



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

ACOG COMMITTEE OPINION

Number 756

(Replaces Committee Opinion No 658, February 2016)

Breastfeeding Expert Work Group Committee on Obstetric Practice

This Committee Opinion was developed by the American College of Obstetricians and Gynecologists' Breastfeeding Expert Work Group and the Committee on Obstetric Practice in collaboration with work group members Susan D. Crowe, MD and Lauren E. Hanley, MD, IBCLC.

Optimizing Support for Breastfeeding as Part of Obstetric Practice

ABSTRACT: 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. 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 prenatal care, during their maternity stay, and after the birth occurs. Enabling women to breastfeed is 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. Contraindications to breastfeeding are few. Most medications and vaccinations are safe for use during breastfeeding, with few exceptions. Breastfeeding confers medical, economic, societal, and environmental advantages; however, each woman is uniquely qualified to make an informed decision surrounding infant feeding. Obstetrician–gynecologists and other obstetric care providers should discuss the medical and nonmedical benefits of breastfeeding with women and families. 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 support women and encourage policies that enable women to integrate breastfeeding into their daily lives and in the workplace. This Committee Opinion has been revised to include additional guidance for obstetrician–gynecologists and other obstetric care providers to better enable women in unique circumstances to achieve their breastfeeding goals.

Recommendations

The American College of Obstetricians and Gynecologists makes the following 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 skills in anticipatory guidance, support for

normal breastfeeding physiology, and management of common complications of lactation.

Support for Breastfeeding Women

- Women are strongly encouraged to breastfeed and the American College of Obstetricians and Gynecologists supports each woman's right to breastfeed. Exclusive breastfeeding is recommended for the first 6 months of life, with continued breastfeeding as complementary foods are introduced during the infant's first year of life, or longer, as mutually desired by the woman and her infant.

- 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 and should be free from coercion, pressure, or undue influence.
- 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.
- 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.
- Breastfeeding is an option for women who have undergone double mastectomy and reconstruction by feeding with a supplemental feeding tube device at the breast.
- Women who experience breastfeeding difficulties are at higher risk of postpartum depression and should be screened, treated, and referred appropriately.
- Most medications and vaccinations are safe for use during breastfeeding.
- Obstetrician–gynecologists and other health care providers should consult lactation pharmacology resources for up-to-date information on individual medications because inappropriate advice often can lead women to discontinue breastfeeding unnecessarily.
- 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 and working with hospital staff to facilitate early, frequent milk expression starting within 1 hour of delivery, if possible.

Policy

- Obstetrician–gynecologists and other obstetric care providers should support women and encourage policies that enable women to integrate breastfeeding into their daily lives and in the workplace.
- The World Health Organization’s “Ten Steps to Successful Breastfeeding” should be integrated into maternity care to increase the likelihood that a woman will initiate and sustain breastfeeding and achieve her personal breastfeeding goals.

- Policies that protect the right of a woman and her child to breastfeed in public and that accommodate milk expression, such as insurance coverage for breast pumps, paid maternity leave, on-site child-care, break time for expressing milk, and a clean, private location 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). For example, in a sample of infants born between 2010 and 2013, there was a 17.2% difference in the rate of initiation among black and white women in the United States. Furthermore, there was a 7.8 percentage point difference in 6-month exclusive breastfeeding rates and a 13.7 percentage point difference in any breastfeeding at 12 months (3). 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 prenatal care, during their maternity stay, and after the birth occurs (4). 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. This Committee Opinion has been revised to include additional guidance for obstetrician–gynecologists and other obstetric care providers to enable women in unique circumstances achieve their breastfeeding goals.

Benefits of Breastfeeding

Clinical management of lactation is a core component of reproductive health care. However, education surrounding lactation is often lacking in graduate and postgraduate medical education (5). Enabling women to breastfeed is 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, 6, 7).

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 2014, 82.5% of women in the United States initiated breastfeeding, 55.3% were breastfeeding at 6 months, and 33.7% were breastfeeding at 1 year after giving birth (8) (Table 1).

Breastfeeding confers medical, economic, societal, and environmental advantages; however, each woman is uniquely qualified to make an informed decision surrounding infant feeding. Obstetrician–gynecologists and other obstetric care providers should discuss the medical and nonmedical benefits of breastfeeding with women and families, (9) because engaging and educating fathers and significant others have been shown to improve breastfeeding success (10). 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 and vaccinations are safe for use during breastfeeding, with few exceptions.

Use of medically indicated drugs or treatment for substance use disorders may not be a contraindication to breastfeeding. For example, women on stable doses of methadone or buprenorphine, who are not using illicit drugs, and who have no other contraindications, should be encouraged to breastfeed (11–13). There are insufficient data to evaluate the effects of marijuana use on infants during lactation. In the absence of data, marijuana use is discouraged (14). As the number of states legalizing and decriminalizing marijuana use increases, screening and counseling women about

medicinal and recreational marijuana use during pregnancy and lactation is important and should not be overlooked. More details on marijuana use and lactation can be found in Committee Opinion No. 722, *Marijuana Use During Pregnancy and Lactation* (14).

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

The American College of Obstetricians and Gynecologists strongly encourages women to breastfeed and supports each woman’s right to breastfeed. 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 during 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 (7) and the Association of Women’s Health, Obstetric and Neonatal Nurses (15). The American College of Obstetricians and Gynecologists additionally supports public health and policy efforts to enable more women to breastfeed, including Healthy People 2020 targets for increasing 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

Table 1. Healthy People 2020 Goals for Breastfeeding

	Healthy People Goals (%)	Current Data U.S. National	Non-Hispanic Black
Increase the proportion of infants who are breastfed at the following stages:			
Ever breastfed	81.9	82.5±1.1*	68.0±3.5
Breastfed at 6 months	60.6	55.3±1.4*	41.5±3.7
Breastfed at 1 year	34.1	33.7±1.3*	21.5±3.1
Breastfed exclusively through 3 months	46.2	46.6±1.4*	32.7±3.5
Breastfed exclusively through 6 months	25.5	24.9±1.3*	15.0±2.7
Increase the proportion of employers who have worksite lactation support programs	38	49 [†]	N/A
Reduce the proportion of breastfed newborns who receive formula supplementation within the first 2 days of life	14.2	15.5±1.0*	N/A
Increase the proportion of live births that occur in facilities that provide recommended care for lactating women and their newborns	81	7.79 [§]	N/A

*2014 Births (Centers for Disease Control and Prevention. Breastfeeding among U.S. children born 2002–2014, CDC National Immunization Survey. Atlanta (GA): CDC; 2017. Available at: https://www.cdc.gov/breastfeeding/data/nis_data/results.html. Retrieved June 26, 2018).

[†]Society for Human Resource Management. 2018 employee benefits: the evolution of benefits. Alexandria (VA): SHRM; 2018. Available at: <https://www.shrm.org/hr-today/trends-and-forecasting/research-and-surveys/Documents/2018%20Employee%20Benefits%20Report.pdf>. Retrieved June 26, 2018.

[‡]Offer onsite lactation/mother’s room, defined as a separate room that goes above and beyond 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/2016. Atlanta (GA): CDC; 2016. Available at: <https://www.cdc.gov/breastfeeding/pdf/2016breastfeedingreportcard.pdf>. Retrieved June 26, 2018.

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.

Obstetrician–gynecologists can play an active role in breastfeeding support by helping to ensure that their office practice setting aligns with these goals. The following practices are evidence-based options that obstetricians can implement to optimize the office setting: a written breastfeeding policy to facilitate support for breastfeeding patients and employees, providing information to patients about infant feeding that is free of artificial infant formula advertising, displaying posters and pamphlets with images of women breastfeeding that reflect the diversity of the population, and partnering with regional breastfeeding support services where patients can be referred for additional breastfeeding support after delivery (16–18).

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 and should be free from coercion, pressure, or undue influence (19). Women and families should receive noncommercial, accurate, and unbiased information so that they can make informed decisions about their health care (20). 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 (6). 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. A woman with a history of breast surgery usually can successfully breastfeed with the supervision of a health care provider to watch for any milk supply challenges or other anatomic issues related to the procedure. Of particular concern is a history of breast reduction, extensive wide local excision or multiple biopsies because these procedures can affect the ability to produce a full milk supply or permit normal anatomic drainage through the ducts, or both. Obstetrician–gynecologists 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 woman’s and family’s goals. 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.

Breast cancer is the most common cancer in women worldwide (21). The range of treatment options for breast cancer is wide and many of these women will go on to have children. Women who undergo lumpectomy and radiation may opt to breastfeed. The volume of milk produced after breast radiation is decreased. In addition, breast milk from an irradiated breast can have a higher sodium concentration and lower fat concentration. Infants will sometimes reject the milk from an irradiated breast or show strong preference for the nonirradiated breast, or both (22). A full milk supply may develop in the nonirradiated breast, however, counseling about nipple soreness and complications is prudent. Breastfeeding is an option for women who have undergone double mastectomy and reconstruction by feeding with a supplemental feeding tube device at the breast (23). This device has a container, often a syringe, that has a small tube attached that can be held or taped to the woman’s breast. When the infant latches, the milk from the container is drawn into the infant’s mouth through this tube. These women can still participate in skin-to-skin contact and should be offered alternative approaches to feeding their infants if desired. Some women in this population may choose to use donor milk if it is available. It is important to support these women and provide resources for them, including referral to lactation specialists who have experience in breastfeeding after a breast cancer diagnosis. There are specific support groups addressing these concerns (24).

As breastfeeding rates continue to increase in the United States, more than 33% of infants are breastfeeding at 12 months and beyond (8). Thus, the topics of lactation during pregnancy and tandem nursing (when an older child and newborn are both nursing) are becoming even more relevant to the obstetrician-gynecologist than in the past. Many nursing women may notice nipple soreness or a decrease in milk supply when they become pregnant, or both. Therefore, these symptoms should trigger pregnancy testing. A review of the limited literature available suggests that there is no increase in spontaneous abortion and preterm birth among low risk women who are breastfeeding during pregnancy, and most infants will wean from breastfeeding during the first or second trimester of the woman's subsequent pregnancy. There is an increased risk of anemia in women who breastfeed while pregnant, and they can expect their milk supply to diminish. They also can expect to transition to colostrum during later parts of pregnancy. Tandem nursing has not been consistently associated with diminished infant growth, with some studies showing less and others showing more growth. More data are needed to fully understand the effect of breastfeeding during pregnancy in developed countries (25).

Intrapartum Care

Maternity care practices affect breastfeeding outcomes. The World Health Organization's "Ten Steps to Successful Breastfeeding" (Ten Steps) is an evidence-based set of health care practices that support breastfeeding physiology, including early skin-to-skin care, enabling rooming-in, and feeding on demand (see Box 1) (2). In a systematic review of randomized controlled trials, skin-to-skin care in the first hour of life increased breastfeeding duration by a mean of 64 days (95% CI, -37.96 to 89.50) (26). Rooming-in enables women to learn and respond to infant cues and facilitates early breastfeeding. It is important to communicate the rationale for rooming-in to families during prenatal care and during the maternity care stay. A woman's clinical situation, fatigue, or a specific request for alternative arrangements may necessitate different rooming options. 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 (27). 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 (28).

As hospitals are making progress towards providing skin-to-skin care and rooming-in, which facilitate breastfeeding initiation, it is important that infants are adequately supervised to ensure safety, prevent falls, and prevent sudden unexpected postnatal collapse.

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.

*The 1994 report of the Healthy Mothers, Health 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.

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.

Particular attention is required for breastfeeding dyads when the woman is using opioid analgesia. Practicing a standardized approach to infant monitoring, which includes optimal infant positioning and observation, is vitally important in order to avoid adverse events (see Box 2) (29). The American College of Obstetricians and Gynecologists' Committee Opinion No. 742 and Committee Opinion No. 711 include further discussion about opioid use and breastfeeding (11, 30).

Healthy People 2020 and the Joint Commission have targeted unnecessary 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 (31) and implies that formula is a recommended feeding method.

Box 2. Components of Safe Positioning for the Newborn While Skin-to-Skin

1. Infant's face can be seen
2. Infant's head is in "sniffing" position
3. Infant's nose and mouth are not covered
4. Infant's head is turned to one side
5. Infant's neck is straight, not bent
6. Infant's shoulders and chest face mother
7. Infant's legs are flexed
8. Infant's back is covered with blankets
9. Mother–infant dyad is monitored continuously by staff in the delivery environment and regularly on the postpartum unit
10. When mother wants to sleep, infant is placed in bassinet or with another support person who is awake and alert

Reprinted from Ludington–Hoe SM, Morgan K. Infant assessment and reduction of sudden unexpected postnatal collapse risk during skin-to-skin contact. *Newborn Infant Nurs Rev* 2014;14:28–33.

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 (32). Such marketing should not occur in inpatient or outpatient health care settings.

The adolescent birth rate continues to decrease in the United States, but it remains the highest in the developed world. Most adolescent mothers would like to breastfeed, but they face unique challenges particular to their age. This cohort breastfeeds less exclusively and for shorter duration than their older counterparts when dividing women by age 20 years or younger (33). When adolescents are exposed to more components of the Ten Steps, they also tend to breastfeed longer and more exclusively. Thus, Ten Steps care is a practice that supports females of all ages and should not be denied to adolescents. Adolescent mothers are a vulnerable population in whom the health effects of breastfeeding could be particularly beneficial (34).

Overall, the preterm birth rate in the United States is currently 9.8% and black women have a prematurity rate of 13.3%, which is 49% higher than the preterm birth rate among all other women (35). The American Academy of Pediatrics states that all preterm infants should receive human milk. If a woman's own milk is not available, pasteurized donor human milk is the next best alternative (36). When fed human milk, this fragile group of infants has a lower risk of necrotizing enterocolitis, retinopathy of prematurity, late onset sepsis, and lower readmission rates in the first year of life (37, 38). Sharing this information with women who have given birth to preterm infants and who intend to formula feed can increase breastfeeding

initiation without increasing maternal anxiety (39). Obstetrician–gynecologists 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 (40). 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 and working with hospital staff to facilitate early, frequent milk expression starting within 1 hour of delivery, if possible (41, 42). It is important to recognize and support this vulnerable group of mother–infant dyads because these women have particular challenges to initiate and maintain milk supply.

Clinical Management of the Breastfeeding Dyad

The offices of obstetrician–gynecologists and other obstetric care providers should be a resource for breastfeeding assistance throughout the entire breastfeeding relationship. Breastfeeding 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, perceived or actual low milk supply, breast infections, and maternal medication safety should, therefore, be coordinated with the infant's health care provider as appropriate. Office staff should be prepared to triage common breastfeeding concerns and to refer women, as needed, to a certified lactation professional in the community, such as an International Board Certified Lactation Consultant or other lactation provider. Embedding lactation professionals within the offices of an obstetrician–gynecologist or other obstetric care provider may be feasible with coverage of lactation services included as preventive care under the Affordable Care Act (43). The American College of Obstetricians and Gynecologists encourages each health care provider to learn his or her own community resources to best support patients. In addition, screening patients for Women, Infants, and Children eligibility during prenatal care is an important way to help provide breastfeeding and nutrition support to many women and families. This type of collaborative care model helps enable women to achieve their feeding goals (44).

Most medications are safe for use during breastfeeding. Obstetrician–gynecologists and other health care providers should consult lactation pharmacology resources for up-to-date information on individual medications (12) because inappropriate advice often can lead women to discontinue breastfeeding unnecessarily. LactMed is a free resource updated monthly from the National Institutes of Health National Library of Medicine and available online or as an app compatible with

most smartphones. Information about drug safety in pregnancy should not be extrapolated to breastfeeding because 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 (45). 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 (46). Breastfeeding can be continued without interruption after the use of iodinated contrast during a computed tomography scan or gadolinium contrast with magnetic resonance imaging (12, 47).

Low milk supply is a common concern and may reflect misinterpretation of normal infant feeding behaviors, low production, or inadequate milk transfer (48). 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 (49).

Pain is a common cause of premature weaning. In one study of more than 1,300 women who stopped breastfeeding in the first month, approximately two out of three cited pain or sore, cracked, or bleeding nipples as an important reason (50). The differential diagnosis of nipple or breast pain is broad and complex. The support of the breastfeeding woman with pain requires time and knowledge. If the symptoms, history, and physical examination do not confer a diagnosis, additional evaluation with a certified lactation professional should be strongly considered (51).

Disrupted lactation is common, with one in eight women reporting early, undesired cessation of breastfeeding because of multiple problems with pain, low milk supply, or the infant being unable to latch on to the breast (48). 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. Women who experience breastfeeding difficulties are at higher risk of postpartum depression and should be screened, treated, and referred appropriately (6).

Contraception is an important topic for all women, and comprehensive discussion of methods should not be delayed for breastfeeding women. Although breastfeeding without introducing any complementary solids or

formula will in most cases prevent ovulation and, thus, pregnancy for up to 6 months after giving birth, it will do so only when women are fully or nearly fully breastfeeding and there is continued amenorrhea. Contraceptive options should be explained in detail and include non-hormonal methods (copper intrauterine devices, condoms, diaphragms, lactational amenorrhea method), and hormonal methods (levonorgestrel intrauterine device, etonogestrel implant, medroxyprogesterone acetate injection, progestin-only pills, and combined hormonal contraceptive pills) (52). The American College of Obstetricians and Gynecologists endorses the Centers for Disease Control and Prevention's evidence-based medical eligibility criteria for contraceptive use, which states that, for breastfeeding and nonbreastfeeding women, the advantages of progestin-only pills, injectable contraception, contraceptive implant, and intrauterine devices outweigh the risks for use any time in the postpartum period, including immediately after birth. Because of an increased risk of venous thromboembolism, the advantages of combined hormonal contraceptives, however, do not outweigh the risks for women until 1 month after giving birth (53). The Centers for Disease Control and Prevention and the World Health Organization diverge on recommendations for combined hormonal contraceptives beyond the early postpartum period; according to the World Health Organization, primarily breastfeeding women generally should not use combined hormonal contraceptives from 6 weeks through 6 months after giving birth (54).

Theoretical concerns exist that exogenous progesterone could prevent the onset of milk production because progesterone withdrawal after delivery of the placenta is thought to trigger onset of lactogenesis (48). Women considering immediate postpartum progestin-only contraception should be counseled about the theoretical risk of reduced duration of breastfeeding and about the preponderance of evidence that has not shown a negative effect on actual breastfeeding outcomes (55–57). Obstetric care providers should discuss any 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 and encourage policies that enable women to integrate breastfeeding into their daily lives 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 a woman and her child to breastfeed in public and that accommodate milk

expression, such as insurance coverage for breast pumps, paid maternity leave (58), on-site childcare, break time for expressing milk, and a clean, private location for expressing milk (59), 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 (15, 16). Laws vary by state, and health care providers should be aware of their state and local laws to inform and empower patients to feel comfortable breastfeeding in public and supported in achieving their breastfeeding goals (see the For More Information section for more information on state and local laws) (2).

For More Information

The American College of Obstetricians and Gynecologists 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.

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 website, or the content of the resource. The resources may change without notice.

References

- Odom EC, Li R, Scanlon KS, Perrine CG, Grummer-Strawn L. Reasons for earlier than desired cessation of breastfeeding. *Pediatrics* 2013;131:e726–32.
- 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.
- Anstey EH, Chen J, Elam-Evans LD, Perrine CG. Racial and geographic differences in breastfeeding—United States, 2011–2015. *MMWR Morb Mortal Wkly Rep* 2017;66:723–7.
- Perrine CG, Galuska DA, Dohack JL, Shealy KR, Murphy PE, MLIS, 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.
- Shen Y, Rudesill R. Impact of an educational intervention on breastfeeding counseling behavior of OB/GYN residents. *Breastfeed Med* 2016;11:293–6.
- Stuebe AM. Enabling women to achieve their breastfeeding goals. *Obstet Gynecol* 2014;123:643–52.
- Breastfeeding and the use of human milk. Section on breastfeeding. *Pediatrics* 2012;129:e827–41.
- Centers for Disease Control and Prevention. Breastfeeding among U.S. children born 2002–2014, CDC National Immunization survey. Atlanta (GA): CDC; 2017. Available at: https://www.cdc.gov/breastfeeding/data/nis_data/results.html. Retrieved April 11, 2018.
- Bartick MC, Schwarz EB, Green BD, Jegier BJ, Reinhold AG, Colaizy TT, et al. Suboptimal breastfeeding in the United States: maternal and pediatric health outcomes and costs [published erratum appears in *Matern Child Nutr* 2017;13(2)]. *Matern Child Nutr* 2017;13.
- Bell DL. Expanding community support for breastfeeding: the role of fathers. *Breastfeed Med* 2017;12:468–9.
- Opioid use and opioid use disorder in pregnancy. Committee Opinion No. 711. American College of Obstetricians and Gynecologists. *Obstet Gynecol* 2017;130:e81–94.
- 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.
- Reece-Stremtan S, Marinelli KA. ABM clinical protocol #21: guidelines for breastfeeding and substance use or substance use disorder, revised 2015. *Breastfeed Med* 2015;10:135–41.
- Marijuana use during pregnancy and lactation. Committee Opinion No. 722. American College of obstetricians and gynecologists. *Obstet Gynecol* 2017;130:e205–9.
- Association of Women's Health, Obstetric and Neonatal Nurses. Breastfeeding support: preconception care through the first year. 3rd ed. Washington, DC: AWHONN; 2015.
- Rosen-Carole C, Hartman S. ABM clinical protocol #19: breastfeeding promotion in the prenatal setting, revision 2015. Academy of Breastfeeding Medicine. *Breastfeed Med* 2015;10:451–7.
- New York State Department of Health. New York State ten steps to a breastfeeding friendly practice implementation guide. Albany (NY): DOH; 2016. Available at: <https://www.health.ny.gov/publications/2970.pdf>. Retrieved April 11, 2018.
- California Department of Public Health. 9 steps to breastfeeding friendly: guidelines for community health centers and outpatient care settings. Sacramento (CA): CDPH; 2015. Available at: <http://calwic.org/storage/documents/bf/2016/9StepGuide.pdf>. Retrieved April 11, 2018.
- Ethical decision making in obstetrics and gynecology. ACOG Committee Opinion No. 390. American College of Obstetricians and Gynecologists. *Obstet Gynecol* 2007;110:1479–87.
- 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.
- World Health Organization. Breast cancer: prevention and control. Available at: <http://www.who.int/cancer/detection/breastcancer/en/index1.html>. Retrieved April 11, 2018.
- Leal SC, Stuart SR, Carvalho Hde A. Breast irradiation and lactation: a review. *Expert Rev Anticancer Ther* 2013;13:159–64.
- Penny F, Judge M, Brownell E, McGrath JM. What is the evidence for use of a supplemental feeding tube device as an alternative supplemental feeding method for breastfed infants? *Adv Neonatal Care* 2018;18:31–7.
- Living Beyond Breast Cancer. Breastfeeding after treatment for early-stage breast cancer. Bala Cynwyd (PA): LBBC;

2016. Available at: <http://lbbc.org/young-woman/your-medical-needs/breastfeeding-after-treatment-early-stage-breast-cancer>. Retrieved April 11, 2018.
25. Lopez-Fernandez G, Barrios M, Goberna-Tricas J, Gomez-Benito J. Breastfeeding during pregnancy: a systematic review. *Women Birth* 2017;30:e292–300.
 26. Moore ER, Bergman N, Anderson GC, Medley N. Early skin-to-skin contact for mothers and their healthy newborn infants. *The Cochrane Database of Systematic Reviews* 2016, Issue 11. Art. No.: CD003519. DOI: 10.1002/14651858.CD003519.pub4. Available at: <http://cochranelibrary-wiley.com/doi/10.1002/14651858.CD003519.pub4/abstract>. Retrieved April 11, 2018.
 27. DiGirolamo AM, Grummer-Strawn LM, Fein SB. Effect of maternity-care practices on breastfeeding. *Pediatrics* 2008; 122(suppl 2):43.
 28. Hung KJ, Berg O. Early skin-to-skin after cesarean to improve breastfeeding. *MCN Am J Matern Child Nurs* 2011;36:6.
 29. Feldman-Winter L, Goldsmith JP. Safe sleep and skin-to-skin care in the neonatal period for healthy term newborns. Committee on Fetus and Newborn, Task Force on Sudden Infant Death Syndrome. *Pediatrics* 2016;138:e20161889.
 30. Postpartum pain management. ACOG Committee Opinion No. 742. American College of Obstetricians and Gynecologists. *Obstet Gynecol* 2018;132:e35–43.
 31. Howard C, Howard F, Lawrence R, Andresen E, DeBlicke E, Weitzman M. Office prenatal formula advertising and its effect on breast-feeding patterns. *Obstet Gynecol* 2000;95: 296–303.
 32. 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: <https://www.ers.usda.gov/publications/pub-details/?pubid=46808>. Retrieved April 11, 2018.
 33. Olaiya O, Dee DL, Sharma AJ, Smith RA. Maternity care practices and breastfeeding among adolescent mothers aged 12–19 years—United States, 2009–2011. *MMWR Morb Mortal Wkly Rep* 2016;65:17–22.
 34. Feldman-Winter L, Shaikh U. Optimizing breastfeeding promotion and support in adolescent mothers. *J Hum Lact* 2007;23:362–7.
 35. March of Dimes. 2017 premature birth report card. White Plains (NY): March of Dimes; 2017. Available at: <https://www.marchofdimes.org/materials/PrematureBirthReportCard-United-States-2017.pdf>. Retrieved April 11, 2018.
 36. Donor human milk for the high-risk infant: preparation, safety, and usage options in the United States. Committee on Nutrition, Section on Breastfeeding, Committee on Fetus and Newborn. *Pediatrics* 2017;139:e20163440.
 37. Underwood MA. Human milk for the premature infant. *Pediatr Clin North Am* 2013;60:189–207.
 38. 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.
 39. 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.
 40. Furman L, Minich N, Hack M. Correlates of lactation in mothers of very low birth weight infants. *Pediatrics* 2002; 109:e57.
 41. Parker LA, Sullivan S, Krueger C, Kelechi T, Mueller M. Effect of early breast milk expression on milk volume and timing of lactogenesis stage II among mothers of very low birth weight infants: a pilot study. *J Perinatol* 2012; 32:205–9.
 42. Parker LA, Sullivan S, Krueger C, Mueller M. Association of timing of initiation of breastmilk expression on milk volume and timing of lactogenesis stage II among mothers of very low-birth-weight infants. *Breastfeed Med* 2015;10: 84–91.
 43. National Breastfeeding Center. Model payer policy - payer coverage of breastfeeding support and counseling services, pumps and supplies. 3rd rev ed. Nyack (NY): NBFC; 2016. Available at: <https://www.nbfcenter.com/model-payer-policy.html>. Retrieved June 26, 2018.
 44. McCoy MB, Geppert J, Dech L, Richardson M. Associations between peer counseling and breastfeeding initiation and duration: an analysis of Minnesota participants in the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC). *Matern Child Health J* 2018;22: 71–81.
 45. National Library of Medicine. Drugs and lactation database (LactMed). Available at: <https://toxnet.nlm.nih.gov/newtoxnet/lactmed.htm>. Retrieved April 11, 2018.
 46. Reece-Stremtan S, Campos M, Kokajko L. ABM Clinical Protocol #15: analgesia and anesthesia for the breastfeeding mother, revised 2017. *Breastfeed Med* 2017;12:500–6.
 47. American College of Radiology. ACR manual on contrast media. Version 10.3. Reston (VA): ACR; 2017. Available at: <https://www.acr.org/Clinical-Resources/Contrast-Manual>. Retrieved April 11, 2018.
 48. 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.
 49. ABM clinical protocol #9: use of galactagogues in initiating or augmenting the rate of maternal milk secretion (first revision January 2011). Academy of Breastfeeding Medicine Protocol Committee. *Breastfeed Med* 2011;6:41–9.
 50. Li R, Fein SB, Chen J, Grummer-Strawn LM. Why mothers stop breastfeeding: mothers' self-reported reasons for stopping during the first year. *Pediatrics* 2008;122(suppl 2):S69–6.
 51. Berens P, Eglash A, Malloy M, Steube AM. ABM clinical protocol #26: persistent pain with breastfeeding. *Breastfeed Med* 2016;11:46–53.
 52. Van der Wijden C, Manion C. Lactational amenorrhoea method for family planning. *The Cochrane Database of Systematic Reviews* 2015, Issue 10. Art. No.: CD001329. DOI: 10.1002/14651858.CD001329.pub2. Available at: <http://cochranelibrary-wiley.com/doi/10.1002/14651858.CD001329.pub2/abstract>. Retrieved April 11, 2018.

53. Curtis KM, Tepper NK, Jatlaoui TC, Berry-Bibee E, Horton LG, Zapata LB, et al. U.S. medical eligibility criteria for contraceptive use, 2016. *MMWR Recomm Rep* 2016;65:1–104.
54. World Health Organization. Medical eligibility criteria for contraceptive use. 5th ed. Geneva: WHO; 2015. Available at: http://www.who.int/reproductivehealth/publications/family_planning/MEC-5/en/. Retrieved July 1, 2018.
55. Immediate postpartum long-acting reversible contraception. Committee Opinion No. 670. *American College of Obstetricians and Gynecologists. Obstet Gynecol* 2016;128:32–7.
56. Lopez LM, Grey TW, Stuebe AM, Chen M, Truitt ST, Gallo MF. Combined hormonal versus nonhormonal versus progestin-only contraception in lactation. *Cochrane Database of Systematic Reviews* 2015, Issue 3. Art. No.: CD003988. DOI:10.1002/14651858.CD003988.pub2.
57. Phillips SJ, Tepper NK, Kapp N, Nanda K, Temmerman M, Curtis KM, et al. Progestogen-only contraceptive use among breastfeeding women: a systematic review. *Contraception* 2016;94:226–52.
58. U.S. Surgeon General. The Surgeon General’s call to action to support breastfeeding. Washington, DC: Department of Health and Human Services; 2014. Available at: <https://www.surgeongeneral.gov/library/calls/breastfeeding/index.html>. Retrieved April 11, 2018.
59. U.S. Department of Labor. Break time for nursing mothers under the FLSA. Fact Sheet #73. Washington, DC: DOL; 2013. Available at: <https://www.dol.gov/whd/regs/compliance/whdfs73.htm>. Retrieved April 11, 2018.

Published online on September 24, 2018.

Copyright 2018 by the American College of Obstetricians and Gynecologists. All rights reserved. No part of this publication may be reproduced, stored in a retrieval system, posted on the Internet, or transmitted, in any form or by any means, electronic, mechanical, photocopying, recording, or otherwise, without prior written permission from the publisher.

Requests for authorization to make photocopies should be directed to Copyright Clearance Center, 222 Rosewood Drive, Danvers, MA 01923, (978) 750-8400.

**American College of Obstetricians and Gynecologists
409 12th Street, SW, PO Box 96920, Washington, DC 20090-6920.**

Optimizing support for breastfeeding as part of obstetric practice. ACOG Committee Opinion No. 756. *American College of Obstetricians and Gynecologists. Obstet Gynecol* 2018;132:e187–96.

This information is designed as an educational resource to aid clinicians in providing obstetric and gynecologic care, and use of this information is voluntary. This information should not be considered as inclusive of all proper treatments or methods of care or as a statement of the standard of care. It is not intended to substitute for the independent professional judgment of the treating clinician. Variations in practice may be warranted when, in the reasonable judgment of the treating clinician, such course of action is indicated by the condition of the patient, limitations of available resources, or advances in knowledge or technology. The American College of Obstetricians and Gynecologists reviews its publications regularly; however, its publications may not reflect the most recent evidence. Any updates to this document can be found on www.acog.org or by calling the ACOG Resource Center.

While ACOG makes every effort to present accurate and reliable information, this publication is provided “as is” without any warranty of accuracy, reliability, or otherwise, either express or implied. ACOG does not guarantee, warrant, or endorse the products or services of any firm, organization, or person. Neither ACOG nor its officers, directors, members, employees, or agents will be liable for any loss, damage, or claim with respect to any liabilities, including direct, special, indirect, or consequential damages, incurred in connection with this publication or reliance on the information presented.

All ACOG committee members and authors have submitted a conflict of interest disclosure statement related to this published product. Any potential conflicts have been considered and managed in accordance with ACOG’s Conflict of Interest Disclosure Policy. The ACOG policies can be found on acog.org. For products jointly developed with other organizations, conflict of interest disclosures by representatives of the other organizations are addressed by those organizations. The American College of Obstetricians and Gynecologists has neither solicited nor accepted any commercial involvement in the development of the content of this published product.