

Informed Decision Making
and
Infant and Young Child Feeding
A Position Paper
August 2011



NLPHA Vision: An effective public health system that promotes and supports the health and well-being of the people and communities of Newfoundland and Labrador.

The Newfoundland and Labrador Public Health Association (NLPHA) gratefully acknowledges the Ontario Public Health Association (OPHA) Breastfeeding Promotion Group for their permission to adapt the original OPHA Informed Decision Making and Infant Feeding Position Paper (OPHA, 2007) for the Newfoundland and Labrador health system environment.

Executive Summary

The Newfoundland and Labrador Public Health Association (NLPHA) has become aware that many pregnant families and those with infants and young children are concerned that they are not being fully informed about infant feeding options. The general public looks to health care providers for information that is current, accurate, and reflective of best practice. It has been found that only partial information is being used to make decisions that have both short- and long-term health consequences for children, mothers, and the community. This concern prompted the NLPHA to adapt and endorse the OPHA (2007) *Informed Decision Making and Infant Feeding Position Paper*, with the expectation that it will increase awareness regarding informed decision making pertaining to infant and young child feeding, and lead to a change in policy and practice. The components of informed decision making are outlined in the Breastfeeding Committee for Canada Baby-Friendly Initiative (BFI) guidelines.

Health Canada recommends that all healthy term infants be exclusively breastfed for the first six months of life, and then continue to breastfeed, with the addition of safe and appropriate complementary foods, for up to two years of age or beyond. Both the initiation and continuation of breastfeeding are, however, quite negatively influenced by early, unnecessary supplementation with human milk substitutes¹.

¹ A human milk substitute means any food marketed, including infant formula, or otherwise represented as a partial or total replacement for breastmilk, whether or not suitable for that purpose.

The Baby-Friendly Initiative (BFI), introduced by the World Health Organization/United Nations International Children's Emergency Fund (WHO/UNICEF) in 1991, is an international program to improve breastfeeding outcomes for mothers and babies (WHO/UNICEF 2009). The Breastfeeding Committee for Canada (BCC) is the national authority for the BFI and has guidelines for implementing the BFI in both hospital and community health services (BCC, 2011). All of the BFI guidelines reflect evidence-based, best practice standards. The guidelines include provisions for the initiation and maintenance of breastfeeding if mother and baby are separated, and supplementation of the baby when medically indicated. In addition, the guidelines outline the information required to make an informed decision about infant feeding and what constitutes appropriate care for the non-breastfed baby.

Health care providers need knowledge, skill, and support to deliver risk and benefit messages regarding infant feeding practices. Information to parents should focus not only on the importance of breastfeeding, but also on the health consequences of not breastfeeding. This is particularly relevant to Newfoundlanders and Labradorians because of the low numbers of women initiating and continuing breastfeeding, and the population's high rates of obesity, diabetes, and other chronic diseases. Feeding with human milk substitutes is associated with higher risks for major chronic diseases such as Type 2 diabetes, obesity, asthma, and other common childhood illnesses (Arenz, Ruckerl, Koletzko & von Kries, 2004; Ip et al., 2007; Owen et al., 2008). When parents and caregivers make informed decisions about infant feeding, their level of satisfaction with their decision, as well as their ability to provide their baby with safe and informed care, are optimized. This is an emerging issue for which NLPHA can provide

leadership, thus inspiring organizations to increase education, skill development, and related policy.

Recommendations

Recommendation 1

The NLPHA and its partners will work with professional health associations, Regional Health Authorities (RHAs), Aboriginal Health Services, and the Department of Health and Community Services to (1) update infant and young child feeding policies based on current knowledge; and (2) to increase education and skill development for all health care providers servicing infants, young children, and their families.

Recommendation 2:

Health care providers should link parents to community resources such as mother-to-mother support groups, breastfeeding clinics, telephone support lines, La Leche League, and Healthy Baby Clubs to help parents initiate and sustain appropriate infant and young child feeding practices; they should also make them aware of infant feeding specialists such as International Board Certified Lactation Consultants and Registered Dietitians when the knowledge and skills of these specialists are needed.

Recommendation 3:

Health care providers should carefully explain all available options in situations where babies cannot, or should not be breastfed, or when the mother decides not to exclusively breastfeed. Alternatives include expressed breastmilk from the baby's mother, pasteurized breastmilk from a human milk bank, or a commercially prepared human milk substitute. The guidelines for the BFI

provide information regarding acceptable medical reasons for the supplementation of babies (BCC, 2011).

Recommendation 4:

Health care providers should ensure that mothers and relevant family members are fully informed of the risk to mother and child by providing human milk substitutes. They should also inform them of the benefits of breastfeeding for both mother and child.

Recommendation 5:

Health care providers must ensure that mothers, families, and caregivers who decide to use human milk substitutes are given the necessary information and support (WHO/UNICEF, 2009). Information should be provided on an individual basis and not in a group setting. Mothers and other family members who will be preparing and giving human milk substitutes must be shown how to do so safely before they leave the hospital or birthing centre and be provided with written instructions. All health care providers should ensure that this information has been understood, and those practicing in the community must ascertain that the information is being followed.

Recommendation 6:

Health care providers must find ways to provide accurate information about the financial costs of using human milk substitutes and the difficulty of reversing the decision once breastfeeding is stopped. Health care providers should also advocate for the establishment of breastfeeding and family friendly workplace policies to support the needs of parents returning to the workplace.

Recommendation 7:

In accordance with BFI standards, health care providers should ensure that all mothers and babies (including the non-breastfed baby) benefit from Baby-Friendly practices: these include

uninterrupted skin-to-skin contact immediately following birth, non-separation of mother and her baby, cue-based feeding, family-centred care, and opportunities to make informed decisions about care (BCC, 2011).

Recommendation 8:

The Department of Health and Community Services and the Regional Health Authorities should develop a work plan to ensure that all attain Baby-Friendly designation by a set date.

Rationale for the Position Statement

In Newfoundland and Labrador the Health Canada recommendations for breastfeeding are not being adequately followed. Health Canada recommends that all healthy term infants be exclusively breastfed for the first six months of life and then continue to be breastfed, with the addition of safe and appropriate complementary foods, for up to two years of age and beyond (Health Canada, 2004). This recommendation was based on a careful review of international evidence presented by the World Health Organization (WHO) and information relevant in a Canadian context. This recommendation is also consistent with health professional association policy statements (Association of Registered Nurses of Newfoundland and Labrador, Canadian Association of Midwives, Canadian Nurses Association, Canadian Pediatric Society, Canadian Pharmacists Association, Canadian Public Health Association, Dietitians of Canada). Because of

the irrefutable evidence outlining the health, nutritional, and economic benefits of breastfeeding, health care providers have an ethical obligation to protect, promote, and support breastfeeding, and to take a strong, unequivocal stance in recommending breastfeeding to pregnant women and new mothers (Miracle & Fredland, 2007).

The public looks to health care providers for health information that is current, evidence-based and reflective of best practice. Research shows that health care providers influence the health decisions that clients make in relation to breastfeeding (Lu, Lange, Slusser, Hamilton & Halfon, 2001; Miracle, Meir, & Bennett, 2004), and breastfeeding promotion and support by health care providers has a profound effect on a woman's infant feeding choices (Lu et al., 2001). A large US survey found that when a health care provider encouraged breastfeeding this practice had an independent positive influence on breastfeeding initiation across all strata of the sample (Lu et al., 2001). A Cochrane review of support for breastfeeding evaluated 34 randomized trials that included 29,385 mother-infant pairs from 14 countries. The review indicated that women who were encouraged by their health care providers to breastfeed were less likely to stop breastfeeding at four months after birth, and were more likely to exclusively breastfeed in the first three months of life (Britton, McCormick, Renfrew, Wade & King, 2007).

If the public received timely, evidence-based breastfeeding information, including risk and benefit messages, the tendency to resort to early, unnecessary supplementation would be limited. When the risks of giving a human milk substitute are clearly explained to parents, the likelihood of exclusive breastfeeding to six months is increased because parents know how supplementing

with human milk substitutes or weaning early can impact the health and well-being of their baby (International Baby Food Action Network, 2009).

Regional Health Authorities (RHA), Aboriginal Health Services, and community partners provide pre and postnatal education and support for infant and young child feeding. Research has shown that mothers generally know that breastfeeding is best for their babies; information about the specific health consequences of not breastfeeding, however, is often unknown (McCann, Baydar & Williams, 2007). This is not surprising given findings from a qualitative research study in the US which found that information about breastfeeding and human milk substitutes is rarely provided by obstetricians during prenatal visits (McFadden & Toole, 2006).

Newfoundland and Labrador

Because children need their parents or caregiver to act on their behalf to determine how and what they will be fed, the issue of informed decision making and infant and young child feeding affects all children born in Newfoundland and Labrador. Information about infant and young child feeding is available from many sources, including the baby formula and food industry, as well as other commercial enterprises. But mothers primarily look to health care providers for knowledge and information about human milk and human milk substitutes. Unfortunately many health care providers view the two as equivalent in terms of health and nutrition benefits. The result is a neutral and lukewarm endorsement of breastfeeding. In one research study, mothers noted that health care providers who told them that breastmilk and formula were the same had

failed to do their job (Miracle et al., 2004). Has this happened in Newfoundland and Labrador where breastfeeding rates fall well below national recommendations? In 2010, 65.6 % of women initiated “any” breastfeeding compared with a national average of 88% (Newfoundland and Labrador Provincial Perinatal Program, 2011; Statistics Canada, 2009). Only 10% of Newfoundland and Labrador women breastfeed exclusively for six months (Statistics Canada, 2009).

The initiation of breastfeeding is also heavily influenced by early, unnecessary supplementation with commercially prepared human milk substitutes (Forster & McLachlan, 2007). A recent chart review in the largest health centre in Newfoundland and Labrador noted that only 25.6% of babies are exclusively breastfeeding on discharge (Kidd, 2010). Anecdotal reports from public health nurses and new mothers suggest that many breastfeeding babies are receiving non-medically indicated supplementation. This problem is not unique to Newfoundland and Labrador. A large Toronto Public Health survey found that rates of exclusive breastfeeding at hospital discharge in several Toronto area hospitals ranged from 27% to 79% (Wood, Wade, Fordham, Mather & Jovkovic, 2010). A 2006 Canadian survey of mothers’ maternity experiences reported that 21.3% of breastfeeding mothers had supplemented their breastfeeding with other liquids within the first week after birth, and only 14.4% reported breastfeeding exclusively at six months (Chalmers, Levitt, Heaman, O’Brien, Sauve & Kaczorowski, 2009).

Informed decision making around infant and young child feeding is important in health policy programming and practice in Newfoundland and Labrador. The Department of Health and

Community Services and all RHAs are striving to establish BFI policies and practices. In addition, the document *Education and Support Standards for Pregnancy, Birth and Early Parenting* (Government of Newfoundland and Labrador, 2004) outlines the importance of “women and families being active partners in decisions affecting their health and well-being”; it also recommends that prenatal education include discussion about the importance of exclusive breastfeeding and the risks of using human milk substitutes. Ensuring informed decision-making regarding infant and young child feeding has been challenging, as there are gaps in the information about breastfeeding that parents receive from health care providers. The NLPHA recognizes that this gap may be one of several factors influencing current breastfeeding rates in Newfoundland and Labrador.

Recommendation 1

The NLPHA and its partners will work with professional health associations, Regional Health Authorities (RHAs), Aboriginal Health Services, and the Department of Health and Community Services to (1) update infant and young child feeding policies based on current knowledge; and (2) to increase education and skill development for all health care providers servicing infants, young children, and their families.

Facilitating an Informed Decision

The WHO International Code of Marketing of Breast-Milk Substitutes (“the Code”)and subsequent, relevant World Health Assembly resolutions recognize that health care providers play a significant role in guiding infant and young child feeding practices (WHO/UNICEF, 1981). The intent of the Code is to contribute to the provision of safe and adequate infant and young child nutrition through the protection and promotion of breastfeeding, and by ensuring the proper use of human milk substitutes when necessary. When health care providers are aware of their responsibilities under the Code, and adhere to the Code, they are following best practice.

Health care providers need to be able to provide accurate and up-to-date information about health issues in an objective manner. Besides knowledge, the values, attitudes, and beliefs of health care providers regarding particular health issues significantly impacts the way they practice.

Reflective practice exercises and transformational learning approaches can be helpful in increasing self-awareness and providing quality care to clients. Most health care providers also have regulatory or governing bodies that set standards of care and practice guidelines. These often include information about the role of the health care provider in assisting clients in making informed decisions.

Clients seek information from their health care provider when making health-related decisions. Studies suggest that in the area of breastfeeding and human lactation, the clinical knowledge of health care providers is limited, and many are not prepared to answer basic questions. A survey of pediatricians found that many did not believe that the benefits of breastfeeding outweigh the challenges, and they reported many reasons to recommend against it (Feldman-Winter, Schanler,

O'Connor & Lawrence, 2008). Forty-five percent (45%) of pediatricians surveyed agreed with the statement that breastfeeding and the use of human milk substitutes are equally acceptable methods for feeding babies. Szucs, Miracle and Rosenman (2009) identified gaps in health care providers' breastfeeding knowledge, counselling skills and professional education/training. Providers often used their own breastfeeding experiences to replace evidenced-based knowledge. Many health care providers report that they do not feel confident in their knowledge and skills to address specific breastfeeding issues (Tavernas et al., 2004).

When working with families, the health care provider can facilitate informed decision making by discussing with the client the available infant feeding choices. The benefits and risks of each option, as well as the potential barriers to breastfeeding success, should be discussed. Health care providers recognize that risk messages are best delivered before challenges are encountered. It is important that the information provided is current, evidence-based and free from commercial influence. Asking open-ended questions and facilitating discussion enhances the family's knowledge. Sensitivity to the feelings, wishes, and concerns of the family is important in facilitating an informed decision. Preferences need to be respected and families must feel supported in order for them to make informed decisions that reflect their needs and goals. Health care providers are comfortable providing evidence-based counselling about the risks of not using car seats and seatbelts, and the dangers associated with smoking and alcohol. They stress the benefits of sunscreens. They should also adopt a similar approach when discussing breastfeeding and the use of human milk substitutes (Miracle & Fredland, 2007).

Recommendation 2:

Health care providers should link parents to community resources such as mother-to-mother support groups, breastfeeding clinics, telephone support lines, La Leche League, and Healthy Baby Clubs to help parents initiate and sustain appropriate infant and young child feeding practices; they should also make them aware of infant feeding specialists such as International Board Certified Lactation Consultants and Registered Dietitians when the knowledge and skills of these specialists are needed.

Infant Feeding Decisions

Human milk is unique in that it contains the exact combination of specific ingredients needed for optimal growth and development of the human baby; it must be stressed that this is not provided by other milks or human milk substitutes. The production of breastmilk is a natural part of the reproductive process. Most mothers can breastfeed and most babies can be breastfed.

Sometimes it is medically necessary to supplement a breastfed baby. In these instances it is important to preserve the breastfeeding relationship. The goal of any supplementation is to return to full breastfeeding; therefore, thoughtful consideration of the potential risks and benefits of the supplement and how the supplement will be given is needed. Mothers need to know how to establish or maintain lactation, and the health care provider can provide the necessary

information and support. Whenever possible, mothers and babies should be kept together in the same room with frequent skin-to-skin contact.

The feeding of severely ill babies, babies in need of surgery, and very low birth weight babies (who are usually in special care units) should be individually determined, and the mother's own breastmilk or banked human milk given whenever possible.² After birth, when babies are well enough to be with their mothers there are few situations that require supplementation.

Sometimes babies may be born with inborn errors of metabolism, or with acute water loss which cannot be resolved with exclusive breastfeeding. Supplementation may also be required when the baby has not regained birth weight by the age of two to three weeks, or in other situations where the baby cannot obtain a sufficient intake of milk by exclusive breastfeeding.

Supplements may be needed temporarily when a mother is severely ill (e.g., sepsis, eclampsia, psychosis). There may need to be a longer term use of supplements when the mother is taking one of the few medications which are contraindicated when breastfeeding (e.g., cytotoxic drugs, radioactive drugs).

Recommendation 3:

Health care providers should carefully explain all available options in situations where babies cannot, or should not, be breastfed, or when the mother decides not to exclusively breastfeed.

Alternatives include expressed breastmilk from the baby's mother, pasteurized breastmilk from a

² The Canadian Pediatric Society recommends the establishment of Human Milk Banks in Canada (Kim & Unger, 2010).

human milk bank, or a commercially prepared human milk substitute. The guidelines for the BFI provide information regarding acceptable medical reasons for the supplementation of babies (BCC, 2011).

The Decision to Give Human Milk Substitutes

The giving of human milk substitutes has been traditionally considered as having no negative consequences. A steadily growing body of evidence, however, clearly shows that feeding commercially prepared human milk substitutes has negative health consequences for babies, mothers, and society (Stuebe, 2009).

Babies who are not breastfed, or who do not receive human milk, are at greater risk of developing health problems, such as the growth of potentially harmful microbes (Stark & Lee, 1982), a heightened risk of allergies (Host, Husby, & Osterballe, 1988), obesity, diabetes (Type 1 and Type 2), otitis media, gastroenteritis, severe lower respiratory tract infections, atopic dermatitis, asthma, Sudden Infant Death Syndrome (SIDS), childhood leukemia and urinary tract infections (Horta, Bahl, Martines & Victora, 2007; Ip et al., 2007; Levy et al., 2009; Marild, Hansson, Jodal, Oden & Svedberg, 2004), higher blood pressure and higher total cholesterol later in life (Horta, Bahl, Martines & Victora, 2007; Martin, Gunnell, & Smith, 2005; Owen et al., 2008) and a deficient response to immunizations (Pabst, 1997; Han-Zoric, 1990). There is compelling evidence that for premature babies the risk for necrotizing enterocolitis, a potentially

fatal disease, can be mediated with the exclusive use of human milk (Ip et al., 2007; Noerr, 2003).

Studies have shown that there are differences in the brain composition of babies who are fed human milk substitutes and babies who are fed breastmilk (Cunnane, Francescutti, Brenna, & Crawford, 2000; Farquharson et al., 1995). More recent research suggests that prolonged and exclusive breastfeeding improves children's cognitive development (Kramer et al., 2008; Quigley et al., 2009).

Not breastfeeding also carries health risks for the mother, such as increased risk of postpartum haemorrhage due to slower involution of the uterus following childbirth (Chua, Arulkumaran, Lim, Selamat & Ratnam, 1994), an earlier return of fertility (Vekemans, 1997), loss of protection for premenopausal breast cancer, ovarian cancer, and Type 2 diabetes (Ip et al., 2007; Jordan, Siskind, Green, Whieman & Webb, 2009; Stuebe, Willet & Michels, 2009; World Cancer Research Fund, 2007), and increases a woman's risk of osteoporosis (Blaauw, 1994).

More recent research suggests that women who breastfeed lower their risk of developing metabolic syndrome, and that breastfeeding may have positive effects on women's long-term cardiovascular health (Gunderson et al., 2010) and body mass index (Bobrow, Qigley, Green, Reeves & Beral, 2009). In addition, although the literature is mixed, mothers who do not breastfeed may be at greater risk of postpartum depression (Dennis & McQueen, 2009). Non-breastfeeding mothers do not experience the same release of the maternal hormones that promote

the development of maternal behaviour and attachment between mother and baby that breastfeeding mothers experience (Uvnas-Moberg, 1996). Many of the positive health outcomes associated with breastfeeding are more pronounced with exclusive and longer breastfeeding (dose response) (Riordan, 2010).

Recommendation 4:

Health care providers should ensure that mothers and relevant family members are fully informed of the risk to mother and child by providing human milk substitutes. They should also inform them of the benefits of breastfeeding for both mother and child.

Using Human Milk Substitutes: Potential Concerns

Human milk substitutes are manufactured by humans, and as such, are subject to human error. Contamination with pathogens, heavy metals, dyes, chemicals, and other harmful substances pose a potential threat to the health of babies. Manufacturing errors involving incorrect amounts of one or more ingredients have resulted in serious health issues for babies. Human milk substitutes are often recalled or withdrawn from the market because they have been found to be unsafe (See Health Canada advisories). Powdered human milk substitutes are not sterile and can be contaminated with microorganisms such as enterobacter sakazakii, to which babies who are premature, have low birth weight, or are immunocompromised, are at particular risk. Meningitis, sepsis, necrotizing enterocolitis, neurological deficits, and even death have been reported.

Incorrect handling, storage, and preparation of formula once it reaches the consumer can also put the baby at significant risk (Health Canada, 2010; Riordan, 2010). Problems can also occur once the commercially prepared formula is purchased. These include language barriers, literacy issues, and inadequate storage facilities in the home. Many families are unaware of the health risks associated with formula that has been prepared and not kept at an appropriate temperature.

Parents and health care providers need to be aware that all commercially prepared infant formula has an expiry date and should be discarded once this date has passed.

Parents and caregivers need to be aware of the importance of carefully following the instructions that accompany the product. Inconsistencies in mixing instructions and measuring tools provided by different manufacturers can lead to unsafe handling, storage, and preparation of formula that can cause confusion and put the baby at significant risk. Over-concentrated or under-concentrated feedings can occur when an incorrect amount of water is added; these errors can cause illness and death, and are recognized as one of the top pediatric emergencies (Brousseau & Sharieff, 2007). Unhygienic practices in the preparation of formula can also result in contamination and subsequent illness. In addition, the water used to prepare infant formula must be safe, free of pathogens and other contaminants, and not contain high levels of substances such as lead, nitrate, cadmium, fluoride, and sodium. Boil water advisories are common in communities throughout Newfoundland and Labrador (Government of Newfoundland and Labrador, 2011). In emergencies, when clean water is not available, the widespread distribution of human milk substitutes to infants and young children who would normally be breastfeeding

exposes them to increased morbidity and mortality. Black et al. (2008) have concluded that suboptimal breastfeeding is responsible for 1.4 million child deaths worldwide.

It is also important for health care providers to know that the giving of human milk substitutes can interfere with the mother's own milk production (WHO/UNICEF, 2009). Mothers need to be aware of the difficulty of reversing the decision to formula feed should they change their mind and decide to breastfeed.

Recommendation 5:

Health care providers must ensure that mothers, families, and caregivers who decide to use human milk substitutes are given the necessary information and support (BCC, 2011; WHO/UNICEF, 2009). Information should be provided on an individual basis and not in a group setting. Mothers and other family members who will be preparing and giving human milk substitutes must be shown how to do so safely before they leave the hospital or birthing centre and be provided with written instructions. All health care providers should ensure that this information has been understood, and those practicing in the community must ascertain that the information is being followed.

Costs of Human Milk Substitutes

The financial costs associated with human milk substitutes compared with breastmilk are

important and should be discussed. Income is an influential determinant of health, and the additional expense of formula feeding and accessory equipment can be a risk factor to vulnerable populations. For example, communities on the north coast of Labrador often pay as much as \$90.00/case for commercially prepared infant formula in the winter months.

Because breastfed babies are sick less often and therefore require fewer visits to physicians and admissions to hospital for common childhood illnesses and other diseases, breastfeeding decreases costs to the health care system. Recent research in the United States estimated the costs of suboptimal breastfeeding at \$13 billion. If 90% of US families complied with the recommendation of exclusive breastfeeding for six months, the researchers proposed that more than 900 deaths could be prevented (Bartick & Reinhold, 2010). Given the known health benefits of breastfeeding it is also likely that breastfeeding mothers who return to the workplace will have less absenteeism and lower health care costs (Spatz & Lessen, 2011).

Recommendation 6:

Health care providers must find ways to provide accurate information about the financial costs of using human milk substitutes and the difficulty of reversing the decision once breastfeeding is stopped. Health care providers should also advocate for the establishment of breastfeeding and family friendly workplace policies to support the needs of parents returning to the workplace.

Support the Mother's Informed Decision

Some mothers decide to give their babies human milk substitutes. Studies show that if the mother makes an informed decision, she usually feels no regret for the decision she made (Lawrence & Lawrence, 2005). Moreover, when information about feeding the baby is presented in a professional, scientific, and objective manner, women do not feel pressured or guilty about their decision. Mothers need to feel supported by their health care providers regarding their decision, and should receive the appropriate information and guidance to promote the health and well-being of their infants and young children.

Recommendation 7:

In accordance with BFI standards, health care providers should ensure that all mothers and babies (including the non-breastfed baby) benefit from Baby-Friendly practices: these include uninterrupted skin-to-skin contact immediately following birth, non-separation of mother and her baby, cue-based feeding, family-centred care, and opportunities to make informed decisions about care.

Newfoundland and Labrador

Because of Newfoundland and Labrador's high rates of obesity, diabetes, (Newhook, et al., 2008; Twells & Newhook, 2010) and cardiovascular disease, it is essential for the Department of

Health and Community Services to actively promote breastfeeding and ensure each RHA works toward Baby-Friendly designation. The establishment of Baby-Friendly health settings is a key strategy recommended in the recently released Public Health Agency of Canada (2010) statement *Curbing Childhood Obesity: An Overview of the Federal, Provincial and Territorial Framework for Action to Promote Healthy Weights*.

Recommendation 8:

The Department of Health and Community Services and the Regional Health Authorities should develop a work plan to ensure that all attain Baby-Friendly designation by a set date.

Conclusions

The NLPHA believes that health care providers play a vital role in assisting mothers and families to make informed decisions regarding healthy and safe infant and young child feeding practices. To properly assist mothers and their families in making informed health decisions, it is imperative that the information presented is current and based on evidence and best practice. Exclusive breastfeeding for the first six months of life with the addition of complementary foods after six months optimizes the health and well-being of most children. Health care providers who provide infant and young child feeding information to mothers should ensure that their knowledge of feeding methods are current, and employers should have up-to-date policies and

allow for continuing education on this topic.

When circumstances require that other feeding options be considered, the health care provider can promote informed decision making by the mother and family by practicing in accordance with the guidelines provided by the WHO/UNICEF BFI and the Code. All parents and families need to be given the opportunity to make truly informed health decisions and be supported in the decisions they make. Once an informed decision has been reached, information and support around the feeding practice can be provided by the health care provider to help ensure the health and well-being of the child.

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