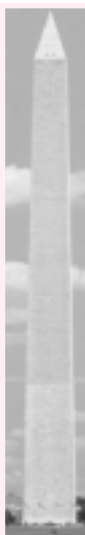


# Breastfeeding

# OUTLOOK

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Formerly  
Breastfeeding Today



## The NATIONAL FRONT

**Federal Legislation:** Rep. Maloney will host a public news conference Wednesday, March 8 at the U.S. Capitol at 11:00 a.m. to support the Pregnancy Discrimination Act of 2000, which she will introduce on that day. This bill will protect women from being fired and/or discriminated against in the workplace based on lactation. Currently the law

protects women based on "pregnancy, childbirth, and related medical conditions." This bill will clarify that lactation is a related medical condition. (It is similar to H.R. 1478 that was introduced in 1999, but with a few minor changes suggested by the U.S. Department of Labor.)

**Baby-Friendly™ Hospital Initiative:** Boston Medical Center in Boston MA and Kaiser Sunnyside Medical Center in Clackmus Oregon, have become the 22nd and 23rd facilities in the United States to achieve the Baby-Friendly™ designation. Congratulations to all staff who helped make this happen!

**The United States Breastfeeding Committee** met in San Diego CA on January 21 and 22, 2000. The committee ratified its new bylaws, and finalized the strategic plan for breastfeeding in the United States. The plan consists of these four main goals:

- Assure access to comprehensive, current, and culturally appropriate lactation care and services for all women, children, and families.

See **National Front (cont.)** page 7

## Early Hospital Discharge and Early Discontinuation of Breastfeeding are Not Related

**M**ost breastfeeding advocates assumed that shorter hospital stays would result in early cessation of breastfeeding, or poor clinical outcomes. To date, however, no study has substantiated this fear.

### Studies Show No Correlation

Several descriptive studies here in the United States and abroad have shown no correlation between early hospital discharge and early discontinuation of breastfeeding. In Sweden, there was no significant difference in

See **Early Discharge** next page



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# Guilty, Guilty, Guilty!

MARIE BIANCUZZO, RN, MS, Editor

Often, someone says to me, “Yes, breast is best, but you don’t want to make mothers feel guilty, do you?” What a strange question! Apparently it’s okay for me to make mothers feel guilty if they don’t get immunizations for their babies, but if I mention another infection-protection mechanism, I’m out of line. Oddly, we don’t even presume there’s a choice for other issues. When did you last hear a colleague ask a parent, “Do you plan to use a car seat or hold the baby on your lap? Do you plan to smoke or not smoke after the birth of your baby?” If it’s car seats, smoking, immunizations, or other issues, we simply tell parents what is best, with the full expectation that they will do what’s best. We don’t ask. So what sort of message do we give when we ask, “Do you plan to breastfeed or bottle-feed your baby?”

Presenting the question with those words implies that breastfeeding and artificial feeding are equivalent. Heaven knows, we don’t need any more people telling women that artificial milk is as good as mother’s milk, or at least the “next best thing.” Further, in asking such a question, we delay establishing the cultural norm. When discussing delivery issues, we never ask, “Do you want to have a vaginal or cesarean delivery?” We simply assume that the woman is going to do the “natural” thing. When discussing feeding issues, it would be much better to say, “Tell me what you know (or what you’ve heard) about breastfeeding.” This does two things. First, it establishes breastfeeding as the cultural norm. Second, it allows us to quickly glance at the mother’s attitudes, beliefs, and values. Usually, those who plan to breastfeed give some answer along the lines of “It’s best for the baby” whereas women who plan to bottle-feed often respond by saying how painful, inconvenient or distasteful breastfeeding is. That gives the interviewer a chance to talk about the woman’s fears, misconceptions, previous experiences or objections. It invites open dialogue. Asking which method she has chosen usually results in a dead end when she says, “Bottle-feed.”

So do I want to make mothers feel guilty for choosing bottle-feeding? A resounding “Yes” to this question! I certainly want to be respectful of the mother’s choices and feelings and values, but it’s my legal and ethical responsibility to tell parents what’s best for their babies — whether it’s using a car seat or breastfeeding. If they feel guilty for making a second-best choice, they should. Every baby deserves the best that the parent can provide.

## Early Discharge from page 1

breastfeeding rates at 6 months for mothers who had been discharged from the hospital at 24–48 hours compared to those who had been discharged at 6 days postpartum.<sup>1</sup> The same investigator conducted a later study that confirmed the initial results, and went on to show that there was also no correlation between early discharge and use of supplemental feedings.<sup>2</sup>

Here in the United States, studies have shown either no association between early discharge and breastfeeding rates, or an increase in breastfeeding rates. One randomized controlled study (n=131) showed early hospital discharge was associated with a greater likelihood of exclusive breastfeeding at one month.<sup>3</sup> (It’s important to remember that these mothers had in-person follow-up). Another study (n=101) looked at breastfeeding outcomes for primiparae discharged from the hospital at 24 hours with a follow-up home visit in comparison to primiparae who were discharged at 48 hours.<sup>4</sup> Breastfeeding incidence was measured at 6–8 weeks postpartum. There was no significant difference in continuation of breastfeeding between these groups.

A prospective cohort study by Mandl and colleagues<sup>5</sup> was conducted to determine the effect of early discharge on the incidence of breastfeeding at 3 weeks and 8 weeks. A total of 1015 women, discharged at a mean of 41 hours postpartum, were surveyed by telephone at 8 weeks, and at that time, there was no difference in breastfeeding rates between the group that had been discharged before 48 hours, and the longer-stay group.

A very recent study on early discharge was conducted here in the United States by Britton et al.<sup>6</sup> A prospective, longitudinal study was conducted on 146 subjects who were discharged at less than 36 hours postpartum. The investigators studied not only breastfeeding outcomes, but also mother-infant interaction and security of attachment. At 3 months, there was no significant difference in the incidence of exclusive breastfeeding between the early or the late discharge groups. The results of this study are consistent with Mandl’s findings<sup>5</sup> at 3 months postpartum.

## Clinical Implications of These Studies

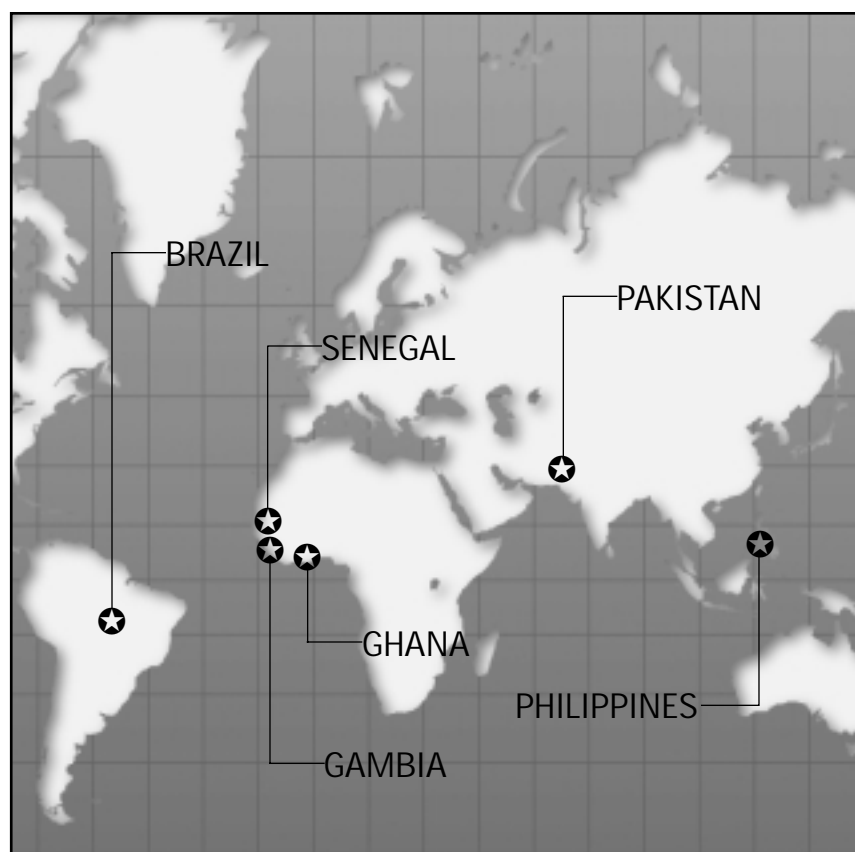
The results of these studies show that early hospital discharge does not appear to sabotage breastfeeding. It’s important, however, to recognize that breastfeeding will not automatically

See Early Discharge page 7

# A Meta-Analysis of Risk and Benefits: Policy Implications for Breastfeeding

**T**he WHO Collaborative Team did a meta-analysis of previously conducted studies to assess “the effect of not breastfeeding on the risk of death due to infectious diseases.” This meta-analysis<sup>1</sup> was undertaken to determine if breastfeeding significantly reduces death from infection in less developed countries where HIV is also a killer.

To perform this meta-analysis, investigators first determined which previous studies would be included in the present study. The investigators first identified 13 published and unpublished data sets by consulting with international health experts and searching the MEDLINE database for studies conducted between 1980 and 1998 that addressed infant/child mortality and feeding practices. Then, they excluded studies if they contained factors that could erroneously influence results. For example, studies were excluded if infant deaths occurred during the first week of life, as it was presumed that human milk would not have had a significant impact on infant mortality in so short a time period. (Most of these deaths, however, were due to perinatal causes or congenital anomalies.) Similarly, deaths that were not caused by infection, or those that resulted from unknown causes, were excluded from most analyses. Eight studies met the criteria; one could not be used because the original data had been destroyed, and another was excluded because the author did not respond to investigator’s requests. The six studies that remained in the meta-analysis were conducted in Brazil, Gambia, Ghana, Pakistan, Philippines, and Senegal.



Only the studies conducted in Brazil, Philippines, and Pakistan were used in the analysis of the first year. Nearly every infant was breastfed throughout the first year in the three African studies, so these studies could not be included in the analysis describing the effects of lack of breastfeeding on death within the first year. The African studies, as well as the other three, were used in analyses for deaths during the second year.

The protection that breastfeeding offers against mortality was inversely related to the age of the infant or child. More specifically, however, protection against diarrhea declined markedly with age, whereas protection against acute respiratory infection was fairly continuous. The investigators conclude that infants in these less developed countries have a 6-fold greater risk of dying of infection in the first 2 months, compared to cohorts who are fed with artificial milk.

A strength of this study is that it ruled out the possibility of reverse causality, i.e., the “which came first” question. Previous studies have not addressed this, so it may be that feeding changes were a result of illness, rather than illness being a result of feeding. The authors point out that a limitation is that this meta-analysis may have failed to include smaller studies, or those that were unpublished.

What does this mean for HIV positive mothers in less developed countries who wish to breastfeed? The authors give no precise answer, but suggest that policy makers should recognize that infant and child mortality results from infections, and is more likely to occur when infants and children in less developed countries are fed artificial milk rather than human milk. Similar to the WHO/UNAIDS/UNICEF document,<sup>2</sup> this study emphasizes that the mother should be the ultimate decision-maker of the feeding method used.

1. WHO Collaborative Team on the Role of Breastfeeding on the Prevention of Infant Mortality. Effect of breastfeeding on infant and child mortality due to infectious diseases in less developed countries: a pooled analysis. *Lancet* 2000, 451–455.
2. WHO/UNAIDS/UNICEF. HIV and infant feeding. Guidelines for decision-makers. 1998. Web Page. Available at: <http://www.unaids.org/publications/documents/mctct/infantpolicy/html>.

# Exclusive Breastfeeding Protects Against Asthma

Oddy and her colleagues recently conducted a prospective, longitudinal cohort study of 2187 children in western Australia. <sup>1</sup> This study was designed to show the correlation between the continuation of exclusive breastfeeding and the incidence of asthma. Investigators followed children until they were six years old, relying primarily on parents' reports but also on the results of skin prick tests and a doctor's diagnosis of asthma. The investigators controlled for confounding factors including sex and gestational age of the child, smoking in the household, and early child care arrangements.

After adjusting for confounding variables, a correlation was shown between the age at which the children consumed non-human milk, and the development of asthma. Children who exclusively breastfed for at least 4 months were at significantly less risk for asthma than those who had been partially breastfed, or those who had been weaned prior to 4 months of age.

This was a well-done study. A large sample size, subjective and objective definitions of asthma, differentiation between exclusive and partial breastfeeding, and control of confounding variables help to convince the reader of this study's results and conclusions. Some previous studies failed to show a correlation between breastfeeding and either asthma or atopy <sup>2,3,4</sup> whereas others <sup>5-7</sup> showed results consistent with those found here. Whether these results can be generalized to other populations, however, has yet to be determined.

1. Oddy WH, Holt PG, Sly PD, et al. Association between breast feeding and asthma in 6 year old children: findings of a prospective birth cohort study. *BMJ*. 1999;319:815-9.
2. Juvonen P, Mansson M, Andersson C, Jakobsson I. Allergy development and macromolecular absorption in infants with different feeding regimens during the first three days of life. A three-year prospective follow-up. *Acta Paediatr*. 1996;85:1047-52.
3. Strachan DP, Anderson HR, Johnston ID. Breastfeeding as prophylaxis against atopic disease [letter]. *Lancet*. 1995;346:1714.



4. Halpern SR, Sellars WA, Johnson RB, Anderson DW, Saperstein S, Reisch JS. Development of childhood allergy in infants fed breast, soy, or cow milk. *J Allergy Clin Immunol*. 1973;51:139-51.
5. Saarinen UM, Kajosaari M. Breastfeeding as prophylaxis against atopic disease: prospective follow-up study until 17 years old. *Lancet*. 1995;346:1065-1069.
6. Wilson AC, Forsyth JS, Greene SA, Irvine L, Hau C, Howie PW. Relation of infant diet to childhood health: seven year follow up of cohort of children in Dundee infant feeding study. *BMJ*. 1998;316:21-5.
7. Tariq SM, Matthews SM, Hakim EA, Stevens M, Arshad SH, Hide DW. The prevalence of and risk factors for atopy in early childhood: a whole population birth cohort study. *J Allergy Clin Immunol*. 1998;101:587-93.

## CHILDREN'S BOOKS

### MICHELE: THE NURSING TODDLER

BY JANE M. PINCZUK

ILLUSTRATED BY BARBARA MURRAY

BOOK . . . . . 32 pages

Hard Cover . . . (ISBN 0-912500-40-9) . . . \$14.95

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<http://www.lalecheleague.org>

Reading Level: Ages 4-8

The pastel watercolor illustrations perfectly accent this gentle tale of love. The character of Michelle is based on the author's own daughter, and the story shows a little girl's transition from a breastfeeding baby to a happy and independent child.

This book would be especially reassuring for a toddler who is still nursing, but is showing the first signs of independence. The message is that the security of love and care that Michelle receives as a breastfed baby is a



legacy of love, health and security even into adulthood. Recommended.

Marsha Forchuk Skrypuch, BA, MLS

## Quarterly Media Review

### BREASTS AND BREASTFEEDING: COMMON EARLY CONCERNS

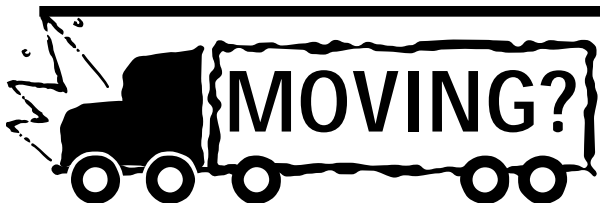
BY KARIN CADWELL PhD RN IBCLC &  
CINDY TURNER-MAFFEI MA IBCLC  
in collaboration with Kittie Frantz RN CPNP  
and Kay Hoover MEd IBCLC  
\$29.95 plus S&H  
15 minutes  
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Phone: 888-888-8077  
Phone: 508-888-8044  
Fax: 508-888-8050

This videotape begins and ends by saying that all mothers can breastfeed, regardless of the size and shape of their breasts, or the problems that they may encounter. Multiple still photos and drawings are shown as the narrator describes normal and abnormal anatomy of the breasts, engorgement, sore nipples, plugged ducts, mastitis, breast abscesses and Candidiasis. Clinical treatments are described, and citations from the scientific literature are printed on the screen to substantiate some recommendations.

This videotape would be helpful for individuals in clinical practice who wish to have an overview of several common concerns. The drawings and photographs to demonstrate the points made by the narrator are particularly helpful. There is much information packed into these 15 minutes, and the viewer may wish to stop the videotape to make notes. Recommended.

—Marie Biancuzzo, RN MS IBCLC



Don't count on the post office to forward mail. Be proactive and send your new address to [newsletter@wmc-worldwide.com](mailto:newsletter@wmc-worldwide.com) or WMC Worldwide, PO Box 387, Herndon VA 20172. Our goal is to get *Breastfeeding Outlook* to you on time, every time, so that you can stay current!

## New Product Announcements

**Milk Storage Bags:** Bailey's new polyethylene bags feature easy-to-use built-in wire closures and fit directly onto many cycling pumps. Packages of 25 bags with instructions in English and Spanish retail for \$8.00. Wholesale price is \$96 for a case of 24 packages. Call 800-413-3216 (805-528-5781) or visit <http://www.baileymed.com> for details.

**New Posters** are available from InFact Canada. All show positive images of breastfeeding and have clever captions. Contact InFact Canada 416-595-9819 or visit <http://infactcanada.ca>.



## RECENTLY SEEN...

- Blair, P.S. et al. (1999). Babies sleeping with parents: case-control study of factors influencing the risk of the sudden infant death syndrome. *BMJ* 319, 1457-1462.
- Carbajal, R. et al (1999). Randomized trial of analgesic effects of sucrose, glucose, and pacifiers in term neonates. *BMJ* 319, 1393-1396.
- Chambers, C.D. (1999). Weight gain in infants breastfed by mothers who take fluoxetine. <http://www.pediatrics.org/cgi/content/full/104/5/e61>
- Clark, J.P. (1999). Babes and boobs? Analysis of JAMA cover art. *BMJ* 319, 1603-1605.
- Grupp-Phelan, J. et al, (1999). Early newborn hospital discharge and readmission for mild and severe jaundice. *Arch Pediatr Adolesc Med* 153, 1283-1288.
- Hill, P. D., Aldag, J.C. & Chatterton, R.T. (1999). Breastfeeding experience and milk weight in lactating mothers pumping for preterm infants. *Birth* 26(4), 233-238.
- Lawrence, R.A. (1999). Storage of human milk and the influence of procedures on immunological components of human milk. *Acta Paediatr Suppl* 1999 88(430), 14-18.
- Oulis, et al. (1999). Feeding practices of Greek children with and without nursing caries. *Pediatr Dent* 21(7), 409-416.
- Rodrigues, S. et al. (1999). Interaction of body weight and ethnicity on risk of gestational diabetes mellitus. *Am J Clin Nutr* 70-1083-1089.
- Schanler, R.J., O'Connor, K.G. & Lawrence, R.A. (1999). Pediatricians' practices and attitudes regarding breastfeeding promotion. <http://www.pediatrics.org/cgi/content/full/103/3/e35>
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# Cups Are Good Alternative to Bottles

Howard and colleagues<sup>1</sup> remind clinicians that cup-feeding may or may not be a way to prevent so-called nipple confusion. The phenomenon of nipple confusion has not been clearly established, and if such a phenomenon does exist, it is only one of many factors that should be considered when deciding how to best administer a feeding.

This descriptive study compared the physiologic effects of bottle-feeding and cup feeding in newborns aged 1-3 days. Nurses administered artificial milk from a cup (n=51) or a bottle (n=47) while mothers breastfed their own infants (n=25). Heart rate, respiratory rate, oxygen saturation rates were monitored in all of the infants. Investigators also measured the amounts ingested, and the length of time it took to complete the feedings.

This is the first randomized trial that measured the physiologic stability of infants fed by cup in comparison to those fed by bottle. There was no significant difference in heart rates, respiratory rates, or oxygen saturation rates between the cup-fed and the bottle-fed groups. The breastfed infants, however, had significantly better heart rates, respiratory rates, and oxygen saturation rates.

Quite apart from the physiologic data, this study also showed that newborns who cup-fed ingested as much, and in about the same amount of time as those who were bottle-fed. Breastfed newborns spent more time during their feeding.

The study did have a few limitations. The authors point out that a possible limitation of the study is that the mothers held and fed at the breast, whereas nurses fed the artificially-fed infants. More importantly, however, one might wonder if the artificial milk influenced results, as a previous study has shown that artificial milk itself contributes to less physiologic stability.<sup>2</sup>

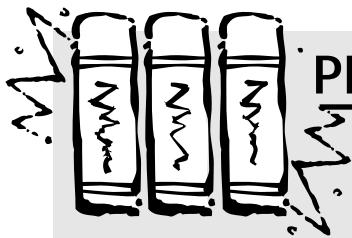
Many clinicians have had difficulty creating hospital protocols to support the use of a cup because of the fears that cup feeding is unsafe. Interestingly, bottle-feeding has never come under such scruti-



PHOTO COURTESY OF DEBI BOGAR

ny, and this study has shown bottle-feeding is no more physiologically advantageous than cup-feeding.

1. Howard CR, de Bleeck EA, ten Hoopen CB, Howard FM, Lanphear BP, Lawrence RA. Physiologic stability of newborns during cup- and bottle-feeding. *Pediatrics*. 1999;104:1204-7.
2. Butte NF, Smith EO, Garza C. Heart rates of breast-fed and formula-fed infants. *J-Pediatr-Gastroenterol-Nutr*. 1991;13:391-6.



## PROFESSIONAL LIBRARY

*Sore Nipples: Prevention and Problem-Solving* by Marie Biancuzzo is now available for \$16 plus S&H. Fax your request to 703-758-0891, or order from the web site at

<http://www.wmc-worldwide.com> or e-mail your request to [info@wmc-worldwide.com](mailto:info@wmc-worldwide.com).

*Clinical Therapy in Breastfeeding Patients* by Thomas Hale, PhD is now available from Pharmasoft Publishing for \$19.95 plus S&H. Call 806-376-9900 or toll-free 800-378-1317. You may also fax your order to 806-376-9901 or purchase from their web site at <http://www.perinatalpub.com>

*The Breastfeeding Atlas* by Barbara Wilson-Clay BS IBCLC and Kay Hoover MEd, IBCLC is available for \$39 plus S&H from Barbara Wilson-Clay. Call 512-292-7227 or e-mail [bwc@jump.net](mailto:bwc@jump.net).

*The Clinical Management of Breastfeeding for Health Professionals* Part I and II is available for \$395 plus S&H from Vida Communications. Call 800-550-7047 or 617-864-4334. You may also fax your order to 617-864-7862.



## You Asked...

**Women at the military base frequently ask if it's okay to get an anthrax vaccine while they are breastfeeding. What can we tell them?**

The anthrax vaccine is considered safe for a lactating woman. The vaccine is an alum precipitate of the antigen from the bacteria. In general, only a live vaccine would be considered contraindicated for the breastfeeding mother. See [http://www.cdc.gov/ncidod/dbmd/diseaseinfo/anthrax\\_g.htm](http://www.cdc.gov/ncidod/dbmd/diseaseinfo/anthrax_g.htm)

## Early Discharge from page 2

continue after hospital discharge. Mothers mentioned in some of the studies here have had professional follow up, and/or telephone follow-up after hospital discharge. Without such follow-up, one could not assume that breastfeeding would continue as it did for the mothers in these studies. Further, breastfeeding is more likely to continue when nurses who have knowledge about breastfeeding make home visits and observe a feeding<sup>7</sup> rather than when others, including aides and nannies, simply visit the mother.<sup>8</sup>

A successful education program for breastfeeding mothers begins with careful planning. A three-tiered approach, beginning during the antepartum period, and continuing through the intrapartum and postpartum periods should have clear affective, psychomotor, and cognitive learning objectives.<sup>9</sup> Antepartum objectives must focus on motivating the mother to choose breastfeeding. Early postpartum objectives must teach the how-to of breastfeeding and promote the critical biologic needs of the mother and infant. Objectives during the continuing postpartum period should focus on ways to support the mother in her efforts and to know how and when to get extra support. None of this can be accomplished without the interdisciplinary collaboration between multiple members of the health care team, including those who work in both in-house and ambulatory setting.

1. Waldenstrom U, Sundelin C, Lindmark G. Early and late discharge after hospital birth: breastfeeding. *Acta-Paediatr-Scand.* 1987;76:727-32.
2. Waldenstrom U, Nilsson CA. No effect of birth centre care on either duration or experience of breast feeding, but more complications: findings from a randomized controlled trial. *Midwifery.* 1994;10:8-17.
3. Carty EM, Bradley CF. A randomized, controlled evaluation of early postpartum hospital discharge. *Birth.* 1990;17:199-204.
4. Quinn AO, Koepsell D, Haller S. Breastfeeding incidence after early discharge and factors influencing breastfeeding cessation. *J Obstet Gynecol Neonatal Nurs.* 1997;26:289-94.
5. Mandl KD, Brennan TA, Wise PH, Tronick EZ, Homer CJ. Maternal and infant health: effects of moderate reductions in postpartum length of stay. *Arch Pediatr Adolesc Med.* 1997;151:915-21.
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7. Kuan LW, Britto M, Decolongon J, Schoettker PJ, Atherton HD, Kotagal UR. Health system factors contributing to breastfeeding success. *Pediatrics.* 1999;104:e28.
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9. Biancuzzo, M. Breastfeeding education for early discharge: a three-tiered approach. *J Perinat Neonatal Nurs.* 1997; 11(2):10-22.

## Letters to the Editor

I just received the Autumn issue of your newsletter *Breastfeeding Today* (soon to become *Breastfeeding Outlook* in 2000).

Outstanding. Concise, well laid out and illustrated, referenced, full of variety, just the size to attract attention on a bulletin board, for busy clinicians to take a moment to glance at in an odd moment here and there while they're on hold on the phone, or a few minutes early for shift change.

K. Jean Cotterman RNC, IBCLC

## National Front (cont.) from page 1

- Ensure that breastfeeding is recognized as the normal and preferred method of feeding infants and young children.
- Ensure that all federal, state, and local laws relating to child welfare and family law recognize and support the importance and practice of breastfeeding.
- Increase protection, promotion, and support for breastfeeding mothers in the work force.

Many sub-goals and strategies have been written to support the main goals. This strategic plan has been submitted to the government, and money for implementing the plan is anticipated to follow. The strategic plan, in its entirety, will be published by this summer. See the USBC web page at <http://www.wmc-worldwide/usbc> for updates.

## Parent Education Resources

InJoy Video has produced a series of four breastfeeding videotapes for parents, **Breastfeeding Basics**, copyrighted 1999. Volume 1 is *The Breastfeeding Game: Benefits of Breastfeeding* (22 minutes); Volume 2 is *Valerie's Diary: Beginning Breastfeeding* (23 minutes); Volume 3 is *Straight Talk from Breastfeeding Moms: Beyond the Newborn* (21 minutes); and *Simple Solutions: Problems, Pumping and Storing Milk* (25, 12 minutes). Along with a worksheet for parents, each videotape is \$149.95 plus S&H if purchased separately, or the series is \$449.95 for a limited time only. Call InJoy at 303-447-2082 or toll-free at 800-326-2082 or visit their web site at <http://www.injoyvideos.com>

**The Benefits of Breastfeeding** is a new award-winning videotape from Eagle Video Productions, featuring Dr. Ruth Lawrence. Designed for early child-birth classes, this 21-minute video is available for \$59 (plus \$5 S&H); Spanish version is in production. Call 1-800-838-5848 or visit <http://www.eaglevideo.com>

