Should All Mothers Breast-Feed?

EDITORIAL

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I recently saw a professional couple with their 10-day-old, first-born infant in Saturday morning clinic. I immediately sensed that tension was high. The mother was having difficulty breast-feeding. She had spent an extra day in the hospital working on it and had already made several postpartum visits to the hospital lactation specialists. Although she was nursing frequently, her baby was just beginning to gain weight. Nursing was painful (her nipples were sore and cracked) and tiring (she hadn't had much sleep for the past 10 days). She had only 3 months with her baby before going back to work. She had anticipated enjoying that time, relaxing and getting to know her baby. It wasn't turning out that way. She was having second thoughts about breast-feeding.

In this issue of **ecp**,[1] Deshpande and Gazmararian address how we might encourage breast-feeding by providing better access to lactation support. Notably, only 1% of the women surveyed in this managed care sample reported access to breast-feeding support in the postpartum period, but those who did have these services were more likely to breast-feed. The authors note that mothers who took advantage of postpartum support may have had a stronger commitment to breast-feeding in the first place, which could have partially confounded the results. But it makes sense that better postpartum lactation support could increase the chances of success, especially in the 10% to 20% of women who have difficulty establishing lactation.

But how strongly should we encourage breast-feeding? It turns out that my patient had been ambivalent about breast-feeding from the beginning. She was modest, and the exposure made her uncomfortable. She wondered if it was worth the effort, considering that she planned to stop as soon as she went back to work. But she was under the impression that there were large health benefits conferred to her baby by breast-feeding, even for a short time. Naturally, she didn't want to jeopardize her baby's health.

The presumption is, of course, that by stopping she would be. For developing nations, there is little question that the presumption is correct—failure to breast-feed dramatically increases infant mortality.[2] Much of the benefit of breast-feeding in those countries is due to reduced exposure to contaminated water sources. As shown in **Table 1**, a retrospective survey of 1262 Malayian women[3]

TABLE 1

Interactive Effects of Breast-Feeding and Sanitation on Infant Mortality in a Developing Nation

SANITATION AT HOME	INFANT MORTALITY RATE BY FEEDING TYPE*		ATTRIBUTABLE RISK (LOWER BOUND OF THE 95% CI)	RELATIVE RISK (LOWER BOUND OF THE 95% CI)
	BOTTLE	BREAST		
Neither toilet nor water	190	37	153 (60)	5.1 (2.8)
Toilet only	76	28	48 (14)	2.7 (1.7)
Toilet plus water	47	19	28 (10)	2.5 (1.6)

**Deaths per 1000 live births. Relative risk and attributable risk adjusted for ethnicity, sex, year of birth, birthweight, and close intervals between pregnancy.*

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demonstrated that the risk of bottle-feeding is modified by the degree of sanitation in the home. In the worst case, where neither a toilet nor running water were present in the home, the infant mortality rate (per 1000 births) in bottle-fed infants was 190 compared with only 37 for breast-fed infants. The protective effect of breast-feeding was smaller for those who lived in homes with a toilet and running water. Overall, breast-feeding prevented 61% of infant deaths in this study, demonstrating the importance of aggressive advocacy-based lactation-support programs in developing nations.

In the developed world, however, the risks of bottle-feeding are much smaller. Most homes have toilets and running water, and comparatively few infants die of infectious diseases during infancy. The risks that have been documented relate to acute minor infections during the first year of life. **Figure 1** shows the results of a prospective cohort study of 750 mother–infant pairs in Scotland.[4] The protective effect of exclusive breast-feed-

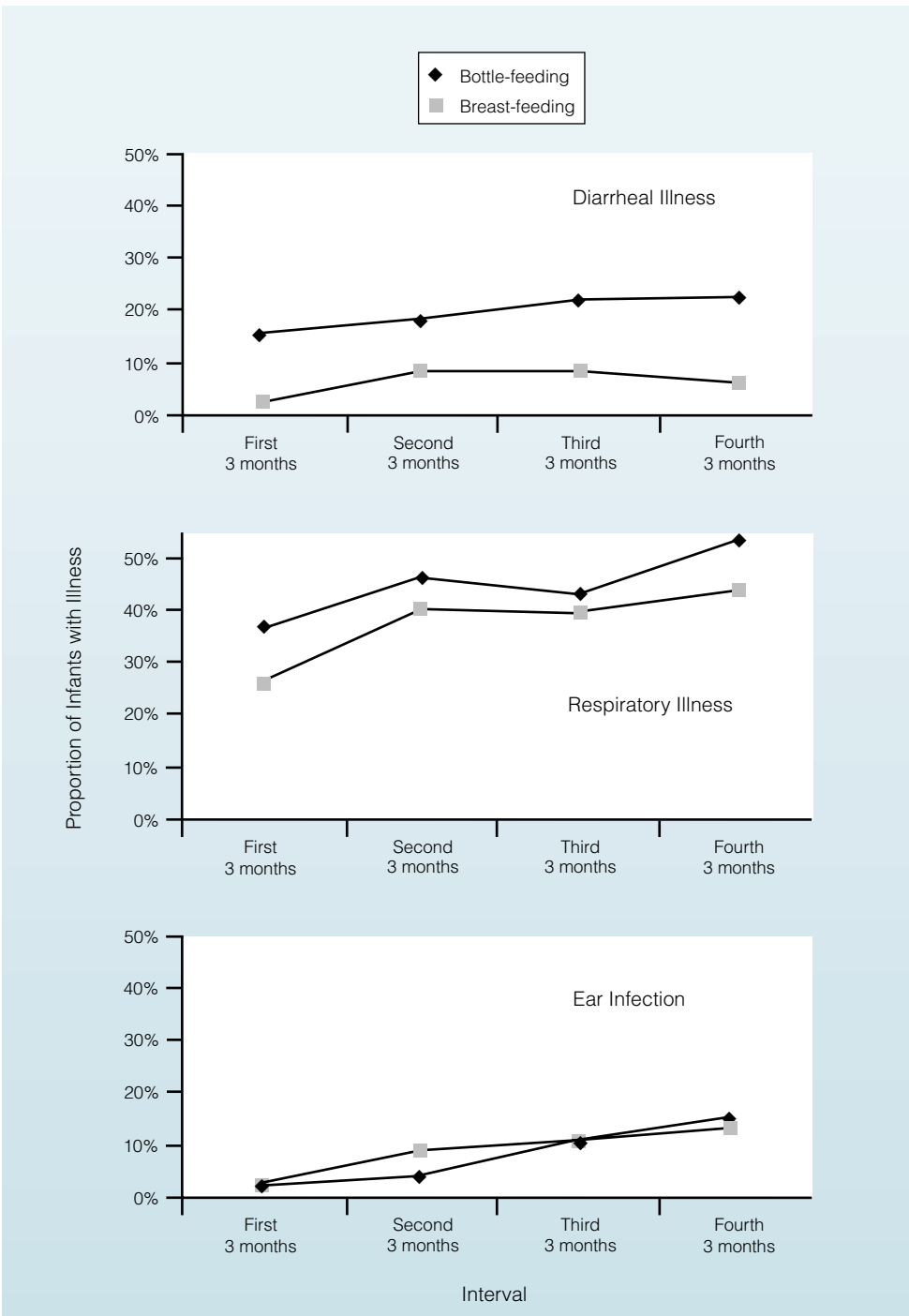

FIGURE 1. Relation between breast-feeding and bottle-feeding and the probability of developing three common illnesses during the first year of life.

ing for 4 months was largest for diarrheal diseases, smaller for acute respiratory illness, and nonexistent for otitis media. The Tucson Children's Respiratory Study,[5] a prospective cohort including 1220 mother–infant pairs, showed that exclusive breast-feeding for 4 months reduced the chances of getting an ear infection during the first year of life from 68% to 56% and reduced the chances for recurrent otitis media from 20% to 15%.

Although definitions of breast-feeding are not uniform and outcomes differ slightly in other prospective studies conducted in developed countries, the results are remarkably similar: Not breast-feeding is associated with modest increases in the rate of acute gastrointestinal and respiratory infections during the first year of life. And because it is difficult to adequately adjust for the confounding effect of socioeconomic status (i.e., poverty is associated with both lower rates of breast-feeding and higher rates of infection), these estimates probably overstate the protective effects of breast-feeding.

To put these numbers in context, consider another decision that new parents face: day care. Infants placed in day care centers (those with more than two unrelated children) are twice as likely to develop lower respiratory tract infections in the first 3 years of life than those who stay at home.[6] Although neither issue is assessed as thoroughly as one would like, the benefit of breast-feeding is roughly in the same ballpark as the benefit of keeping one's child at home.

A substantial number of health activists, policymakers, and health providers assume all women want to breast-feed and that all women should. Too often, programs that support postpartum lactation in the United States are less about assistance and more about advocacy. Although it is reasonable to encourage all new mothers to at least try breast-feeding, providers of postpartum lactation support must acknowledge that there is more than one viable choice. They must also take care not to overstate the health benefits of breast-feeding. Mothers need assistance in weighing the benefits against the drawbacks, which can be substantial for some—particularly after they return to work. Just as we are careful not to make a mother feel guilty about her decision to send her child to day care, we must not make her feel guilty or inadequate about her decision to discontinue breast-feeding.

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