IFMSA Policy Document
Breastfeeding

Proposed by Team of Officials
Presented to the IFMSA General Assembly March Meeting 2020, in Rwanda.

Policy Statement

Introduction:

Breastfeeding is described by the World Health Organization as “an unequaled way of providing ideal food for the healthy growth and development of infants”. It is an incomparable source of nutrition for the health of infants, affording a range of benefits to both mother and child, in addition to its contribution to environmental sustainability. Despite its many positive impacts, the worldwide rates of breastfeeding are far from ideal. According to recent publications, breastfeeding could save the lives of more than 823,000 children annually around the globe. However, breastfeeding rates vary due to many barriers that women face, including cultural, social, political and medical issues as well as private sector influence. It is also directly linked to critical gender equality issues.

IFMSA position:

The IFMSA affirms its commitment and belief that breastfeeding is an unparalleled source of nutrition for the growth and development of infants and believes that it is a basic right for women to be informed about breastfeeding benefits, conditions, and practices, and to make well-informed choices related to breastfeeding. The IFMSA believes that action should be taken to support and promote positive breastfeeding practices globally.

Call to Action:

Therefore, IFMSA calls on:

1. **Governments to:**

a. Monitor national levels of breastfeeding as well as the progress of policies and mandate compliance with the International Code of Marketing of Breastmilk Substitutes.
b. Develop public education initiatives regarding the benefits of breastfeeding and create awareness campaigns directed to the broad public to break the stigma against breastfeeding.
c. Review national laws that restrict breastfeeding for women in order to create a breastfeeding-friendly environment for women
d. Implement maternity leave laws, thus encouraging exclusive breastfeeding during the first 6 months
e. Create and strengthen Human Milk Banks in order to support breastfeeding practice and human milk donation.
f. Review national laws on human resources management to ensure the wage and hour division allows for sufficient break time for nursing mothers.
g. Develop national strategies for the establishment of lactation rooms in public facilities, also with sufficient equipment for breast-pumping.
h. Integrate the “Ten Steps to Successful Breastfeeding” as the standard of care across all maternity and newborn facilities in the country.

2. NGOs and International Institutions to:

a. Provide guidance and counseling opportunities for mothers on appropriate care and feeding practices, in addition to nutrition education to improve complementary feeding and the best alternatives to breastfeeding.

b. Advocate for national laws to protect breastfeeding and stop infant formula companies from using unethical marketing practices.
c. Work with governments to develop and enforce policies that provide time, space and support for women to breastfeed.
d. Campaign for the empowerment of communities on the topic of breastfeeding and provide informal learning opportunities for breastfeeding.

3. The health sector professionals and hospitals to:
a. Advocate for greater awareness of the health benefits of breastfeeding within the communities and support all efforts for its advancement. In addition, work with community leaders in rural areas to help develop community-based strategies and campaigns that will encourage women in rural settings to breastfeed.
b. Stop supporting the advertisement of breast milk substitutes by pharmaceutical companies.
c. Ensure that mothers and expectant mothers are fully informed about the health and nutritional benefits of breastfeeding, as well as the nutritional requirements of the breastfeeding mother, the medical conditions preventing breastfeeding, and the best alternatives to breastfeeding.
d. Ensure new mothers receive support during the breastfeeding process, from initiation and maintenance of breastfeeding to learning how to manage difficulties.
e. Facilitate uninterrupted close contact between mother and infant after birth, enabling mothers to initiate breastfeeding of the infant as soon as possible and counseling mothers on how to feed on demand.
f. Refuse funding from companies that produce breast milk substitutes.
g. Implement the Baby-Friendly Hospital Initiative to ensure the protection, promotion, and support of breastfeeding in maternity facilities.

4. Medical schools to:
a. Provide medical students with education on the benefits of breastfeeding and its management. In addition, encourage them to support the vital role played by other healthcare professionals such as nurses, community health workers, and midwives.
b. Provide medical students with the understanding that problems related to breastfeeding have different origins, from medical to social, which are often beyond the control of the individual and include the social determinants of health and wellbeing.
c. Incorporate basic training of proper breastfeeding into the curriculum, where appropriate, in addition to all the needed knowledge about breastfeeding mothers' support, the medical conditions, both maternal and neonatal, that may prevent it as first choice and the most appropriate breast milk substitutes.

5. Members and national member organizations to:
a. Contribute to preserving and re-establishing a breastfeeding culture by promoting a positive attitude towards breastfeeding in society as a whole.
b. Increase the understanding among their members and their communities that breastfeeding is one of the most important determinants for child and maternal health, and relevant action should be taken to support its importance within countries.
c. Advocate and carry out campaigns to raise awareness in the general population and health care professionals around the benefits of breastfeeding, the role of the industry, and the barriers women face.
d. Positively influence medical schools to ensure a complete and comprehensive inclusion of issues surrounding breastfeeding in the medical curriculum, always ensuring an intersectional approach.

POSITION PAPER

Introduction

Breastfeeding is described by the World Health Organization as “an unequaled way of providing ideal food for the healthy growth and development of infants” (1). It is an incomparable source of nutrition for the health of infants, affording a range of benefits to both mother and child, in addition to its contribution to environmental sustainability. Despite its many positive impacts, the worldwide worldwide rates of breastfeeding are far from ideal. According to a recent Lancet publication, the promotion of breastfeeding “could save the lives of more than 823,000 children under age 5” annually around the globe (2). However, breastfeeding rates vary due to many barriers that women women face, including cultural, social, political and medical issues as well as private sector influence. It is also directly linked to critical gender equality issues.

Background information

Proven Benefits of Breastfeeding

Breastfeeding provides a wide range of proven benefits, on both child and mother’s health. Some of the benefits of breastfeeding include the positive impact on a child's development, health, survival, and nutrition, as breast milk can provide all the infant’s needs in nutrients, vitamins, and minerals for growth in the first six months with no other liquid or food necessary. It helps to maintain the maternal-fetal immunological link after birth, providing potentially life-saving immunological protection and reducing the risk of gastrointestinal infections and non-enteric infections by providing an antimicrobial activity against several viruses, bacteria, and protozoa. That subsequently entails a fivefold reduction in hospitalization in the first year of life due to gastroenteritis or respiratory illness, which are collectively the primary global causes of child mortality. In addition to the short term benefits of breastfeeding, long-term benefits are found such as a reduced risk of developing high blood pressure, high cholesterol and diabetes as well as decreased risk of obesity, while the intelligence and behavior test performance increases (3) (4).

The benefits of breastfeeding on the mother are also plenty. For example, not breastfeeding is a known risk factor for developing breast cancer (5). Invasive breast cancer risk is less common in mothers who have previously breastfed, and findings of metaanalysis suggest that for each year of breastfeeding mother’s risk of invasive breast cancer decreases by more than 4%. Moreover, mothers who breastfeed have a significantly lower risk of obesity (“mothers who breastfeed have less visceral obesity and smaller waist circumferences in later life”), which in consequence decreases risk for diabetes mellitus as well as hyperlipidemia. Other benefits include decreased risk of coronary heart disease, myocardial infarction, increased arterial pressure (women who never breastfed had 29% higher risk for hypertension regardless of adjustment for lifestyle factors or family history) and ovarian cancer (mothers who never breastfed have 32% high risk of developing ovarian cancer) (6).

The World Health Organization emphasizes the importance of promoting and maintaining breastfeeding practices and provides recommendations for breastfeeding that support the optimum growth, development and health of the child. In the first six months of an infant’s life, exclusive breastfeeding is recommended. There are still a number of avenues of research into the benefits of breastfeeding which are yet to be fully explored, for which the World Health Organization recommends policy-makers to develop legislations which support exclusive breastfeeding, examples including “increasing maternity leave, strengthening the quality of care in maternity facilities to include lactation counseling, and protecting against aggressive marketing of breast-milk substitutes so that mothers can gain confidence in their breastfeeding abilities” (7).

Difference between Breastfeeding and Formula

There have been many studies carried out that prove the benefits of human milk versus the infant formula, outlining their essential differences. While breast milk contains high amounts of long-chain polyunsaturated (LCP) fatty acids, the infant formulae lack preformed dietary LCP such as are arachidonic and docosahexaenoic acids (8). In addition, breast milk enhances protein instead of oxidation, which leads to promoting tissue growth. This results in preferential babies fat-free mass deposition, which in turn contributes to the better health outcomes for preterm babies. Thus, breast-feeding should be promoted whenever possible in mothers who are able to breast-feed (9).

Role of marketing and Pharmaceutical Companies

A major factor in early breastfeeding cessation is the early introduction of breast-milk substitutes, due to societal and commercial pressure, which includes marketing and promotion by formula producers, in addition to the inaccuracy of the medical advice from health workers who lack the skills and training in breastfeeding support. The World Health Organization provides guidelines on the marketing and provision of breastmilk substitutes to ensure their proper use and appropriate methods of marketing. Under the Code, it is specified that no health care system should promote the use of infant formula; that health authorities should make health workers aware of their responsibilities under the Code; and that health workers should encourage and protect breastfeeding practices. Further, it is specified that there should be no promotion of breastmilk substitutes, and no samples of substitutes distributed to pregnant women, mothers or their families, except in exceptional circumstances where breastfeeding is not possible. These factors represent opportunities to better enable women to breastfeed in order to facilitate a global rise in breastfeeding practices (10).

Discussion

Barriers to Breastfeeding

Social Barriers: A Part of the Fight for Women's Right

Breastfeeding is one of the areas affected by gender inequities as women lack support by family, worksites, and communities. In a male-dominated society, women's breasts are being objectified and sexualized, and public breastfeeding is being stigmatized, limiting women's mobility in public spaces, which can prompt the choice to bottle feeding as a substitute (11) . In returning to work, many mothers cease breastfeeding or begin mix feeding due to a lack of time, a lack of privacy, or an environment that is not conducive to continuing breastfeeding in addition to other employers' perception of the presence of infants in the workplace and work regulations and rules which bar children from the workplace. Consequently, paid maternity leave, the option to work part-time, breastfeeding breaks, on-site crèches and facilities for expressing and storing breast milk have been identified as factors protective of continuing breastfeeding (12). Moreover, a positive relationship has been observed between the length of the maternity leave and the overall breastfeeding duration (13).

A lack of education about breastfeeding is one of the main social barriers to breastfeeding. With public awareness lacking about breastfeeding, especially to new mothers who need it, women tend to refer to a pediatrician, general practitioner or obstetrician, and with little training given to healthcare professionals on breastfeeding, no elaborated information is provided to women, to help them to make the best choice. In addition, few healthcare professionals seek information about the topic, which is not considered as a priority, and many of them do not present a supportive attitude toward breastfeeding (14).Also, higher rates of breastfeeding have been found in families with a high education level in general, and in non-vulnerable population, in comparison with families with low socio-economical and education level, and vulnerable population respectively (15).

Medical Barriers: Mother's Medical Condition

Though breastfeeding gives the complete nutritional requirements needed by the infant most especially within the first 6 months of life and also confers a benefit to the mother, there are some medical indications however that may serve as barriers to breastfeeding. These contraindications include but are not limited to the presence of Ebola disease, infection with T-cell, untreated brucellosis, active herpes simplex virus, active varicella and tuberculosis (16). Some other factors that have been indicated as negatively influencing breastfeeding include advanced maternal age,mastitis, and nipple fissures (17).

Some mothers may also experience barriers to lactation due to primiparity, maternal obesity, gestational diabetes, stress and various other factors (18) (19). Moreover, psychological factors also play a role in the barriers to breastfeeding - for example, a study in women with a BMI of more than 30 kg/m2, who were less likely to breastfeed, a number of psychological barriers has been identified such as friends and families who do not breastfeed their babies; low belief in breast milk's nutritional value; as well as poor body image (20). Maternal reassurance in addition to mechanical breast pumping and early postnatal follow-up have been suggested as potential strategies in the management of delayed, reduced or absent lactation (21).

Human milk bank is an option of mothers that are not able to breastfeed due to various reasons. Breast milk is the optimum source of nutrition for the first six months of life, and regardless of advance in infant formulas, human milk offer benefits that cannot be replicated by other sources of nutrition, thus, human donor breast milk should be considered as an alternative (22), especially for the low-birth weight infants (23). Thus, development and support of human milk banks are crucial for the promotion of breastfeeding.

Breastfeeding in Global Health Context

Breastfeeding is internationally recognized as a relevant global health topic with the response from institutions such as UNICEF and World Health Organisation in the light of only 41% of infants under 6 months exclusively breastfed. The Global Breastfeeding Collective encourages countries concentrating on improving breastfeeding practices aiming for a healthier population. Policymakers and legislators are at the core of the development of positive environments for breastfeeding and contributing to better decision-making in families regarding this highly important topic (24). In 2012 WHO analysis, out of 182 countries which had data regarding national policy for breastfeeding breaks in the workplace, 45 countries (25%) had no policies, which can impose severe restrictions to the promotion of breastfeeding. A policy ensuring paid breastfeeding breaks was in place in 130 countries (71%), while in seven countries (4%) policies guaranteeing unpaid breaks were developed (25).

The Baby-Friendly Hospital Initiative (BFHI), launched by the WHO and the United Nations Children's Fund (UNICEF), aims to create hospital environments where breastfeeding is encouraged (26). This involves the integration of the 'Ten steps to successful breastfeeding', outlined below:

"1a. Comply fully with the *International Code of Marketing of Breast-milk Substitutes* and relevant World Health Assembly resolutions.
1b. Have a written infant feeding policy that is routinely communicated to staff and parents.
1c. Establish ongoing monitoring and data management systems
2. Ensure that staff have sufficient knowledge, competence and skills to support breastfeeding
3. Discuss the importance and management of breastfeeding with pregnant women and their families
4. Facilitate immediate and uninterrupted skin-to-skin contact and support mothers to initiate breastfeeding as soon as possible after birth.

5. Support mothers to initiate and maintain breastfeeding and manage common difficulties.
6. Do not provide breastfed newborns any food or fluids other than breast milk, unless medically indicated.
7. Enable mothers and their infants to remain together and to practice rooming-in 24 hours a day.
8. Support mothers to recognise and respond to their infants' cues for feeding.
9. Counsel mothers on the use and risks of feeding bottles, teats and pacifiers.
10. Coordinate discharge so that parents and their infants have timely access to ongoing support and care." (26)

References:

1. Breastfeeding [Internet]. [cited 2020 Jan 31]. Available from: https://www.who.int/nutrition/topics/exclusive_breastfeeding/en/
2. Breastfeeding: achieving the new normal. Lancet. 2016 Jan 30;387(10017):404.
3. Breastfeeding [Internet]. UNICEF. 2015 [cited 2020 Jan 31]. Available from: https://www.unicef.org/nutrition/index_24824.html
4. Horta BL, de Lima NP. Breastfeeding and Type 2 Diabetes: Systematic Review and Meta-Analysis. Curr Diab Rep. 2019 Jan 14;19(1):1.
5. Basree MM, Shinde N, Koivisto C, Cuitino M, Kladney R, Zhang J, et al. Abrupt involution induces inflammation, estrogenic signaling, and hyperplasia linking lack of breastfeeding with increased risk of breast cancer. Breast Cancer Res. 2019 Jul 17;21(1):80.
6. Schwarz EB, Nothnagle M. The maternal health benefits of breastfeeding. Am Fam Physician. 2015 May 1;91(9):603–4.
7. WHO | Early childhood development begins with a mother's breast. 2016 Aug 1 [cited 2020 Feb 1]; Available from: https://www.who.int/mediacentre/commentaries/2016/childhood-development-breastfeeding/en/
8. Decsi T, Adamovich K, Szász M, Berthold K. [Long-chain polyunsaturated fatty acids in breast-fed and formula fed healthy infants]. Orv Hetil. 1995 Mar 26;136(13):643–7.
9. Gianni ML, Roggero P, Mosca F. Human milk protein vs. formula protein and their use in preterm infants. Curr Opin Clin Nutr Metab Care. 2019 Jan;22(1):76–81.
10. WHO | International Code of Marketing of Breast-Milk Substitutes. 2017 Apr 13 [cited 2020 Feb 1]; Available from: https://www.who.int/nutrition/publications/infantfeeding/9241541601/en/
11. "Is it just so my right?" Women repossessing breastfeeding [Internet]. dokumen.tips. [cited 2020 Feb 1]. Available from: https://dokumen.tips/documents/is-it-just-so-my-right-women-repossessing-breastfeeding.html
12. Murtagh L, Moulton AD. Working mothers, breastfeeding, and the law. Am J Public Health. 2011 Feb;101(2):217–23.
13. Navarro-Rosenblatt D, Garmendia M-L. Maternity Leave and Its Impact on Breastfeeding: A Review of the Literature. Breastfeed Med. 2018 Nov;13(9):589–97.
14. Societal Barriers to Breastfeeding | Breastfeeding [Internet]. [cited 2020 Feb 1]. Available from: http://pathwaystofamilywellness.org/Breastfeeding/societal-barriers-to-breastfeeding.html

15. Heck KE, Braveman P, Cubbin C, Chávez GF, Kiely JL. Socioeconomic status and breastfeeding initiation among California mothers. Public Health Rep. 2006 Jan;121(1):51–9.

16. Contraindications to Breastfeeding or Feeding Expressed Breast Milk to Infants | Breastfeeding | CDC [Internet]. 2019 [cited 2020 Feb 1]. Available from: https://www.cdc.gov/breastfeeding/breastfeeding-special-circumstances/contraindications-to-breastfeeding.html

17. Colombo L, Crippa BL, Consonni D, Bettinelli ME, Agosti V, Mangino G, et al. Breastfeeding Determinants in Healthy Term Newborns. Nutrients [Internet]. 2018 Jan 5;10(1). Available from: http://dx.doi.org/10.3390/nu10010048

18. Nommsen-Rivers LA. Does Insulin Explain the Relation between Maternal Obesity and Poor Lactation Outcomes? An Overview of the Literature. Adv Nutr. 2016 Mar;7(2):407–14.

19. Matias SL, Dewey KG, Quesenberry CP Jr, Gunderson EP. Maternal prepregnancy obesity and insulin treatment during pregnancy are independently associated with delayed lactogenesis in women with recent gestational diabetes mellitus. Am J Clin Nutr. 2014 Jan;99(1):115–21.

20. Lyons S, Currie S, Peters S, Lavender T, Smith DM. The association between psychological factors and breastfeeding behaviour in women with a body mass index (BMI) ≥30 kg m −2 : a systematic review : Breastfeeding and Psychological Factors. Obes Rev. 2018 Jul 24;19(7):947–59.

21. Hurst NM. Recognizing and treating delayed or failed lactogenesis II. J Midwifery Womens Health. 2007 Nov;52(6):588–94.

22. Kim J, Unger S. Human milk banking. Paediatr Child Health. 2010 Nov;15(9):595–602.

23. WHO | Donor human milk for low-birth-weight infants. 2019 Jul 22 [cited 2020 Feb 1]; Available from: https://www.who.int/elena/titles/donormilk_infants/en/

24. WHO | Increasing commitment to breastfeeding through funding and improved policies and programmes: Global breastfeeding scorecard 2019. 2019 Jul 29 [cited 2020 Feb 1]; Available from: https://www.who.int/nutrition/publications/infantfeeding/global-bf-scorecard-2019/en/

25. WHO | Breastfeeding policy: a globally comparative analysis. 2013 Jun 21 [cited 2020 Feb 1]; Available from: https://www.who.int/bulletin/volumes/91/6/12-109363/en/

26. Organization WH, Others. Evidence for the ten steps to successful breastfeeding. World Health Organization; 1998.