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Editorial

Breast-feeding: part of the slow food movement?

This past spring saw the publication of new international standards for children's growth by WHO[1] and, in the USA, the culmination of a national breast-feeding awareness campaign by the US Department of Health and Human Services[2]. Both promote the idea of breast-feeding as the biological norm, and the WHO recommendation that infants be breast-fed exclusively for the first six months of life[3].

This issue of *Public Health Nutrition* features six articles on infant feeding[4–9], including two describing the prevalence and correlates of breast-feeding in Auckland, New Zealand[4] and in Gateshead, UK[5]. Together, the latter two articles lead to two observations regarding the current status of breast-feeding practices.

First, despite wide differences in breast-feeding prevalence across populations – 24% of infants in Gateshead and 95% of infants in Auckland were receiving any breast milk at 6 weeks – both populations showed poor compliance with WHO recommendations. The prevalence of exclusive breast-feeding at 6 months postpartum was 9% in Auckland. In Gateshead, the prevalence of *any* breast-feeding at 4 months postpartum was 15%. Breast-feeding differed by socio-economic factors in both countries, albeit in different ways. Exclusive breast-feeding was not associated with maternal education in Auckland, but it was negatively associated with mother's full-time employment. In Gateshead, in contrast, breast-feeding was positively associated with both maternal education and affluence. Notably, though, even in the group with the highest breast-feeding prevalence in each country, prevalence was low. In Auckland, 10% of non-working women exclusively breast-fed at 6 months postpartum, as compared with 0% of full-time workers. Estimates for exclusive breast-feeding are not available for Gateshead, but in that study 49% of the most highly educated women were doing any breast-feeding at 4 months postpartum versus $<15\%$ of women with less education.

A second observation from the two articles is their confirmation of rather well-known reasons for mothers either to introduce complementary liquid foods or to give up breast-feeding completely. In both populations, over half of the women reported concerns over the adequacy of their milk supply to satisfy their baby's hunger or to meet their baby's demand.

The problem of how to encourage continued breast-feeding is the subject of many articles and interventions. A particular finding in the Gateshead study[5] offers an additional insight into a potential cause and target for intervention, at least in the context of a bottle-feeding culture. In their study, Wright *et al.* found that having received supplementary feeds in the hospital was predictive of giving up breast-feeding by the time of discharge. Moreover, this was true whether or not women reported difficulties feeding in the hospital. For the 10 women who reported no difficulties feeding, it would be interesting to know their reasons for giving up breast-feeding so soon. Possibly, when facing a crying and apparently hungry baby, still waiting for mature breast-milk to flow and being exhausted from having just given birth, the option of supplementary feeds becomes entirely reasonable and actually quite attractive. In the hospital and thereafter, supplemental feeds are a way to provide immediate relief at a baby's crying – more immediate than breast-feeding, which requires time to establish and which keeps a mother guessing as to how much her baby has actually drunk.

The downside of supplemental feeds, of course, is its effect on breast-feeding. An editorial in the previous issue of this journal noted that 'increasingly the populations of the world rely on buying food, rather than growing and preparing it for themselves'[10]. Infant formula is the earliest possible introduction to buying food for consumption, undermining breast milk as the most basic food source for a baby. We might view the bottle- versus breast-feeding issue as akin to the fast food versus the slow food movement[11]. Do we benefit more from saving our precious time and effort by eating pre-processed food, or from investing our precious time and effort in preparing and eating natural, unprocessed food? In this issue of the journal, Lauer *et al.*[6] provide a sobering calculation of the impact of suboptimal breast-feeding on infant deaths in the developing world. A similar analysis of the burden of morbidity in developed countries attributable to suboptimal breast-feeding practice may provide some valuable perspective on this question for Western countries.

Regardless of the size of the burden of morbidity, Lauer *et al.* point out that 'the size of the gap between practice and recommendations is striking', and that improving breast-feeding practices requires societal commitment to provide the appropriate resources and enabling conditions for women to continue breast-feeding. It also requires, as Wright *et al.*[5] state, that mothers be properly prepared for the commitment that breast-feeding demands. Taken together, what is needed is a movement to change our culture – indeed, a movement akin to the Slow Food Movement[11]:

> *Slow Food activism is curious but simple: the idea is to protest the spreading evils of fast food and the bland, unhealthy cuisine of the globalized economy by going back to the locally grown, 'authentic' food that our grandparents cherished. [. . .] The Slow Food movement [. . .] is a defiant determination to preserve unprocessed, time-intensive food from being wiped off the culinary map.*

Whether or not infant formula is an evil, bland or unhealthy fast food is arguable. But breast milk is locally grown, authentic, unprocessed and certainly time-intensive; its practice requires concerted efforts for its preservation; and its preservation has well-established benefits. As the Slow Food Movement manifesto declares: 'Slow Food guarantees a better future'[12].

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