October 2015 Leader Today

Welcome to our October issue!

In Breast Milk's Circadian Rhythms, Briana Tilman shares how human milk changes in composition during the course of a day. Shaheda Yashmin explains how cultural and religious practices influence breastfeeding in Islamic and Cultural Practices in Breastfeeding. Samantha Cowell offers an alternative Series Meeting plan with a family theme and Suzy Landreth summarizes how Leaders can help mothers prepare for leadership in A New Co-Leader in Four Easy Steps. We are also pleased to have a book excerpt from breastfeeding author Maureen Minchin's Milk Matters: Infant Feeding & Immune Disorder and Helen Gray lists all the impressive marketable skills that volunteering for LLL can provide. Finally please Meet the LLLI Professional Advisory Board who are so valuable to LLLI behind the scenes.

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Keeping Up to Date

Breast Milk's Circadian Rhythms

Briana Tillman, Colorado Springs, Colorado, USA

Human milk's complex adaptations are amazing. Breast milk undergoes biochemical changes during a feeding; the consistency develops visually over the course of a pumping session from watery foremilk to creamier hindmilk. Human milk also has the ability to provide for an infant's changing nutritional needs with age. The percentages of fat and protein levels change over time to meet the increased energy demands of mobile babies.(1) If these changes in human milk don't impress you, recent research suggests that its composition shifts in synchrony with mothers' circadian rhythms[1] as well, giving breastfed babies a head start in neurological development and sleep patterns.

Bleary-eyed lactating mothers might be surprised by reports that breastfed babies sleep, on average, 45 minutes longer per night and experience less colic than their formula-fed peers.(2) Variables affecting infant sleep are notoriously difficult to measure in isolation, but in recent years some scientists have begun to look at breast milk biochemistry as a potential source of "chrononutrition"[2]. Interesting findings include several substances that vary in accordance with the mother's circadian rhythms, including some amino acids, melatonin, trace elements, and even a few nucleotides—the building blocks in many important biological processes.

In 2008, Spanish researchers took breast milk samples from 77 women in three-hourly increments and measured the levels of 16 amino acids.(3) Of these, four amino acids that are precursors to activity neurotransmitters ("wakefulness" amino acids) were found to peak during the daytime and reach their lowest levels at night. Conversely, tryptophan, a precursor to melatonin infamous for causing drowsiness, peaks during the night. While these amino acid circadian rhythm indicators are not present during the colostrum phase (with the exception of tryptophan), they do seem to help inform the newborn's neurological development during transitional and mature milk periods.

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[1] A **circadian rhythm** can be likened to an internal body clock influencing sleeping and eating patterns over 24 hours.

[2] Chrononutrition is an eating plan developed by a French nutritionist that emphasizes consuming certain nutrients at different times of the day.

Another Spanish study confirmed the circadian rhythm of tryptophan in breast milk and carried the research further by studying the levels of a melatonin metabolite (breakdown product) extracted from the urine in breastfed infants' diapers.(4) The diaper study was worth the trouble; not only did the melatonin metabolite show clear circadian rhythms in the breastfed babies, but its rhythm was also linked to the mothers' levels of tryptophan. The graphs are striking in their synchronicity, with babies' levels showing a slight delay to allow for construction and metabolism of melatonin before its metabolite is excreted.

Important precursors to melatonin follow circadian rhythms in breast milk, but the hormone itself is also present and increases during periods of darkness.(5) This is especially important during the first few weeks of life, when babies are not yet making their own supply of melatonin. Since the hormone serves both a hypnotic role and also relaxes the gastrointestinal muscles, breast milk melatonin could be a major factor in early neurological development of sleep/wake cycles, as well as reduced colic incidence.

Scientists have found other substances in breast milk that follow circadian rhythms, but the purposes or causes remain unclear. Iron, for example, peaks at noon, vitamin E peaks at about 6 pm(6), and magnesium and zinc are both at their highest levels in the morning.(7) Sodium and potassium also follow predictable variations in breast milk during the day(8), but neither the mechanism nor the possible impact of these changes is yet understood. Fat content shows significant changes during the night(9); this may, however, be related to changes in frequency of feeding rather than circadian rhythms brought about at a cellular level.(10) In short, researchers are just beginning to discover the many new implications of day/night variation in breast milk.

For breastfeeding mothers and La Leche League Leaders, there are two clear messages:

1. **Formula can't compare**

The uniqueness of breast milk as individually tailored for normal neurological and biological development remains unchallenged by any formula company in the world. Formula does not include melatonin and other important chrononutritive components, and no formula has yet achieved circadian rhythms in composition.

2**. Breast milk affects a baby's sleep patterns**

Labeling pumped milk with the time of day collected may help maintain the valuable connection between breast milk components and infant sleep even when mother has to be away.

As scientists continue to explore the biochemical makeup of human milk, we may find new keys to unlocking the secrets of chrononutrition, neurological development, and hormonal activity. Until then, continuing to support breastfeeding

mothers improves the health of future generations in many ways, some of which we are only beginning to understand.

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4. Cubero, J. et al. The circadian rhythm of tryptophan in breast milk affects the rhythms of 6-sulfatoxymelatonin and sleep in newborns. *Neuro Endocrinology Letters* 2005; 26(6):657-61.
5. Engler, 730.
6. Barkova, E.N. et al. Diurnal variations in qualitative composition of breast milk in women with iron deficiency. *Bulletin of Experimental Biology and Medicine* 2005; 140(4):394-6.
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Biography

Briana Tillman became an LLL Leader in 2008, and started the first La Leche League Group on the Korean peninsula. Since then she has served as a Leader in Germany, and her current Group is in Colorado Springs, Colorado, USA. Briana became an International Board Certified Lactation Consultant (IBCLC) in 2014 and plans to begin medical school later this year. Briana has three children, aged nine, seven, and four years.

A Family Affair: Series Meeting Plan, LLL Isle of Man

Samantha suggests alternative titles for Series Meetings to discuss ways that breastfeeding can affect the whole family, including how friends and family can support and complement the nursing relationship between mother and baby.

Meeting 1: Breastfeeding and Me

Discussion ideas to explore together:

- How has breastfeeding affected you?
- Do you think breastfeeding has helped you parent your baby?
- How has breastfeeding helped you grow as a person?
- What messages would you like your children to receive about breastfeeding?
- What has helped you feel a connection with other women through breastfeeding?

Meeting 2: Breastfeeding and Family

Discussion ideas to explore together:

- In what ways are caregivers, other than mother, important for a child's healthy development?
- How can people around us best support a breastfeeding mother and child?
- How can mothers help loved ones understand the importance of breastfeeding and the normal behaviors of breastfed children?
- In what ways does breastfeeding affects the relationship between siblings?

Meeting 3: Breastfeeding and Society

Discussion ideas to explore together:

- Have you ever felt judged or criticized in your feeding choices?
- What have you found helpful when faced with criticism or a breastfeeding challenge?
- Have you ever felt praised and encouraged?
- What positive comments supporting you and your baby were particularly uplifting?
- Whose attitude affects you the most?

- How have your thoughts and actions changed because of your experiences so far?
- How do our personalities influence the way we handle criticism or praise?

Meeting 4: Breastfeeding and Health

Discussion ideas to explore together:

- Has pregnancy and breastfeeding changed your awareness of the impact of our diet?
- How do you think breastfeeding has affected your family's health?
- Which healthy first foods did you choose to offer your baby?
- How do you balance the needs of each family member with regard to personal tastes and special requirements?

Samantha Cowell has been a Leader with LLL Isle of Man since 2012. She has two daughters aged six and four and a baby son who is one. Samantha enjoys taking calls as part of La Leche League Great Britain's Helpline team, along with supporting local mothers one-to-one and via a busy Facebook group.

Helping Mothers

Islamic and Cultural Practices in Breastfeeding

Shaheda Yashmin, Clapham, Great Britain

Breastfeeding is important to me for several reasons. One reason is my religion. As a Muslim parent, I always try to follow Islamic guidelines and I was fascinated to discover breastfeeding is mentioned in the Quran[3] (Islam's holy book). As I read more about Islam and breastfeeding, I came across some controversial issues and realized that many cultural practices get mixed and confused with religious practices. As with any religion, some Muslims will adhere strictly to the religious teachings as defined by the Quran and Sunnah [sayings, practices and teachings of the Prophet Muhammad]. Other Muslims will take a more relaxed approach to the religion but may have heavy cultural influences. Helping Muslim mothers adopt good breastfeeding practices requires an understanding of the differences between the religious basis of breastfeeding and the cultural practices followed by some Muslims.

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[3] Traditionally called "Koran" in English.

A Muslim View of Breastfeeding
Most Muslims see breastfeeding as the God (Allah) given right of the child according to the rules of Shariah (Islamic Law). The religious laws regarding breastfeeding are all from the Quran and give parents a degree of flexibility and choice.

Duration of Breastfeeding
Following the teachings of the Quran, Muslim mothers often aim to breastfeed their babies until the age of two years. This refers to the Islamic months—the lunar year—so it will be approximately 22 days before the child reaches his/her second birthday. However, it is not mandatory to breastfeed a child for two years if both the parents agree to wean the baby for a legitimate reason.

When Muslim mothers face breastfeeding problems, they may feel very disappointed and scared that they might not be able to reach their goal of breastfeeding for two years and often may experience feelings of guilt. Reassuring mothers that they tried their best is what counts and can be a helpful way to put things into perspective. In many modern cultures the duration of breastfeeding is much shorter, often ending after one year.

There is a huge variation in practice regarding the maximum age limit for breastfeeding, depending on which school of Islamic jurisprudence the family chooses to follow. The opinions of Muslim scholars fluctuate, but generally range between two and seven years. This means that any mothers who prefer a more natural weaning approach have the flexibility to do so. In some cultures extended breastfeeding is frowned upon. For example in the sub-Indian cultures it may be acceptable for a girl to be nursed for longer, but not for a boy.

Weaning
Weaning methods are heavily influenced by cultural practices in Muslim families, as there is no specific mention of how to wean in the Quran. Bangladeshi families may have a weaning celebration at six months when solids are first introduced by giving the baby six rice grains. In some African-Muslim tribal cultures (Hausa cultural belief), babies are expected to have water as well as breast milk from birth and mothers may even have their colostrum expressed before nursing their baby. Some India-Pakistan cultures also used to have this belief in the past. There is a vast range of practices within different tribal groups. In addition, breastfeeding while pregnant may seem strange and unacceptable in some cultures. Mothers may rush to wean their child if they become pregnant thinking that it is unsafe or that the milk will be spoiled.

Tahneek

Soon after the birth of a baby, many Muslim families practice a religious tradition of prelacteal feeds known as “Tahneek”. This originates from the Hadith (sayings of the Prophet). Tahneek is the practice of softening a date and rubbing a bit of it on the hard palate of the newborn’s mouth with a clean finger. It is only the “taste of the sweetness” that is sought. Sometimes honey[4] or cane sugar is used instead.(1) Sometimes it will be a close relative (usually the grandparents) who gives the baby this first taste and occasionally they may put a large quantity in the baby’s mouth not knowing the negative effects that this could have. A medical professional who knows about these practices can help to explain the dangers sensitively.

The Islamic Father’s Role

In Islam fathers play an important role in breastfeeding. Many of the responsibilities of fathers are mentioned in the Quran. Key responsibilities of a father include the following:

- The father provides moral support and encouragement.
- The father must provide the means to feed and clothe the nursing mother.
- The father must find an alternative milk source and pay the compensation in kindness if the baby’s mother does not breastfeed.
- If the father dies during the nursing period, the maintenance cost of the baby should be borne by his heirs (usually the baby’s paternal grandfather).
- Discussing and deciding weaning together with the mother is not a sin.

The fact that the father has to be the main person responsible for the finances is so important in Islam that even if a couple gets divorced, the father has to continue to pay for the mother’s and child’s expenses until the baby is weaned (within two years).

Although the father’s roles are clear, in many cultures the father does not seem to get as involved. Instead, extended family members help the mother and baby and may often hire a maid for the early days. Co-sleeping is very common and in many cultures the father will sleep in a different room for the first few weeks.

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[4] Honey can sometimes contain spores of a bacteria that can cause botulism in babies; a very serious illness. Health authorities recommend against giving a baby honey until they’re 12 months old.

Wet Nursing and Adoption
Wet nursing was a common practice in pre-Islamic Arabia and at the time of the Prophet Muhammad. He was breastfed by his own mother and two different wet nurses.

If the mother is unable to breastfeed, she and the father can mutually agree to let a wet nurse feed the child. This demonstrates the preference in Islam of feeding the baby human milk instead of animal milk. This aspect of Islamic culture has been lost in most Western countries and many Muslim mothers in the West who have problems breastfeeding usually turn to formula milk without considering a wet nurse. However, in Arab countries it is still widely practiced and Arab mothers may first look for a wet nurse within their extended families. See Milk Sharing in an Age of Social Media for information on LLLI milk donations policy.

Children who have been regularly breastfed (three to five or more times) by the same woman are considered "milk-siblings" and are prohibited from marrying each other. It is forbidden for a man to marry his milk mother (wet nurse) or for a woman to marry her milk mother's husband.

Muslims who have adopted children may try their best to breastfeed the baby because under Islamic Shariah law, breastfeeding an infant three to five or more feeds when the child is under two years gives the adopted child the rights of a birth child. It also makes the child a mahram (an unmarriageable kin with whom sexual intercourse is considered incestuous). For a Muslim mother who wears the hijab (veil), this is usually very important to her since she is not required to veil herself in front of her adopted son when he reaches puberty, and this will give her more freedom.

Do Breastfeeding Mothers Need to Fast During Ramadan?
Ramadan is a month in the Islamic calendar when Muslims fast from dawn to dusk. However, those with sound excuses are exempt from fasting, until the reason for which they have been exempted has passed. When Ramadan falls in the summer, the fasts are very long and many mothers worry about how they will manage to fast and continue breastfeeding. However, pregnant and breastfeeding mothers are exempt from fasting according to the Hadith.

Some cultures interpret the Hadith very generally and will not fast at all if breastfeeding. In other cases and in Arab cultures in particular, mothers will only miss fasts in cases of

hardship. They will often continue to fast during breastfeeding unless it has a negative effect on them or their babies. If they do not fast at the appropriate time, they will have to “pay back” the fast when they are able. Some mothers with children spaced very close together will choose to make up the fast after all of their children have weaned. Some scholars say that instead of making up the fasts, these mothers can pay a compensation by feeding poor people a meal for the number of fasts missed.

If a mother feels that she is able to fast, then it is important to keep herself well hydrated by drinking lots of water between Iftar (breaking the fast at sunset) and Suhoor (starting the fast at dawn). Making sure she eats a nutritious Iftar and Suhoor meal and has plenty of rest during the day will ease the fast.

Feeding in Public

An important aspect of breastfeeding in Muslim cultures is the mother’s concern about her privacy and modesty when breastfeeding. Muslim mothers may worry about how they will feed in front of others without exposing their skin/breast. They may also have added pressure from relatives and husbands to cover up. In some cultures mothers feel uncomfortable with breastfeeding in front of people generally even if no skin is showing.

Having big families and frequent visitors in the early days can lead to disruption of breastfeeding because latching and positioning may need a good deal of attention. It is almost impossible to feed without showing a little skin and unfortunately for many Muslims this can pose such a difficulty that bottle-feeding seems like the easier option.

Once breastfeeding is going well, it becomes easier to cover up. There is a large variety of breastfeeding covers/aprons available to mothers to purchase or, if the mother wears a hijab, it may even be big enough to cover her baby. “Discreet” nursing can be challenging if a child totally refuses to be covered up. Wearing a loose nursing top can be useful in this situation.

Another problem arises if there are men around. Many mothers feel uncomfortable breastfeeding in the same room as men (and mahram men) even if nothing is showing and baby is well covered up. There may also be a taboo about saying the word “breastfeeding” in front of men, depending on the cultural traditions of the family.

Special Foods to Increase Mothers' Milk

Mothers may be advised to take black seed (Nigella sativa) which is commonly known as "the blessed seed". This is a very important herb in the Muslim community, as it is believed to have healing properties for most illnesses. Many Muslims take it as part of a healthier lifestyle (although it should not be taken during pregnancy). Black seed[5] can act as a herbal galactogogue.

Another food that Muslim mothers may be encouraged to eat during labor and post-partum are dates. This is because in a Quranic verse Mary was told to eat dates at the time of giving birth to Jesus.

Dates have high sugar content for that burst of energy that is needed after an exhausting labor. Dates contain many vitamins and minerals including iron and are high in fiber. They also contain substances that have similar properties to oxytocin, which is essential for the let-down reflex to occur.

In Egyptian culture mothers are given "mughaat," which is a special mix of powdered fenugreek seeds with nuts fried in butter and sugar, to increase a mother's milk. Mothers are also encouraged to have a lot of broth and soup post labor. In some African cultures certain herbs are rubbed on the breast to increase milk and in some regions mothers are given special diets for 40 days. Chile foods are usually restricted but one African tribe actually encourages the new mother to have plenty of chile in the belief that it will increase her milk supply. Again there is a huge difference among the various cultures. Bangladeshi mothers have their drinking water restricted in the first few days because it is believed that it will make them swell up, but in neighboring cultures the mothers are given plenty of water. Pakistani mothers are usually also given a dish or drink containing fenugreek seeds to help with milk supply.

There are many variations in the Islamic and cultural practices of Muslim mothers. Although this information is not exhaustive, I hope it will be useful to you when supporting Muslim mothers.

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[5] Lactmed says " **Black seed** has been used orally as a galactogogue in India; however, no scientifically valid clinical trials support this use."

(1) McKenna, K. and Shankar, R. The Practice of Prelacteal Feeding to Newborns Among Hindu and Muslim Families *Journal of Midwifery & Women's Health* 2009;54(1): 78-81.

Biography

Shaheda Yashmin has been a Leader for three years and her children are now aged eight and five. Shaheda is homeschooling her children, is a student of Arabic, and blogs at Motherly Nurturing.

Growing your Group

Being a Leader—Is it All for Nothing?

Helen Gray, London, Great Britain

Helen ponders on the fact that although Leaders receive no financial reward in exchange for giving their time to help mothers breastfeed, they do get paid in a multitude of skills, experience, and job satisfaction.

Well, we don't get paid, that is for sure.

But in fact, being a volunteer also gives us a freedom to do something we are passionate about, *without* leaving our children behind (how many jobs allow that?). In addition, we are constantly learning, along with doing incredibly rewarding and fulfilling work. Surveys show that many mothers would like to spend some time at home with their children or work part-time to spend more time with their families. Leadership is a wonderful opportunity for many mothers.

I recently heard it said that LLL leadership is "giving something for nothing. It doesn't lead anywhere." I disagree! One of the wonderful things about LLL is that there is *so much* scope for personal growth within the organization. While it is recommended that new Leaders concentrate on leading their Groups for the first year, to gain experience and confidence, after that the sky is quite literally the limit.

There are so many skills involved in leading an LLL Group, for example speaking in public by leading discussions every month. Before my first meeting, I was up until 2 am to write note cards for every possible tricky situation. Yet now, if a co-Leader cancels at the last minute, I can lead a meeting at the drop of a hat. I can even stand up at a conference or National Health Service (NHS) meeting and speak to an audience of mothers, health professionals, and managers.

In addition, Leaders gain excellent organizational skills, such as handling finances, fundraising, helping mothers become a Leader in the Group, and much more! There are many different roles within LLL, so there is truly something for everyone. Leaders can take on:

• research, writing, and editing roles with LLL publications
• roles in the Leader Accreditation Department (LAD)
• opportunities for research into breastfeeding
• specialized skills in the Professional Liaison Department (PLD)
• mentoring and supporting Leaders in an administrative position
• management, strategy, and finances as a member of the local administrative team.

And then there are all those jobs repeated at at the level of Area Network or Affiliate, and again at a global level! We have representatives to the World Alliance for Breastfeeding Action, to the Baby Friendly Hospital Initiative, and to the Baby Feeding Law Group (great for WHO Code followers).

We have Leaders in LLL Great Britain who have served in the LLL European Area Network and the LLLI Leader Accreditation Department and who have even been on the LLLI Board of Directors. Many of our administrators are closely involved in international work.

I love that a young teenage mother, who left school at 16, could not only find support for her passion for mothering, but became confident enough to lead an LLL Group, edited the national magazine for years, issued press releases including being interviewed on national media, joined the local administrative team, and became chairman, representing LLL at an international level. And all while raising a large family with many children.

Talk about experience and career progression! Thank you La Leche League for giving us all these skills so generously.

Biography
Originally from the USA, Helen Gray is a La Leche League Leader in London, UK, where she and her husband Julian live with their three teenaged children. Helen is an IBCLC and joint coordinator of the UK working group of the World Breastfeeding Trends Initiative (WBTi). She represents LLL Great Britain on the Baby Feeding Law Group which works to implement the *WHO International Code* into UK and European law. Helen tweets as @HelenGrayIBCLC

Keeping Up to Date, Book Excerpt

Milk Matters: Infant feeding & immune disorder, 2015

Maureen Minchin, Geelong, Australia
Reprinted with permission.

Comp feeding: legal implications and duty of care[6]
How many mothers would be willing to give early formula feeds if fully informed in writing of the real nature of formula? That it is non-sterile, contains fats made by genetically altered marine algae and soil fungi, and may come with industrially produced bacteria as well as foods for those bacteria to grow on; that these substances will affect gut development in ways that cannot be predicted and have not been monitored. And that safer alternatives340 exist: breastfeeding, or if that is difficult or impossible (and it rarely is with the right support) assistance with expressing milk, or the use of donor human milk?

Not to give this information could quite fairly be seen as a failure of the doctor's legal duty to warn of material risk.341 And if mothers are not given that information, how can any consent they give be informed?342 And if mothers do not give informed consent to the use of such products – as most mothers in the twentieth century certainly did not! – legal opinion is that giving the product to their child may constitute the offence of battery.343 I think it might also be argued nowadays to be a 'lack of reasonable skill and care', the basis of many negligence lawsuits; or 'the loss of a chance for a better outcome', which surely the unnecessary distortion of the infant microbiome causes.

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[6] Comp Feeding ie complementary neonatal feeds of formula

An interesting question that arises is the possible reporting obligation of those who are aware that unnecessary fluids have been given, with their attendant risks. According to one expert group, insured medical practitioners have a duty to report all incidents that they might reasonably know could lead to a claim at a later date, or they will not be covered by their medical insurance. Adverse events that must be notified are those where:

• a patient suffers a major complication
• there is an error in providing health care
• an adverse outcome results in serious anger in the patient or his family
• the doctor concerned is aware that something has happened (including a complaint, investigation, or enquiry) which is thought may lead to a claim.

How soon will it be before there are plaintiff lawyers considering cases of NEC [necrotizing entercolitis] or sepsis or meningitis or juvenile diabetes or even eczema where infant formula has been given to a neonate? When the importance of exclusive breastfeeding is becoming ever more obvious, and parents are often angry that their wishes are disregarded, only the current confusion of scientific studies protects those responsible.

It could be argued in court that

• world and national health authorities already consider it an error to subject infants to unnecessary artificial feeds (or to put it another way, unjustified dietary assaults), particularly where parents are not warned of risks and so do not give informed consent; or there is no proof that they gave such consent;
• not supporting and enabling women to provide their breast milk for sick infants, or not maintaining a breast milk bank, results in the loss of a chance of a better outcome;
• hospitals that do not encourage reporting of incidents of needless exposure to formula, or that fail to take seriously the reports of concerned staff about routine practices, are failing in their duty of care;
• staff who do not consider such practices reportable incidents, and so fail to notify their insurers, will not be covered if claims are made. And given what we are learning about the lifelong effects of early artificial feeding, those claims might arise decades later.

To some this may seem far-fetched. In the 1970s pregnant women, with medical blessing, smoked in hospital wards, making me vomit as I recovered from primary and secondary postpartum haemorrhages. It seemed far-fetched then to imagine smoking in public places would end, but public health awareness increased and the public demanded protection.

Infant formula is not poison, not tobacco, and is currently necessary for the survival of many babies. But formula is still a risk, and a needless one wherever breast milk is available, which is wherever women are lactating and society values breast milk. (In Leipzig in 1989, just 95 paid donors supplied 10,000 litres of breast milk over and above the needs of their own infants, and breastfed longer in order to do so.344) Imagine the consequences if infant formula were to be seen as a risk, “the tobacco of the twenty-first century,”345 in as short a space of time. Such a recognition is possible, even likely, despite the powerful forces arrayed against it.

When and how will the message about the potential and real harms of inappropriate formulas reach health professionals? Possibly when industry begins to market their solutions to the problem they have caused: formulas with synbiotics, mixtures of both probiotics and prebiotics, which result in a gut microbiome and infant faeces more like that of [but not the same as] the breastfed infant. If the usual marketing patterns are followed, marketing of synbiotics will be done through inferences and exaggerated claims believed by uncritical health professionals and vested interests, and popularised via the social media and websites.

It may not be far away now!346 There must surely be some intelligent commentators who will ask questions about the practice of feeding industrially produced bacteria to infants as we learn more about how bacteria can share genes and morph into different strains of greater virulence.

But of course it’s possible that this recognition will be delayed by the fact of formula faeces and breast milk faeces becoming more alike in some ways. It seems possible that once enough of the industry-produced bugs are being consumed in yoghurts by mothers, fed to babies, and spread everywhere in the postnatal environment, breastfeeding mothers will pick up the bugs of industry’s choice. Hospital comp feeds [neonatal feeds of formula] are the perfect vehicle for changing maternal microbiomes via their breastfeeding infants. Feed the bugs to the newborn baby, bugs colonise baby, mother handles baby, changes nappies, kisses and fondles baby, is herself colonised, and so mother’s milk may come to contain the patented commercial

products industry has chosen as suitable for inclusion in infant feeds.347 Those pathways designed to sample the biodiverse natural environment and react appropriately could ensure that breastfeeding mother's microbiota includes formula-derived organisms! So, ironically, breast milk could become more like formula, and industry can then claim that formula is more like breast milk … If I were a marketing manager, I'd see the provision to hospitals of ready-to-feed formula in neat single doses as an investment likely to repay its cost. Then if a food company, I'd sell yoghurt containing the infant formula bacteria and market it as organisms found in mother's milk … If they're not there already, they soon may be!

340 While all options carry risks, I think the greater safety of these alternatives (assuming due care in preparation)
is conclusively proven.
341 'A risk is material if in the circumstances of a particular case a reasonable person in the plaintiff 's position, if
warned of the risk, would be likely to attach significance to it, or if the doctor is or should be reasonably aware
that the patient if warned of the risk would be likely to attach significance to it.' (FJ Purnell SC. Negligence
and Birth Injuries. Transcript of talk at PSANZ (Perinatal Society of Australia and New Zealand) Conference
Canberra March 2001.)
342 What informed consent means for legal defence cases in Australia is discussed at length in the manual of the
Medical Defence Association of Victoria, Medicine and the Law: A practical guide for Doctors. (MDAV 2006).
For the medical duty to disclose risks , and the loss of a chance for a better outcome, see Ch. 17.
343 This has already been argued in one Washington DC court. I predict that with a few decades such a case
will be successful. Awareness of this risk is driving the use of 'informed consent' forms which are frequently
quite inadequate in content and process of administration, but which may enable hospitals to say the mother
consented.
344 I visited this milkbank then and was given this information. See ALCA News 1990
345 Professor Peter Hartmann made this statement at a conference some years ago.

346 Closa-Monasterolo R, Gispert-Llaurado M, Luque V, Ferre N et al. Safety and efficacy of inulin and
oligofructose supplementation in infant formula: Results from a randomised clinical trial. Clinical Nutrition
2013. Doi: 10.1016/j.clnu.2013.02.009). Recruitment was in the first month, not from birth.
347 Perhaps as with GM corn in Canada, mothers will have to pay for the privilege of being contaminated with
patented products. Will mothers need a licence to make milk containing patented probiotics? Mad, I know, but
who would have guessed that an organic crop contaminated by pollen from a neighbour's GM crop would result
in confiscation of the organic crop, not damages awarded against the polluters?

Book availability

Milk Matters: Infant feeding & immune disorder is available from Amazon and Book Depository worldwide and also LLLGB Books in the UK. In Australia, orders can be made via the author's website. If any other LLL Group or entity wishes to order multiple copies, the author can arrange publication in the US or Europe at a substantial discount. Contact Maureen Minchin via her website for further information.

Biography

Maureen Minchin has been pivotal in global efforts to protect, promote, and support better infant feeding practices since the 1970s. She helped create the lactation consultant profession, was consultant to international bodies such as the World Health Organization (WHO) and UNICEF, and worked to educate health professionals both directly and by being involved in creating university-based courses in the UK and Australia. She was involved in the creation of the global WHO/UNICEF Baby Friendly Initiative. Her ground-breaking book, *Food for Thought*, *a parent's guide to food intolerance*, was published in Australia, the UK, and Japan. She is on the Editorial Board of the open access *International Breastfeeding Journal* and can be reached via her website for media enquiries and speaking engagements.

Preparing for Leadership

A New Co-Leader in Four Easy Steps

Suzy Landreth, Nebraska, USA
Adapted from an article in the Nebraska *Pioneer,* Spring/Summer 2013

I remember years ago when my mother purchased a new Video Cassette Recorder (VCR). Yes, I said it was years ago! My husband was trying to explain to her what all the little buttons were and what they did. She said to him, "I won't worry about learning that now, just show me how to turn it on and off."

That is how I am sometimes: part my mother and part Scarlett O'Hara from *Gone with the Wind* who said, "I can't think about that right now. If I do, I'll go crazy. I'll think about that tomorrow." I approach learning new information on a "need to know" basis. If it pertains to me personally, I am more apt to want to acquire the new knowledge.

Learning about a new skill, such as breastfeeding, is much more enjoyable when you are pregnant or have just given birth, than, say, when you are 16 years old and reading about it for health class. You might feel the same way about supporting a Leader Applicant if you have no experience working with Applicants or if you haven't seen any potential Applicants on the horizon. You might switch into "Scarlett O'Hara mode" and think you will learn about that tomorrow.

Helping mothers prepare for leadership is easier when you have some basic understanding of the application process. Would you feel more confident when approaching a mother about leadership if you knew you could have a new co-Leader in four easy steps?

Before the application

Step one: Pre-Application Dialogue

Leaders can access *Pre-Application Guidelines for Leaders* at http://www.llli.org/docs/lad/TaLLLPre-ApplicationGuidelinesforLeaders.pdf from the *Leader's Pre-Application Packet.* Learn about the four prerequisites a mother needs to meet to apply for leadership: Personal Breastfeeding Experience, Mothering Experience, Organizational Experience, and Personal Traits. In addition to describing the prerequisites, this resource will also guide your discussion of LLL philosophy, the work of a Leader, what is involved in an application, and the costs of applying.

Step two: Leader Recommendation
After you have thoroughly discussed the items in the *Leader's Pre-Application Packet* with the potential Applicant, you will complete a Leader Recommendation form which is also included in the *Packet*.

During the application

Step three: *Checklist of Topics to Discuss in Preparation for LLL Leadership*.
Set up regular times to discuss these topics. Ask your Leader Accreditation Department (LAD) representative for a copy of this checklist organized by the responsibilities of Leadership. A compact version of the *Checklist* is available in the *Leader Applicant's Resource Kit* (LARK), combined version, Part 3.

Step four: *Preview of Mothers' Questions/Problems and Group Dynamics/ Management (Preview)*
Many Leader Applicants save this until the end of their application but it can also be used at any time during the application. The *Preview* is a tool for Leaders and Leader Applicants to work together in mock helping situations. It can also be completed when the Applicant works through the *Breastfeeding Resource Guide* (BRG). For example, after she completes the BRG section on nipple problems, she might practice a *Preview* response about sore nipples.

As you and the Applicant address Steps 3 and 4, she can also be working on other parts of the application by herself or by corresponding with the LAD representative. For instance, she can be writing portions of her personal history, going through the background reading, and researching the topics in the BRG if she chooses to work on it on her own. Your LAD representative can give you a graphic summary of the application work. This can also be found in the LARK.

Breaking down your work with a potential Leader into steps and acquiring the knowledge to help her prepare for leadership through her application can be a fun and enjoyable way to gain a new co-Leader.

After all, as Scarlett O'Hara said, "Tomorrow is another day."

Suzy Landreth has been an LLL Leader in Nebraska, USA since January 1995. She has held the positions of Area Coordinator of Leaders (ACL), Area Conference Supervisor

(ACS), District Advisor (DA), Area Leaders' Letter Editor (ALLE), and two separate terms as Coordinator of Leader Accreditation (CLA). She and her husband, Tim, have eight children; four boys aged 27, 26, 25, and 12, and four girls aged 22,19,15, and 8.

Keeping Up to Date

Meet the LLLI Professional Advisory Board

The international Professional Advisory Board provides voluntary assistance to LLLI by advising the Board of Directors and the Executive Director. The LLLI Professional Advisory Board (PAB) is comprised of three councils that include members of the **health professions** (Health Advisory Council or HAC), the **legal profession** (Legal Advisory Council or LAC), and the **business community** (Management Advisory Council or MAC).

Members of these councils are selected for their:
• professional knowledge and experience
• understanding of the importance of breast milk and of all aspects of the breastfeeding relationship
• appreciation of LLLI as an organization in promoting, protecting, and supporting breastfeeding worldwide.

Protecting the reputation of La Leche League
PAB members serve LLLI by sharing information in their areas of expertise, contributing financially to the organization, speaking at LLL conferences and seminars, and promoting and protecting the image and reputation of La Leche League. They are willing to respond to LLLI Board inquiries and to use their own professional resources in accessing and researching the answers to questions that are brought to them. These professionals help to substantiate the credibility of the organization, including its publications, programs, policies, and procedures.

Nominations welcome
Recommendations for potential PAB membership are always welcomed. Names are presented for consideration to the LLLI PAB Committee Chairman by LLLI Board members, LLL Leaders or administrators, current and former PAB members, or by self-nomination. The LLLI Board strives for professional representation from around the

world. PAB members serve five-year terms, which are renewable. When a PAB member retires, the LLLI Board may grant a special Emeritus status in perpetuity in order to recognize and honor their faithful, dedicated, long-term service and assistance to La Leche League International.

The PAB Committee
The PAB Committee of the LLLI Board oversees the actions related to the three councils. Volunteer PAB Communications Facilitators are appointed by the Board to assist the PAB Committee and council members in their work. LLL Leader Betty Crase currently serves in the PABCF position.

The PAB Committee is currently looking for additional LLL Leader volunteers interested in becoming PAB Communications Facilitators to join Betty in this important and rewarding responsibility. Communication exchanges take place electronically. Extensive experience in the LLL Professional Liaison Department is a prerequisite, and an appreciation for working with busy health, legal, and/or management professionals is essential.

Health Advisory Council members
At the March 2015 Annual Session, the LLLI Board took action on the membership of the PAB Health Advisory Council (HAC). Two new HAC members were appointed, one former member was reappointed, and twenty-one members who had just completed 5-year terms were renewed. These members are as follows:

Newly appointed:
Kathleen Kendall-Tackett, PhD, IBCLC, FAPA (USA)
Frank J. Nice, RPh, DPA, CPHP (USA)

Reappointed:
Armond S. Goldman, MD, FAAP (USA)

Renewed:
Naomi Baumslag, MD, MPH (USA)
Arthur I. Eidelman, MD, FABM, FAAP (Israel)
Rolando Figueroa, MD, FACOG (El Salvador)
Carlos Gonzalez Rodriguez, MD (Spain)

Jay Gordon, MD, FAAP (USA)
Thomas Hale, RPh, PhD (USA)
Miriam H. Labbok, MD, MPH, IBCLC, FACPM, FABM, FILCA (USA)
Ruth Lawrence, MD, FAAP, FABM, FAACT (USA)
James J. McKenna, PhD (USA)
Paula P. Meier, DNSc, RN, FAAN (USA)
Audrey J. Naylor, MD, DrPH, FAAP, FABM (USA)
Jack Newman, MD, FRCPC (Canada)
Victoria Nichols Johnson, MD, FACOG, FABM (USA)
Michel Odent, MD (United Kingdom)
Horacio Reyes Vazquez, MD (Mexico)
Richard Schanler, MD, FAAP, FABM (USA)
William Sears, MD, FAAP (USA)
Christina M. Smillie, MD, FAAP, IBCLC, FABM (USA)
Penelope A. Stanway, MB, BS (Ireland)
Mark Thoman, MD, FAAP, FACMT (USA)
William G. White, MD (USA)

The following HAC members were acknowledged for their many years of dedicated service and granted Emeritus status:

Retiring:

Cheston M. Berlin, Jr., MD, FAAP (USA)
Marianne Neifert, MD, FAAP (USA)
Edward R. Newton, MD, FACOG (USA)
Jairo Osorno, MD (Columbia)
Jan Riordan, EdD, ARNP, FAAN, IBCLC (USA)
Arnold L. Tanis, MD, FAAP, FABM (USA)

Deceased:

Paul M. Fleiss, MD, MPH, FAAP (USA)
Brian Palmer, DDS (USA)
Harry Torney, BDS (Ireland)

Additional members of the HAC currently in midterm service include the following:
Carol Bartle, RN, RM, IBCLC, MHSc, PGDiplomat Child Advocacy, IBCLC (New Zealand)
Maya Bunik, MD, MSPH, FABM (USA)
Claire Dalidowitz, MS, MA, RD, CD-N (USA)

Alicia Dermer, MD, FABM, IBCLC (USA)
Anne Eglash, MD, FABM (USA)
Hammam Kandil, MD, IBCLC (Saudi Arabia)
Joan Younger Meek, MD, MS, RD, IBCLC , FAAP, FABM (USA)
Denise Punger, MD, FAAFP, IBCLC (USA)
Kath Ryan, BPharm, PhD, MPS (Australia)
Robert Sears, MD, FAAP (USA)

This brings the current membership of the LLLI PAB, Health Advisory Council to 34 internationally distinguished health professionals and researchers. Information will be shared about the Legal and Management Advisory Councils in a future issue of *Leader Today*.

Written by the PAB Committee and Betty Crase, PABCF. For further information contact the PAB Commmittee co-Chairs, KVelasquez@llli.org and JHurley@llli.org

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