REPORT OF THE COUNCIL ON SCIENTIFIC AFFAIRS

CSA Report 2-A-05

Subject: Factors that Influence Differences in Breastfeeding Rates

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Referred to: Reference Committee D
(Sally J. Trippel, MD, Chair)

Resolution 412 (A-04), introduced by the Medical Student Section and adopted at the 2004 Annual Meeting, asked that our AMA investigate the factors contributing to the differences in breastfeeding rates between various racial and ethnic groups with a report back that includes possible actions to address these factors.

Introduction

The Healthy People 2010 goals, developed by the US Department of Health and Human Services (DHHS), are directed at improving the quality and longevity of life in addition to eliminating disparities in health among population groups. Breastfeeding is addressed in Objective 16-19, Increase the proportion of mothers who breastfeed their babies. The 2010 related subobjectives identify specific goals linked to infant ages. Objective 16-19a targets a 75% breastfeeding goal for the early postpartum period; Objective 16-19b targets a 50% breastfeeding goal for infants at 6 months of age; and Objective 16-19c has a breastfeeding target of 25% for children at one year of age.[1] Our AMA supports these objectives through its Memorandum of Understanding with the DHHS in recognition of the Healthy People 2010 objectives.

Socioeconomic, anthropological, biomedical, cultural, psychological, geographic, and other factors influence breastfeeding rates in this country. This report focuses on the factors that are reviewed in the medical and public health literature in addition to considering the impact of employment-related policies. Medical organization policies are considered with respect to physician guidelines for educating women about the benefits of breastfeeding and supporting mothers' efforts to continue breastfeeding when/if they return to work. Our AMA has several policies that address breastfeeding, many of which contain similar elements (see below). Accordingly, this report also recommends consolidation of several existing policies where appropriate. Policy H-20.916 (AMA Policy Database), Breastfeeding and HIV Seropositive Women, is not affected by this consolidation.

Methods

Literature searches were conducted in the MEDLINE database for English-language articles published between January 1995 and February 2005 using the search terms "breastfeeding rates," "minority breastfeeding rates," and "physician breastfeeding education." A total of 264 citations were identified and 63 were retrieved for analysis with additional references culled from the bibliographies of these references. Breastfeeding policies of primary care medical organizations were reviewed in addition to considering federal work-related policies.

Action of the AMA House of Delegates 2005 Annual Meeting: Council on Scientific Affairs Report 2 Recommendations Adopted, and Remainder of Report Filed.

Current AMA Policy

AMA has eight policies that address breastfeeding. These policies, which are noted in the Appendix, encourage breastfeeding of newborn infants, emphasize education of mothers about the superiority of breast milk as a source of infant nutrition, support the availability and appropriate use of breast pumps, promote increased breastfeeding by participants in the Supplemental Nutrition Program for Women, Infants, and Children (WIC Program), note the importance of physician consultation prior to making decisions about using infant formula, encourage public facilities to provide designated areas for breastfeeding and breast pumping, investigate factors that contribute to differences in breastfeeding rates, counsel HIV seropositive women not to breastfeed and not to donate breast milk, and generally support breastfeeding within the health care system.

Health Benefits of Breastfeeding

Breastfeeding offers infants significant benefits including decreases in the incidence and/or severity of a wide range of infectious diseases, such as bacterial meningitis, bacteremia, diarrhea, respiratory tract infections, necrotizing enterocolitis, otitis media, urinary tract infection, and late-onset sepsis in preterm infants.[2] Additional evidence supports not only the physiological health benefits of breastfeeding but also the possible benefits for cognitive development.[3] A review of several studies found some evidence for a lower risk of overweight in children who had been breastfed, after confounders were controlled.[4] The American Academy of Pediatrics (AAP) policy statement, developed by its Section on Breastfeeding, emphasizes that human milk is uniquely superior for infant feeding. The AAP recommends that breastfeeding begin as soon after birth as possible, and considers exclusive breastfeeding without supplementation as the ideal nutrition for the first 6 months of life.[5]

Health effects from breastfeeding accrue to mothers as well as to their infants. Compared to the general population, women with a lifetime history of breastfeeding are at reduced risk for premenopausal breast cancer and ovarian cancer.[6] Under carefully controlled conditions, breastfeeding can be an appropriate temporary method of birth control for a few months postpartum. Breastfeeding may also reduce risks for spinal and hip fractures for postmenopausal women in spite of the apparent bone loss that occurs in women during lactation.[6]

Economic benefits are also linked to breastfeeding. A study on the incidence of lower respiratory tract illnesses, otitis media, and gastrointestinal illnesses for one-year old children compared 1000 infants who were exclusively breastfed for at least 3 months with 1000 never-breastfed infants. After adjusting for confounders, the study's investigators found several differences between the two groups of infants. Formula-fed children had more medical office visits, more days of hospitalization, and more prescriptions than the breastfed children. During their first year of life, the additional services for formula-fed children were estimated to cost managed care systems between $331 and $475 per child compared to expenses for children who were exclusively breastfed for the first 3 months of life.[7] Expenses related to preventable diseases, annual costs of infant formula for families, costs of formula that is purchased for federal programs, and the environmental costs of producing infant formula could be greatly reduced by increasing breastfeeding rates.[8,9]

Contraindications to Breastfeeding

In spite of the multiple benefits of breastfeeding for mothers and infants, a few medical conditions contraindicate breastfeeding in the best interests of infants. Mothers with active

untreated tuberculosis and those with human T-cell lymphotropic virus type I or type II positive should not breastfeed their infants. Additionally, mothers who are receiving diagnostic or therapeutic radioactive isotopes or who have been exposed to radioactive materials should not breastfeed as long as radioactivity can be detected in their breast milk. Other contraindicated conditions include mothers who are receiving antimetabolites or chemotherapeutic agents, or a small number of other medications, until their milk is clear. Mothers who are infected with human immunodeficiency virus (HIV) and women who are abusing drugs also are advised against breastfeeding their infants.[5] All mothers who are uncertain about breastfeeding and its relationship to their medical conditions, medications they are taking, or medical treatments they are receiving should consult their physician about contraindications for breastfeeding.

Rates of Breastfeeding

The Ross Laboratories Mothers Survey (RLMS), a large, national mail survey conducted since 1955, provides the most extensive data set for tracking national breastfeeding trends of infants from birth to 12 months of age. The RLMS questionnaires, mailed to a probability sample of new mothers, asks mothers to recall the type of milk their baby was fed in the hospital, at one week of age, and in the last 30 days. The RLMS survey reaches a large sample; 1.4 million questionnaires were mailed in 2001. Data from the RLMS indicated that the prevalence of breastfeeding initiation increased dramatically from 51.1% in 1990 to 69.5% in 2001. For the years 1997 to 2001, exclusive breastfeeding in the hospital remained at around 46% to 47%.[10]

In late 2001 the National Immunization Survey started including questions related to the duration and initiation of breastfeeding. Findings from this study identified significant differences among women related to breastfeeding practices, maternal age, and socioeconomic status. For example, mothers of non-Hispanic black children were less likely to have ever breastfed their children (51.5%) than mothers of non-Hispanic white children (72.1%); 19.7% of mothers of non-Hispanic black children continued to breastfeed for 6 months compared to 36.6% of non-Hispanic white mothers. Only 5.4% of non-Hispanic black infants were exclusively breastfed at 6 months compared to 14.6% of non-Hispanic white infants and 13.8% of Hispanic infants.[11] Rates of breastfeeding initiation increased as mother's age, education, and income level increased, and breastfeeding was more common among married than unmarried women.[12] The women least likely to breastfeed were young, low-income African-Americans who had less than 12 years of education.[13] The Pregnancy Risk Assessment Monitoring System (PRAMS) is an ongoing state and population-based surveillance system that monitors selected maternal behaviors including breastfeeding. Recent PRAMS data assessed adolescent breastfeeding in 8 states; adolescents met the Healthy People 2010 targets in only 2 of the states included in the survey.[14]

Factors Affecting Breastfeeding

Employment policies and workplace characteristics can affect breastfeeding rates. The Family and Medical Leave Act of 1993 provides full-time employees of large companies the right to 12 weeks of unpaid leave plus job reinstatement for a range of medical and family reasons including pregnancy leave.[15] However, some employees are not protected under the action, especially workers employed for less than 1 year. The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 requires that welfare recipients must work after 2 years on assistance; few exceptions are allowed. States are required to make initial assessments of recipients' job skills to facilitate placements.[16] Childcare funding was designed to help more mothers move into jobs; consequently, emphasis was placed on families becoming self-sufficient through employment. Unfortunately, when policy decision-making was shifted to the state level, it gave rise to the adoption of a myriad of different policies across the nation. Policies can have

unintended consequences that counter the efforts of other policies and programs. For example, mothers who participate in these programs may decrease or even stop breastfeeding when they return to work. Also, women with employer-sponsored health and dental insurance may choose to return to work sooner if their jobs do not offer insurance coverage during unpaid leaves of absence.[12] Investigations of the interaction between work schedules and breastfeeding found that returning to work does not have a negative impact on the decision to initiate breastfeeding[17] ; however, full-time employment decreases the duration of breastfeeding[18] and was one of the strongest predictors for discontinuing breastfeeding at 12 weeks' postpartum.[19]

Employer day care is another aspect of a woman's work life that can influence breastfeeding rates. According to the Bureau of Labor Statistics, half of mothers with infants younger than 12 months of age were working in 2002.[20] Places of employment that encourage breaks during which mothers can express breast milk or nurse a child who participates in employer-sponsored, on-site or nearby day care are supporting breastfeeding for mothers of young children. Other workplace accommodations for nursing mothers include a lactation room where mothers can use breast pumps.

Other factors that influence breastfeeding rates include access to information about and support for breastfeeding. A study that used the National Center for Health Statistics' 1988 National Maternal and Infant Health Survey data examined the percentages of African-American and non-Hispanic white women who reported receiving advice from health care providers during pregnancy. Breastfeeding was one of the topics included in the analysis of this data set. Overall, only 51% of all women in the survey reported receiving breastfeeding advice; in fact, advice that promoted breastfeeding was the least reported by study participants. Breastfeeding advice was reported most frequently as received by white women who were married and had more than 12 years of education. Women who had the lowest reported rates for receiving advice about breastfeeding were single, had less than 12 years of education, had lower income levels, and were nonparticipants in the WIC Program. The disparity in the receipt of breastfeeding advice approached statistical significance.[21]

A study of new adolescent mothers found similar results. The study's sample included 40% Mexican-American, 30% African-American, and 30% Caucasian; participants were surveyed to determine their intentions to breastfeed their infants. From this sample, 55% of Mexican-Americans, 45% of Caucasians, and 15% of African-Americans decided to breastfeed their infants. Across all groups, health care providers were most frequently cited as offering the most encouragement for breastfeeding. The African-American adolescents were the least likely to identify receiving encouragement from their mothers, their partners, and their friends. Other factors that significantly influenced African-American adolescents' decisions to breastfeed included living with a partner and the partner's feeding preference, having a mother who breastfed, and encouragement from a health care provider to breastfeed.[22] Similar to other studies, the African-American women in this study did not seem to have been encouraged to breastfeed by health care providers.

Starting in the early to mid-1990s, a number of studies identified physicians' lack of preparation for promoting, teaching, and supporting breastfeeding for their patients.[23-28] More recent studies have reviewed the characteristics of physician efforts to promote breastfeeding through the Baby-Friendly Hospital Initiative (www.babyfriendly.us) that features "Ten Steps to Successful Breastfeeding" [29] as well as other efforts to assist mothers through primary care interventions that were designed to promote breastfeeding. The single most effective intervention was educational programs.[29-32] Typically, these programs were antepartum sessions that were conducted by lactation specialists or nurses. The content was structured and core topics included discussions of

basic anatomy and physiology, breast milk as an ideal food for infants, and the benefits of breastfeeding for both mother and infant. Although most educational sessions were 30 to 90 minutes in length, no apparent association existed between the session length and effectiveness. Also, the support programs that were reviewed included telephone or in-person visits by a lactation consultant and nurse or peer counselor at pre-arranged or unscheduled times. The intervention content was structured to meet patient needs. With respect to the studies in the meta-analysis, the combination of education with a support program did not offer substantially different benefits from the education-only approaches to encouraging breastfeeding.[33] In addition to physician-focused interventions, primary care clinicians can refer women to peer counseling programs, which have been found to significantly improve breastfeeding initiation and continuation rates.[34] Physicians can also share materials from and information about the National Women's Health Information Center, which provides breastfeeding information that is targeted at mothers from specific racial and ethnic groups in addition to a media campaign that features print, television, and radio public service announcements that describe problems associated with not breastfeeding children.[35,36]

Primary care medical organizations encourage physicians to assume an active role in promoting breastfeeding to mothers. Current AAP policy outlines Recommendations on Breastfeeding for Healthy Term Infants, which includes 14 recommendations that stress the importance of acquiring knowledge and skills, promoting breastfeeding policies and procedures in hospitals, establishing a schedule of pediatric visits that monitor and evaluate breastfeeding, and other related issues.[5] The American College of Obstetricians and Gynecologists (ACOG) "…calls upon its Fellows, other health professionals caring for women and their infants, hospitals, and employers to support women in choosing to breastfeed their infants."[37] The American Academy of Family Physicians has developed a breastfeeding position paper that includes information about the history of breastfeeding, its health effects, special issues, and education for medical students, residents, and practicing physicians in addition to other issues.[38] The ACOG covers similar essential topics for physicians in its Educational Bulletin.[39] Based on the potential health care disparities related to chronic diseases for mothers who do not breastfeed and for children who are not breastfed, physicians can assume a key role in promoting breastfeeding to the women whose breastfeeding rates are traditionally lower than the women who are meeting the Healthy People 2010 breastfeeding targets.

Summary and Conclusion

Breastfeeding initiation rates are close to the Healthy People 2010 targets. However, the most significant short- and long-term protection against disease for both mothers and infants accrues when children are breastfed exclusively for the first 6 months of life. African-American women and their children are not meeting this goal for a number of reasons. Policies that influence when mothers of infants return to work and working conditions that do not support breastfeeding are aspects of employment that affect breastfeeding rates in addition to having access to information about and support for breastfeeding. Physicians can educate patients about the benefits of breastfeeding during patient encounters, refer patients to community programs that are culturally sensitive and demonstrate effectiveness, support workplace policies that facilitate breastfeeding, and participate in research that is designed to enhance understanding of the differences between women who do and women who do not breastfeed their children.

RECOMMENDATIONS

The Council on Scientific Affairs recommends that the following statements be adopted and that the remainder of the report be filed:

1. That a new AMA Policy H-245.982 be adopted that responds to Resolution 412 (A-04) and that incorporates elements of existing policies H-245.996; H-245.993; H-245.980; H-245.991; H-245.974; H-245.982; and H-245.975 to read as follows:

H-245.982 AMA Support for Breastfeeding

(1) Our AMA: (a) recognizes that breastfeeding is the optimal form of nutrition for most infants; (b) endorses the 2005 policy statement of American Academy of Pediatrics on Breastfeeding and the use of Human Milk, which delineates various ways in which physicians can promote, protect, and support breastfeeding practices; (c) supports working with other interested organizations in actively seeking to promote increased breast-feeding by Supplemental Nutrition Program for Women, Infants, and Children (WIC Program) recipients, without reduction in other benefits; (d) supports the availability and appropriate use of breast pumps as a cost-effective tool to promote breast feeding; and (e) encourages public facilities to provide designated areas for breastfeeding and breast pumping; mothers nursing babies should not be singled out and discouraged from nursing their infants in public places.

(2) Our AMA: (a) promotes education on breastfeeding in undergraduate, graduate, and continuing medical education curricula; (b) encourages the education of patients during prenatal care on the benefits of breastfeeding; (c) supports breastfeeding in the health care system by encouraging hospitals to provide written breastfeeding policy that is communicated to health care staff; (d) encourages hospitals to train staff in the skills needed to implement written breastfeeding policy, to educate pregnant women about the benefits and management of breastfeeding, to attempt early initiation of breastfeeding, to practice "rooming-in," to educate mothers on how to breastfeed and maintain lactation, and to foster breastfeeding support groups and services; (e) supports curtailing formula promotional practices by encouraging perinatal care providers and hospitals to ensure that physicians or other appropriately trained medical personnel authorize distribution of infant formula as a medical sample only after appropriate infant feeding education, to specifically include education of parents about the medical benefits of breastfeeding and encouragement of its practice, and education of parents about formula and bottlefeeding options; (f) supports the concept that the parent's decision to use infant formula, as well as the choice of which formula, should be preceded by consultation with a physician. **(Modify Current HOD Policy)**

2. That policies H-245.974; H-245.975; H-245.980; H-245.991; H-245.993; and H-245.996 be rescinded. **(Rescind HOD Policy)**

Fiscal Note: No Significant Fiscal Impact

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Appendix

H-20.916 Breastfeeding and HIV Seropositive Women
Our AMA believes that, where safe and alternative nutrition is widely available, HIV seropositive women should be counseled not to breastfeed and not to donate breast milk. HIV testing of all human milk donors should be mandatory, and milk from HIV-infected donors should not be used for human consumption. (CSA Rep. 4, A-03)

H-245.974 Promotion by Physicians and Hospitals of Breastfeeding
Our AMA: (1) promotes education on breastfeeding in undergraduate, graduate and continuing medical education curricula; (2) encourages the education of patients during prenatal care on the benefits of breastfeeding; (3) strengthens the support for breastfeeding in the health care system by encouraging hospitals to provide written breastfeeding policy that is communicated to health care staff; and (4) encourages hospitals to train staff in the skills needed to implement written breastfeeding policy, to educate pregnant women about the benefits and management of breastfeeding, to attempt early initiation of breastfeeding, to practice "rooming-in," to educate mothers on how to breastfeed and maintain lactation, and to foster breastfeeding support groups and services. (Res. 412, A-04)

H-245.975 Promoting Breastfeeding of Infants
Our AMA policy is that mothers nursing babies should not be singled out and discouraged from nursing their infants in public places and will affirm and inform the public that nursing usually is the best possible way of feeding an infant. (Res. 405, A-04)

H-245.980 Payor Financial Support for Breast Pumps.
The AMA supports the availability and appropriate use of breast pumps as a cost-effective tool to promote breast feeding. (Substitute Res. 107, I-94; Reaffirmed: CSA Rep. 6, A-04)

H-245.982 AMA Support for Breastfeeding.
The AMA encourages: (1) perinatal care providers and hospitals to ensure that physicians or other appropriately trained medical personnel authorize distribution of infant formula as a medical sample only after appropriate infant feeding education, to specifically include: (a) education of parents about the medical benefits of breastfeeding and encouragement of its practice, and (b) education of parents about formula and bottlefeeding options; and (2) public facilities to provide designated areas for breastfeeding and breast pumping. (Res. 506, A-93; Appended: Res. 512, I-98).

H-245.991 Infant Formula Advertising.
Our AMA (1) adopts the policy that breast-feeding is the optimal form of nutrition for most infants; and (2) supports the concept that the parent's decision to use infant formula, as well as the choice of which formula, should be preceded by consultation with a physician. (Res. 64, A-90; Reaffirmed: Sunset Report, I-00)

H-245.993 Encouragement of Breast-Feeding by WIC Participants.
The AMA supports working with other interested organizations in actively seeking to promote increased breast-feeding by WIC recipients, without reduction in other benefits. (Sub. Res. 49, I-87; Reaffirmed: Sunset Report, I-97)

H-245.996 Infant Nutrition.
The AMA endorses the policy statement of American Academy of Pediatrics urging pediatricians, particularly in developing countries, to encourage breast feeding of newborn infants wherever appropriate and to educate mothers about the superiority of breast milk as a source of infant nutrition, and working to curtail inappropriate formula promotional practices. (CSA Rep. D, A-80; Reaffirmed: CSA Rep. C, A-82; CLRPD Rep. B, I-90; Reaffirmed: Sub. Res. 210, A-94; Reaffirmed and Modified: CSA Rep. 6, A-04)