Re: Balancing Breastfeeding Promotion

We read with interest the quality report by Feldman-Winter et al[1] in which they described their efforts to increase breastfeeding initiation and exclusive breastfeeding rates by helping hospitals achieve Baby-Friendly Hospital Initiative (BFHI) designation. Not only did they track and improve BFHI, they also tracked and improved rates of overall and exclusive breastfeeding. We applaud their success but note an important omission: a lack of balancing measures. All interventions bring both intended and unintended consequences, and quality improvement scientists have the responsibility to track the benefits but also the potential risks of their interventions. Balancing measures are integral to quality improvement, yet we note a lack of balancing measures in this report and in the breastfeeding promotion literature in general, including the United States and international articles associated with the BHFI. Candidate measures could include some of the well-described complications that occur when breast milk supply is inadequate, including hypernatremic dehydration and hyperbilirubinemia,[2] both of which can trigger hospital readmission and, in rare cases, severe morbidity. Additionally, given the results from 1 large study in which breastfeeding rates at 1 month were lower in hospitals with BFHI certification[3] and from another small trial in which limited amounts of formula supplementation were associated with better long-term breastfeeding success,[4] outpatient breastfeeding rates would be another useful metric. Evaluating cosleeping (which is associated with breastfeeding and potential asphyxiation) is another possibility. Although the net benefit of breastfeeding is certain, the magnitude of benefit has been questioned by recent cluster randomized trials,[5] making an objective measurement of potential risks even more important.

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CONFLICT OF INTEREST: The authors have indicated they have no potential conflicts of interest to disclose.

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doi:10.1542/peds.2017-2658A

Authors' Response

Garber et al have questioned the lack of "balancing measures" in our quality improvement intervention, Best Fed Beginnings (BFB).[1] Their concerns include potential complications related to inadequate breast milk supply, outpatient breastfeeding rates, "cosleeping" (which we interpret as bed-sharing), and breastfeeding itself.

Increased rates of exclusive breastfeeding in the hospital is a desired outcome of the BFHI and was a desired outcome for the BFB improvement intervention along with achieving Baby-Friendly (BF) designation. There is convincing evidence that breastfeeding rates improve after BF designation.[2] As part of the BFB project, we did include patient experience as a balancing measure. These data were captured as part of the BF mother audits and strategically included discussions about patient safety, including bed-sharing and additional newborn outcomes. Hospitals individually used the results of the audits to inform their improvement efforts and to ensure that their processes and system redesigns did not suboptimize the experiences of mothers. In consideration of reducing the reporting burden to hospitals, hospitals were required to do the audits, report internally, and to only report out qualitatively what they were learning from the results. We agree that it would be interesting for a future collaborative to add balancing measures related to safety that are reported and tracked.

As indicated by a recent Cochrane review by Smith et al,[3] the World Health Organization's recommendation of exclusive breastfeeding for the first 6 months of life is supported by the best evidence. Furthermore, this evidence-based review clarified that there is no evidence to support the provision of water or glucose water as a method to prevent hypoglycemia, hypernatremia, or hyperbilirubinemia, and this additional fluid does not support increasing the duration of breastfeeding. The BFHI, as guided by the Ten Steps to Successful Breastfeeding, does not preclude the use of infant formula for medical indications such as newborns who demonstrate a need for enteral feeding when their mother's own milk is unavailable. Thus, deviations from exclusivity for medical reasons are already built into the structure of the intervention. After controlling for sociodemographic variables, evidence supports wide variability between hospitals in exclusive breastfeeding

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Pediatrics 2017;140;
DOI: 10.1542/peds.2017-2658A originally published online October 31, 2017;

PEDIATRICS®
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DOI: 10.1542/peds.2017-2658A originally published online October 31, 2017;