BREASTFEEDING MEDICINE
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ABM Statements

Position on Breastfeeding

The Academy of Breastfeeding Medicine Board of Directors

The Academy of Breastfeeding Medicine is a worldwide organization of physicians dedicated to the promotion, protection, and support of breastfeeding and human lactation. Our mission is to unite into one association members of the various medical specialties with this common purpose.

THE SCIENCE OF BREASTFEEDING and human lactation requires that physicians of many specialties have a collaborative forum to promote progress in physician education and research. In order to optimize breastfeeding practices universally, physicians must learn evidence-based breastfeeding medicine, skills, and attitudes. There have been relatively few physicians committed to these goals, therefore requiring an establishment of a dedicated organization to meet the unique educational needs of physicians. Because the study of breastfeeding and human lactation has never been recognized as a subspecialty of medicine, the maintenance of a multispecialty, physician-only organization dedicated to physician education and expansion of knowledge in this field is imperative.

1. Purpose

The purpose of this position statement is to emphasize the extent to which physicians play a central role in the promotion, protection, and support of breastfeeding. We stress that breastfeeding and human lactation warrant serious, increased, and significant attention in medical training, practice, and research, given the substantial and longitudinal impact of breastfeeding on maternal, child, and societal health, as well as the influence healthcare policies and practices have on women's breastfeeding decisions and success in achieving their goals.

2. Definitions

The Academy of Breastfeeding Medicine defines "breastfeeding" as the mother/child act of milk transference, "breastmilk feeding" as the provision of the mother's milk to the infant, and "human milk feeding" as the feeding of human milk from any other individual or pooled milk. Exclusive breastfeeding means that no other liquid or solid is fed to the infant, with the exception of medicines. ABM further defines commercial infant formula as artificial breastmilk substitutes, in accordance with the language of the *International Code of Marketing of Breast-milk Substitutes*.[1]

3. Background

Suboptimal breastfeeding practices are unequivocally associated with a greater risk of infant morbidity and mortality not only in developing countries, but in industrialized countries as well. Increasing breastfeeding rates is one of the most important behaviors that we can promote to decrease infant death and illness worldwide.[2,3] In developing countries and in situations of disaster or food insecurity, infants who are not breastfed have a markedly higher risk of infant mortality and morbidity from infectious diseases, and mothers experience shorter birth intervals with the negative health sequelae for the woman and her infant of short birthspacing. In developed nations, the increased risk of morbidity and mortality for non-breastfed children is less dramatic, but long-term consequences of not breastfeeding have become apparent, such as a higher risk of sudden infant death syndrome, necrotizing enterocolitis, elevated blood pressure and cholesterol, obesity, type 1 and 2 diabetes, cancers, and, particularly in premature infants, poorer developmental outcomes.[4]

Women who do not receive adequate support are at risk for shorter durations of breastfeeding that carry a higher risk of breast and ovarian cancers, type 2 diabetes, and postpartum depression.[4] Women who use artificial breastmilk substitutes are more likely to use sick days to care for their ill children and are less productive at work than women who follow recommended breastfeeding practices.[4] Artificial feeding is associated with a substantial environmental burden, generating waste from the use of bottles and teats, the transportation of commercial breastmilk substitutes, and refuse from its packaging.[5]

4. ABM Affirms the Following Tenets:

a. *Improved breastfeeding promotion, protection, and support are needed globally* and at all levels, including increased support by physicians, other health workers and healthcare systems, schools, communities, corporations, and governments. *ABM's primary goal is to educate physicians worldwide* in breastfeeding and human lactation.

b. Physician undergraduate and postgraduate *medical education must include knowledge of the current evidence, instill the necessary attitudes, and provide experience in the skills* necessary to fulfill their responsibility *to promote, protect, and support breastfeeding*.

c. *Optimal infant and young child feeding is exclusive breastfeeding for 6 months, and continued breastfeeding for at least 1 and up to 2 years or longer*, with age-appropriate complementary feeding. This is in accord with the World Health Organization (WHO)/UNICEF's 2002 description of optimal feeding and as interpreted in the policies of the American Academy of Pediatrics, American College of Obstetrics and Gynecology, American Academy of Family Physicians, European Union Blueprint on Breastfeeding, International Federation of Gynecology and Obstetrics, International Pediatric Association, and many other physician groups.[6]

d. *Breastfeeding is, and should be considered, normative* infant and young child feeding. Health professionals widely acknowledge that breastfeeding is biologically uniquely appropriate for the mother and infant. As the norm, breastfeeding is the standard against which all other forms of infant feeding are compared in research and in clinical support. Feeding other than direct breastfeeding should be supported only for valid medical reasons or absence of the mother. Breastfeeding should be continued for up to 2 years and beyond for as long as the mother and child desire.

e. *Medical professionals have a responsibility to promote, protect, and support breastfeeding* in their practice of medicine according to at least three values of medical ethics: the ethical mandates of "beneficence," the principle of taking actions that benefit your patient, and that is in their best interest; "non-maleficence," that is, first do no harm; and "truthfulness and honesty," the principle of informed consent.[7,8]

f. *Breastfeeding is a human rights issue* for both mother and child. Children have the right to the "highest attainable standard of health,"[9] which entails the right to be breastfed, and women have the right to breastfeed as related to self-determined reproductive rights.[10] Furthermore, women have the right to accurate, unbiased information needed to make an informed choice about breastfeeding via the right to "specific educational information to help to ensure the health and well-being of families."[10] As breastfeeding is both a woman's and a child's right, it is therefore the *responsibility of the healthcare system, the media, business and marketing sectors, government, and society in general to support and enable each woman to fulfill her breastfeeding goals and to eliminate obstacles and constraints to initiating and sustaining optimal breastfeeding practices.* We note that the majority of women in the world initiate breastfeeding, but cite insufficient support and societal barriers as key impediments to achieving recommended and/or desired breastfeeding rates and patterns.

g. The *practice of medicine*, at clinical, administrative, and public health policy levels, *should be guided*, whenever possible, *by available evidence*. Evidence-based medicine, the conscientious, explicit, and judicious use of current best evidence,[11] may be applied to human lactation and breastfeeding as it is to both other human physiologic systems and other health behaviors. Some aspects of breastfeeding medicine lack high-quality evidence on which to base guidelines and decisions. *Funding for research in human lactation and breastfeeding medicine is critical* in order to address the gaps.

h. *There is a need for a continuum of maternity, neonatal, and child care* across time, place, and health issues. This continuum of care for maternal, neonatal, and child health requires access to coordinated synergistic care throughout the life cycle, including adolescence, pregnancy, childbirth, the postnatal period, interpregnancy interval, preconception, and childhood. Optimizing health depends on high coverage and quality of integrated, mutually supportive services throughout the continuum, so that the care provided at each time and place contributes to overall effectiveness.[12]

i. Medical professionals and healthcare systems also have an *ethical responsibility to avoid conflict of interest*, or at the very least disclose potential conflicts, as may occur with gift receipt (e.g., accepting branded samples) or other interests in all realms of medicine, patient care, teaching, and research.

j. *Corporations* and all other manufacturers and distributors of breastmilk substitutes have a *moral responsibility* to adhere to the World Health Assembly's *International Code of Marketing of Breast-milk Substitutes*[1] and subsequent resolutions, and physicians have the responsibility to avoid interactions and support of companies that do not adhere to this Code.

k. *Breastfeeding is a continuation of the reproductive cycle, providing support for early child development and resolution of maternal pregnancy-based physiological changes. Noninvasive maternity practices, immediate skin-to-skin, and early initiation of breastfeeding* are essential for enabling exclusive breastfeeding. Practices such as delayed clamping of the cord, providing necessary nutrient stores for the early months of exclusive breastfeeding, should be considered and incorporated as clinically indicated into standards of practice. *Health systems* play a crucial role in breastfeeding promotion and support, and both inpatient and outpatient settings should *implement practices conducive to breastfeeding*. Evidence-based guidelines for hospitals and maternity centers are widely available.[13]

l. Family, community, and employer *recognition for the contribution made by the breastfeeding woman* is necessary, as is commensurate support, which minimally must entail emotional support and relief from other duties. The International Labour Organization[14] (note date of coming into force of July 2, 2002) supports at least 14 weeks of paid maternity leave to include the 6 weeks postpartum, with job protection, and many countries offer much more.

m. *Governments are responsible* for protecting the rights of women and children, including the right to breastfeed in both hospital and home settings and in the community, and are therefore dually responsible *for promoting breastfeeding* as a right in itself and as a means to diminish infant and child mortality and combat disease and malnutrition.

n. *Alliance and collaboration with other international organizations* seeking to promote, protect, and support breastfeeding may be mutually beneficial and are therefore objectives of the ABM.

5. ABM Accepts and Endorses:

The following global statements on breastfeeding and on infant and young child feeding:

a. *International Code of Marketing of Breast-milk Substitutes*[1] and subsequent World Health Assembly resolutions
b. *Innocenti Declaration on the Protection, Promotion and Support of Breastfeeding*,[15] which includes a call for all governments to also support national breastfeeding authorities and multidisciplinary committees, *Ten Steps to Successful Breastfeeding*,[13] and maternity leave protection
c. United Nations' *Convention on the Rights of the Child*[9]
d. WHO/UNICEF's *Global Strategy for Infant and Young Child Feeding*,[6] which includes an urgent call for action on the Innocenti goals, defines optimal infant feeding as 6 months exclusive, continued breastfeeding with age-appropriate complementary feeding for up to 2 years or longer, and increased attention to maternity issues, emergencies, and communities
e. *HIV* [human immunodeficiency virus] *and Infant Feeding: Framework for Priority Actions*, emphasizing the importance of exclusive breastfeeding support in HIV-endemic areas[16]
f. The 2008 WHO statement on *HIV and Infant Feeding*, recognizing that exclusive breastfeeding is an important choice for HIV-positive women in many settings[17]
g. *Innocenti Declaration 2005 on Infant and Young Child Feeding*,[18] which outlines recommended actions to implement the *Global Strategy for Infant and Young Child Feeding*[6]
h. Human Milk Banking Association of North America, *Position Paper on Donor Milk Banking*[19]

The following global initiatives and programs:

- The *Baby-friendly Hospital Initiative* (BFHI) initiated following the Innocenti Declaration as an initiative to implement the Ten Steps, as revised and updated in 2008[20]
- UNICEF and WABA's *Physician's Pledge*[21] (and as modified by the ABM)[22]
- *Saving Newborn Lives Inititative*[23] and associated partnerships that include attention to the protection, promotion, and support of optimal breastfeeding

6. Given the Above, and the Experience of ABM Global Membership as Physicians from Multiple Disciplines of Medicine, We Call Upon:

a. All parties to:

1. Become aware of the vital importance of breastfeeding for maternal and child health and survival, and for achievement of the Millennium Development Goals
2. Provide financial support for research and program development. Topics currently deserving attention for increased donor support include:

   - Pre-service and in-service training and curricula in breastfeeding knowledge, skills, and practices for physicians
   - Effective ways to promote, support, and protect immediate initiation of breastfeeding and skin-to-skin contact post-birth, exclusivity, and continued breastfeeding while appropriate complementary feeding is introduced after 6 months. Foci of studies should include at least clinical activities, public health programs, and social marketing.
   - Use of human milk and neonatal intensive care unit practices related to breastfeeding
   - Identification and successful implementation of cost effective strategies to achieve substantial and sustainable support for breastfeeding in medical training, healthcare systems and workplaces, tailored to specific cultural and socioeconomic contexts.
   - Optimal duration/indicators for continued breastfeeding after introduction of complementary foods
   - Maternal and infant health outcomes
   - Appropriate contraceptive use and revitalization of the Lactational Amenorrhea Method of contraception
   - Differential impact on mother and child of breastfeeding versus breastmilk feeding
   - Protection of women and children's right to the highest attainable standards of health care; and
   - Sustainability and cost reduction for implementation of the Ten Steps/BFHI

b. Governments to:

- Allocate budgetary support for action to support optimal breastfeeding across many sectors, based on the recommendations in supported statements and documents, e.g., *Global Strategy for Infant and Young Child Feeding*,[6] *the Innocenti 2005 Declaration*,[15] and *the European and U.S. Department of Health and Human Services Blueprints for Action on Breastfeeding*.[24]

c. National and international health professional organizations to:

- Adopt and support policy statements that fully endorse infant and child feeding principles of UNICEF; and

d. The United Nations and multilateral organizations to:

- Support protected maternity rights, such as the International Labour Organization's Maternity Protection Convention, which calls for paid maternity leave of at least 14 weeks with job protection and nursing breaks.

References

1. World Health Organization (WHO). International Code of Marketing of Breast-Milk Substitutes. 1981. http://www.who.int/nutrition/publications/code_english.pdf (accessed 10 February 2008).
2. Jones G, Steketee RW, Black RE, et al. How many child deaths can we prevent this year? *Lancet* 2003;362:65–71.
3. Horta BL, Bahl R, Martinés J, et al. Evidence on the long-term effects of breastfeeding: systematic reviews and meta-analysis. 2007. http://whqlibdoc.who.int/publications/2007/9789241595230_eng.pdf (accessed 10 February 2008).
4. Ip S, Chung M, Raman G, et al. Breastfeeding and Maternal and Infant Health Outcomes in Developed Countries. AHRQ publication number 07-E007. 2007. http://www.ahrq.gov/downloads/pub/evidence/pdf/brfout/brfout.pdf (accessed 10 February 2008).
5. Labbok MH. Breastfeeding as a women's issue: conclusions and consensus, complementary concerns, and next actions. *Int J Gynaecol Obstet* 1994;47(Suppl):S55–S61.

6. WHO/UNICEF. Global Strategy on Infant and Young Child Feeding. 2003. http://www.who.int/nutrition/publications/gs_infant_feeding_text_eng.pdf (accessed 10 February 2008).
7. World Medical Association International Code of Medical Ethics, Extrapolated and Adapted. http://www.wma.net/e/policy/c8.htm (accessed 10 February 2008).
8. Medical Ethics. http://en.wikipedia.org/wiki/Medical_ethics#Values_in_medical_ethics (accessed 10 February 2008).
9. United Nations High Commissioner for Human Rights. Convention on the Rights of the Child. 20 November 1989. http://www2.ohchr.org/english/law/crc.htm (accessed 10 February 2008).
10. United Nations High Commissioner for Human Rights. Convention on the Elimination of All Forms of Discrimination Against Women. 18 December 1979. http://www2.ohchr.org/english/law/cedaw.htm (accessed 10 February 2008).
11. Sackett DL, Rosenberg WMC, Gray JAM, et al. Evidence based medicine: What it is and what it isn't: It's about integrating individual clinical expertise and the best external evidence. *BMJ* 1996;312:71–72.
12. Kerber KJ, de Graft-Johnson JE, Bhutta ZA, et al. Continuum of care for maternal, newborn, and child health: From slogan to service delivery. *Lancet* 2007;370:1358–1369.
13. WHO/UNICEF. Ten Steps to Successful Breastfeeding. Protecting, Promoting and Supporting Breastfeeding: The Special Role of Maternity Services, a Joint WHO/UNICEF Statement Published by the World Health Organization. 1989. http://www.unicef.org/newsline/tenstps.htm (accessed 10 February 2008).
14. International Labour Organization. Convention Concerning the Revision of the Maternity Protection Convention (Revised), 1952. http://www.ilo.org/ilolex/cgi-lex/convde.pl?C183 (accessed 10 February 2008).
15. WHO/UNICEF. Innocenti Declaration on the Protection, Promotion and Support of Breastfeeding. 1990. http://www.unicef.org/programme/breastfeeding/innocenti.htm (accessed 10 February 2008).
16. WHO/UNICEF. HIV and Infant Feeding: A Framework for Priority Action. 2003. www.who.int/nutrition/publications/hiv_infantfeed_framework_en.pdf (accessed 10 February 2008).
17. World Health Organization (WHO). HIV and Infant Feeding Technical Consultation—Consensus Statement. 2007. http://www.who.int/child_adolescent_health/documents/pdfs/who_hiv_infant_feeding_techni cal_consultation.pdf (accessed 10 September 2008).
18. UNICEF Innocenti Research Centre. Celebrating Innocenti 1990–2005: Achievements, Challenges and Future Imperatives—Innocenti Declaration 2005 on Infant and Young Child Feeding. 2005. http://www.innocenti15.net/declaration.pdf (accessed 10 February 2008).
19. Human Milk Banking Association of North America. The Value of Human Milk: HMBANA Position Paper on Donor Milk Banking. http://www.hmbana.org/downloads/position-paper-donor-milk.pdf (accessed 10 February 2008).
20. UNICEF/WHO. Baby-Friendly Hospital Initiative. 1991. http://www.who.int/nutrition/topics/bfhi/en/index.html (accessed 10 February 2008).
21. UNICEF. News release, 1994. Physician's Pledge. http://www.waba.org.my/docs/WABA%20Endorsement%20Form.doc (accessed 19 February 2008).
22. http://www.sph.unc.edu/images/stories/centers_institutes/CIYCFC/Documents/ABMS_PHYSICIANS_PLEDGE.pdf (accessed 19 February 2008).
23. Save the Children. Saving Newborn Lives Initiative. 2005. http://www.savethechildren.org/programs/health/saving-newborn-lives/ (accessed 10 February 2008).
24. Office on Women's Health, U.S. Department of Health and Human Services. HHS Blueprint for Action on Breastfeeding. 2000. http://www.cdc.gov/breastfeeding/pdf/bluprintbk2.pdf (accessed 5 November 2008).

ABM position statements expire 5 years from the date of publication. Evidence-based revisions are made within 5 years or sooner if there are significant changes in the evidence.

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1. The Academy of Breastfeeding Medicine Protocol Committee. 2010. ABM Clinical Protocol #7: Model Breastfeeding Policy (Revision 2010)ABM Clinical Protocol #7: Model Breastfeeding Policy (Revision 2010). *Breastfeeding Medicine* **5**:4, 173-177. [Abstract] [Full Text] [PDF] [PDF Plus]
2. Amanda L. Watkins, Joan E. Dodgson. 2010. Breastfeeding Educational Interventions for Health Professionals: A Synthesis of Intervention Studies. *Journal for Specialists in Pediatric Nursing* **15**:3, 223-232. [CrossRef]