

Position of the American Dietetic Association: Promoting and Supporting Breastfeeding

ABSTRACT

It is the position of the American Dietetic Association (ADA) that exclusive breastfeeding provides optimal nutrition and health protection for the first 6 months of life, and breastfeeding with complementary foods for at least 12 months is the ideal feeding pattern for infants. Breastfeeding is also a public health strategy for improving infant and child health survival, improving maternal morbidity, controlling health care costs, and conserving natural resources. ADA emphasizes the essential role of dietetics professionals in promoting and supporting breastfeeding by providing up-to-date, practical information to pregnant and postpartum women, involving family and friends in breastfeeding education and counseling, removing institutional barriers to breastfeeding, collaborating with community organizations and others who promote and support breastfeeding, and advocating for policies that position breastfeeding as the norm for infant feeding. ADA also emphasizes its own role by providing up-to-date information to the public, encouraging empirical research, providing continuing education opportunities, providing cultural sensitivity and cultural competence training to dietetics professionals, and encouraging universities to review and update undergraduate and graduate training programs.

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POSITION STATEMENT

It is the position of the American Dietetic Association (ADA) that exclusive breastfeeding provides optimal nutrition and health protection for the first 6 months of life, and breastfeeding

with complementary foods for at least 12 months is the ideal feeding pattern for infants. Breastfeeding is also a public health strategy for improving infant and child health survival, improving maternal morbidity, controlling health care costs, and conserving natural resources.

Breastfeeding, or lactation, is the ideal method of feeding and nurturing infants. The Bellagio Child Survival Study Group identified breastfeeding in the first year as one of the most important strategies for improving child survival (1-3). Health professionals in the United States recommend that infants be exclusively breastfed for the first 6 months of life, and then be breastfed with complementary foods for at least the first year (4-8). Internationally, the World Health Organization recommends that breastfeeding be continued up to 2 years of age or beyond, with appropriate supplementation of solid foods (9,10). Breastfeeding involves primary, and to a lesser extent, secondary prevention of acute and chronic diseases. Achieving the Healthy People 2010 objectives (4) for breastfeeding could lead to a significant decrease in pediatric health care costs in the United States (11). The benefits of breastfeeding are well recognized and include decreased infant and child morbidity and mortality, protection against common childhood infections, and decreased risk of certain acute and chronic diseases. There are also extensive health benefits for mothers who breastfeed (4,10).

BREASTFEEDING TRENDS IN THE UNITED STATES

Breastfeeding rates in the United States are lower than in most nations. Globally, about 79% of infants are breastfed for 12 months, compared with 17% to 20% in the United States (10,12,13). In colonial America, almost all infants were breastfed. By

the 1880s, mothers began to supplement breastfeeding with raw cow's milk (some starting soon after giving birth) and to wean their infants before they were 3 months old. Infants fed raw cow's milk died at much higher rates than breastfed infants until the 1920s, when pasteurization made cow's milk safer and readily available for infant feeding. Over the next 50 years, breastfeeding rates declined sharply because of the widespread belief that pasteurized cow's milk eliminated the differences between human and cow's milk feeding (14). The decline continued when other milk substitutes (evaporated cow's milk and infant formula) became widely available. These were promoted as being more convenient for the mothers and being more nutritious than human milk. Breastfeeding rates reached an all-time low in the United States in 1971, with only 24% of mothers initiating breastfeeding (15).

As a result, the US Department of Health and Human Services (HHS) set goals for breastfeeding initiation and duration rates in the late 1970s. The United States has since seen a steady increase in breastfeeding rates (4). Breastfeeding initiation rates increased from a low of about 24% in the early 1970s to a high of 61.9% in 1982 (15,16). After a decline in breastfeeding rates through 1990, breastfeeding initiation rates have increased yearly, exceeding 70% in 2002 (12,13) (Figure 1). Breastfeeding rates are expected to continue increasing as a result of several national efforts, including the *HHS Blueprint for Action on Breastfeeding* (5), the US Department of Agriculture (USDA)/Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) *Loving Support Makes Breastfeeding Work* campaign (17), the *HHS Breastfeeding Awareness Campaign* (18), and the US Breastfeeding Committee's strategic

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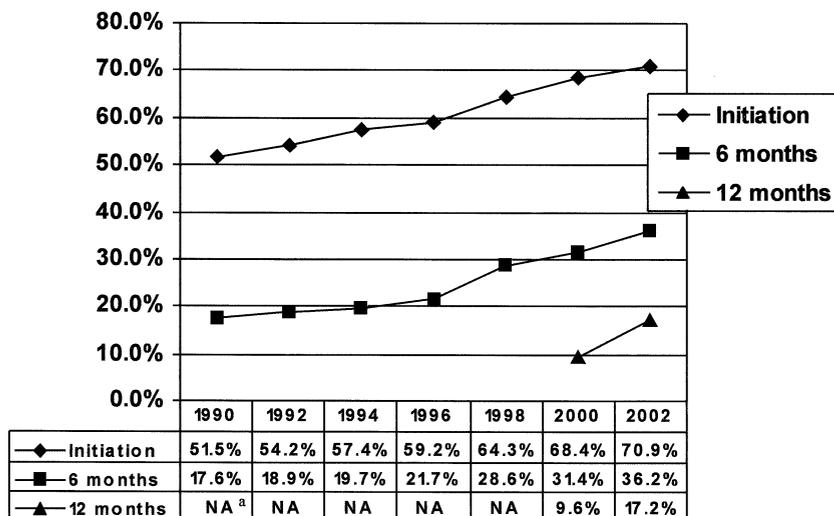


Figure 1. US breastfeeding rates (1990 to 2002). 1990 to 2000 data from reference (12). 2002 data from reference (13). ^aNA=not available.

plan for breastfeeding (19). The US Breastfeeding Committee’s strategic plan is endorsed by HHS and more than 20 other professional and public health organizations.

According to National Immunization Survey data, 14 states have achieved the national Healthy People 2010 objective for 75% of mothers initiating breastfeeding (Figure 2), and the national goal seems to be within reach (13). Breastfeeding initiation rates continue to be highest among women who are white, college educated, older than 30 years, employed part-time, not enrolled in WIC, and living in the Mountain or Pacific regions (12,13). Although all demographic groups reported increases in breastfeeding initiation since 1990, the largest increases occurred among mothers who have historically been less likely to breastfeed—women who are black, Hispanic, less educated, employed full-time, less than 24 years old, living in the South Atlantic region, participating in WIC, and with low-birth-weight infants (12).

Considerable work remains to achieve the two Healthy People 2010 goals for breastfeeding duration—50% of infants breastfeeding at 6 months of age and 25% breastfeeding at 12 months of age (4). Six states have achieved the objective for breastfeeding duration at 6 months of age (see Figure 2). However, nationally only 33.2% to 36% of all infants are breastfeeding at 6 months of age

(12,13). The largest increases in breastfeeding duration rates have occurred among New England residents, Hispanic mothers, and non-WIC participants (12). Eight states have achieved the objective for breastfeeding duration at 12 months of age (see Figure 2). Nationally, only 17% to 20% of all infants are breastfeeding at their first birthday (12,13). Worldwide, 79% of infants are still breastfeeding at 12 months of age (10).

US breastfeeding initiation rates are much higher than breastfeeding exclusivity rates. Despite the limited data about breastfeeding exclusivity and the variety of definitions of exclusivity used across studies, the available data provide important insight. Exclusive breastfeeding in hospitals has remained steady over the last 4 years, but significant differences exist by demographic segments. For example, mothers with a college education are more likely to have exclusively breastfed their infants than mothers without a college education. Non-WIC mothers exclusively breastfed their infants at higher rates than WIC mothers, and white mothers exclusively breastfed at a rate nearly double that of black mothers. At 6 months of age, similar gaps existed for these same demographic segments (12,13).

The primary source of breastfeeding data in the United States since 1955 has been proprietary data collected by Ross Products Division of

Abbott Laboratories. The Ross Mothers Survey (12) collects data through an ongoing mail survey periodically sent to a nationally representative sample of new mothers. The data have been relied on to monitor breastfeeding rates by state, by geographic region, and nationally. Another data source for monitoring breastfeeding trends was instituted in 2003 by the Centers for Disease Control and Prevention and the National Center for Health Statistics (13). Breastfeeding questions were incorporated into the National Immunization Survey, which uses random-digit dialing to survey households with children ages 19 to 35 months. Breastfeeding initiation, duration, and exclusivity of breastfeeding rates are reported for the overall population, states, and selected geographic areas within states. Trend data from the latter survey will be critical for monitoring breastfeeding rates in the future.

HEALTH BENEFITS TO INFANTS

According to the American Academy of Pediatrics, the breastfed infant is the reference against which all alternative feeding methods must be measured with regard to growth, health, development, and other outcomes (6). Human milk has many beneficial effects on the health of infants (including premature and low-birth-weight infants) and young children. These benefits are magnified with exclusive breastfeeding and breastfeeding beyond 6 months of age (3,10).

Human milk is uniquely superior to all other milk substitutes and is specifically tailored to meet the nutritional needs of the human infant. It has the appropriate balance of nutrients provided in easily digestible and bioavailable forms (4,10,20). The milk changes its composition, from colostrum for the newborn to mature milk for the older infant, to meet the nutrient needs of the growing infant. It provides generous amounts of carbohydrates, essential fatty acids, saturated fatty acids, medium-chain triglycerides, long-chain polyunsaturated fatty acids, and cholesterol. The relatively low protein content presents a relatively modest nitrogen load to the immature kidney. The protein is largely α -lactalbumin, a whey protein that forms a soft, easily di-

75% Breastfeeding initiation	50% Breastfeeding at 6 months	25% Breastfeeding at 12 months
Alaska	Hawaii	Alaska
Arizona	Idaho	California
California	Oregon	Hawaii
Colorado	Utah	Idaho
Hawaii	Vermont	Oregon
Idaho	Washington	Utah
Kansas		Vermont
Minnesota		Washington
Montana		
Nevada		
Oregon		
Utah		
Vermont		
Washington		

Figure 2. States achieving national Healthy People 2010 breastfeeding objectives. Source: Centers for Disease Control and Prevention. 2003 National Immunization Survey.

Benefits for infant	Benefits for mother
<ul style="list-style-type: none"> ● Provides optimal nutrition for infant ● Guarantees safe, fresh milk ● Enhances immune system ● Protects against infectious and non-infectious diseases ● Protects against allergies and intolerances ● Decreases risk of diarrhea and respiratory infections ● Promotes correct development of jaws, teeth, and speech patterns ● Decreases risk of childhood obesity ● Increases cognitive function ● Reduces risk for heart disease ● Increases bonding with mother 	<ul style="list-style-type: none"> ● Promotes faster shrinking of the uterus ● Reduces postpartum bleeding ● Decreases risk of breast and ovarian cancer ● Delays resumption of the menstrual cycle ● Improves bone density ● Decreases risk for hip fracture ● Improves glucose profile in gestational diabetics ● Strengthens bond with the infant ● Enhances self-esteem in the maternal role ● Eliminates the need for preparing and mixing formula ● Saves money not spent on formula

Figure 3. Benefits of breastfeeding.

gestible curd. Human milk has a relatively low sodium content, allowing the fluid requirements of the exclusively breastfed infant to be met while keeping the renal solute load low. Minerals in breast milk are largely protein bound and balanced to enhance bioavailability. The 2:1 calcium-to-phosphorus ratio is ideal for the absorption of calcium, phosphorus, and magnesium. The limited amount of iron and zinc is highly absorbable (21). Given the nutrient content of human milk and decreased exposure to sunlight, a vitamin D supplement is recommended for all breastfed infants until they consume at least 500 mL per day of vitamin D–fortified infant formula (or milk for infants after their first birthday) (22). Breastfed infants who are 6 months and older may need a fluoride supplement if the total amount of fluoride from the local

water supply or other sources available to the infant is inadequate (23).

Breastfeeding, especially exclusive breastfeeding, during the first 6 months of life is an important factor in reducing infant and childhood morbidity and mortality (9). Breastfeeding decreases the risk for a large number of acute and chronic diseases (Figure 3). Breastfeeding decreases the incidence and severity of diarrhea and gastrointestinal illnesses (24,25), lower respiratory infection (26), otitis media (24,25,27), bacterial meningitis (28,29), necrotizing enterocolitis (30), malocclusions or misalignment of teeth (31), allergic diseases (30), childhood asthma (32), childhood leukemia (33), childhood obesity (34), and Sudden Infant Death Syndrome (SIDS) (35). Evidence continues to accumulate confirming the benefits

of breastfeeding in reducing the risk for cardiovascular diseases and type 1 diabetes (36). Breastfeeding also has been linked with enhancement of cognitive development, with some studies showing evidence that these cognitive developmental benefits increased with the duration of breastfeeding (37) and extended through the school-age years (38,39).

Studies relating to the benefits of breastfeeding have been criticized for methodological and analytical flaws including lack of control for confounding factors, poorly designed tools, varying definition of breastfeeding, and researcher bias (11,40). However, professional health organizations stand behind their recommendations for promoting breastfeeding as the optimal food for human infants.

HEALTH BENEFITS TO WOMEN, FAMILY, AND SOCIETY

Maternal Benefits

Women choose to breastfeed for many reasons. Although women may be aware of the health benefits to infants, they may not be fully aware of the wide range of health benefits for themselves (see Figure 3). The degree to which some of these health benefits may be realized depends on breastfeeding duration, frequency, exclusivity, and other personal factors (41). Breastfeeding increases oxytocin levels, resulting in less postpartum bleeding and greater uterine involution (shrinking) (42). Lactation amenorrhea (delayed menstrual cycle) causes less menstrual blood loss, which conserves iron stores (42). Other benefits of breastfeeding include a decreased risk for postmenopausal hip fractures (43), bone remineralization to levels exceeding those present before pregnancy (44), an improved glucose profile for those with gestational diabetes (45), a decreased risk of type 2 diabetes (41), a decreased risk for ovarian cancer (46), a decreased risk for premenopausal breast cancer (47), and increased weight loss and fat loss (48-50).

The studies on breastfeeding and weight loss have produced mixed findings. In the short term, breastfeeding women experience greater weight and fat loss than nonbreastfeeding women (48,49). Women who breastfeed for more than 6 months and those who do so exclusively are more likely to achieve maximum weight loss. However, the weight difference may not be sustained past 18 months (50). It should be noted that weight loss and body composition changes are highly variable among postpartum women (50,51). In addition, prepregnancy weight and total pregnancy weight greatly impact postpartum weight loss (50).

Economic Benefits

Breastfeeding provides significant economic benefits to the family and society. Breastfeeding allows the family to save the money that otherwise would be spent on infant formula, other milk substitutes, and feeding equipment. It also improves household food security and saves the family's disposable income for food for older children and adults. Families that do not breastfeed

spend close to \$700 for standard formulas in the first year. Other direct family savings include the defrayed or reduced health care-related expenses. (11,52,53). Indirect costs to the family include time and income lost from work to take care of a sick child (11).

There also would be economic benefits to the nation if more women would breastfeed. The USDA estimates that at least \$3.6 billion could be saved in health care costs if breastfeeding rates were increased from current levels to those recommended by the US Surgeon General. The savings could be much higher because this figure only represents cost savings from the treatment of three childhood illnesses (otitis media, gastroenteritis, and necrotizing enterocolitis) (11). It is also estimated that \$30 million would be saved if all of the women in WIC breastfed for 1 month. An additional \$48 million could be saved if 75% of the mothers in WIC breastfed for 3 months (11,52,53). In addition to the savings in direct medical costs, data are emerging that document the economic benefits of breastfeeding support to employers, including lower maternal absenteeism attributable to infant illness, increased employee loyalty, improved productivity, and enhanced public image (11,54). Breastfeeding is a cost-effective and socially beneficial health practice that should be encouraged and supported.

Environmental Benefits

Breastfeeding contributes to the health of the environment in numerous ways (55,56). Human milk is a natural resource that is renewable with each pregnancy. It is produced and delivered to the consumer without using and wasting other resources, and it creates no pollution. In contrast to infant formula, human milk does not require manufacturing, packaging, shipping, disposing of containers, or extensive advertising. It also conserves natural resources such as fossil fuels. By delaying the return of menses (57), breastfeeding suppresses fertility and increases birth spacing, improving maternal and child health while limiting population growth.

BARRIERS TO BREASTFEEDING

Despite the many benefits of breastfeeding, many women still choose not to do so. The reasons include inadequate knowledge of the benefits of breastfeeding (58), embarrassment and social reticence (59,60), lack of interest or negative perception of breastfeeding (59,61,62), lack of support from partner and family members (59,60,62), partner's negative perception of breastfeeding (63), mother not breastfed as a child (63), the need to work or go to school (59,62), other family responsibilities (59), perceived decrease in father-child bond (59), and aggressive marketing by infant formula companies (64).

Although the majority of American mothers initiate breastfeeding, less than one third continue to breastfeed at 6 months postpartum. Reasons for early termination of breastfeeding include inconvenience (62), perceived restriction of freedom and independence (59), the need to work or go to school (59), embarrassment and societal disapproval (59,60), discomfort about breastfeeding in public (59,60), short or unpaid maternity leave (59,60), unsupportive work environment (59), lack of public and workplace facilities to breastfeed comfortably (59), early supplementation with formula or other milk substitutes (65), pacifier use (65), unsupportive health care environment (65), inconsistent implementation of breastfeeding promotion policies (66), and limited availability of lactation consultant services, especially after hospital discharge (65). Providing samples of infant formula in physician offices, in clinics, and on hospital discharge promotes maternal-infant separation, undermines maternal confidence, and contributes to early mixed feedings that interfere and sometimes interrupt establishing an adequate milk supply (63,64).

SPECIAL CONSIDERATIONS

The advantages of breastfeeding and the use of human milk are particularly salient for premature and low-birth-weight infants. If these infants are unable to nurse, the mother's milk can be administered through various feeding routes, although fortification may be needed to achieve adequate growth (21,67). Human

milk has also been successfully used with infants with cleft palate, cystic fibrosis (with pancreatic enzyme replacement), Down syndrome, and in-born errors of metabolism, especially phenylketonuria (with careful supplementation of low-phenylalanine formula) (21). In each of these situations, mothers need support from health care providers to achieve and maintain an adequate milk supply. Health care providers should provide anticipatory support and be alert to early signs or symptoms of feeding difficulties so that effective early intervention can be initiated.

Despite the many benefits of breastfeeding, there are some situations in which the infant should not be breastfed. These include galactosemia (6) and the infant whose mother uses illegal drugs (68), has active tuberculosis (6,69), is infected with the human immunodeficiency virus (HIV), has acquired immunodeficiency syndrome, or has other diseases in which the immune system is compromised (6,70). In countries with a high prevalence of HIV/acquired immunodeficiency syndrome, the infant mortality risks associated with not breastfeeding may be greater than the risk of acquiring HIV (71).

Medical advances have improved the health outcomes of many pregnant women with chronic diseases such as type 1 diabetes mellitus, systemic lupus erythematosus, and hypothyroidism. However, few data exist to provide guidance to these women if they choose to breastfeed (21). Guidelines are available regarding the advisability of breastfeeding in women with infectious diseases and other maternal conditions (21). The key to successful breastfeeding for these women is the appropriate choice of medications, treatments, and lactation support from the early prenatal to the postpartum period.

Most prescribed and over-the-counter medications are safe for the breastfed infant, and resources are available to assist in evaluating the safety of drug use in lactation (21,68,72). However, there are a few medications that mothers may need to take that may make it necessary to interrupt breastfeeding. They include radioactive isotopes, antimetabolites, cancer chemotherapy agents, lithium, ergotamine, and a small number of other medications (68). Breastfeeding

mothers should be encouraged to discuss any use of prescription drugs, over-the-counter drugs, and herbal medications with their primary care providers. Although herbal products are widely used in the United States, data are lacking about the safety of their use during lactation.

With the exception of maternal chemical poisoning, human milk remains a safe feeding method for infants and young children. Contamination of breast milk with environmental pollutants is a concern when mothers have had specific exposure to heavy metals or insecticides (73). In situations in which maternal exposure and probability of transfer in breast milk lipids are determined to be significant, analysis of milk is recommended, with decisions regarding safety being made from estimated average intake. Environmental contaminants get into human milk when mothers have had geographic, occupational, or accidental exposure. Dioxins produced during industrial processes and organochlorine pesticides and polychlorinated biphenyls are of greatest concern because of their long half-lives and their contribution to the mother's and infant's overall body burden of contaminants (74). Research shows that the greatest risk period for adverse effects from exposure is prenatally (75).

Breastfeeding mothers should be encouraged to reduce their own exposure to known chemical contaminants. For example, women who may become pregnant, who are pregnant, or who are breastfeeding should reduce their exposure to methylmercury (76). Large bottom-dwelling fish are the most common food source of methylmercury, so the Food and Drug Administration and the Environmental Protection Agency recommend the following guidelines for eating fish:

- Avoid shark, swordfish, mackerel, and tilefish.
- Eat up to 12 oz of other kinds of fish every week, with a maximum of 6 oz of albacore (white) tuna per week.
- Check local advisories about eating locally caught fish. If no advice is posted, limit intake of locally caught fish to 6 oz per week and consume no other fish in that same week (77).

ROLE OF DIETETICS PROFESSIONALS IN PROMOTING AND SUPPORTING BREASTFEEDING

As experts in food and nutrition throughout the life cycle, it is the responsibility of dietetics professionals to promote and support breastfeeding for its short-term and long-term health benefits. The ADA emphasizes the essential role of dietetics professionals in promoting breastfeeding as the norm for infant feeding; supporting local, state, and national efforts to increase breastfeeding initiation, duration, and exclusivity rates; reducing individual, social, and institutional barriers to breastfeeding; and increasing access to lactation care and services. The ADA recommends the following strategies to promote and support breastfeeding:

Counsel and Educate Prenatal and Postpartum Women

- Recognize and respect that breastfeeding is a personal decision. Effective educational strategies that strike a balance of support and education result in informed decisions about infant feeding, not guilt.
- Provide women with practical information about breastfeeding that addresses their specific questions and concerns. This patient-centered approach may help dietetics professionals identify breastfeeding problems early and prevent unnecessary or premature weaning.
- Target women who are less likely to breastfeed (eg, racially and ethnically diverse groups, low education levels, adolescents) and counsel in a culturally relevant and sensitive manner. Adolescents need to hear that breastfeeding strengthens the bond with their infants.
- Identify mothers who are at risk for early cessation. The first 6 weeks are especially crucial. Predictors of early cessation include education level, working intentions, workplace support, social support, and previous breastfeeding experience (77).
- Encourage overweight and obese women to achieve a healthful weight before pregnancy. Overweight and obese women who are lactating may have a lower prolactin response, which may result in decreased milk production and

Every facility providing maternity services and care for newborn infants should:

1. Have a written breastfeeding policy that is routinely communicated to all health care staff.
2. Train all health care staff in skills necessary to implement this policy.
3. Inform all pregnant women about the benefits and management of breastfeeding.
4. Help mothers initiate breastfeeding within 1 hour of birth.
5. Show mothers how to breastfeed and how to maintain lactation, even if they are separated from their infants.
6. Give newborn infants no food or drink other than breast milk, unless *medically* indicated.
7. Practice “rooming in”—allow mothers and infants to remain together 24 hours a day.
8. Encourage unrestricted breastfeeding.
9. Give no artificial teats or pacifiers to breastfeeding infants.
10. Foster the establishment of breastfeeding support groups and refer mothers to them on discharge from the hospital or clinic.

Figure 4. Ten steps to successful breastfeeding for hospitals. World Health Organization and United Nations Children’s Fund, 1989. Source: reference (81) Baby Friendly USA, www.babyfriendlyusa.org.

early cessation of breastfeeding (78).

- Provide appropriate and timely information on weaning. The decision to wean should be based on the desires and needs of each breastfeeding dyad. Ideally, weaning should be gradual and solid foods should be offered based on the age and developmental stage of the child.
- Encourage women who are returning to work or school to explore their options for continuing to breastfeed. Discuss on-site arrangements to express and store milk for later use. For women who cannot pump or hand express on site, discuss how to supplement breastfeeding with formula while apart and breastfeed when with the infant.
- Evaluate client education materials and service delivery sites for product bias. Changes should be made to the counseling environment to clearly communicate that breastfeeding is the norm for infant feeding.

Involve Family and Friends

- Identify support networks as early in pregnancy as possible, and develop programs and materials aimed at partners, parents, and grandparents.
- Include partners and grandmothers in breastfeeding education and counseling sessions. Support from a woman’s partner and her mother significantly increase her chances of breastfeeding and continuing to breastfeed. Partners need to learn how to be part of a successful breastfeeding family.

Enhance Professional Development

- Participate in continuing education programs to keep up-to-date with the art and science of lactation. Intensive courses in lactation training and education are available through various organizations.
- Consider completing the requirements to obtain the voluntary credential (International Board Certified Lactation Consultant), through the International Board of Lactation Consultant Examiners (79,80).
- Participate in continuing education programs on cultural competence. The low prevalence of breastfeeding among racial/ethnic minority groups demands ongoing training in cultural competence. Dietetics professionals must ask questions and invite dialogue to identify and understand the specific barriers for a group, then design or refine services and messages to address those barriers. Focusing on hands-on interventions, skill building, and problem solving can begin the process of social change.
- Conduct critical internal reviews of undergraduate and graduate dietetics training programs to ensure that nutrition and lactation, lactation physiology, breastfeeding management, and cultural competence are incorporated into curricula. This will ensure that dietetics professionals entering the field understand the health implications of breastfeeding. There also is a need to recruit more racially and ethnically diverse students into dietetics training programs.

Initiate Institutional Change

- Initiate and create institutional and organizational policies to reduce or eliminate institutional bias (eg, hospitals, clinics) for infant formula and incorporate appropriate lactation promotion and support policies in their place. Dietetics professionals must present the breastfed infant as the standard against which infants fed human milk substitutes are compared.
- Encourage hospitals and birthing centers to adopt The Ten Steps to Successful Breastfeeding for Hospitals as outlined by the United Nations Children’s Fund/World Health Organization and promoted by Baby-Friendly USA (81). (See Figure 4.)

Collaborate with Others Who Promote Breastfeeding

- Participate in professional and volunteer activities. Collaborative opportunities exist for ADA members to work with the International Lactation Consultant Association, La Leche League International, Nursing Mothers’ Counsel, Healthy Mothers Healthy Babies coalitions, state and local WIC programs, the National WIC Association, the African American Breastfeeding Alliance, and breastfeeding task forces at all levels to promote and support breastfeeding.

Initiate and Support Breastfeeding Campaigns

- Work with pro-breastfeeding organizations to promote breastfeeding as the social norm.
- Support extending the reach of

breastfeeding promotion campaigns to men, grandmothers, and adolescent mothers.

- Initiate campaigns that promote breastfeeding exclusivity and breastfeeding beyond 6 months. Breastfeeding is more than meeting the nutrition needs of young infants. It offers health, physical, and psychological benefits to infants that influence health outcomes later in life. Breastfeeding must be part of a broader strategy to reduce existing health disparities.

Advocate for Policy Change

- Support legislation to eliminate barriers to breastfeeding. More than half of the states have enacted legislation to address breastfeeding in public, on the job, and on jury duty (82).
- Advocate for other policy changes affecting a woman's ability to continue breastfeeding, including longer family leave, facilities for child care and breastfeeding at the worksite or nearby in the community, paid lactation or milk expression breaks, flexible employment arrangements, breastfeeding support personnel/lactation consultation, and third-party reimbursement for lactation consultation and management services.
- Encourage school boards to review curriculum to ensure that breastfeeding is presented as the norm in texts, other resources, and classroom discussion at elementary and secondary schools. Dietetics professionals can volunteer to work with curriculum committees and science fair committees, and can guest lecture in classes such as social studies, life management, and science.
- Advocate for adequate facilities and breaks for mothers who are students and those who are teachers.

Conduct Empirical Research

- Take the initiative to conduct empirical research. Research is needed on topics such as cultural influences on infant feeding, social marketing of breastfeeding, effectiveness of breastfeeding promotion programs, cost-effectiveness, hospital/clinic use rates, eliminating barriers to extended breastfeeding, and nutri-

ent needs for women and children with special needs. Research should be theory-based and have policy implications. Larger-scale studies with better designs are needed.

- Develop and/or advocate for a consistent definition of breastfeeding in research studies to improve the understanding of the benefits of exclusive breastfeeding.
- Support a national policy to track breastfeeding trends using nonproprietary data. Policies are also needed to centralize national infant and child morbidity and mortality data.

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ADA position adopted by the House of Delegates on March 16, 1997, and reaffirmed on September 12, 1999, and June 6, 2003. The update will be in effect until December 31, 2008. The ADA authorizes republication of the position, *in its entirety*, provided full and proper credit is given. Requests to use portions of this position must be directed to ADA Headquarters at 1-800-877-1600, ext 4835, or ppapers@eatright.org. *Authors*: Delores C. S. James, PhD, RD (University of Florida, Gainesville, FL); Brenda Dobson, MS, RD (Iowa Department of Public Health, Des Moines, IA). *Reviewers*: Jessica Donze Black, MPH, RD (ADA, Washington, DC); Dietetic Technicians in Practice Dietetic Practice Group (Josie Klein, DTR, Mount Olivet Careview, Minneapolis, MN, and Connie Urich, DTR, Children's Mercy Hospital, Kansas City, MO); Deborah Krauter, RD (Massachusetts Department of Public Health, Boston, MA); Esther Myers, PhD, RD (ADA, Chicago, IL); Judith B. Roepke, PhD, RD (Ball State University, Muncie, IN); Jane V. White, PhD, RD, FADA (University of Tennessee-Knoxville, Knoxville). *APC Workgroup*: Ida Laquatra, PhD, RD (chair); Cynthia Taft Bayler, MS, RD; Rachelle Lessen, MS, RD (content advisor).