

Roundtable report

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THE IMPORTANCE OF EARLY NUTRITION

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Midwives and health visitors met recently to explore why breastfeeding prevalence in the UK is low relative to similar countries around the world. They shared their experiences in overcoming barriers to breastfeeding and called for the tools needed to provide the best possible care for all mothers, regardless of how they choose to feed their babies.

THE PANEL...



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The Importance of Early Nutrition

A study published in *The Lancet* reported that only 34% of babies in the UK are receiving some breast milk at six months, compared with 49% in the US and 50% in Germany.¹ At 12 months this drops to 0.1% in the UK, compared with 27% in the US and 23% in Germany.

To gain an understanding of why prevalence is so low, delegates focused on why infant nutrition is a UK public health issue and what can be done to support appropriate infant nutrition, including breastfeeding.

Infant nutrition as a UK public health issue

All UK maternity, health visitor and neonatal support staff are required to achieve and maintain UNICEF Baby Food Initiative (BFI) accreditation. All midwives and health visitors (hereafter referred to as healthcare professionals) attending this roundtable were fully aware of the importance of nutritional **programming** of the infant in the first 1,000 days of life. They had a clear understanding of its importance in infant brain development, in understanding the baby cues that underpin responsive feeding, in bonding and skin-to-skin contact, and in the importance that quality and quantity of feeding in the first 1,000 days will have on the growth and development of the infant for years to come.

Healthcare professionals are also aware of the short-, medium- and long-term **benefits** of breastfeeding, for the mother as well as for the baby (see further reading on page 6). For the mother, a reduced risk of infection, as well as breast and ovarian cancers, and a strengthened emotional bond are three benefits in which healthcare professionals are well versed. They also know that breastfed infants will have fewer gastrointestinal and allergic problems than their formula-fed counterparts and are less likely to die

from sudden infant death syndrome. Of even greater significance to this group of healthcare professionals, breastfed infants are less likely to become obese as adults, and therefore less likely to develop medium- and long-term health conditions associated with obesity, such as diabetes and cardiovascular problems.

There was also awareness, understanding and agreement with **UK recommendations**, including those issued by the National Institute for Health and Care Excellence (NICE), which recommends that infants be breastfed exclusively for the first six months, and for up to two years as part of a complementary diet.² They were also aware of the 2018 British Dietetic Association (BDA) Breastfeeding Policy Statement, which recommends that “mothers should be supported to initiate and maintain exclusive breastfeeding from birth to around six months of age and from six months onwards breastfeeding should be supported alongside complementary foods for as long as the mother and infant wish to continue.”

Practical tips to overcome barriers to breastfeeding

Potential barriers were drawn from the experiences of the delegates and grouped into three categories, comprising factors pertaining to healthcare professionals, society and the mother/carer (see Box 1 on page 4). Of particular importance to the delegates were the following:

Midwives and health visitors

Delegates reported that they are not adequately alerted to the evidence-based research on which to base the advice of the mother/carer.

It is essential that midwives are able to discuss the benefits that breastfeeding brings to the infant in the short-, medium- and long-term with the mother during the antenatal visits. It is



Catherine Masterson

also vital that health visitors continue with support and advice through their supervision of women and infants in their care. Budgetary cuts that result in fewer midwives and health visitors inevitably result in a lower standard of care, making it difficult for them to discharge their responsibility to a level they consider professionally acceptable.

Society

Societal pressures and cultural factors that discourage breastfeeding in the home and in public are strong deterrents.

Mothers/carers

Physical and psychosocial difficulties in breastfeeding may be perceived as impossible to overcome.

Mothers may lack trust in their healthcare professionals or confidence in their advice. This may be fuelled by a lack of continuity between midwives and health visitors, and by mixed messages from healthcare professionals and manufacturers of formula milk. Mothers need a single, trusted source of advice they know they can trust.

Box 1. Potential barriers to breastfeeding

Factors pertaining to midwife/health visitor

- Some healthcare professionals who may not see advising on breastfeeding as their responsibility.
- Communication between healthcare professionals and mothers/carers impeded by language barriers.
- Healthcare professionals who are not alerted to evidence-based research on which to base their advice.
- Staff shortages resulting in midwives who lack the time to discuss the short-, medium- and long-term benefits of breastfeeding at the antenatal stage, when the mother is likely to be most receptive.
- Mixed messaging – mothers want a single source of advice that they know they can trust.
- Lack of continuity and communication between health visitors and midwives.

Societal factors

- Inadequate local community support (including peer support).
- Societal pressures and cultural values that discourage breastfeeding.

Factors pertaining to mother/carer

- Mothers/carers do not always listen to advice.
- Mothers may not have the time to breastfeed.
- Body image.
- Mother's perception of appropriate baby weight gain.
- Mother's lack of confidence that her baby is getting enough to eat, when volume cannot be measured.
- Physical difficulty in breastfeeding (undiagnosed tongue tie, inverted nipples, weak sucking, difficulty in latching, sleep deprivation).
- Psychological difficulty in breastfeeding (infant rejection, pressures to breastfeed, feelings of failure if not breastfeeding).
- Mothers'/carers' lack of trust in the midwife/health visitor and lack of confidence in the advice given.

The learning from this analysis of the potential barriers to breastfeeding was that they are multifaceted, lying within the structure of healthcare, societal and cultural norms, and pressures and expectations of the mother/carer. Delegates shortlisted their thoughts on **how these barriers might be overcome** (see Box 2), based on their own experience. Importantly, they unanimously believed that delivery of the following action points put forward in

Box 2. Overcoming barriers to breastfeeding

- Local services need to set priorities and address the questions: what can this service do that will have an impact on Public Health? Where are we going to invest our limited resources? How will investment in infant nutrition affect the burden of healthcare in the medium- and long-term? How many midwives and health visitors are required to deliver the service we choose to have? Will staffing levels allow sufficient time at the antenatal stage to advise mothers on the benefits of breastfeeding?
- Midwives and health visitors must find the time to observe feeding, to ensure any difficulties are addressed and that confidence is instilled in the mother.
- Trust is the cornerstone of optimal nutritional care. The healthcare professional must trust the source of the evidence base supporting breastfeeding, and mothers must trust the nutritional advice given by their healthcare professional.
- Communication between the healthcare professional and the mother (including the communication of evidence-based research) must be unambiguous, consistent, non-judgemental, delivered by the person the mother trusts, and at a time and in a form to suit the mother.
- Mothers who want peer support can be signposted to local gatherings, e.g. breastfeeding cafés, support groups.
- It is important to be realistic – breastfeeding is neither glamorous nor easy, and mothers must be under no illusions. Mothers are to be supported to persevere but, if it is the mother's decision to formula-feed, that decision must be respected.
- Responsibility for improving breastfeeding prevalence sits with the midwife, the health visitor and the mother, and, in the best interest of the infant, everybody should take it seriously.

the BDA Breastfeeding Policy Statement (and here stated) would substantially improve breastfeeding prevalence rates:

- *"Inclusion of breastfeeding in personal, social, health and economic education in schools"*
- *"UK government to legislate for employers to support breastfeeding through parental leave, feeding breaks and facilities suitable for breastfeeding or expressing breast milk"*
- *"Evaluated and structured local breastfeeding support"*
- *"The preservation of universal midwifery and health visiting services"*

- *"A UK-wide strategy to change negative societal attitudes to breastfeeding"*
- *"All maternity, health visitor, family nurse and neonatal services to achieve and maintain UNICEF Baby Friendly Initiative (BFI) accreditation in the UK"*
- *"Training for healthcare professionals to ensure they are aware of the support available for breastfeeding mothers"*

In summary, the relationship between the healthcare professional and the mother must be defined by a sense of realism of the difficulties the mother will face, a climate of trust, the instilling of confidence to the mother, and communication that is unambiguous, consistent and non-judgemental.

Role of breastmilk research in overcoming barriers

One of the ways to nurture trust and confidence in the mother/healthcare professional relationship is for the healthcare professional to maintain an awareness of the **evidence base**, the nutritional value of breastmilk and the research on its constituents.

There appear to be gaps in the levels of **awareness** of such research, including the breastfeeding prevalence rates cited at the beginning of this report. Some of the delegates receive updates from their trust breastfeeding leads but, for the most part, there is no acknowledged alerting service that feeds information through to healthcare professionals in a timely manner, in a format they find useful.

There are two gaps in the **communication** of breastmilk research: one between the originator of the research and the healthcare professional, and the other between the healthcare professional and mother. Both would ideally be provided in a digestible format,



Trish Lyall



Lovett Okeke

‘Responsive feeding is about baby cues’

– Lovett Okeke

containing key points in a style and use of language appropriate for the intended reader. The most effective time in which to communicate evidence-based research to the mother is before her baby is born, when she has the time and energy to be most receptive. Once the infant has been delivered, many potential barriers will assert themselves, which may be insurmountable if the mother is unable to sustain a conviction that breast is best.

When evidence-based education of the mother on the benefits of breastfeeding has run its course, there remains the issue of how to provide equitable infant nutritional care and advice for the mother who chooses not to breastfeed her baby.

Equitable care

One of the delegates discussed an internal three-month infant feeding audit that her trust recently completed. It reported that the trust had achieved over 80% on all standards relating to breastfeeding. However, this was far from the case regarding formula-fed infants, where the trust was failing (i.e. scoring less than 80%) on all six areas:

- Only 46% of mothers gave the first feed while in skin contact with their baby
- Only 41% of mothers were given appropriate information on correctly making up the feeds

- Only 72% of mothers knew when to feed their baby (i.e. when the baby displays feeding cues)
- Only 75% of mothers were advised to use breast milk for the first year
- Only 75% of mothers were given information on what enhances closeness and responsiveness to help baby feel secure and enhance brain development
- Only 62% of mothers had a discussion appropriate to needs about comforting and caring for the baby in the antenatal period.

It was the general consensus of the delegates that mothers who choose to formula-feed their babies are being failed by the system and that, in all the areas cited above, it is the responsibility of healthcare professionals to improve their provision of care.

The mother’s decision to formula-feed must be respected and guilt-free, but there is huge disparity in the quality and quantity of support, and information the women receive from their healthcare professionals when compared with women who breastfeed. It was the consensus that this is in urgent need of correcting, with whatever time and resources possible.

Breastfeeding prevalence in the UK is low, and all possible means must be found to raise it. But the best possible nutritional care is surely the right of every baby. Delegates contributed to a wish list of what they would like to see and have to improve the care they provide (see Box 3). One of them

Box 3. Midwife and health visitor wish list

- More time to spend with mothers to advise on early nutrition. (By this, it is meant that they would like to see midwifery and health visitor services staffed to such a degree as to allow more time in their schedules.)
- How to answer the single more frequently asked question from mothers who elect not to breastfeed: “which formula is best?” There is a conflict between what they are allowed to say, and what they perceive to be their duty of care toward all mothers.
- Online training and alerts on infant nutrition, from a trusted source.
- The removal of inconsistencies in the advice and recommendations given by various bodies (e.g. the National Institute of Health and Care Excellence, UNICEF, manufacturers).
- Rapid communication of evidence-based research from trusted sources so they have confidence in the advice they give mothers, and so they can package research findings in the language that mothers will appreciate and be able to understand.
- Greater peer support, for example, more opportunities to meet in roundtables such as this, to share and discuss challenges and opportunities regarding infant nutrition.
- Bottle-feeding cafés, as there are breast-feeding cafés, where peer support and expert advice could be on hand.
- Any information on formula-feeding that would enable midwives and health visitors to provide greater equality in infant nutritional care and support for mothers who breastfeed and those who choose not to.
- Greater equality of emphasis on the importance of early nutritional advice, regardless of how the mother chooses to feed her baby.

encapsulated the collective resolve of this group of professionals with the words:

“Let us make a big effort to ensure that we provide the best possible care for all mothers, regardless of how they choose to feed their baby.”

References

1. Victora CG, Bahl R, Barros AJD, et al. Breastfeeding in the 21st century: epidemiology, mechanisms, and lifelong effect. *Lancet*. 2016;387:475-90.
2. NICE. Maternal and child nutrition, Public health guideline [PH11]. 2008.

Further reading

[Baird J, Fisher D, Lucas P, et al. Being big or growing fast: systematic review of size and growth in infancy and later obesity. *BMJ*. 2005;331\(7522\):929.](#)

A systematic review of 24 studies found that larger size or a rapid phase of growth at a range of intervals during the first and second year of life predisposed to later obesity. The consistency of the associations observed between both infant size and growth, and later obesity, across a range of settings and time periods suggest that the association is robust even with limitations of varied definitions of outcome. This paper concluded that infants who are at the highest end of the distribution for weight or body mass index or who grow rapidly during infancy are at increased risk of subsequent obesity.

[The British Dietetic Association. Breastfeeding Policy Statement. 2018.](#)

In its strong support of breastfeeding, the British Dietetic Association has issued a policy statement that sets out its beliefs, its view on barriers to breastfeeding and a list of action points to drive the same quality and standard of care, regardless of feeding choice.

[Gale C, Logan KM, Santhakumaran S, et al. Effect of breastfeeding compared with formula feeding on infant body composition: a systematic review and meta-analysis. *Am J Clin Nutr*. 2012;95\(3\):656-69.](#)

A systematic review and meta-analysis of longitudinal and cross-sectional studies that were performed in infancy and examined body composition in vivo in relation to breastfeeding and formula feeding. Growth patterns differ between breastfed and formula-fed infants; by 12 months of age formula-fed infants weigh on average 400–600 g more than breastfed infants, with significantly higher fat-free mass than breastfed infants.

[Harder T, Bergmann R, Kallischnigg G, Plagemann A. Duration of breastfeeding and risk of overweight: a meta-analysis. *Am J Epidemiol*. 2005;162\(5\):397-403.](#)

A meta-analysis of 17 studies reporting duration of breastfeeding and risk of overweight. The duration of breastfeeding was inversely associated with the risk of overweight, and categorical analysis confirmed a dose-response association. The risk of overweight was seen to be reduced by 4% for each additional month of breastfeeding and benefits of breastfeeding are still apparent with partial or combination feeding. The definitions of overweight and age had no influence. The paper supports a dose-dependent association between longer duration of breastfeeding and decrease in risk of overweight.

[Koletzko B, Brands B, Poston L, et al. Early nutrition programming of long-term health. *Proc Nutr Soc*. 2012;71\(3\):371-78.](#)

Proceedings of the Nutrition Society Symposium on Early Nutrition Programming of Long Term Health – Evidence that excessive weight gain in pregnancy and/or rapid early infant weight gain leads to later obesity should help to formulate policies to reverse the increasing rates of childhood obesity and related disorders. Moreover, further research on dietary modifications in infancy, in particular relating to breast-feeding and complementary feeding practices, as well as novel compositional approaches to infant formula, can reduce the risk of obesity and related disorders in offspring.

[Koletzko B, von Kries R, Closa R, et al. Lower protein in infant formula is associated with lower weight up to age 2 y: a randomized clinical trial. *Am J Clin Nutr*. 2009;89\(6\):1836-45.](#)

The Childhood Obesity Project study is a double-blind, randomised, multicenter intervention trial. A total of 1,138 healthy term infants, in five European countries, were randomised to receive a higher or lower

protein content infant formula, or were breastfed for the first year of life. At 24 months, the average weight-for-length z-score in the lower protein formula group was lower than in the higher protein group and was similar to that of the breastfed reference group.

[Monteiro POA, Victora, CG, et al. Rapid growth in infancy and childhood and obesity in later life – a systematic review. *Obesity Reviews*. 2005;6\(2\):143-154.](#)

A systematic review of 16 studies addressing the role of rapid growth in infancy and childhood as possible determinants of overweight and obesity later in the life course. There was wide variability in the indicators used for defining rapid growth as well as overweight or obesity. The age range in which weight or adiposity was measured ranged from 3 to 70 years. In spite of differences in definitions used, 13 articles that reported on early rapid growth found significant associations with later overweight or adiposity. The most frequent definition for rapid growth in this review was a z-score change greater than 0.67 in weight for age between two different ages in childhood. Regarding obesity, the definition proposed by the International Obesity Task Force also appears to be most appropriate. This paper concluded that early growth is indeed associated with the prevalence of obesity later in the life course.

[NHS Digital. The 2010 Infant Feeding Survey. 2012.](#)

The Infant Feeding Survey (IFS) has been conducted every five years since 1975. The 2010 IFS was the eighth national survey of infant-feeding practices to be conducted. The main aim of the survey was to provide estimates on the incidence, prevalence, and duration of breastfeeding and other feeding practices adopted by mothers in the first 8–10 months after their baby was born.

The survey is based on an initial representative sample of mothers who were selected from all births registered during August and October 2010 in the UK. Three stages of data collection were conducted with Stage 1 being carried out when babies were around 4–10 weeks old, Stage 2 when they were around 4–6 months old, and Stage 3 when they were around 8–10 months old. A total of 10,768 mothers completed and returned all three questionnaires.

[Ong KK, Loos RJ. Rapid infancy weight gain and subsequent obesity: systematic reviews and hopeful suggestions. *Acta Paediatr*. 2006;95\(8\):904-8.](#)

A systematic review of 21 studies with data on the association between rapid infancy weight gain, up to age two years, and subsequent obesity risk. All 21 published studies found positive, statistically significant associations between weight gain in the first two years of life and later obesity. Rapid infancy weight gain is consistently associated with increased subsequent obesity risk, but the predictive ability of different weight gain cut-offs needs to be tested. The reviewers caution that we should be increasingly aware of current dietary practices that clearly lead to excess nutrition in infants who are not gaining weight poorly, such as the combination of formula-feeding and early introduction of solid foods.

[Owen CG, Martin RM, Whincup PH, et al. The effect of breastfeeding on mean body mass index throughout life: a quantitative review of published and unpublished observational evidence. *Am J Clin Nutr*. 2005;82\(6\):1298-307.](#)

A systematic review of published studies investigating the association between infant feeding and a measure of obesity or adiposity in later life, which was supplemented with data from unpublished sources. Analyses were based on the mean differences in BMI between subjects who were initially breastfed and those who were formula-fed. Mean BMI is lower among breastfed subjects. However, the difference is small and likely to be strongly influenced by publication bias and confounding factors. Promotion of breastfeeding, although important for other reasons, is not likely to reduce mean BMI.

Owen CG, Martin RM, Whincup PH, et al. Effect of infant feeding on the risk of obesity across the life course: a quantitative review of published evidence. *Pediatrics*. 2005;115(5):1367-77.

A systematic review of published studies investigating the association between infant feeding and a measure of obesity. Sixty-one studies met this criteria; of these, 28 (298,900 subjects) provided odds ratio estimates. In these studies, breastfeeding was associated with a reduced risk of obesity, compared with formula feeding. The inverse association between breastfeeding and obesity was particularly strong in 11 small studies of <500 subjects but was still apparent in larger studies of ≥500 subjects. In six studies that adjusted for all three major potential confounding factors (parental obesity, maternal smoking, and social class), the inverse association was reduced markedly (from an odds ratio of 0.86 to 0.93) but not abolished. A sensitivity analysis examining the potential impact of the results of 33 published studies (12,505 subjects) that did not provide odds ratios (mostly reporting no relationship between breastfeeding and obesity) showed little effect on the results. This paper concluded that initial breastfeeding protects against obesity in later life. However, a further review including large unpublished studies exploring the effect of confounding factors in more detail is needed.

Powe CE, Conklin-Brittann N. Infant Sex Predicts Milk Energy Content. *Am J Hum Biol*. 2010;22:50-4

The people behind this study quantified nutrient and energy content in the breast milk of 25 Massachusetts mothers with infants aged 2–5 months, and found that mothers of male infants produced milk that had 25% greater energy content than that of mothers of female infants. They postulate that this variation may account for greater rates of growth in male compared with female infants.

Savage JS, Birch LL, Marini M, et al. Effect of the INSIGHT Responsive Parenting Intervention on Rapid Infant Weight Gain and Overweight Status at Age 1 Year: A Randomized Clinical Trial. *JAMA Pediatr*. 2016;170(8):742-9.

The Intervention Nurses Start Infants Growing on Healthy Trajectories (INSIGHT) study is an ongoing randomised clinical trial comparing a Responsive Parenting intervention designed to prevent childhood obesity with a safety control. The study includes primiparous mother–newborn dyads (n = 291) and was conducted at the Penn State Milton S. Hershey Medical Centre, Hershey, Pennsylvania. At two weeks post-partum intervention materials were sent to the home and home visits at three weeks, 16 weeks, 28 weeks, and 40 weeks; a research centre visit occurred at one year. Intervention messages were around infant feeding, sleep hygiene, active social play, emotion regulation, and growth record education. The control group received a developmentally appropriate home safety intervention also delivered by nurse home visitors. Results showed that a Responsive Parenting intervention is associated with reduced rapid weight gain during the first six months after birth and overweight status at age one year.

Singhal A, Lucas A. Early origins of cardiovascular disease: is there a unifying hypothesis? *Lancet*. 2004;363(9421):1642-4.

The authors propose that an adverse long-term effect of faster growth is the common denominator for programming cardiovascular disease and suggest that this notion should be termed the 'postnatal growth acceleration hypothesis'. The effect of early growth and nutrition on later cardiovascular health is substantial. The 3 mm Hg reduction in diastolic blood pressure observed in infants fed a lower-nutrient (versus nutrient-enriched) diet is greater than all other non-pharmacological means of reducing blood pressure, including weight loss, salt restriction, and exercise. Lowering population-wide diastolic blood pressure by only 2 mm Hg was estimated to reduce

prevalence of hypertension by 17%, coronary heart disease by 6%, and stroke and transient ischaemic attacks by 15%, and prevent 10,000 cardiovascular events yearly in the USA alone.

Thakkar SK, Giuffrida F, Cristina CH, et al. Dynamics of Human milk Nutrient Composition of Women from Singapore with a Special Focus on Lipids. *Am J Hum Biol*. 2013;25:770-79

It has previously been reported that human milk composition changes with lactation stages and according to the gender of the infant. In this study, Thakkar and colleagues in Switzerland report that human milk for male infants compared with females at 120 days was higher for energy content and lipids by 24% and 39%, respectively. They also observed that other bioactive lipids such as linoleic acid, phospholipids and gangliosides were also significantly different based on gender.

Victoria CG, Bahl R, Barros A JD, et al. Breastfeeding in the 21st century: epidemiology, mechanisms, and lifelong effect. *Lancet*. 2016;387: 475–90.

This meta-analysis indicates protection against child infections and malocclusion, increases in intelligence, and probable reductions in overweight and diabetes. It did not find associations with allergic disorders such as asthma or with blood pressure or cholesterol, and noted an increase in tooth decay with longer periods of breastfeeding. For nursing women, breastfeeding gave protection against breast cancer and improved birth spacing. It may also protect against ovarian cancer and type 2 diabetes. Recent epidemiological and biological findings from the past decade expand on the known benefits of breastfeeding for women and children, whether they are rich or poor.

Victoria CG, Bahl R, Barros A JD, et al. Breastfeeding in the 21st century: epidemiology, mechanisms, and lifelong effect. *Lancet*. 2016;387(S1):475–90.

Supplement: [https://www.thelancet.com/journals/lancet/article/PIIS0140-6736\(15\)01024-7/supplemental](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(15)01024-7/supplemental)

The importance of breastfeeding in low-income and middle-income countries is well recognised, but less consensus exists about its importance in high-income countries. An analysis of global breastfeeding prevalence reports that the UK lags behind both the USA and Germany in the percentage of babies receiving breast milk at six months (34%, compared with 49% and 50%, respectively) and 12 months. A total of 0.5% of babies receive any breastmilk at all, compared with 27% in the USA and 23% in Germany.

Weber M, Grote V, R Closa-Monasterolo, et al. Lower protein content in infant formula reduces BMI and obesity risk at school age: follow-up of a randomized trial. *Am J Clin Nutr*. 2014;99:1041–51.

A six-year follow-up of The Childhood Obesity Project found that infant formula with a lower protein content reduces BMI and obesity risk at school age. Avoidance of infant foods that provide excessive protein intakes could contribute to a reduction in childhood obesity.

WHO. Exclusive breastfeeding for six months best for babies everywhere. 2011.

Summary of the systematic review of the evidence on the "optimal duration of exclusive breastfeeding" (Kramer MS, Kakuma R. The Cochrane Library, 2009, Issue 4).

The systematic review's findings suggest exclusive breastfeeding of infants with only breast milk, and no other foods or liquids, for six months has several advantages over exclusive breastfeeding for 3–4 months followed by mixed breastfeeding.

IMPORTANT NOTICE: The World Health Organisation (WHO) has recommended that pregnant women and new mothers be informed on the benefits and superiority of breastfeeding – in particular the fact that it provides the best nutrition and protection from illness for babies. Mothers should be given guidance on the preparation for, and maintenance of, lactation, with special emphasis on the importance of a well-balanced diet both during pregnancy and after delivery.

Unnecessary introduction of partial bottle-feeding or other foods and drinks should be discouraged since it will have a negative effect on breastfeeding. Similarly, mothers should be warned of the difficulty of reversing a decision not to breastfeed. Before advising a mother to use an infant formula, she should be advised of the social and financial implications of her decision: for example, if a baby is exclusively bottle-fed, more than one can (400 g) per week will be needed, so the family circumstances and costs should be kept in mind. Mothers should be reminded that breast milk is not only the best, but also the most economical food for babies. If a decision to use an infant formula is taken, it is important to give instructions on correct preparation methods, emphasising that unboiled water, unsterilised bottles or incorrect dilution can all lead to illness.



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