The American College of Obstetricians and Gynecologists
WOMEN'S HEALTH CARE PHYSICIANS

COMMITTEE OPINION

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Committee on Obstetric Practice

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Optimizing Support for Breastfeeding as Part of Obstetric Practice

ABSTRACT: Although most women in the United States initiate breastfeeding, more than one half wean earlier than they desire. As reproductive health experts and advocates for women's health who work in conjunction with other obstetric and pediatric health care providers, obstetrician–gynecologists are uniquely positioned to enable women to achieve their infant feeding goals. The American College of Obstetricians and Gynecologists recommends exclusive breastfeeding for the first 6 months of life, with continued breastfeeding as complementary foods are introduced through the infant's first year of life, or longer as mutually desired by the woman and her infant. Because lactation is an integral part of reproductive physiology, all obstetrician–gynecologists and other obstetric care providers should develop and maintain knowledge and skills in anticipatory guidance, physical assessment and support for normal breastfeeding physiology, and management of common complications of lactation. Obstetrician–gynecologists and other obstetric care providers should support each woman's informed decision about whether to initiate or continue breastfeeding, recognizing that she is uniquely qualified to decide whether exclusive breastfeeding, mixed feeding, or formula feeding is optimal for her and her infant. Obstetrician–gynecologists and other obstetric care providers should support women in integrating breastfeeding into their daily lives in the community and in the workplace. The offices of obstetrician–gynecologists and other obstetric care providers should be a resource for breastfeeding women through the infant's first year of life, and for those who continue beyond the first year.

Recommendations

Education

- Clinical management of lactation is a core component of reproductive health care.
- Because lactation is an integral part of reproductive physiology, all obstetrician–gynecologists and other obstetric care providers should develop and maintain knowledge and skills in anticipatory guidance, physical assessment and support for normal breastfeeding physiology, and management of common complications of lactation.

Support for Breastfeeding Women

- The American College of Obstetricians and Gynecologists (the College) strongly encourages women to breastfeed and supports each woman's right to breastfeed. The College recommends exclusive breastfeeding for the first 6 months of life, with continued breastfeeding as complementary foods are introduced through the infant's first year of life.
- Obstetrician–gynecologists and other obstetric care providers should support each woman's informed decision about whether to initiate or continue breastfeeding, recognizing that she is uniquely qualified to decide whether exclusive breastfeeding, mixed feeding, or formula feeding is optimal for her and her infant.
- A breastfeeding history should be obtained as part of prenatal care, and identified concerns and risk factors for breastfeeding difficulties should be communicated to the infant's health care provider.

- All obstetrician–gynecologists and other obstetric care providers should support women who have given birth to preterm and other vulnerable infants to establish a full supply of milk by providing anticipatory guidance, support, and education for women. Obstetrician–gynecologists and other obstetric care providers should work with hospital staff to facilitate early, frequent milk expression.
- Women who experience breastfeeding difficulties are at higher risk of postpartum depression, and should be screened, treated, and referred appropriately.
- Obstetrician–gynecologists and other obstetric care providers should support women in integrating breastfeeding into their daily lives in the community and in the workplace.
- The offices of obstetrician–gynecologists and other obstetric care providers should be a resource for breastfeeding women through the infant's first year of life, and for those who continue to breastfeed beyond the first year.

Policy

- Obstetrician–gynecologists and other obstetric care providers should be in the forefront of policy efforts to enable women to breastfeed, whether through individual patient education, change in hospital practices, community efforts, or supportive legislation.
- The World Health Organization's "Ten Steps to Successful Breastfeeding" should be integrated into maternity care to increase the likelihood that a woman achieves her personal breastfeeding goals.
- Policies that protect the right of a woman and her child to breastfeed and that accommodate milk expression, such as paid maternity leave, onsite childcare, break time for expressing milk, and a location other than a bathroom for expressing milk, are essential to sustaining breastfeeding.

Introduction

Although most women in the United States initiate breastfeeding, more than one half wean earlier than they desire (1). In addition, substantial disparities persist in initiation and duration of breastfeeding that affect population health (2). Maternity care policies and practices that support breastfeeding are improving nationally; however, more work is needed to ensure all women receive optimal breastfeeding support during their maternity stay (3). Given this mismatch between women's intentions for and experience of breastfeeding, the previous version of this Committee Opinion was revised to address how obstetrician–gynecologists and other obstetric care providers can enable women to achieve their infant feeding intentions. As reproductive health experts and advocates for women's health who work in conjunction with other obstetric and pediatric health care providers, obstetrician–gynecologists are uniquely positioned to enable women to achieve their infant feeding goals.

Benefits of Breastfeeding

Clinical management of lactation is a core component of reproductive health care. Enabling women to breastfeed is also a public health priority because, on a population level, interruption of lactation is associated with adverse health outcomes for the woman and her child, including higher maternal risks of breast cancer, ovarian cancer, diabetes, hypertension, and heart disease, and greater infant risks of infectious disease, sudden infant death syndrome, and metabolic disease (2, 4).

Although lactation is the physiologic norm, cultural norms for infant feeding have changed dramatically in the past century. In 1971, only 24.7% of women left the hospital breastfeeding. Since then, breastfeeding initiation rates have progressively increased. In 2011, 79% of women in the United States initiated breastfeeding, 49% were breastfeeding at 6 months, and 27% were breastfeeding at 1 year postpartum (5). Exclusive breastfeeding rates are lower (Table 1).

Breastfeeding is optimal and appropriate for most women. Contraindications to breastfeeding are few and include those women who have an infant with galactosemia, are infected with human immunodeficiency virus (HIV) or human T-cell lymphotropic virus type I or type II, and have active untreated tuberculosis or varicella or active herpes simplex virus lesions on the nipple. Most medications are safe in breastfeeding, with rare exceptions such as cytotoxic chemotherapy drugs. Use of drugs or illicit substances or treatment for such may not be a contraindication to breastfeeding. For example, women on stable doses of methadone should be encouraged to breastfeed (6, 7). There are insufficient data to evaluate the effects of marijuana use on infants during lactation and breastfeeding, and in the absence of such data, marijuana use is discouraged (8).

The Role of Obstetrician–Gynecologists and Other Obstetric Care Providers in Supporting Breastfeeding

The American College of Obstetricians and Gynecologists (the College) strongly encourages women to breastfeed and supports each woman's right to breastfeed. The College recommends exclusive breastfeeding for the first 6 months of life, with continued breastfeeding as complementary foods are introduced through the infant's first year of life, or longer as mutually desired by the woman and her infant. This recommendation is consistent with those of other medical and nursing organizations, such as the American Academy of Pediatrics (9) and the Association of Women's Health, Obstetric and Neonatal Nurses (10). The College further supports public health and policy efforts to enable more women to breastfeed, including Healthy People 2020 targets for increasing

Table 1. Healthy People 2020 Goals for Breastfeeding ⇦

	Healthy People 2020 Goals (%)	Current Data (%)
Increase the proportion of infants who are breastfed at the following stages:		
Ever breastfed	81.9	79.2 ± 1.2*
Breastfed at 6 months	60.6	49.4 ± 1.5*
Breastfed at 1 year	34.1	26.7 ± 1.3*
Breastfed exclusively through 3 months	46.2	40.7 ± 1.5*
Breastfed exclusively through 6 months	25.5	18.8 ± 1.2*
Increase the proportion of employers that have worksite lactation support programs	38	28†‡
Reduce the proportion of breastfed newborns who receive formula supplementation within the first 2 days of life	14.2	19.4 ± 1.3*
Increase the proportion of live births that occur in facilities that provide recommended care for lactating mothers and their babies	8.1	7.79§

*2011 births (Centers for Disease Control and Prevention. Breastfeeding among U.S. children born 2002–2012, CDC National Immunization Surveys. Available at: http://www.cdc.gov/breastfeeding/data/nis_data/index.htm. Retrieved September 2, 2015.)

†Society for Human Resource Management. 2014 employee benefits: an overview of employee benefits offerings in the U.S. Alexandria (VA): SHRM; 2014. Available at: http://www.shrm.org/Research/SurveyFindings/Documents/14-0301%20Benefits_Report_TEXT_FNL.pdf. Retrieved September 2, 2015.

‡Offer onsite lactation/mother's room, defined as a separate room that goes above and beyond the The Patient Protection and Affordable Care Act law, which requires that employees be "shielded from view" and "free from intrusion" during their break. Six percent offer lactation support services.

§Centers for Disease Control and Prevention. Breastfeeding report card: United States/2014. Atlanta (GA): CDC; 2014. Available at: http://www.cdc.gov/breastfeeding/pdf/2014breastfeedingreportcard.pdf. Retrieved September 2, 2015.

worksite lactation programs, reducing formula supplementation of breastfed infants in the first 2 days of life, and increasing the proportion of births that occur in facilities that provide recommended care for lactating women and their infants (Table 1).

Because lactation is an integral part of reproductive physiology, all obstetrician–gynecologists and other obstetric care providers should develop and maintain skills in anticipatory guidance, support for normal breastfeeding physiology, and management of common complications of lactation. Obstetrician–gynecologists and other obstetric care providers should be in the forefront of policy efforts to enable women to breastfeed, whether through individual patient education, change in hospital practices, community efforts, or supportive legislation.

Prenatal Care

The advice and encouragement of the obstetrician–gynecologist and other obstetric care providers are critical in assisting women to make an informed infant feeding decision. As when discussing any health behavior, the obstetrician–gynecologist is obligated to ensure patient comprehension of the relevant information and to be certain that the conversation is free from coercion, pressure, or undue influence (11). Families should receive noncommercial, accurate, and unbiased information so that they can make informed decisions about their health care (12). Obstetric care providers should be aware that personal experiences with infant feeding may affect their counseling. In addition, pervasive direct-to-consumer marketing of infant formula adversely affects patient and health care provider perception of the risks and benefits of breastfeeding.

Beginning conversations about lactation early in prenatal care by asking the patient and her family, "What have you heard about breastfeeding?" sets the stage for a patient-centered discussion. When taking an obstetric history, obstetrician–gynecologists and other obstetric care providers should specifically ask about any breast surgeries, prior breastfeeding duration, and any previous breastfeeding difficulties. Prior problems leading to earlier-than-desired weaning should be discussed, anticipatory guidance should be provided, and appropriate lactation support resources should be identified. The breast examination can identify surgical scars indicating prior surgery, as well as widely spaced, tubular breasts that may indicate insufficient glandular tissue (4). A breast assessment and breastfeeding history should be obtained as part of prenatal care, and identified concerns and risk factors for breastfeeding difficulties should be discussed with the woman, and communicated to the infant's health care provider, either directly or as part of shared records. Obstetrician–gynecologist and other obstetric care providers should engage the patient's partner and other family members in discussions about infant feeding and address any questions and concerns. This

patient-centered approach allows the health care provider, the patient, and her family to anticipate challenges, develop strategies to address them, and collaborate to develop a feeding plan that is compatible with the family's individual values, circumstances, and concerns. Obstetrician–gynecologists and other obstetric care providers should support each woman's informed decision about whether to initiate or continue breastfeeding, recognizing that she is uniquely qualified to decide whether exclusive breastfeeding, mixed feeding, or formula feeding is optimal for her and her infant.

Intrapartum Care

Maternity care practices affect breastfeeding outcomes. The World Health Organization's "Ten Steps to Successful Breastfeeding" is an evidence-based set of health care practices that support breastfeeding physiology, including early skin-to-skin care, rooming-in, and feeding on demand (see Box 1) (2). In a meta-analysis of randomized controlled trials, skin-to-skin care in the first hour of life increased breastfeeding duration by 42.6 days (95% CI, −1.7 to 86.8) (13). The Ten Steps should be integrated into maternity care to increase the likelihood that a woman will initiate and sustain breastfeeding and achieve her personal breastfeeding goals (14). Cesarean birth is associated with lower breastfeeding rates, and women who undergo cesarean delivery may need extra support to establish and sustain breastfeeding. Skin-to-skin contact is feasible in the operating room and is associated with reduced need for formula supplementation (15).

Healthy People 2020 and the Joint Commission have targeted unindicated formula supplementation as a barrier to establishing breastfeeding, and maternity care providers can provide anticipatory guidance for families regarding the rationale for avoiding early introduction of formula. Distribution of formula marketing packs reduces breastfeeding initiation and duration (16) and implies that formula is a recommended feeding method. Moreover, provision of samples implies the health care provider's endorsement of a specific brand, which encourages families to purchase more expensive brand-name products, rather than generic equivalents (17). Such marketing should not occur in inpatient or outpatient health care settings.

For preterm infants, human milk feeding, in particular the woman's own milk, is associated with a reduced risk of necrotizing enterocolitis (18) and other infectious morbidity. Sharing this information with women who have given birth to preterm infants and who intended to formula feed increases breastfeeding initiation and does not increase maternal anxiety (19). The obstetrician–gynecologist and other obstetric care providers should collaborate with the pediatric care provider to share this information as soon as a preterm birth is anticipated because initiation of milk expression within 6 hours of birth is associated with improved milk production (20). Drops of colostrum obtained from early expression can be used for oral care as well as for initial feedings of even the smallest preterm infant. All obstetrician–gynecologists and other obstetric care providers should support women who have given birth to preterm infants to establish a full supply of milk by providing anticipatory guidance and working with hospital staff to facilitate early, frequent milk expression.

Box 1. Ten Hospital Practices to Encourage and Support Breastfeeding* ⇦

1. Have a written breastfeeding policy that is routinely communicated to all health care staff.
2. Train all health care staff in the skills necessary to implement this policy.
3. Inform all pregnant women about the benefits and management of breastfeeding.
4. Help women initiate breastfeeding within 1 hour of birth.
5. Show women how to breastfeed and how to maintain lactation, even if they are separated from their newborns.
6. Give newborns no food or drink other than breast milk, unless medically indicated.
7. Practice rooming-in—allow mothers and newborns to remain together 24 hours a day.
8. Encourage breastfeeding on demand.
9. Give no pacifiers or artificial nipples to breastfeeding infants.†
10. Foster the establishment of breastfeeding support groups and refer to them on discharge from the hospital or birth center.

Data from Baby-Friendly USA. Guidelines and evaluation criteria for facilities seeking baby-friendly designation. Sandwich (MA): Baby-Friendly USA; 2010. Available at: https://www.babyfriendlyusa.org/get-started/the-guidelines-evaluation-criteria. Retrieved October 29, 2015.

*The 1994 report of the Healthy Mothers, Healthy Babies National Coalition Expert Work Group recommended that the UNICEF-WHO Baby Friendly Hospital Initiative be adapted for use in the United States as the United States Breastfeeding Health Initiative, using the adapted 10 steps above.

†The American Academy of Pediatrics endorsed the UNICEF-WHO Ten Steps to Successful Breastfeeding but does not support a categorical ban on pacifiers because of their role in reducing the risk of sudden infant death syndrome and their analgesic benefit during painful procedures when breastfeeding cannot provide the analgesia.

Clinical Management of the Breastfeeding Dyad

The offices of obstetrician–gynecologists and other obstetric care providers should be a resource for breastfeeding assistance through the first year of life, and for those women who continue to breastfeed beyond the first

year because many of the health benefits associated with breastfeeding increase with longer duration of breastfeeding. Lactation is a two-person activity, and evaluation of breastfeeding problems requires assessment of the woman and her infant, as well as the active engagement and support of her partner, extended family, or other identified support. Management of issues such as pain, low milk supply, breast infections, and maternal medication safety should, therefore, be coordinated with the infant's care provider as appropriate. Office staff should be prepared to triage common breastfeeding concerns and to refer women, as needed, to certified lactation professionals in the community, such as an International Board Certified Lactation Consultant or Certified Lactation Counselor. Embedding lactation consultants within the offices of an obstetrician–gynecologist or other obstetric care provider may be feasible now that coverage of lactation services is included as preventive care under the Affordable Care Act (21).

Most medications are safe for use during breastfeeding. Obstetrician–gynecologists and other health care providers should consult lactation pharmacology resources, such as LactMed (22), for up-to-date information on individual medications (6) because inappropriate advice often can lead women to discontinue breastfeeding unnecessarily. Information about drug safety in pregnancy should not be extrapolated to breastfeeding, as the physiology of the placenta and breast are not the same. For example, warfarin crosses the placenta and can cause embryopathy, but minimal amounts enter breast milk, so it is considered to be safe during lactation (22). Counseling regarding medication use during lactation should address the risks of drug exposure through breast milk and the risks of interrupting lactation. After anesthesia for surgical procedures, women who have given birth to healthy infants generally may breastfeed as soon as they are stable, awake, and alert enough to hold the infant (23). Breastfeeding can be continued without interruption after the use of iodinated contrast or gadolinium (6).

Low milk supply is a common concern and may reflect misinterpretation of normal infant feeding behaviors, low production, or inadequate milk transfer (4). The most common cause of low milk supply is inadequate breast stimulation. Careful evaluation by a certified lactation professional to ensure frequent breast stimulation and milk removal is the most effective strategy to increase milk production. There is limited evidence for medications and herbal galactagogues to increase milk supply (24).

Disrupted lactation is common, with one in eight women reporting early, undesired cessation of breastfeeding because of multiple problems with pain, low milk supply, and the infant being able to latch on to the breast (25). Obstetric care providers should collaborate with certified lactation professionals and the infant's health care provider to evaluate and manage breastfeeding problems. Even with comprehensive support, some mother–infant dyads are unable to establish sustained, exclusive breastfeeding. Women who are not able to achieve their breastfeeding intentions report considerable distress, and obstetrician–gynecologists and other health care providers should validate each woman's efforts and experience (4). Women who experience breastfeeding difficulties are at higher risk of postpartum depression and should be screened, treated, and referred appropriately.

Although breastfeeding without introducing any complementary solids or formula will in most cases prevent ovulation and, thus, pregnancy for up to 6 months postpartum, it will do so only when women are fully or nearly fully breastfeeding and there is continued amenorrhea. Contraception is an important topic for all women, and discussion of other methods should not be delayed in breastfeeding women. Contraceptive options should be explained in detail and include nonhormonal methods (copper intrauterine devices, condoms, diaphragms) and hormonal methods (levonorgestrel intrauterine device, etonogestrel implants, medroxyprogesterone acetate injection, progestin-only pills, and combined hormonal contraceptive pills). Immediate postpartum initiation of hormonal methods is controversial (26). The Centers for Disease Control and Prevention states that the advantages outweigh the risks of progestin-only contraception immediately after birth and for combined hormonal methods at 1 month postpartum (27). Data are limited, however, and theoretical concerns exist because progesterone withdrawal after delivery of the placenta is thought to trigger onset of lactogenesis, so exogenous progesterone could prevent onset of milk production (25). Obstetric care providers should discuss these limitations and concerns within the context of each woman's desire to breastfeed and her risk of unplanned pregnancy, so that she can make an autonomous and informed decision.

Breastfeeding in the Community

Obstetrician–gynecologists and other obstetric care providers should support women in integrating breastfeeding into their daily lives in the community and in the workplace. Before discharge from the maternity center, women should be provided with contact information for community-based lactation support. Maintaining milk supply depends largely on frequency of milk removal through breastfeeding and through expressing milk (breast pumping or manual expression) when the woman and her infant are separated. Policies that protect the right of the woman and her child to breastfeed and that accommodate milk expression, such as paid maternity leave (28), on-site childcare, break time, and a location other than a bathroom for expressing milk (29), are essential to sustaining breastfeeding. Obstetric care provider offices and hospitals can set an example through supportive policies for lactating staff, accommodations for nursing patients, awareness and educational materials, and staff training (10, 30).

For More Information

These resources are for information only and are not meant to be comprehensive. Referral to these resources does not imply the American College of Obstetricians and Gynecologists' endorsement of the organization, the organization's web site, or the content of the resource. The resources may change without notice.

ACOG has identified additional resources on topics related to this document that may be helpful for ob-gyns, other health care providers, and patients. You may view these resources at www.acog.org/More-Info/ObBreastfeedingSupport.

References

1. Odom EC, Li R, Scanlon KS, Perrine CG, Grummer-Strawn L. Reasons for earlier than desired cessation of breastfeeding. Pediatrics 2013;131:e726–32. [PubMed] [Full Text] ⇦
2. Breastfeeding in underserved women: increasing initiation and continuation of breastfeeding. Committee Opinion No. 570. American College of Obstetricians and Gynecologists. Obstet Gynecol 2013;122:423–8. [PubMed] [*Obstetrics & Gynecology*] ⇦
3. Perrine CG, Galuska DA, Dohack JL, Shealy KR, Murphy PE, Grummer-Strawn LM, et al. Vital signs: improvements in maternity care policies and practices that support breastfeeding — United States, 2007–2013 . MMWR Morb Mortal Wkly Rep 2015;64:1112–7. [PubMed] [Full Text] ⇦
4. Stuebe AM. Enabling women to achieve their breastfeeding goals. Obstet Gynecol 2014;123:643–52. [PubMed] [*Obstetrics & Gynecology*] ⇦
5. Centers for Disease Control and Prevention. Breastfeeding among U.S. children born 2002–2012, CDC National Immunization Surveys. Available at: http://www.cdc.gov/breastfeeding/data/nis_data/index.htm. Retrieved September 2, 2015. ⇦
6. Sachs HC. The transfer of drugs and therapeutics into human breast milk: an update on selected topics. Committee on Drugs. Pediatrics 2013;132:e796–809. [PubMed] [Full Text] ⇦
7. Reece-Stremtan S, Marinelli KA. Guidelines for breastfeeding and substance use or substance use disorder. ABM Clinical Protocol #21. Academy of Breastfeeding Medicine. Breastfeed Med 2015;10:135–41. [PubMed] [Full Text] ⇦
8. Marijuana use during pregnancy and lactation. Committee Opinion No. 637. American College of Obstetricians and Gynecologists. Obstet Gynecol 2015;126:234–8. [PubMed] [*Obstetrics & Gynecology*] ⇦
9. Breastfeeding and the use of human milk. Section on Breastfeeding. Pediatrics 2012;129:e827–41. [PubMed] [Full Text] ⇦
10. Association of Women's Health, Obstetric and Neonatal Nurses. Breastfeeding support: preconception care through the first year. 3rd ed. Washington, DC: AWHONN; 2015. ⇦
11. Ethical decision making in obstetrics and gynecology. ACOG Committee Opinion No. 390. American College of Obstetricians and Gynecologists. Obstet Gynecol 2007;110:1479–87. [PubMed] [*Obstetrics & Gynecology*] ⇦
12. The limits of conscientious refusal in reproductive medicine. ACOG Committee Opinion No. 385. American College of Obstetricians and Gynecologists. Obstet Gynecol 2007;110:1203–8. [PubMed] [*Obstetrics & Gynecology*] ⇦
13. Moore ER, Anderson GC, Bergman N, Dowswell T. Early skin-to-skin contact for mothers and their healthy newborn infants. Cochrane Database of Systematic Reviews 2012, Issue 5. Art. No.: CD003519. DOI: 10.1002/14651858.CD003519.pub3. [PubMed] [Full Text] ⇦
14. DiGirolamo AM, Grummer-Strawn LM, Fein SB. Effect of maternity-care practices on breastfeeding. Pediatrics 2008;122(suppl 2):S43–9. [PubMed] [Full Text] ⇦
15. Hung KJ, Berg O. Early skin-to-skin after cesarean to improve breastfeeding. MCN Am J Matern Child Nurs 2011;36:318–24; quiz 325–6. [PubMed] ⇦
16. Howard C, Howard F, Lawrence R, Andresen E, DeBlieck E, Weitzman M. Office prenatal formula advertising and its effect on breast-feeding patterns. Obstet Gynecol 2000;95:296–303. [PubMed] [*Obstetrics & Gynecology*] ⇦
17. U.S. Department of Agriculture. WIC and the retail price of infant formula. Food Assistance and Nutrition Research Report No. 39. Washington, DC: USDA; 2004. Available at: http://www.ers.usda.gov/media/330246/fanrr39-1_1_.pdf. Retrieved September 2, 2015. ⇦
18. Meinzen-Derr J, Poindexter B, Wrage L, Morrow AL, Stoll B, Donovan EF. Role of human milk in extremely low birth weight infants' risk of necrotizing enterocolitis or death. J Perinatol 2009;29:57–62. [PubMed] [Full Text] ⇦
19. Sisk PM, Lovelady CA, Dillard RG, Gruber KJ. Lactation counseling for mothers of very low birth weight infants: effect on maternal anxiety and infant intake of human milk. Pediatrics 2006;117:e67–75. [PubMed] ⇦
20. Furman L, Minich N, Hack M. Correlates of lactation in mothers of very low birth weight infants. Pediatrics 2002; 109:e57. [PubMed] [Full Text] ⇦
21. United States Breastfeeding Committee, National Breastfeeding Center. Model policy: payer coverage of breastfeeding support and counseling services, pumps and supplies. 2nd rev ed. Washington, DC: USBC, NBFC; 2014. Available at: http://www.usbreastfeeding.org/model-payer-policy. Retrieved September 2, 2015. ⇦
22. National Library of Medicine. Drugs and Lactation Database (LactMed). Available at: http://toxnet.nlm.nih.gov/newtoxnet/lactmed.htm. Retrieved September 2, 2015. ⇦
23. Montgomery A, Hale TW. Analgesia and anesthesia for the breastfeeding mother. ABM Clinical Protocol #15. Academy of Breastfeeding Medicine. Breastfeed Med 2012;7:547–53. [PubMed] [Full Text] ⇦
24. Use of galactogogues in initiating or augmenting the rate of maternal milk secretion. ABM Clinical Protocol #9. Academy of Breastfeeding Medicine. Breastfeed Med 2011;6:41–9. [PubMed] [Full Text] ⇦
25. Stuebe AM, Horton BJ, Chetwynd E, Watkins S, Grewen K, Meltzer-Brody S. Prevalence and risk factors for early, undesired weaning attributed to lactation dysfunction. J Womens Health (Larchmt) 2014;23:404–12. [PubMed] [Full Text] ⇦

26. Berens P, Labbok M. Contraception during breastfeeding. ABM Clinical Protocol #13. Academy of Breastfeeding Medicine. Breastfeed Med 2015;10:3–12. [PubMed] [Full Text] ⇦

27. U.S. medical eligibility criteria for contraceptive use, 2010. Centers for Disease Control and Prevention (CDC). MMWR Recomm Rep 2010;59(RR-4):1–86. [PubMed] [Full Text] ⇦

28. U.S. Department of Health and Human Services. The Surgeon General's call to action to support breastfeeding. Washington, DC: Department of Health and Human Services, Office of the Surgeon General; 2011. Available at: http://www.surgeongeneral.gov/library/calls/breastfeeding/calltoactiontosupportbreastfeeding.pdf. Retrieved September 2, 2015. ⇦

29. U.S. Department of Labor. Break time for nursing mothers under the FLSA. Fact Sheet #73. Washington, DC: DOL; 2013. Available at: http://www.dol.gov/whd/regs/compliance/whdfs73.htm. Retrieved September 2, 2015. ⇦

30. Breastfeeding promotion in the prenatal setting. ABM Clinical Protocol #19. Academy of Breastfeeding Medicine. Breastfeed Med 2009;4:43–5. [PubMed] ⇦

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