Australian College of Midwives (ACM) Position Statement on the use of Donor Human Milk

The purpose of this document is to articulate the position of the Australian College of Midwives (ACM) in relation to the use of donor human milk. The ACM supports the rights of babies to optimal nutrition and the right of women to make informed infant feeding decisions, which includes the use of donor human milk.

Background

Historically all infants were mother or wet-nurse fed (Fildes1988). Breastmilk sharing occurred in many Australian maternity hospitals up until the 1980s (Thorley, 2009) when fears about Human Immunodeficiency Virus (HIV) and Cytomegalovirus (CMV) stopped this informal practice. The use of donor human milk re-emerged in the Australian health care system in 2006. King Edward Memorial Hospital in Perth, WA opened a formal milk bank in response to the evidence supporting the use of human milk for premature babies (Hartmann et al 2007). There are now both community-based and hospital-based donor human milk banks operating in Australia. In addition, in some Australian communities is it culturally normal for women to share the breastfeeding of infants.

Donor human milk is currently accessible to Australian women and their families via a number of pathways:

- Formal milk banks (personally unknown donor, strictly regulated service);
- Hospital-based known donor protocols (personally known donor, partially regulated service);
- Informal sharing amongst family and friends (known source, unregulated service);
- Informal sharing via multi-media sites (unknown source, unregulated service);
- Commercial transactions via Internet (unknown source, may be unregulated service).

The Australian College of Midwives (ACM) supports and encourages women to exclusively breastfeed their children to six months, with continued breastfeeding to 12 months and beyond as recommended by the National Health and Medical Research Council (NHMRC) Infant Feeding Guidelines: Information for Health Workers (2012). The benefits of exclusive breastfeeding are well documented (Ip, et
al 2007; AAP 2012), as are the risks of milk sharing or using artificial formula (Gribble and Hausman 2012). Health professionals and parents need to be aware of these benefits and risks when making an informed decision on how infants are fed. The ACM believes parents should be fully informed of the options to achieve exclusive and continued breastfeeding, and supports the use of donor human milk as one option to achieve ongoing breastfeeding.

**Key principles**

- The World Health Organization noted that “for those few health situations where infants cannot, or should not, be breastfed, the choice of the best alternative – expressed breast milk from an infant’s own mother, breast milk from a healthy wet-nurse or a human-milk bank or a breast-milk substitute… depends on individual circumstances.” (WHO 2003, p.10)
- The benefits of exclusive breastfeeding are well researched and documented (Ip, et al, 2007; AAP 2012). The high initiation rate of breastfeeding in Australia demonstrates that women are seeking ways to optimise the start to life that exclusive breastfeeding can afford their infant (AIHW, 2010). Women and their families should be fully informed of the options to achieve this goal. When situations occur where a mother’s own breastmilk is unavailable or insufficient, then use of donor human milk can be considered.
- There are a number of non-regulated avenues to obtaining donor human milk including Internet-based milk sharing models. Women using such non-regulated sources of donor human milk, need to be well informed about potential risks, and how to mitigate the risk to make a safe choice.
- Health professionals need to ensure ethical safe practice is upheld when considering the recommendation of, or proceeding with, the use of donor human milk by assessing and mitigating the viral and bacterial transmission risks, and ensuring informed consent has been provided by both donor and recipient mother.

**Ensuring Best Practice in a Health Care Setting**

- Donor human milk via formal milk banks organised on a regional or national level will provide cost effective production and ensure greater equity of access (Renfrew et al 2009).
- The National Institute for Health and Clinical Excellence (NICE) (NICE 2010) regulatory guidelines for the operation of donor milk bank services can be successfully adapted to suit the Australian context (Hartman et al 2007).
- Donors need to be carefully screened for health concerns and potential infections that can be transmitted via breastmilk. This process is similar to screening that occurs in a blood bank. Additionally, questions are asked related to the donor’s health and that of her infant; any medical treatments, tests, prescribed and non-prescription (complementary) medications being
taken; herbal supplements; recent infections; environmental and chemical contaminant exposure; cigarette use or exposure and alcohol consumption (NICE 2010). During formal screening, assessment of the potential donor’s breast milk supply is needed to ensure her own baby is thriving and assess whether she has surplus breast milk to donate.

- International recommendations for Donor Human Milk Banks (as described in NICE 2010) is to screen potential donors for HIV 1 and 2 antibodies; Human T cell Lymphotrophic Virus I and II antibody; Hepatitis B surface antigen and Hepatitis B core antibody; Hepatitis C antibody and Syphilis antibody.
- It is preferable that commercial Holder pasteurisation (heating to 62.5°C for 30 minutes) of the breastmilk is carried out to ensure bacteria removal and virus inactivation (Hartmann, 2007). If this process is not available, the addition of Cytomegalovirus to the screening blood tests is recommended (Hartmann 2007).
- Donor milk needs to be tested for the presence of pathogens and any other additives prior to pasteurisation. Un-pasteurised (raw) breastmilk should contain less than $10^5$ Colony Forming Units (CFU)/ml of total viable microorganisms, or less than $10^4$ CFU/ml S Aureus or less than $10^4$CFU/ml Enterobacteriaceae. Milk that has been pasteurised should be retested and if there is any measurable level of bacteria it should then be discarded. The donor should be tracked and notified; it is for these reasons that breastmilk from a number of donors should not be not “pooled” together (NICE 2010).
- Donors require the provision of information on best practice for hygienic collection, labelling, storage and transporting of their breastmilk.
- Staff handling donated breastmilk must follow established procedures for dealing with expressed milk to ensure correct handling and storage occurs as set out in the NHMRC Infant Feeding Guidelines (2012). A tracking and tracing protocol must be implemented (NHMRC 2012).
- Where a formal and fully regulated procedure of donated human milk is not available, it may be an acceptable, feasible and cost effective process to consider the use of donors known to the mother for the provision of a directed donation of breastmilk. Maternity hospitals who support the use of known donors / directed donation of breast milk should develop appropriate local policies and guidelines accordingly which utilise all the above mentioned precautions and testing, and ensure informed decision-making by the recipient mother and the donor occurs. Confidentiality of information and test results are a significant additional consideration.

**Community Considerations**

- The decision amongst friends and family to share the provision of breastmilk to an infant, either by direct feeding or via expressed breast milk is a personal one. As a health professional, awareness of this practice amongst families indicates a need for careful scrutiny to ensure informed decision making by the women and others has occurred.
• The manner in which a community donor collects and stores breastmilk for donation is very important. Information for prospective donors on best practice is necessary to minimise risks (Hartmann et al 2007). Information on expressing and storing breastmilk is readily available from the Australian Breastfeeding Association website (ABA 2014).

• Families accessing donor breastmilk in the community need to ensure the breastmilk is transported and stored correctly and consumed within accepted timeframes for expressed milk, as detailed in the NHMRC Infant Feeding Guidelines (2012).

• Knowledge of how to access a local Human Milk Bank and what service it provides will assist women who may need this information. Hospital-based milk banks will only provide pasteurised donor milk for babies who are in hospital.

• There is breast milk sharing advertised via commercial and non-commercial sites on the internet, including several Facebook pages. Caution is needed to ensure safety and honesty for both sides of this transaction (Akre et al 2011; Gribble 2012).

• If cultural considerations or cultural matching is an important consideration for parents this would be best achieved via known donor breastmilk sharing.

Resources to Guide Practice
Australian Breastfeeding Association, Information on expressing and storing breastmilk;


Mercy Health Breastmilk Bank: www.mercyhealthbreastmilkbank.com.au

Mothers Milk Bank: www.mothersmilkbank.com.au


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References

Australian Breastfeeding Association, Information on expressing and storing breastmilk;


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