



International Breastfeeding Initiatives and their Relevance to the Current State of Breastfeeding in the United States

Marsha Walker, RN, IBCLC

Exclusive breastfeeding is becoming an endangered practice. Breastfeeding has fallen from the foundation of public health to something that is nice but not necessary in the minds of many consumers and health care professionals. Numerous international initiatives have been created to improve the initiation, duration, and exclusivity of breastfeeding throughout the world. These include the International Code of Marketing Breast-milk Substitutes, the Innocenti Declaration, and the Baby-Friendly Hospital Initiative. In the United States, the National Alliance for Breastfeeding Advocacy (NABA), the US Breastfeeding Committee (USBC), and Baby-Friendly USA have played important roles in improving breastfeeding. We begin with a brief history of these initiatives and organizations and move on to discuss some of the progress and programs that can help return breastfeeding to its rightful place as the initial and most basic act of health protection. *J Midwifery Womens Health* 2007;52:549–555 © 2007 by the American College of Nurse-Midwives.

keywords: advocacy, Baby-Friendly, breastfeeding, the Code, Innocenti Declaration

INTRODUCTION

Lactation is an ancient process that predates placental gestation. It represents the normal and expected way to feed infants and young children, yet continues to suffer from cultural and commercial barriers that make it difficult for mothers to adhere to the medical recommendation to breastfeed exclusively for 6 months, and to continue breastfeeding with appropriate complementary foods for 1 year and beyond.¹ Infant feeding through the ages has been subject to shifting attitudes toward the mother/child relationship, the understanding (or misunderstanding) of the process of lactation and the composition of human milk, and the escalating acceptance of the use of human milk substitutes.² More than 1700 years of published Western medical advice, both ancient and current, often implies that the mother is inadequate to breastfeed her own infant or that her milk is not sufficient to sustain normal growth without being supplemented.³ This is a persistent and unfortunate belief that still lingers in many hospital maternity units, where the supplementation rate of breastfed infants approaches 50%.⁴

Until the mid-1800s, almost all babies in the United States were breastfed. By the 1890s and early 1900s, however, a shift occurred from breastfeeding to bottle-feeding. A confluence of factors caused breastfeeding to lose its place as the foundation of preventive health care. The shift to artificial feeding redefined what constituted “normal” infant feeding. European manufacturing of infant

formulas began in the 1840s, and by the 1890s, these products were available worldwide. Advertisements for commercial human milk substitutes appeared in US women’s magazines, formula manufacturers offered free samples through the mail, and mothers and physicians adopted the belief that artificial feeding was efficient, modern, and scientific.⁵ The pasteurization of cow’s milk and the drop in infant mortality seemed to cancel out the difference between cow’s milk and human milk, facilitating cow’s milk supplementation of breastfed infants.⁶ Mothers continued to doubt their ability to produce sufficient amounts of milk, especially as women’s magazines popularized mothers’ faulty ability to breastfeed. Childbirth itself became medicalized and moved into hospitals. The practice of giving breastfed newborns supplemental bottles was routine in hospital maternity units by the 1930s.⁷ The more infant feeding became supervised by physicians, the more mothers decided they were incapable of producing sufficient amounts of milk without help from physicians and artificial feeding products.⁸ Breastfeeding also became medicalized.^{9,10} While breastfeeding was promoted in medical publications, it was often mishandled in practice, a problem that persists today.¹¹ To help stem the slide into a bottle-feeding culture, numerous international strategies have been initiated over the last 3 decades that are designed to address many of the challenges to breastfeeding.

The International Code of Marketing of Breast-Milk Substitutes

The decline in breastfeeding was not confined to the United States. In 1939, Dr. Cicely Williams gave a speech to the Singapore Rotary entitled “Milk and Murder” which linked artificial or commercial feeding to

Address correspondence to Marsha Walker, RN, IBCLC, 254 Conant Road, Weston, MA 02493. E-mail: Marshalact@aol.com

Table 1. Selected Provisions of the International Code of Marketing of Breast-milk Substitutes

No advertising to the public of any product within the scope of the Code
No free samples to mothers
No promotion of products in health care facilities, including the distribution of free or low-cost supplies
No company sales representatives to advise mothers
No gifts or personal samples to health workers
No words or pictures idealizing artificial feeding, or pictures of infants on labels of formula cans or other foods for infants
Information to health workers should be scientific and factual
Information to mothers should include the benefits and superiority of breastfeeding, how to prepare for and continue breastfeeding, that the addition of formula bottles will cause reduced breastfeeding, and how difficult it may be to return to breastfeeding once bottle-feeding is established
If materials discuss the use of infant formula, they must include: the cost of using artificial feeding products, the social implications, and the possible risks to the baby's health
Unsuitable products, such as sweetened condensed milk, should not be promoted for babies
Manufacturers should comply with the Code's provisions even if the country has not adopted laws or other measures to implement the Code

infant death, raising the alarm regarding the dramatic drop in breastfeeding rates worldwide and the accompanying rise in infant mortality. In 1977, the US-based Infant Formula Action Coalition (INFACT) launched a consumer boycott of Nestlé products to protest harmful formula marketing practices in developing countries that included Nestlé employees dressed up as nurses passing out formula samples in maternity units. In response, Senator Edward Kennedy convened a Senate hearing in 1978 and referred the issue to the World Health Organization (WHO). WHO and the United Nations Children's Fund (UNICEF) convened an international meeting in 1979 on infant and young child feeding. The major outcome of the meeting was the recommendation to adopt the International Code of Marketing of Breast-milk Substitutes ("the Code").¹² The Code is a set of marketing recommendations, not a ban on the manufacture and sale of infant formula. The Code was adopted for the entire world with no distinction between developing and developed countries. It recognized that breastfeeding is a health issue, not a commercial one, and that it needs protection. The Code functions as a tool to curb unethical marketing practices, false and misleading advertising, and the complicity of the health care system in persuading a mother to partially or completely replace her milk with a commercial substitute. In 1981, the United States was the only country to vote against the adoption of the Code, but in 1994 it joined in the consensus in endorsing the Code and subsequent resolutions to that point. No part of the Code is legislated in the United States. The scope of the Code covers products that are marketed in a way that encourages bottle-feeding or hinders breastfeeding. Products include infant formula, follow-on formulas, infant cereals, complementary foods, and other breast milk substitutes when marketed for use as partial or total

replacement of breast milk. Feeding bottles and artificial nipples are also included, but pacifiers and breast pumps are excluded. Selected provisions of the Code can be found in [Table 1](#).

No Advertising to the Public of Any Product Within the Scope of the Code

Pregnant women are inundated with cases of formula, coupons, booklets, and formula company gifts throughout their pregnancy. Misleading text in ads and on labels work to convince mothers that infant formula is equivalent to human milk. Companies promise smarter and healthier babies with better vision, claiming formula is "just like breast milk," because of the addition of two long-chain polyunsaturated fatty acids. However, research has shown that there is little evidence to support any beneficial effects in cognitive, motor, or visual functioning from the addition of these fatty acids.¹³⁻¹⁵

No Free Samples to Mothers

Samples are a marketing tool given to create brand recognition and brand loyalty. Hospital distribution of formula company discharge bags is such an effective marketing tool that it is used as an example in marketing textbooks. This hospital endorsement of formula feeding results in mothers starting to use formula earlier and breastfeeding for shorter durations.¹⁶ In the presence of these bags, exclusive breastfeeding is reduced at all points measured between 0 and 6 months.¹⁷

No Promotion of Products in Health Care Facilities, Including the Distribution of Free or Low-Cost Supplies

Health care facilities, including hospitals, physician offices, and clinics continue to be used as a primary distribution channel for the promotion of infant formula.^{18,19} Obstetric offices introduce pregnant mothers to formula²⁰ through such gifts as a changing pad rolled around a can of powdered formula. These gifts result in a substantial negative effect on the exclusivity and

Marsha Walker, RN, IBCLC, is the executive director of the National Alliance for Breastfeeding Advocacy: Research, Education, and Legal Branch (NABA REAL) in Weston, MA. She serves on the board of directors of the Massachusetts Breastfeeding Coalition and Baby-Friendly USA.

Table 2. The Ten Steps to Successful Breastfeeding

1. Maintain and routinely communicate a written breastfeeding policy to all health care staff.
2. Train all health care staff in skills necessary to implement this policy.
3. Inform all pregnant women about the benefits and management of breastfeeding.
4. Help mothers initiate breastfeeding within 1 hour of birth.
5. Show mothers how to breastfeed and how to maintain lactation, even if they are separated from their infants.
6. Give infants no food or drink other than breast milk, unless medically indicated.
7. Practice “rooming in”—allow mothers and infants to remain together 24 hours a day.
8. Encourage unrestricted breastfeeding.
9. Give no pacifiers or artificial nipples to breastfeeding infants.
10. Foster the establishment of breastfeeding support groups and refer mothers to them on discharge from the hospital or clinic

Source: WHO and UNICEF.²⁶

duration of breastfeeding, especially with mothers who have uncertain or short breastfeeding goals.²¹

No Gifts or Personal Samples to Health Workers

Gifts form the basis of building relationships between clinicians and formula companies. Even small gifts work to promote friendly and cooperative relationships with the manufacturer, whose primary duty is to its shareholders. This conflicts with the primary obligation of clinicians, which is to act in the best interests of their patients.²² Formula salespeople often appear on maternity units with food. Eating together promotes a cozy and snug working relationship that removes professional barriers between vendors and health care professionals. When salespeople combine food with flattery, recipients tend to like them more, regardless of what it is they have to say.²³ Many professional societies rely on industry sponsorship from companies that violate the Code, creating the potential for a conflict of interest.

Additionally, other provisions of the Code restrict misleading claims and pictures of infants from being shown on formula can labels. All information provided to health workers should be scientific and factual. Most studies funded by a manufacturer report outcomes favorable to the sponsoring company.²⁴ The Code also contains 14 subsequent resolutions that close loopholes to prevent exploitation by the baby food industry.

Once the Code was set in motion, WHO's World Health Assembly continued with efforts to improve global breastfeeding rates. Recognizing that the quality of breastfeeding support in the hospital is crucial for mothers to meet their breastfeeding goals,²⁵ WHO and UNICEF issued a joint statement in 1989 entitled *Protection, Promotion and Support of Breastfeeding: The Ten Steps to Successful Breastfeeding*. This document calls on hospitals and healthcare facilities to adopt practices that encourage and protect breastfeeding by implementing ten interventions. The Ten Steps (Table 2) are a series of best practice standards describing a pattern of care where commonly found practices harmful to breastfeeding are replaced with evidence-based practices proven to improve breastfeeding outcomes.²⁶

THE INNOCENTI DECLARATION

The Innocenti Declaration was created by participants at the WHO/UNICEF policymakers' meeting on “Breastfeeding in the 1990s: A Global Initiative,” which was co-sponsored by the United States Agency for International Development (USAID) and the Swedish International Development Authority (SIDA) and held at the Spedale degli Innocenti, Florence, Italy, in 1990. The document was signed by the United States and set an international agenda, specifying targets that governments were to attain by 1995. These goals included establishing national breastfeeding coordinators and committees, ensuring appropriate maternity services (inspiring development of the Baby-Friendly Hospital Initiative), renewing efforts to implement the International Code of Marketing of Breast-milk Substitutes, and enacting imaginative legislation protecting the breastfeeding rights of working women. The World Alliance for Breastfeeding Action (WABA) was formed in 1991 to act on the Innocenti targets, specifically through large-scale social mobilization projects such as the annual World Breastfeeding Week.

While the US government has established breastfeeding objectives for the nation (Table 3), it has not implemented any of the Innocenti goals.²⁷ Breastfeeding advocates have worked to partially fulfill the ambitious targets. The National Alliance for Breastfeeding Advocacy (NABA) was formed in 1995, as the US member of the International Baby Food Action Network (IBFAN). NABA monitors violations to the Code within the US, reports them to relevant agencies, and provides suggestions for reducing the commercial barriers to breastfeeding that non-adherence to the Code creates.^{18,19} NABA works on advocacy issues at the federal level and facilitated the formation of the US Breastfeeding Committee (USBC) in 1998. The USBC is a collaborative partnership of more than 40 organizations working to protect, promote, and support breastfeeding in the United States by focusing on national policy issues. It fulfills the Innocenti goal for establishing a national breastfeeding committee. The American College of Nurse-Midwives has been a valued member from the beginning. Recent

Table 3. Healthy People 2010 Revised Breastfeeding Objective

Objective No.	Increase in Percentage of Mothers Who Breastfeed	1998 Baseline Unless Noted (%)	2010 Target (% of Mothers)
16-19a.	In early postpartum period	64	75
16-19b.	At 6 months	29	50
16-19c.	At 1 year	16	25
16-19d.	Exclusively through 3 months	43 (2002)	60
16-19e.	Exclusively through 6 months	13 (2002)	25

Source: Office of Disease Prevention and Health Promotion.²⁷

USBC projects include the convening of a national summit of state breastfeeding coalitions to advance state and local breastfeeding activities, and the provision of input into a model benefits plan that the National Business Group on Health has constructed for businesses as a recommendation of what health benefits should be covered or provided by employers. Breastfeeding recommendations include a \$2500 per child per year durable medical equipment credit for banked breast milk within the bounds of industry standard medical necessity criteria, and up to 5 lactation consultant visits per pregnancy (all women/all infants) provided by a primary care provider or international board certified lactation consultant (IBCLC).

No part of the Code is legislated in the United States; however, New York and Massachusetts include restrictions in their perinatal regulations regarding hospital distribution of commercial discharge bags. There is no federal legislation protecting the rights of breastfeeding women in the workforce, but a few states have versions of worksite protection laws.

THE BABY-FRIENDLY HOSPITAL INITIATIVE

The Baby-Friendly Hospital Initiative (BFHI), launched in 1991 by WHO and UNICEF, is a call to action for all maternity services, whether freestanding or in a hospital, to become centers of excellence in breastfeeding support. Maternity centers become accredited when they demonstrate that they meet the WHO/UNICEF criteria as a Baby-Friendly Hospital. In 1997, Healthy Children Project, Inc. formed Baby-Friendly USA as the non-profit organization that implements the Baby-Friendly Hospital Initiative in the United States. There are 56 hospitals and birthing centers in the US holding the Baby-Friendly certificate.

A maternity facility can be designated Baby-Friendly when it does not accept free or low-cost breast milk substitutes, does not provide feeding bottles or artificial nipples, and has implemented 10 specific steps to support successful breastfeeding. The Ten Steps address a major factor in the erosion of breastfeeding: maternity care practices that interfere with or are ineffective in supporting breastfeeding. Baby-Friendly hospitals support breastfeeding through education of health care providers

in maternity and neonatal services. Institutional changes in hospital practices are effective in increasing both initiation and duration of breastfeeding.²⁸ During the implementation of the BFHI in one inner city hospital, breastfeeding rates rose from 58% to 87%. Of interest was the increase among US-born African American mothers, whose breastfeeding rates rose from 34% to 74%.²⁹ A study conducted by researchers from several federal agencies surveyed 1085 new mothers about their hospital experience regarding the presence or absence of 5 of the Ten Steps (initiation of breastfeeding within 1 hour of birth, 24-hour rooming-in, no supplements, feeding on cue, and non-use of pacifiers). Only 7% of the mothers experienced all 5 steps. Those who experienced none of the steps were 8 times more likely to have discontinued breastfeeding before 6 weeks' postpartum. The more steps a mother experienced, the more likely she was to continue breastfeeding to 6 weeks and beyond. The major risk factors for early termination of breastfeeding were late initiation of breastfeeding and supplementing the baby.³⁰

The evidence-based breastfeeding management that the BFHI promotes is designed to improve exclusive breastfeeding rates at discharge, with exclusive breastfeeding during the first month being linked with a breastfeeding duration of longer than 6 months.³¹ Exclusive breastfeeding is an important concept, as babies who are mixed-fed or formula-fed tend to have increased rates of acute and chronic diseases and conditions, such as respiratory tract infections and otitis media.³² For each month of breastfeeding, there is a 4% decrease in the risk of being overweight in childhood.³³ Receiving no infant formula decreased overweight by 11%.³⁴ Researchers have shown consistent evidence of a relationship between breastfeeding and reduced risk of obesity, with a dose-response relationship (i.e., the higher the dose of breast milk the lower the incidence of overweight and obesity).³⁵

Misconceptions Regarding the BFHI

Mothers Will Be Forced to Breastfeed

The BFHI is not a coercive approach to improving breastfeeding rates, duration, and exclusivity. It is a

mechanism to remove barriers that occur in maternity facilities while educating staff in a series of best practices for breastfeeding management.

Babies Cannot Have Bottles

Non-medical formula supplementation is associated with early abandonment of breastfeeding. Two or more bottles before 20 hours of age can contribute to early weaning by 7 to 10 days postpartum.³⁶ Infants given non-medically indicated supplements in the first 48 hours of life or offered pacifiers are 2 to 3 times more likely to have suboptimal breastfeeding behaviors on days 3 and 7.³⁷ Supplemental feedings should only be given when a medical indication exists.³⁸ Mothers who exclusively bottle-feed are provided with formula for their infants and instructions on how to prepare, use, and feed formula to their baby.

BFHI Facilities Cannot Buy Formula

Formula can be purchased for about \$0.20 to \$0.50 per bottle. The cost of providing food for infants is passed on to the patient in the room and board charges, just like food on any other unit in the hospital. Formula manufacturers may claim that the hospital would have to pay exorbitant amounts of money based on a costing of other goods and services the hospital receives from the company, but this is not the case.³⁹

It Will Make Bottle-Feeding Mothers Feel Guilty

There are no data showing that bottle-feeding mothers in Baby-Friendly hospitals are adversely affected by birthing in such a setting. In a study of preterm mothers whose initial intent was to formula feed but subsequently initiated lactation following encouragement of neonatal intensive care unit (NICU) care providers, mothers denied feeling forced or pressured into breastfeeding by staff who presented an unequivocal message regarding the importance of breastfeeding.⁴⁰ Women who are subsequently made aware of the nutritional and immunological properties of human milk in relation to improved health outcomes often express anger and frustration with the health care professionals who failed to share this knowledge with them.⁴⁰ The health care provider has an ethical responsibility to avoid withholding information related to the non-evidence-based concern that to inform mothers of research-based options may make them feel guilty if they choose not to breastfeed.⁴¹

Clinicians Are Supposed to be Neutral on Infant Feeding

Inadequate, insensitive, or apathetic approaches to breastfeeding by health care providers often culminate in a downward spiral of frustration and weaning by 2 weeks. Mothers reporting that hospital staff expressed no preference regarding infant feeding were more likely to

be bottle-feeding at 6 weeks, especially if the mother's original intent was to breastfeed for less than 2 months.⁴²

Mothers Will Not Come to a Hospital Where they Cannot Get Their Free Discharge Bag

Most Baby-Friendly hospitals distribute their own gift bag, marketing the hospital's birthing services. The commercial discharge bag is not really free. It markets the most expensive brands of infant formula, resulting in a formula-feeding family paying approximately \$700 more to feed their baby the hospital-endorsed brand compared with store brand formulas. The mothers who purchase formula pay for the "free" gift bags. If a mother really wants this bag, she can call the toll-free number of the manufacturer and order one.

Benefits of the Baby-Friendly Status

Hospitals can experience numerous benefits by becoming Baby-Friendly. Many of the Ten Steps are easily adaptable as quality improvement projects. The Joint Commission, which accredits US health care organizations, looks favorably upon voluntary efforts to improve patient care and services. Hospitals may benefit from cost containment because increased breastfeeding rates can have impact on many health care costs, such as reducing emergency department visits. Insurers may engage in preferential referral to Baby-Friendly hospitals and increase their reimbursement to these hospitals because it reduces the costs of insuring babies who use less health care services. One study looked at the excess costs of office visits, hospitalizations, and prescriptions for three common childhood illness (otitis media, gastrointestinal illness, and lower respiratory illness) in formula-fed infants compared with infants exclusively breastfed for 3 months. These additional services cost the insurers an extra \$331 to \$475 per never breastfed baby during the first year of life.⁴³ Insurers may therefore be more willing to increase reimbursement for in-hospital lactation services. Some insurers may institute pay for performance measures where BFHI status or adoption of specific steps or practices that result in longer duration and exclusivity of breastfeeding are reimbursed at higher levels. BFHI also presents an opportunity for favorable public relations and marketing. Families who feel adequately supported during the vulnerable postpartum days will return for other health care needs and serve as a community source for recommending the facility to others. Last but certainly not least, the BFHI award is very prestigious. The receipt of this international award engenders pride in both staff and administration.

CONCLUSION

Breastfeeding serves as the foundation of health, yet its exclusive practice is diminishing. Numerous international initiatives have been created to improve the initi-

Table 4. Clinician Actions**Hospital Actions**

Contact the Quality Improvement Department, perinatal practice committee, or similar group and begin the process of becoming a Baby-Friendly hospital.

Start to implement the Ten Steps, one at a time.

Work to eliminate commercial influences within the maternity unit.

Ask all formula company salespeople to adhere to the hospital's vendor policy.

Abandon the practice of distributing commercial discharge bags to new mothers.

Ask colleagues to remove formula company materials and gifts from their offices.

Community Actions

Join a state or local breastfeeding coalition as an individual, and ask professional organizations (e.g., ACNM state chapter) to join also.

Work on state legislation for worksite protection of breastfeeding.

Meet with state health insurers to improve coverage for lactation care and services in hospitals, in the outpatient setting, in offices and clinics, and in the community.

Review the state perinatal regulations. Ask the Department of Public Health to amend the regulations to include best breastfeeding management practices for hospitals and a prohibition on the hospital distribution of commercial discharge bags. Ask that these regulations require lactation management training for hospital staff and require that each hospital with maternity and newborn services have an International Board Certified Lactation Consultant on staff.

ation, duration, and exclusivity of breastfeeding throughout the world, and several US organizations are working towards these goals. There are a number of actions that clinicians can take to build on the foundation of these international initiatives and national organizations (Table 4). A renewed commitment in advocacy to remove breastfeeding barriers will have outcomes that last a lifetime.

REFERENCES

- Gartner LM, Morton J, Lawrence RA, Naylor AJ, O'Hare D, Schanler RJ, et al. Breastfeeding and the use of human milk. *Pediatr* 2005;115:496–506.
- Fildes V. *Breasts, bottles, and babies: A history of infant feeding*. Edinburgh, Scotland: Edinburgh University Press, 1986.
- Gartner LM, Stone C. Two thousand years of medical advice on breastfeeding: Comparison of Chinese and western texts. *Semin Perinatol* 1994;18:532–6.
- Gagnon AJ, Leduc G, Waghorn K, Yang H, Platt RW. In-hospital formula supplementation of healthy breastfeeding newborns. *J Hum Lact* 2005;21:397–405.
- Levenstein H. *Revolution at the table: The transforming of the American diet*. Berkeley, CA: University of California Press, 2003.
- Wolf JH. Low breastfeeding rates and public health in the United States. *Am J Pub Health* 2003;93:2000–10.
- Apple RD. The medicalization of infant feeding in the United States and New Zealand: Two countries, one experience. *J Hum Lact* 1994;10:31–7.
- Berney A. *Reforming the maternal breast: Infant feeding and American culture, 1870-1940 [dissertation]*. University of Delaware, 1998.
- Apple RD. *Mothers and medicine: A social history of infant feeding 1890-1950*. Madison, WI: University of Wisconsin Press, 1987.
- Wolf JH. The first generation of American pediatricians and their inadvertent legacy to breastfeeding. *Breastfeeding Medicine* 2006;1:172–7.
- Hausman BL. *Mother's milk: Breastfeeding controversies in American culture*. New York: Routledge, 2003.
- Breastfeeding Committee for Canada Web site. The international code of marketing of breastmilk substitutes and subsequent resolutions. Available from: www.breastfeedingcanada.ca/html/webdoc12.html [Accessed June 10, 2007].
- Simmer K. Longchain polyunsaturated fatty acid supplementation in infants born at term. *Cochrane Database Syst Rev* 2001;4:CD000376.
- Singhal A, Morley R, Cole TJ, Kennedy K, Sonksen P, Isaacs E, et al. Infant nutrition and stereoacuity at age 4-6 y. *Am J Clin Nutr* 2007;85:152–9.
- Wright K, Coverston C, Tiedeman M, Abegglen JA. Formula supplemented with docosahexaenoic acid (DHA) and arachidonic acid (ARA): A critical review of the research. *J Spec Pediatr Nurs* 2006;11:100–12.
- Guise JM, Palda V, Westhoff C, Chan BK, Helfand M, Lieu TA, et al. Effectiveness of primary care-based interventions to promote breastfeeding: Evidence and meta-analysis. *Ann Fam Med* 2003;1:70–8.
- Donnelly A, Snowden HM, Renfrew MJ, Woolridge MW. Commercial hospital discharge packs for breastfeeding women. *Cochrane Database Syst Rev* 2000;2:CD002075.
- Walker M. *Selling out mothers and babies: Marketing of breast milk substitutes in the USA*. Weston, MA: National Alliance for Breastfeeding Advocacy, 2001.
- Walker M. *Still selling out mothers and babies: Marketing of breast milk substitutes in the USA*. Weston, MA: National Alliance for Breastfeeding Advocacy, 2007 (in press).
- Howard CR, Howard FM, Weitzman ML. Infant formula distribution and advertising in pregnancy: A hospital survey. *Birth* 1994;21:14–9.
- Howard C, Howard F, Lawrence R, Andresen E, DeBlicke E, Weitzman M. Office prenatal formula advertising and its effect on breast-feeding patterns. *Obstet Gynecol* 2000;95:296–303.
- Moynihan R. Who pays for the pizza? Redefining the rela-

tionship between doctors and drug companies. *Br Med J* 2003;326:1189–92.

23. Katz D, Caplan AL, Merz JF. All gifts large and small: Toward an understanding of the ethics of pharmaceutical industry gift-giving. *Am J Bioethics* 2003;3:39–46.

24. Bekelman JE, Li Y, Gross CP. Scope and impact of financial conflicts of interest in biomedical research: A systematic review. *JAMA* 2003;289:454–65.

25. Kuan LW, Britto M, Decolongon J, Schoettker PJ, Atherton HD, Kotagal UR. Health system factors contributing to breastfeeding success. *Pediatrics* 1999;104:e28.

26. Philipp BL, Radford A. Baby-friendly: Snappy slogan or standard of care? *Arch Dis Child Fetal Neonatal Ed* 2006;91:F145–9.

27. Office of Disease Prevention and Health Promotion, US Department of Health and Human Services. Healthy People 2010 midcourse review: Maternal, infant, and child health. Available from: www.healthypeople.gov/data/midcourse/pdf/FA16.pdf [Accessed June 10, 2007].

28. Fairbank L, O'Meara S, Renfrew MJ, Woolridge M, Sowden AJ, Lister-Sharp D. A systematic review to evaluate the effectiveness of interventions to promote the initiation of breastfeeding. *Health Technol Assess* 2000;4:1–171.

29. Philipp BL, Merewood A, Miller LW, Chawla N, Murphy-Smith MM, Gomes JS, et al. Baby-Friendly Hospital Initiative improves breastfeeding initiation rates in a US hospital setting. *Pediatrics* 2001;108:677–81.

30. DiGirolamo AM, Grummer-Strawn LM, Fein S. Maternity care practices: Implications for breastfeeding. *Birth* 2001;28:94–100.

31. Piper S, Parks PL. Predicting the duration of lactation: Evidence from a national survey. *Birth* 1996;23:7–12.

32. Chantry CJ, Howard CR, Auinger P. Full breastfeeding duration and associated decrease in respiratory tract infection in US children. *Pediatrics* 2006;117:425–32.

33. Harder T, Bergmann R, Kallischnigg G, Plagemann A. Du-

ration of breastfeeding and risk of overweight: A meta-analysis. *Am J Epidemiol* 2005;162:1–7.

34. Taveras EM, Rifas-Shiman SL, Scanlon KS, Grummer-Strawn LM, Sherry B, Gillman MW. To what extent is the protective effect of breastfeeding on future overweight explained by decreased maternal feeding restriction? *Pediatrics* 2006;118:2341–8.

35. Owen CG, Martin RM, Whincup PH, Smith GD, Cook DG. Effect of infant feeding on the risk of obesity across the life course: A quantitative review of published evidence. *Pediatrics* 2005;115:1367–77.

36. Hall RT, Mercer AM, Teasley SL, McPherson DM, Simon SD, Santos SR, et al. A breast-feeding assessment score to evaluate the risk for cessation of breast-feeding by 7 to 10 days of age. *J Pediatr* 2002;141:659–64.

37. Dewey KG, Nommsen-Rivers LA, Heinig MJ, Cohen RJ. Risk factors for suboptimal infant breastfeeding behavior, delayed onset of lactation, and excess neonatal weight loss. *Pediatrics* 2003;112:607–19.

38. Academy of Breastfeeding Medicine. Protocol #3: Hospital guidelines for the use of supplementary feedings in the healthy term breastfed neonate. Available from: www.bfmed.org/ace-files/protocol/supplementation.pdf [Accessed June 10, 2007].

39. Merewood A, Philipp BL. Becoming Baby-Friendly: Overcoming the issue of accepting free formula. *J Hum Lact* 2000;16:279–82.

40. Miracle DJ, Meier PP, Bennett PA. Mothers' decisions to change from formula to mother's milk for very-low-birth-weight infants. *J Obstet Gynecol Neonatal Nurs* 2004;33:692–703.

41. Rodriguez NA, Miracle DJ, Meier PP. Sharing the science on human milk feedings with mothers of very-low-birth-weight infants. *J Obstet Gynecol Neonatal Nurs* 2005;34:109–19.

42. DiGirolamo AM, Grummer-Strawn LM, Fein SB. Do perceived attitudes of physicians and hospital staff affect breastfeeding decisions? *Birth* 2003;30:94–100.

43. Ball TM, Wright AL. Health care costs of formula-feeding in the first year of life. *Pediatrics* 1999;103:870–6.

The Breastfeeding Rights: With Apologies to Miranda

1. You have the right to remain breastfeeding.
2. Any breast milk you pump may be used if put in the refrigerator.
3. If you are under the age of 18, any time you breastfeed as a juvenile, your juvenile offspring can mature you and make you an adult, so that soon you will be breastfeeding as an adult.
4. You have the right to talk to a lactation consultant before giving up breastfeeding, for answering any questions.
5. You have the right to breastfeed your baby immediately after birth, during your La Leche League meetings and while meeting your lactation consultant during the questioning.
6. If you cannot afford a lactation consultant, one will be appointed for you without cost, before or during breastfeeding, if you desire.
7. Do you understand these rights?

Reprinted with permission from The Friends of Breastfeeding Society, *Compleat Mother Magazine*.