

THE COMMITTEE ON THE RIGHTS OF THE CHILD

Session 61

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REPORT ON THE SITUATION OF INFANT AND YOUNG CHILD FEEDING IN CANADA



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1) Reporting to the CRC

Canada's 3rd and 4th combined periodic report will be reviewed by the CRC Committee at its 61st session, in September 2012. At the last review in 2003 (session 34), IBFAN presented an alternative report.

At the last review, the Committee addressed the issue of equal access to health services (Para. 35): *"The Committee recommends that the State Party undertake measures to ensure equal enjoyment of all children with the same quality of health services, with special attention to indigenous children and children in rural and remote areas."*

2) General situation concerning breastfeeding in Canada

While both breastfeeding initiation rates and exclusive rates for the first six months have generally been increasing across Canada over the past several decades, initiation, exclusive and sustained breastfeeding rates continue to remain far from optimal. More recent trends in breastfeeding practices are signalling that the percentage of mothers who breastfeed is stagnating rather than increasing (Table 1).

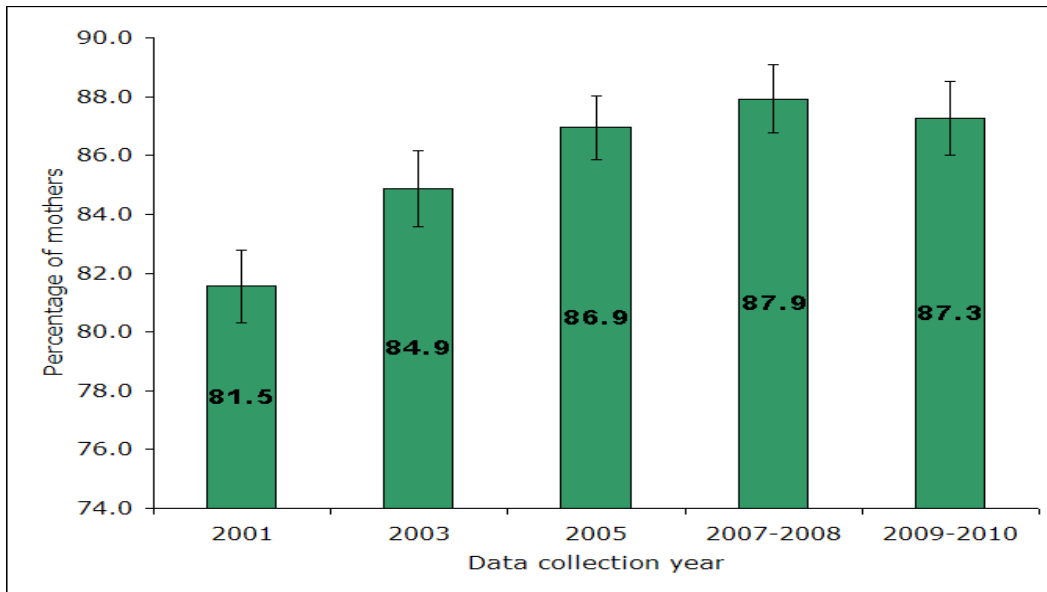
From 2000 to 2005, the latest Canadian Perinatal Health Report (2008) notes that the rates of breastfeeding initiation had increased steadily. By 2005, 87% of mothers who gave birth in the previous five years initiated breastfeeding, compared to 81.6% in 2000–2001. Similarly, rates of exclusive breastfeeding for at least six months had increased. For 2005, 16.4% of infants were breastfed exclusively for six months compared to 14.2% in 2003.

However recent data, from the Canadian Community Health Survey (CCHS) 2009-2010, (see Table 1) show no increase in rates between 2008 and 2010, in fact it shows a slight decline. Similarly exclusive breastfeeding outcomes shown in Table 2 are also of concern, demonstrating stagnation and indicating that Canada's breastfeeding rates remain far from the optimal recommended by Health Canada and the WHO/UNICEF Global Strategy for Infant and Young Child Feeding.

What is of considerable concern is the disparity in rates between Canada's Aboriginal and non Aboriginal populations (see Table 3). Canada's Aboriginal mothers have the lowest initiation rates compared to all mothers and to all other cultural and racial backgrounds. Housing, water and other economic, social and environmental conditions in First Nations communities significantly increases the health risks and outcomes for First Nations mothers and children when breastfeeding is not practiced.

The current CCHS 2009-2010 report also assessed the reasons for not breastfeeding or for early cessation. The predominant reason given for using infant formula was "mother has a medical condition", followed by bottle-feeding is easier and breastfeeding is unappealing.

Table 1: Percentage of mothers who breastfed or tried to breastfeed their last baby. 2001 to 2009-2010

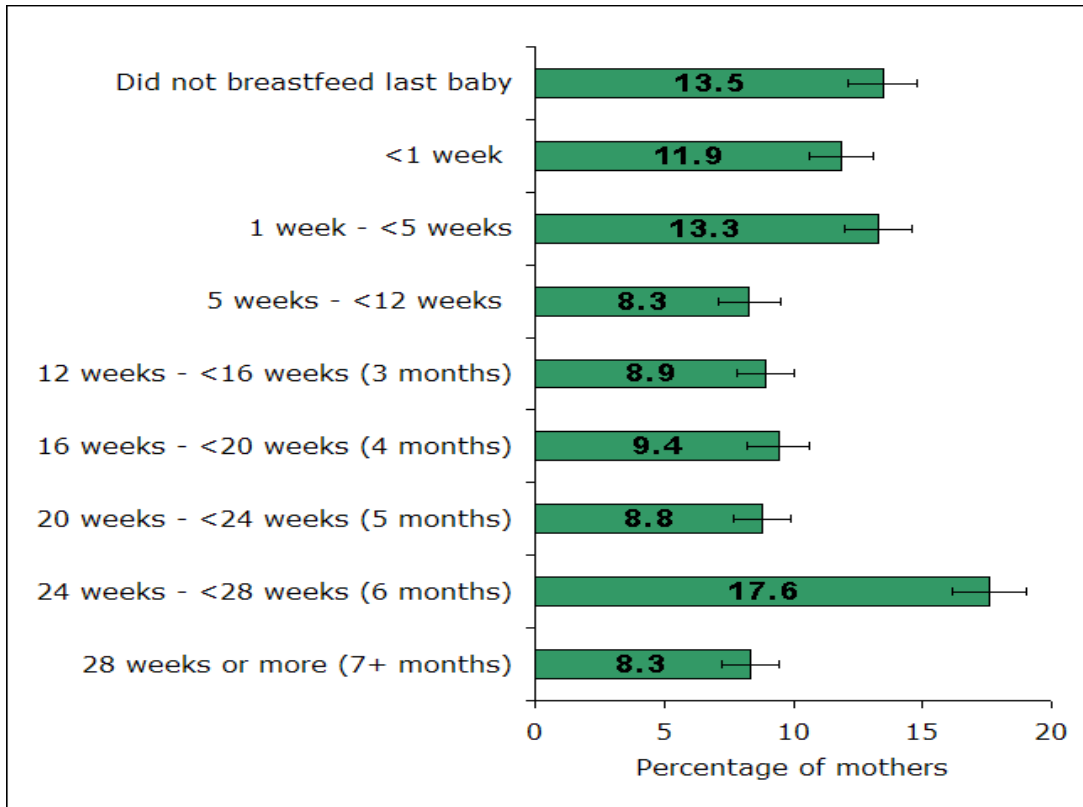


Based on information provided by females aged 15 to 55 who had a baby in the last 5 years.

Source: Health Canada.

Data Source: Statistics Canada, Canadian Community Health Survey, 2001, 2003, 2005, 2007-2008, 2009-2010

Table 2: Duration of exclusive breastfeeding, Canada, 2009-2010



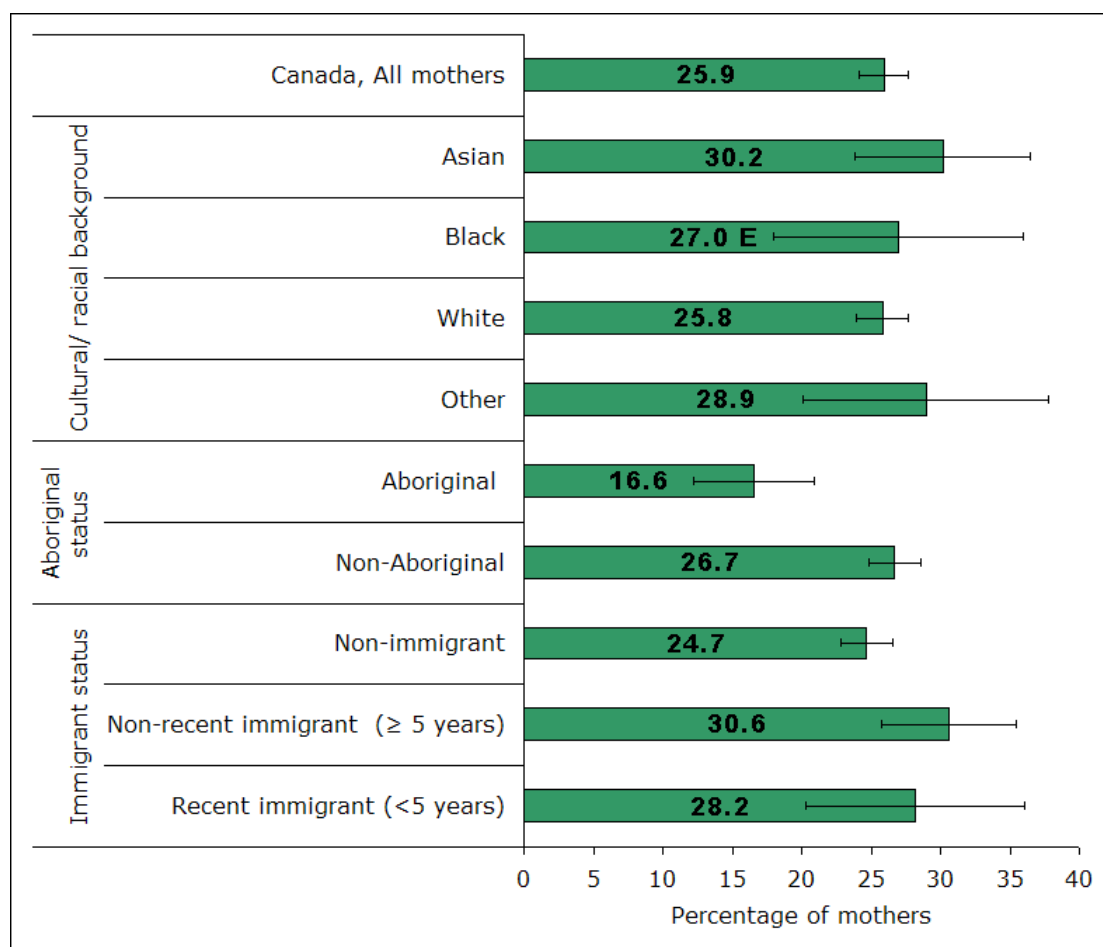
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Based on information provided by females aged 15 to 55 who had a baby in the last 5 years. Exclusive breastfeeding refers to the practice of feeding only breast milk (including expressed breast milk) to babies. The duration of exclusive breastfeeding is a derived variable based on questions about length of breastfeeding and the introduction of liquids or solids.

Source: Health Canada

Data Source: Statistics Canada, Canadian Community Health Survey, 2009-2010

Table 3: Exclusive breastfeeding for six months (or more) by cultural/racial background, Aboriginal status and immigrant status, Canada, 2009-2010



E – Data with a coefficient of variation from 16.6% to 33.3%; interpret with caution.

Based on information provided by females aged 15 to 55 who had a baby in the last 5 years. Exclusive breastfeeding refers to the practice of feeding only breast milk (including expressed breast milk) to babies. The duration of exclusive breastfeeding is a derived variable based on questions about length of breastfeeding and the introduction of liquids or solids.

Source: Health Canada

Data Source: Statistics Canada, Canadian Community Health Survey, 2009-2010

3) Government efforts to protect breastfeeding through Code implementation

Canada's response to the **International Code of Marketing of Breastmilk Substitutes** and World Health Assembly (WHA) subsequent resolutions relating to infant and young child nutrition has been abysmal. Despite strong urgings from the various health sectors, parents and advocacy organizations, the government of Canada continues to take a voluntary, self-regulatory approach.

The federal government has argued that because the Code was not “legally binding” it is not obligated to integrate the various articles of the International Code and WHA resolutions into its regulatory framework. This response is maintained by strong lobbying from the formula industry. Hence the government does little to inform sectors that are accountable under the Code (i.e. industry, health care professionals and health care institutions) about its provisions and as a result, formula companies routinely and blatantly violate the Code and WHA resolutions with impunity. Even where some provisions of the International Code and WHA resolutions are in conformity with the Canadian Food & Drugs Act, the regulations are only considered and possibly enforced when there is an external complaint. INFACT Canada or its individual members usually initiate these complaints.

Health Canada, together with the Canadian Paediatric Society and the Dietitians of Canada is currently leading an infant nutrition review of its policy statement: **Nutrition for Healthy Term Infants**. Advocacy groups are recommending:

- increased implementation, monitoring and enforcement of marketing provisions for infant formula and related products to improve breastfeeding protection measures;
- improved support to enable mothers to successfully breastfeed exclusively for the first six months and sustained breastfeeding for two years or more as recommended by the Global Strategy for Infant and Young Child Feeding;
- active support for the Baby Friendly Initiative (BFI);
- a review of maternity benefits to include more sectors of working women, i.e. self employed, temporary and part-time employees; mandatory breastfeeding breaks in the workplace;
- policies and funding supports for the establishment of donor milk banks across Canada;

Despite the government's weak position on the International Code, Health Canada does offer programs to help encourage breastfeeding for Canada's most vulnerable groups. Health Canada's **Canada Prenatal Nutrition Program (CPNP)** is a comprehensive nutrition program that applies a population health approach to improve pregnancy outcomes for vulnerable women and their babies, promote breastfeeding and increase access to health services.

The Government of Canada provides long term funding through a joint management agreement with provincial and territorial governments to community groups. More than 95% of projects target pregnant women who are teens; women who are Aboriginal or recent immigrants; women who live in poverty or in geographic isolation; women who use tobacco, alcohol, or other substances; and women who have poor access to services.

Program delivery models vary across the country and from community to community as each project responds to what works well in the local community. Participant involvement in all aspects of program planning and delivery is expected. The recommended program elements include: food supplementation; nutrition assessment and counselling; support, education and counselling on lifestyle issues; breastfeeding promotion and support;

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peer support models, drop-ins, collective kitchens and gardens; and a registered dietitian in planning and support to project staff and participants.

Based on the enhancement from the 1999 Federal Budget, the budget for the non-reserve portion of CPNP is \$30.8 million as of 2002/03. Of this, \$27 million goes directly to communities in the form of grants and contributions. The latest report CPNP report (2007) reports similar budget allocations.

Clearly although the needs are increasing as Canada's immigration and aboriginal populations are growing, budgetary allocations have not kept pace.

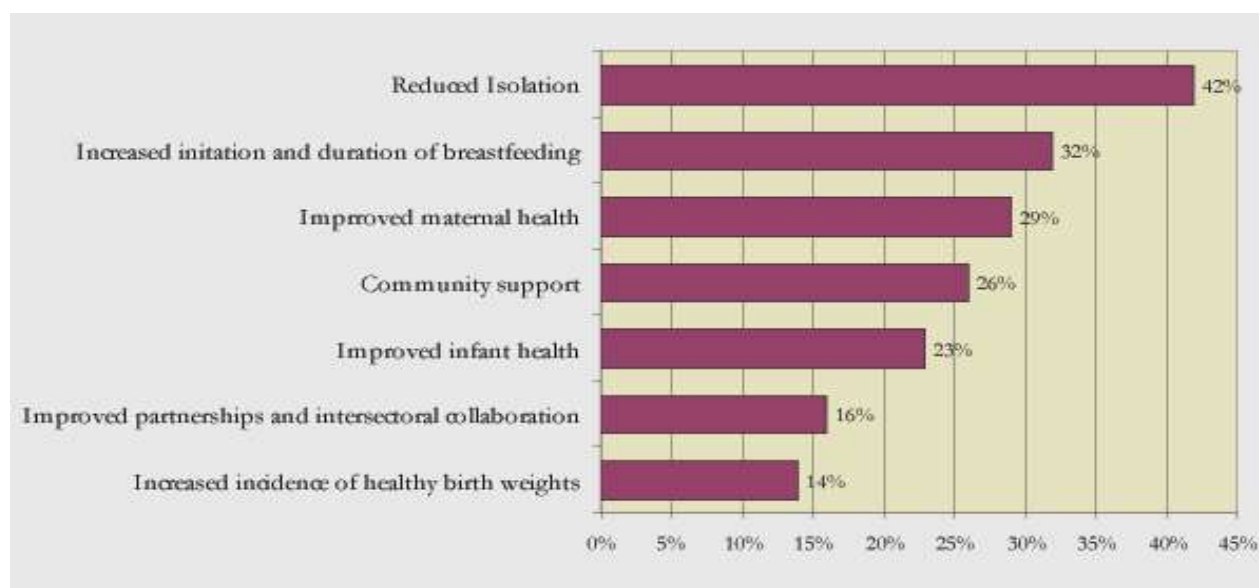
The CPNP reports show that in 2005 and 2006, 66% of CPNP projects reported that they provided breastfeeding information and/support services. (See Table 4)

Table 4: Services offered by CPNP Projects (2005-2006)

Services	% of projects (n=187)
Food/vitamin supplements or vouchers	95%
Nutrition counselling/education	84%
Social support	80%
Service to a specific target group	78%
Pre/postnatal information/support	68%
Breastfeeding information/support/incentive programs	66%
Transportation assistance/bus tickets	17%
Other	15%
Health counselling/support	10%

From 2003-2006, 32% of CPNP programs reported increased initiation and duration of breastfeeding (see Table 5).

Table 5. CPNP: Most Frequently Reported Program Outcomes (2003-2006)



The CPNP community based programs are important cost-efficient tools to improve breastfeeding supports and increase breastfeeding rates. Since the program targets the most vulnerable mothers, impoverished, single, teen-aged and Aboriginal mothers, within the Canadian population, it is these very mothers who have the most to gain by breastfeeding. Hence this is a critical program that must be maintained and strengthened to ensure these positive impacts are maintained.

4) Baby Friendly Initiative (BFI)

In 1996, the Breastfeeding Committee for Canada (BCC) identified the WHO/UNICEF BFHI as a primary strategy for the protection, promotion and support of breastfeeding. The WHO/UNICEF global guidelines for the BFHI state that each country must identify a BFHI National Authority to facilitate the assessment and monitoring of the progress of BFHI within its borders. The Breastfeeding Committee for Canada is the National Authority for the BFHI and will implement the BFHI in partnership with Provincial and Territorial Implementation BFI Committees.

In June 1999, the Brome-Missiquoi-Perkins Hospital in Cowansville, Quebec was designated as the first Baby-Friendly™ Hospital in Canada. St. Joseph's Health Care in Hamilton, Ontario, was designated in March 29, 2003. Since then close to 40 facilities have been designated as BFI in the province of Quebec and 10 community health facilities and 5 hospitals in the rest of Canada. The momentum for BFI is increasing as more and more hospitals are improving birthing and breastfeeding practices; community health facilities are increasing home visits, providing facilities for mother-to-mother support; the number of health care providers trained in the 20-hour breastfeeding course is increasing every year; and annually more health care providers are being certified as lactation consultants.

It should be noted that federal government financial support and leadership for BFI implementation remains non-existent.

5) Maternity protection for working women

Bill C-204 came into effect as of January 1, 2001 and extended the maternity/parental benefit period payable through Canada's Employment Insurance program. Maternity leave was extended from a total of 25 weeks of maternal/parental leave to a full year.

Generally, a parent must have worked 600 insurable hours in the year before claiming parental leave benefits in order to qualify for them. As well a mother must have contributed to Employment Insurance (EI) during that same year. If a mother is self-employed she can choose to pay into EI and she must do so for at least one year before she is eligible for parental leave benefits.

The basic formula for paid parental leave is 55 per cent of one's average weekly earnings up to a maximum amount, which is set yearly. As of January 2012 the maximum amount of eligible yearly earnings is \$45,900. With that limit the maximum amount a parent can receive for parental leave benefits would be \$485 per week.

Although Canada's maternity benefits are rated as one of the best in the world, qualifying factors remain as barriers for many women to take advantage of Canada's maternity benefits.

Many women because of their dual roles of primary care givers participate in the workforce as part-time, contract or self-employed workers, leaving them ineligible for the program.

Since payment is based on a sliding benefit structure, this restricts potential use of the program by many women. Affordability remains an issue for many Canadian families. Although the maximum payout benefit of 55% with a maximum of \$485 per week is available, the average weekly pay out can be considerably lower.

Breastfeeding when returning to work received important rights status in 1997 when the British Columbian courts (Poirier versus the Government of British Columbia) determined that the "workplace needs to make reasonable accommodation to the needs of the breastfeeding woman". This BC legal precedent has implications for all employed lactating women across Canada. Women now have the right to negotiate their breastfeeding needs with their employer. However some reluctance remains as women fear job loss or job discrimination and may avoid this right. Mandatory paid breastfeeding breaks for lactating women in the workplace would solve this problem.

6) HIV and infant feeding

Canada's current national infant feeding recommendations, "Nutrition for Healthy Term Infants", (the statement of the Joint Working Group: Canadian Paediatric Society, Dietitians of Canada and Health Canada) states, "Recommend an acceptable alternative to breastfeeding for mothers who are HIV infected".

WHO's revised policy (2009) provides additional information such as the economic, environmental and cultural conditions and recommends the application of the AFASS criteria. As well the WHO provides information on the use of heat treated expressed or donor milk for infants of HIV+ mothers. Since HIV rates are increasing in the most vulnerable mothers, counseling and the WHO AFASS criteria are vital to ensure the best possible outcomes for both mother and infant.

7) Obstacles and recommendations

The following **problems/obstacles** have been identified:

- The failure of the Canadian Government to regulate the marketing of infant and young child feeding products that come under the scope of the International Code and WHA resolutions.

Formula companies, retailers and publishers routinely violate the Code and WHA resolutions and sabotage breastfeeding mothers through flagrant advertising, couponing and sampling of infant feeding products to prospective and new mothers.

- Self-employed, part-time and temporary employees are not adequately covered to receive maternity benefits. Many women fall into this category, leaving them unqualified for benefits. Women who do not qualify for maternity benefits cannot afford to take adequate leave from paid work.
- The failure to eliminate conflicts of interest in policy development in infant and young child nutrition.

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A recent example is the presence of those working for the infant foods and formula industries at the table for the current revision of Canada's infant feeding recommendations, "Nutrition for Healthy Term Infants".

- The failure of federal, provincial and territorial governments to provide adequate funding for breastfeeding promotion and support programmes, in particular the BFI programmes.
- Inadequate training of health care workers in lactation support and management.
- The use of language which promotes breastmilk as value-added in policy statements. This inadvertently establishes formula feeding as the norm.
- The decision to breastfeed is still considered an issue of maternal lifestyle choice, rather than a health issue.
- The lack of support and leadership in the establishment of donor milk banks across Canada as a support not only for high needs infants but also as a support to enable breastfeeding mothers to achieve recommended breastfeeding practices.
- The disparity in breastfeeding rates between Aboriginal and non Aboriginal populations.

Recommendations include:

- Fully implement the International Code for the Marketing of Breastmilk Substitutes and relevant WHA resolutions through national legislation and make adequate provisions for monitoring and sanctioning of violations.
- Eliminate conflicts of interest in policy development by ensuring that all advisory committee experts and consultants are independent from the baby foods industries.
- Improve maternity benefits accessibility criteria for part-time, self-employed and temporary mothers.
- Legislate the International Labour Organization's Maternity Protection Convention (ILO 183 2000) that provides for maternity protection and the support of paid breastfeeding breaks for breastfeeding mothers in the workplace.
- Increase funding for breastfeeding promotion, support and training of health care workers.
- Make appropriate amendments to the Canada Food and Drugs Act to regulate formula products in a similar fashion to tobacco and alcohol.
- Place warnings on formula packaging, similar to cigarette packaging that warns of potential health impacts.
- Update Canada's policy on HIV and infant feeding.
- Improve birthing and breastfeeding culturally appropriate supports for First Nations communities.
- Provide independent research and funding for donor milk capacity across Canada.

Data sourced from:

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<http://www.hc-sc.gc.ca/fn-an/consult/infant-nourrisson/recommendations/index-eng.php#a1>

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