHO member states at the 55th World Health Assembly in May 2002 provides a basis for public health initiatives to protect, promote and support breastfeeding.

Extensive experience clearly shows that breastfeeding can be protected,

promoted and supported only through concerted and coordinated action. The Blueprint for Action, written by breastfeeding experts representing all EU and associated countries and the relevant stakeholder groups, including mothers, is a model plan that outlines the actions that a national or regional plan should contain and implement. It incorporates specific interventions and sets of interventions for which there is an evidence base of effectiveness. It is hoped that the application of the Blueprint will achieve a Europe- wide improvement in breastfeeding practices and rates (initiation, exclusivity and duration); more parents who are confident, empowered and satisfied with their breastfeeding experience; and health workers with improved skills and greater job satisfaction.

Prevailing budgets, structures, human and organizational resources will have to be considered in order to develop national and regional action plans based on the Blueprint. Action plans should build on clear policies, strong management and adequate financing. Specific activities for the protection, promotion and support of breastfeeding should be supported by an effective plan for information, education and communication, and by appropriate pre- and in-service training. Monitoring and evaluation, as well as research on agreed operational priorities, are essential for effective planning. Under six headings, the Blueprint recommends objectives for all these actions, identifies responsibilities, and indicates possible output and outcome measures.

1.Policy and planning

A comprehensive national policy should be based on the Global Strategy on Infant and Young Child Feeding and integrated into overall health policies.

Specific policies for socially disadvantaged groups and children in difficult circumstances may be needed to reduce inequalities. Professional associations should be encouraged to issue recommendations and practice guidelines based on national policies. Long- and short-term plans should be developed by relevant ministries and health authorities, which should also designate suitably qualified coordinators and inter-sectoral committees. Adequate human and financial resources are needed for implementation of the plans.

2.Information, education, communication (IEC)

Adequate IEC is crucial for the re-establishment of a breastfeeding culture in countries where artificial feeding has been considered the norm for several years/generations. IEC messages for individuals and communities must be consistent with policies, recommendations and laws, as well as consistent with practices within the health and social services sector. Expectant and new parents have the right to full, correct and optimal infant feeding information, including guidance on safe, timely and appropriate complementary feeding, so that they can make informed decisions. Face-to-face counseling needs to be provided by adequately trained health workers, peer counselors and mother- to-mother support groups. The particular needs of the women least likely to breastfeed must be identified and actively addressed. The distribution of marketing materials on infant feeding provided by manufacturers and distributors of products under the scope of the International Code of
Marketing of Breast-milk Substitutes should be prevented.

3.Training

Pre- and in-service training for all health worker groups needs improvement. Pre- and post-graduate curricula and competency on breastfeeding and lactation management, as well as textbooks, should be reviewed and developed. Evidence-based in-service courses should be offered to all relevant health care staff, with particular emphasis on staff in frontline maternity and childcare areas. Manufacturers and distributors of products under the scope of the International Code should not influence training materials and courses. Relevant health care workers should be encouraged to attend advanced lactation management courses shown to meet best practice criteria for competence.

4.Protection, promotion and support

Protection of breastfeeding is largely based on the full implementation of the International Code, including mechanisms for enforcement and prosecution of violations and a monitoring system that is independent of commercial vested interests; and on maternity protection legislation that enables all working mothers to exclusively breastfeed their infants for six months and to continue thereafter.

Promotion depends on the implementation of national policies and recommendations at all levels of the health and social services system so that breastfeeding is perceived as the norm. Effective support requires commitment to establish standards for best practice in all maternity and child care institutions/services. At individual level, it means access for all women to breastfeeding supportive services, including assistance provided by appropriately qualified health workers and lactation consultants, peer counselors, and mother-to-mother support groups. Family and social support

through local projects and community programs, based on collaboration between voluntary and statutory services, should be encouraged. The right of women to breastfeed whenever and wherever they need must be protected.

5.Monitoring

Monitoring and evaluation procedures are integral to the implementation of an action plan. To ensure comparability, monitoring of breastfeeding initiation, exclusivity and duration rates should be conducted using standardized indicators, definitions and methods. These have not been agreed yet in Europe; more work is urgently needed to develop consensus and issue practical instructions. Monitoring and evaluation of practices of health and social services, of implementation of policies, laws and codes, of the coverage and effectiveness of IEC activities, and of the coverage and effectiveness of training, using standard criteria, should also be an integral part of action plans.

6.Research

Research needs to elucidate the effect of marketing practices under the scope of the International Code, of more comprehensive maternity protection legislation, of different IEC approaches and Interventions, and in general, of public health initiatives. The cost/benefit, cost/effectiveness and feasibility of different interventions need also further research. The quality of research methods need to substantially improve, in particular with regards to adequate study design, consistency in the use of standard definitions of feeding categories, and use of appropriate qualitative methods when needed. Ethical guidelines should ensure freedom from all competing and commercial interests; the disclosure and

handling of potential conflicts of interest of researchers is of paramount importance.

Breastfeeding is not fully promoted and supported. Many health care and social institutions provide services that often represent obstacles to the initiation and continuation of breastfeeding. As a result not all children in Europe get this ideal start to life.

Low rates and early cessation of breastfeeding have important adverse health and social implications for women, children, the community and the environment, result in greater expenditure on national health care provision and increase inequalities in health.

If a new vaccine became available that could prevent one million or more child deaths a year, and that was moreover cheap, safe, administered orally, and required no cold chain, it would become an immediate public health imperative.
Breastfeeding can do all of this and more, but it requires its own "warm chain" of support - that is, skilled care for mothers to build their confidence and show them what to do, and protection from harmful practices. If this warm chain has been lost from the culture or is faulty, then it must be made good by health services.[6]

The importance of protecting, promoting and supporting breastfeeding has also been reiterated in important European Union (EU) documents. The EURODIET project strongly recommended a review of existing activities and the development and implementation of a EU action plan on breastfeeding. Following on from EURODIET, the so-called 'French

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Initiative' on nutrition highlighted the need for action on breastfeeding surveillance and promotion. The French Initiative led to the EU Council Resolution on Nutrition and Health in December 2000, where breastfeeding was officially recognized as a priority.

EU countries are currently coordinating action in other health fields and social sectors. Action on breastfeeding in Europe is presently uncoordinated. Not all countries have national policies and plans, and even when these are in place, they are sometimes not acted upon, or may not be compatible with universally recognized best evidence-based recommendations.

Finally, a program for the protection, promotion and support of breastfeeding is not just a list of separate interventions. Interventions are usually multifaceted, interrelated and integrated in order to maximize their combined and cumulative effect. Moreover, the effect will depend on continuity, because a change in the behavior of mothers, families and health workers, and of the infant feeding culture in a given society, requires that interventions and program be sustained for a sufficient length of time. [6]

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BABY-FRIENDLY HOSPITAL INITIATIVE (WHO/UNICEF)

Steady improvement of maternity ward routines in Norway since 1993 culminated in the Baby-Friendly Hospital Initiative (BFHI), a government funded project, carried out according to the WHO/UNICEF guidelines. BFHI is a global effort to implement practices that protect, promote and support breastfeeding.

The BFHI did not really believe in a significant change during the 90´s, the main motive was: "breastfeeding with less sweat, blood and tears". So the question is: did it make any change?

YES! It certainly did. In 1993 when the project started, 86% of mothers breastfed at 3 months and 14% breastfed at 12 months. In 1999 when the hospitals were re-evaluated, 90% of mothers were breastfeeding at 3 months and 31% at 12 months. These numbers have increased dramatically even further up to today. After 2000 there has been further work up with the Baby-Friendly Hospitals in Norway, now also having neonatal departments. Also the work with so -called "health stations" are well established. [9]

BFHI-Norway offers all neonatal intensive care units (ICUs) an adaptation of the 10 steps (see chapter about WHO), special courses and literature. Practically all premature babies are today fed human milk, mainly from their own mothers.

Human milk banks have now been established in ¾ of hospitals with neonatal ICUs.

The BFHI (and other initiatives that promote evidence-based changes in

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hospital practices) are implemented in many countries, but only a few countries have achieved widespread participation across the whole maternity care sector. In some countries none of the maternity hospitals have, as yet, achieved the standard for BFH designation. Expansion of the BFHI beyond the maternity care setting to include community health care services and pediatric hospitals is taking place in some countries. [2]

Since the BFHI was launched by UNICEF and WHO, the initiative has grown, with more than 20,000 designated facilities in 152 countries around the world over the last 15 years. [4] The BFHI has measurable and proven impact, increasing the likelihood that babies will be exclusively breastfed for the first 6 months, and reducing the risk of gastro-intestinal infections.

"HIV and Infant Feeding – Framework for priority Action" (2003) endorsed by 9 UN agencies recommends support for optimal infant and young child feeding for all, including support for BFHI in settings with high HIV prevalence.[4]

The Global Criteria for the BFHI provides a standard to measure adherence to the Ten Steps for successful Breastfeeding, aspects of the International Code of Marketing of Breast-milk substitutes, support for infant feeding in the context of HIV and mother-friendly care. These criteria can link with other quality assurance systems in health facilities to assist in mainstreaming BFHI.[4]

See table 1 in Appendix. Looka at number 4 in Appendix to see an educational tet made by the BFHI.

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AMMEHJELPEN

THE NORWEGIAN BREASTFEEDING ASSOCIATION

The founding of the Norwegian Breastfeeding Association, "Ammehjelpen", in 1968 was a milestone in the history of breastfeeding in Norway. The association is a coalition of mother-to-mother support groups. Women who had breastfed volunteer to be on call to help mothers who encounter problems in breastfeeding.

Members of the group also act as watchdogs for the implementation of the National Code of Marketing of Breast-milk Substitutes, which in Norway is done through a voluntary agreement between the industry and the government. In addition, "Ammehjelpen" initiates training programmes for health personnel. They also work hard with changing the attitude in the community.

The Norwegian Association of Breastfeeding was established at a crucial time of women's awakening and during a wave of feminist orientation. When women organized to protect and promote breastfeeding, they were challenging the power of medical practitioners. A real breakthrough in the promotion of breastfeeding would have been difficult without the support of the authorities. Maternal leave has gradually increased in length, and currently lasts for one year with 80% pay, or for 46 weeks with full pay.

Labour market regulations entitle women to take the necessary breaks if they breastfeed or to shorten the working day with one hour.

”Ammehjelpen” has a clear and restricted objective, aimed at helping healthy mothers and children with normal problems, and it refers pathological cases to the health services.

Health professionals were instrumental in the creation of the movement, and health workers are still an important part of the network, both as technical advisers and ordinary members. The network has been a catalyst producing the major changes that have taken place in the routines of maternity wards.

Deliveries are still performed in hospitals, but the atmosphere is totally different than it was 30-40 years ago. Fathers are now welcome to be in the room, early skin-to-skin contact between the baby and parents is promoted and early breastfeeding is encouraged.

The main task for ”Ammehjelpen” has always been the support of individual mothers. While most mothers can breastfeed without much problem, some need encouragement or advice. Another important task is to comfort mothers who for some reason or another cannot breastfeed. It has always been a policy of ”Ammehjelpen” to support mothers, not to work against them. Educational material for mothers has been developed by ”Ammehjelpen”, and is distributed by the Government free of charge to mothers after having given birth.

The high prevalence of breastfeeding in Norway truly shows that mothers choose to breastfeed if they are enabled to do so.

In Norway, the great increase in breastfeeding prevalence came about when women themselves took action. They used their own expertise, and were

convinced that their expertise was valid. Over the years the general attitude towards breastfeeding has become more and more favourable. Woman breastfeed in public, in restaurants, meetings, parks, beaches and so on. This is highly appreciated by the general public.

When the Government was to select a national coordinator for the Baby Friendly Hospital Initiative of UNICEF and WHO, it was only natural to look to ”Ammehjelpen” to find a suitable person, and a health professional and a long-standing member of the movement to this important position. [5]

THE ROLE OF MEDIA

Media plays an important role in making women breastfeed. Media is motivating both parents and health personnel.

The mass media have the potential to be powerful friends or foes in promoting breastfeeding. The media could help by putting the issue of breastfeeding on policy agendas and by framing breastfeeding as healthy and normative for baby and mother. Currently, however, it looks as if the media are more often contributing to perceptions that breastfeeding is difficult for mothers and potentially dangerous for babies. Some insights into the market forces and human psychological factors may play a role into media representations of breastfeeding, and strategies to help breastfeeding advocates work more effectively with the media.

It is a good way to inform people about good research news about mother's milk and breastfeeding. The media could play important and positive roles in promoting breastfeeding. Advocates for other public health issues such as tobacco control have learned a number of lessons about what it would take. Media campaigns are most effective when messages are simple, clear, tailored to the needs and tastes of specific audience segments, and placed in channels that reach important target audiences. Straightforward messages to expectant and new mothers promoting the health effects of breastfeeding are important. But campaigns should also focus on changing cultural norms so that breastfeeding mothers are seen as a natural part of the community and workplace. The news media can be helpful in promoting public policies such as paid maternity leave, baby-friendly work environments, and affordable childcare that will make it easier for working mothers to breastfeed.

Sustained exposure over time is key. One strategy would be to develop partnerships with media producers to assure that the issue of breastfeeding stays on the media news agenda, and that news and entertainment portrayals are positive. Advocates could develop relationships with producers and screenwriters, supplying story lines that make breastfeeding seem healthy, normative, and positive. Such "entertainment-education" efforts on behalf of other health issues, such as unplanned pregnancy and emergency contraception, have been effective in increasing audience awareness

Famous people also have a great effect on women. When we see celebrities who breastfeed in the public they are sort of making a new trend that other people wants to follow.

See picture 2 in Appendix.

A 2000 Cochrane review suggests that media campaigns, particularly television commercials, have been shown to improve attitudes toward breastfeeding and increase initiation rates.

BREASTFEEDING AROUND THE WORLD

If we look at past and present trends in developed countries and across national borders, it becomes clear that where social conditions are difficult, survival of children is greatly dependent on the mother's ability to breastfeed. But breastfeeding is under threat as its prevalence decreases due to "modernization".

The history of breastfeeding in Norway illustrates how vulnerable breastfeeding can be. Countries that now experience a drop in breastfeeding prevalence need not accept this as inevitable. Prevention is of course better than cure, butt he Norwegian history of breastfeeding implies it s possible to reverse the trend.

Studies from developing countries show that infants under 5 months of age are 25 times more likely to die from diarrhoea if they are not exclusively breastfed. Promoting breastfeeding is a way of obtaining household food security for a vulnerable part of the population.

Breastfeeding costs little, and promotion can be seen as a good investment.

The extra food a nursing mother needs costs little compared to the prices for breast milk substitutes, which can cost many times the income of a mother employed outside the home. Training of personnel carries a cost, but hospitals will save a great deal of money if they do not have to provide supplements, and the country will save foreign currency on import. To these direct savings one could add the money saved by having healthier babies, who require less medical attention and treatment. See picture no. 3 in Appendix.

CHALLENGES

There are still many challenges related to breastfeeding in Norway.

Many women breastfeed for a shorter period of time than they have planned to. Many mothers find that the start of breastfeeding can be particularly hard, and more could be done to alleviate their problems and worries.

Training for health personnel in breastfeeding management needs drastic improvement.

Although the law provides for breastfeeding pauses, many women have difficulties in claiming this right in a hectic working situation. Furthermore, there is still a difference between the social classes, as women of lower socioeconomic status breastfeed less than more affluent women.

Smoking is prevalent among women, and too few stop smoking during pregnancy and lactation. What about the risk of contaminated mothers milk (E.g. high levels of environmental toxins, PCB, dioxin, estrogen-imitators, naturally occurring toxins such as aflatoxins)? The study of toxic contamination of breastmilk is a large and complicated field and beyond the scope of this thesis, but nevertheless should be considered.

SUMMARY

Norway is the leading country in the aspect of promotion, protection and support of breastfeeding. From 1968 and up to today, 2010, Norway has increased the prevalence of breastfeeding from 5% breastfeeding at 3 months to 98% breastfeeding at 3 months today.

Many organizations at different levels are involved with the work promoting breastfeeding. The World Health Organization (WHO) is working worldwide. WHO have put up 10 recommendations about breastfeeding.

The European Union are also widely involved. With the EU Blueprint of Action a model was made to outline the actions a national or regional plan should contain and implement if effective protection, promotion and support of breastfeeding are to be achieved.

The Baby-Friendly Hospital Initiative (BFHI) is a government-funded project carried out according to the WHO/UNICEF guidelines. BFHI is a global effort to implement practices that promote, protect and support breastfeeding.

The Norwegian Breastfeeding Association (Ammehjelpen) was established in 1968. This was a milestone in the history of breastfeeding in Norway. This is a mother-to-mother support group where women who used to breastfeed volunteer to help mothers who encounter problems in breastfeeding.

There are still many challenges related to breastfeeding in Norway, but the work with promotion, protection and support is definitely going in the right direction.

CONCLUSION

The aim of this thesis was to point out what is being done to promote, protect and support breastfeeding, with special interest in Norway.

Reduction in breastfeeding is often seen as inevitably accompanying modernization, urbanization and development. Norway's experience shows that this is not necessarily the case. Even after the prevalence of breastfeeding has decreased dramatically, it is possible to reverse the trend.

On a global basis the work with promoting and protecting breastfeeding is widespread. The guidelines of WHO, the BFHI and local initiatives within each country (as Ammehjelpen in Norway) have together made this work a success.

If women's roles as mothers cannot be combined with participation in society, motherhood can be disempowering. But if conditions are made conductive to childcare, even breastfeeding can be combined with participation in the work force and in public activities. In the late 1960s, when breastfeeding due to various reasons had declined in Norway, women, in cooperation with health personnel, took the matter into their own hands. The core of their activities was mother-to-mother support, but other measures were also taken to promote and support breastfeeding. The prevalence rose again, and has been high ever since. Mothers breastfeed because they want to, and feel it is best for the baby. Favourable responses and support from authorities have acted synergistically with the activities of volunteers who support others, and researchers have given scientific backing. With increasing awareness of the importance of breastfeeding for

child health and survival, and because exclusive breastfeeding postpones the return to fertility, promoting, supporting and protecting breastfeeding should be seen as a central activity in population policy. The economic advantages of breast-milk over breast-milk substitutes gives even more weight to the case but it is vital to involve women, listen to them, and let them assume their central role as the real experts.

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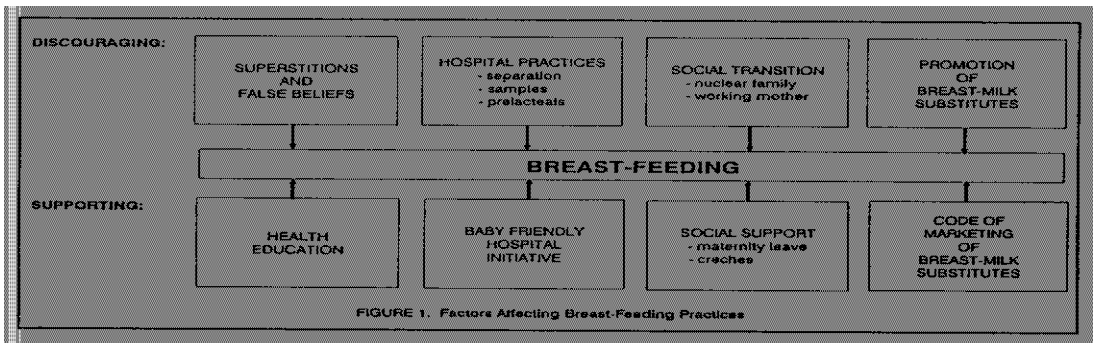
Appendix

1.



(ref:http://apjcn.nhri.org.tw/server/APJCN/Volume1/vol1.2)

2.

Angelina Joly breastfeeding. A picture from a women´s magazine. Do pictures of celebrities affect our attitude towards breastfeeding?

3.

Photo by Christen Ræstad

4. What to expect from a baby-friendly hospital?

Education is important for the baby friendly hospital initiative – these recommendations and advices include:

- "In good time before the delivery you should be well informed about the advantages with breastfeeding and how you best initiate it, making you well prepared."
- "Right after delivery you should have your baby close to your body undisturbed. The baby should have time to find the breast himself."
- "If this has to be delayed for some reason, e.g. caesarean section or complications, you will get the child close to you within 30 minutes after asking for it and when you are prepared to handle it."
- "Healthcare workers will control from the very beginning that everything is going well with the breastfeeding. You will get guidance

whenever needed and as often as necessary. If any problems arise you will get help how to solve them yourself."

- "Nevertheless, if you become separated from your baby you will learn how to use other alternatives, e.g. a pump, and you will learn how to maintain the milk production."
- "If your baby need extra care in the neonatal care unit, you will have the opportunity to stay with your child during most f the day."
- "Your newborn child does not receive any other forms of nutrition, except when medical reasons require so."
- "Healthcare workers will provide you with additional support if you feel tired and they care for you so you will have enough energy to care for your child."
- "You will be encouraged to breastfeed when needed, self-regulation. Meaning the child will suck whenever he wants to, within limits, if this is fine with you. "
- "You will be thought that too sleepy babies who don't ask for food should be taken up, stimulated, and you can wake the baby up and put him to your breast if you feel for it, e.g. because of breast engorgement. "
- "Bottles are not used in the hospital. You will be advised to avoid this, at least until the breast feeding is well established and you have a sufficient and stable milk production."
- "You will be told whish healthcare centre you can contact if any problems arise after returning to your home. Also you will be

informed about Ammehjelpen, the Norwegian breastfeeding association, and how to get in contact with it."[12]

All points mentioned above correlates with UNICEFs and the WHOs 10 facts for successful breastfeeding. All Norwegian delivery departments are informed about these through the Baby Friendly Hospital Initiative.

Before the mother leaves the hospital, she should be well informed about the routines and procedures of breastfeeding. She should be educated in both the sitting and laying down position. Breastfeeding should feel good for both the mother and the child. A mother who is not relaxed will feel tension and be exhausted after the breastfeeding.

5. BREASTFEEDING AFTER BIRTH

When a baby is born he or she should be laid on the mothers breast straight away. This skin-to-skin contact and connection with the mother makes the big environmental change from the warm uterus to the outside cold and noise a little bit softer. The mother is the first to touch the baby without gloves. Until now the baby has been almost in a sterile environment. Now the whole body is going to be covered by bacteria. It is important that these come from the mother because she will produce antibodies against these bacteria in the breastmilk, and thus protect the baby.

The baby will look at the mother. This eye contact will strengthen the connection between mother and child (bonding).

Now the baby will start to make noises. Small, high pitched sounds. Almost as a reflex response, the mother will answer with a soft, high frequency

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voice. It is proved that babies prefer the mothers voice in front of anybody else's.

Soon, the baby will feel the smell of his mother, especially the breast areola, which is covered by glands secreting fluid. The mouth will now start to move. The lips and the tongue searching for the nipple. It takes time to find it but after some hard work, maybe with some guidance from the mother, the little baby will find it. The baby should have a large piece of the breast in the mouth, not just the nipple. Next time it takes shorter time to signal the desire for milk and to find the nipple.

The baby should get milk as often as he wants to. In the uterus he got nutrition continuously and it take time to get used to the interval between each feeding. Breastmilk is easily digested and pass through the stomach quickly. Research shows that most children need approximately 12 feedings per day after the first week. [12] A mother who always has her child nearby will soon learn to interpret the signals from her baby before it even starts to scream.

When the baby sucks on the nipple, signals runs from the breasts, via bone marrow, to the hypophysis. This stimulates the production of lactating hormones, the most important straight after birth being oxytocin. The release of oxytocin stimulates contraction of the ducts, squeezing the milk out to the baby. It is important that the baby gets time to suck long enough to make these signals reach the hypophysis. For some decades ago, breastfeeding was often a timed process where the child was taken away from the mother after 5 minutes, just when the signals where about to work.

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Prolactin is another important hormone. If the sucking is interrupted after 10 minutes the prolactin level would be extremely low compared to if the baby was sucking for 30 minutes. Thus, let the baby get breastmilk as often he wants and let him suck for as long time as he wants!

The time it takes from a baby is born until it lays on the mothers breast receiving breastmilk may take minutes or several hours – average is 0,5 – 1 hour. [12]

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