Chapter Five

The Scandinavian Breastfeeding Adventure: The First Years (1968–78)

Elisabet Helsing, Dr.Med.Sci.

Personal History

As a young Scandinavian mother in 1965, I have to confess that I was not particularly interested in breastfeeding. Of course, I myself breastfed, that was the done thing. And I was first mildly surprised, then irritated, at the doublespeak of the nurse at the health station, who gave me for free two little satchels of infant formula saying, "Of course, breast is best, but should you not have enough milk, these are nice to have." Not enough milk? Never struck me as the remotest possibility. But as time went by and I spoke with young co-mothers in my vicinity, I learned otherwise. Even the official literature distributed to mothers at the health station gave little encouragement: "Relatively few mothers," it was stated, "indeed only some 30 percent of the total, produce sufficient milk to carry their babies through the entire period of breastfeeding…" (Njå, 1965). That set off my "breastfeeding career."

Why was I different, having no problems with breastfeeding? For one thing, I apparently belonged to the lucky 30 percent who "had enough." But why? One of my friends provided a further clue, "I, too, 'lost' my milk during a bad bout of flu," said she. "But I refused to accept it, so I put him to the breast incessantly and hey, presto! The milk came back." It sounded like a miracle: could it be that the loss of milk was *reversible*? Very interesting. Being by nature a curious person, I started reading up on the subject.

The U.S. Sets an Example

I soon stumbled across a slim blue book with the (in my opinion) somewhat romanticized title: *The Womanly Art of Breastfeeding*. This book, however, had it all: the why, what, and how of breastfeeding, told in simple words.

A few newspaper articles and radio performances on my part later, it was becoming clear to me that those who maintained that modern mothers were not interested in feeding their offspring in the old-fashioned way were dead wrong. The articles I wrote resulted in a flood of letters from mothers, letters full of tears, sad tales, and queries about breastfeeding. I found myself repeating the same points over and over again, and eventually I started writing them down.

Latching on (to stay with the vocabulary) to the ideas expressed in the little blue book, and noting that the organization behind the book, La Leche League International, might have room for a group in Norway, I wrote to them. I soon received an answer from Edwina Froehlich, one of the LLL Founders, welcoming me into the organization. First, however, there were some formalities, which, much to my chagrin at the time, were never completed, since the LLL mother charged with the admission of new members from abroad had had a baby and, therefore, never had the time to complete my application. Sound familiar?

Unstoppable Scandinavians

Not to be stopped, I decided to establish an organization myself, independent of others. Including me, I had ten mothers who had declared their willingness to help other mothers. We called ourselves *Ammehjelpen* (Amme = breastfeed, hjelpen = help) and with incredible speed, or so it seemed to the initiators, the organization grew and spread. None of us had experience in organizing, and all of us worked for free. It never struck any one of us that it could be otherwise. Ammehjelpen was established in October 1968, and became, to my later knowledge, the third mother-to-mother support group created globally. In 1973 Sweden followed suit when *Amningshjälpen* was formed. Just as they chose a name very similar to the Norwegian one, the organizational structure was quite similar in the Swedish and the Norwegian movement, but the recruitment of "help mothers" was a little different. In Sweden, the mothers recruited were more often what may be termed "alternative." There seemed to be, for example, a higher percentage of vegetarians in Amningshjälpen than in the population in general. Unfortunately, the Swedish organization never got the support from the health authorities that Ammehjelpen enjoyed in Norway. For example, when a ministerial "Expert Committee on Breastfeeding" was established in 1973 in Sweden and in 1974 in Norway, the Swedish committee had one person out of 13 representing mothers (and she was by chance Norwegian). The Norwegian committee had four mother representatives out of 14. The secretary of the committee was from

Ammehjelpen and wrote much of the text in the recommendations of the group.

In Denmark the organizational picture seemed to be more varied. An important difference was that the Danish mother-to-mother support group, corresponding to the Swedish and Norwegian ones, had been led by a La Leche League member since 1974. They called themselves "*Ammehjælpen, associated with LLLI.*" In 1981 they were one of several organizations in Denmark providing mother-to-mother support in breastfeeding. An organization primarily formed to improve birthing conditions, under the name *Parents & Birthing,* had a sub-group named *The Breastfeeding Counseling Group*, which was a mother-to-mother support group. Finally, small projects such as "*Mother Earth*" and "*Women's association for developing countries, the group on breastfeeding,*" were also established.

Projects Versus Movements

At this point it may be useful to make a distinction: since mother-to-mother support groups are new to most societies, they will be looked upon as interventions. Any discussion of "interventions," however, should distinguish between *projects* and *movements*.

Ideally, *projects* are of limited duration—they have a starting point and a termination date. Projects are planned in advance and may or may not be open to adjustment under way. Projects are usually very dependent on resources from outside the project area—material as well as human resources. Problems and solutions are usually defined by well-meaning outsiders, not by those with the problems targeted for support, the problem owners.

Ideally, *movements* are first and foremost characterized by control over priorities and actions by those who have the problem. The ideas behind a movement may well come from outside the movement itself, but the ideas take time to grow and mature and become adjusted to the local reality. The problem owners formulate their views about problems, priorities, and solutions. There is no fixed plan available a long time in advance, although good movements need both planning and analysis; movement leaders first have to use their intuition to feel their way forward. Intuition is an important tool for understanding the exceedingly complex situation which problems taken up by a movement usually play. This requires intimate knowledge of the problems, as well as their causes. Movement leaders need to understand not only what is said and expressed openly, but also what is behind the words and under the surface.

Movements take their own time and have no defined time frame. Their exact starting point may be difficult to grasp, and so may their end. Either they peter out and die, or they are suppressed (as is very often the case), or they grow and lead to social change. The latter may be the most significant aspect of movements versus projects: the great potential of movements for social change. This was what we saw and experienced as regards breastfeeding in those heady first years. In order to survive, the mother-to-mother support had to be expressed and organized as a movement, not a project.

Mother Support or Mother-To-Mother Support

In retrospect, I personally see a distinction between mother support (MS) and mother-to-mother support (MtMS) groups. The BFHI Step 10 is not much help in clarifying this distinction since it does not give a clear definition of what is meant by *"Foster the establishment of breastfeeding support groups and refer mothers to them on discharge from the hospital or clinic."* As we found out the hard way, health workers should not be expected to start MtMS groups. Too many attempts at doing that, however well meaning, have failed simply because the health workers were trying and failing to act on behalf of the problem-owners, the mothers.

It is very desirable that health workers and MtMS groups are on good terms and work together. It would be highly undesirable if these potential helpers of mothers should see one another as enemies.

It might be helpful to go back to the basic question: "*What is breastfeeding?*" A great many women with breastfeeding problems are helped solely by being asked: "What would you have done with your breastfeeding problem if you had been cast off with your baby on a deserted island?" Most, but not all, breastfeeding problems are simple. Helping a mother requires empathy, but not enormously much in the way of training. But as we know, humans are tricky things, and a few will need specialist support. Then the lactation specialists enter the scene, and we are no longer talking about mother-to-mother support, but rather about a specialized form of mother support. Mother support can have as many expressions as there are facets to breastfeeding. Just a few examples are:

- Maternity protection legislation supports mothers.
- Baby-Friendly Hospitals support mothers.
- Prohibition of infant formula marketing supports mothers.
- Mother-to-mother support supports mothers.
- IBCLC support supports mothers.

- Evidence-based material on breastfeeding in practice supports mothers.
- Etc., etc., etc.

Back to Scandinavia

The Scandinavian countries are, in spite of appearances to the contrary, quite different. Table 5.1, for example, shows the differences in live births 1996-2000, that is, potentially breastfed babies in the three Scandinavian countries. Sweden is by far the largest of the three.

Table 5.1. Average number of live births annually in the Scandinavian countries 1996–2000

Country	Live Births
Denmark	66,951
Norway	58,522
Sweden	90,688

Source: NOMESCO (Nordic Medico-Statistical Committee). (2005). *Health statistics in Nordic countries 2003*. Copenhagen: NOMESCO.

As the years went by, the example of LLLI continued to be important to the Scandinavian groups, but in the Norwegian Ammehjelpen, we still felt it necessary to retain our independence. There were several reasons for this. The North American material, when translated to Norwegian, looked odd. There was nothing wrong with the factual information; it was the presentation that was distinctly un-Norwegian. But this did not deter us from using existing organizational ideas and practical knowledge whenever we came across it. At that time publications on practical aspects of breastfeeding, however, were few and far between, but we used the little there was. Apart from the LLL material, our mentors were the Jelliffes, Illingworth, Applebaum, and the Newtons,[3] among others. As time went by, the trickle of information on breastfeeding and human milk swelled to the present deluge, where one can indulge in the luxury of picking out the best. Evidence-based material in quite specialized areas is also available now.

Organizations and Organizing

Few of the Scandinavian initiators had any organizational experience. This was reflected in a rather experimental attitude to organizing. The advantage of this experimentation was that a model might be found that suited this

3 Note: Dr. Derrick B. Jelliffe, Mrs E.F. Patrice Jelliffe, Dr. Richard M. Applebaum, and Drs. Michael and Niles Newton were leading breastfeeding advocates who were important sources of information and support to the new mothers' groups. [Editors]

particular group of organizing citizens: mainly young mothers with babies and small children. The disadvantage was that experimentation invariably leaves some people disappointed, and much time is used in discussing and trying out models that fail.

One particular trait that seemed to repeat itself in many of the Mother-to-Mother Support groups was the basic structure. There had to be leadership, but quite a lot of effort went into seeing to it that the structure did not become hierarchical. This might be a more or less conscious effort to avoid a "male" organizing pattern in organizations that necessarily would be female-dominated. This being 1969-1970, there was a strong influence from the feminist movement, and many of us were doubling as feminists and *ammehjelpers* ("help mothers"). In Norway we had no problems in explaining this double loyalty: the problem as we saw it was not at all with breastfeeding or not breastfeeding. There is really no alternative to the breast, just as there is no alternative to the uterus. The question was not whether or not to breastfeed, but rather whether or not to have babies. If we went in for procreation, this meant taking the whole package, so to speak.

In the MtMS groups, many questions arose as the membership grew: What should be the criteria for allowing a woman to become a counselor in the framework we provided? Could men be members? Could women who had not breastfed be members? What were the limits to our advice—should we include other aspects of infant feeding or rearing? Birthing? Do we really need something as formal as a constitution? How do we keep in touch with new developments and research? How do we keep in touch with each other? How will the modern means of communication influence the way we interact with mothers? With one another? The answers to these many questions would vary from country to country, from group to group. They would vary with the initiators and the support the initiators were able to drum up.

Something to Read

As mentioned above, I found myself writing the same advice to mothers over and over again, since the problems mothers had were of similar origin (often brought on by misinformation and thoughtless remarks). LLLI had a "hospital brochure" for use right after birth. I translated it and adapted it to our realities. To cut a long story short, I then went to our Directorate of Health with the draft brochure and met a kindred spirit in Dr. Gro Harlem Brundtland who immediately saw its importance.

Initially, however, a number of health professionals resisted the idea that mere mothers should be allowed to express themselves on the subject of breastfeeding on behalf of the Directorate of Health. Sense however prevailed, and in early 1969, after having been vetted by all who were presumed to have anything to say on the matter, the brochure was ready. It turned out that there was a constant demand for the little printed matter, not least from the health workers. It was repeatedly reprinted, and today 2 million copies have been issued, which means that all primiparas may have been given a copy in the maternity ward. It has grown over the years, from 12 pages in 1969 to 40 pages today. The small booklet was written "*by mothers for mothers*": this was the *problem owners* speaking up, defining their problem.

A small book was the next project. I had some difficulty in finding a publisher, being constantly met with the incredulous "a whole book about breastfeeding? That is not possible!" But it turned out to be not only possible, but the book was a bestseller. Eventually, 70,000 copies were printed.

Health Workers and Ammehjelpen

How did health professionals receive professional breastfeeding mothers? Again we have to turn to the familiar terrain of Norway for evidence from real life.

By the mid-1970s, Ammehjelpen had about 500 active "help mothers," as they called themselves at that time. With 50,000 to 60,000 births per year and each counselor having from five to 10 contacts per year, about five to 10 percent of mothers with babies contacted Ammehjelpen at one point in time.

This hardly meant that Ammehjelpen threatened the established health system. Still, the fact that mothers started to organize in order to teach each other how to breastfeed initially puzzled and sometimes annoyed health workers. It seemed to indicate that they had failed in what they considered one of their areas of responsibility—and this was true, to some extent. Although breastfeeding was *encouraged* in the maternity wards, it was not actually *taught*. This being before the IBCLCs (lactation consultants) came on the scene; it was not readily acknowledged that breastfeeding was a subject worthy of teaching. Being the author of several books about the subject, I have often had to explain myself to incredulous listeners who exclaim, "Come on—don't tell me that you have written a whole book about *breastfeeding* …? Ha, ha, ha!"

In the beginning, therefore, Ammehjelpen often had to appear as critics—of the system, of misinformation from individual health workers, and of misleading statements from the baby food industry. The organization had not chosen this role for itself; its aim was teaching those who wanted to be taught. And the remuneration to the ammehjelpers has continued to be the apparently deeply felt gratitude of those who succeed in something that meant a lot to them, depicted in the dry statistics below (Table 5.2).

Table 5.2. Breastfeeding in Scandinavia During the First Year of Life

Full breastfeeding (%)				Partial breastfeeding (%)	
Country	1st week	4 mos.	6 mos.	6 mos.	12 mos.
Denmark 1995	86	60	17	61	18
Norway 1998/99	96	44	7	80	36
Sweden 1997	94	69	42	74	

Source: NOMESCO (Nordic Medico-Statistical Committee). (2005). *Health statistics in Nordic countries 2003*. Copenhagen: NOMESCO.