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INTRODUCTION

> Breastfeeding is the ultimate biocultural phenomenon; in humans breastfeeding is not only a biological process but also a culturally determined behaviour...for more than 99% of our existence, all human infants have obtained their main nutrition through breastfeeding and as mammals we have an evolutionary history of lactation that is even more ancient. So it is that humans have evolved as biological entities and social creatures.
>
> **(Stuart-Macadam & Dettwyler, 1995)**

Culture can be defined as the values, beliefs, norms, and practices of a particular group which are learned, shared and which guide attitudes, decisions and actions in a patterned way (Leininger, 1985). Breastfeeding in Canada reflects diverse cultural norms and practices. This paper will provide a summary of various beliefs and practices underlying breastfeeding and related infant feeding practices in Canada. It serves as a stepping stone to a mutual respect and understanding of cultural diversity.

In Section One, a variety of cultural communities has been selected, based on the most current immigration trends over the past five years and projected patterns of immigration (see Appendix for regional groupings of countries). Section Two gives a synopsis of beliefs and practices related to breastfeeding within the Islamic culture.

A literature search was conducted for each cultural group, using several health and social databases. Key informant interviews were conducted with members of various

communities who were identified as knowledgeable about breastfeeding patterns and infant feeding practices. While every attempt was made to include and emphasize Canadian literature, the scarcity of Canadian publications relevant to this area thwarted our effort. Subsequently, literature from a variety of sources was included, particularly where findings were confirmed by interviews conducted with Canadian key informants.

When using this profile, it is important to keep in mind the following considerations.

- There tends to be as much, or more, variation among individual members of the same cultural group or community as there is among different groups or communities. Variations can occur in language, behaviour, concepts, interests, beliefs and values, as all are influenced and mediated by individual experience.
- Generalizations are inherent in cultural profiles and are necessary for discussions or illustration purposes. However, "... they should not be interpreted as representing characteristics applicable to all or, in some instances, even most of the individuals within a community. Generalizations may, in fact, be completely inappropriate when applied to any specific individuals or circumstances without regard to the individual or circumstance." (Masi, 1988)
- Individuals from the same socioeconomic levels but different cultural groups are likely to have more in common, including health beliefs and behaviours, than those from different socioeconomic levels within the same cultural group. Some socioeconomic characteristics such as education, occupational status and access to health opportunities may transcend cultural barriers (Masi, 1988).

The discussion of breastfeeding in Canada from a multicultural perspective reflects to a great extent the concept of acculturation.

Acculturation is the process by which members of one group adopt the cultural traits of another group with whom they are in contact. It is both a group and an individual phenomenon...., acculturation is never automatic, wholesale, or equal across groups, but is first, selective and piecemeal, second, more likely under some circumstances, and third more prevalent among some groups than others. (Henderson & Brown, 1987, p.155)

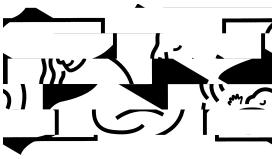
In many cultures examined in this paper, breastfeeding is dominant in the country of origin. However, upon immigration to North America, a unidirectional change from breastfeeding to bottle-feeding occurs. It is interesting to note that the adoption of commercially prepared infant formula in developing countries is so frequent that some anthropologists see the continuation of breastfeeding as an inverse indicator of acculturation to Western ways (Bader, 1979 as cited in Henderson & Brown, 1987). In other words, researchers suggest that the rate at which a particular cultural group adopts bottle-feeding and decreases breastfeeding can be used as a measure of the extent to which that culture has replaced its traditional beliefs and practices with those of the Western world. A

consistent finding from the literature and key informant interviews was the perception by immigrant and refugee women that the dominant and preferred form of infant feeding in North America is formula.

The process and extent of acculturation in a new country is affected by many of the same factors that determine beliefs and practices in the country of origin. Socioeconomic status, proximity of extended family, and urban versus rural habitation are examples of a few such factors.

Patterns in infant feeding will be explored from a variety of cultural perspectives and other factors that may play a role in infant feeding decisions will be examined.

SECTION ONE



CULTURAL COMMUNITIES

EAST ASIAN AND SOUTHEAST ASIAN CULTURES

Cambodian, Chinese and Vietnamese people practise a humoral medical system involving a balance of vital life forces. *Yang-ch'i* (*Yang* in Mandarin, *Am* in Vietnamese, *Kdao* in Cambodian) is seen as the masculine, positive energy force associated with warmth and fullness. *Yin-ch'i* (*Yin* in Mandarin, *Duong* in Vietnamese, *Trarcheak* in Cambodian) denotes the feminine, negative forces of darkness and cold. Disequilibrium between these two life forces is thought to produce ill health. Foods are also classified as "hot", "cold" or neutral, not according to temperature or spiciness, but rather the perceived intrinsic nature of the food (Mathews & Manderson, 1981).

After giving birth, Vietnamese, Chinese and Cambodian women may follow a series of customs called "doing the month" (Mathews & Manderson, 1981; Pillsbury, 1978). Giving birth is thought to deplete a woman of heat, blood and vital breath. During the first 28 to 30 days postpartum, women are thought to be very vulnerable to cold, wind and magic. In order to correct this imbalance, postpartum women are expected to stay at home, avoid drafts, avoid bathing, dress warmly, and, if getting out of bed is necessary, to take very small steps. This is generally a time when the new mother is pampered by relatives. Foods classified as "hot" are favoured while "cold" foods are avoided. The pervasive use of alcohol, including rice wine and brandy, are also avoided. Prescribed foods include chicken, pork, ginger, salt, black pepper, boiled rice and Chinese tea. Foods to avoid include raw and cold vegetables and fruits, specifically spinach, mung beans, melon, lemon and bananas, as well as deep-fried and fatty foods. These practices are used in order to avoid a number of health problems, including headaches, varicose veins, arthritis or a prolapsed uterus, as well as health problems for the infant (Mathews & Manderson, 1981). Confinement to the home during the first month postpartum has obvious implications for lactational support services

that need to be accessible and culturally sensitive. For example, examination of the lactating breasts must be done in such a way as to conserve heat and protect the mother from drafts and chills.

Soup with cabbage, carrots, cauliflower and potatoes is thought to increase the mother's supply of breast milk. Avoidance of "cold" foods in the mother's diet is also thought to protect the baby from diarrhea, coughs and colds, as properties are thought to be transferred directly through the breast milk (Mathews & Manderson, 1981).

In Canada, East Asian and Southeast Asian women may follow some or none of these customs. Attempts to follow some practices may be thwarted by hospital practices, as well as a lack of prescribed foods. New mothers may not request changes to their care or diet while in hospital for fear of appearing ungrateful and impolite (Mathews & Manderson, 1981). Furthermore, the absence of familial support such as that normally given by the maternal and paternal grandmothers may make "doing the month" unfeasible. If the mother is returning to work or school, she may be forced to abandon these cultural practices early. Fishman, Evans and Jenks (1988) found that for Indochinese immigrants, the most enduring customs centred around the consumption of "hot" foods. In fact, East Asian and Southeast Asian women may feel they are more susceptible to cold and illness associated with the North American climate and hospital practices – therefore, adhering to the traditional postpartum diet may take on greater significance.

Breastfeeding promotion and prenatal education programs targeting Chinese women have been found to increase breastfeeding initiation rates but have had no significant effect on duration rates after the first month postpartum (Chan-Yip & Kramer, 1983; Rossiter, 1994; Tuttle & Dewey, 1995).

Vietnamese, Cambodian and Laotian Cultures

In rural areas of Vietnam, Cambodia and Laos, the vast majority of children are typically breastfed for more than a year (Manderson & Mathews, 1981; Jambunathan & Stewart, 1995). Imported formula is considered too expensive or may not be available. Breastfeeding is simply the norm (Henderson & Brown, 1987; Jambunathan & Stewart, 1995; Romero-Gwynn, 1989). However, even in the absence of formula supplementation, breast milk is commonly supplemented with pre-chewed rice paste or rice and sugar porridge (Fishman, Evans & Jenks, 1988). A thin gruel of boiled rice flour (*bot*) followed by porridges are introduced into the baby's diet at around six months of age (Henderson & Brown, 1987; Mathews & Manderson, 1980).

In urban areas of Vietnam and Cambodia, infants are more likely to be formula-fed. For many women who immigrate to North America from Vietnam and Cambodia, formula feeding is often the method of choice (Romero-Gwynn, 1989). Serdula, Cairns, Williamson and Brown (1991) reported that while 93 percent of Southeast Asian children were

breastfed in their country of origin, only 10 percent born in the United States were breastfed. A similar trend has been reported with Hmong refugees (Faller, 1985). Breastfeeding initiation rates of 88 percent were reported in a study of Hmong women living in a refugee camp in Thailand. The majority of mothers reported that they planned to breastfeed their infants until the birth of their next child (Lee, 1986). Following immigration, breastfeeding initiation rates appeared to fall off sharply (Stewart Faller, 1985).

This pattern appears to reflect the Canadian experience as well (key informant interviews). Following immigration, the presence of a family member to assist the mother in the postpartum period is positively correlated with breastfeeding initiation in the postpartum period (Rossiter, 1992). In addition, if the women have had more education on the benefits of breastfeeding, they may be more open, but typically will wean before the child is four months of age (key informant interviews). Other authors report an average of nine months for breastfeeding duration post-immigration (Mathews & Manderson, 1980; Romero-Gwynn, 1989; Serdula *et al.*, 1991). The duration reported by Canadian sources is significantly shorter.

The perception of an insufficient milk supply is often given as a reason for switching to formula (Jambunathan & Stewart, 1995), and formula feeding is associated with fat babies who are more likely to survive. Breast milk is viewed as an unstable substance, the consistency of which depends upon the mother's health and nutrient intake, both of which may be compromised (Fishman, Evans & Jenks, 1988; Henderson & Brown, 1987).

Romero-Gwynn (1989) found that formula samples exerted a statistically significant effect on breastfeeding initiation and duration rates among Indochinese women. Although this effect has been reported with other cultures, this may be a particularly vulnerable population. Formula feeding is seen as more convenient and more likely to produce an "independent" child (Fishman, Evans & Jenks, 1988).

Vietnamese women view breastfeeding in public as embarrassing (Rossiter, 1992) and potentially dangerous, particularly in the workplace (Leininger, 1987), and breastfeeding is often abandoned when the mother returns to school or work. If economically feasible and available, a wet-nurse is employed to continue breastfeeding the baby (Leininger, 1987), however, key informants suggest that this is rarely done in North America.

While North American women may appreciate the weight loss that often accompanies breastfeeding, Indochinese women feel that breastfeeding may make them too skinny and drain their energy. A conflict also arises after the first month, when the mother must choose between eating "hot" foods that are good for her health and "cold" foods that are thought to enhance the milk supply (Fishman, Evans & Jenks, 1988).

Colostrum is seen as "old milk" and is often discarded. Infants are fed either ginseng tea, herbal-root tea or boiled sugar-water for the first two to three days of life. However, this custom is not practised as much in North America, with babies often being given formula or

breast milk within the first 24 hours (Henderson & Brown, 1987). Expressed milk is considered dirty and is typically expressed to relieve engorgement only (Fishman, Evans & Jenks, 1988; Rossiter, 1992).

For some, Western medicines are seen as potentially harmful. A study by Rosenberg (1986) noted that Western treatment may be modified with more traditional approaches. The example is given of a Cambodian mother who obtained oral antibiotics but crushed them and mixed them with Tiger balm, then applied them topically.

The Hmong people of Laos consider the head and neck to be sacred parts of the body, therefore, health care professionals assisting with lactation should attempt to avoid touching these areas. Assistance from a female practitioner is often more readily accepted than from a male (Jambunathan & Stewart, 1995), although it is not uncommon among the Hmong for the father to be present in order to assist the mother during and after the birth (Lee, 1986; Morrow, 1986). In the Hmong culture, breastfeeding begins when the baby is "ready" – this may be after the baby has had a couple of bowel movements and is more alert and active. In the words of one mother, "If you let the baby nurse right away when the milk hasn't come in, the baby will get mad and cry a lot. So you wait till the milk comes in....It may be a few hours or it may be overnight till you feel the milk has come in." (Excerpted from Morrow, 1986). Although breastfeeding until the next baby is born or practising tandem nursing is the norm in Laos, Hmong women who immigrated to North America weaned early or did not breastfeed at all (Nelson & Hewitt, 1983). The need to return to work shortly after giving birth was cited as a particular factor for decreased duration. One woman described how working and nursing had been easier to combine in Laos: "Yes, I breastfed all my babies [in Laos]. I just took the baby to the field with me, strapped to my back. Then, when the baby cried, I'd stop and feed it. Then go back to work again." (excerpted from Morrow, 1986)

Chinese Culture

In rural areas of mainland China and Taiwan, infants are typically breastfed, since formula is not readily available and is very expensive. However, in urban areas and in Hong Kong, formula-feeding predominates. A large study (n = 95, 578) in the People's Republic of China indicated that breastfeeding was initiated with 75 percent of rural infants and 49 percent of urban infants. At six months, 60 percent of infants in rural areas were still being breastfed while only 34 percent of those in urban areas were (Yun, Kang, Ling & Xin, 1989). The perception of insufficient breast milk and the birth of twins, as well as urban women's participation in the workforce, were factors that exerted a negative influence on breastfeeding initiation and duration. Mixed feedings were not uncommon (Yun, Kang, Ling & Xin, 1989).

A recent study of infant feeding practices in Sichuan, China indicated that although the majority (73 percent) of caregivers acknowledged breast as best, only 32 percent of infants were still being breastfed at four months postpartum. Two thirds of the infants were not put to the breast until more than 24 hours had elapsed after birth. Rooming-in was significantly associated with breastfeeding, however, only one third of the hospitals offered rooming-in. Inadequate milk supply was given as the primary reason (68 percent) for discontinuing breastfeeding early. Inconvenience and returning to work were also cited as reasons for switching to formula (Guldan, Maoyu, Guo, Junrong & Yi, 1995).

There is great variation among Chinese immigrants to Canada regarding infant feeding practices. Women from Hong Kong who have had more formal education and are of a higher socioeconomic status are more likely to be informed about the benefits of breastfeeding and are more likely to initiate and continue breastfeeding in Canada (key informant interviews). However, women from mainland China and Taiwan appear less likely to initiate breastfeeding and, if they do, they are more likely to discontinue within the first two to four weeks (key informant interviews). These findings are supported by data from two recent studies examining breastfeeding rates among Chinese and Vietnamese families in the City of Toronto (Abernathy, Tung & Barber, in press). In 1993, breastfeeding initiation rates for Hong Kong immigrants were 86 percent compared to 47 percent for mothers from mainland China. These rates are substantially higher than those of the previous year when only 21 percent of Chinese and Vietnamese mothers reported breastfeeding their infants at birth.

A variety of reasons has been postulated for the low breastfeeding rates among immigrant women from mainland China. Research by Chan-Yip and Kramer (1983) indicated a number of reasons for low rates among Chinese women in Montreal: the women have been told that formula is superior to breast milk; some women are embarrassed to breastfeed in front of others, particularly in crowded living quarters; formula-feeding is more convenient, especially when returning to work; and there exists the perception that breastfeeding is viewed as “old-fashioned”. In addition, Chan-Yip and Kramer (1983) found that the Chinese women in their studies were unaware of breastfeeding support services or where to get assistance with lactation.

Findings from a focus group involving women who had recently immigrated from Hong Kong indicated that all of the women had bottle-fed or planned to bottle-feed their children, notwithstanding the fact that they had all been breastfed themselves. Greater convenience, avoidance of embarrassment, more free time, plans to return to work, and the perception of formula as being modern, more stable and nutritious than their own milk were reasons put forth by the participants. The participants were either unaware or sceptical of the benefits of breastfeeding. They did suggest that in order to convince Chinese women to breastfeed, programs and promotional material should be in Chinese and should reflect Chinese cultural beliefs (Health Canada, 1995).

A survey conducted in Toronto's "Chinatown" revealed that even young people are still very aware of the Yin-Yang principles, and customs associated with this ancient philosophy continue to be widely followed. For example, in order to adhere to traditional dietary customs, Chinese-Canadian women often avoid eating the meals served in maternity wards and instead only consume food brought from home (Yeung, Cheung & Sabry, 1973). Newborns often receive herbal medicine and solids are started early, beginning with rice or barley "soup" (key informant interviews).

Japanese Culture

Having healthy children is highly valued within the Japanese culture and is seen as the way in which a woman becomes complete (Engel, 1989). Children are given great status within the social structure. The traditional role of women includes rearing and nurturing children, activities seen as important aspects of family life. Within this context, breastfeeding is viewed as very positive and very necessary for the health of the children. As such, it is promoted in all segments of society (Yeo, Mulholland, Hirayama & Breck, 1994).

Exclusive and prolonged breastfeeding was traditionally the norm in Japan. Even today, it is not uncommon for children to be breastfed for long periods. In fact, the Japanese kindergarten admission application asks how long the child was breastfed and if the child has been weaned (Sharts-Hopko, 1995). At the same time, mixing breastfeeding and bottle-feeding and exclusive formula-feeding are increasingly common, particularly in the advent of pervasive marketing by multinational formula companies (Barger, 1996; Sharts-Hopko, 1995). Riordan (1993) reported that approximately half of Japanese mothers are breastfeeding at three months postpartum but this rate drops to a third after six months. The Ministry of Health in Japan is actively promoting a return to breastfeeding, but many Japanese women are caught between the traditional values and practices of their culture versus working outside the home, bottle-feeding and other "Western" ways (Riordan, 1993).

Modesty is emphasized, with public breastfeeding being discouraged. A low-calorie diet of rice, gruel and soup is believed to help breastfeeding mothers increase their milk production (Sawada, 1981). A plaque or figurine (*ema* in Japanese) may be provided to the breastfeeding mother to help her prayers for sufficient milk be answered (Riordan, 1993).

It is common for a Japanese woman to go to her mother's house prior to giving birth. She remains there for six to eight weeks following the birth. The Japanese share the "hot" and "cold" beliefs of other Asian cultures that view the mother as being more susceptible to cold following the act of giving birth. Japanese women are prohibited from showering or washing their hair for a week or more after delivery (Sharts-Hopko, 1995).

SOUTH ASIAN CULTURES

Indian Culture

Key informants indicated that breastfeeding was favoured by Indian women, but was not often the infant-feeding method of choice. Initiation and duration rates appear to differ according to rural versus urban habitation, with rural women often breastfeeding their infants until the next child is born (Sundararaj & Pereira, 1975). A Canadian study of Hindu Indian families in British Columbia corroborated this report. In the study by Desai, Lee Pai and Wright (1983), 25 percent of mothers reported breastfeeding their babies; another 25 percent reported bottle-feeding and 50 percent indicated that they had combined methods. Cereals were introduced at about three months of age, followed by fruits and vegetables between four and six months. Commercial infant formula was used to supplement breast milk and in place of breast milk.

In India, new mothers would not be allowed out for the first 40 days, and they would often go to stay with their mothers. This practice was to facilitate the mothers' recovery. In Canada, many women find it difficult to follow this tradition and to a certain extent it has been abandoned out of necessity (Yoshida & Davies, 1982).

The baby is protected from the "evil eye" of a visitor by placing a black spot of soot on the baby's palm, temple or behind the ear. In addition, the baby is swaddled tightly to keep it from jerking its limbs, which could be harmful.

Dietary customs include avoiding spicy, heavy foods that may cause the baby to have diarrhea. The mother is encouraged to drink milk, and sometimes a special porridge of millet flour and hot milk with sugar is provided to the mother to help her own milk production.

Indian mothers generally do not breastfeed their infants in public or in front of male visitors. In India, the mother would use a part of her head covering to provide privacy.

Sri Lankan Tamil Culture

In Sri Lanka, breastfeeding has been the norm. Recently, however, formula or cow's milk has been introduced to women who are returning to work or to those "unable" to breastfeed. Women who do not work outside the home are inclined to breastfeed for longer periods than those who are employed. In Canada, Tamil women still tend to breastfeed. However, if they return to work, they will typically switch to formula when their children are about three to four months of age.

The mother and new baby are confined to the house for 30 days. During this time, the mother is not expected to engage in any kind of activity. The family cares for her and helps her to recuperate. During the first five days, the mother takes herbal baths and eats only one meal a day consisting of rice with dried fish. She limits her intake of water and consumes no fruits, vegetables or fruit juices. After the initial five days, fresh fish and chicken are permitted, and then certain vegetables. The number of meals gradually increases so that by day 30 she is again eating three meals per day. The particular foods chosen are thought to increase the amount of breast milk and improve the mother's strength (key informant interviews).

On the 31st day after childbirth, a small religious ceremony is held in the home, officiated by the priest from the local temple. The baby and mother are purified and close relatives offer gifts of gold to the baby. On the 41st day after birth, mother and child are allowed out of the house for the first visit to the temple (City of Toronto, Department of Public Health, 1989).

In Canada, and in the absence of close relatives, it is more difficult for the Tamil women to adhere to the traditional restrictions during the first 30 days. Dietary practices may also be altered depending upon how long they have lived in Canada and their exposure to Canadian norms (key informant interviews).

In Sri Lanka, solids are introduced to boys at six months of age and to girls at seven months of age. A ceremonial feeding of sweet rice at the temple, given by someone who eats well, constitutes the introduction to solids. This is thought to ensure prosperity for the child and prevent feeding problems. In Canada, Tamils still practise the ceremonial feeding at the temple, however, Canadian Tamils are also more open to introducing Pablum™ prior to the ceremonial feed (City of Toronto, Department of Public Health, 1989).

LATIN AMERICAN AND HISPANIC CULTURE

The Hispanic community in Canada is diverse and multi-ethnic, from a variety of origins including Mexico, South America, Central America, the Caribbean, parts of Africa and Europe. It must be emphasized that there is great variance within this culture.

In Mexico, more than 80 percent of women initiate breastfeeding, regardless of social class. However, by three months postpartum, two thirds of the urban elite discontinue the practice (Dimond & Ashworth, 1987). Thirty-eight percent of infants are exclusively breastfed for up to three months (Akre, 1993). Exclusive breastfeeding is more prevalent among urban poor and rural groups, but by four months of age the majority of infants had been introduced to solids and breast milk substitutes (Dimond & Ashworth,

1987). In 1991, the Government of Mexico established the National Committee on Breastfeeding to promote breastfeeding and increase rates. As well as legislating and regulating aspects of the World Health Organization (WHO) Code, education regarding breastfeeding has been included in the curriculum at all levels of education, and breastfeeding promotion campaigns have now been established (Akre, 1993).

Findings from a study of 131 Peruvian infants living in a poor, rural community demonstrated that 99 percent of infants were initially breastfed and 60 percent of the children were still being breastfed at 12 months of age (de Kanashiro, Brown, de Romana, Lopez & Black, 1990). Exclusive breastfeeding is the exception, however, with two thirds of all infants being introduced to breast milk substitutes and/or other foods by three months of age (Akre, 1993). Similar trends have been reported in Guatemala (WHO, 1981) and Bolivia, where 59 percent of infants are breastfed exclusively for up to three months (Akre, 1993).

Following immigration, breastfeeding initiation and duration rates within the Hispanic community appear to drop sharply (Bryant, 1982; Smith, Mhango, Warren, Rochat & Huffman, 1982; Young & Kaufman, 1988). Surveys indicate that breastfeeding initiation rates hover around 48 percent in the United States (Ryan, Rush, Krieger & Lewandowski, 1991; Williams & Pan, 1994). In Canada, key informants reported that Spanish-speaking women will often initiate breastfeeding but may not continue for very long. The women appear to be influenced by what they perceive to be the cultural norm and wean their babies to formula. A disconcerting trend that appears to confirm the negative influence of acculturation is the fact that breastfeeding initiation and duration among Latin American immigrants decreases as the length of time post-immigration increases (John & Martorell, 1989; Romero-Gwynn & Carias, 1989; Scrimshaw, Engle, Arnold & Haynes, 1987).

The primary reason put forth for discontinuing breastfeeding is returning to work (key informant interviews; Scrimshaw, Engle, Arnold & Haynes, 1987; Shapiro & Salzer, 1985). Bryant (1982), in her study of Latin American women in Miami, found that although breastfeeding is viewed as favourable and having many advantages, it is also seen as “impractical” and “too demanding”, especially for mothers who work or go to school. The embarrassment associated with breastfeeding in public also appears to be a deterrent in North America (Bryant, 1982; Shapiro & Salzer, 1985; Weller & Dungy, 1986; Young & Kaufman, 1988).

Information regarding breastfeeding practices appears to be filtered through the social network, and more credibility has been ascribed to family members and neighbours than to health care professionals. The maternal grandmother, followed by the paternal grandmother, appear to be the most significant sources of social support and influence regarding infant-feeding practices in the Hispanic community (Baranowski, Dee, Rassin, Richardson, Brown, Guenther & Nader, 1983; Bryant, 1982).

Some studies, however, indicate that education level is a strong determinant of whether or not a mother will seek and accept advice from a health care professional. Williams and Pan (1994) found that Spanish-speaking women who discuss breastfeeding with a physician are more likely to have high school education or above and are more likely to initiate breastfeeding post-immigration. Balcazar, Trier & Cobas (1995) also found that Hispanic women who are advised to breastfeed at prenatal care visits are twice as likely to breastfeed than those who have not received such advice.

Similar to the Indochinese, Hispanic cultures believe that the mother and baby are more vulnerable and susceptible to illness and evil in the post-partum period. "*La Cuarentena*" is a 40-day postpartum rest period involving activity and dietary restrictions so that the mother will have a healthy recovery. During this time, the mother is encouraged to stay at home, not do any heavy work, avoid sexual intercourse and avoid bathing (Clark, 1978; Zepeda, 1982). The feet in particular must be covered to protect against the cold (Clark, 1978). Foods considered too acidic, such as oranges, tomatoes, lemons and grapefruit, are avoided. Foods prescribed during this period include dry white cheeses, roasted tortillas, *cafe con leche*, chocolate or cocoa, and roast hen (Bertelsen & Auerbach, 1987). Foods considered intrinsically "hot" are seen as being of benefit to both mother and baby; again, this classification system is independent of observable characteristics or physical temperature and refers rather to the ascribed characteristics of the food (Currier, 1966).

Nursing, one of the most expressive symbols of intimacy and support in human life, is also closely bound up with the qualities of heat and cold. Exposure to cold diminishes the flow of milk, while warmth increases it. On the other hand, too much warmth within the mother may cause the child to become *enlechado*, a condition in which milk curdles inside the child and cannot be digested (Currier, 1966).

Interestingly, there is little agreement around which foods should be considered hot (*caliente*) or cold (*fresco* or *frio*) (Currier, 1966; key informant interviews).

There is also the belief that the baby consumes everything the mother eats. So, for example, Hispanic women would avoid hot spicy foods because these foods might cause stomach problems for the baby (key informant interviews). Malt drinks, black beer and a drink made from boiled corn and milk are all thought to increase the production of breast milk (City of Toronto, Department of Public Health, 1992; key informant interviews). Family members may bring these foods into hospital for the parturient woman. Parsley and vegetables are restricted during the 40 days as it is believed they will dry up the breast milk; conversely, the mother who has chosen to formula-feed may increase her intake of these foods in order to dry up her milk (Bertelsen & Auerbach, 1987; key informant interviews). Family members, especially grandmothers and aunts, are relied upon to assist and support the mother during this period.

A survey of 30 Spanish-speaking Americans by Zepeda (1982) revealed that 80 percent of mothers attempted to adhere to "*La Cuarentena*" but found it difficult to do so if they had other children or lacked social support. Some of the practices were followed (such as abstinence from intercourse) while others were abandoned or practised for a short period of time only. Canadian sources indicate that, because of this and the absence of extended family to provide the prescribed rest and relaxation, the mother may be more prone to post-partum depression (City of Toronto, Department of Public Health, 1992).

The binding of the infant's umbilical cord is another custom that Spanish-speaking women may continue to practise (Zepeda, 1982). Gauze, cloth or special *fajeros* are wrapped around the infant's abdomen and umbilicus in order to prevent umbilical hernia or a protruding navel. Infants are sometimes heavily clothed and swaddled to prevent *mal aire* (bad air) or cool air from endangering the baby. The child is also protected against the evil eye (*mal de ojo*) by tying a red ribbon to the wrist or arm or pinning an amulet to the child's clothing. The evil eye, which results when someone gazes upon the baby in a desirous way, is thought to cause harm and illness. For those providing lactational support, touching while admiring the baby helps prevent *mal de ojo* (Riordan, 1993).

Key informants from the Canadian Hispanic community also report that confinement for 40 days postpartum is still widely practised. The concern is that the mother will "catch the wind"; this would be detrimental to both the mother and the baby.

Colostrum is considered "dirty" or "stale" milk; mothers may refrain from putting the baby to the breast for several days after birth to avoid the colostrum (Bertelsen & Auerbach, 1987).

Information from a health care professional can often alter this practice. For example, those providing lactational support may suggest that a mother need express only a few drops of colostrum to extract the "impure" milk, and this may reassure the mother while respecting her beliefs. Occasionally, herbal teas or a teaspoon of olive or castor oil is given to the baby to stimulate the passage of meconium, or first bowel movement (Clark, 1978).

A belief commonly held by Latin American women is that if they experience too much stress or emotional upset, they will produce *leche agitada,* or agitated milk, altering the quality and quantity of the milk and even souring it. Consequently, a mother may feel it is better to provide formula than to expose the baby to the harmful effects of *leche agitada* (Bertelsen & Auerbach, 1987; Weller & Dungy, 1986). As well as believing that a mother's anxiety will spoil her breast milk, Bryant (1982) also found that mothers of Cuban and Puerto Rican origin believe that unless the mother is healthy and well nourished, breast milk can harm the baby.

Latin American babies are weaned early, often by three months of age (Bertelsen & Auerbach, 1987; Bryant, 1982). Tandem nursing is uncommon, as Latin American women tend to believe that the mother's milk becomes weak and watery when she is pregnant, a

condition thought to lead to illness in the breastfed child. Hence, babies are weaned abruptly and completely when a woman finds herself pregnant (Currier, 1966). Commercial formula is introduced as a supplement early, followed by cow's milk. The introduction of infant cereals and mashed fruit often occurs before the baby is six weeks of age (Bryant, 1982). Weaning foods also include *sopa de frijol* (the juice of cooked beans), mashed sweet potatoes and *agua de panela* (brown sugar water) (Bertelsen & Auerbach, 1987). Sugar, cornstarch or corn syrup are often added to the baby's bottle (Bryant, 1982; key informant interviews). Bertelsen and Auerbach (1987) reported that in some Latin American grocery stores, cornstarch is placed next to infant foods and breast milk substitutes. Three quarters of poor Peruvian children who were studied by de Kanashiro et al. (1990) had sugar and sweet teas introduced into their diets in the first month of life. This practice is thought to help keep the baby satisfied, manage colic and induce the baby into sleeping longer.

Prenatal classes and counselling regarding breastfeeding appeared to have a positive effect on breastfeeding initiation and duration rates in a group of Spanish-speaking immigrants in North Carolina. Incentives in the form of infant clothing and care items significantly increased attendance in this study (Young & Kaufman, 1988). The presence of a "doula" or support person in the postpartum period to help support and assist the mother has also been associated with an increase in breastfeeding duration (Raphael, 1976).

PORTUGUESE CULTURE

The Portuguese community shares the "hot-cold" belief system and customs of the 40-day postpartum recuperative period mentioned above. However, numerous sources indicate that bottle-feeding has become the norm among Portuguese-Canadians. Formula is viewed as clean, modern and scientific. Bottle-feeding is also seen as more compatible with returning to work (City of Toronto, Department of Public Health, 1992; Yoshida & Davies, 1982; key informant interviews). For women who do breastfeed, practices such as covering the breasts with layers of clothes and drinking hot herbal teas are thought to increase the supply of milk (Yoshida & Davies, 1982).

SELECTED AFRICAN CULTURES

While exclusive and prolonged breastfeeding was once the norm in most African countries, such is not the case now. In Nigeria, Zaire and other parts of Africa, milk-distribution programs have presented a mixed blessing. While providing a temporary solution to a pressing need, they may also have inadvertently undermined breastfeeding and traditional weaning foods and subsequently contributed to a decline in breastfeeding rates. Such programs may also have created a demand for a product, the

provision of which cannot be sustained for the masses. Within Africa, the greatest declines in breastfeeding duration have occurred in areas where food-distribution programs are most extensive (King & Ashworth, 1987). Child spacing has also been negatively affected by the introduction of breast milk substitutes. Lactational amenorrhea, as well as taboos that prohibit intercourse during lactation, had traditionally been used for birth control. The decline in exclusive breastfeeding has had a serious and detrimental effect on fertility patterns (Meldrum & DiDomenico, 1982). Adoption by many African countries of the WHO International Code of Marketing of Breast-milk Substitutes (1981), as well as community-based education programs, have helped reverse some of the negative trends.

A large 1950's survey in Nigeria found that only 13 percent of mothers had ever used artificial milk (Jelliffe, 1953). However, since the early 1960s, the use of artificial milk has become much more commonplace. While almost 100 percent of women in Nigeria begin by breastfeeding their babies, duration has declined, particularly among low-income urban women (King & Ashworth, 1987). The use of artificial milks, including commercial formula, peaks at about six months and then declines. A study by Meldrum and DiDomenico (1982) found that artificial formula is considered preferable. By six months of age, approximately half of all infants have been introduced to other foods, including traditional cereals and gruels.

In Kenya, breastfeeding is considered natural, essential and not particularly problematic. Women do not worry or complain about breastfeeding and rarely have problems with the process (Van Esterik & Elliott, 1986). Urban and rural mothers tend to breastfeed their infants for at least 12 months regardless of social class (Dimond & Ashworth, 1987). While more than 85 percent of mothers initiate breastfeeding, exclusive breastfeeding is rare beyond the first month postpartum. The majority of urban and rural infants receive supplementary milk and other foods by two to three months of age. Water and fruit juice are used to supplement the breastfed baby, particularly during the first month of life (Dimond & Ashworth, 1987). Despite early supplementation, breastfeeding is prolonged in Kenya.

Prolonged breastfeeding is also prevalent among rural groups and the urban poor of Ethiopia and Zaire. Most low-income women in Zaire still breastfeed for at least 12 months (Gussler & Mock, 1983; King & Ashworth, 1987). Among the urban elite, breastfeeding is more common in Kenya, Ethiopia and Nigeria and less so in Zaire (WHO, 1981). In Zaire, few mothers can afford commercially prepared formulas; consequently, only 30 percent of bottle-feeders use formula. Traditional paps are introduced by the time the baby is four months of age and are often fed during the day if the mother is not working near the home (Gussler & Mock; 1983 King & Ashworth, 1987).

In Mali, friends and neighbours provide assistance and advice when the mother returns home after giving birth. If family members are available, they may assist the mother through the 40-day recuperative period. Otherwise, the mother resumes her usual tasks by about the third day postpartum.

Except in some remote rural areas, most mothers give birth in a maternity clinic. Most babies nurse within a few hours of delivery and colostrum, which is considered neither good nor bad, is given to the baby. Babies are carried in a sling strapped to the mother during the day and sleep with the mother at night until they are weaned. This facilitates breastfeeding on demand. Solid foods are introduced at around six months of age. Breast milk is thought by the Malians to link a mother to a child as "blood" relatives; hence, two children who have nursed from the same woman cannot marry, even if they are not genetically related. Infant formula is rarely introduced and then only to supplement breast milk if the mother has been ill or does not have enough milk. Only 11 percent of the study sample had ever received any kind of formula or bottle.

Children are typically weaned from the breast at around two years of age. Women will also wean a child if they become pregnant, but this is rare, as women tend to abstain from sexual intercourse during lactation. Such sexual taboos are adhered to more strictly in rural areas (Dettwyler, 1987).

In a study investigating the infant feeding practices of Black women in Johannesburg, South Africa, 97 percent were found to initiate breastfeeding but fewer than 30 percent were exclusively breastfeeding at 20 weeks (Chalmers, Ransome & Herman, 1990). Two thirds returned to working outside the home within a year of giving birth. Continuation of breastfeeding was seen as generally incompatible with returning to work, although some mothers did continue to breastfeed after work hours.

Somalia Culture

In most of Somalia, prolonged breastfeeding is the norm. Breastfeeding is seen as natural and essential to survival; typically, commercial formula is not accessible to the majority of the population (key informant interviews). Furthermore, most Somalians are Muslim and follow the teachings of the Qur'an, which instructs women to breastfeed [see the section on Muslim beliefs and practices]. In urban centres, however, an increasing trend is to combine breastfeeding with bottle-feeding, or to switch to bottle-feeding. Breastfeeding is seen by many urban women as "old-fashioned" (The Somali Women's Health Group, 1991).

Somali women who have immigrated to Canada still tend to initiate breastfeeding, but many wean before the baby is one year of age or even much earlier. Mothers may be more inclined to switch to formula in Canada because it is more accessible and because they find it too difficult to breastfeed while looking for a job or going to school. Key informants from the Somalian community feel that information on how to continue breastfeeding while

working or studying would be most helpful to these mothers. However, encouraging mothers to bring the babies to school or work would not be an option, as Somali women are prohibited from breastfeeding in the presence of men.

In Canada, Somali women continue to adhere to the custom of staying at home for the first 40 days postpartum so as to avoid the cold. The prevalent belief is that following birth, the mother's pores are wide open, making her vulnerable to illness. While confined, the mother is fed soups, porridges and foods with lots of fat to help her recover and also to bring in her milk. During the 40 days, the mother may choose to stay with a female relative or a member of the same clan. Women who do not receive this traditional support often feel lonely and overwhelmed (The Somali Women's Health Group, 1991; key informant interviews).

Some Somalians also believe that newborns need to be protected from the "evil eye" in the first 40 days postpartum. If a stranger looks upon the baby and desires it, bad things will happen to the child. Consequently, lactational support may have to be provided through a mediator – someone the mother knows who can relay the information.

Colostrum is seen as "bad" milk that the mother will hand express and discard until her milk comes in. She may continue to express a few drops of milk prior to each feed. Supplemental feeds and solids are typically introduced early in this community, even when breastfeeding is prolonged (key informant interviews).

CARIBBEAN CULTURES

Prolonged breastfeeding has been the norm in Caribbean cultures; however, a noticeable decline in duration rates in urban centres has been observed (King & Ashworth, 1987). Urban mothers tend to introduce non-milk foods at an earlier age than rural mothers, and more than 80 percent of infants in all areas have been introduced to artificial milk by three months of age (King & Ashworth, 1987). The baby is kept close to its mother to facilitate breastfeeding and breastfeeding in public is encouraged (Yoshida & Davies, 1982; key informant interviews).

Although there are a number of folklores associated with pregnancy (Landman & Hall, 1983), there are few restrictions and customs associated with the postpartum period. At one time, women were discouraged from going outside the home for the first two to three weeks, but for the most part, this custom has been largely abandoned (City of Toronto, Department of Public Health, 1992; Clark, 1978). Traditional prelacteal feeds of castor oil, bush-tea and sugar-water have been replaced with colostrum (King & Ashworth, 1987). There continues to be widespread belief that the baby consumes the same foods that the mother eats, therefore the mother may avoid spicy foods to avoid upsetting the baby's stomach. Some women also believe that maternal stress or anger can change the nature and taste of the mother's milk, and that such negative emotions may curdle or dry it up (key informant interviews).

Weaning foods such as sweets, fruits and cereals are introduced early, even when breastfeeding is prolonged. Returning to work is the main reason Caribbean women stop breastfeeding. If available, a wet-nurse, particularly if she is a relative, may be used (key informant interviews). In the Caribbean, concern regarding water purity is a factor that discourages women from adopting the use of formula. The absence of this concern in North America, as well as the availability of breast milk substitutes, have been linked to a downward trend in breastfeeding duration among Canadian women of Caribbean origin and descent (key informant interviews).

RUSSIAN, CENTRAL AND EASTERN EUROPEAN CULTURES

The political, social and economic situations in Central and Eastern European countries and Russia are changing rapidly. Such changes have had a direct impact on health care and infant feeding practices. The care and nourishment of children is highly valued within these cultures (Riordan, 1993). Breastfeeding continues to be the optimal form of infant nutrition and is greatly encouraged. The health benefits of breast milk have been cited as the primary reason women choose to breastfeed (Miner, Witte & Nordstrom, 1994). Various sources report that 100 percent of mothers breastfeed upon discharge from hospital (Miner *et al.*, 1994; key informant interviews); however, despite positive attitudes toward breastfeeding, hospital practices and government policies serve to undermine successful lactation. Hence, by two to three months postpartum, only 30 percent of women still breastfeed (key informant interviews).

New mothers often remain in hospital for seven to fourteen days postpartum (Riordan, 1993). During that time, the babies stay in the nursery and are brought en masse to the mothers at scheduled intervals for time-restricted feedings. At each feeding, mothers are encouraged to empty both breasts in order to avoid “milk stasis” which is thought to lead to breast abscesses. Excess breast milk is expressed manually, sterilized and pooled, to be used as needed by the maternity hospital. Following each feeding, babies are supplemented with breast milk substitutes, as breast milk alone is perceived to be insufficient and inadequate. Breastfeeding is typically initiated three to six hours after delivery. Colostrum is given but is also “topped up” with a breast milk substitute. Glucose water is also given as a supplement while the infant is in hospital (Chalmers, 1995).

Following each feeding, the mouth of the baby and the mother’s nipples are swabbed with an antiseptic wash [Green Brilliant]. Babies are tightly swaddled from head to toe so that their movement is completely restricted. This makes proper positioning at the breast difficult; consequently, sore and cracked nipples are not uncommon. Weaning foods are introduced early at the recommendation of health care professionals. Within the first

two months, most infants have been introduced to juices and cereal. The perception of insufficient milk supply is cited as the reason most often reported by women for discontinuing breastfeeding (Chalmers, 1995). Although paid maternity leave is available for 18 (Riordan, 1993) to 25 months (Miner *et al.*, 1994), with the reassurance of returning to the same job, many women return to work earlier, as job security is not always protected (key informant interviews).

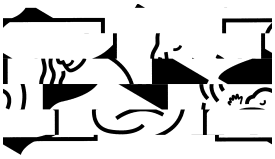
Until 1991, commercially prepared infant formulas were not available in many of these countries. Breast milk substitutes consisted of products that were prepared locally by the milk kitchens or pharmacies. These preparations were available free of charge if prescribed by a physician – a common practice. Banked breast milk was also provided to mothers whose own supplies were deemed inadequate. Since 1991, multinational formula companies have gained access to this large market. But for the vast majority of families, commercially prepared infant formulas are economically out of reach. With albeit benevolent intentions, the government has taken on the role of distributing infant formula, large quantities of which have been donated through humanitarian aid programs. Along with this increase in availability, mothers are being told that "Western" breast milk substitutes are healthy and convenient (Miner *et al.*, 1994; key informant interviews).

Adoption of the principles of the WHO International Code of Marketing of Breast-milk Substitutes, as well as participation in the UNICEF-sponsored Baby Friendly Hospital Initiatives, are helping to re-establish an environment where breastfeeding is supported and promoted.

Although Canada has experienced an influx of immigrants from USSR, Poland*,[1] the Former Yugoslavia*, Bosnia-Hercegovina*, Romania*, Ukraine*, Belarus, Estonia, Hungary, Latvia, and so forth, particularly in the last five years, there is little empirical information regarding infant-feeding practices post-immigration. Key informants emphasized that women aspire to breastfeed and that breastfeeding is highly valued. Although eager to breastfeed, many may be sceptical of their ability to adequately nourish their infants. Women attending prenatal classes will express a desire to breastfeed but may qualify their choice with phrases such as "if I can" or "if I have enough milk". The early introduction of solids appears to be favoured, but hard data regarding this practice in Canada are not currently available. Furthermore, the impact on infant-feeding practices of dramatically different hospital practices in Canada, maternity leave policies and the general availability of commercial breast milk substitutes needs to be evaluated.

1. Preliminary figures obtained from Statistics Canada indicate that in 1994 alone, approximately 16 760 people immigrated to Canada from the countries marked with an asterisk (*). This group of immigrants constitutes the fourth largest group of immigrants that year, with immigrants from Hong Kong, the Philippines and India ranking first, second and third respectively. Refugee claimants in Canada from CIS/USSR ranked second in 1993 and third in 1994.

SECTION TWO



RELIGION AND CULTURE

A discussion of the multicultural nature of breastfeeding in Canada would not be complete without examining the role that religion plays in the determination of health beliefs and practices. Ethnicity and religion are often so closely intertwined that religion is often the determinant of an ethnic group rather than country of origin or language (Spector, 1995).

The following section will briefly explore some of the beliefs and behaviours associated with the Islam. Recent immigration patterns account for the fact that after Christians and Jews, Muslims now form the third-largest religious group in Canada. The number of Muslim immigrants increased by 158 percent between 1981 and 1991. New immigrants from a wide variety of countries and continents include a higher proportion of Muslims (4 percent) than those who are Canadian-born (0.3 percent) (Statistics Canada, 1993). It is not unrealistic to assume that health care professionals and others involved in the promotion of breastfeeding will encounter members of this group.

It is important to note that there may be variation among individuals and communities within an organized religion, even when belief-systems are shared. Muslims practise their faith in varying ways. Furthermore, religious beliefs and practices may be influenced by factors such as socioeconomic status, level of education and country of origin, as well as processes such as acculturation and assimilation.

ISLAMIC CULTURE

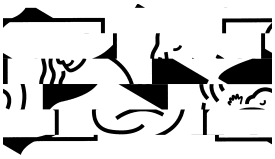
For the Muslim woman, Islam is more than a religion, it is a way of life permeating all aspects of her being. The most critical determinant of Islamic culture is the understanding of and adherence to the Qur'an and the Sunnah (Saleh & Kerr, 1996). The Qur'an specifically promotes breastfeeding: "Mothers shall give suck to their children for two full years for those who desire to complete the term" (Qur'an, 2:233). This directive emphasizes that breastfeeding is good and normal for the mother and baby and is beneficial to all of humanity (key informant interviews). When breastfeeding is not carried out, a wet-nurse may be employed; however, this practice is uncommon in Canada due to economic constraints and lack of feasibility. According to Islamic law, the wet-nurse becomes the child's "mother in lactation" as she gives of her body and her life to the infant. Children who are breastfed by the same woman are considered siblings and are forbidden from marrying, even if they are not biologically related (Saleh & Kerr, 1996).

The Prophet advised against lactating women becoming pregnant (Saleh & Kerr, 1996). For some women, this may be interpreted as the prohibition of intercourse during lactation. Other women will use contraception (Saleh & Kerr, 1996).

During the Holy Month of Ramadan, followers of Islam observe a fast from sunrise to sunset. Pregnant and lactating mothers are given a temporary exemption from fasting, but all missed days must be made up at a later time (Prentice, Prentice, Lamb, Lunn & Austin, 1983). In Canada, most lactating women choose to fast with their communities. It is generally the preference to receive family and community support rather than having to fast alone at a later date (key informant interviews). Research has shown that healthy women who fast while lactating do not experience significant metabolic disturbances (Malhotra, Scott, Gee & Wharton, 1989; Prentice *et al.*, 1983). In fact, findings from recent studies suggest that Islamic fasting may improve the cell-mediated immune response, as well as the cardiovascular and endocrine systems (as cited in Saleh & Kerr, 1996).

In many Islamic communities, it is customary to recite a special prayer before the baby is put to the breast. Traditionally, a male does the incantation, which calls for the infant to be guided by prayer, but a woman may do the honour if a male is unavailable.

CONCLUSION



A number of people were contacted from various cultural groups and agencies. Without exception, people gave generously of their time and were more than happy to respond to the numerous questions posed by the authors. Many key informants stressed time and again that breastfeeding support services need to be provided in a culturally sensitive manner and, ideally, in the family's mother tongue. They were eager to participate in this project in the hopes of promoting further discourse on the topic in order to help increase cross-cultural awareness and improve cross-cultural care. Key informants emphasized that parents of all cultures want what is best for their children.

This document may raise more questions than it answers. Hopefully though, it will serve to stimulate further inquiry and generate future research. Researchers, program planners and health care professionals need to adopt the International Group for Action on Breastfeeding standard definitions:

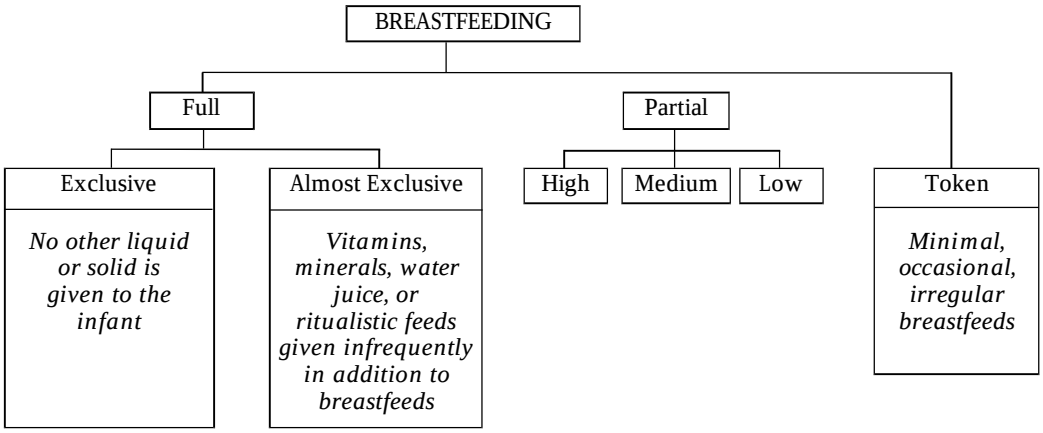


Figure 1 - Schema for Breastfeeding Definition
Reprinted with the permission of the Population Council, from Miriam Labbok and Katherine Krasovec, "Toward consistency in breastfeeding definitions". *Studies in Family Planning* 21, No. 4, (July-August, 1990): 227.

Further research is needed regarding infant feeding patterns, both pre- and post-immigration, and on cultural beliefs and practices related to infant feeding in Canada. Research is greatly needed to determine the best ways to support lactation and promote breastfeeding among *all* cultures.

APPENDIX

Regional Groupings of Mother's Country of Birth

Africa

Benin, Burkina Faso, Cape Verde, Côte-d'Ivoire, Gambia, Ghana, Guinea-Bissau, Guinea, Liberia, Mali, Mauritania, Nigeria, Niger, Senegal, St. Helena, Sierra Leone, Togo, British Indian Ocean Territory, Burundi, Comoros, Djibouti, Ethiopia, Kenya, Madagascar, Malawi, Mauritius, Mozambique, Reunion, Rwanda, Seychelles, Somalia, Tanzania-United Republic of Uganda, Zambia, Zimbabwe, Algeria, Egypt, Libyan Arab Jamahiriya, Morocco, Sudan, Tunisia, Western Sahara, Angola, Cameroon, Central African Republic, Chad, Congo, Equatorial Guinea, Gabon, Sao Tome and Principe, Zaire, Botswana, Lesotho, Namibia, South Africa, Swaziland.

Latin America

Argentina, Bolivia, Brazil, Chile, Colombia, Ecuador, Falkland Islands, French Guiana, Guyana, Paraguay, Peru, Suriname, Uruguay, Venezuela, Belize, Costa Rica, El Salvador, Guatemala, Honduras, Mexico, Nicaragua, Panama.

Europe

Austria, Belgium, France, Germany, Liechtenstein, Luxembourg, Monaco, Netherlands, Switzerland, Albania, Andorra, Gibraltar, Greece, Italy, Malta, Portugal, San Marino, Spain, Yugoslavia, Holy See, Bulgaria, Czechoslovakia, Hungary, Poland, Romania, Denmark, Faeroe Islands, Finland, Iceland, Ireland, Norway, Sweden, United Kingdom.

Caribbean

Anguilla, Antigua and Barbuda, Aruba, Bahama, Barbados, British Virgin Islands, Cayman Islands, Cuba, Dominica, Dominica Republic, Grenada, Guadeloupe, Haiti, Jamaica, Martinique, Montserrat, Netherland Antilles, Puerto Rico, Saint Kitts and Nevis, Saint Lucia, Saint Vincent and the Grenadines, Trinidad and Tobago, Turks and Caicos Islands, United States Virgin Islands, West Indies-unspecified.

South Eastern Asia

Brunei Darussalam, East Timor, Indonesia, Laos (Lao People's Democratic Republic), Malaysia, Philippines, Singapore, Thailand, Vietnam, Cambodia, Myanmar, South East Asia-unspecified.

South Asia

Afghanistan, Bangladesh, Bhutan, India, Iran, Maldives, Nepal, Pakistan, Sri Lanka.

Western Asia

Bahrain, Cyprus, Iraq, Israel, Jordan, Kuwait, Lebanon, Middle East-unspecified, Oman, Qatar, Saudi Arabia, Syrian Arab Republic, Turkey, United Arab Emirates, Yemen, Gaza Strip (Palestine).

East Asia

China, Japan, Hong Kong, Korea North, Korea South, Macau, Mongolia, Taiwan.

Oceania

Australia, Christmas Islands, Cocos (Keeling) Islands, New Zealand, Norfolk Island, American Samoa, Cook Islands, Fiji, French Polynesia, Guam, Kiribati, Marshall Islands, Micronesia-Federal States of, Nauru, New Caledonia, Northern Mariana Islands, Papua New Guinea, Pitcairn, Samoa, Solomon Islands, Tonga, Tuvalu, Vanuatu, Wallis and Futuna Islands, Canton and Enderbury Islands, Midway Islands, Pacific Islands (Palau), Wake Island.

Other

Antarctica, Byclorussian SSR, Neutral Zone, USSR, Ukrainian SSR.

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