December, 2000 Topics

- HHS Blueprint for Action on Breastfeeding
- Major Factors Influencing Breastfeeding Rates
- FDA Announces Decision on Health Claims for Dietary Supplements
- Functional Foods: What does it mean and what are they?
HHS Blueprint for Action on Breastfeeding

The Office of the U.S. Surgeon General has released the first comprehensive national framework to promote breastfeeding and optimal breastfeeding practices. The HHS Blueprint for Action on Breastfeeding was developed by experts from 14 federal agencies and 23 health care professional organizations, including the American Academy of Pediatrics and the American Academy of Family Physicians.

Healthy People 2010, the nation’s health agenda for the next decade, has set an objective to increase the proportion of all mothers who breastfeed in the early postpartum period to 75%. The Blueprint offers action steps for the health care system, families, the community, researchers, and the workplace, to better focus attention on the importance of breastfeeding. Specifically, the plan is based on the recommendation that infants be exclusively breastfed during the first four to six months of life, preferably for a full six months. The plan also suggests that, ideally, breastfeeding should continue through the first year of life.

The Blueprint recommends that:

- health care professionals who provide maternal and child care should be trained on the basics of lactation and breastfeeding counseling
- women who return to work after childbirth should have access to childcare facilities or private rooms on site to accommodate breastfeeding;
- social support and information resources be established for women such as hotlines and peer counseling
- research be conducted on issues surrounding breastfeeding.

Extension educators may have opportunities to promote breastfeeding, discuss nutrition with women who are breastfeeding, or teach about infant feeding. Extension educators should be familiar with the basics of breastfeeding or should be prepared to refer questions about breastfeeding to a colleague or agency who can support breastfeeding in a manner consistent with this Blueprint for Action on Breastfeeding.

The full text of the HHS Blueprint for Action on Breastfeeding can be found on a new specialty section on breastfeeding on the National Women’s Health Information Center website (www.4woman.gov) or through its toll-free telephone service at 1-800-994WOMAN (TDD:1-888-220-5446). To see some of the many programs and services currently promoting and supporting breastfeeding within health care, work sites, and communities nationwide, visit the web site developed by the Division of Nutrition and Physical Activity, www.cdc.gov/breastfeeding.
Major Factors Influencing Breastfeeding Rates

A study published in the November, 2000 issue of *Pediatrics* investigated factors influencing the decision to breastfeed or bottle feed, and breastfeeding duration.

A survey was mailed to 245 mothers whose infants received well-child care from birth to one year of age at a northwest PA hospital. In this sample, 44.3% of mothers started breastfeeding but by the time the infant was 6 months old, the rate had dropped to 13%. The decision to breastfeed or to bottle feed was most often made before pregnancy or during the first trimester.

The most common reasons mothers chose breastfeeding included:
1. Benefits to the infant’s health
2. Naturalness
3. Emotional bonding with the infant

The most common reasons mothers chose bottle feeding included:
1. Mother’s perception of father’s attitude
2. Uncertainty about the quantity of breast milk
3. Return to work

Mothers who chose bottle feeding reported that factors that would have encouraged them to breast feed included:
1. More information in prenatal class
2. More information from TV, magazines, and books
3. Family support

The authors comment that in general, barriers to breastfeeding include the negative attitudes of women, their partners, and family members, as well as health care professionals, toward breastfeeding. Research has shown that mothers who were single, smoked, and did not participate in childbirth education classes were less likely to exclusively breastfeed. Women who breastfeed exclusively are often older, have post-high school education, and are white. In other studies, women who smoked stopped breastfeeding sooner and said insufficient milk was the reason. Time constraints, early return to work, and the ready availability of formula influence women’s decision to continue breastfeeding.

These authors recommend that educators reinforce the reasons women give for choosing to breastfeed. Because the father’s attitude is important to the mother’s decision, they recommend the father be included in all discussions about the type of feeding the infant will receive. Education about using a breast pump and creating a breastfeeding-friendly work environment would be important in addressing mothers’ concerns about returning to work. To address their concerns about whether their milk supply is adequate, mothers should be advised to listen for an audible swallow, note the number of wet diapers per day, and record growth at well child visits. The authors also comment that since the decision to breastfeed is usually made before pregnancy or during the first trimester, educators have a relatively small window of time to influence breastfeeding decisions.


[www.pediatrics.org/cgi/content/full/106/5/e67]
In response to a court decision, FDA has announced three decisions on health claims for dietary supplements.

January of 1993, FDA decided not to authorize three health claims for components of foods: dietary fiber and cancer, antioxidant vitamins and cancer, and omega-3 fatty acids and coronary heart disease. Later that year, FDA followed up with a decision not to allow those health claims in labeling dietary supplements. At the same time, FDA did authorize a health claim for folic acid and the prevention of neural tube defects, but did not allow a claim that folic acid from one source would be better than folic acid from any other source. FDA issued a final rule on these claims in March of 1996.

In 1998, FDA’s decision was challenged and in 1999, the U.S. Court of Appeals ordered FDA to reconsider the evidence. They also ordered FDA to clarify the standards they use for authorizing health claims.

FDA’s revised standards are as follows: if a health claim meets FDA’s standards for significant scientific agreement (SSA), they will authorize the claim. Rather than denying all claims that don’t meet the SSA standard, FDA can use its discretion to allow a qualified health claim for a dietary supplement when all four of the following conditions are met:

1. The health claim petition meets FDA requirements
2. The scientific evidence supporting the claim outweighs the scientific evidence against the claim
3. Consumer health and safety are not threatened; and
4. The claims meet the general requirements for a health claim.

In October of this year, FDA announced their decisions about folic acid and dietary fiber. They did not authorize the claim that 0.8 mg of folic acid in a dietary supplement was more effective in reducing the risk of neural tube defects than a smaller amount consumed in food. They did not authorize the claim that dietary fiber supplements reduce the risk of colorectal cancer because studies consistently show a lack of relationship between dietary fiber supplements and the risk of colorectal cancer. The claim could not be qualified because the evidence against the claim outweighs the evidence for the claim.

FDA decided to allow a qualified health claim about omega-3 fatty acids in supplements and reduced risk of heart disease. The qualified claim will be allowed even though it did not meet the SSA standard that had been previously established.

The qualified health claim states: "The scientific evidence about whether omega-3 fatty acids may reduce the risk of coronary heart disease (CHD) is suggestive, but not conclusive. Studies in the general population have looked at diets containing fish and it is not known whether diets or omega-3 fatty acids in fish may have a possible effect on a reduced risk of CHD. It is not known what effect omega-3 fatty acids may or may not have on risk of CHD in the general population." This claim may be used in labeling supplements containing EPA and DHA omega-3 fatty acids, provided that those supplements do not recommend or suggest in the labeling, or under ordinary conditions of use, daily intakes exceeding 2 grams EPA and DHA omega-3 fatty acids.

FDA continues to review the research on antioxidant vitamins and cancer.
Many nutrition education participants assume from magazine articles or other media reports that the benefits of products like fish oil capsules are accepted by nutrition experts. These recent FDA decisions will help document that such reports are premature and that a balanced diet is still one of the best strategies for reducing one’s risk of many chronic diseases.

For more information, check out the FDA website at [www.cfsan.fda.gov](http://www.cfsan.fda.gov). Select the section “Dietary Supplements” under “Program Areas.” This summary was based on two FDA Talk Papers dated Oct. 11, 2000 and Nov. 2, 2000.
Functional Foods: What does it mean and what are they?

From the desk of Sherry T.:

“Functional Foods” is a term that covers all foods that have an associated health claim beyond basic nutrition. What sorts of functional foods are found on our grocery shelves?

- Foods that have naturally occurring components that are either increased (breakfast cereals with added bran) or decreased (low-fat cheese).
- Foods that have components or ingredients added, like orange juice with calcium, bread with folic acid or teas with added herbs.
- Beverages that include sports drinks formulated to provide a balanced replacement of fluids during exercise and sodas or fruit drinks that include herbs and vitamins.

A recent article in the November 2000 issue of Food Technology, pages 50-54, entitled “Functional Beverage Juggernaut Faces Tighter Regulations,” raised concern about the influx of “functional beverages” onto the marketplace. The beverage category of functional foods has grown faster than all other segments, selling $13 billion last year. Most of the recent beverages developed rely on the health claims of popular herbal supplements, soy, antioxidant vitamins and minerals that are added to the product.

Most supplements, including those added to beverages, are considered “Generally Recognized as Safe” (GRAS) by the U.S. Food and Drug Administration (FDA). The FDA has to show that the added ingredient(s) is unsafe before it can take action to restrict the product’s use. This also allows beverage marketers to make nutrient content and nutrition support claims that include “structure-function” claims. The FDA requires that claims be based on a statement from recognized scientific bodies such as the National Academy of Sciences. Moreover, for structure-function claims, like “Calcium builds strong bones”, a disclaimer must appear on the product label stating that the FDA has not evaluated that product and the product is not intended to diagnose, treat, cure or prevent disease.

The Herb Research Foundation (HRF) has issued a position statement based on the idea that herbs and herb extracts added to foods are still a “whole food” and not a food chemical “additive”. HRF states:

- Claims should be based on solid science and directions stating how much of the functional food is needed to achieve the benefit should be provided.
- False or poorly documented claims should not be used to market functional foods.
- Consumers can distinguish between marketing language and health benefit claims, and the Federal Trade Commission and FDA have adequate authority to assure truthful labeling and safe products.

While the first two points are straightforward, the third point is debatable. Do consumers have the knowledge needed to understand and discern reliable health claims from marketing language?

In the next couple of years, it seems that the beverage market will still be able to grow unless regulators decide to impose more rules on health claims or change the GRAS status of herbs.

In a related article in the October 2000 Dietitian’s Edge, pages 58-69, entitled “The Nutraceutical Beverage Market,” the current market and nutritional analysis of several beverages are described.
and outlined. In a recent market analysis, June 1999, by Sloan Trends & Solutions, “healthy” foods are still the number one means, other than over-the-counter medications, of treating conditions such as the common cold with 68% of consumers turning to food as a remedy. Other items on the list and the percentage of individuals using that mode are as follows: vitamin and mineral supplements (60%), fortified foods like juices and teas (59%) and herbal preparations (34%).

As nutrition educators, we need to be aware that nutraceutical beverages may be part of our clients’ “healthy” diet. While it is impossible to know all of the components of every new beverage that enters the marketplace, having awareness and basic information will help us when we are asked about “health” benefits and safety. For example, many of the beverages contain a significant amount of carbohydrate and therefore provide calories to the diet and may displace other healthy drinks like milk. Moreover, these products may not be worth the cost when one considers the uncertain health value of most herbal products and the fact that “standards for their purity, potency and composition are being developed” (Dietary Guidelines for Americans, 2000, page 19).

It is interesting to note that a diet high in fruits and vegetables is associated with reduced risks of disease including various forms of cancer and heart disease. Thus, for most of us promoting fruits and vegetables as necessary “functional foods” is certainly within the guidelines of the Food Guide Pyramid and the Dietary Guidelines for Americans.