

Breastfeeding and the Use of Human Milk: An Analysis of the American Academy of Pediatrics 2012 Breastfeeding Policy Statement

Arthur I. Eidelman

Background

IN 1997 THE SECTION ON BREASTFEEDING of the American Academy of Pediatrics (AAP) published its first Policy Statement on breastfeeding. A revised statement was published in 2005 entitled "Breastfeeding and the Use of Human Milk."¹ Per the current regulations of the Academy, after 5 years, existing Policy Statements expire and no longer represent Academy Policy and thus must be renewed and/or revised. In February 2012 a new Policy Statement was published.² While the lead authors (Arthur I. Eidelman and Richard J. Schanler) of the Statement represented the Section of Breastfeeding Medicine, it is important to note that the document underwent a review process that included review by all the relevant Sections and Committees of the Academy and the Board of Directors, so it is appropriate to state that it represents the consensus and approval of the entire AAP.

Underlying Philosophy

In contrast to the previous Policy Statements, the current document reflects a decision to deemphasize details as to the management of breastfeeding maternal–infant dyad and to highlight broader issues that have public health implications. As such, the Statement referred to standard textbooks and manuals for details of clinical management and cited the Academy of Breastfeeding of Medicine Clinical Protocols as a major source of authoritative information.

Highlights of New Policy Statement

Six major issues were addressed in the new statement:

- Conceptual change as to choice of breastfeeding
- Categorization of health disadvantages of not breastfeeding
- Focus on duration and exclusivity of breastfeeding
- Importance of feeding human milk to very low birth weight premature infants
- Monitoring of growth
- Public health data and recommended policies.

Conceptual change

The major conceptual change that underlined all the subsequent recommendations is that the decision to breastfeed should *not* be conceived either by the mother, the attending physician, or society as a life style choice but rather as a basic and critical health decision that impacts on the well-being of the infant and mother. As such, breastfeeding needs to be related to independently of the choice of parenting style or philosophy or as a simple nutritional issue.

Health issues

Breastfeeding and the feeding of human milk were once again defined as the normative standard of infant feeding and nutrition. A wealth of evidenced-based data was presented that emphasized the health disadvantages of not breastfeeding for both the infant and the mother. The protective effect of breastfeeding was quantitated and noted to be a function of the combination of duration and exclusivity of the breastfeeding. The benefits were presented in a dose–response fashion, and Table 1 summarizes a select number of such benefits (see the Statement² for the complete list).

Exclusivity and duration

The AAP once again affirmed its recommendation of "exclusive breastfeeding for about 6 months," aligning itself with other major health organizations such as the Academy of Breastfeeding Medicine and the World Health Organization (WHO). The 6 months of breastfeeding are to be continued "for one year or longer" while complementary foods are introduced. No specific duration of breastfeeding beyond 1 year was recommended; rather, an open and flexible recommendation for "as long as mutually desired by mother and infant" was advocated.

Feeding the premature infant

The documented benefits of feeding of human milk to the high-risk very low birth weight (<1,500 g) premature infant were detailed. They include a reduction in the frequency and severity of necrotizing enterocolitis and improved long-term

Professor, Department of Pediatrics, Shaare Zedek Medical Center, Jerusalem, Israel; Hebrew University School of Medicine, Jerusalem, Israel; and Faculty of Health Sciences, Ben Gurion University of the Negev, Beersheva, Israel.

TABLE 1. DOSE-RESPONSE BENEFITS OF BREASTFEEDING

Disease entity	% reduction in risk	Breastfeeding duration
Otitis media	50	>3 months
Asthma (+ Fam Hx)	40	>3 months
RSV bronchiolitis	74	>4 months
Pneumonia	72	>6 months exclusive
Atopic dermatitis (+Fam Hx)	42	>3 months exclusive
Type 1 (juvenile) diabetes	30	>3 months exclusive
Acute lymphatic leukemia	20	>6 months
SIDS	36	>1 month
NEC (preterm infants)	77	Exclusive
Maternal breast cancer	28	>12 months cumulative
	4.3	For every month

+ Fam HX, positive family history; NEC, necrotizing enterocolitis; RSV, respiratory syncytial virus; SIDS, sudden infant death syndrome.

neurodevelopment. The reduction of the rate of surgery required for treatment of necrotizing enterocolitis and the subsequent reduction in mortality are most pronounced when the preterm infant is fed human milk supplemented by a fortifier from a human milk source. The implication for this recommendation is not only an incentive to provide maximum support for mothers to provide mothers' own milk for their infants, but to develop a network of supervised human milk banks to provide a backup in those situations where the mother cannot provide adequate volumes of human milk. Furthermore, insurance reimbursement for the care of the preterm infant should be extended to include the cost of banked human milk and the newly developed human milk fortifiers.

Growth monitoring

As breastfeeding is the normative standard of infant feeding, monitoring the growth of the infant should be based on the recently published WHO growth curves. These curves are based on data from healthy, primarily breastfeeding infants from six varied geographic sites worldwide and are thus a basis for universal growth standards as opposed to the Centers for Disease Control and Prevention reference curves. Monitoring infants for the first 2 years of their life with the WHO curves will minimize mislabeling infants as poor growers.

Public health policies

As noted, the Policy Statement did not present a comprehensive management approach to the care of the mother-infant dyad. In contrast, supporting and developing public health and educational policies were emphasized. Thus, once again the WHO/UNICEF 10 step program for successful breastfeeding was endorsed, as was the Baby Friendly In-

itiative and the Joint Commission policy of utilizing exclusive breastfeeding rates as a core measure of hospital quality. The need for developing support and implementation for programs for the mothers returning to the work force was detailed, and the need to implement U.S. Public Law 111-48 that requires employers to provide both facilities and reasonable release time was emphasized.

Conclusions

Review of the data as to the status of breastfeeding practices in the United States notes two striking phenomenon. Although overall the rates of initiation of breastfeeding have approached the Healthy Peoples Goals, both the rate and duration of exclusive breastfeeding and the duration of any breastfeeding precipitously drop within a short time after birth. Furthermore, great disparities exist in all the rates among different populations, with the lowest rates occurring among the low socioeconomic mothers of color. Thus, it is clear that professional medical organization policies must go beyond the details of management of the individual mother-infant dyad to focus broadly on the needs of targeted populations with new and imaginative public health programs backed by administrative and legislative regulations. Particular emphasis is needed to work with business leaders and employers so as to improve the workplace environment to make it both friendly for the breastfeeding mother while demonstrating that it makes good business sense to provide this breastfeeding support. Insurance coverage needs to be expanded to include the use of human milk for high-risk infants. Such programs will confirm the health value of human milk beyond its nutritional role. Presenting these concepts and recommendation in the forum of the Fourth Annual Summit on Breastfeeding was an opportunity to familiarize policy makers, nongovernmental organizations, media representatives, business leaders, and the like with the urgent public health need for the support of breastfeeding for the overall welfare of all.

Disclosure Statement

No competing financial interests exist.

References

- Gartner LM, Morton J, Lawrence RA, et al. Breastfeeding and the use of human milk. *Pediatrics* 2005;115:496-506.
- Section on Breastfeeding Medicine. Breastfeeding and the use of human milk. *Pediatrics* 2012;129:e827. Epub ahead of print February 27, 2012. DOI: 10.1542/peds.2011-3552.

Address correspondence to:
Arthur I. Eidelman, M.D.
Shaare Zedek Medical Center
P.O. Box 3235
Jerusalem 91031, Israel

E-mail: arthur.eidelman@gmail.com