

ABM Position on Breastfeeding—Revised 2015

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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.

Introduction

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. Historically, there have been relatively few physicians committed to these goals; therefore, a dedicated organization was established to meet the unique educational needs of physicians. Because the study of breastfeeding and human lactation has not yet been widely 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.

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. 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.

Definitions

The Academy of Breastfeeding Medicine (ABM) defines “breastfeeding” as the mother/child act of milk transference; “exclusive breastfeeding” means that no other liquid or solid food is fed to the infant, with the exception of medicines.

“Breastmilk feeding” or “mother’s milk feeding” is the provision of the mother’s milk to the infant, and “human milk feeding” is the feeding of milk from any other mother or pooled human milk. 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

Optimal Infant and Young Child Feeding

Optimal infant and young child feeding includes immediate and continued skin-to-skin contact, early initiation of baby-led breastfeeding (within 1 hour of birth), 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 2003 description of optimal feeding² 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. ABM supports the use of milk from donor human milk banks when needed.

Background

Suboptimal breastfeeding practices are unequivocally associated with a greater risk of infant morbidity and mortality not only in developing countries, but also in industrialized countries. Increasing breastfeeding rates is one of the most important behaviors that we can promote to decrease infant death and illness worldwide.^{3,4} In developing countries and in situations of disaster or food insecurity, infants who are not

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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. In developed nations, the increased risk of morbidity and mortality for nonbreastfed children may be less dramatic, but long-term associations with 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.^{5,6}

Women who do not receive adequate breastfeeding support are at risk for shorter durations of breastfeeding that are associated with a higher risk of breast and ovarian cancers, type 2 diabetes, hypertension, and cardiovascular disease.^{5,6} Women who use artificial breastmilk substitutes are more likely to miss work to care for their ill children and are less productive at work than women who follow recommended breastfeeding practices.⁷ Artificial feeding is associated with a substantial environmental burden, generating waste from the use of bottles and teats, the production and transportation of commercial breastmilk substitutes, and refuse from its packaging.⁸⁻¹⁰

UNICEF and WHO are now calling for a revitalization of commitment to protect, promote, and support optimal breastfeeding.¹¹ Therefore, ABM reaffirms its commitment to this global need through the work of its international membership and its role as a core partner with the World Alliance for Breastfeeding Action (WABA).

ABM Affirms the Following Tenets

- a. *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 young child. As the norm, breastfeeding is the standard against which all other forms of infant feeding should be compared in research and in clinical support. Breastfeeding (at the breast) appears to have benefits beyond those of breastmilk feeding,¹² including issues related to feeding from a bottle and nipple (teat),¹³⁻¹⁵ and is therefore preferred unless there are valid medical reason(s) or maternal–infant separation is necessary. Policies such as paid maternity leave are needed to enable more mothers to breastfeed at the breast (see [m] below). Breastfeeding should be continued for up to 2 years and beyond for as long as the mother and child desire.
- b. *There is a need for a continuum of maternity, neonatal, and child care* across time, place, and health needs. 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 integrated mutually supportive services that are of high quality and have a broad coverage throughout the continuum, so that the care provided at each time and place contributes to overall effectiveness.¹⁶
- c. *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.¹⁷
- d. *Breastfeeding is a human rights issue* for both mother and child. Children have the right to the “highest attainable standard of health,”¹⁸ which entails the right to be breastfed, and women have the right to breastfeed as related to self-determined reproductive rights.¹⁹ 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.”¹⁹ 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 inspire, prepare, and empower as well as 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.
- e. *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.
- f. *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.^{20,21}
- g. *Medical professionals must recognize the important role that fathers/partners, and sometimes extended family members, have in the decision to initiate breastfeeding* as well as their ongoing support during the breastfeeding period. Support and education of fathers/partners on the importance of breastfeeding and human milk should be included in breastfeeding education classes, prenatal maternity care, and well child visits.
- h. *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. All physicians, regardless of specialty, have an obligation to acquire at least minimal competencies.²²

- i. The *practice of medicine*, at clinical, administrative, public health/preventive medicine, and policy levels, should be guided, whenever possible, by available evidence. Evidence-based medicine, the conscientious, explicit, and judicious use of current best evidence,²³ may be applied to human lactation and breastfeeding as it is to other human physiologic systems and health behaviors. *Funding for research in human lactation and breastfeeding medicine is critical* in order to provide high-quality evidence on which to base guidelines and clinical decisions.
- j. Medical professionals and healthcare systems 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.
- k. *Corporations* and all other manufacturers and distributors of breastmilk substitutes and other foods that may displace breastfeeding (e.g. toddler formulas and foods) *have an ethical 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 support of companies that do not adhere to this Code.
- l. *A comprehensive approach, including civil society, social structures, communities, and all levels of the socio-ecological framework*,²⁴ in addition to the skilled support of the medical professionals, is necessary to achieve and sustain optimal breastfeeding in all settings. Local, national, and international coordination among partners can include social marketing and complementary programs that stay current with each new generation.
- m. Civil society and government alike are strongly influenced by media and the theater arts. These sectors should also assume the ethical responsibility to support and protect an optimal breastfeeding norm.
- n. Family, community, government, 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. Therefore, governments should support and implement the recommendation of the International Labour Organization²⁵ of nondiscrimination against breastfeeding mothers, including breaks and facilities at work, and at least 14–18 weeks of paid maternity leave to include a mandatory 6 weeks postpartum, with job protection. Many countries offer much more.
- o. *Governments are responsible for protecting the rights of women and children, including the right to breastfeed in the hospital, home, community, workplace, and any setting where the mother's presence is legal.* Governments are therefore responsible to allocate increased resources and to create laws and regulations to fully support optimal breastfeeding as a right in itself, as well as as a means to diminish maternal and child morbidity and mortality.
- p. *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.*

ABM Accepts and Endorses

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

- a. the International Code of Marketing of Breast-milk Substitutes¹ and subsequent World Health Assembly resolutions
- b. the Innocenti Declaration on the Protection, Promotion and Support of Breastfeeding,²⁶ which includes a call for all governments to also support national breastfeeding authorities and multidisciplinary committees, Ten Steps to Successful Breastfeeding,¹⁷ and maternity leave protection
- c. the United Nations' Convention on the Rights of the Child¹⁸
- d. WHO/UNICEF's Global Strategy for Infant and Young Child Feeding,² which includes an urgent call for action on the Innocenti goals, defines optimal infant feeding as 6 months exclusive and continued breastfeeding with age-appropriate complementary feeding for up to 2 years or longer, and calls for 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 areas²⁷
- f. The 2010 WHO statement on HIV and infant feeding, recognizing that exclusive breastfeeding reduces mother-to-child transmission compared with mixed feeding and that breastfeeding is an important choice for HIV-positive women in many settings,²⁸ and these dyads must have access to appropriate antiretroviral prophylaxis or treatment while breastfeeding
- g. the Innocenti Declaration 2005 on Infant and Young Child Feeding,²⁹ which outlines recommended actions to implement the Global Strategy for Infant and Young Child Feeding²
- h. the Human Milk Banking Association of North America's Position Paper on Donor Milk Banking³⁰

The following global initiatives and programs:

- a. The Baby-Friendly Hospital Initiative (BFHI) initiated following the Innocenti Declaration as an initiative to implement the Ten Steps, as revised and updated in 2008³¹
- b. UNICEF and WABA's Physician's Pledge as modified by the ABM³²
- c. the Saving Newborn Lives Initiative³³ and associated partnerships that include attention to the protection, promotion, and support of optimal breastfeeding
- d. UNICEF's Committing to Child Survival: A Promise Renewed,³⁴ in which early initiation of breastfeeding is central
- e. UNICEF/WHO's Breastfeeding Advocacy Initiative: For the Best Start in Life³⁵

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

a. All parties to:

- i. Become aware of the vital importance of breastfeeding for maternal and child health and survival, and for achievement of the Sustainable Development Goals
- ii. Provide financial support for research and program development. Topics currently deserving attention for increased support include:
 - Preservice 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 postbirth, exclusivity, and continued breastfeeding while appropriate complementary feeding is introduced at 6 months. Foci of studies should include at least clinical activities, public health programs, and social marketing
 - Causes of and best treatment options for common problems related to breastfeeding, such as low milk supply, breastfeeding-associated pain, mastitis, and tongue-tie
 - Effects of maternal medications on lactation physiology and on the breastfed infant
 - 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, with careful attention to longitudinal intensity of each of mother's milk, donor human milk, artificial breastmilk substitutes, and both cow's milk- and human milk-based human milk fortifiers
 - 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:

- i. Allocate budgetary support for action to support optimal breastfeeding across many sectors, based on the recommendations in supported statements and documents (e.g., the Innocenti 2005 Declaration,²⁶ the Global Strategy for Infant and Young Child Feeding,² the European blueprint for action on breastfeeding,³⁶ and the U.S. Surgeon General's Call to Action to Support Breastfeeding³⁷) as well as nationally established guidelines and the WABA World Breastfeeding Week activities

- ii. Measure hospitals' performance in relation to the Ten Steps and report these figures nationally

c. National and international health professional organizations to:

- i. Adopt and support policy statements that fully endorse infant and child feeding principles of UNICEF, including support for the Ten Steps, health worker skills training, and reduction of the influence of commercial formula marketing in the healthcare sector

d. The United Nations and multilateral organizations to:

- i. Increase support for healthcare training in breastfeeding skills
- ii. Support protected maternity rights, such as the International Labour Organization's Maternity Protection Convention, which calls for paid maternity leave of at least 14–18 weeks with job protection and nursing breaks²⁵

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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