Breastfeeding Support in Early Childhood Centres: Practice, Policy and Research

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Abstract

In this paper we provide a brief overview of the research evidence on the health and learning outcomes for children who are breastfed and look at national data on breastfeeding rates. This is followed by an overview of the evidence on the effects of breastfeeding for maternal health, women's participation in the labour market and family well-being. We then explore possible reasons for the apparent oversight of breastfeeding in early childhood research literature as well as in written guidelines and policies in early childhood centres. The paper concludes with an explanation of how breastfeeding support in the early childhood setting fits with the government's current goals of increasing participation in early childhood education, improving the quality of services, and promoting collaborative relationships with parents, families and others

Introduction

Across the early childhood education sector and within education policy there has been an absence of written information on why and how early childhood professionals should support breastfeeding. Yet, there is powerful evidence that, even in advanced economies such as New Zealand, infants are at increased risk of both poorer health *and* learning outcomes if they are not breastfed and that breastfeeding also provides mothers with increased protection against certain conditions, including breast cancer.

In April 2003 we released a report on an exploratory research study titled "*Developing Breastfeeding-Friendly Childcare to Support Mothers in Paid Employment and Studying*" (Farquhar & Galtry, 2003). This research was part of a larger study by Judith on workplace support for employees who were breastfeeding, funded by the Equal Employment Opportunities Contestable Fund administered by the Trust, the Department of Labour, and the Ministry of Women's Affairs (Galtry & Annandale, 2003). Judith had successfully argued with the Trust for the need to include an examination of breastfeeding in childcare services alongside that of workplace support for the reason that without effective child care support women's ability to continue breastfeeding is constrained. Judith asked Sarah who has a background in early childhood education to undertake case studies of two early childhood centres that supported breastfeeding. Together, we drafted a tentative set of guidelines for early childhood services to use.

Since the release of the report on *"Developing Breastfeeding-Friendly Childcare"*, we have received a lot of interest from groups and individuals in the health sector, and only a small number of requests from individuals in the early childhood education sector. Since the report's release, media attention has centred on the case of a mother who laid a formal complaint with the Humans Rights Commission after being told by early childhood centre staff on her son's second day at the Centre that he would not be allowed back if she breastfed him at the centre. This is not an isolated case, as our research identified the possibility that many more mothers are being directly and indirectly asked to decide between (a) giving up breastfeeding or breastfeeding in secrecy (e.g. taking baby down the road from their centre to breastfeed in the car), and (b) not enrolling in an early childhood service or delaying their return to work because they do not have adequate childcare support.

Breastfeeding Policy and Practice in New Zealand

Child health has been identified by the Ministry of Health as an area in which our country has a relatively poor record and the health of New Zealand's children is a priority area for improvement (Ministry of Health, 1998a, 1998b). Included amongst the key issues identified for child health is the need for a focus on the requirements of children in their first year of life, with breastfeeding central to this focus.

International recommendations advise exclusive breastfeeding (breastmilk only) for the first six months of a child's life and continued breastfeeding with appropriate complementary foods through to two years and beyond (World Health Organisation, 2002).

A major problem in this country is the high drop-off in breastfeeding from five to six weeks after birth. The Ministry of Health (2002) reports on the percentage of infants that are fully breastfed; that is, receive breastmilk only and no other liquids or solids aside from a minimal amount of water and prescribed medicines. As shown in Figure 1, there is a significant trend away from breastfeeding. The target age for continuing to breastfeed is at present 6 months. However, in 2002, Ministry of Health figures show that 13% of Maori, 17% of Pacific Island, and 21% of European or other infants were being fully breastfed at 6 months.

Health and Learning Outcomes for Children

There is an extensive body of research establishing the protective health effects of breastfeeding. According to a global epidemiological review, breastfeeding decreases the incidence and/or severity of diarrhoea, lower respiratory tract infection, otitis media (glue ear), blood poisoning, bacterial meningitis, necrotising enterocolitis (death of bowel tissue) and urinary tract infection (American Academy of Paediatrics, 1997; Bartle, 2002). Maori and Pacific infants and young children are

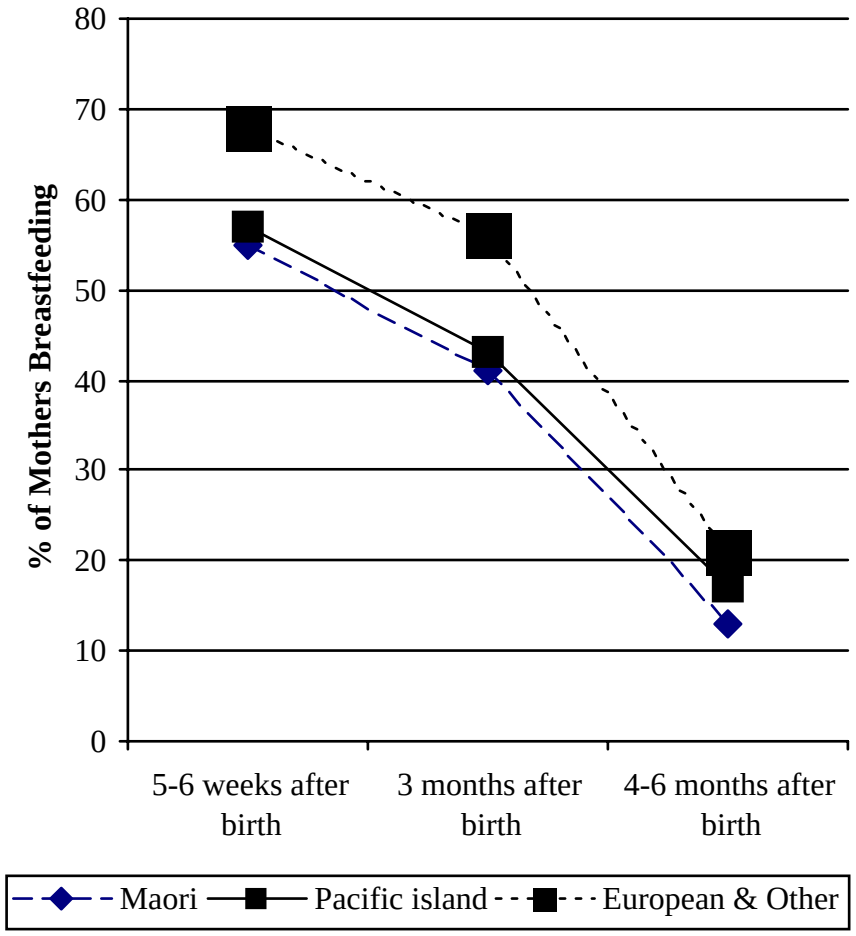

Figure 1. Maintenance of breastfeeding after the birth of an infant (Ministry of Health, 2002).

more at risk of conditions such as otitis media with effusion (glue ear), which, if repeated, can lead to hearing loss and subsequent learning difficulties (Public Health Commission, 1995).

Human breast milk also offers increased protection against sudden infant death syndrome (SIDS), Type I diabetes mellitus, Crohn's disease, lymphoma, ulcerative colitis, and allergic diseases. It is important that early childhood teachers know that breastfeeding is also associated with enhanced cognitive development in infants, as borne out by a range of studies including the Dunedin longitudinal study (Angelsen, Jacobsen & Bakketeig, 2001; Bartle, 2002; Horwood & Fergusson, 1988; Horwood, Darolow & Mogridge, 2001; Morley, Cole, Powell, & Lucas, 1988).

It is well documented that participation in early childhood education and care places children at greater risk of infectious illnesses, including respiratory illness, otitis media and gastrointestinal disease (Bedford, 2001; Galtry, 2002; Forssell, Hakansson, & Mansson, 2001; Matson, 1994; McCutcheon & Fitzgerald, 2001; Wald, Dashefsky, Byers, Guerra, & Taylor, 1998). Breastfeeding plays a potentially important role in reducing the severity, incidence and duration of infectious illness. This is an area however that has received relatively little attention in the New Zealand context (Galtry & Callister, 1995).

Breastfeeding, even for periods as short as three months, reduces the risk of otitis media (middle ear infection) among infants in early childhood centres (Duffy, Faden, Wasielewski, Wolf, & Krystofik, 1997). This association is strongest among infants who are breastfed exclusively and for longer durations. The implications of middle ear infections are potentially serious. While single episodes of otitis media usually have a good prognosis, repeated episodes may lead to conductive hearing loss in early childhood. This may, in turn, result in some forms of learning impairment such as poor reading and language development skills and, consequently, reduced levels of educational attainment (Galtry, 2002). The costs to society of otitis media are potentially high, given that language and educational skills are the fundamental building blocks for high levels of "human capital".

For children who are already at risk of poor health and education outcomes, due to factors such as low maternal education, parental lack of ability (including transport and knowledge) or willingness to access medical and child health services and low family income, breastfeeding and breastmilk can help to protect and provide a buffer against risk factors.

Benefits for Maternal Health, Women's Labour Market Participation, and Family Well-being

It is not only infants and children who benefit from breastfeeding. Breastfeeding also offers mothers increased protection against a range of illnesses as well as other potential advantages for themselves and their families.

Medical research has shown that not breastfeeding is associated with an increase in the risk of premenopausal breast cancer, ovarian cancer, osteoporosis and endometrial cancer in women (American Academy of Pediatrics, 1997). Psychology research shows that breastfeeding offers women advantages in enhancing their self-esteem and for enhanced bonding with their children (Labbok, 2001). Breastfeeding can be good for a mother's psychological health and enhance the quality of the parent-child relationship. Early childhood services that provide effective support for breastfeeding would therefore be good for women's physical and emotional health as well as supporting the mother-child bond which is important for effective parenting.

Whole families can benefit from early childhood services enabling mothers to continue with breastfeeding. Research shows that breastfed infants are less likely to be excluded from their early childhood centre on account of illness, medical costs are lower, and parents are less likely to take time off from work to care for sick children or to have to pay for alternative care (Jones, & Matheny, 1993; Schwartz, Giebink, Henderson, Reichler, Jereb, & Collet, 1994). Breastmilk is free and there are financial costs for families of artificial feeding or early weaning from breastmilk (Ball & Wright, 1999; Walker, 1993). A review of the influence of parental income on children's outcomes shows that family income is more important during the first few years than at any other stage of the child's life (Mayer, 2002). For some families, however, the choice is between ensuring income through the mother's early return to work – sometimes at the expense of breastfeeding if their childcare situation does not support its practice – and staying at home to breastfeed but finding themselves unable to make ends meet.

In New Zealand, as in most industrialised nations, childbearing women have increased their labour market participation in recent years. Department of Statistics figures indicate that in 1986, 21 percent of mothers with a child under one year old were in paid work. By 1991, this had risen to 23 percent; in 1996 to 31 percent; and, by 2001, to 34 percent. There has been an increasing focus in recent years on the need to accommodate breastfeeding/breastmilk expression in the workplace, including through the introduction of supportive employment policy (Galtry & Annandale, 2003). For instance, breastfeeding provided an important rationale for the introduction of paid parental leave legislation in 2002. These moves are progressive, signifying a growing acceptance of the realities and complexities of many women's lives.

Many New Zealand mothers nevertheless continue to be ineligible for paid parental leave. This is especially so for many low-income mothers, including many Måori and Pacific Island women. This group often has little option but to resume employment soon after the birth, despite any concerns regarding their own and their newborn's wellbeing (Callister & Podmore, 1995). It is important that all parents from all ethnic and socio-economic groups experience the same opportunity to breastfeed (Galtry, 1995 & 1997). This could be achieved through greater support and encouragement for breastfeeding in early childhood education services. A national survey of parents' childcare responsibilities showed that childcare availability and suitability has a major impact on women's employment and participation in study/training (Dept of Labour & NACEW, 1998). Recent years have witnessed an increased focus on breastfeeding as an employment concern, including in the area of "work-life balance" policy development (Ministry of Women's Affairs, 2002; New Zealand Council of Trade Unions, 2003). However, the links between breastfeeding practice and early childhood policies, practices and provision have not, as yet, been strongly identified.

Breastfeeding in the Early Childhood Sector: Deliberate Silence or Unintentional Oversight?

In the early childhood education sector there are no published guidelines for supporting breastfeeding in early childhood centre settings. Some centres obtain handouts and literature on breastfeeding from La Leche League and the Ministry of Health for parent libraries. But this material represents only a start towards telling parents that breastfeeding is acceptable from the early childhood centre perspective. Such written materials tend to cover only the practicalities and likely difficulties of breastfeeding for mothers. They are not specific to the informational needs of early childhood professionals in order to know how to support breastfeeding children and mothers effectively within the context of the early childhood centre setting.

The only reference to breastfeeding in official policy documents we could find was in the *Early Childhood Curriculum: Te Whariki* (Ministry of Education, 1996) which refers to the support of mothers who are breastfeeding as an example (i.e. not a requirement) to illustrate how services may encourage family involvement under the goal of "belonging". Breastfeeding is not discussed in the curriculum document in relation to children's learning and health. Effective breastfeeding support is not required for early childhood services in order to be licensed, chartered, and be government funded. In short, there is an absence of national policy, no consistent guidelines for early childhood services, and no collaboration between the Ministries of Health and Education on this matter.

The lack of interest in breastfeeding support shown by the early childhood education sector, education officials, and policy makers suggests that this is not considered to be an issue of relevance to the provision and quality of early childhood education services. Why is this? Perhaps most significantly, there has been a lack of overlap between research in early childhood education and in health both nationally and internationally (Galtry, 2002). Another possible reason is the historical link between the growth of childcare services and feminism. Mainstream feminist thinking has, in recent decades, tended to focus on promoting and facilitating women's employment outside the home, including among the mothers of infants and young children. Early childhood professionals may therefore view a stance to support breastfeeding as support for women being the full-time carers of their own children and not using an early childhood service. A further possible reason for this oversight is the inter-sectoral nature of the issue, with both the Ministries of Education and Health able to side-step their respective responsibilities in this regard, thereby also avoiding inevitable funding implications. Despite current concerns regarding the entrenchment of a "silo mentality" within various departments and ministries, spheres of operation and responsibilities tend to be narrowly envisaged by government agencies. Another possible reason is that supporting mothers to

breastfeed may be thought to be at odds with government initiatives to (a) increase the number of children in early childhood education, and (b) boost the number of women returning to the workforce through making childcare more financially accessible and available. In reply to these reasons we note:

1. That with the policy push to increase participation in early childhood education the need to support breastfeeding becomes even more urgent. There is a strong evidence base for the importance of breastfeeding for children's learning and children's and mother's health. Early childhood education should be about improving outcomes and creating health and learning promoting environments, rather than increasing risks for adverse outcomes.
2. That breastfeeding support is an issue that should concern feminists and those involved in advancing women's social, economic and physiological wellbeing. For many mothers the decision to resume employment will be influenced by, and even reliant upon, the degree of support provided for breastfeeding within their local or workplace early childhood services.

The Case for Breastfeeding-Friendly Policies and Practices in Early Childhood Education

The Strategic Plan for Early Childhood Education (Ministry of Education, 2002) states three main goals of increasing participation, improving quality, and promoting collaboration between services, with parents and families and others.

Participation of Children

There has been a considerable increase in enrolments of infants in early childhood education services. According to Ministry of Education statistics, between 1993 and 2003 there was a 47% increase in the number of under-ones (from 6,074 to 8,976) and a 53 % increase in the number of one-year-olds (from 14,708 to 22,611) enrolled in early childhood education. This increase in participation is considerably higher than the total population growth in New Zealand over the same period of 12.3 percent.

Current government policies are focussed on further increasing the participation rate of young children in early childhood education. This is a concern because of a lack of policy support, training for early childhood service staff, and resource information on breastfeeding support and on the correct storage and handling of expressed human breastmilk. It is also a concern because no data have been gathered on the impact of enrolment in an early childhood service on breastfeeding rates. Such data would be useful for policy advisers to consider in formulating strategies that both increase participation in early childhood education **and** promote optimal health and learning outcomes for children.

Centres that support breastfeeding encourage family involvement in early childhood education. Joyce (1999), for example, writes that she continued taking her son to Playcentre as soon as one week after the birth of a new sibling because she was allowed to breastfeed and the transportability (ease of) breastfeeding made going with a toddler and baby manageable. In our case study of two early childhood centres which supported breastfeeding (Farquhar & Galtry, 2003), a common theme was that enrolment is delayed, and breastfeeding is affected when parents do not know if they will receive support to breastfeed and whether teachers will allow them to provide expressed breastmilk to be given to their child. As illustrated in the following selection of quotes from parents, to increase participation in early childhood education it is important for early childhood services to communicate with parents and to make their support of breastfeeding known:

> If you know that a centre supports breastfeeding and you had to go to work, you would think "that's cool, I can carry on breastfeeding".
>
> You know how you can look up information about what to ask about childcare centres, and I never thought one of the questions could be "how do you feel about breastfeeding?". So I was going around all these centres asking all the proper questions and I never asked about the breastfeeding. I just thought they didn't do that or that you fitted it in when you could. If I had another child I would be asking that question.
>
> I didn't know the parents' room was available when I enrolled. Having the room available so that I can feed him before and after the session is very good for breastfeeding continuation.
>
> If I had known that you could leave bottles, I might have done things differently. When you come in to do the enrolment interview, maybe they could have a little talk with you, "Are you breastfeeding", "Would you like to keep breastfeeding". I think that would have been great. I probably would have come in not too early but (enrolled) a little earlier. I was lucky I had support (at home) but if I didn't have that I would have had to wean her off and go to work. (Farquhar & Galtry, 2003, p.15)

Quality

According to Joyce (1999), services should support breastfeeding as this reflects the principles and strands of the national curriculum, *Te Whariki* (Ministry of Education, 1996). By its very nature breastfeeding is holistic and providing support

for breastfeeding is a family and a community responsibility. It is also about relationships, the empowerment of children to learn and grow, and the empowerment of women and families to take care of their children. For children, breastfeeding meshes well with the curriculum strands of promoting wellbeing, belonging, contribution, communication and exploration (Joyce, 1999).

Our study shows there is a need for early childhood teachers to know how to effectively support breastfeeding in the centre setting (Farquhar & Galtry, 2003). Misconceptions about breastfeeding and uncertainties abound because teachers have not had training in this area. A clear distinction also has to be drawn between ensuring that teachers are trained in supporting not only breastfeeding *per se* but also the correct techniques for storing, preparing and feeding expressed breastmilk. This may be achieved through initial training and ongoing professional development, as well as by the promulgation of a national set of guidelines/standards to ensure a baseline of safe and consistent practices for breastfeeding support that parents can expect to experience at any early childhood service.

Collaboration

The development of breastfeeding-friendly policies and practices could go alongside a change of focus from disease prevention in early childhood services to health promotion. Health promoting early childhood services develop practices and maintain environments that promote the wellbeing of children and families (Hayden & MacDonald, 2000). Early childhood teachers are in a good position to support mothers to continue with breastfeeding and there are many ways they can do this (Canadian Child Care Federation, 2002). They are also in a position to collaborate with and make referrals to child health professionals, such as breastfeeding consultants and Plunket Nurses.

Target Goals for Breastfeeding

There are also strong health sector rationales for the promotion and support of breastfeeding in early childhood services. Not least of these are the government's target goals for increased breastfeeding rates.

In 2002, the Ministry of Health recommended the following New Zealand breastfeeding targets:

- To increase the breastfeeding (exclusive and fully) rate at 6 weeks to 74 percent by 2005, and 90 percent by 2010.
- To increase the breastfeeding (exclusive and fully) rate at 3 months to 57 percent by 2005, and 70 percent by 2010.
- To increase the breastfeeding (exclusive and fully) rate at 6 months to 21 percent by 2005, and 27 percent by 2010.

Further Research and Development of Guidelines

Our small exploratory study (Farquhar & Galtry, 2003) draws attention to breastfeeding support being an issue for early childhood education. The study provides some interesting questions and challenges such as how early childhood centres can reduce the cost of fees when mothers are present and breastfeeding – can mothers book their children in and out during the session or during the day? Clearly there is an urgent need for further research to look closely at the questions and challenges raised by the study, and to develop an evidence base that policy advisers and early childhood planners can be informed by.

A set of draft guidelines for breastfeeding support in early childhood centres has been proposed elsewhere (Farquhar & Galtry, 2003). These guidelines require development through research and consultation within the early childhood sector. This is a very new area of research for early childhood researchers and it is one where work is urgently needed for the reasons discussed, including:

- The rapid rise in the number of young children enrolled in early childhood services and government commitments to further increasing the number of places in early childhood education;
- The benefits of breastfeeding for children, mothers and families, and in turn society and the economy, and
- The need for early childhood professionals to know how to effectively support breastfeeding and the changes they can make in their practice and in their centre environment.

Conclusion

In this paper we have noted that support for breastfeeding is neither professionally nor officially recognised as important in early childhood services in New Zealand. Provisions, policies and practices to encourage and support breastfeeding in early childhood settings appear to be in their infancy and *ad hoc* (Farquhar & Galtry, 2003). We have identified several rationales that may explain this apparent oversight or silence. These include:

- the lack of overlap between early childhood education and health research, both nationally and internationally;
- the historical link between the growth of feminism and early childhood services;
- the intersectoral nature of the issue and hence its falling between the responsibility gaps of the Ministries of Education and Health; and, finally,

- the government's push towards increasing children's participation in early childhood education and the associated assumption that support for breastfeeding is antithetical to this.

We have further argued that when early childhood services support breastfeeding, women's re-entry to the workforce after having a baby is more likely to be enabled rather than hindered. Supportive childcare arrangements can be empowering for families, have positive health benefits for women and children, and be cognitively beneficial for children. It is therefore critical that there are mandatory professional development programmes or modules for early childhood teachers in the handling, storing and feeding of expressed breastmilk as well as in the necessary emotional and material support for breastfeeding in the context of the early childhood centre.

Breastfeeding does, however, have to be explicitly recognised and addressed as involving both a health and learning component. In New Zealand, early childhood education and care has always been very concerned with the education component. Many of the principles of *Te Whariki,* the New Zealand early childhood curriculum (Ministry of Education, 1996) are met by supporting breastfeeding in centres. Breastfeeding is another means of ensuring children get the best possible start in life to bring about optimal life long learning. Strong evidence in support of breastfeeding's importance for infants' cognitive development should also be harnessed to help ensure its progress on the early childhood policy agenda. There is a pressing need for further research to build on our small exploratory study and a need for sector-wide consultation and research of the draft guidelines (Farquhar & Galtry, 2003). The evidence presented here on the benefits for children, women and families should be taken up to bring about change towards the development and implementation of breastfeeding-friendly early childhood service policies, practices and environments.

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Dr Judith Galtry has extensive experience and publications in the area of breastfeeding and women's employment. In 2001-2 she was funded by Cornell University, New York to research the intersection of breastfeeding and employment as an international policy concern. Dr Sarah Farquhar has a background in early childhood education with an established record of research in the area. Both Judith and Sarah have had first hand experience as breastfeeding mothers who also worked/studied and needed childcare support.