Moderator: Hello and welcome to Breast-Feeding Grand Rounds (BFGR) 2014. I'm Dr. Mary Applegate, the associate dean for public health practice at the University of Albany School of Public Health and I will be the moderator today. Before we get started, I’d like to ask that you please fill out the online evaluation at the end of the web cast, and we’ll ask you take the short post-test and as your feedback is helpful in the planning of future programs. We encourage you to let us know what topics are of interest to you and how we can best serve your needs. As for today’s program, we will be taking your questions throughout the hour. The toll free number is on your screen or you may send your written questions by e-mail. Please email us at any time at bfgr.ny@gmail.com.

It's a special pleasure to welcome you to our 20th annual breast-feeding ground round. Our program this morning has two parts. The first is on the international code of marketing of breast milk substitutes and the other half is about the Vermont WIC program’s experience promoting and supporting breast-feeding among their clients. With me in the studio is David Clark, an attorney from Unicef, where he played the key role in writing the international code. Ms. Tricia Cassi, the state-wide breastfeeding coordinator for Vermont’s Department of Health WIC program and Dr. Ruth Lawrence, the long-time star of breast feeding grand rounds a world class expert on breast-feeding, professor of pediatrics and obstetrics at the University of Rochester School of Medicine and Dentistry. Welcome to you and thank you all so much for being here.

Our focus today is on promoting hospital practices that support breast-feeding. We have talked about hospital practices on several past editions of Breast-Feeding Grand Rounds so you may be wondering why again? There is strong evidence for what happens around the time where the baby's birth has a profound impact on the likelihood the baby will be breast-fed and that breast feeding will continue throughout the first year of life as medical and public health experts recommend. That’s why we think it's worth revisiting this issue. Most of our past discussions of breast feeding promotion in the hospital setting have focused on hospitals implementation of UNICEFS 10 steps to successful breast feeding, one of the key component of the UNICEF world health organization’s baby friendly hospital initiative. We have spent much less time talking about the other key ingredient in the baby friendly recipe, the international code of marketing breast milk substitutes, known by its admirers as the code. By adhering to the requirements of the code, hospitals avoid letting artificial baby milk, aka infant formula or breast milk substitutes, reach families with their own subtle marketing messages that undermines the hospital's own breast feeding promotion efforts. For a refresher of the 10 steps I encourage you to visit the University Of Albany School Of Public Health Center for Continuing Public Health Educations extensive archives of past webcasts, particularly the 2006 and 2010 show. The 2006 featured Mr. Clark's former unicef colleague, Dr. Merriam Laback(?) and the 2010 show with the director of baby friendly USA, Patricia MacIntire.

Breast-feeding initiation rates across New York and nationwide are increasing, but there’s still work to do. A few years ago we finally reached the Healthy People 2010 goals for breast-feeding initiation, which was 75%. However, ever since the Department of Health and Human Services started setting healthy people objectives in the 1980, we are still falling far short of the Healthy People targets for exclusive breast-feeding which sets the stage for continued breast-feeding throughout the first six months and 12 months of life.

Serious disparities still exist in breast feeding rates between African-American, Caucasian, Hispanic and Asian women, between middle class and low income women, between women in western NY and the Hudson region and between Vermont and women in Mississippi and so on. There's plenty of progress we still need to make. During the second half of the broadcast, we'll hear Vermont’s successful efforts to improve breastfeeding exclusivity and continuation rates among the women served by their
WIC program, a population subgroup that has lagged behind much of the rest of the country for many years.

Let's talk with David Clark about the history and key provisions about the international code of marketing. So, David, we are going to take a two-tiered approach today to discussing how to increase breast-feeding rates. One area is looking at individuals in Vermont and how to encourage breast-feeding among or at the individual level. David we are excited to have you here to talk about the international code. Let's start first by hearing a little bit of the history of what went into the development, why the international code and the key components of this. So why do we even need to have an international code of marketing of breast milk substitutes?

David Clark: Well, you know, there's a multibillion baby food industry out there.

Moderator: We have heard.

David Clark: Yes. They would like to have as many women as possible give up breast-feeding and artificially feed their babies.

Moderator: As soon as possible.

David Clark: As soon as possible. So clearly the World Health Organization (WHO) pointed out that anybody in a market is there to increase the market for their product and that means less women breast-feeding and then they want to persuade you to buy their product. Since there are a finite number of babies out there, the more successful the industry is in persuading mothers to give up breast-feeding the bigger their market share. It's a very important to have something in place to stop this from happening.

Moderator: Are there reasons to believe promoting breast milk substitutes has a significant impact on the rates of breast-feeding?

David Clark: You would think it's obvious that when companies spend millions of dollars to try and advertise their products, it's going to have an impact. Studies show that exposure, mother's exposure to promotional tactics be it advertisements or free samples, has a negative impact on both the duration and the exclusivity of her breast-feeding.

Moderator: Much the same as we have seen with the smoking industry and the tobacco companies efforts to promote that through advertising.

David Clark: Exactly.

Moderator: As always, that industry is better funded than public health, but moving on and stopping that rant. Has there been research showing the relationship between the exposure of breast milk substitutes and rates of breast-feeding?

David Clark: There have been. They look specifically at exposure to advertisements in parent magazines and to the receipt of free gifts and samples and things like that. As I mentioned before, this is has a direct and negative effect on the duration and exclusivity of breast-feeding.

Moderator: Is this kind of promotion by the industry a new phenomenon that we are getting tuned into because it's new or is it something that's been going on for a long time and we are only now waking up to it?
David Clark: It's been going on for a very long time. In fact, I have some examples of advertisements from the early 20th century from the United States, Europe and from the industrialized countries where these products were developed, but, of course, as time went on, the companies looked for new markets and began to aggressively promote the products in the developing world.

Moderator: How long has it been recognized that breast milk substitutes are harmful to breastfeeding and to children's health here and throughout the world?

David Clark: We refer to a speech made by one of the child health pioneers, Dr. Cicely Williams in Singapore in 1939. She made a speech to the rotary club in Singapore which she called “Milk and Murder”.

Moderator: Not pulling any punches.

David Clark: Not pulling any punches. She was upset after years of working in developing countries in Africa and Asia and seeing the devastating consequences of this promotion of artificial feeding. She said misguided propaganda or advertising of infant feeding should be punished as the most serious form of sedition and should be referred to as murder. So 1939 is where we look back to and see somebody trying to bring the attention of the world to this issue.

Moderator: Decades and decades, we collectively have been aware of it it’s just that many of us have only in recent years have wakened up and realized this is a huge issue we need to deal with. Can you talk with us about some of the anti-formula campaigns in the 1970s and how they helped lead to the creation of the international code?

David Clark: Not a lot happened after the time that Cicely Williams spoke out. As time went on, more people became aware of this. In the 1960s, another pioneer, Dr Derek Jelliffe, coined the term of Commericiogenic Malnutrition that could be related back to the commercial activities of the formula companies. A big thing happened in the ’70s when a British charity published a brochure called "The Baby Killer" trying to show how this unethical promotion was killing babies. In Switzerland, a small group of students translated that into German. Instead of translating it as “the baby killer”, it was translated as “Nestle kills babies”. Of course Nestle was not happy about this and sued the group, which, strategically was not a great thing to do.

Moderator: Not great for Nestle.

David Clark: Not great for nestle. As soon as a multinational corporation is suing a bunch of students that obviously hit the press.

Moderator: it was way before YouTube, so they couldn't go viral.

David Clark: Right.

Moderator: Nestle did them a huge favor.

David Clark: Exactly, the students were taken to court, they were found guilty, the judge said you can't prove Nestle is going to kill babies. The judge only gave them a token fine. The judge said to nestles they would have to think fiercely about their marketing practices. That then led to hearings in the United States. In the meantime, there was a case where an order of nuns had filed a suit against Bristol Myers, the U.S. formula company.
Dr. Ruth Lawrence: That was not just a little order; it was nuns across the country in every hamlet and every town. There were very active protests.

David Clark: That’s great to know that it was so widespread and it certainly had an impact.

Dr. Ruth Lawrence: Including Rochester, New York.

Moderator: You were probably behind it as with so many things.

Dr. Ruth Lawrence: I was with it.

Moderator: All right.

David Clark: Well, that, in actual fact, rather than go through the whole thing or the court case, Bristol Myers settled and said they would not promote their products directly to the public. However that was not a great loss since they had a way to promote through the health care system. This eventually led to hearings in the U.S. senate that were chaired by senator Edward Kennedy, who actually brought the CEOs of these companies to try and hold them accountable. That’s where we hear for the first time, the talk about the need for some kind of regulatory mechanism at the international level. That eventually led to, in 1979, 40 years after Cicely Williams raised the alarm, there was a joint meeting with WHO and unicef.

Dr. Ruth Lawrence: At that hearing, because I happened to be there defending on behalf of the American Academy of Pediatrics. Nestle sat there and their representative cried and she spoke over the allotted time because Nestle had not been allowed into the market and the decision was, we have a free enterprise in this country. Ted Kennedy's committee said its okay, let them in. So we had a lot of work to do.

David Clark: Absolutely.so, this actually led to the decision to create the code and it was drafted by WHO with help from UNICEF, health experts, NGOs involved.in actual fact, the industry was involved in negotiating the code it's no perfect thing.

Moderator: So, what were some of the key provisions of the code?

David Clark: Well I think it was emphasized in the introductory part of the code.

Moderator: We hold these truths to be self-evident, that part?

David Clark: There they talk about the vulnerability of infants in the early months. I think it's very important because it's not just the risk of contamination of infant formula, but that newborns are very vulnerable. Their immune system is not up and running. If they are not getting their mother's breast milk, they are placed at risk. They spoke about the risks of inappropriate practices and inappropriate feeding practices. In all countries, not just the developing countries, they were talking about children being at risk when they are not breast-fed and therefore they were saying that the marketing of breast milk substitutes requires special treatment. Breast milk substitutes cannot be marketed or promoted in the same way as other products because of the risk they place to the health of our most vulnerable members of our communities and societies.

Moderator: We see this from the public health perspective, the mortality rate among infants in their first month of life, you don't reach another month-to-month mortality rate that high until people are in
their, I think 70s or 80s. It’s an extraordinarily vulnerable time of life, as you said. It’s a special population that needs the rest of us to protect them because they can't vote.

David Clark: Absolutely.

Moderator: What are some of the other key provisions of the code?

David Clark: Well, I can go through some of the key provisions and can give you some examples of the sorts of violations that are occurring, which I have collected and also have been collected by some of my NGO colleagues particularly on the international baby food action network from around the world. We have to remember, this code is a global recommendation to all governments and to incorporate the code into national legislation, the only way to hold companies accountable is when we have national legislation in place and the means to monitor and force and impose sanctions. That is what changes corporate behavior. Companies are urged and were part of the negotiation and agreed they would endeavor to ensure their practices, at all times, at all levels comply with the codes irrespective with what governments have done. We know they don't do that, they find all sorts of ways --

Moderator: They probably had their fingers crossed behind their backs when they said that.

David Clark: People say this code is, you know the code was developed in 1981 for goodness sake, it's so out of date, technology has changed, but the code is updated regularly every couple of years by the world health assembly with subsequent resolutions for the e-marketing practices or developments in science or whatever just to keep the code up to date. So it is current and it is up-to-date.

Moderator: It's obviously an extensive document; there are links to read the whole thing in its entirety. What are the key aspects you hope the audience will take to work with them today?

David Clark: I think the first one is that there should be no advertising or no other forms of promotion of breast milk substitutes to the general public. That is the number one take away from this, no advertising and I think I’m showing here a recent advertisement from Canada where you can see the way the company is really trying to equate breast-feeding and formula feeding as if they were exactly the same thing. That is not allowed under the code, you are not allowed to suggest that there is equivalency between infant formula and breast-feeding.

Moderator: They weren't good students, really.

David Clark: The other important one is there should be no samples. No free samples of infant formula to mothers because we know that that's an incredibly successful marketing tool.

Moderator: It undermines the mother's confidence in all kinds of ways.

David Clark: It undermines their confidence. If the sample is given in the health care center or setting then the mother thinks it's carrying the endorsement of the doctors and nurses.

Moderator: Right, I should be giving this to my baby.

David Clark: Yeah, I got it in the hospital therefore it must be good for the baby.

Moderator: my breast milk must isn’t enough, even if I am going to breast feed, I must give them some of this. We have seen that over and over again around New York.
David Clark: The next one is that there should be no promotion, no special promotions in shops or retail outlets. You don't want to have cut price formula, half off, two for the price of one. Where someone is making the decision to artificially feed their baby, they need to take into account that is going to be an expensive undertaking. If it's based on the fact that this week the formula is half price at the supermarket and next week, it's back up to you may not be able to buy sufficient amounts. There shouldn't be any type of endorsement in the shop. The slide had there, in china, for example, where the companies have a field day, if you bought six tins of formula; you got a paddling pool for your baby.

Moderator: Oh, what fun.

David Clark: These things are not allowed, but they happen around the world. The other thing is, there should be no gift giving to mothers, gifts that can promote the use of breast milk substitutes or feeding bottles or teeth. Of course, these gifts are a way to introduce the mother to the brand, to the company. What a wonderful company this is, it's giving me a cd or cute baby clothes. If any of these things are given in a hospital, which happens in some countries, again, the company is having the endorsement or the apparent endorsement of the health care system. One of the other things, we spoke of samples, giving the mother a small quantity to try out. One of the other things that is not allowed and was an incredibly marketing tactic was the provision of hospitals with as much free formula as they wanted.

Moderator: And provision of free formulas or kickbacks to the WIC program for many years, which is probably still in a lot of states.

David Clark: This is a good moneymaker for the companies. It's getting their brand of formula into the hospital. A very small investment, given the amount of time the mother is in the hospital. They get her hooked on that formula or her baby hooked on that formula and then you have a customer for six months or 12 months or even longer.

Moderator: Brand loyalty.

David Clark: Brand loyalty because again it is coming with the apparent endorsement of the hospital. It's such a good moneymaker that in some hospitals in New York and in Canada, companies were prepared not only to get the formula for free, but to pay hospitals to take their brand of formula. What a good sales technique that is or promotional technique. The next thing is that the code says the health care system should not be used for the promotion of breast milk substitutes, bottles or teethes. Again, companies try to find all sorts of ways to get their brand name, their product name seen in the hospital. People will then infer the endorsement by the hospital.so, this should not be allowed. I think -- you will see growth charts and all sorts of things with the familiar name, logo or whatever.

Moderator: We have a couple of roll in videos to show over the course of the morning. One of them is from Erie County where we spoke with folks from the Erie County web program and spoke of their challenges in breast-feeding rates and many of their successes as well. Let's go to that roll-in and hear what they had to say directly.

Catholic Charities Video: The mission of catholic charities is we are a catholic sponsored human service agency serving anyone in the need in the eight counties of western New York. We advocate for those who are in need, particularly those who are poor and most vulnerable so the work of WIC fits in perfectly with the mission of catholic charities. In 2009 when we started the WIC program here in Erie County, our breast feeding initiation rate was only 44% for our two counties. Now, in May of 2014, we are up to 62.3%. So in a short time we have had great success in increasing our breast-feeding rates. I think our biggest impact had to be our staff. We have a really fabulous, enthusiastic staff that is eager to
create change in the community. They help to empower our moms, to provide education for our moms and to be that support to give breast-feeding a try. Most of our moms didn't have family or friends that had ever breast-fed. So may have been their only support to even consider breast-feeding. Similar things we do that are maybe unique or different with our WIC program are that we have a very extensive peer counselor program. Every prenatal mom is paired with a peer counselor as soon as she is pregnant and in our WIC program. We have peer counselors who have twins and triplets, some peer counselors that speak Spanish. We have counselors that were teen moms themselves. We try to pair them up with someone who is like them. We also have cell phones for our counselors so moms can reach them outside of normal WIC hours. It's always Friday night at 8:00 when you have a question about your baby. At our agency, we support moms with breast-feeding in a non-judgmental atmosphere. We have a lot of support just within our agency as well as in the community.

We try to focus on mom's goals because it's not about us, of course we would want to see every mom breast-feed exclusively for a year, but that's not going to happen. If she's happy with breast-feeding for six months or six weeks, then that's what we want to help them achieve. It happens all the time that we get clients who are not interested in breast-feeding or have a lot of barriers and maybe not a lot of support at home and are maybe scared to try something new because all they know is formula feedings. At WIC, we can be their support. We are moms ourselves. We have breast-fed and been there and try to come across as their friend. We don't try to pressure them into breast-feeding. It's definitely their choice and we are there to support them and help educate and break down the barriers.

Some of the challenges we face are the high number of moms supplementing with formula in the hospital. Some of the physician misinformation that our moms receive are two of the biggest barriers with healthy moms exclusively breast-feeding and continuing to breast-feed. A couple of things we have done to overcome these barriers is we now have peer counselors visiting moms in the hospital. Four days a week, we have coverage at Buffalo’s Women and Children hospital where our peer counselors go and visit mothers with babies and moms there on bed-rest. It's a really great way to provide support and encouragement, talk about stomach, about skin to skin, nursing on demand. The lactation consultants at the hospital are very busy. They may have 25 to 30 mothers to see so it's nice that the peer counselors are there as well to provide extra support to the moms before they come home.

I think the turning point is when they want to try or they are open to the option of trying comes from knowing that they are not alone and that if they don't have the support at home, they have support through WIC. They have support at their pediatrician’s office, in the hospital; we have the peer counselors who are there at nighttime and on weekends. They have 24 hour support and they are not alone. It shouldn't be a scary thing. Just give it a shot. I always tell them, you have nothing to lose and the baby has everything to gain. Just try it, if you don't like it, no harm done.

End of Video Clip

Moderator: I always love hearing directly from people who are working with moms and babies about these issues. David, could you talk more about things that the companies do to insert themselves into the process even when they aren't actually giving out free formula to people?

David Clark: I think it's important to know that the code does address health workers and provides or places some responsibility on them to actually have an obligation to protect, promote and support breast-feeding. They are supposed to know their obligations under the code but we can't expect them to know it intuitively. We have to do a better job of informing them about the code, their responsibilities
and how the code can protect them from being manipulated by the formula companies within the health care system.

Moderator: What specifically does the code say to those health care workers?

David Clark: It basically says they should encourage and protect breast-feeding and should make themselves familiar with the code and their responsibilities under the code to prevent the companies coming between the mother and the baby, if you like with their subtle ways, particularly through the health care system to try and interrupt breast-feeding.

Moderator: If the companies can't make their move through health care institutions or through individual providers, what does the code say about their efforts, which we know are many and vary to get directly to mom?

David Clark: The code is actually clear on this, it wants to make sure there is a solid barrier between them and mothers, pregnant women and mothers. We want women to make fully informed decisions based on the up-to-date scientific information we have about the benefits of breast-feeding, the risks of not breast-feeding and the implications of not breast-feeding. So you don't want mothers to be ill advised on how to feed their babies by people with an interest in selling their product. The code is clear, there should be no direct or indirect contact between the companies or mothers.

Moderator: What do you mean by direct and indirect?

David Clark: Direct is the sales person coming directly to the mother or mailing things to them. Indirect, I would say covers things that are becoming very clear like putting up help lines of baby club numbers or that kind of thing. I think this is an indirect contact because the company claims that they didn't contact the mother, that the mother contacted them. They are reaching out with this number or club to join so they can get the mother's information, the age of the baby and send out samples or information to promote their products when the baby reaches those particular milestones.

Moderator: In these days of modern times, I'm sure there are websites and blogs written by unbiased moms sharing their experience raising babies that are actually written by the advertising directors at the formula companies.

David Clark: Absolutely, I think the companies discovered the new technology and use them better than we do especially because they have larger budgets than we do. In some countries new mothers are receiving promotional messages on their cell phones, for example.

Moderator: And being friended by companies who “want the best for their babies”, but really want the best for their bottom line.

David Clark: Absolutely.

Dr. Ruth Lawrence: Most communities, births are public information. There's a published list of births in the paper. So it's open.

Moderator: Open season on babies.

David Clark: That's right.

Moderator: What about gifts or free samples sent not to mothers, but to the health care providers?

David Clark: Well, the code allows health care providers to receive a sample of the products for the purposes of evaluation or for scientific research and of course this has been used as a means, as a loophole, because the company will, in fact, deliver many, many tins of samples to the doctor and they are distributed to mothers. That is not allowed.

Moderator: The camel's nose under the tent.

David Clark: Exactly. The other thing is giving of gifts; research now shows that it takes a very, very small gift to change the prescribing doctor's behavior. It's all about the creation of friendship, a feeling of dependency or the need to reciprocate and the companies know this. So there are two ways they want to get to the health professional with the gifts. One is creating this point of you scratch my back, I'll
Moderator: The other is by having the gifts with the company's name and logo in the hands of the doctor or midwife or nurse is carrying the endorsement of the company and getting its name to the mother or caregiver.

Moderator: What does the code say about the atmospherics, what the companies put on the packaging of baby formula, or other baby food products?

David Clark: In terms of formula, there shouldn't be any images or words that idealize the use of artificial feeding. There certainly should not be baby faces or infant faces on the packaging.

Moderator: Big chubby cheeks baby faces.

David Clark: Yeah, the packaging is part of the promotional strategy and having attractive, appealing looking labels obviously draws the attention of the purchaser and it's not allowed under the code.

Moderator: How about restrictions on the types of information provided to health care workers?

David Clark: Well, the health care workers are allowed to receive information about the products if it's restricted to scientific and factual information. But my slide here shows you what the companies consider to be scientific and factual. It's heavily promotional and very little scientific information in there. Of course, what happens is the company will provide the doctor with many, many copies of this and it will be used, it will get into the hands of mothers and be a promotion to mothers.

Moderator: Essentially, the code attempts to take on the full range of necessary of nefarious practices that the companies engage in and get rid of all of them.

David Clark: Yes, when it is implemented it actually does prevent unethical practices that undermine breast-feeding and promote artificial feeding and companies know this. They know that -- they worry about successful code implementation.

Moderator: What do you mean when you say they know it?

David Clark: They know that there's good code implementation that it impacts the sales of their products. We read in a marketing report that government regulation is a growing constraint. This is in the words of the industry and they are taking a rear guard action on a country by country basis to undermine the legislation that is either in place or is proposed.

Moderator: Again, huge parallels with the tobacco industry tactics. Please give us an example about how the code differs in different countries in terms of its level of enforcement and the impact of all that.

David Clark: I have a slide from your monitor report which shows the huge difference in the sales of infant formula in India which is the barely seen grey boxes at the bottom of the screen because the sale of infant formula has been stagnant for years because of a strong law in place and the government implements and enforces it and takes companies to court. The orange bars are the formula in China where there's no real regulation in place, no enforcement and the companies do pretty much what they like, for example offering a free paddling pool if you order six things of formula, which I referred to before, and you can see this in the sales of the formula.

Moderator: India has taken to heart the importance of widespread promotion of breast-feeding and tamping down the efforts to underline that.
David Clark: Exactly.

Dr. Ruth Lawrence: In Vietnam there is a campaign where nestle promoted coffee creamer and used all sort of baby images and everything.

Moderator: So people started feeding their babies coffee creamer?

Dr. Ruth Lawrence: Yes, because it was cheaper than formula and of course it has absolutely no nutrients at all.

David Clark: This was a problem in Lazo as well; in fact, the logo on the coffee creamer and the infant formula was almost identical. It was very, very difficult to distinguish. It took a lot of effort to get them to stop doing that.

Moderator: Unless you think like the formula companies, you would never dream of encouraging people to feed their babies coffee creamer. What are examples of victories that unicef and w.h.o. have had in taking down companies that have been practicing against the code? I'm sure you have some good pictures there.

David Clark: It's not actually unicef and w.h.o., it's the government that does it. We support the government in adopting the legislation and then it's the government that does that. I have a couple examples. In this example, in Botswana, they have been fierce in enforcing the codes and legislation. This is a billboard not for a brand of formula, but for an insurance company. They mistakenly thought they would use this image of a bottle feeding baby; however it was not code compliant. As soon as it was reported, they ripped it down. Another good way to tell where there has been success is the label of products because you can take the same take the labels of two countries and compare the labels. Here we have a Gerber package from Bangladesh. You cannot have a baby face on baby food products, you can only promote that product from the age of six months so not to undermine exclusive breast-feeding. You can see the product from Bangladesh in Malaysia, where they don't have a law, but instead they have an agreement with the company, the company puts the baby face on the product and promotes the same product for four month olds, undermining exclusive breastfeeding. So, I think it shows you how it can work.

Moderator: It's not just instant milk substitutes, these look like they are baby cereals and fruits, things that shouldn't be given to 2-month-old babies.

David Clark: Absolutely. A product is -- a cereal product promoted from four months is a breast milk substitute.

Moderator: It's going to push out the food the baby needs most. Based on evidence like these comparisons of marketing in Bangladesh and Malaysia which have, in the global scheme of things, fairly similar cultures, what are the recommended actions governments can take to enforce the code better?

David Clark: I think the important thing to do is to adopt legally enforceable regulations, which they are called upon to do from the code. The code says, you know, in doing this, they can turn to unicef and w.h.o. for assistance, we provide that assistance. What it doesn't say is for them to turn to the company itself for assistance in drafting the law. Companies are keen of that happening, but we don't want to have that happening.

Moderator: What progress has been made in getting the code implemented?
David Clark: In the last 20 years or so, there has been considerable growth. We now have about 90 countries around the world. You can see from this graph, the growth between 1991 and 2013. We have had a huge rise in the number of countries that have adopted the code about 99 have legislation covering all or most of the provisions of the code. However, how well they are monitored and enforced is another question. We are certainly making progress in terms of getting legislation adopted to help with the code.

Moderator: Government agencies are historically underfunded and probably don't have a team of code enforcement police. Is there a role for the health care provider sector in being those surrogate baby milk substitute police?

David Clark: Absolutely. I think the code says clearly that NGOs, professional groups, institutions and individuals all have a role to play in drawing attention where there are violations to the appropriate authorities and encouraging appropriate action to be taken. It can be done successfully. We have examples of very small NGOs finding a multinational corporation that is doing something wrong. They can make huge changes. The companies will try to get away with it if they feel they are not being checked or monitored. It only takes one small group to write a letter to the headquarters and inform w.h.o.

Moderator: And embarrass the big multinational if nothing else. What are the specific provisions in the code about health workers?

David Clark: Well, health workers have to encourage and protect breast-feeding. Clearly they should promote principles of the code. It is important for them to know about the code and that it can protect them and can give them the courage to say to formula a representative, “No, I’m not having this, I don’t want it, please leave me alone”. Governments health authorities need to give appropriate information and advice to health workers so they can carry out these -- again, remember health care facilities should not be used for the promotion of products covered by the code.

Moderator: We already talked about what government’s responsibilities are according to the world health assemblies’ recommendation. Let’s skip the next couple slides, we are falling behind, it’s so much fun to have conversation. What are some of the strategies that individuals and organizations can use to avoid these conflicts of interest and code violations?

David Clark: You know, there are all different types of sponsorship that come into play and can have an impact. The world health assembly said we should avoid any of these types of conflicts of interest. Things like gift items, meals, we should all bear in mind, there’s no such thing as a free lunch. Remember that. Help with conference expenses as I said before, creates a sense of obligation or a need to reciprocate. You know, it influences your attitude to the company and its product and we noted it as impact on the advice.

Ruth Lawrence: There’s no regulation against them exhibiting at medical meetings, right?

David Clark: They should -- they can exhibit at professional meetings if it's restricted to scientific and factual matters. It shouldn’t be used as a promotion, but we know that’s not the case. I have been to professional conferences and you can see the mascots like the blue bear. Somebody inside a bear suit that is not scientific and factual, but that’s the sort of thing that goes on.

Moderator: What do international professional organizations have to say in response to the code?
David Clark: You know, I think if we look to the -- if we look to the international pediatric association, they have guidelines, which say they should not accept the donation or will not accept donations from companies directly engaged in violations of the international code of marketing of breast milk substitutes. All the large, multinational baby food companies are involved in violations of the international code of marketing of breast milk substitutes. I have to say, however, when it comes to the national level, in some countries, the national pediatric associations are not following these guidelines and get lured into it. It's a serious matter that has to be resolved.

David Clark: It's wonderful to have the support of organizers. In India they have been strong there with their pediatric association has been very strong at cutting the ties and it has had an impact on the outcomes we saw from the slide on the formulas in India.

Moderator: Since legislatures around the world and governors and presidents and so on are heavily courted by the formula companies in their efforts to keep countries from having strong legislation, what can be done in the absence of legislation? We can't just throw up our hands and say we can't get a law passed, so we have to pack our bags and give up.

David Clark: I think, for example in New York City, Mayor Bloomberg, the previous mayor, he did this initiative where he stopped hospitals from handing out formula samples. That's one thing that can be done since it's a successful marketing tactic, why not start there? They had what they called the latch on initiative and I think they have already been seen some increase in hospitals taking part in one where breast-feeding increased from 39% to 68%. It's very clear that there are certain practices that can be dealt with in the hospital setting that can have a huge impact.

Moderator: Forced to do it by law that is are adamantly enforced hospitals on their own, individual practitioners on their own, all of us can play a role in this enforcement and adhering to the code better.

David Clark: Absolutely.

Moderator: Finally, what are the take away messages you would like our audience to take home with them and back to work with them when it comes to the code because time marches on and we need to move on to the individual level conversations about Vermont.

David Clark: There’s clear evidence that if we allow the companies to promote their products, this is going to have an impact on breast-feeding rates, a negative impact on breast-feeding. We know the health care system and health care workers are targeted as a channel for the promotion of breast milk substitutes. We have to protect our health care workers and mothers so they are not manipulated and used by the companies. The health workers need to be aware of the code and responsibilities and we know that successful code implementation can work and can protect mothers from the commercial pressures and enticements to give up breast-feeding so their babies will have the best start in life.

Moderator: That is the good news about the international code. Thank you for giving us this first person narrative about why the code, what it involves and what it means to the health of moms and babies around the world.
David Clark: My pleasure.

Moderator: Let's move now to the much smaller scale and turn to Tricia Cassi, a WIC coordinator from Vermont to talk about what you have been doing with your population in terms of increasing exclusivity and as a result continuity rates for breast-feeding.

Tricia Cassi: Thank you, WIC implemented a study that combined screening, targeted counseling and social marketing to better support our WIC mothers to reach their own breast-feeding goals. Before we start with that, I would like to start with some history because Vermont did not always have high breast-feeding rates. We started with 35% in the early 90s. Each implementation of the work we do in WIC, the work we do with our community partners inched the breast-feeding rates higher. Over time, we have seen a nice move until our exclusive breast-feeding rates are fairly good. We still have work to do as most states do. I think this graph shows the possibility of all the work and partnering with our community partners and health care providers that can make an impact at the local level.

Moderator: As I often said, to have a satisfying career in public health, graphs like that have to stir your heart and make you think yes, we did it, yes we can. That’s wonderful to see there was this steady upward movement, but with some significant up ticks when specific things started happening. I’m sure you will tell us about those.

Tricia Cassi: Yes, those programs really make a difference. Before the study, most moms do initiate breast-feeding in Vermont, but we did see a quick drop off. Many moms stop breast-feeding before they are ready to stop, that’s been a problem across the nation. I think we see that in Vermont and we see that in other states, too, New York included. For many of us, initiation can be high, then the drop off can

Moderator: Within a week or two.

Tricia Cassi: Yeah, it’s quite quick. We looked at the pregnancy risk assessment system (PRAMS) they included questions that got to the heart of this to ask about those practices that were successful breast-feeding practices.

Moderator: It helps you get under those sheer numbers and figure out why this is happening and what you can do about it.

Tricia Cassi: Right. That questionnaire showed us moms stop breast-feeding early on and similar, proportions of wick and non-wick moms reported stopping breast-feeding because of milk related issues. They stopped because they thought the baby wasn’t gaining weight or they believed that breast milk alone was not satisfying the baby. Some report they didn't make enough milk. Some of these comments hinted at the lack of knowledge of the importance of exclusive breast-feeding.

Moderator: And what to expect in those early days. It’s perfectly normal for the baby to want to eat every hour or two. This doesn't mean the baby isn't getting enough milk, it means the baby is helping you build up your milk supply.
Tricia Cassi: Absolutely. We realized we had to do more education in the prenatal period to teach moms these important concepts. We also know that both WIC and non-WIC moms reported reasons to stop breast-feeding that lacked professional support and confidence in their own breast-feeding skills. They stopped because of sore nipples or they had difficulty with nursing. As we see around the country, many moms stop because of going back to work or school because that can be a significant barrier.

Moderator: They confront, often, if not a hostile work environment to breast-feeding, at least a not a work environment that nurtures them and helps them continue to breastfeed after that transition.

Tricia Cassi: Right. Right.

Moderator: Did you find anything noteworthy in your review of PRAMS data? PRAM is known around the country, it is the CDC study that every state implements to one degree or another. Everybody in the listening audience has access to PRAM data about your own state or if you don't have access, find out who, in your health department does. Anyway, back to what I was going to ask, what noteworthy findings did you have about differences both real differences and perceived differences in the kind of support that was provided to mothers who were part of the WIC program and to the non-WIC mothers, the higher income moms in the state.

Tricia Cassi: The PRAM survey data also showed that WIC moms had different hospital experiences than non-WIC moms. When they responded to the questions that talked about the ten steps to successful breast-feeding and these are the foundation from the baby friendly hospital initiative. Compared to WIC mothers, mothers in the non-WIC program were less likely to report feeding the baby breast milk in the hospital. They were more likely to report receiving a gift of formula and more likely to report the baby using a pacifier in the hospital. They were less likely to report the baby rooming in with them and breast-feeding the baby in the hospital. They also talked about how hospital staff did not help them learn how to breast-feed and hospital staff did not always tell mom to feed on demand or on cue. Sometimes the hospital would not give phone numbers for follow up support which is really crucial in those early weeks when moms need extra help.

Moderator: Especially in the early hours and days when you are home by yourself and there's no owner's manual that came with the baby.

Tricia Cassi: This is self-reported data so that may limit the conclusions, but there may be some real differences in the support received and there were perceived differences in the support received from the hospital.

Moderator: In a case like this, perception is, I would say, 90% of the game, if the mother doesn't feel like she was given the support she needed in the hospital and in the days after she wasn't given the support she needed. Self-report is the key ingredient here. What troubles me is hearing the results is that the women in the WIC program are likely to be the women most in need of outside support systems because they are the women most likely not to come from generations of breast-feeding women, so they probably don't have their own mother, their own older sisters and aunts and cousins. They don't have a built-in support network helping them become a successful breast-feeder. They are even more
Tricia: Right a striking finding from the PRAM surveillance data is the low portion of WIC and non-WIC moms who agreed with the statement, I felt it was the right time to stop breast-feeding. So we know that moms want to breast-feed and yet, 3/4 of them begin weans before the time is right, that is a substantial amount of moms.

Moderator: We in the breast-feeding community are often accused of forcing women to do things they don't want to do. I think rightly in the past several years, we have moved to talking in the terms you are talking about helping women achieve their own personal breast-feeding goals. I don't know many people at all who say oh, yeah, I only want to breast-feed for a day or two, then get rid of it. Most women start out wanting to breast-feed for at least a matter of a month or two and often they want to breast-feed through the whole first year of life because they have heard it's the best thing for their baby and it is.

Tricia Cassi: Yes it certainly is. These moms do want to breast-feed and we need to help them get there. We developed a study that was designed to emphasize the importance of social and professional support. It also focused on breast-feeding knowledge for the moms and confidence so they could build this confidence and get the skills they needed to be successful with breast-feeding.

Moderator: What did you find were the key ingredients in maternal success?

Tricia Cassi: We found moms’ confident commitment was key. We looked at a paper from Alexis Avery and talked about the confidence in the mother's ability to make milk, how the biology works, her confidence in her ability to breast-feed. A belief she's going to breast-feed rather than I think I'm going to try, that makes a big difference.

Ruth Lawrence: It's interesting, way back in the '40s, breast-feeding is a confidence game so that’s where it originated from.

Tricia Cassi: It certainly did and we found this out to be very much true and the moms that had the confidence were more likely to succeed.

Moderator: It's a formula, as it were, of confidence plus adequate knowledge and support really goes to having successful breast-feeding experience. We have another roll-in coming up. this one involved staff and peer counselors and mothers from Harlem Hospital, which is one of the earliest hospitals in New York State to go baby friendly, not the first one on most people's list of places they would expect but they did. Let's look at the roll-in about the experience of the hospital and their WIC peer counselors.

Roll In Video Clip:

I'm Harriet Myers, the WIC director at Harlem Hospital. I oversee the program so I manage the core delivery group and make sure everything goes well. We wanted to be known as a breast-feeding WIC
program we are in a population, not just African-American, but we are Africans who migrated to America and we want to be able to support their transition. So we’ve managed to increase our breast-feeding rate doing several things and one of them was to first hire peer counselors and ultimately extend the peer counselors contact. So we increased our resident peer counselors’ hours and then we also hired more peer counselors. I think one of the key points in making it increase so rapidly is by hiring peer counselors who speak the language of the breast-feeding mothers.

Breast feeding coordinator means you have to be committed, you have to be decisive and you have to have an attitude to do this job. You have to trust your pcs and -- my job is to promote, support and encourage breast-feeding mothers. my goal is every mother that comes through the door to Harlem Hospital has to be referred to the breast-feeding peer counselor because after we see them, that’s where we go.

My name is Liza Rivera and I’m a breast-feeding counselor here at the WIC office. Basically, breast feeding counselors are here to help educate and support moms on breast-feeding decisions on their breast feeding journeys. Even if they don’t want to breast-feed, we are here to support them and just, you know, let them know the benefits are of breast-feeding and why they should try it. We like to let them know that some type of breast milk is better than none. We are here to help them. A lot of times they are scared to breast-feed because they hear horror stories from other moms so the first thing I let them know you have a head start because you have a pc here to help you.

I would say, you know, make sure your peer counselor can interact with the moms. Language barrier, make sure you hire according to your language barrier, your participants. Over here at this WIC office, we have moms that speak many languages because we are a mostly African community; we have two African peer counselors that speak different languages. You want to communicate with them and be experienced peer counselor so you know they can relate to the mom’s problems.

The lesson I learned is trust, you have to trust your participant, yourself, your staff and you have to hire committed peer counselors you have to have your vision, you have to have energy because when they see the energy that you are here to help.

With this approach, everyone has to be on board, not just the breast-feeding peer counselor or coordinator, but when we dieticians on all the support staff, being on board with the vision of the mission of the breast-feeding program. What we have is everybody streamlining all the breast-feeding participants, particularly pregnant women don’t like to sit in one place, they get hungry and things bother them very easily. We try to fast track them through. When we have everyone understanding and knowing this, we are able to fast track the breast-feeding, the pregnant women and breast-feeding mothers.

End Video Clip

Moderator: So, how did you and your wick colleagues in Vermont help women gain this confidence that they are talking about in Harlem?

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Tricia Cassi: We also looked at another paper from Paula Duncan she explored asset building as a way of improving adolescent health and we believed this similar approach could be used with mothers to help them reach their personal breast-feeding goals. The strength based approach for healthy adolescent choices is new moms need support and direction as they acquire and master skills and we wanted to help them do that. We know that raising awareness about what skills they might need will help her accomplish her own goals that way. We wanted her to build her confident commitment that seemed fundamental to reaching her own goals. We have the opportunity in WIC to do a lot of work in this prenatal period and we use peer counselors a lot and they help us work with the moms.

Moderator: You have talked about one of your own goals was not only to get women to change their perceptions about their own abilities, their own self-efficacy but you wanted them to look at WIC in a different way. Could you talk about that?

Tricia Cassi: We wanted to change the perception of WIC as a place to go for good breast feeding support, not just be the place to go for formula. We know to get moms past the first weeks, you know, to breast-feed for a long time; we need to get her breast-feeding at least for a few days and to help and support her in those early days.

Moderator: Just one day at a time and the more she does it, the more confident she’ll be.

Tricia Cassi: We developed a plan and we trained our staff. Our goal was that our staff would have some very good assessment skills so they could assess where mom is at. We wanted to assure that they would have referrals to community partners to who could support those moms, lactation consultants who would be able to support that mom with the knowledge she needs and also to recommend for the WIC certifiers (cpas) to promote our higher value food package. at the time we did our study, WIC had just introduced a brand new food package in 2009. this food package was perceived as having a higher benefit, often moms thought of WIC as the place to go for formula and that was perceived as having an economic benefit. We wanted to put in a whole policy change that introduced a new food packet so moms who were exclusively breast-feeding would have good quality foods, fresh fruits and vegetables and have it for a longer time so that created more value and perception.

Moderator: As friend of the show, Trish Macintyre, often says WIC has been engaged in an effort to transform your image to the world from being the formula people to being the breast-feeding people and we have seen around the country examples of how that has happened very successfully and Vermont is one of the shining examples of that.

Tricia Cassi: It really happens most successfully with peer counselors because they are the mom-to-mom support and they are the ones that really can help. We also worked a lot with peer counselors both prenatally and post-partum.

Ruth Lawrence: The peer counselor program was started 40 years ago by a WIC leader in Georgia, Wanda Grogan and she had the idea of a peer counselor that isn’t some medical person who comes in and tells you about it, but somebody who has been there. It’s been around the country 40 years.
Tricia Cassi: It makes such a difference. I started out as a leader and that was my original peer support group and they were wonderful.

Moderator: If you look at the lineup of the four of us sitting at the table, we would not be very effective in reaching out to a Haitian immigrant or a young 15-year-old mother whose own mother was 15 when she was born and she would hear what we have to say and throw it out. So, peer counselors, every one of us would agree that is one of the absolute keys. What are some of the other strategies?

Ruth Lawrence: And they should be paid, they aren’t volunteers.

Moderator: This should be a career ladder from that to being lactation consultants to IBCLC

Tricia Cassi: Right, right. Vermont does pay our peer counselors and we are very pleased about that.

Moderator: What were some of your other successful strategies?

Tricia Cassi: Well, we used two interrelated interventions because we also knew we needed to talk to physicians. We had two goals. Our first goal was to increase exclusive breast-feeding by 10% at four weeks post-partum. We figured if moms could make it to four weeks, they are more likely to continue for several more weeks, months or years. We decided to front load our intervention in the pre-natal period and see if it stuck by measuring breast-feeding rates at three and six months. We called this “You Can Do It”. Our second goal was to improve WICs reputation in the community as a sincere and credible partner of breast-feeding support especially among the OB, pediatric and family medicine providers. We called this intervention “WIC Can Help”. The intervention design included support from peer counselors at the time, we only had three offices with peer counselors so we used the study in those offices.

Moderator: So, “You Can Do It” and “WIC can help”, together create this combination of confidence, knowledge and support that's key to success, as we were saying earlier.

Tricia Cassi: That's right, that's right.

Moderator: When you start thinking about changing the WIC policies and changing WICs perception in the community, who did you get advice from about how to go about that?

Tricia Cassi: We talked with local area physicians and breast-feeding champions and worked with the staff in our local district offices so they could see that this intervention would work in their office and to make sure it could be implemented with the time and staffing available.

Moderator: So, going back to the “You Can Do It” program, what were the specific components of that?

Tricia Cassi: Well, we had a very much a prenatal time where we talked with moms a lot. We brought them in for that first enrollment and we did a screening. We used a screening tool the breast feeding nutrition attrition tools we screened mothers for risks and when they came back for mid pregnancy visit, we talked about the results of that and targeted the counseling to meet their needs we had a breast-feeding group they could attend, we invited their partners, their mothers, their mother-in-laws,
any family members that wanted to come and learn more about breast-feeding so this could be a group visit they could invite their friends and family along, if they wanted to.

Moderator: As we know, families support or lack of support can make a huge difference.

Tricia Cassi: Right. We also had some targeted social marketing materials for the moms to take home with them. Often they didn't have their partners and families with them. The social marketing materials bridged that gap and helped them. Post-partum mothers can receive three more contacts in the first four to six weeks and staff assessed mom's knowledge regarding the signs that her baby was getting enough to eat. A second screening was done by the WIC counselors to assess for risk of early weaning and also exclusively breast-feeding mothers received that immediate food package upgrade so they got the higher value food package.

Moderator: what were some of the demographics of the study population you were working with?

Tricia Cassi: Our study moms were more likely to have completed high school; they were more likely to be pregnant for the first time and more likely to have intentions to breast-feed.

Ruth Lawrence: Which matches all studies of socioeconomic, it’s so important.

Moderator: People who want to breast-feed are more interested in being part of a study about breast-feeding support than those thinking it seems like a bother, I won't.

Ruth Lawrence: Well education is an important part. It's not about -- it's not about money, it's about education.

Moderator: We are not talking a Ph.D in lactation science; we are talking a high school degree.

Tricia Cassi: the goal of our study is to increase exclusivity so we weren’t trying to convince the moms who wanted to formula feed that they ought to change their minds and switch to breast-feed. It was really to get the moms who wanted to breast-feed to do it longer and use exclusive breast-feeding rather than partial breast-feeding.

Moderator: What do you find about the women who didn't participate in the study who were part of the wick program at the same time?

Tricia Cassi: Two different groups. There were moms who had previous breast feeding experience and they felt they knew what they were doing and they didn’t need the intervention and other mothers were undecided and weren't sure about breast-feeding.

Moderator: What does the data show about the rates of exclusive breast-feeding over time related to the number of contacts you had with the mothers and between them and WIC staff?

Tricia Cassi: We found the more contacts we had, the better the results were. This included contacts with peer counselors, of course. It’s not just coming into WIC. Certainly, the peer counselors do a tremendous amount of heavy lifting for WIC so when we found that the mothers that had more contact
that came to more of these visits that spoke to their peer counselors more, breast-fed at higher rates than the mothers that did not. This was very successful.

Moderator: Very nice response curve there. We like to see this when we look at causation. You mentioned this breast-feeding attrition prediction tool. Could you tell us about that and whether other people can get it and where?

Tricia Cassi: The short name for it is the BAPT the screening tool was developed by Jill Jankey and there's a questionnaire that was revised by Sara Gill. This is a validated tool so if you do use this, you need to use these questions and not change them at all because this has been studied and it's tested and proven. During the prenatal certification visit, we screen study participants and we use this to help them predict whether they would be successful or not. It has three domains and it has questions about knowledge about how breast-feeding works and what to expect. It has questions about support from family, friends and professionals like a health care provider. There are questions about their confidence in the biology of breast-feeding and breast-feeding is a skill that can be learned.

Moderator: Can other people outside of Vermont use the tool?

Tricia Cassi: Yes you can write to us for that. Sara Gill has a version in Spanish that I believe New York WIC will adopt and use when they do this study also.

Moderator: Wonderful. At the end of the broadcast and in people's materials, they have your e-mail address. Are you the person to write to?

Tricia Cassi: They can write to me about that and I'll get that information to them.

Moderator: So, in the other half of the program, the WIC can help, what did you do to get the provider community more engaged?

Tricia Cassi: We went out with detailed visits similar to what the drug representatives do and David mentioned how gifts can make a huge impact. We thought we would bring gifts to them also. We brought a nice lunch for the providers. We met them during their lunch hour this was at the time when WIC had just brought out a new food package with fruits and vegetables and whole grains so we prepared a lunch using the WIC foods and that was really nice.

Ruth Lawrence: Well I was struck looking at this picture. This is very expensive cheese. This cheese and other things are much cheaper.

Moderator: They wanted to make a point.

Tricia Cassi: Yes. Yes.

Moderator: As we all know, the way to health care providers’ heart is through their stomach, so, we were following that guideline.
Tricia Cassi: We also brought them some resources. This was a study that was funded was part of the WIC special project grant so we had some money available to conduct this so we had some resources available to us that perhaps other agencies may not have.

Moderator: Other agencies could have applied for resources and replicate the whole thing.

Tricia Cassi: Absolutely, yes. There is certainly grant funding out there for much of this kind of work. We gave them copies of the breast-feeding answers and books and also Ruth Lawrence’s book.

Moderator: Yea, I was going to say that I thought that book in the middle looked familiar

Tricia Cassi: Those are resources you could offer your providers. The Well Start International Resource is free and that is available online and many physicians are using it.

Ruth Lawrence: You know the originator of that lives in Vermont.

Tricia Cassi: We certainly know that. We enticed her to come up because she's an amazing resource. We are grateful that she is in our area.

Moderator: She is a past star of breast-feeding grand rounds. Breast-feeding is the key part to emergency preparedness and emergency response.

Ruth Lawrence: She’s not a past star, she’s a living star. A shining star.

Tricia Cassi: She’s a shining star in Vermont that’s for sure.

Moderator: Other than those kinds of paper and print book resources, did you have electronic resources to offer people?

Tricia Cassi: Well, now more resources are available, at that time, they didn't have as many apps and things. At this point, we have apps for providers. The Texas Ten-Step program came out with a nice one for health care providers that is a great guide. We have one from the Massachusetts breast-feeding coalition they came out with a breast-feeding management app and Lac Med is a nice data base resource to find out what drugs may be compatible for mothers. Physicians may recommend apps for moms. We have a new app that is out there, the Coffective App is out there it’s a great resource for mothers to learn about breast feeding, to learn what to expect in the first days and it has information about what the perspective of her baby might be and how her partner and family can support her. That’s one of many, but there are others out there as well. There are apps for mothers and providers, lots of things for providers.

Moderator: The modern catch phrase is, there's an app for that and there is an app for that.tough be careful which app.

Ruth Lawrence: You do have to be careful looking at the apps

Moderator: Yes, you do have to be careful and make sure it doesn't have subliminal images. They try to make them look as much like the good guy apps as they can to trick us all into being part of them. The
New York statewide breast-feeding coalition and the New York WIC program have a wonderful website, but I don't think we have an app, yet. It's on the list of things to do when we have more time.

TC: And that is [http://www.breastfeedingpartners.org/](http://www.breastfeedingpartners.org/) we use that in Vermont to help train our WIC peer counselors. We think that is a wonderful resource and I would recommend any state to use that. It’s a good one.

Moderator: So, since we are engaged this morning in a program of continuing education, I’m naturally interested in hearing about what kinds of continuing education offerings you provide as part of your WIC Can Help efforts.

TC: Well after the initial detailed visit, we offered continuing education for the providers and their staff. We worked with physician champions MDs and IBCLCs we also worked with residents at the University of Vermont. They came and gave trainings to providers on things like how to increase milk supply and how to deal with sore nipples and breasts so we used the physician collaborative materials from Washington to do that.

Moderator: You mentioned a couple minutes ago there was a social marketing aspect to this, too. A couple years ago on this broadcast, I think it was 2008, but I might be wrong about that, it may have been 2005 we did a whole and breast-feeding, you can watch the 2005 episode. What kind of social marketing efforts did you do in Vermont?

TC: We developed materials that would help moms build confidence and address those needs of knowledge and social support, also. We used lots of materials, we developed many on our own like our breast-feeding checklist and we used materials from Texas WIC program and we used some materials for providers and others for mothers. They were quite successful. We are willing to share. That’s the nice thing about WIC when we do a program like this part of the research with the special project grants is you can develop a study and it is supposed to be transferable to other states. You can use your own materials, you don’t have to use ours, I think New York is doing that, they are using some of their own materials and combining them with ours.

RL: There are beautiful materials, I was telling Mary, the pictures are so gorgeous that people take them home for art. We have baby cafes, do you have baby cafes yet?

TC: Not in Vermont.

RL: We have them.

Moderator: I’m getting messages we are falling behind. Let’s cut to the chase and hear from you what were the results, what was the impact of this pair of studies you did?

TC: The goal was to increase breast-feeding interest by 10% and we exceeded that and that was really wonderful. At 4 weeks we increased exclusive breast feeding by 16% and at 3 months we increased extensive breast-feeding by 21% and at six months by 18%. This was tremendously successful.
Moderator: Beyond your wildest dreams, perhaps?

TC: It was, it was.

Moderator: so, when you compared the women who participated in your studies with the one who is were in the WIC program, not participating, what were the differences you saw there?

TC: For the moms, who declined to participate in the study, we could still follow them and we found that the mothers who participated in the study breast-fed exclusively at higher rates than the moms that declined to participate. So the study was effective.

Moderator: You mentioned earlier you prepared a lunch for the providers using the WIC food package. Could you talk about what the enhancements are to the package? I remember the old days when a breast-feeding mom got a pound of carrots and can of tuna fish, which was basically her enticement to breast-feed.

TC: We added more fruits and vegetables in this package and whole grains. The thing is it was a policy change. Mothers who planned on exclusively breast-feeding no longer received a can of formula in that first month so that was a policy change it was more than a food package, it was really, that's also what helped increase the breast-feeding rates. It was a policy change from WIC.

Moderator: giving them the subliminal message as well as the spoken message that you can do it, you don't need this formula stuff it will harm your efforts.so, go on and feed your baby the way mother nature wanted you to. So, as you have looked over time, what have you found comparing women who got the enhanced food package and policies and the women who also got the extra you can do it part of the program?

TC: We have a great chart to show this one. You will see that by just offering the food package alone, which did come with a policy change, of course, that did bump up the breast feeding rates-- when we layered that with the study with all these interventions that helped mom build that confidence and skills she needed, that's when we saw the biggest bump. We really increased the rates of exclusivity through the food package change and also through our study.

Moderator: Based on all these results, what recommendations do you have for the rest of us in what we should be doing during different stages of pregnancy?

TC: Definitely get out there and talk to your health care providers and let them know you are there and what support you use. If they know what you can do in WIC or what you can do in another agency, you can work together more. That's really helpful. In the first trimester, we screen for breast-feeding challenges and help moms talk to friends and family to help them understand this is what she really wants and to help her meet her own goals. In the second trimester, we provide that targeted counseling and found that the BAPT screening tool helped save a lot of time in our clinics because the counseling was more targeted. We also encouraged mothers to talk to their health care providers so they knew that they were all on the same page. In our third trimester, we had to breast-feeding group and we helped
her connect with her peer counselor to talk more about that and we recommended that they contact WIC as soon as their baby was born.

Moderator: Those all sound like excellent recommendations. We met with staff at Saint Barnabas Hospital WIC program in the Bronx. This is the third video roll-in. We wanted to hear about their approach and their recommendation for increasing breast-feeding. Let's go to roll-in number three and hear what they have to say.

Video Roll-in 3

My name is Maggie DuMont, I have been working at Saint Barnabas Hospital now for 31 years, for the last 13 years, I have been responsible for the Saint Barnabas WIC program. The population we serve has gone through a transitional phase where they used to be largely Hispanic, now we have Hispanics, African-American, Caribbean American, Africans and we have other populations. In keeping with our culture, breast-feeding is the norm. I am proud to say we have gone from an initiation rate of 78% in 2010 to the current rate of 90.5%. That is due to all of us supporting and promoting breast-feeding and that is from me the WIC Director and the six clerks.

My name is Magda Ramos and I am the breast-feeding coordinator at the Saint Barnabas Hospital WIC program. I have been here for about 20 years and as a breast-feeding coordinator for about five years. As a breast-feeding coordinator, we start discussing breast-feeding with our clients when they come in during that initial visit. We start probing as to this is the first pregnancy, have they thought about breast-feeding? If they have other children, did they breast-feed? Were they successful? Once you get an idea of where they are at, then it's easy to share information with our client. We want them to have a successful breast-feeding experience. What has contributed to our increase is our communication with staff. Not only myself with them, but staff communicating with me. I'll sometimes get a phone call from one of the staff members indicating we just got a mom and she’s fully breast-feeding or mostly breast-feeding, and a plan for the next visit. You get to hear the excitement from the staff when it happens.

>> I think the most important thing I would like to share with my colleagues in regards to our success and increasing our breast-feeding rates is that you need to listen to your clients, there are negatives and positives. Listen to your staff, support them in their needs, whether it's training or a listening ear. I believe that right now we are changing the trend from breast-feeding clients that have always been scared to breast-feed, scared of the pain to breast-feed to knowing that it is the best thing for their child. It will keep them healthy and strong and mothers always want to give their children the best that they have and that's breast-feeding.

End of Video Roll-in

Moderator: That was well said, mothers always want to give their babies the best and that is breast-feeding. We have heard three examples of WIC agencies around New York State and the success of the WIC program in Vermont. For people who want to get more information about these successful strategies, what online or other resources do you recommend for follow up refreshers?
TC: We have two online resources for, we have one for moms. Our “You Can Do It” page is an inspiration for moms with social marketing materials on there, videos from Amy Spangler that talks about the five things mothers and parents need to know for their babies. There are resources for health care providers, we have the birth and beyond ten-step project which is a curriculum you can use for training health care staff for the maternity practices.

Moderator: We are delighted that you have been here this morning and have been able to give us such a thorough introduction to the successful strategies you have been using in Vermont. We have a slide next of your contact information and people have that available both on the screen now and in the materials we have sent them. Any questions about WICs success in Vermont can be addressed to you. You also have your web addresses and all those good things. Just like good breast-feeding support providers in the hospital, we aren't leaving people just to go out and fend for themselves from now on. So, let's move on to the next part of the broadcast, which is, as always, at least a few minutes to answer questions that have been written in or phoned in by members of the audience. I'm sure that's one of the biggest draws that gets us to the literally over 1,000 people watching our broadcast these days. We have come a long way in the past 20 years Dr. Lawrence. I have a sheet of questions. We probably won't get to all of them, but let's get started. Here is a call from Florida. Hospitals still get out formulas to newborns, can you review the guidelines? Is there anything we need to say that we haven't said before that people can't just go back and re-listen to the broadcast?

DC: In terms of recommendations from the international code this is an absolute no. It's an incredibly harmful practice. These need to be translated into regulation at the national level to put a stop to it.

TC: I would say training the hospital staff, getting everybody on the same page with breast-feeding is helpful. That's why we did the “Birth and Beyond Project”.

RL: There are programs in Florida. Look to your friends down there.

Moderator: Right. Look to the left and the right, somebody has an answer to this.

Moderator: A call from somewhere in New York, doesn't say where. What about parents signing up for books and magazines while there in the hospital, then formula companies sending formula to their houses. You talked about this is bit, David. That's a way they get their hands on you.

DC: Again, this is prohibited under the international code and in many countries. This is a sort of direct or indirect contact that is prohibited — we need to put a protection between the formula companies and the parents and again, that comes down to translating international code into national state.

RL: the magazines all have ads.

DC: Many of them have advertisements which are a violation.
Moderator: They are not that black and white plain texts, they are full of pictures of adorable babies smiling into their mommy's eyes while they are fed.

DC: One of the things we have a lot in these advertisements are they are made for the formulas and once again that's what the World Health Assembly said should not be allowed on foods for infants and children, including infant formula. The health claims, we know the only thing that will improve intelligence will improve immunity is breast-feeding. So, these claims made about these formulas should not be...

Moderator: False advertising, of the worst kind...of the baby killing kind.

Moderator: Here is an excellent question from North Carolina. How do peer counselors get funded? We do not get enough money from Wick nationally or at the state level to provide peer counselors, how does Vermont do that?

TC: we wish we had more funding. We don't. We do not have peer counselors in all local agencies, but we do have them in a number of them. Even the other agencies that don't have peer counselors are supposed to use this study and implement this in all districts. We are trying to provide the support. We are hoping it will become a core benefit in WIC and rolled out to every mother. It's not there yet. Vermont has to kick in money to support the counselors.

RL: Two other sources, one is local health department. We have had peer counselors in Rochester for many years. Unfortunately, when there's a budget cut, it's the first thing to go. Also grant support. Grant support is much more generous. The Kellogg foundation is supporting programs across the country.

Moderator: One of their big focus areas is on reducing disparities and peer counselors are a key strategy for reducing disparities as we heard from the WIC centers around the state. Another thing, Ruth and I admire you enormously for paying your peer counselors in Vermont. For many years in most agencies around the country and probably still today in most WIC agencies, peer counselors aren't paid. This doesn't mean it's absolutely free because you have to have somebody pay to coordinate the work of this vast -- peer counselors going out to work with women. You can't just say, okay, you are a peer counselor, go. It's not 100% free. It's amazing what a vast amount of volunteers from the heart work you get from breast-feeding mother who is have been -- especially those who have been helped by peer counselors themselves. You said you got started as a leader. My first entry into the world of breast-feeding promotion after my daughter was born 29 years ago was, I got involved in a group called the nursing mother's counselor, which is a hospital based version of aging, which is more community based. There were 30 of us and we took turns every day one of us would go to the hospital and meet with all her women who had given birth in the past 24 hours and provide that warm line of support. Make sure they had the answers they need. So, that was 100% volunteer effort. So, it really is astonishing the amount of volunteer community service that goes into promoting breast-feeding. It doesn't take a ton of money.

RL: The other thing that peer counseling and paying them have in effect in our community was that these women, felt confident in breastfeeding but confident in themselves. They realized they were a
real person and worth something, they got paid. The turnover was terrific. We kept having to train new ones because they went out and got a real job.

Moderator: Right right

RL: very important contribution to the community and the culture.

Moderator: Even when they were no longer on the payroll as official peer counselors, they were part of that community chain of support. So when they had sisters or cousins or neighbors who had babies in the normal course of chatting with them, they were doing their peer counselor mode.

TC: Trained peer counselors, they are going to promote and support breast-feeding for the rest of their lives. They will always do that, support their family and friends. We used to think of it as seeding the community when we trained the peer counselors and we knew there was high turnover sometimes and that was okay. They were still out there supporting moms, just no longer working for WIC.

Moderator: We have another phone call from somebody who says what about stores that sell information. I bought clothing at motherhood maternity and got bombarded by formula and diaper companies for months. They sell customer information. That kind of help we don't need. It’s humorous when somebody like me gets baby related presents for my daughter when she's pregnant and suddenly I start getting formula samples and stuff. I think you are so barking up the wrong tree…bring your sorry selves into the World Health Organization police and they will get you. What about finding practices on part of merchants who are selling your information for their own profit to formula companies and other places?

DC: It’s clearly against the codes; we have to remember what they said. Promotional tactics for other products when it comes to breast milk substitutes. These are things that risk a child's health development and even life at risk. It’s really sad people are thinking of ways to be able to get to parents and mothers with these samples. It’s really --

Moderator: it's like the cardiologist selling their patient information to tobacco companies so the tobacco companies can supply them with free samples just to help.

Moderator: This is a terrible one. Some hospitals in Florida have contracts with artificial baby milk companies. How is this allowed? Well, in a word, it isn’t. In two words, it isn't.

DC: The World Health Organization in the last few years, they brought up again and again the idea of conflict and interest and how to avoid that. Particularly in relation to maternity hospitals, the BFHI and when we’re dealing with the health of infants and young children.

Moderator: here is a question, specifically for Trisha Cassy. Will the screening test [BFAPT] breast-feeding attrition prediction test be available or will it discourage mothers with lower scores if the purpose is to identify them and get them more help.
Moderator: Notwithstanding counseling New paper good want resource where Cuomo that. Tomorrow that in TC: feed, RL: a public. game. number have have to yes, don't have to give some here. Good. Because is important of the app because is important of the app, this is the 20th edition of Grand Rounds. The other milestone that happened 20 years ago is that the New York State legislature passed the governor, father of our current governor, Mario Cuomo signed into law a section of the New York state civil rights law protecting the right to breast-feed in public. New York was the first of many states to pass the law. Here in the entirety, it's very short, is the right to breast-feed law. Not with standing, I love lawyer talk, we are happy your here, David. Notwithstanding a provision of law, you can breast-feed public or private where a mother is authorized to be irrespective of whether or not the nipple of the breast is covered during the breast-feeding. There you have it. The law in full, so, that means a woman can't go into an employee's only lounge and breast-feed, but the food court at a shopping mall, the back row in her child's kindergarten class, they are all fair game. One of the things that got this law passed was an act of civil disobedience. Now famous, the New York City subway caravan. It's become an annual tradition in NYC for the past two decades. Tomorrow is this year's caravan. There's time to get your ticket to the city and be part of it. It has involved many, many mothers and babies, thousands riding the rails together and nursing all the way. You don't have to have a nursing baby with you to participate, but it helps and you certainly have to be
nice to the nursing moms who are there. So, in celebration of this milestone and in recognition of the great distance we still have to travel, before this right is firmly established in the hearts and minds of all New Yorkers, not just in the law books, we send out a call months ago for breast-feeding supporters around the world to help us by creating as many origami paper cranes and sending them to Albany. 1000 origami were sent.

It's a gift in Japan to show a friend or family member they have many people watching their backs, thinking about them and wishing them well as they face an important and daunting task, whether it's making New York state a truly baby friendly state or writing a doctoral dissertation, hi, Michelle or a number of challenges we have ahead of us in this world. So, in celebration of this milestone, we have been collecting these cranes which have flown in, literally, from around the world. We have cranes from the Philippines, cranes from Korea, cranes from Germany, cranes from every corner of the United States. I'm not sure whether Alaska and Hawaii have participated, but maybe. Not everybody put their return addresses on their cranes. I looked up what a bunch of cranes is. It's not a flock, it is a siege of cranes. So we have an international siege of cranes flown in from all over to celebrate this occasion. The other major milestone this year is an even more significant one. It's the real reason why we made the cranes, but we wanted to have a cover story. That reason is our own Dr. Lawrence has a significant birthday coming up in a week and a half. So, with these cranes are for you.

RL: Oh, my goodness.

Moderator: Here they are Trisha, if you want to do the honors; you can dump them in her lap or just give them to her gracefully.

RL: I wish you all could see them.

Moderator: the WIC program we heard from in buffalo sent a whole canister of about a quart and a half full of these tiny, tiny little cranes. They are right there on the table. I can't imagine having to do them let alone the patience to fold one of them. I didn't count those, but I estimated there are about 200. We go. Roughly 1,000 paper cranes, maybe more, maybe fewer. There you go.

RL: Should i throw them?

Moderator: You can throw them. Throw them at the camera. Don't throw the basket.

RL: All right. More amazing ones at the bottom. Fabulous.

Moderator: Souvenirs for everybody who is here. After the broadcast, for anybody who is within driving distance of Albany, the four of us here will be going over to the school of public health in Rensselaer, New York for the meeting of the New York State breast feeding coalition. We will take the cranes along and everybody can take home a crane in honor of this auspicious occasion. I have been told there's a question in here that we really need to get to that has to do with HIV and breast-feeding. I’m not positive I will get to it it so let me read a question that I do know we wanted to get to. It's kind of a collection of questions wrapped in one. Maybe David, you could leaf through and see if you can find the HIV question while we are at it. It's possible it is embedded in here. Tracy Mitchell, director of
community health initiatives, in Rochester. When you say there should be no sales on formula, it seems like you are ignoring the privilege around breast-feeding. There are often Socio-economic reasons women cannot breast-feed, having to work in a job where breast-feeding is not supported and increased price in formula would do more harm than good for these families. This conversation is coming from a place that assumes breast-feeding is number one, easy. I’m breast-feeding right now and it's one of the hardest things I have ever done. The level of pain i experience is something i never expected. I got so much less sleep than if I formula fed was the only person who could feed my child. I woke up at 4:00 a.m. to pump enough in the morning to have enough milk to send to the child care center. Pumping takes 45 minutes each session, etc. cutting to the chase, we can post it on our website for everybody to read the whole thing.

We have found the HIV question.

It is not easy, free or supported. I’m doing it because of the level of shame put on people who do not breast-feed. I’m a proud feminist. I have no problem breast-feeding in public and haven't experienced any negative interactions due to breast-feeding; however I have experienced negative interactions when feeding my baby a bottle of breast milk. I would love to hear your thoughts on breast-feeding and societal shame. Without going into that, because we have a couple minutes left. How do we include HIV positive women in breast-feeding in 30 seconds?

DC: We know that with the use of antiretroviral, with them, exclusive breast-feeding has become much, much safer and in certain circumstances much, much better because of the risk of mortality, morbidity due to not breast-feeding. Again, it's the government's decision and as to the recommendation but we have come a long way, exclusive breast-feeding with antiretroviral it make it safer.

Moderator: You really wanted to say something in response.

DC: Let’s not get it confused, the code prohibits no promotion of breast substitutes. Breast milk substitutes can be sold in the supermarket. It’s not banning their availability or use; it's abandoning the promotion, the manipulation.

TC: As a lactation consultant, I work with moms who don't make a full milk supply for various reasons. We support them to provide as much breast milk as possible and supplement as needed.

Moderator: Not to interrupt, but I have to thank you David Clark from UNICEF, thank you Trisha Cassy from Vermont and thank you Ruth Lawrence from Rochester, the epicenter of all breast-feeding. Thank you and our viewing audience for joining us today. Please remember to fill out your evaluations online. Your feedback is always helpful in the development of programs in the future, continuing education credits are available but only for people who fill in the post test. Continuing education hours, CME and CHEZ credits you have to complete the evaluation. Information on upcoming web casts and health topics can be found on Facebook. Don't forget to like us on Facebook and stay in touch and stay up to date. This web cast will be available on demand at our website within two weeks of today's show along with a lot of the roll-ins on the YouTube channel. So, please join us for our next web cast from the school of public health on September 18th [cancer prevention through community based interventions]. I’m Mary
Applegate. Thank you for joining us. See you next year on breast-feeding number 21. We'll be old enough to vote, no, to drink and smoke. Yeah, but we won't.