

Lactation & Breastfeeding

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EDITORIAL

Dear members, dear colleagues,

time to lay back after an inspiring and successful conference in a unique location one will never forget.

Meeting colleagues from different countries with the same jobs but other ideas is so motivating and fruitful.

These nice warm summer days are ideal for lactating women! Babies can easily latch on the breast at the beach or during a hike in the countryside. Breasts are easily available. But from an ethical point of view a few “inexperienced” or uninvolved people find it provoking to open your blouse or bra.

Ethics and conflicts of interests represent the main topic of this issue of “Lactation & Breastfeeding”.

Baby-Friendly-Initiative Germany make a clear statement on exclusive breastfeeding in the first six months of life. Additionally they take a firm stand on the observance of the WHO Codex.

The journalist Dörthe Ziemer has contributed a wonderfully honest article: “Possible influences on young families through conflicts of interests” on the topic of the introduction of solid foods. She describes in a very multifaceted way, which interests can be behind various recommendations.

In his article - “Freeze-drying of breast-milk – a new-old way to make breast-milk available and long-lasting for at-risk premature infants” - Franz Koettnitz, M.D. takes an approach, which makes possible a new, responsible way of managing this. The handout deals with the WHO Codex for health care workers. Furthermore Alessia Bibi, from IBFAN Geneva, gives us an insight into breastfeeding issues from a human rights perspective.

Is exclusive breastfeeding in the first six months still achievable or will the idea have to be discarded? Time will tell and the current debate will be going on. We will follow this discussion! I am looking forward to the coming two years of leading ELACTA with new faces in our board and new energy as well as to the release of many new issues of “Lactation & Breastfeeding”.

On behalf of my board 2018-2020
Warm regards

Karin Tiktak
President ELACTA

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LETTER TO THE EDITOR –
PSYCHOTROPIC DRUGS AND BREASTFEEDING

I have read, with much interest, the article by Prof. Dr. Stephanie Krüger on the topic of psychotropic drugs and breastfeeding. Nevertheless, I was very irritated by one passage in the text. Professor Krüger describes how breastfeeding means stress for many emotionally ill women, that they need a daily routine that is as structured as possible and a good night's rest. However, should women decide against breastfeeding, those in their environment may suggest that they [should] have a guilty conscience. You conclude this section with the sentence – "The decision about whether an emotional illness is a contraindication for breastfeeding, should be made by the attending physician."

As IBCLCs, we repeatedly live with conflicting priorities: that women will stop drug therapy or will not even visit the doctor or therapist, not only out of concern that they will harm their baby, but above all, out of fear that the decision on "breastfeeding YES or NO" and, thereby, a part of their maternal competence and their womanly power, will be taken out of their hands, that these questions will be decided by an outside person

Naturally, discussing this comprehensively would go well beyond the topic of "psychotropic drugs and breastfeeding". If, however, there is concern about a structured daily routine, about sufficient sleep and about the stress connected with breastfeeding, the IBCLC would be an excellent contact to help the woman and her family make an "achievable" breastfeeding and feeding plan and to discuss with the mother various options for feeding her baby. In case of weaning, the IBCLC can support the mother competently. If conservative weaning is possible, not only could the side-effects of suppressing prolactin (i.e. depression) be avoided, but the mother could then actively and consciously experience and help shape the weaning process. Whenever possible, the mother must be included in the decision "breastfeed or not breastfeed". The lactation consultant would be a valuable support in the therapeutic context. If there is an acute emotional crisis, so that the baby cannot immediately be breastfed, lactation should be maintained until the mother can take part in the decision process again. If mothers are perceived and taken seriously in this area of life as well, therapeutic competence will also be strengthened.

Andrea Hemmelmayr, IBCLC

Breastfeeding from a Human Rights perspective

Geneva Infant Feeding Association, IBFAN-GIFA

Author: Alessia Bigi,

The link between breastfeeding and human rights is not as immediate as most people working in the field of infant and young child feeding (IYCF) would think. The health professionals who have received specific training on breastfeeding, or those who have learnt about breastfeeding during their academic career are often not aware of the human rights protection world. Similarly, those who are familiar with international human rights law and UN mechanisms are often lacking in-depth knowledge on the psychological and physiological aspects of breastfeeding. However, breastfeeding is a matter of human rights and it is important to raise awareness on this perspective.

Back in 1999, UNICEF's Deputy Executive Director, Mr. Stephen Lewis stated that "those who make claims about infant formula that intentionally undermine women's confidence in breastfeeding, are not to be regarded as clever entrepreneurs just doing their job, but as human rights violators of the worst kind."

More recently, in 2016, a joint statement by the UN Special Rapporteurs on the Right to Food, Right to Health, the Working Group on Discrimination against Women and the Committee on the Rights of the Child was released in order to push governments to increase efforts to protect, promote and support breastfeeding. The first sentence of the statement reads: "Breastfeeding is a matter of human rights for the mothers and the babies".^[1]

In 2019, the Convention on the Rights of the Child (CRC) will celebrate its 30th anniversary. This Convention is particularly important for human rights defenders working on IYCF, like the International Baby Food Action Network (IBFAN), as it includes all the fundamental rights of the child that breastfeeding contributes to. The International Covenant on Economic, Social and Cultural Rights (ICESCR) is another key source where human rights in connection with breastfeeding can be found.

For the many health benefits of breastfeeding, it is easy to see its unique contribution to the enjoyment of the **right to health**^[2]. However, several other human rights are associated with breastfeeding: first of all, **the right to life, survival and development** (art. 6 CRC). Breastfeeding could save the lives of over 800'000 children every year^[3]. It is a pillar of a child's **right to adequate food and nutrition** (art. 11 ICESCR, art. 12.2 and art. 14.2(h) CEDAW, art. 24.2(c) CRC): breastmilk is by definition THE adequate food for newborns and it covers all the nutritional needs of children aged 0-5 months. After the first 6 months, WHO recommends the introduction of



Breastfeeding is a human right both for mother and child

adequate complementary foods, while continuing breastfeeding until 2 years and beyond, because breastmilk evolves together with the baby and remains a highly valuable source of nutrition to cover the baby's needs, as long as it continues.

Compared with artificial feeding, breastfeeding has much less impact on households' budgets as it is free and renewable. It therefore contributes to the **right to an adequate standard of living** (art. 11 ICESCR, art. 27 CRC). Additionally, breastfeeding allows an equal and fair start in life for all children, independently from where they are born, and this belongs to their **right of non-discrimination** (art. 2, CRC).

Articles 24.2(c) and 24.2(e) of the Convention of the Rights of the Child establish children's **right to live in a safe, clean, healthy and sustainable environment**. Breastfeeding has no ecological impact and zero carbon footprint, compared to artificial feeding. It does not imply packaging or waste, nor fuel for transportation and no cleaning agents for daily preparation and use.^[4] It does not require water for production and preparation and therefore contributes to mitigate climate change.^[5] It is the most environmentally friendly food available.^[6]

Breastfeeding must be protected, through the implementation of the International Code of Marketing of Breastmilk Substitutes and subsequent WHA Resolutions, i.e. through the protection of the

right to receive unbiased information on IYCF, free of commercial influence. Art. 24.2(e) of the CRC states that all segments of society, in particular parents and children, must be informed, have access to education and must be supported in the use of basic knowledge of child health and nutrition and the advantages of breastfeeding. Parents hold this right and the consequent right to make informed decisions on how to feed their children.

Last but not least, the Convention on the Rights of the Child sets specific responsibilities for the governments to ensure children's **right to be protected in armed conflicts**. Art. 38.4 affirms that State parties "*shall take all feasible measures to ensure protection and care of children who are affected by an armed conflict*". If children must be protected, as a particularly vulnerable population, this implies that their life, survival, health should be protected. Breastfeeding is a lifeline during emergencies. To translate this into concrete actions, the IFE Core Group of the Emergency Nutrition Network (ENN), developed an Operational Guidance on Infant Feeding in Emergencies^[7], aimed at Emergency Relief Staff and Programme Managers, providing technical guidance on how to ensure that optimal IYCF is adequately protected, promoted and supported. Governments are invited to use this Guidance and integrate it into their national emergency preparedness plans.

Two key sources of international human rights law have been mentioned above: the CRC and the ICESCR. Breastfeeding belongs to the human rights sphere because it directly contributes to the enjoyment of several human rights. Similarly, on the other way around, breastfeeding can be considered as a right in itself, with the mother/child dyad as the right holder. In this perspective, **maternity protection at work** becomes crucial for the enjoyment of this mother-and-child right. Therefore, the third UN Convention that has a direct link with breastfeeding, and with maternity in particular, is the Convention for the Elimination of All Forms of Discrimination Against Women (CEDAW). Article 12 of the CEDAW affirms women's rights to health care and "*appropriate services in connection with pregnancy, confinement and the post-natal period [...] as well as adequate nutrition during pregnancy and lactation.*"^[8]

It is important to remember that when ratified by a State party, all Conventions need to be implemented nationally, and this implementation regularly monitored. The bodies in charge of this monitoring are called Treaty bodies and the ones who are related to the above-mentioned conventions are: the Committee on the Rights of the Child (CRC Committee), the Committee on Economic, Social and Cultural Rights (CESCR Committee), the Committee for the Elimination of All Forms of Discrimination Against Women (CEDAW Committee). The Commit- ➤

tees meet three times a year to review the status of implementation of the Conventions by the States who have ratified them. States send their reports and meet the Committees members for a dialogue on the progress of implementation at national level. Civils society organizations and movements are also able to participate to these reviews, sending alternative reports with additional information from the field. After the dialogue, the Committees issue specific recommendations to the governments in order to fill gaps in the policies or urge for specific measures.

In addition to this role of monitoring bodies, the Committees can issue General Comments, as authoritative interpretations and complimentary descriptions of specific rights in the Conventions. Breastfeeding and the International Code of Marketing of Breastmilk Substitutes^[9] are both often mentioned in such General Comments, confirming their place in the human rights arena. In fact, they can be found in CRC General Comment 15 on the right to health (2013), CRC General Comment 16 on the impact of business sector on children's rights (2013)^[10], CESCR General Comment 12 on the right to adequate food (1999), CESCR General Comment 24 on the States obligations under the ICESCR in the context of business activities (2017)^[11], CEDAW General Recommendation 34 on the rights of rural women (2016)^[12]. Breastfeeding and the International Code are also mentioned in the Technical Guidance on the application of a human rights-based approach to the implementation of policies and programmes to reduce and eliminate preventable mortality and morbidity of children under 5 years of age, developed by the Office of the UN High Commissioner on Human Rights in 2014^[13].

Finally, the UN Special Rapporteurs on the right to health^[14] and the right to food^[15] have included breastfeeding in many of their reports, reiterating its fundamental role for the mother's and child's full enjoyment of their rights.

In conclusion, whenever optimal IYCF is not being protected, promoted and supported, we are facing a human right violation, for all the reasons explained above. Breastfeeding contributes to the enjoyment of a variety of human rights. We all have a responsibility to stay informed and hold our governments accountable whenever they fail in their duty to ensure protection, respect and fulfilment of our human rights.



Alessia Bigi

Alessia BIGI holds a MA in International Relations and is currently working as Programme Officer at the Geneva Infant Feeding Association (GIFA), international liaison office of the International Baby Food Action Network (IBFAN).



RESSOURCES

- > ^[1] The full text of the Joint Statement is available online at : www.ohchr.org/EN/NewsEvents/Pages/DisplayNews.aspx?NewsID=20871
- > ^[2] Children's right to health is clearly defined by article 24 of the UN Convention on the Rights of the Child: www.ohchr.org/EN/ProfessionalInterest/Pages/CRC.aspx ; the right to health is also embedded in the International Covenant on Economic, Social and Cultural Rights, art. 12: www.ohchr.org/EN/ProfessionalInterest/Pages/CESCR.aspx
- > ^[3] The Lancet Series on breastfeeding, 2016.
- > ^[4] As mentioned in IBFAN's statement at the 142nd Executive Board of the World Health Organization, in January 2018. The statement is available at: www.gifa.org/wp-content/uploads/2018/01/EB142-IBFAN-Statement-item3.5-Climate-Change.pdf
- > ^[5] See above
- > ^[6] Breastfeeding Promotion Network of India/IBFAN Asia (2014), Formula for Disaster: weighting the impact of Formula Feeding VS Breastfeeding on Environment,
- > ^[7] IFE Core Group (2017), Infant and Young Child Feeding in Emergencies: Operational Guidance for Emergency Relief Staff and Programme Managers, available online at: www.enonline.net/operationalguidance-v3-2017
- > ^[8] The rights linked with maternity protection are also found in the International Labour Organization (ILO) Convention 183 (2000) and in ILO Recommendation 191 (2000).
- > ^[9] And subsequent relevant WHA Resolutions.
- > ^[10] The General Comments of the CRC Committee are available online at : www.ohchr.org/en/HRBodies/CRC/Pages/CRCIndex.aspx
- > ^[11] The CESCR Committee General Comments are accessible at : http://tbinternet.ohchr.org/_layouts/treatybodyexternal/TBSearch.aspx?Lang=en&TreatyID=9&DocTypeID=11
- > ^[12] All the CEDAW Committee General Recommendations are available online at : www.ohchr.org/EN/HRBodies/CEDAW/Pages/Recommendations.aspx
- > ^[13] The Technical Guidance is available online at: www.ohchr.org/Documents/Issues/Children/TechnicalGuidance/TechnicalGuidancereport.pdf
- > ^[14] Website of the UN Special Rapporteur on the Right to Health : www.ohchr.org/EN/Issues/Health/Pages/SRRRightHealthIndex.aspx
- > ^[15] Website of the UN Special Rapporteur on the Right to Food: www.ohchr.org/EN/Issues/Food/Pages/FoodIndex.aspx

What is a Conflict of Interest?

We are probably all permanently affected by conflicts of interest, without actually recognizing it. Although conflicts of interest are not bad or reprehensible *per se*, in common parlance, they have acquired the very negative but, first of all, unjustified aftertaste of “corruption” Author: Andrea Hemmelmayr

Conflicts of interest are defined as situations, which create a risk that professional ability to judge or take action related to a primary interests may be inappropriately influenced by a secondary interest. (Thompson 1993, 2009).

In breastfeeding counselling, the primary interest would be the well-being of the mother and baby or the resolution of breastfeeding problems in the interest of the mother. Secondary interests of the breastfeeding counsellor could be of a material (professional fee) or of an immaterial (recognition/respect, implementation of her own therapeutic concepts ...) nature. Since all of us, as a rule, receive some kind of reward or recognition for caring for the mother and baby, this shows that: As breastfeeding counsellors, we too are not immune to conflicts of interest. Conflicts of interest are ever-present in breastfeeding counselling, just as they are in medicine or science. No-one is without conflicts of interests. Consequently we should not immediately condemn the presence of conflicts of interest but consider them value-free for the moment. Equating this term with corruption or corruptibility hinders the actual disclosure of conflicts of interest or the discussion about possible inappropriate influence or compromised ability to judge.



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Conflicts of interest can, for instance, lead to overestimating the usefulness of a measure and underestimating the possible harm – or vice-versa. How do we judge the “thoughtless” use of a nipple shield, the recommendation of a “breastfeeding-friendly” bottle or a nipple that is similar to the mother’s breast? How do we weight study results which demonstrate the superiority of breast-feeding by comparison to study results which report possible disadvantages of breastfeeding? If we are facing decisions or conclusions, which we ourselves perceive to be materially, socially or psychologically advantageous, do we examine the facts less rigorously and give these facts more weight? Information which is perceived to be disadvantageous is more rigorously examined, less well accepted and/or given less weight.

Thereby, “one of the biggest problems of distorted judgment formation is the confidence of those judging that *they* are not affected by the distortion.” Misjudgement, due to a “blind spot”, has already been shown in several studies and can be observed over and over again in “real life”. (Lieb et al., 2011). For this reason, it is important to be consciously aware of the conflicts of interests, to admit them and limit the risk they pose with appropriate regulation.



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REFERENCES

- > Gartner G: derstandard. at/2000048464843/ Warum-uns-Interessenkonflikte-der-Aerzte-kuemmern-sollten
- > Lieb K, Klemperer D, Ludwig W-D: Interessenskonflikte in der Medizin – Hintergründe und Lösungsmöglichkeiten. Springer Verlag, 2011.
- > Thompson DF: Understanding financial conflicts of interest. N Engl J Med 1993;329:573-576.
- > Thompson DF: The challenge of conflict of interest in medicine. Z Fortbild Qual Gesundheitswesen (ZEFQ) 2009;103: 136 – 140.

Avoiding Inappropriate Conflicts of Interest at the Level of (Inter)national Breastfeeding Recommendations.

Sensible regulations to protect the well-being of children and mothers.

Authors: Zsuzsa Bauer and Andrea Hemmelmayr



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The infant food industry draws in skilled personnel and opinion leaders through, among other things, sponsored continuing education, research and publication projects.

Influencers and lobbyists make use of social rules. One of these, the reciprocity rule, says that we must reciprocate for the gifts, favors, and invitations that we receive from others. Widespread favors by the industry to influence decision-makers include, among other things, taking over the costs of travel and lodging for congresses, reduced price or free continuing education, equipping medical practices and hospitals, as well as giving free or reduced-price products. The industry ensures the loyalty of influential opinion leaders through lavish professional fees for advisory functions and speaking engagements, as well as the financing of research and publication projects.

Such influence has a particularly devastating impact where national or international recommendations are made because such recommendations have a broad reach. As Cattaneo and colleagues (2011) have shown, there are close ties between the infant formula industry and the members of influential professional organizations. Leading authors from the European Food Safety Authority (EFSA), and the European Society for Pediatric Gastroenterology, Hepatology and Nutrition (ESPGHAN) who have written, among other things, the influential recommendations for infant feeding with early introduction of complementary foods ((Agostoni et al. 2008; EFSA, 2009; Fewtrell et al., 2017) work for Nestlé, Danone, Hipp, Humana, Mead Johnson, the Federation of Infant

Food Manufacturers and a range of other companies: They are active as consultants with long-term contracts, receive funding for research on infant formula and complementary feeding products or grants for writing scientific review articles. It is not only the individual authors, but also the professional societies which are dependent on the monies from the food industry. For many years, ESPGHAN organized its meetings at Nestlé headquarters and let its congresses be sponsored by the infant formula industry (Cattaneo et al., 2011). Hereby, justifiable doubts about the credibility of recommendations on infant feeding, made by these organizations, arise. As the journalist, Dörthe Ziemer, shows in her article in this issue, the primary authors of the official German recommendations for action

on breastfeeding and the introduction of complementary foods, which, by contrast to the WHO recommendations, propagate a shortened duration of exclusive breastfeeding, are also active on behalf of the infant formula industry. In their argumentation for a shorter duration of exclusive breastfeeding, the authors of the German recommendations for action, refer to the relevant publications of the EFSA and ESPGHAN as well as the German Research Institute for Child Nutrition (FKE), all of which are affected by conflicts of interest due to their close ties to the infant formula industry. In this way, the influence of the food industry on the recommendations made are concealed and, at the same time, cemented.

How can such conflicts of interest be avoided or, at least, reduced? The disclosure of conflicts of interest is a necessary, if also insufficient, step in the right direction. As experience shows, it makes sense to develop comprehensive, standardized questionnaires and not leave to a self-as-

essment, whether secondary interests could pose a risk of (negatively) influencing the ability to judge. Otherwise, these things remain willingly unmentioned, as in the publications of the EFSA, the ESPGHAN and the German Recommendations for Action. However, the declaration of conflicts of interest is not sufficient in itself because declared conflicts can also lead to a distorted picture and the disclosure can even reinforce this distortion (Loewenstein et al., 2012). Therefore, relevant regulations on how to deal with the existing conflicts of interest must be defined.

In 2008, the American Institute of Medicine of the National Academy of Science suggested that the affected members of a guidelines group abstain from voting on the evaluation of these measures. In 2011, the document published by the umbrella organization of the US professional societies, the Council of Medical Specialty Societies (CMSS) introduced further regulations, which were adopted by all of the

important professional societies in the USA (Lempert & Brevern, 2015):

- > Relinquishment of financial connections to the industry by the leaders of the professional societies
- > Financial independence of the leading authors of guidelines, position papers and other statements
- > Exclusion of biased authors from voting
- > No acceptance of industry donations

Such regulations are urgently needed for bodies which make national and international recommendations for the duration of exclusive breastfeeding, for the introduction of complementary foods and for the total breastfeeding duration.

Individual professional societies, which largely forego industry sponsoring of their continuing education events, such as the American Psychiatric Association or the Drug Commission of the German Medical Association (AkdÄ), go even further. Lecturers for the AkdÄ must not have any financial conflicts of interest due to personal fees for consulting activities, >

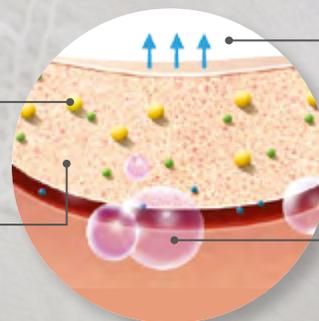
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- › lectures or through the financing of attendance at continuing educational events. Thereby, the AkdÄ wants to ensure that, when imparting knowledge, this is not in the marketing interests of the industry, but that evidence-based, independent recommendations for the patients are paramount (Lieb & Ludwig, 2016). Such objectives should also apply when breastfeeding recommendations are made.

The World Health Organization (WHO) also indicates in its handbook, "Guidance on ending the inappropriate promotion of foods for infants and young children. Implementation manual" (2017), draws attention to the high relevance of conflicts of interest in a chapter of its own. As presented in the WHO handbook, employees and institutions of the health sector are frequently targeted and influenced by the infant formula and baby food industry

through promotional activities, personal relationships and diverse incentives. In its handbook, the WHO urges that health care workers, public health systems, professional medical societies and non-governmental organizations should, similarly, avoid conflicts of interest through influencing by the infant formula and baby food industries because both their loyalty to their actual mission or to the persons whom they should primarily be serving, as well as their ability to make an independent judgment, are also at risk (WHO, 2017).

Sensible proposals for regulation in dealing with conflicts of interest already exist – it is high time that these be considered at the level of national and international recommendations on breastfeeding and the introduction of complementary feeding.



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SOURCES

- › Agostoni C, Decsi T, Fewtrell M, Goulet O, Kolacek S, Koletzko B et al.: **Complementary feeding: a commentary by the ESPGHAN Committee on Nutrition.** J Pediatr Gastroenterol Nutr 2008;46:99–110.
- › Cattaneo A, Williams C, Pallás-Alonso CR, Hernández-Aguilar MT, Lasarte-Velillas JJ, Landa-Rivera L, Rouw E, Pina M, Volta A, Oudesluys-Murphy AM: **ESPGHAN's 2008 recommendation for early introduction of complementary foods: how good is the evidence?** Matern Child Nutr 2011;7(4):335–43.
- › **EFSA Panel on Dietetic Products Nutrition and Allergies. Scientific opinion on the appropriate age for introduction of complementary feeding of infants.** EFSA J 2009;7:1–38.
- › Fewtrell M, Bronsky J, Campoy C, et al.: **Complementary feeding: A position paper by the European Society for Paediatric Gastroenterology, Hepatology, and Nutrition (ESPGHAN) Committee on Nutrition.** J Paediatr Gastroenterol Nutr 2017;64:119–132.
- › Institute of Medicine of the National Academies: **Clinical practice guidelines we can trust.** 2011. www.awmf.org/fileadmin/user_upload/Leitlinien/International/IOM_CPG_lang_2011.pdf. besucht im Mai 2018.
- › Koletzko B, Bauer C-P, Cierpka M et al. **Ernährung und Bewegung von Säuglingen und stillenden Frauen.** Zeitschrift für Kinder- und Jugendmedizin. Sonderdruck, 2016.
- › Lieb K, Ludwig W-D: **Arzneimittelkommission will mit gutem Beispiel vorgehen.** Deutsches Ärzteblatt 2016;113(1-2):A16-18.
- › Lempert T, von Brevern M: **Die Fachgesellschaften sind am Zug.** Deutsches Ärzteblatt 2015;112(3):A84-86.
- › Loewenstein G, Sah S, Cain DM: **The unintended consequences of conflict of interest disclosure.** JAMA 2012;307:669–70.
- › World Health Organization: **Guidance on ending the appropriate promotion of foods for infants and young children. Implementation manual.** WHO, 2017, Recommendation 6 – Avoidance of Conflict of Interest.



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Complementary Feeding Recommendations and Business Interests

The influences from the business sector and conflicts of interest to which the Recommendations for Action of the Young Family Network were subjected Author: Dörthe Ziemer, Journalist



Photo: © iStock.com/PicturePartners

The recommendation to offer babies complementary foods before the 7th month of life is influenced by economic interests. This thesis is my conclusion after a ten-month research project that I was able to carry out at the Free University in Berlin in 2013/2014 thanks to a grant from the European Journalism Fellowships (EJF)

At the beginning, there was my own experience, two years before, with the introduction of complementary feeding to my first daughter. She didn't at all stick to the frequently and penetratingly recommended "Nutrition Plan for the First Year of Life"^[1] published by the Research Institute

for Child Nutrition in Dortmund, which is also propagated in the Recommendations for Action of the Young Family Network / "Healthy in Life". Instead of "every day a spoonful more", as our paediatrician recommended, my daughter ate less every day – until she completely refused it. No airplane game with the spoon, no urging and begging, no tricks helped. Then I discovered the concept of "baby-led weaning" (Rapley and Murkett, 2013), by which the child determines – at her own pace - when and how much of the finger food she is offered she eats. And suddenly, eating was fun again for my daughter and for us as parents. A few months later, she was praised by outsiders for how well she ate. Everything felt good.

One year before this, a journalist from the daily paper, *Die Welt*, (The World) showed, with concrete examples, how nutritional recommendations for babies are

influenced by the food industry. First, on July 6, 2010, an announcement was published by the German Press Agency (dpa) under the title "Babies need more than just mother's milk" (i.e., iron-containing complementary food). A journalist from the same daily paper was taken aback by this and researched the dpa announcement. Ultimately he came to the following conclusion: "Breastfed babies do not need meat from a jar" (*Die Welt*, July 24, 2010). *What happened there? How can it be that two articles on the same announcement can be written with contradictory conclusions? And can that occurrence be generalized?* – That was the question that I followed up during my EJF fellowship research.

To do this, I first got an overview of the different positions on complementary foods in Germany, but also world-wide. The widespread recommendation in Germany to give complementary foods >

¹ The FKE "Nutrition Plan for the First Year of Life" was repeatedly adopted, as a simple Google search with the key word "Nutritional Plan FKE" (ernährungsplan fke) reveals. Listing examples here would go beyond the scope of this article.



Picture 1: Parents read the large numbers, 4, 6, 8, 12 etc. on the jar of baby cereal. Only on closer inspection can it be seen that the number 4 means after the first month, but with all of the others from the 6th or 8th month is meant.

from the (beginning) of the 5th month of life at the earliest and latest from the (beginning of) the 7th month, goes back to a “consensus decision” of various professional organizations. This consensus^[2] was developed in 2010 under the direction of the Network “Healthy in Life”. The network is supported by the government and, according to its own statement, wants to send uniform messages to multipliers and parents. Previously, every professional organization had its own recommendations. The World Health Organization recommends beginning complementary feeding from the 7th month.

Were parents to follow the World Health Organization, they would first give complementary foods when the baby is six months old. If they follow the Network’s recommendation, they begin complementary feeding at the earliest when the baby is four months old. If they follow the label on the baby food jar, they even begin *in* and not *after* the fourth month, because the number 4 is written large on the jars. They possibly ignore the addition – “after the” written in small script (picture 1). For, on the jars for older children, it reads *from the*

5th or 6th month. Foterek et al. (2014) show that complementary food is introduced for 29.4% of infants before the end of the 4th month – and, in fact, by parents who have above-average education and above-average socioeconomic status.

So, between the earliest possible point for introducing complementary foods, according to the one or the other recommendation, there are two or even three months. From a scientific standpoint, what are the advantages of the one position or the other? As justification for the position of the Network “Healthy in Life” in 2010, at the time of the consensus building, the argument of allergy prevention, in particular, was used (Koletzko et al., 2010, P4). According to this, breastfeeding exclusively for longer than four months would not have any positive effect on allergy prevention. Furthermore, it seemed, then, to be advantageous for the reduction of celiac disease to be still breastfeeding when complementary foods were being introduced. At this point, however, the state of knowledge has changed as the European Society for Pediatric Gastroenterology, Hepatology and Nutrition (ESPGHAN) wrote in 2015. In accordance with this, neither the point in time when gluten is introduced nor still breastfeeding while gluten is being introduced plays a role in the risk for celiac disease (Fewtrell et al., 2017)

Statistical surveys show that only about 20% of all women breastfeed exclusively for six months and that the total duration of breastfeeding is, on average 7.5 months (von der Lippe et al., 2014). Initially, the logical conclusion of the Network was not to begin complementary feeding only after

the sixth month because, otherwise, giving complementary foods would only occur under the influence of breastfeeding in a very few cases. **According to the Network, the women should not be overwhelmed with unrealistic guidelines.** (Telephone interview).

However, the guidelines, which were used for this argumentation, were misconstrued (Kopp, 2012): The preventive effect beyond the 4th month could not be confirmed because a longer period of time was not considered. The inversion of the argument that starting complementary feeding at this time was particularly favorable, is, thus, not correct. But it ought to have manifested itself in the recommendation to begin after the 5th month.

At the latest, by the revision of the Network’s recommendation in 2016, the early introduction of complementary foods should have been reconsidered. As mentioned in an aside in the revised version (Koletzko et al., 2016, P. 442), the current state of knowledge indicates that the time at which gluten is introduced does not, after all, influence the risk of celiac disease nor does breastfeeding at the time of the introduction. The arguments, which might possibly have suggested an earlier introduction of complementary foods, are no longer relevant.

Protection from infection is used as a rationale for the position of the World Health Organization on 6 months exclusive breastfeeding. The risk of infection is, in fact, far higher in developing countries than in industrialized societies. But the WHO (WHO 2018) explicitly makes its recommendations for all countries. With a longer period of exclusive breastfeeding, the risk of getting ill with respiratory infections, lung infections, middle ear infections and intestinal infections and, later on, to become obese, is considerably reduced. The recommendation to breastfeed exclusively for 6 months, must, therefore, also be in the interest of governmental public health prevention.

A further argument for an earlier or later start on complementary feeding is the nutrient supply. The Network “Healthy in Life” sees that as being put at risk if complementary foods are first given at the beginning of the 7th month. However the systematic review by the international Cochrane Collaboration (CC) has not confirmed this (Kramer & Kakuma, 2012). The authors of this review see, in the discussion between the position “4-6 months exclusive breastfeeding” and

² The consensus was a result of an introductory workshop initiated by the Young Family Network, on 08.12.2008, which took place at the Federal Ministry for Food, Agriculture and Consumer Protection with 55 representatives of institutions and multipliers in the area of “Pregnancy, Breastfeeding, Birth and Young Families”. It was compiled and published in a special issue of the monthly journal *Kinderheilkunde* (Pediatrics): Koletzko, B.; Brönstrup, A.; Cremer, M. et al: Säuglingsernährung und Ernährung der stillenden Mutter (Infant Nutrition and the Nutrition of the Breastfeeding Mother). In: *Monatsschrift Kinderheilkunde, Sonderdruck Oktober 2010* (Special Issue, October 2010)

the position “6 months exclusive breastfeeding”, the expression of a supposed dilemma: namely the dilemma between the preventive effect of exclusive breastfeeding on infectious illnesses and a possibly insufficient intake of energy and nutrients from mother’s milk.

However, the authors come to the conclusion that, in relationship to weight gain and growth in length, deficits have not been demonstrated either in developing or in developed countries. Therefore, according to the review, the basis of a public health policy should be the recommendation for 6 months exclusive breastfeeding. This applies to developing and industrialized countries alike – basically with respect to healthy, full-term babies with a birth weight in normal range.

The bottom line: The arguments, which were used for an earlier introduction of complementary food in 2010, were, even at that time, questionable and are now, by and large, moot according to the current scientific state of knowledge. The nutritional needs of babies, who are healthy, full-term and of normal weight, will be covered by exclusive breastfeeding for 6 months or longer. To be sure, many infants in some underdeveloped countries, who are exclusively breastfed for 6 months, have a higher risk for iron deficiency (Kramer & Kakuma, 2012), but these concerns are largely irrelevant in Germany because practically all pregnant women have access to prenatal check-ups and to iron supplementation, if needed, and because premature infants and small-for-gestational age (SGA) babies routinely receive iron supplements (Cattaneo et al., 2011). Nevertheless, exclusive breastfeeding in the first 6 months of life reduces the risk of gastrointestinal and respiratory infections in both developing and developed countries (Kramer & Kakuma 2012; WHO, 2018). Furthermore, with the recommendations of the Network to begin complementary feeding from the 5th month of life, “relaxed, exclusive breastfeeding until 6 months is systematically discouraged and hampered” writes Utta Reich-Schottky from the German Training Institute for Breastfeeding Support” (see this issue, Reich-Schottky, 2018)

Where does the insistence on an early start to complementary feeding in Germany come from compared to the international recommendations?

From an economic point of view, it makes a great difference whether babies are fed porridge three months sooner or

later – thus, whether, for three months, parents pay more or less money for jars of baby food. For this reason, in the further course of my research, I have taken a closer look at the structures around the Network “Healthy in Life” and the people involved in it.

First of all, it should be noted that critics of the Network position have already seen scientific weaknesses in the formal approach to building consensus in the Network: Instead of systematic scientific reviews, as the WHO carries out for its recommendations, with the 2010 consensus building, *negotiations over the existing positions* of the professional organizations took place (personal interviews).

Persons involved in the consultations report that the consensus building on the duration of breastfeeding was particularly controversial and even emotional (personal interviews). After a “hard struggle”, wrote the *Berliner Zeitung* (Brodmerkel 2011) at the time, the mainstream medical practitioners were able to bring the midwives on board. However, the breastfeeding organizations, such as the Association of German Lactation Consultants IBCLC e.V., La Leche League Germany e.V. (LLL) and the Working Group of Free-Standing Breastfeeding Groups (AFS) – by contrast to the National Breastfeeding Commission – were not represented in the Network and, consequently, were not involved in the consensus building. Overall, the midwives remained dissatisfied with the compromise. In the course of the process, one midwife was even replaced as the representative in the Steering Committee (personal interviews).

Furthermore, participants speak of opinion leadership among pediatricians and nutritional scientists in the Network (personal interviews). Among these opinion leaders are some who are closely linked with the industry. Thereby, it is definitely not always about direct exertion of influence, but also about a professional background with close proximity to the industry.

Thus, a free-lance editor, who described herself as a “food-journalist”, was involved in the development of the Network’s recommendations for action. On her website she writes: “I present food in all facets and also gladly answer tricky questions. Thereby, PR agencies and the food industry are my customers.” Among these customers are also the Association of the German Confectionary Industry, which she already supported with an extreme-consumption-friendly press release. In

it, ahead of the 2010 Football WM, she advertised, as a nutritional expert, for a moderate but pleasurable consumption of sweets in front of the television (Newsmax Pressemitteilung, 2010).

In the Steering Group of the Network “Healthy in Life”, besides professional organizations and supporting ministries, is the Platform on Nutrition and Movement (abbreviated: PEB). It is an open confederation with more than 100 members from the public sector, science, business, sport, the health care sector and civil society. According to their own description, they “actively promote balanced nutrition and more movement as essential components of a health-promoting lifestyle for children and youth”. Among the members of the PEB are also many food manufacturers whose products are incompatible with a health promoting lifestyle, as well as trade associations, among them the Federal Association of the German Confectionary Industry, Info-Center Chocolate, the Sugar Industry Association, Coca Cola, Ferrero, Mars, Ltd as well as manufacturers of infant formula, among them Nestle, Danone and the Dairy Association.

The PEB was taken into the Steering Group of the Network at the wish of the participating ministries – notwithstanding its controversial role as a gateway for lobbyists: Started as a discussion platform in 2004, after ten years it had become a “black hole” “into which all good intentions disappear” (*Die Zeit*, 2013). This was so formulated by the earlier Consumer Protection Minister in a report by the ZDF Magazine *Frontal 21*. According to this report, the industry sets the tone in the PEB and rejects suggestions that could be bad for business.

Consumer Protection Organizations, such as Foodwatch, recognize a mechanism behind this: Firms try to intervene in political debates in such platforms, in order to ward off regulation (personal interview). And they want to make it appear as if, with social engagement and as a responsible partner, they are indispensable.

In the scientific advisory board of the Network and in the author team of the *Recommendations for Action*, the Research Institute for Child Nutrition Dortmund is represented by Mathilde Kersting. The institute developed the feeding plan for the first year of life, which the Network also recommends. In years past, the institute has repeatedly attracted attention through research in the interest of the industry. While it received institutional funding for decades from the state and, later, ▶

Acknowledgments

The study was supported by the Central Marketing Organization of German Agricultural Economics (CMA). Study food was provided by Hipp GmbH and Co. Vertrieb KG and Nestlé Nutrition GmbH.

Picture 2: Expression of thanks to the infant formula industry and the German Agricultural Marketing Board in the article on babies' iron requirements from the Research Institute for Child Feeding (FKE) in Dortmund. (Dube et al., 2010)

from the federal government, the institute is now supported on a project basis (Federal Government, 2014). Even in 2005, the then-CDU-led state government did not want to support the institute any more. Then, in 2012, came the end through the SPD government³. In 2008, the Research Institute for Child Nutrition GmbH Dortmund was spun off. The institute operated on its internet presence under the tab “transfer” as a limited liability company (Ltd.), under the tabs “applied research” and “FKE as a registered society – without this double structure being explicitly declared anywhere (vaguely under the tab FKE – History – Structures). The double structure should apparently make it possible to acquire industry funding.

³ Pediatrics also published: <https://www.derwesten.de/staedte/dortmund/sued/institut-fuer-kindernaeehrung-in-dortmund-soll-abspecken-id8424538.html>; The Project “previkids NRW” was funded from 16.11.2009 until 15.11.2012. The funding was acquired from the resources of the European Fund for Regional Development (EFRE) and the state of North Rhine-Westphalia (NRW). Information from the Press Office.

Thus, the article on the iron requirements of babies mentioned at the beginning, can be traced back to a study by the FKE, which was co-funded by the then-still-existent Central Marketing Company for German Agriculture CMA (picture 2). As described in the beginning, this recommended giving babies iron-containing complementary foods early. Apparently, this aimed at increasing the sales of meat-containing baby food, as the journalist, Andreas Fasel, wrote. He then looked more closely at the studies and queried scientists of other institutions. He concluded that the opposite was the case and that parents don't need to worry about iron deficiency anemia in their infants.

The FKE also cooperates on other research projects with the manufacturers of infant and small child foods – with the ambition of improving their products (picture 3). But the question is, whether children need ready-made products at all. At any rate, the consumer protection organizations oppose the FKE on this.

A further example of the fusion of industry and research is the Munich pediatri-

cian, Berthold Koletzko. He is the spokesperson for the scientific advisory board of the Network, first author, as well as corresponding author, of the Recommendations for Action and, concurrently, researches on the improvement of infant formula. Simultaneously, a member of the National Breastfeeding Commission, Koletzko does say in one of his scientific articles that he is “biased in favor of breastfeeding” (Ernährungskommission DGKJ, 2014, S. 536) and that, for him, the research for better products for all those who do not breastfeed, does not conflict with his work in breastfeeding promotion. Furthermore, he advocates for a prohibition of inappropriate advertising of infant formula.

Nevertheless, that did not prevent Berthold Koletzko from appearing at an industry symposium during the annual conference of the German Society of Pediatrics and Adolescent Medicine (DGKJ) in Leipzig in 2014 (personal observation). The symposium was sponsored by the company Hipp; Koletzko presented the results of his research on a Hipp powdered milk. According to Koletzko's basic statement, the infant formula is, again, a bit better than the previous product – and a bit more like mother's milk. This study was supported financially by Hipp. Subsequently Koletzko invited those in the auditorium – mostly pediatricians – to have a sausage at the Hipp stand, where messages, such as “modelled on Nature” shone.

This example shows the basic problem with industry-financed research: The scientists who are financed in this way are servants of two masters, which affects their independence (see also picture 4). It has been shown in the research on the topic of conflicts of interest in science that scientists assess scientific data different-

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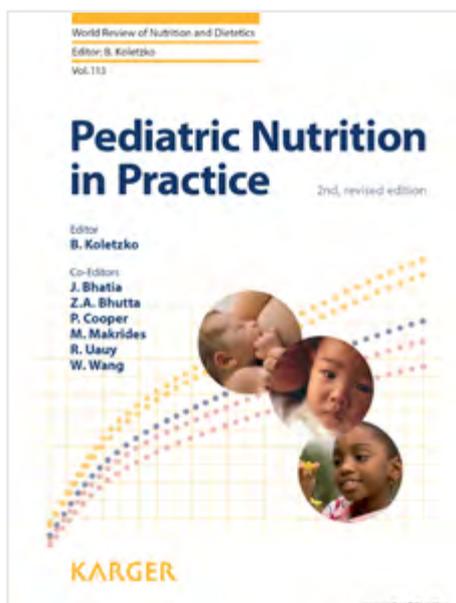


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Picture 3: Excerpt from a 2010 flyer from the Research Institute for Child Nutrition (FKE) in Dortmund with a clear reference to the close cooperation with the infant formula industry.



Picture 4: Berthold Koletzko, lead author and corresponding author of the Recommendations for Action of the network, was able to complete an international book project on the topic of child nutrition with financial support from Nestlé. The following statement is in the imprint of the book: “Supported by an unrestricted educational grant from the Nestlé Nutrition Institute.”

ly - even unconsciously - depending on whether there are conflicts of interests. Science strives for transparency in that, at the end of each study, conflicts of interest through links of the authors to industry are stated. However, even the disclosure of a conflict of interest can unintentionally have an effect, so that the information is more strongly distorted than it would be without disclosure (Loewenstein et al., 2012)

It is interesting that Berthold Koletzko discloses conflicts of interest in a few publications, but does not, however, in many others on the same topic (picture 5). With the disclosure of a conflict of interest, it is not only the credibility of the scientist that is at stake. Along with this, there is also the plausibility of official recommendations for action that is affected by such questionably financed research. For this reason, consumer protector experts demand that political

decisions and governmental recommendations be backed up exclusively by independent and publically financed research.

Another example which has nothing to do with the Network, “Healthy in Life”, but does have to do with the duration of exclusive breastfeeding. A review article which appeared in the *British Medical Journal* in 2010 came to the conclusion after a review of various, self-selected studies, that there was no need for a six month duration of exclusive breastfeeding in western industrialized countries. (Fewtrell et al., 2001) On the contrary: The risks of iron-deficiency anemia or threatening allergies and celiac disease argue against it, according to the authors. In the declaration of conflicts of interest, three of the four researchers stated that they had been employed in an advisory capacity for manufacturers of infant formula and complementary foods in the previous three years and/or had received

research money from them. Thus, three of the four authors of this study are, again, servants of two masters.

What makes this example more interesting is the reception in the German press. One article in the *Berliner Tagesspiegel* reported on the results of this study without pointing out the conflict of interests (Müller-Lissner, 2011). Three days before the article appeared in the *Tagesspiegel*, there was a critical statement on the study by the World Health Organization (WHO, 2011) and the British non-governmental organization (NGO), Baby Milk Action (2011). However, these were not taken into consideration in the article – the study results were presented without critique.

The aforementioned study by the FKE Dortmund on meat-containing complementary foods was picked up in a similar way by the German Press Agency. To a great extent, the dpa reported only on the press release that gave information on the study results. The dpa text appeared in many German newspapers, also in the daily paper *Die Welt (The World)*. There, the journalist mentioned above read it and thereupon looked at the study more closely. Ten days later, he published the exact opposite conclusion - also in *Die Welt*.

With this, I have almost come back again to the starting point of my research and this text. I have answered my question, posed at the beginning, about whether the finding on the two articles about the FKE Dortmund study on meat-containing complementary foods can be generalized with a *Yes* with respect to the exertion of influence on scientific research and the recommendations on feeding of babies, which result from it. However, the text at hand contains only some of the examples which I collected during my research. ➤

The Network's 2016 Recommendations for Action

Interessenkonflikt. B. Koletzko, C.-P. Bauer, M. Cierpka, M. Cremer, M. Flothkötter, C. Graf, I. Heindl, C. Hellmers, M. Kersting, M. Krawinkel, H. Przyrembel, K. Vetter, A. Weißenborn und A. Wöckel geben an, dass kein Interessenkonflikt besteht.

Deutsches Ärzteblatt, 2016

Interessenkonflikt

Prof. Koletzko erhielt Erstattung von Reise- und Übernachtungskosten sowie Honorare für wissenschaftliche Fortbildungsveranstaltungen von Herstellern von diätetischen Produkten Danone, DGC, Hochdorf, Med Johnson und Nestlé. Für ein von ihm initiiertes Forschungsvorhaben bekam er Sachmittelunterstützung von Abbott, Danone und Nestlé. Des Weiteren erhielt er Gelder für die Durchführung von klinischen Studien von Herstellern von diätetischen Produkten Abbott, Danone und Nestlé. Als Mitglied der Nationalen Stillkommission spricht sich Prof. Koletzko eher für das Stillen aus.

Picture 5: While Koletzko and co-authors state in the Recommendations for Action that they are free from any conflicts of interest, in another article, appearing at virtually the same time in the German medical journal, *Deutsches Ärzteblatt*, Koletzko declares his comprehensive financial connections with countless infant formula manufacturers.

For me, what came out of the research – also quite personally – was the recognition that the introduction of complementary foods is completely possible without the “Nutritional Plan for the First Year of Life” and that this gives many babies and parents the gift of a relaxed start with complementary foods. My (meanwhile two) children have long since outgrown the complementary feeding age. But the findings of my research work are just as valid today as they were then.

So, in March 2018, the Round Table for Breastfeeding Promotion requested that six months of exclusive breastfeeding be made the measuring stick for breastfeeding promotion in Germany. The Network “Healthy in Life” holds fast to a minimum time of four months exclusive breastfeeding. However, only every third infant in Germany is even breastfed so long. That is what the Network wants to improve with the project “Becoming Breastfeeding Friendly”. One member in the expert committee, beside breastfeeding counsellors and representatives of health communication research and the ministries is also Professor Berthold Koletzko.



ABOUT THE AUTHOR:



Dörthe Ziemer was a free-lance journalist when she researched the topic of complementary foods in the course of her EJF fellowship in 2013/2014.

After studying Russian and German philology and Eastern European history, she worked as a trainee in 2003/2004 at the *Lausitzer Rundschau (Lausitz Review)* in Cottbus and, afterwards, was active for 5 years as a journalist in Lausitz. Following that she was an editor for the Network for Eastern European reporting. After her maternity leave, she went back to freelancing and continued to work with a focus on Eastern Europe and Lausitz, but also on topics such as complementary feeding or power-napping. Since 2017, she has been the Press Officer for the city of Lübben in Spreewald.



REFERENCES:

- > Baby Milk Action: **WHO breastfeeding recommendations under attack from industry-funded scientists.** Pressemitteilung 14. Januar 2011. <http://info.babymilkaktion.org/news/policyblog140111>
- > Bundesregierung: **Antwort der Bundesregierung auf die Kleine Anfrage der Abgeordneten Nicole Maisch, Kai Gehring, Kordula Schulz-Asche, weiterer Abgeordneter und der Fraktion BÜNDNIS 90/DIE GRÜNEN, 2014.** <http://dipbt.bundestag.de/doc/btd/18/021/1802170.pdf>
- > Brodmerkel A: **Immer mehr Ärzte empfehlen, Kinder bereits nach vier Monaten mit Brei zu füttern. Hebammen und Ernährungswissenschaftler halten dagegen Vier Monate? Sechs Monate? Zwei Jahre?** Berliner Zeitung 26.03.2011. www.berliner-zeitung.de/14643252
- > Die Zeit: Raether, Elisabeth; Stelzer, Tanja: **Süße Geschäfte.** Die Zeit, 8. Mai 2013; www.zeit.de/2013/20/kinder-marketing-werbung/komplettansicht
- > Dube K, Schwartz J, Mueller MJ, Kalhoff H, Kersting M: **Complementary food with low (8%) or high (12%) meat content as source of dietary iron: a double-blinded randomized controlled trial.** Eur J Nutr 2010;49:11-18.
- > Ernährungskommission der Deutschen Gesellschaft für Kinder- und Jugendmedizin (DGKJ) et al.: **Ernährung gesunder Säuglinge.** Monatsschr Kinderheilk, 2014;6:527-438.
- > Fewtrell M, Bronsky J, Campoy C et al.: **Complementary Feeding: A Position Paper by the European Society for Paediatric Gastroenterology, Hepatology, and Nutrition (ESPGHAN) Committee on Nutrition.** J Pediatr Gastroenterol Nutr 2017;64:119-132.
- > Fewtrell, Mary et al: **Six months of exclusive breast feeding: how good is the evidence?** British Medical Journal 2011. Vol. 342. S. 209-212. www.bmj.com/content/342/bmj.c5955
- > Foterek, Hilby, Alexy: **Breastfeeding and weaning practices in the DONALD Study: Age and time Trends.** JPGN 2014;58:361-367.
- > Koletzko, B.; Brönstrup, A.; Cremer, M. et al: **Säuglingsernährung und Ernährung der stillenden Mutter.** In: Monatsschrift Kinderheilkunde, Sonderdruck Oktober 2010, S. 4
- > Koletzko, B.; Bauer, C.-P.; Cierpka, M. et al: **Ernährung und Bewegung von Säuglingen und stillenden Frauen.** In: Monatsschrift Kinderheilkunde, Sonderdruck September 2016, S. 442
- > Kopp, Matthias: **Die Leitlinie Primäre Allergieprävention auf dem Prüfstand.** Pädiatrische Allergologie 15 - 2/2012
- > Loewenstein G, Sah S, Cain DM. **The Unintended Consequences of Conflict of Interest Disclosure.** JAMA: The Journal of the American Medical Association 2012;307:669-70.
- > Müller-Lissner A: **Neue Studie zu Babynahrung.** Der Tagesspiegel 17.01.2011. www.tagesspiegel.de/wissen/gesundheit-neue-studie-zu-babynahrung/3705224.html
- > Kramer MS, Kakuma R: **Optimal duration of exclusive breastfeeding.** Cochrane Database Syst Rev 2012 Aug 15;(8):CD003517. doi: 10.1002/14651858.CD003517.pub2
- > **Newsmax Pressemitteilung, 2010.** www.newsmax.de/fuballwm-2010-experten-geben-tipps-zum-spannungsausgleich-und-ungetruebten-knabberspa-news30691.html
- > Prell C, Koletzko B: **Stillen und Beikost. Empfehlungen für die Säuglingszeit.** Dtsch Arztebl Int 2016;113:435-444.
- > Rapley, Gill; Murkett, Tracey: **Baby-led Weaning.** Kösel-Verlag 2013.
- > Reich-Schottky U für das DAIS - Deutsches Ausbildungsinstitut für Stillbegleitung: **Sechs Monate ausschließliches Stillen ermöglichen – für die Gesundheit der Kinder und der Mütter.** Stellungnahme Februar 2018
- > **Runder Tisch Stillförderung in Deutschland: Sechs Monate ausschließliches Stillen ist die Messlatte!** Pressebericht 4.3.2018.
- > von der Lippe E., Brettschneider A.-K., Gutsche J., Poethko-Müller C., KiGGS Study Group. **Einflussfaktoren auf Verbreitung und Dauer des Stillens in Deutschland.** Ergebnisse der KiGGS-Studie – Erste Folgebefragung (KiGGS Welle 1). Bundesgesundheitsbl 2014;57:849-859.
- > World Health Organization (WHO): **Infant and young child feeding.** 16. Februar 2018. www.who.int/en/news-room/fact-sheets/detail/infant-and-young-child-feeding
- > World Health Organization (WHO): **Exclusive breastfeeding for six months best for babies everywhere.** 15. Januar 2011. www.who.int/mediacentre/news/statements/2011/breastfeeding_20110115/en/

Press Report 4.3.2018

Round Table on Breastfeeding Promotion in Germany:

Six months exclusive breastfeeding is the benchmark!

The Round Table on Breastfeeding Promotion is an informal association of breastfeeding organizations and federations in Germany. Those participating work together to identify and remove barriers to breastfeeding. The goal is to enable successful breastfeeding for both mothers and babies, namely six months exclusive breastfeeding and continued breastfeeding up to the age of two years or beyond. At its last meeting in February two projects took center stage.

“Becoming Breastfeeding Friendly”

At the invitation of the Round Table, Dr. Stephanie Lücke from “Healthy in Life” presented the project, “Becoming Breastfeeding Friendly”. Through this project, the breastfeeding situation in Germany is to be assessed and improved.

Benchmark: “Six months exclusive breastfeeding”

Assessments need benchmarks. The standard international benchmark is “six months exclusive breastfeeding”. “Healthy in Life” plans to shorten this benchmark to four months exclusive breastfeeding. There is no evidence for this. The participants of the Round Table unanimously urge that the benchmark of **six** months exclusive breastfeeding also be used in Germany. A letter has gone to the German Federal Government, the National Breastfeeding Commission and “Healthy in Life” as the three bodies responsible for the project. A response is still outstanding.

Effective Recommendations for Action

To remove obstacles, one of members of the Expert Commission, set up by the project director, should develop recommendations for action. The Round Table urges that the professional groups involved in practical work with mothers and children, the mothers themselves and also a representative of children’s rights be involved promptly so that the recommendations are actually practical and effective. This request has also been sent to the bodies responsible for the project

Collection of Breastfeeding Data “SuSe 2”

What measures to remove obstacles to breastfeeding are effective? To know that, we must know how many mothers breastfeed for how long and, namely **before** the measures are carried out and afterwards. There is only a little meaningful data of this sort in Germany. At the invitation of the Round Table, Prof. Mathilde Kersting reported on the currently running Germany-wide study “Breastfeeding and Infant Feeding SuSe 2”. It was twenty years ago that such a study was

carried out, thus the “2”. The Round Table hopes that the study will deliver meaningful data. The participants agreed that, beyond this, data must be collected regularly.

“Breastfeeding – a Foundation for Life”

This is the motto for World Breastfeeding Week 2018. The Round Table has agreed, as in every year, on the German translation of the international motto. The actions during World Breastfeeding Week are intended to inform the public and support young families.

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Enable Six Months of Exclusive Breastfeeding – for the Health of Children and Mothers

Comment Utta Reich-Schottky for DAIS – German Training Institute for Breastfeeding Support, February 2018

WHO, UNICEF and leading professional associations call for enabling and encouraging six months of exclusive breastfeeding world-wide. In Germany, mothers are frequently hindered in reaching this goal – also by the recommendations for action of the “Healthy in Life – Young Family Network” and their implementation.

International and German (Rebhan et al 2009) studies and expert bodies repeatedly come to the conclusion: Six months of exclusive breastfeeding is an appropriate recommendation (AAP 2012, ESPGHAN 2017, Kramer et al 2012, NHS UK

2018, Smith et al 2016, WHO 2017, among others). The nutrients are sufficient for this period (Butte et al 2002). An earlier start on complementary feeding increases susceptibility to infection, even in industrialized countries. (Chantry et al 2006, Ladomenou et al 2010, WHO 2017, among others).

At about six months, most babies reach the maturity for complementary foods, a developmental step, such as learning to walk. Visible signs are the diminishment of the tongue-thrust reflex, the ability to sit with support and eye-hand coordination with conscious grasping and putting-into-the-mouth. The gastrointestinal tract and the immune system also develop in a similar direction. The various developmental lines all seem to converge at about six months. Only a few children reach all of these milestones before six months, many only somewhat later (Cattaneo et al 2011, Naylor et al 2001).

The health of the mothers also benefits from longer and exclusive breastfeeding (Victoria et al 2016, Farland et al 2017, among others).

Allergies

The argument often made for beginning complementary foods before 6 months is that this serves as allergy prevention. With reference to celiac disease, this has, meanwhile, been refuted (Silano et al 2016). With peanuts, it seems that the fewest allergies occur if the mother has eaten pea-

nuts during the breastfeeding period and the child herself has been given peanuts before the age of 12 months (Pitt et al 2017). With peanuts and chicken and egg protein their introduction between 4 and 6 months does not seem to significantly reduce the frequency of allergy as compared to introducing them from 6 months (SACN). The German recommendations for action state that: “Overall, it seems that there may possibly be advantages to introducing complementary foods before the start of the 7th month of life for allergy prevention, but these have not been proven” (Koletzko et al 2016).

Allergy prevention is no reason to begin complementary foods before six months

Starting Complementary Foods in the Recommendations for Action of “Healthy in Life”

Nevertheless, in Germany, infants are to receive complementary foods earlier. These recommendations for action say “Complementary foods should be introduced, at the earliest, at the beginning of the 5th month of life and, at the latest, at the beginning of the 7th month of life (Koletzko et al 2016). In the further instructions for implementation, the emphasis lies on “the beginning of the 5th month of life”: The graphic, “Feeding Plan from the 5th Month”, shows, with no “ifs” or “buts”, the first porridge at the beginning of the 5th month and, by the beginning of the 7th month, three porridge meals with only a small amount of breastfeeding (Gesund ins Leben 2018). Thereby, beginning complementary foods at the start of the 5th month of life is set as the norm – optically at any rate.

Relaxed and exclusive breastfeeding until 6 months is systematically discouraged and hampered. On top of that, the complementary food in the recommendations for action is reduced to porridge and the infants are pictured with a spoon in their mouths. Hand blenders and spoons are fairly new inventions. They can be useful, but their use with complementary foods is not, however, compulsory. For millions of years, families have succeeded in arranging

the transition from breastfeeding to family foods with very different forms of nutrition and without a spoon (Palmer 2009).

Just as healthy infants are able, from birth on, to search for the breast and regulate their milk intake by themselves, they can also employ this skill when eating complementary foods (Rapley et al 2015). There is no proof that infants who are fed by spoon from the 5th month are healthier and display healthier eating behavior as youngsters and adults than do their peers who, as infants, having reached the maturity for complementary foods at about 6 months, have independently eaten from among the foods which were offered. Also, there is no difference in risk of choking (Fangupo et al 2016). The recommendations for action should be disentangled from the fixation on porridge and spoons.

In the last 20 years, the average duration of breastfeeding in Germany (with respect to the mothers who even began breastfeeding) has remained unchanged at 7.5 months (von der Lippe et al 2014). The recommendations of “Healthy in Life” encourage early reduction of breastfeeding and, thereby, the breastfeeding duration.

Complementary food products as an economic factor

Whether complementary foods are introduced at the beginning of the 5th month or after half a year, makes a clear difference for the baby food industry. At the beginning of the 5th month, only pureed food is possible and therefore, as a rule, it comes from a jar. When complementary feeding is begun after half a year, many parents don't even start with baby food in jars. Experience shows that those who begin complementary foods earlier mostly wean earlier too – and that improves the sales of follow-on milk. With around 700,000 newborns a year and about 1€ per jar per day, the 60 days between the beginning of the 5th and the beginning of the 7th month can produce revenue of up to 40 million Euros. Added to that, in the next four months, there is perhaps a further 40 million Euros for baby food in half of the families, who

would not have used baby food in jars had they begun complementary feeding later. For two additional months, follow-on milk for about a third of the children, with two bottles a day and with ca. 28g of powder per bottle and a kilo price between 8€ and 24€ there is excess revenue of ca. 15 million Euros. A rough estimate of the annual excess revenue is roughly over 90 million Euros.

There is a strong financial motive to influence the breastfeeding recommen-

dations. The interests of the industry are, thereby, contrary to the health interests. For this reason, the personnel in the two areas of interest should be separate. Those who receive commissions, honoraria or sponsoring from the baby food industry or their institutes (such as, for instance, the "Nestlé Nutrition Institute") should not sit in bodies that decide the general breastfeeding recommendations (See also Lempert et al 2015, Lieb et al 2011).

Summary

Recommend and enable six months of exclusive breastfeeding. Consider the signs of maturity in setting a time for beginning complementary feeding. Be open to varied approaches to complementary foods. Support continued breastfeeding along with appropriate complementary foods until the age of two or beyond: All of this together benefits the health of children and mothers and takes the pressure off of the families (and thereby, also supports health).



LITERATURE:

- > American Academy of Pediatrics: **Breastfeeding and the Use of Human Milk** 2012 <http://pediatrics.aappublications.org/content/early/2012/02/22/peds.2011-3552>
- > Butte N, Lopez-Alarcon M, Garza C. **Nutrient adequacy of exclusive breastfeeding for the term infant during the first six months of life.** WHO, Genf2002
- > Cattaneo A, Williams C, Pallás-Alonso C, Hernández-Aguilar M, Lasarte-Velillas J, Land-Rivera L, Rouw E, Pina E, Volta A, Oudesluys-Murphy A: **ESPGHAN's 2008 recommendation for early introduction of complementary foods: how good is the evidence?** Commentary. *Maternal and Child Nutrition* 2011, 7:335–343
- > Chantry CJ, Howard CR, Auinger P. **Full breastfeeding duration and associated decrease in respiratory tract infection in US children.** *Pediatrics*2006;117:425–32
- > **ESPGHAN: Complementary Feeding: A Position Paper by the European Society for Paediatric Gastroenterology, Hepatology, and Nutrition (ESPGHAN) Committee on Nutrition.** *J Pediatr Gastroenterol Nurt.* 2017; 64(1):119-132 www.espgan.org/guidelines/nutrition/
- > Fangupo L, Heath A, Williams S, Erickson Williams L, Morison B, Fleming E, Taylor B, Wheeler B, Taylor R. **A Baby-Led Approach to Eating Solids and Risk of Choking.** *Pediatrics* 2016; 138(4):e20160772
- > Farland L, Eliassen H, Tamimi R, Spiegelman D, Michels K, Missmer S. **History of breast feeding and risk of incident endometriosis: prospective cohort study.** *British Medical Journal* 2017;358:j3778 doi:10.1136/bmj.j3778
- > **Gesund ins Leben. Ernährungsschema ab dem 5. Monat** Aufruf 10.2.2018 www.gesund-ins-leben.de/inhalt/breifehrplan-29435.html
- > Koletzko B, Bauer CP, Cierpka M, Cremer M, Flothkötter M, Graf C, Heindl I, Hellmers C, Kersting M, Krawinkel M, Przyrembel H, Vetter K, Weißenborn A, Wöckel A. **Ernährung und Bewegung von Säuglingen und stillenden Frauen.** Aktualisierte Handlungsempfehlungen von „Gesund ins Leben – Netzwerk Junge Familie“, eine Initiative von IN FORM. *Monatsschr Kinderheilkd* 2016; 164(9): 765-789 https://shop.aid.de/_assets/downloads_free/3291_2016_akt_he_saeugling_x000.pdf
- > Kramer MS, Kakuma R. **Optimal duration of exclusive breastfeeding** (Review). *The Cochrane Library* 2012 <http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD003517.pub2/epdf/standard>
- > Ladomenou F, Moschandreas J, Kafatos A, Tselentis Y, Galanakis E. **Protective effect of exclusive breastfeeding against infections during infancy: a prospective study.** *Arch Dis Child* published online September 27,2010
- > Lempert T, v.Brevern M. **Regulierung von Interessenkonflikten: Die Fachgesellschaften sind am Zug.** *Dtsch Arztebl* 2015; 112(3): A-84 / B-74 / C-72 www.aerzteblatt.de/pdf.asp?id=167315
- > Lieb K, Klemperer D, Ludwig W: **Interessenkonflikte in der Medizin,** Springer-VerlagBerlin Heidelberg2011
- > von der Lippe E., Brettschneider A.-K., Gutsche J., Poethko-Müller C., KiGGS Study Group. **Einflussfaktoren auf Verbreitung und Dauer des Stillens in Deutschland.** Ergebnisse der KiGGS-Studie – Erste Folgebefragung (KiGGS Welle 1). *Bundesgesundheitsbl* 2014 ·57:849–859
- > National Health Service UK 2018 **Start4Life** www.nhs.uk/start4life/first-foods
- > Naylor A, Morrow A. (edit). **Developmental Readiness of Normal Full Term Infants to Progress from Exclusive Breastfeeding to the Introduction of Complementary Foods.**
- > Linkages Project 2001 http://pdf.usaid.gov/pdf_docs/PNACS461.pdf
- > Palmer G. (2009) **What is complementary feeding? A philosophical reflection to help a policy process.** IBFAN GIFA, Genf www.ibfan.org/art/IBFAN_CF_FINAL_document.pdf
- > Pitt TJ, Becker AB, Chan-Yeung M, Chan ES, Watson WTA, Chooniedass R, Azad MB. **Reduced risk of peanut sensitization following exposure through breastfeeding and early peanut introduction.** *J Allergy Clin Immunol.* 2017 Aug 22. pii: S0091-6749(17)31104-1. doi:10.1016/j.jaci.2017.06.024
- > Rapley, G., Forste, R., Cameron, S., Brown, A. and Wright, C. **Baby-Led Weaning: A New Frontier? Infant, Child, & Adolescent Nutrition** 2015, 7(2): 77-85. <http://journals.sagepub.com/doi/pdf/10.1177/1941406415575931>
- > Rebhan B, Kohlhuber M, Schwegler U, Fromme H, Abou-Dakn, Koletzko B. **Breastfeeding duration and exclusivity associated with infants' health and growth: data from a prospective cohort study in Bavaria, Germany.** *Acta Paediatr*2009;98:974-80
- > SACN Scientific Advisory Committee on Nutrition UK 2017. **Assessing the health benefits and risks of the introduction of peanut and hen's egg into the infant diet before six months of age in the UK** <https://cot.food.gov.uk/sites/default/files/jointsacnecotallergystatementfinal2.pdf>
- > Silano M, Agostoni C, Sanz Y, Guandalini S. **Infant feeding and risk of developing celiac disease: a systematic review.** *BMJ Open* 2016;6:e009163 <http://bmjopen.bmj.com/content/bmjopen/6/1/e009163.full.pdf>
- > Smith H, Becker G. **Early additional food and fluids for healthy breastfed full-term infants.** *Cochrane Database of Systematic Reviews* 2016, Issue 8. Art. No.: CD006462 <http://bmjopen.bmj.com/content/bmjopen/6/1/e009163.full.pdf>
- > Victora CG, Bahl R, Barros AJD, França GVA, Horton S, Krasevec J, Murch S, Sankar MJ, Walker N, Rollins NC, for The Lancet Breastfeeding Series Group. **Breastfeeding in the 21st century: epidemiology, mechanisms, and lifelong effect.** *Lancet* 2016; 387:475–90
- > WHO. **Infant and young child feeding.** Fact sheet N°342. Updated July 2017. www.who.int/mediacentre/factsheets/fs342/en/

Clear Positions

The Board of Directors and the management of the **BABY-FRIENDLY Initiative Germany** take a stand Author: Alfred Längler



In the last two decades, the Association for the Support of the WHO/UNICEF-Initiative “Baby-Friendly Hospital” (BFHI) has successfully established itself in Germany. With around 130 member hospitals, 100 of them BFHI certified, 20% of all German births currently take place in a *baby-friendly* setting.

The Association, is the only institution that has current, detailed data on the breastfeeding behavior of the mother-baby pairs served and, at regular intervals, reviews and evaluates the criteria for bonding, development and breastfeeding, which must be met. See also the B.E.St.[®]-criteria at www.babyfreundlich.org. The content represented is scientifically evaluated and its evidence has been confirmed in a series of publications. This is fully consistent with the results of the Cochrane-Reviews published on this topic. BFHI has available a large number of scientific experts and experienced practitioners and is, thereby, a sought-after contact on significant questions about breastfeeding and bonding-promoting perinatal care.

Some questions in Germany, both in the national professional world as well as within the Association, have repeatedly attracted a great deal of attention:

1. The adherence to or implementation of the WHO Code on Marketing of Breast-Milk Substitutes
2. The recommendations on the duration of exclusive breastfeeding or the start of feeding complementary foods.

We have made it our business to explain the aforementioned topics in line with a clear and transparent positioning, both for the internal as well as the external public. Our transparency initiative is intended to help give current and future members, the interested public and our cooperation partners some guidance. In individual cases, a future discussion may not be forestalled by this, but is simplified in the sense that the fundamental discussion does not always have to be started from scratch. The basic principles are fixed.

WHO-Code and its Implementation within BFHI

Breast-milk substitutes were and are marketed world-wide in such a way that mothers are deterred from breastfeeding. But this endangers the health of mothers and children. In order to prevent such action, a Code was adopted by the World Health Assembly in 1981. This has been regularly updated and made more precise with further resolutions. All of the resolutions together form the basis of the WHO Code today.

Breast-milk substitutes, similar to prescription medication, should be available and used appropriately when they are needed. But they should not be advertised. Article 1 defines the goal of the WHO Code: “The aim of this Code is to contribute to the provision of safe and adequate nutrition for infants, by the protection and promotion of breastfeeding, and by ensuring the proper use of breastmilk substitutes, when these are necessary, on the basis of

adequate information and through appropriate marketing and distribution.”

In 2017, the current BFHI Board of Directors adopted a binding position paper on dealing with the WHO Code, which offers all members and cooperation partners of the BFHI initiative the necessary clarity and orientation and, with the help of a checklist, provides help for its implementation in daily hospital practice. The position paper has been well-received within and outside of the Initiative and is already in its third printing.

This publically available position paper is supplemented by a voluntary declaration of commitment, which has been signed by all of the currently active members of the Board and the staff in the office. All cooperation partners of the Association are also selected in accordance with the Code criteria.

BFHI promotes, requires and offers transparency. As such, the transparency declarations of all members of the Board and staff are accessible upon request for the members of the Association. Such a statement of any conflicts of interest is not only required by the anti-corruption law, but should also be the obvious and established practice for all opinion-forming institutions, national commissions and scientific advisory boards.

Recommendations on Breastfeeding Duration and complementary Foods

Internationally, there is a broad consensus about the recommended duration of exclusive breastfeeding ii, iii: if there are no special reasons against it, infants should, ideally, be exclusively breastfed for six months. The foundation for this evidence-based expert recommendation, which is regularly updated, is scientifically valid research on short-, medium- and long-term outcomes for breastfed babies and their mothers, depending on the duration of breastfeeding, which is published in peer-reviewed journals (cf. Cochrane Review 2017 and references on www.babyfreundlich.org). Therefore, for us, the discussion conducted

only in Germany and the official recommendation on the duration of exclusive breastfeeding: “Exclusive breastfeeding for at least 4 months, complementary foods at the earliest at the beginning of the 5th and latest at the beginning of the 7th month of life” remain incomprehensible *iv*. Even though a recommendation for 6 months of exclusive breastfeeding is not forbidden, it leaves, yet again, room for discussions among experts and, in our experience, also invites one-sided interpretations. That which is justified as supporting the mother leads, in practice, to a feeling of insecurity among the parents. We may speculate about the background of the enduring German recommendation, which, unfortunately, is significantly behind the international recommendations. However, the studies cited do not clearly support this.

Rather, it is the complex scientific discussion on allergy prevention – as only one of the many factors, influencing the health of mother and child through breastfeeding – that causes confusion and, in cases of doubt, prevents mothers from being able to exclusively breastfeed their babies as long as would make sense to do so.

We would like to spare mothers, parents and professionals unnecessary uncertainty which, in case of doubt, also leads to rates of breastfeeding in Germany that are much too low *v*. Therefore, the Board of Directors and members of the Initiative in a variety of locations (such as, for instance, the National Breastfeeding Commission, the Round Table on Breastfeeding Promotion, the project, Becoming Breastfeeding Friendly, etc.) advocate that infants in Germany also ideally be exclusively breastfed for six months.

On feeding complementary foods from the beginning of the 7th month of life, it should, at any rate, be mentioned that the studies also make clear here, that it must not always be just porridge. The recommendations for action should be disengaged from their fixation on porridge and the spoon.

Summary

The Board of Directors and staff of the BABY-FRIENDLY Initiative, along with all its members, understand it as their task to create the optimal conditions for a good breastfeeding relationship, as well as a successful mother-child bond, as a prerequisite for long-term healthy child development.



LITERATURE:

- > ^[1] www.babyfreundlich.org/fileadmin/downloads/WHO_Kodex_20171107.pdf
- > ^[2] **ESPGHAN: Complementary Feeding: A Position Paper by the European Society for Paediatric Gastroenterology, Hepatology, and Nutrition (ESPGHAN) Committee on Nutrition.** J Pediatr Gastroenterol Nurt. 2017; 64(1):119-132 <http://www.espghan.org/guidelines/nutrition/>
- > ^[3] **WHO. Infant and young child feeding.** Fact sheet N°342. Updated July 2017. www.who.int/mediacentre/factsheets/fs342/en/
- > ^[4] **Prell C, Koletzko B: Breastfeeding and complementary feeding—recommendations on infant nutrition.** Dtsch Arztebl Int 2016; 113: 435–44. DOI: 10.3238/arztebl.2016.0435
- > ^[5] <http://edoc.rki.de/oa/articles/re42cwJXfkWc6/PDF/29igfi1HxxNZU.pdf>



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Checklist

For Code-compliant interaction with the manufacturers or distributors, here, in particular, of breast-milk substitutes, nipples and related products.

1	PRODUCTS which you can use and their sourcing		You can use all products which you need for your work, also all products from the manufacturers mentioned above. This applies for breast-milk substitutes, bottles and nipples, for foods and for non-food products, including breast pumps
			The condition for this is that you regularly buy all the products used (no samples, free delivery, special discounts).
2	ITEMS with company logos		Don't use or display any clocks, calendars, ballpoint pens, post-it-blocks or other objects with a company logo
			Breast-milk substitute products, bottles and nipples are stored out of sight when they are not being used.
			Products from the manufacturer's mother-baby range, such as wet wipes or personal care products for breastfeeding mothers, should – if used at all – also be stored out of sight.
3	WRITTEN MATERIAL WEB LINKS		Please use neutral reusable bottles. With single portion bottles, you do not have to cover the label.
			Do not lay out or pass along brochures, magazines, bed labels etc. with advertisements for Code-relevant products.
			Do not lay out or pass along any information sheets published by Code-relevant companies
4	ADVERTISING for your institution		On the website of your institution place links only to companies, organizations or parent blogs, which do not advertise for products that fall under the WHO Code.
			You can place regular advertisements in any newspaper and any booklet even if advertisements for breast-milk substitute products are in it.
5	GIFTS for	Parents	You can be represented with a stand at any baby- or other trade fair. You preserve your independence by covering the costs for this yourself.
		Personnel	No foods, no samples and no other objects from the manufacturers and distributors mentioned above can be given to parents, not even food supplements, bread boxes, personal care products, coupon books, covers for the child's medical records booklet, information sheets or other such things.
		Hospital	No gifts will be accepted, neither food, nor thermos cans, invitations and the like.
6	CONTINUING EDUCATION	Personnel	No gifts will be accepted, including food, literature, materials or technological equipment.
			When a professional organization or specialist society-sponsored congress is held, you can take part. Depending on the topic, attendance can be recognized as continuing education for baby-friendly staff.
			When you act as a lecturer*, your agreement on fees and expenses should be independent of the sponsors.
		Hospital	With internal continuing education and offers for in-house training, companies which manufacture products falling under the WHO Code, are eliminated from consideration as sponsors.
			Only those persons who are independent of the companies mentioned above and are not paid by them can be considered as lecturers. This also applies to continuing education on breast-milk substitutes.
			With external continuing education which is sponsored or hosted by companies, whose products fall under the WHO Code, baby-friendly hospitals do not appear as co-hosts
			This also applies for institutes or departments of the companies mentioned above.

Breastfeeding Aids – Where is the Problem?

Basic information on the WHO Code Author: Anja Bier



Photo: © Andrea Hemmelmayr

The so-called “WHO Code” is a colloquial abbreviation for the somewhat unwieldy complete title: “International Code of Marketing of Breast-Milk Substitutes”. This code was first adopted by the World Health Assembly (WHA) in 1981 and, since then, has been regularly expanded and adapted. In essence, it is about protecting breastfeeding world-wide and reducing, thereby, infant mortality and health hazards for infants and young children.

To achieve this, the Code has a set of rules, which, above all, limit the marketing and advertising of infant formula, bottles and nipples, but also regulate the dealings of health care professionals with the relevant manufacturers and their products.

Strictly speaking, the Code is a declaration of intent by the signatory states to convert these regulations into national laws, so that violations can also be sanctioned accordingly. However, the implementation

of this step, the actual conversion of the Code into concrete laws, has only occurred in a very rudimentary way, which means that companies that violate the Code must not reckon with serious consequences. On the other hand, there is the market force of the consumer and notorious Code violations have a negative effect on a company’s image.

Andrea Hemmelmayr has commented on the implications for professional practice of central articles of the Code on page „A Guide to the International Code of Marketing of Breast-Milk Substitutes for Medical Personnel“ – page 27 in this issue

What does this mean concretely?

If we are unsure about whether something conflicts with the Code, we can orient ourselves on the following simple overview.

This means: Parents and health care personnel should be informed objectively and factually about the contents of infant

formula, how bottles and nipples function and the way in which they are used, as well as the significance of breastfeeding and the risks that result from not-breastfeeding. Everything which instead of this, advertises the product and serves to make it more attractive and appealing, violates the Code. This applies, for example, to wording, such as “modelled on Nature” or “for satisfied babies” or also to pictures of happy, beaming babies on the package.

It is NOT forbidden to manufacture and sell infant formula or bottles or nipples – on the contrary, the Code explicitly says that these products should be available in the best possible quality in order that they can be used adequately when there is an actual need. What is forbidden is marketing that goes beyond purely factual information

In our daily life, it can be helpful to imagine infant formula, bottles and nipples being equated with certain med- ➤



ical products, i.e., surgical instruments or infusion solutions. Of course, these products are necessary and need to be of high quality, reliable and always available. Furthermore, health care personnel who work with these products, should have information about their proper. Nevertheless, it should be standard practice that neither the health care personnel nor the patients treated with these products be bombarded with advertising flyers, discount actions or “sample packages” from the manufacturing firms.

For many manufacturers, health care personnel represent the ideal group for marketing their products: free deliveries to hospitals ensure that young families are provided with generous amounts of infant formula and, thereby, allow the companies to directly establish a degree of trust in the relevant market. After all, their own hospital, the nice midwife or the experienced nursery nurse have unwittingly “recommended” this product. Furthermore, many manufacturers give utensils that are designed for the work environment of the healthcare personnel: a clock for the unit’s station, note pads for the desk, placards with pictures of breastfeeding positions, measurement and weight cards for the baby beds etc.

It has already been proven in many studies that such gifts influence people subconsciously and that they are more positively inclined towards the respective brand, even if this does not happen directly and publically (the motto for this is: “Small gifts maintain a friendship.” Health care personnel are also not protected from this influence, which leads to a (subconscious) conflict of interest and can, thereby, put unlimited support of breastfeeding at risk.

And what about breastfeeding aids?

Breastfeeding aids do not fall within the explicitly mentioned scope of the Code and were not mentioned. On the other hand, they are frequently used, especially in an attempt to protect breastfeeding and to make

it possible. Thereby, they could, apparently also belong in the category of “completely unproblematic” products, but this requires a more differentiated approach:

The Code speaks clearly about the protection of BREASTFEEDING. This is not synonymous with MOTHER’S MILK FEEDING. Even when it is obvious that feeding with mother’s milk is preferable to feeding with infant formula, it is, nevertheless, not entirely risk-free and is inferior to direct nursing at the breast. Some of the positive health effects do not rest alone on the composition of the mother’s milk, but are due to direct nursing at the breast, intense physical closeness, hormonal interrelationships, the development of the child’s facial muscles, etc.

This means: Pumping milk and methods of feeding the expressed milk, can, indeed, in some cases, support successful breastfeeding or even make it possible. In other cases, however, these interventions are often used in a way that reduces or completely replaces direct nursing at the breast without any medical indication for this.

Obviously, every woman has the right to freely decide for or against breastfeeding or mother’s milk feeding. The Code aims to ensure that, before this decision is made, she receives exclusively correct, scientifically backed-up and factually worded information on this. This means, however, that advertising for a milk pump or a certain method of feeding the pumped milk, constitutes undue influence, especially when such products are presented as a “lifestyle trend”.

Moreover, when, as described above, wording is used that implies that the product “is modelled on the mother’s breast ...” or supports “the same sucking pattern as with breastfeeding”, it quickly becomes apparent that breastfeeding is not being protected here but is, potentially, even endangered.

Manufacturers of breastfeeding aids can also violate the Code, even if they do not market any infant formula. When a

company, which manufactures aids, which make it possible to supplement directly on the breast, also manufactures products for other ways to feed infant formula (i.e. teats and bottles), it falls automatically in the area of application of the Code and it must orient itself to the relevant requirements. And here, it should be remembered that: the manufacturing itself is permitted, the advertising is not, even when the company itself states that its bottles and nipples are “only intended for mother’s milk” (which, in practice, is, of course, not even noticed by many young families and is surely not accidentally mentioned in very small type in the instructions for the product).

Let’s speak candidly about this: one of the biggest players in the field of manufacturing breastfeeding aids, decided some years ago to a) develop its own bottle nipple and market it aggressively, both to health care workers and directly to mothers and b) in their advertising messages, very frequently equate mother’s milk feeding with direct nursing at the breast and even advertise their milk pumps as products for a “modern lifestyle”. The company Lansinoh, which also manufactures breastfeeding aids, has a bottle nipple of its own in its assortment and advertises this.

Then, am I no longer allowed to use any breastfeeding equipment from these companies?

A violation of the Code does NOT imply that the products manufactured are of poor quality or inappropriate for their intended purpose. Breastfeeding aids, which are helpful in supporting breastfeeding and are used appropriately, can and should, of course, also be used even when the manufacturing company violates the Code. As breastfeeding counsellors, we have committed ourselves to the protection and support of breastfeeding and when a breastfeeding aid is necessary for that, it is correct and entirely in line with the Code to use it! This requires correct and factual information about it as well as instruction

CODE VIOLATION



This advertisement, which was placed on the Medela pump cases in a hospital, clearly shows the aggressive marketing strategy for the company's artificial nipple, although even within Medela's product assortment, a good alternative is available: the Supplementary Nursing System (SNS), with which the baby can be supplemented directly on the breast. How would it be if, instead of this, the label read: "Have you thought of the Supplementary Nursing System?"

by a trained, neutral (that is, someone not obligated to the company) professional.

All German-speaking breastfeeding organizations from the voluntary sector, the professional organizations of IBCLCs, the teaching institutes for professional personnel as well as the member organizations of Baby-Friendly Hospitals (BFHI) have committed themselves to complying with the Code and to promoting its observance. This means that, in our work with mothers, we, as breastfeeding counsellors, can continue to use breastfeeding aids made by companies that violate the Code, but should not, for instance, accept any gifts from these companies or attend any continuing education programs financed by these companies or permit them to be sponsors, exhibitors or advertising partners at our events. As decision-makers in hospitals or in other places, we are committed to using breastfeeding aids primarily from Code compli-

ant companies, *to the extent that this is possible*. Milk pumps, nipple shields, nursing pads and lanolin for the mamille are, for example, products that are also offered by Code-compliant manufacturers. A product that is only manufactured by a company that violates the Code, should, obviously, be used anyway if it is needed.

Sometimes, companies that violate the Code argue that the Code also explicitly requires that health care personnel be sufficiently informed about measures that are useful in supporting breastfeeding. Thereby, they see the option for themselves to advertise their products to health care professionals. After all, one can only work with products if they know about their existence and if they have been trained in their use.

However, this should be viewed very critically: it is inarguable that health care personnel need factually correct information about the different products and

breastfeeding aids and should be familiar with their use. However, for this, it is not necessary to allow the employees of the manufacturer to present their products at events – neither as lecturers, nor as exhibitors nor in the form of in-house-training. Training and lectures from neutral institutions and/or experienced breastfeeding experts, who work independently of financial connections to these companies, are, by far, more reliable sources of information. Also the boundary between "factual information" and "advertising" is quickly crossed and even health care professionals are not always immune to being convinced by flowery words. Thus, a particularly critical look is advisable here.

The Ethics Code for IBCLCs – what is that again?

With every recertification, internationally board certified lactation consultants (IBCLC) sign a statement to the effect that they not only feel themselves bound to the WHO Code, but furthermore, they follow a special code of behavior for IBCLCs which, before 2011, was called the "Code of Ethics". Apart from the protection of the child's health, the behavioral code for

Examples of Code-violating marketing of nipples – that is, products, which clearly fall within the scope of the Code:

CODE VIOLATION



For Medela, the milk pump and the Calma-nipple simply belong together - weren't breastfeeding-promotion feeding measures, such as cup feeding or the Supplementary Nursing System (SNS), an option?

CODE VIOLATION



In this picture, there is no mention of breastfeeding – apparently, only mother's milk, a pump and the bottles and nipples are needed for this baby (by the way, also no mother, it seems...)

CODE VIOLATION



The wording, through which the company conveys that feeding with the help of this nipple is equivalent to direct breastfeeding, are clear.



CODE VIOLATION



These companies carry breastfeeding aids too, but also aggressively advertise bottles and nipples.

- › IBCLCs also focus on the health of the mother and the right of every woman to be supported in her personal wishes about breastfeeding. The behavioral code also mandates that IBCLCs, who behave inappropriately, must submit to a disciplinary hearing by the certifying office (IBLCE) and should, in general, disclose and, if possible, avoid any conflicts of interest, which occur through financial or ideological entanglements. This requirement not only explicitly refers to companies which violate the WHO Code, but is intended to sensitize every IBCLC to always self-critically observe relationships to companies and certain products and ensure that, in their work with a mother and child, that they act exclusively on the basis of knowledge and factual competency (and, thereby, for example, not recommend or use products lightly, without a real need).

The Code of Behavior for IBCLCs is only compulsory for this professional group, but can serve as a desirable foundation for the behavior of other breastfeeding counsellors and every other specialist who works with mothers and children. In combination with the observance of the WHO Code, every one of us contributes to an environment that protects and promotes breastfeeding.



Anja Bier

Lactation Consultant IBCLC
Staff member of the European Institute for Breastfeeding and Lactation (EISL), lecturer for the Network "Healthy in Life, employed free-lance as an IBCLC in the Munich area.



LITERATURE:

Primary Sources:

- › **International Code of Marketing of Breast-milk Substitutes.** Geneva, Switzerland: World Health Organization; 1981
- › **WHA-Resolutionen 33.32 (1980) bis 69.9 (2016)**
- › **WHO. UNICEF. IBFAN. Marketing of Breast-milk Substitutes: National Implementation of the International Code.** Status Report 2016. Geneva, Switzerland: World Health Organization; 2016
- › **The International Code of Marketing of Breast-milk Substitutes: Frequently Asked Questions (2017 Update).** Geneva, Switzerland: World Health Organization; 2017
- › **Clinical Competencies for the Practice of International Board Certified Lactation Consultants (IBCLCs),** Updated September 15, 2012. Fairfax, USA: International Board of Lactation Consultant Examiners (IBLCE); 2012
- › **Code of Professional Conduct for IBCLCs,** Effective November 1, 2011, Updated September 2015. Fairfax, USA: International Board of Lactation Consultant Examiners (IBLCE); 2015
- › **Frequently Asked Questions (FAQs) Regarding the Code of Professional Conduct for IBCLCs.** Fairfax, USA: International Board of Lactation Consultant Examiners (IBLCE); 2013
- › **Minimising Commercial Influence on Education Policy,** Effective May 1, 2017. Fairfax, USA: International Board of Lactation Consultant Examiners (IBLCE); 2017

Secondary Sources/Links: (mostly in German)

- › **Zusammenstellung/Link-Sammlung** aller relevanten Dokumente von Utta Reich-Schottky, häufig auch in deutscher Übersetzung: www.reich-schottky.de/kodex.html
- › **Der WHO-Kodex: eine kurze Zusammenfassung,** Artikel von Dr. Zsuzsa Bauer auf der Plattform „Still-Lexikon“: <http://produktguide.still-lexikon.de/der-who-kodex-eine-kurze-zusammenfassung/>
- › **Marketing für Formula in der Kritik,** Artikel von Anja Bier als Anlage zum Fach-Nachrichten des Europäischen Instituts für Stillen und Laktation, März 2018: <http://www.stillen-institut.com/de/marketing-fuer-formula-in-der-kritik.html>
- › **Sammlung der wichtigsten Dokumente zur Ethik für IBCLCs,** teilweise auch auf deutsch verfügbar (Einstellen der Sprache auf der Webseite möglich): <https://ibclce.org/resources/professional-standards/>

A Guide to the International Code of Marketing of Breast-Milk Substitutes for Medical Personnel



Foto: © Moopixel/Shutterstock

The WHO Code is intended to create an environment in which parents can make decisions about feeding their babies, free from commercial influences. Aggressive advertising for infant formula and other products addressed in the Code competes directly with the healthiest form of nutrition for mother and baby – breastfeeding.^[1]

It is the task of medical personnel to create an environment in which informed decisions, a good start to breastfeeding and maintaining the breastfeeding relationship are possible at all. Parents who are reliant on the use of infant formula must also be appropriately instructed in its use. Health care personnel and institutions should not be misused for advertising and conflicts of interest should be avoided.

The WHO Code and the relevant Articles^{[2] [3]}

Article 1: The aim of the Code is the **protection and promotion of breastfeeding**, as well as the **appropriate use of breast-milk substitutes**, where these are used. This should happen on the basis of adequate information and through appropriate marketing and distribution.

Article 2: The **scope of the Code** encompasses **products which are intended as partial or complete substitutes for breast-milk**. These comprise: breast-milk substitutes, including all specialized nutritional products, follow-on milk and foods for infants and young children intended for use before the 36th month of life: foods and drinks, including baby teas, juices and baby water, intended for use before the 6th month of life as well as baby bottles and nipples.^{[4] [5]}

Article 4: Information for parents must include the following points:

- › The value and superiority of breastfeeding
- › Preparation for breastfeeding and its maintenance
- › The fact that even a few (unnecessary) bottle-feeds have a negative effect on breastfeeding
- › The decision not to breastfeed is difficult to reverse

If the informational material reports on infant formula, the following information must also be mentioned:

- › The cost of infant formula
- › Economic and social consequences
- › Possible health risks

No commercial advertising material, camouflaged as informational material, may be given to the mothers:

Informational material on breastfeeding for migrants:

You can find our short introduction to breastfeeding with easily remembered drawings and simple words in 24 different languages www.elacta-magazine.eu

On the home page of the European Institute for Breastfeeding and Lactation, there is a whole range of links to information for parents <http://www.stillen-institut.com/de/elterninformationen-in-verschiedenen-sprachen.html>

Information for migrants on the preparation of infant formula in Arabic, Chinese, English, Spanish, French, Portuguese and Russian.

<http://www.who.int/foodsafety/publications/powdered-infant-formula/en/>



IBCLC

International Board Certified Lactation Consultants are the only internationally approved breastfeeding and lactation specialists having a medical background.

The decision to breastfeed or not to breastfeed has short- and long-term impact on the health of child and mother. However, breastfeeding sometimes turns out to be difficult and perhaps professional, competent assistance is needed.

Article 6: Health Care Systems

- › Health authorities should promote and protect breastfeeding; medical personnel should know about the WHO Code and its content and implement it in practice.
- › No advertising for products in the area of application of the Code in health care facilities
- › Instruction in using breast-milk substitutes should be given by medical personnel and only to parents who need this. The instructions must explain the risks of incorrect use of such products.
- › In no area of the health care system may free or reduced price deliveries of breast-milk substitutes or other products, which come under the scope of the Code, be accepted.^[6]

Article 7: Medical Personnel

- › Medical personnel have the responsibility to protect and promote breastfeeding.
- › No advertising to medical personnel – ONLY scientific facts and hard data may be given to health care personnel.
- › No gifts for the personnel, no free samples for the parents.
- › Sponsoring by manufacturers of products, which fall within the scope of the Code, can hinder the support for breastfeeding and the Baby-Friendly Initiative and should not, therefore be accepted. Corporate sponsorship for research, education or travel must be disclosed.^[7]

Get active!

Read the Code and its Resolutions, consider, together with your colleagues, how you can organize your workplace in a Code-compliant way. Review the informational material that you distribute to see whether it has the necessary information; endeavor to acquire foreign language, but also neutral informational material. Don't let your workplace be misused for advertising purposes and, above all, bear in mind that professional personnel are not immune to advertising.



SOURCES

- › ^[1] Interessenkonflikt kontra Informationsmangel, Laktation & Stillen 3 2013, Andrea Hemmelmayr
- › ^[2] WHO – The International Code of Marketing of Breast-Milk Substitutes, 1981
- › ^[3] Protecting Infant Health: A Health Workers' Guide to the International Code of Marketing of Breastmilk Substitutes, 2002
- › ^[4] The International Code of Marketing of Breastmilk Substitutes – Frequently asked questions updated 2017. <http://www.who.int/nutrition/publications/infantfeeding/breastmilk-substitutes-FAQ2017/en/>
- › ^[5] WHA Resolution 69.9 May 2016, Ending the inappropriate promotion of foods for infants and young children http://apps.who.int/gb/ebwha/pdf_files/WHA69/A69_R9-en.pdf and Implementation Manual <http://www.who.int/nutrition/publications/infantfeeding/manual-ending-inappropriate-promotion-food/en/>
- › ^[6] WHA Resolution 47.5 May 1994
- › ^[7] WHA Resolution 49.15 May 1996

Freeze-Drying of Breast-Milk

A new-old way to make breast-milk available and long-lasting for at-risk premature infants.

Author: Dr. med. Franz Koettnitz, Gynecologist



Photo: © iStock.com/Yobro10

For premature babies, mother's milk is food and medicine.

The Product

Mother's milk, as the most important and most natural food and, sometimes, also medicine for babies born very early, is experiencing a certain renaissance in our time. Scientifically, it is becoming clearer and clearer that the composition and uniqueness of human milk CANNOT be "recreated" – even with such good intentions – from cow's milk or other animal milk. Also, sidestepping this with mare's or goat's milk does not manage to achieve the safety of human milk. Mother's milk, which is rich in antibodies, stem cells, RNA and other important components from the mother, who transmits them to her own child, manages to provide a perpetually wholesome food for the newborn at any age, along with a high caloric intake. Allergization against a variety of allergens and the development of diabetes in later life are observed significantly less frequently when the normal, healthy newborn receives mother's milk – ideally for at least 6 months. If this does not work for various reasons, substitution with a donor-mother's milk (which is then called "human milk") should be available. For babies born very early, from the 24th week of pregnancy, the mother's milk or "human milk" is frequently something like a medication, through which the greatly-feared necrotizing enterocolitis (NEC), which occurs in about 12% of these babies, can very often be prevented. For these babies, a breast-milk substitute made from cow's milk or the milk of other animals, is completely unsuitable. A milk "diet", as much as possible of human origin, dramatically lowers the incidence of NEC, reduces food intolerances and is a guarantor for significantly shorter hospital stays for the affected infants (Assad et al, 2015). Mother's milk, as the biologically classed ideal food for infants, particularly prematures, is thus, again, uncontested. The (German) National Breastfeeding Commission, which was established especially for this in 1994, also documents this impressively. >



Freeze-dried breast-milk has 12.8% of the solid parts of the previously fluid milk. The powder is simply shaken with body-temperature, sterile water.

Need and Resources

To cover the need for human milk for infants, especially premature infants, whose mothers, for various reasons (illness, medications, drugs, etc.) cannot make a sufficient amount of – or any – milk available, there were still, until 1989, in what was then West Germany, around 40 of the original ca. 60 milk banks. However, these were then closed due to the dwindling demand and the hygiene problems arising from the emergence of HIV. The former East Germany retained a portion of the ca. 25 existing milk banks and today there are 13 of them. They can, on request, cover a vanishingly small fraction of the need in other neonatology hospitals in Germany by sharing the mother's milk that is not used in their own hospitals. Meanwhile, for this reason, seven human milk banks have been opened in West Germany. Three more are being planned

After evaluating scientific statistics, we, in Germany, can assume, with some 720,000 births in the year 2015, that ca. 260,000 liters of breast-milk, which are needed to feed all at-risk newborns exclusively with breast-milk, are lacking every year. Unfortunately, making this amount available is currently not possible since the number of mothers with excess milk and their readiness to make this excess available, without the professional logistics to support it, limit the resources.

We want to do this differently in the future. We assume that, with optimal advertising and the help of midwives, it would be possible to collect up to 350,000 liters a year. This would represent the amount of milk that, with a four-to-five-month donation of 150-200 mls a day, by 2% of all mothers of newborns in one year, could

produce ca. 350,000 litres, minus 40% of IgG-CMV-positive mothers whose milk is pasteurized and processed further to (milk) fortifiers, since, without anti IgM-formation, active CM-viruses would again be set free in the milk).

Thereby, we can make this kind of freeze-dried breast-milk available to pediatric hospitals for primarily medically-indicated purposes. A company (AMMEVA GmbH), with headquarters in Potsdam, has been started. For logistical reasons, we are beginning to collect in Potsdam and Berlin, because here, a concentration of ca. 35,000 births per year makes possible the perfecting of completely new logistics in a small area. In a second step, we then want to operate Germany-wide

Unique features

Such breast-milk banks do not yet exist in Germany. By contrast to the institutional breast-milk banks of various hospitals, the participating midwives and breastfeeding counsellors will be remunerated financially. We have another plan for the donors: Up until now, mothers prepared to donate have mostly had to bring their excess milk to the breast-milk banks of the hospitals daily and procur, at their own expense, the milk pumps along with the accessories. By contrast, we want to make the various technology and equipment for pumping and storage available to the mothers and pick up the milk from the mothers' homes. The mothers will receive vouchers for diapers or other drug store products. In this way, we want to prevent mothers from donating milk for financial reasons and possibly then no longer fully breastfeeding their own babies.

As the first breast-milk bank of this kind, we will then conserve the breast milk in a freeze-dry process. The significantly higher biological quality of freeze-dried breast-milk compared to the pasteurized milk at all the current collection points, has been scientifically proven multiple times. The quality advantages consist in the retention of the most important substances, such as the typical proteins and antibodies of human milk which, unfortunately, are, destroyed by pasteurization. There are considerably more components which make the milk valuable and irreplaceable, as already described. Up until now, the freeze-dry process was considered to be too expensive compared to pasteurization and, thereby, not economical, even though it is demonstrably better.

The freeze-dry process which has been further developed and used by us, allows a less expensive, gentle and innovative freeze-drying of breast-milk of the highest quality (the relevant evidence was furnished by authorized laboratories). Thereby, our company can, for the first time, offer long-lasting (at least a year and a half) breast-milk in soluble powder form, which can be prepared by the user with warm water (sterile, but, at least, previously boiled and then cooled to 36°C). The milk is prepared in exactly the same way as powdered infant formula.

The process of human milk donations and collection

The world-wide return to donor milk as a desirable food for both premature and full-term newborns, when sufficient mother's milk is not available, also makes regulation in Germany necessary, as reflected in the



When Breastfeeding Alone is Not Sufficient

Author: Andrea Hemmelmayr

The vast majority of mothers can and should breastfeed, just as the vast majority of babies can and should be breastfed.

For the few situations, in which direct breastfeeding is not possible, the Global Strategy for Infant and Young Child Feeding (WHO, 2003) provides clear guidelines. When the baby cannot or should not feed at the breast, mother's milk (the expressed milk of his own mother) should be fed – ideally in a breastfeeding-friendly way (i.e. cup feeding). If there is no mother's milk available, the next choice should be human milk: either from a healthy wet-nurse or from a human milk bank. Only when there is no human milk available, should infant formula be fed..

renowned, unique and expert document by Dr. Skadi Springer: "Guidelines for Establishing and Operating a Breast-Milk Bank". Published by the Leipziger Universitätsverlag (Leipzig University Press) in 1998, it has proven its worth. Dr. Springer was also appointed to the National Breastfeeding Commission. In her document, the basic hygienic ground rules, which we must observe with the establishment of our breast-milk bank, are clearly outlined and explained exactly. These regulations have, to a very great extent, been incorporated into many guidelines of other nations, such as, for example, the Swiss guidelines (Frischknecht & Waelchli, 2010) or the Italian guidelines (Arslanoglu & Moro, 2010).

The required parameters and hygiene controls there will be managed by us as follows and strengthened by applying our own additional controls.

A woman who applies to be a donor must have a home visit by one of the midwives or lactation therapists contracted by us before being taken into the donor pool. Discussions on this have already taken place with the Federal Representative on Breastfeeding from the German Midwifery Association, Ms. Aleyd von Gartzen (Hannover), who is also a member of the National Breastfeeding Commission, and with the Chairwoman of the Lower Saxony Midwifery Association, Ms Bujny Leer. We have also spoken with the president of the Professional Association of German Lactation Consultants, IBCLC, e.V., Ms Monika Jahnke, (Laatzen) and secured their cooperation. The broad lines and the arrangements for the control tasks as well as the agreements to be signed between the midwives/lactation consultants, >

Global Strategy for Infant and Young Child Feeding, WHO /UNICEF, 2003

1st Choice	Breastfeeding directly on the mother's breast
2nd Choice	Expressed mother's milk (milk of the baby's own mother)
3rd Choice	Human milk (milk of a healthy donor or a wet-nurse)
4th Choice	Infant formula

have been discussed with them and agreed to. First, the contracting partner must be convinced that the donor is exclusively breastfeeding her baby. Then, the data in the mother's maternity record booklet on pathogens detected and other medical information are collected and the donor is informed about the donation process and has the hygienic measures that must be followed explained. Should blood tests be necessary in addition, they will be carried out by our contract partners at our cost. A clear distinction is made between CMV-positive and CMV-negative donors. The donor will be assigned a bar code from which both she and her milk can be identified. The donor will freeze her milk at home, in her own freezer, at -18°C to -20°C - in containers developed specifically for this purpose and which we supply. The containers are so constructed that, after filling them with breast-milk and sealing the shell, they do not have to be opened during transport and the freeze-drying itself, which means a near-total avoidance of contamination during this procedural step. The frozen milk will be picked up at the donor's home address by the company's own transport and, with appropriate deep cooling, brought for processing. It will be ensured that it is verifiable whether the cold-chain has been interrupted. Supplying the milk pumps will initially be taken over by ARDO.

Ethics of the Company and of the Process

It is fully clear to this company, which has now been set up, that there are some key features of the process, which must be subject to ethical review. Among them is the supervision of the donors in light of the fact that they must be fully breastfeeding their own babies when they donate. Further aspects are the target groups, which will consist mostly of the premature infants, who are undersupplied with mother's milk. Along with this, are the production process and the price of the finished product, neither of which must lead to an ethical lapse, just because it is on the mar-

ket. Here, cooperation with the midwives and lactation consultants will also be put to the test.

For this reason, the company is establishing an ethics board which, in the current planning, will consist of a member of the Board of Directors, a representative of the midwives and a representative of the lactation consultants, a donor and a representative of the neonatologists who use this product in our hospital.

On the process of freeze-drying

At the latest, since the fundamental document of C.A. Sager (1958), who wanted to set up breast-milk freeze-drying at the University Hospital in Kiel, it has been clear that freeze-drying represents the absolutely most suitable process for the preparation and storage of donor breast-milk. Due to very unfortunate circumstances, which negatively affected some people, this could not be realized. It has been repeatedly shown - in a great many scientific publications in the past, in the previously cited guidelines of Dr. Springer (1998) and in the Swiss guidelines from 2010 up to Lanzano et al., (2014) - that, while the standard process for sterilization and hygienic preparation is pasteurization, lyophilization is considerably better. However, this process has been considered to be too complex and expensive to implement on a large industrial scale.

Pasteurization has the rather substantial disadvantage of destroying the protein. The comprehensive document, "Breastfeeding and Breast-Milk Feeding, (Springer S.), issued by the (German) National Breastfeeding Commission, under the leadership of Prof. Dr. Psyhyrembel, Cologne 2001) and published by the German Federal Office for Health Education, comments on pasteurization: "The heat treatment, in particular, has negative effects on the immunological and anti-infective components of the mother's milk as well as on enzymes, vitamins and, in particular, folic acid (Donnelly-Vanderloo et al, 1994). Pasteurization does, indeed, guarantee the

inactivation of bacteria, fungi and most viruses (Orloff et al., 1993), but it also destroys lipase (Wardell et al., 1984)" (a. a. Ort S. 168) and "the smaller and less mature the baby is, the more important it is to retain the biological value of the mother's milk. Particularly with patients at high risk for necrotizing enterocolitis, giving fresh, non-pasteurized mother's milk is desirable" (Henker, 1987; Henker and Futschik 1993; Radke 1992, Springer 1995) (a. a. Ort S. 169). This damage through heat exposure does not occur with freeze-drying of breast-milk. Most of the valuable components are retained and, after dissolving the powder in body-temperature water, are available again. The storage and transport of milk powder are also considerably less complicated and are possible for a longer period of time than is the case with pasteurized milk, which must be stored frozen.

Why, despite the clear facts, no one, until now, has taken up this process commercially, remains speculative. The fact is, the decisive impulse-giver, Dr. Prof. Dr. C.A. Sager lost the opportunity, through unfortunate circumstances, to use the technologically more developed freeze-drying process.

The end product achieved by freeze-drying, a breast-milk powder, is not only easy to reconstitute with body-temperature water, it also reduces the pathogens, thanks to the processing technique (Sager 1958, Krieg H. 1966) and, with storage at under 20°C , very likely retains its bactericidal property (Honour & Dolby, 1979 and Carbonare et al., 1996). At least, the pathogen count is reduced significantly with dry storage after the freeze-dry process, which is certainly due to the low chance of survival of bacteria, which have already been attacked by the slow freezing in the freezer at (the mother's) homes and are damaged again by the withdrawal of the water during the freeze-dry process, so that the survival time is considerably reduced. Friedberg and Steinheuer (1958) even proved that the powder resulting from the freeze-drying can be heated to 100°C over a period of

4 hours, without the proteins suffering any great damage – because – yes – the water is withdrawn through the freeze-drying process. Salcedo et al. (2015) describe the successful reduction of germs in breast-milk powder after freeze-drying and storage at -80°C ?

Thereby, there are many processes available for germ-reduction (incl. viral loads), which we have not yet reviewed for their practical use with breast-milk after freeze-drying in a commercial process. However, even the simple freeze-drying that we have occasionally carried out on pooled breastmilk for research purposes -without other germ-killing measures - has led to a reduction in the germ count in the powder or in the reconstituted milk, which remains considerably below the maximum load stipulated in the literature (Springer, 1998). Of course, the batches from donors will also be examined bacteriologically, virologically and toxicologically before the end product (“breast-milk powder”) comes on the market

With respect to the end product, today’s knowledge about the structure and the contents of breast-milk indicates that, with the method of freeze-drying, we could not only cover the total need for premature infants, but even, by extracting and freeze-drying the individual components (fat, sugar, protein), the current still-common enrichment of mother’s milk for her own baby with a bovine “fortifier product” could be made superfluous and, thereby, a very great allergization potential of such feeding would be eliminated (Fusch & Samiee-Zafarghandy, 2014).



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Certified Teacher (Remedial and Special Needs Teacher) and Gynecologist: Education in Germany (Mainz and Essen); Senior physician/Assistant Medical Director and two Head physician and Medical Director positions in Germany, then 10 years in the Netherlands; now since 2013 back in Germany as the Medical Director at Marien Hospital in Papenburg (perinatal focus); Founder of his own scientifically-oriented acupuncture concept “Acu-natal”; Working with breastfeeding and human milk for more than 25 years



LITERATURE:

- > Arslanoglu S, Moro GE: **Guidelines for the establishment and operation of a donor human milk bank.** J Matern Fetal Neonatal Med 2010;2(23).
- > Assad M, Elliott M J, et al.: **Decreased cost and improved feeding tolerance in VLBW infants fed an exclusive human milk diet.** J Perinatol 2015:11.
- > Carbonare S B, Palmeira P, Silva M L, et al.: **Effect of microwave radiation, pasteurization and lyophilisation on the ability of human milk to inhibit Escherichia coli adherence to Hep-2 cells.** J Diarrhoeal Dis Res 1996;6(14)90-4.
- > Friedberg V, Steinheuer K: **Der Einfluß von hohen Temperaturen auf gefriergetrocknete Frauenmilch** Klinische Wochenschrift 1958;2;333-4.
- > Frischknecht K, Wälchli C: **Leitlinie zur Organisation und Arbeitsweise einer Frauenmilchbank in der Schweiz,** 2010.
- > Fusch C, Samiee-Zafarghandy S: **Promoting healthy growth and nutrition in preterm infants: A challenge for clinicians and researchers.** Clin Biochem 2014;47;711-3.
- > Honour P, Dolby JM: **Bacteriostasis of Escherichia Coli by milk. The activity and stability of early, transitional and mature human milk collected locally.** J Hyg Camb 1979;83;243-53.
- > Krieg H: **Der Keimgehalt roher und gefriergetrockneter Frauenmilch.** Med Klinik 1966;61: 953-6.
- > Lanzano B, Castellote A, Montes R, et al.: **Vitamins, fatty acids, and antioxidant capacity stability during storage of freeze-dried human milk.** 2014;9(65);703-7.
- > Sager CA: **Frauenmilchkonservierung durch Gefrier Trocknung.** Archiv f Kinderhkd, Beiheft 1958,37.
- > Salcedo J, Gormaz M, Lopez-Mendoza M C, et al.: **Human Milk bactericidal properties: Effect of lyophilisation and relation to maternal factors and milk components.** J Pediatr Gastro Enterol Nut 2015;60;527-32.
- > Springer S: **Leitlinie für die Einrichtung und zur Arbeitsweise von Frauenmilchbanken** Leipzig 1998, Universitätsverlag.

Report of the ELACTA Board Meeting with their New Member Association VAMY

Finland, in February 2018 in Kemi, Lapland

Report by: Stefanie Rosin, ELACTA Secretary



Board of Elacta met Santa Claus in the arctic circle

Last February Elacta held a board meeting in Kemi in Northern Finland. During this board meeting we had the great opportunity to meet Minna Rantanen and Anitta Nykyri from the board of our new member association VAMY from Finland. We are happy to welcome VAMY to our growing ELACTA Association, and start our co-operation. During our meeting we discussed topics around breastfeeding, education and co-operation. Besides we were able to spend some time in the snowy landscapes of Finnish Lapland.

This meeting was hosted by our sitting board member and treasurer Heli Vanhatalo who lives in Kemi. She works as a pediatric nurse and gives breastfeeding and lactation lectures at Lapland University of applied sciences. Heli invited us to the local maternity clinic where the newborn babies get hand-crafted woolen socks as a gift from the clinic, to celebrate 100 years of independency of Finland.

Find more information about our new member association VAMY on the following page.



Board of Elacta meets President of Vamy Minna Rantanen in a real ice cafe in Kemi



Events Advisory from the Country Associations

Croatia - HUSD Croatian Association of Lactation Consultants

6th Croatian Breastfeeding Symposium entitled "Human milk banks and the use of human milk in the NICU".

› **28. September 2018**

Sisters of Mercy Hospital, Zagreb - Simultaneous translation provided
Special guest:

Dr. Kathleen Marinelli

For more information contact:

irena.zakarija-grkovic@mefst.hr

Austria – VSLÖ & EISL

European Breastfeeding Congress (in German):

› **8. – 10. November 2018**

Vienna

Information www.stillen.at

Belgium – BVL:

The Belgian Lactation Consultants' Conference

› **15. November 2018**

Hasselt

English speaking breastfeeding conference

Guest Speaker: Prof. Katie Hinde

Topics: Primate Milk & Human Uniqueness

How the Biological "Recipe" of Milk Differs for Sons and Daughters
Milk & the Microbiome

Italy

AIPAM Conference 2018

Rome

› **16. November**

Workshops in Italian;

› **17. November**

Guest Speaker: Kay Hoover – "Painful Breastfeeding"
English/Italian

New ELACTA Member Association: VAMY

Report by: Heli Vanhatalo, Pediatric Nurse; Minna Rantanen, VAMY President and Stefanie Rosin, ELACTA Secretary and Anitta Nykyri, Vice President; April 2018

The Finnish VauVAMYöntseisyyskouluttajat ry (VAMY) was founded in 1999. VAMY is short for counsellors on the Baby-Friendly accreditation. We have grown from a small group of members into a quite big society. Today VAMY has approximately 200 members. Most of our members are trained as “Breastfeeding counsellor trainers”. The breastfeeding counsellor training course provides skills and information, enabling participants to develop their breastfeeding support skills and become experts in lactation. In Finland, families are also being supported by breastfeeding counsellors in their work places. A person who has finished this course can also teach the WHO 20 hour breastfeeding course.

We also have members who hold the IBCLC accreditation. Today there’s a growing interest in the IBCLC – training and accreditation. VAMY works together with other organizations that share the same interest in breastfeeding and Baby-Friendliness, e.g. the Finnish organization THL (The National Health and Welfare Institute).

The story of our breastfeeding support begins in 1994 when the 10 steps were translated in to Finnish. After that began the work of couple enthusiastic midwives who started the first professionally organized groups to develop breastfeeding support according to the 10 steps. Also during the 1990s the first breastfeeding peer support groups where founded, as well as the national peer support organization called Imetyksen tuki (Breastfeeding support). During the 1990s hospitals and public health systems also started to work together to develop breastfeeding support.

In the 21st century there has been more and more changes for the better. In 2007 we founded the national breastfeeding workgroup. The group is led by The National Health and Welfare Institute. They have conducted surveys on breastfeeding

rates, participated in writing the new national nutrition recommendation (2016) and they have also written two national policies on breastfeeding support. The latest has just been published. In Finland all midwives and public health nurses receive the WHO 20h training course as a part of their basic training in the University of Applied Sciences.

During the last five years hospitals have shown a growing interest in the Baby Friendly Certificate. Quite a few mother and child health clinics in the public health system have started to work following the 7 steps for successful breastfeeding (BFCl). These steps have been published in the national policy for breastfeeding.

Every year VAMY organizes a two-day meeting. The first day is open for everyone interested in the training program, while the second day is for members only. During these 2 days we have a chance to hear talks about various topics around breastfeeding and other Baby-Friendly topics. This is also a good way to share experiences with other VAMY-members from all over the country.

VAMY has taken part in producing “tools” for every-day work, such as the compasses (kompassit), which are standards and protocols meant to be used in breastfeeding counselling. There are 3 compasses, one for the pregnancy period, one for the early post-partum and one for the period of child growth.

VAMY actively takes part in discussions around family and welfare politics. During the last 6 months we have made powerful statements regarding the issue of the urgent need to have a national breastfeeding coordinator and the new legislation concerning family leave policies.

Every year we celebrate the breastfeeding week in October. VAMY takes part in organizing the seminar for the breastfeeding week; while the seminar is free and open for everyone.

Members of VAMY take part in various educational, research and informational meetings annually. One of the most recent groups that our members are active in is the frenulum group, which is making the subject frenulum better by the Finnish education system for healthcare providers.

Every year VAMY grants scholarships to its members enabling them to participate in seminars and other training courses.

Next year VAMY will celebrate its 20th anniversary. We are happy and excited to have become a part of ELACTA’s international community. The membership in ELACTA will open a whole new level of international education and networking for a common interest.

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