AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 520
(A-22)

Introduced by: Medical Student Section

Subject: Addressing Informal Milk Sharing

Referred to: Reference Committee E

Whereas, A growing body of evidence supported by the American Academy of Pediatrics (AAP) indicates that breast milk protects growing infants--especially preterm infants--against a variety of dangerous diseases and conditions, including bacteremia, urinary tract infections, lower respiratory tract infections, necrotizing enterocolitis, and sudden infant death syndrome, among others[1,2]; and

Whereas, Human milk sharing, also known as using donor human milk, provides access to breast milk for mothers who cannot provide enough for their infants, especially preterm infants in the Neonatal Intensive Care Unit (NICU)[3]; and

Whereas, Donor human milk provides nutrients comparable to a mother's own milk, yielding positive effects on neurodevelopment and tolerance of feedings, as well as reduced risk of sepsis and necrotizing enterocolitis, reduced length of stay in the NICU, and direct cost savings [4, 5]; and

Whereas, Informal or peer milk sharing, defined as the practice of donating or receiving donor human milk directly peer-to-peer, is growing in popularity, with tens of thousands of informal milk exchanges occurring via Facebook groups each year and national surveys of milk sharing participants finding that as many as 64% of respondents have obtained donor breast milk informally[6-11]; and

Whereas, Informal milk sharing is associated with many quality concerns, such as dilution with non-human milk which infants are unable to properly digest for the first year of life[3, 12, 13]; and

Whereas, Informal milk sharing also carries many safety risks including contamination via infectious or toxic environmental agents, with several studies finding that a significant number of informally shared human milk samples were colonized with disease-causing pathogens, including aerobic bacteria, gram-negative bacteria, and coliform bacteria[14, 15, 16, 17]; and

Whereas, These safety risks are of special concern with the coronavirus disease 2019 (COVID-19) pandemic as it cannot be confirmed whether safety precautions known to protect against severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) transmission—including wearing a mask while expressing milk, washing hands and equipment thoroughly, and pasteurizing donor milk—have been taken with informally shared milk[18, 19]; and

Whereas, Non-profit milk banks, which are regulated by the Human Milk Banking Association of North America (HMBANA), serve as a safe alternative to informal milk sharing by providing breast milk that is screened, pooled, tested, and pasteurized to be provided to infants in need[20]; and

Whereas, Non-profit milk banks are associated with many limitations in accessibility, including limited distribution as only 25 non-profit milk banks operate in the United States due to limitations in donor supply and access to funding[3, 21, 22, 23]; and

Whereas, Already-limited milk supplies at non-profit milk banks are being further strained during the COVID-19 pandemic due to inadequate staffing, challenges with donor recruitment, and safety concerns about donor milk[24]; and

Whereas, Access to non-profit milk bank breast milk is also limited by cost, as this milk generally costs $3-$5 per ounce, and although Medicaid, the Special Supplemental Nutrition Program for Women, Infants, and Children, and other aid-providing programs can help to cover costs, this coverage varies by state[25, 26]; and

Whereas, The majority of the public is unable to access non-profit milk bank breast milk as a prescription is often required to receive this milk and the majority of non-profit milk bank breast milk is provided to NICUs due to limitations in supply[3, 27]; and

Whereas, Concerns have risen about informal milk sharing outcompeting milk banks for receipt of human milk donations, and studies have found that women who participate in milk sharing are much more likely to have donated informally than to have donated to a milk bank [5-10, 28, 29]; and

Whereas, The AAP, the U.S. Food and Drug Administration, the European Milk Bank Association, HMBANA, and the Academy of Breastfeeding Medicine have released statements within the last 5 years discouraging informal milk sharing in favor of milk banking[3, 8, 9, 27, 30, 31]; and

Whereas, The AMA has existing policy supporting breastfeeding (H-245.982) and breast milk banking (H-245.972) but these policies and the policy statements they support make no mention of informal milk sharing or donation to milk banks; therefore be it

RESOLVED, That our AMA discourage the practice of informal milk sharing when said practice does not rise to health and safety standards comparable to those of milk banks, including but not limited to screening of donors and/or milk pasteurization; (New HOD Policy) and be it further

RESOLVED, That our AMA encourage breast milk donation to regulated human milk banks instead of via informal means; (Directive to Take Action) and be it further

RESOLVED, That our AMA supports further research into the status of milk donation in the U.S. and how rates of donation for regulated human milk banks may be improved. (New HOD Policy)

Fiscal Note: Not yet determined

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RELEVANT AMA POLICY

Breast Milk Banking H-245.972
Our AMA encourages breast milk banking.
Res. 443, A-07; Reaffirmed: CSAPH Rep. 01, A-17

AMA Support for Breastfeeding H-245.982
1. Our AMA: (a) recognizes that breastfeeding is the optimal form of nutrition for most infants; (b) endorses the 2012 policy statement of American Academy of Pediatrics on Breastfeeding and the use of Human Milk, which delineates various ways in which physicians and hospitals can promote, protect, and support breastfeeding practices; (c) supports working with other interested organizations in actively seeking to promote increased breastfeeding 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 all medical schools and graduate medical education programs to support all residents, medical students and faculty who provide breast milk for their infants, including appropriate time and facilities to express and store breast milk during the working day; (c) encourages the education of patients during prenatal care on the benefits of breastfeeding; (d) supports breastfeeding in the health care system by encouraging hospitals to provide written breastfeeding policy that is communicated to health care staff; (e) 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; (f) 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 bottle-feeding options; and (g) 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.

3. Our AMA: (a) supports the implementation of the WHO/UNICEF Ten Steps to Successful Breastfeeding at all birthing facilities; (b) endorses implementation of the Joint Commission Perinatal Care Core Measures Set for Exclusive Breast Milk Feeding for all maternity care facilities in the US as measures of breastfeeding initiation, exclusivity and continuation which should be continuously tracked by the nation, and social and demographic disparities should be addressed and eliminated; (c) recommends exclusive breastfeeding for about six months, followed by continued breastfeeding as complementary food are introduced, with continuation of breastfeeding for 1 year or longer as mutually desired by mother and infant; (d) recommends the adoption of employer programs which support breastfeeding mothers so that they may safely and privately express breast milk at work or take time to feed their infants; and (e) encourages employers in all fields of healthcare to serve as role models to improve the public health by supporting mothers providing breast milk to their infants beyond the postpartum period.

4. Our AMA supports the evaluation and grading of primary care interventions to support breastfeeding, as developed by the United States Preventive Services Task Force (USPSTF).

5. Our AMA's Opioid Task Force promotes educational resources for mothers who are breastfeeding on the benefits and risks of using opioids or medication-assisted therapy for opioid use disorder, based on the most recent guidelines.

CSA Rep. 2, A-05; Res. 325, A-05; Reaffirmation A-07; Reaffirmation A-12; Modified in lieu of Res. 409; A-12 and Res. 410, A-12; Appended: Res. 410, A-16; Appended: Res. 906, I-17; Reaffirmation: I-18