Ocean County Guide For Breastfeeding Education and Resources

Ocean County Health Department

Women, Infants and Children (WIC) Division

Ocean County Health Department

New Jersey WIC Women, Infants & Children Every Child Deserves a Healthy Start

Public Health Prevent. Promote. Protect.

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Disclaimer:
The guide is intended to serve as a resource when caring for the breastfeeding dyad. The information herein is not to be used for diagnosis. With each breastfeeding mother, variations for appropriate treatment and care should be based on the individual's needs. Every effort was made to ensure accuracy in this guide. However, those compiling this guide are not responsible for any errors or outcomes related to its contents.

Acknowledgements

This guide is the product of a dedicated group of breastfeeding experts, consultants, and advocates from across the state and Ocean County, New Jersey, chosen for their experience with quality breastfeeding support initiatives and their varied perspectives. The Ocean County Health Department is grateful for their participation and responsiveness.

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Mission of the Ocean County Guide for Breastfeeding Education and Resources

To improve and enhance the health of the residents of Ocean County through support, education and collaboration between pregnant and breastfeeding women and health care providers.

Breastfeeding is recognized as the optimal nutritional choice for infants and young children by the World Health Organization (WHO), United Nations Children's Fund (UNICEF), and other international health organizations. The Ocean County Health Department acknowledges and supports breastfeeding as the normal method of infant feeding.

In an effort to reduce childhood obesity, a strategy previously proposed through the Ocean County Community Health Improvement Plan, "A Countywide Approach to Improving Community Health," the OCHD promotes and encourages exclusive breastfeeding through proven policies and practices. There is mounting evidence that breastfeeding provides a myriad of benefits to the health of the infant from birth through the weaning stage and beyond as well as to the breastfeeding mother. Based on current available data and research, breastfeeding provides a level of protection against childhood obesity. Yet despite all the benefits, breastfeeding rates for exclusivity and duration are below the target goals.

The goal of the Ocean County Health Department by providing the *Ocean County Guide for Breastfeeding Education and Resources* is to help bridge the gap between initiation rates and duration rates, especially for exclusivity. Data shows that mothers are initiating breastfeeding in New Jersey (82.8%), a rate which exceeds the Healthy People 2020 Goal of 81.9%, but the rate of exclusivity at 3 months falls by half to 40.6% - less than the Healthy People 2020 Goal of 46.2% and it falls by nearly half again at 6 months (24.4%), again below the Healthy People 2020 Goal of 25.5%.

This guide encompasses a variety of support to help health care professionals and clinical support staff ensure the breastfeeding dyad meet their breastfeeding goals and beyond. The support found in this guide ranges from community resources (ex. La Leche League support groups, WIC clinics) to clinical support as endorsed by the Academy of Breastfeeding Medicine protocols (ex. jaundice). Through this guide, creating quality breastfeeding support as a best practice standard will allow for continuity of care in our breastfeeding community.

The Ocean County WIC Program can be accessed at: https://www.ochd.org/wic.

Target Audience

This is a guide intended for use by health care professionals who provide breastfeeding support, education and guidance to pregnant and breastfeeding women. The information in this guide is intended for quick and easy use for all providers and clinicians based on available information at the time of publication, but are by no means comprehensive. As with any individual, variations of care and treatment will differ and must be taken into consideration. Practice recommendations also change frequently. This guide is to be used only as guidance and not as a singular path of treatment.

Message from Dr. Rose St. Fleur

Of all the milks commonly used, human milk is ideally suited for human infants, and breastfeeding is known by many to have many health benefits for both mothers and babies. However, all too often, providers fall short when the time calls for a structured, organized, and evidence-based approach to breastfeeding management. Unfortunately, education on lactation is usually not a routine part of the medical school or residency curricula. Therefore, providers may lack adequate training needed to care for breastfeeding patients.

It is not uncommon to hear providers share stories of mothers who present to the office or hospital highly distressed over disastrous breastfeeding experiences. In addition, adverse outcomes related to poor breastfeeding can occur. As a result, providers may believe that attempts to support the choice to breastfeed may lead to guilt, embarrassment, and inevitable failure, not to mention substantial risk to the mother and infant. However, there is sufficient medical evidence to show that when there is adequate broad-based support, a mother can not only breastfeed her infant, but she can truly thrive in her breastfeeding, with full ability to attain her goals completely, securely, and with confidence. Providers play a critical role as a core pillar of this support by educating families, encouraging mothers to consider breastmilk as a feeding choice, and ensuring the safe development of mothers and infants through their breastfeeding journeys. Knowing when breastfeeding is "going well," and knowing when to intervene, is both optimal and critical for prevention of adverse outcomes. And, when it *is* "going well," how glorious it is! Mothers are bonded, infants are happy and healthy, and the family unit is empowered knowing that lactation efforts are not in vain.

It is largely a myth that talking about breastfeeding can make patients feel guilt. Many patients rely on the provider to give up-to-date education on health care topics, including breastfeeding. An ethical and compassionate approach is to provide information and gentle encouragement using a family-centered model of care. Guilt is mitigated or prevented altogether when informed choice over feeding is made. If the choice is to breastfeed, every family deserves to receive complete and thorough management from their provider. Consultants, such as lactation consultants and breastfeeding-friendly medical specialists, can provide additional extended care. The provider does not have to feel alone or overwhelmed in caring for breastfeeding families.

Utilize this guide when caring for breastfeeding families. The best outcomes for patients can only be achieved with the right management and care. Thus, the more providers know, the better the outcomes. This resource is designed to arm the provider with essential, easy-to-read, and quickly accessible information. With appropriate education and tools, providers can reduce the likelihood of breastfeeding "disasters" and provide families the merited opportunity for success.

Rose St. Fleur, MD, FAAP, FABM, IBCLC

Baby-Friendly Hospital Initiative's Ten Steps to Successful Breastfeeding

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

Developed by a team of global experts and consisting of evidence-based practices that have been shown to increase breastfeeding initiation and duration. Baby-Friendly hospitals and birthing facilities must adhere to the Ten Steps to receive, and retain, a Baby-Friendly designation.

Establishing Breastfeeding Support

The following strategies to establish community support are taken from "The CDC Guide to Strategies to Support Breastfeeding Mothers and Babies." There are nine strategies outlined which are designed to meet many of the health objectives set forth in *Healthy People 2020*.

STRATEGY 1:
Maternity Care Practices

Breastfeeding is an extremely time-sensitive activity. Experiences with breastfeeding in the first hours and days of life are significantly associated with an infant's later feeding. The maternity care experience can influence both breastfeeding initiation and later infant feeding behavior.

Maternity care practices that support breastfeeding include developing a written breastfeeding policy for the facility, providing all staff with education and training on breastfeeding, maintaining skin-to-skin contact between mother and baby after birth, encouraging early breastfeeding initiation, supporting cue-based feeding, supplementing when medically necessary, and ensuring breastfeeding-knowledgeable post discharge follow-up.

Maternity care practices that can have a negative effect on breastfeeding include using certain medications during labor and giving formula, water, or sugar water to breastfeeding infants when not medically necessary. Infants whose first breastfeed is delayed because of being weighed, measured, and cleaned do not breastfeed as long as infants who are immediately put skin-to-skin with the mother or put to the breast within the first hour after birth.

STRATEGY 2:
Professional Education

Health care providers can influence a woman's decision to breastfeed and her ability and desire to continue breastfeeding. Other health care providers who interact with women of reproductive age, infants and children need to recognize that breastfeeding is a normal and biologically important physiologic process that is critical to infant, child and maternal health, and they need a basic understanding of breastfeeding.

Health care providers need to be aware of how the procedures they perform or the medications they prescribe can directly or indirectly affect women who breastfeed now or who may do so in the future.

Recommendations: Make available and coordinate grand rounds or in-service presentations on breastfeeding by health care professionals with training in this area. Distribute clinical protocols developed by experts, such as the Academy of Breastfeeding Medicine, to local doctors.

STRATEGY 3:
Access to Professional Support

Women's early experiences with breastfeeding can affect whether and how long they continue to breastfeed. Mothers often identify support received from health care providers as the most important intervention the health care system could have offered to help them breastfeed. Professional support can be given in many different ways and settings—in person, online, over the telephone, in a group, or individually.

The Affordable Care Act requires new health plans to cover prenatal and postpartum breastfeeding counseling and supplies. Lack of reimbursement may be a barrier to seeking professional support for many women because they would have to pay out-of-pocket for this support.

Recommendations: Consider options for developing walk-in breastfeeding clinics that are available to all new mothers in the community and that are staffed by trained breastfeeding professionals who are reimbursed for all services provided.

Given that 53% of all new mothers and infants meet eligibility requirements for WIC services, ensure that WIC-eligible mothers are aware they have access to no-cost professional services for breastfeeding support through their local WIC office before they are discharged from the hospital.

For more information on breastfeeding counseling and lactation consultation available in Ocean County, refer to the Community Support Resources section of this Guide.

STRATEGY 4: Peer Support Programs

Women's decision-making processes are highly influenced by their social networks. Peer support may represent a cost-effective, individually tailored approach and culturally competent way to promote and support breastfeeding for women from different socioeconomic backgrounds, especially in places where professional breastfeeding support is not widely available. It is often provided by mothers who are from the same community and who are currently breastfeeding or have done so in the past.

Contact may be made by telephone, in the home, or in a clinical setting. Peer support includes emotional support, encouragement, education about breastfeeding, and help with solving problems. Significant increases in initiation, duration, and exclusivity were observed among women who received support from a peer counselor or other lay person.

STRATEGY 5: Support for Breastfeeding in the Workplace

Working full-time outside the home is related to a shorter duration of breastfeeding. Conversely, rates of breastfeeding initiation and duration are higher among women who have longer maternity leave, work part-time rather than full-time, or have breastfeeding support programs in the workplace.

Several studies have indicated that support for lactation at work benefits not only families but employers as well by improving productivity; enhancing the employer's public image; and decreasing absenteeism, health care costs, and employee turnover.

The right of breastfeeding employees to express their milk at work is protected by both New Jersey and federal law. Effective January 2018, New Jersey law (P.L. 2017, Chapter 263) requires all employers to provide reasonable pumping breaks and a private space to pump that is not a toilet stall and is in close proximity to the employee's work space.

Moreover, the federal "Break Time for Nursing Mothers" law also requires employers to provide reasonable break time and a private place for most hourly wage-earning and some salaried employees (nonexempt workers) to express breast milk at work.

For more information on an employee's right to express milk at work, see:
http://breastfeedingnj.org/breastfeeding-and-employment/

Additional recommendations for employer support for breastfeeding employees include:

- Allowing flexible scheduling to support milk expression during work.
- Giving mothers options for returning to work, such as teleworking, part-time work, or extended maternity leave.

STRATEGY 6: Support for Breastfeeding in Early Care and Education

Early Care and Education (ECE) programs play an important role in supporting breastfeeding mothers and their infants. ECE programs can welcome breastfeeding mothers by making sure staff members are trained to handle breast milk and follow mothers' feeding plans. Increasing access to ECE programs that support breastfeeding families will help contribute to an environment that empowers and supports women in initiating and continuing breastfeeding.

All ECE programs, including those in personal homes, can lower a breastfeeding mother's anxiety by allowing her to feed her infant on-site, having a posted breastfeeding policy that is routinely communicated, making sure procedures for storing and handling breastmilk and feeding breastfed infants are in place, and making sure staff members are well-trained in these procedures.

Clinicians and professionals can help support breastfeeding mothers by educating them on the questions they can ask when choosing an ECE program.

STRATEGY 7: Access to Breastfeeding Education and Information

The goals of breastfeeding education are to increase mothers' knowledge and skills, help them view breastfeeding as normal, and help them develop positive attitudes toward breastfeeding. Even though many women have a general understanding of the benefits of breastfeeding, they may not have access to information about how it is done, and they may receive incorrect information.

Recommendations: Work with health plans to encourage them to routinely offer prenatal classes on breastfeeding to all members. Partner with local community groups that support breastfeeding mothers by providing educational seminars and classes.

STRATEGY 8: Social Marketing

Increasing the number of positive messages and images of breastfeeding, as well as the visibility of the topic, through social marketing promotes breastfeeding and helps mothers and families understand the risks of not breastfeeding. This strategy can also help normalize breastfeeding, which in turn will make it seem a more feasible and attainable goal for many women. It may be used to promote breastfeeding practices in community, hospital, and workplace settings; educate policy makers about issues related to breastfeeding; and educate the public about healthy infant nutrition practices and support programs.

STRATEGY 9:
Addressing the Marketing of Infant Formula

Evidence suggests that the effect of the marketing practices used to promote breastfeeding substitutes is of particular concern because of its disproportionately negative effect on mothers in the United States who are known to be at high risk for early termination of breastfeeding. These groups include WIC participants, first-time mothers, and women who are less educated, non-white, or ill during the postpartum period.

Monitoring how infant formula is marketed to ensure that potential negative effects on breastfeeding are minimized can help reduce barriers to breastfeeding for women who choose to do so. The negative association between the marketing of breastmilk substitutes and breastfeeding rates was the basis of the World Health Organization's *International Code of Marketing of Breastmilk Substitutes* (the Code).

Developed with infant formula manufacturers, the Code is a set of guidelines that apply to the marketing of breast-milk substitutes. It reaffirms the role that key entities–such as governments, health care systems, health care workers, and manufacturers and distributors of breastmilk substitutes—play in making sure infant formula is marketed in ways that minimize its negative effects on breastfeeding.

One common way that infant formula is marketed is by giving women gift bags with free formula samples when they are discharged from the hospital. Seven of the 11 studies found lower breastfeeding rates among women who received discharge bags with formula samples than among women who did not receive bags with formula samples. More recently, receiving a commercial hospital discharge bag was associated with shorter duration of exclusive breastfeeding.

World Health Organization's International Code of Marketing of Breastmilk Substitutes (the Code)

On May 21, 1981, the 34th World Health Assembly adopted the International Code of Marketing of Breastmilk Substitutes in the form of a recommendation, in the World Health Organization (WHO) Constitution. The Code is aimed at health care facilities and providers. It recognizes that the sales promotion of breastmilk substitutes, such as formula, can interfere with a family's confidence with breastfeeding successfully by suggesting such substitutes are medically required, when, in many cases, they are not.

More than 160 countries and territories take steps to implement the Code in their public health policies and laws. However, to date, the United States has no legal provisions which adapt the Code. As a result, certain practices, such as direct-to-consumer advertisements on television and on the internet, are common in the United States, but do not exist in most other countries worldwide.

The aim of the Code is to "contribute to the provision of safe and adequate nutrition for infants, by the protection and promotion of breastfeeding, and by ensuring the proper use of breastmilk substitutes, when these are necessary, on the basis of adequate information and through *appropriate* marketing and distribution." Unfortunately, most marketing and distribution is *inappropriate*. An often-seen example of this is the hospital discharge bag, and other places where families are able to acquire free formula samples and promotions. These samples, while initially free to the family, eventually lead to the belief that their infant needs to stay on the sample product for healthy growth. The sampled product is often a more expensive brand, which, in a year, actually results in the average family spending about $700 more on formula. In the end, "free" is not really free at all to families.

What Can The Health Care Provider Do to Discourage Inappropriate Breastmilk Substitute Marketing?

- **DO NOT** participate in passive sales promotion of formula – for example, remove coupons and advertisements from your office; and do not dispense free formula samples. (In the rare event that a family is in need of formula and cannot afford it, refer to WIC, and/or consider purchasing a small stock for your practice.)

- **DO NOT** accept free dinners, lunches, or other items from formula companies to ensure your continued ability to provide unbiased, uninfluenced information to your patients.

- **DO LIMIT** (or even eliminate) visits from formula representatives to your practice or hospital.

- **DO RECOGNIZE** that your influence as a provider is important. Because the United States has no laws enforcing the Code, the average family is exposed to extremely frequent sales promotion of breast-milk substitutes like formula. This can make breastfeeding a difficult choice to maintain. Offer evidence-based education, support, and praise.

Breastfeeding in Public in New Jersey

New Jersey law protects a mother's right to breastfeed in public. Effective May 19, 1997, New Jersey enacted a law that states that a mother can breastfeed her infant in any location of any place of public accommodation where the mother is otherwise entitled to be. N.J.S.A. 26:4B-4 and N.J.S.A. 26:4B-5. Places of public accommodation include public and private locations that offer goods, services and facilities to the general public, including stores, restaurants, healthcare provider offices, governmental offices, public parks and pools, sports facilities and more. Violations of the law should be reported to the local health department. Violators may be subject to fines under the law.

To report a violation in Ocean County, call the Ocean County Health Department's WIC Program at 732-370-0122, #6.

For more information, visit the New Jersey Breastfeeding Coalition at breastfeedingnj.org.

Latch

Although breastfeeding is a natural process, it is a new skill that is learned by the breastfeeding dyad. An infant's latch allows for the transfer of milk from the mother's breast to the infant.

To start: Position infant's body to face mom's body (belly to belly). Mom is to support infant by placing her hand behind infant's upper back and shoulder area, which will allow for baby's head to extend back when it's time to latch. Infant's nose should be opposite from mom's nipple, allowing for infant's well-developed sense of smell to align his mouth to her breast when he tilts his head back. When infant opens mouth wide (like a yawn), mom will bring infant closely and quickly towards the breast. It is important that mom does not push her nipple into baby's mouth as this will likely result in less than optimal positioning of the nipple inside infant's mouth.

Signs of a good latch:

- Infant's chin will be pressed into mom's breast.
- A larger portion of the areola is visible above the nipple than below. Infant's mouth covers an off-centered area of the areola.

Shallow Latch
(incorrect)

- Infant will start the feed with rapid suckling. There will be more sucks to each swallow at first, and then infant will rhythmically suck and swallow, while taking short pauses in between.
- Mom does not feel any soreness or pain; possibly feels a slight tug.

Deep Latch
(correct)

- Infant's bottom and top lips are flanged out. The bottom lip may be buried into the breast and not visible.
- When the infant releases the breast, mom's nipple tip should appear rounded.

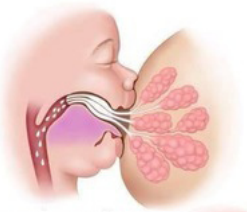
Possible indications of a poor latch:

- Sore nipples or breast pain may be an indicator of a suboptimal latch. While mothers may report nipple tenderness when they first start breastfeeding, breastfeeding should be comfortable once a good latch is established. Blisters, cracks or bleeding are not a normal part of breastfeeding. They are signs of nipple trauma and require prompt evaluation.

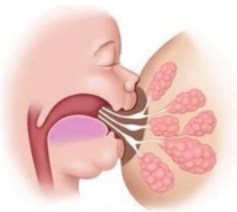
- A shallow latch may be reported because of different nipple sizes and shapes; however, since successful breastfeeding relies on the infant latching to both the nipple and breast, flat, inverted, or large nipples should not prevent a good latch. Professional and peer support can help moms establish a good latch.

Additional latch considerations:

- An infant with ankyloglossia (short lingual frenulum, "tongue-tied") may find it difficult to nurse if they are unable to extend or elevate their tongue far enough to effectively cup and suckle at their mother's breast while feeding. If concerns about an effective latch are raised in infants with ankyloglossia, mothers should be counseled to discuss it with their doctor.



Normal Tongue Position



Tongue-tie

A good latch is crucial! If a mom is interested in successfully breastfeeding, navigation to the support she needs to overcome some common challenges early and often is key. Refer to the Community Support Resources section of this guide for more information on professional services and peer counseling available in Ocean County.

Feeding Cues

Infants will indicate to mom when they are hungry with various feeding cues. Teach moms to respond to the earliest sign of infant hunger to avoid potential latch or feeding issues. Here are those cues:

- Rapid eye movement (REM) under closed eyelids as infant comes out of sleep
- Flexing of arms and legs
- Movements with tongue or lips-smacking and sucking lips; putting hands near mouth
- Rooting – turning head towards mom's breasts; opening mouth
- Making soft noises; cooing sounds

Crying is a late indicator that an infant is hungry. Feeding a crying infant can be stressful for both mom and baby and may not result in the best transfer of milk.

How to Tell if Baby is Getting Enough

Two factors to look at when determining if an infant is transferring enough breastmilk during a feed is infant's weight gain and diaper output. If an infant is feeding well, he should have adequate diaper output.

The following is a checklist for adequate milk intake criteria for exclusively breastfed infants:

- The infant has reached his birth weight within the first two weeks.
- Between days two and three, infant's stools change from black to green and then turn to yellow with "seeds" or "curds" by day five.
- After day four, baby has at least three stools per day that are bigger than a U.S. quarter (after the first four to six weeks, stools may be less frequent but are larger in size).
- After day four or 24 hours after milk comes in, infant has at least five very wet diapers that are odorless and colorless (four wet diapers may be adequate if they are heavily soaked).
- After day four or when milk comes in, infant gains at the following average rate:
    - **First three months:** approximately 1 oz per day or 6 oz per week
    - **Four to six months:** at least 0.6 oz per day
    - **Seven to nine months:** at least 0.4 oz per day
    - **Ten to twelve months:** at least 0.3 oz per day

Newborn Weight Loss/Gain

Weight Loss:

A 5-7% weight loss during the first 3-4 days after birth is normal. A 10% weight loss is sometimes considered normal, but this amount of weight loss is a sign that the breastfeeding needs to be evaluated. It's a good idea to have a routine weight check at 5 days (baby should be gaining rather than losing weight by day 5), so that any developing problems can be caught and remedied early.

Baby should regain birth weight by 10 days to 2 weeks. If baby lost a good bit of weight in the early days, or if baby is sick or premature, it may take longer to regain birth weight. If baby does not regain birth weight by two weeks, this is a sign that the breastfeeding needs to be evaluated.

Things to remember:

- Figure weight gain from the lowest point rather than birth weight
- Baby needs to be weighed on the same scale
- Clothing or diapers can vary in weight; therefore measuring baby naked or in a dry diaper is recommended
- Babies may grow in spurts rather than at a steady rate

Weight Gain:

- Weight gain of 4-7 ounces (112-200 grams) a week during the first month
- An average of 1-2 pounds (1/2 to 1 kilogram) per month for the first six months
- An average of one pound (1/2 kilogram) per month from six months to one year

Engorgement

Swollen, firm, and sore breasts, usually affecting both breasts, is called engorgement.

Causes:

- Vascular dilation
- Milk coming in (usually between 3-5 days postpartum)
- Large amounts of intravenous fluids during labor, which usually causes breast edema
- Missed or delayed feedings due to formula supplements or pacifier use

Concerns:

- Can lead to sore nipples (from shallow latch), ineffective breast emptying and decreased milk supply
- Associated with an increase in the likelihood of early weaning

Prevention:

- 8-12 feedings in 24 hours and feeding on cue
- Rooming in: keep baby with mom in the hospital room as much as possible
- Early and frequent breast emptying
- Gentle breast massage
- Avoid unnecessary supplemental feeds and pacifiers

Treatment:

- Brief use of warm, moist compresses on the breasts before feeding or a warm shower may help promote milk flow
- Feed from both breasts
- If infant cannot latch or stay latched because of breast firmness, use gentle breast massage, then hand express or pump briefly to soften the breast to enable the latch, and use reverse pressure softening if necessary
- Reverse pressure softening, applying fingertip pressure to help soften the areola, is useful for breast edema (and helps improve infant latch and let-down reflex). For instructions: https://kellymom.com/bf/concerns/mother/rev_pressure_soft_cotterman/

- After the feeding, apply cold packs to the breasts for approximately 20 minutes after a feed to reduce swelling and pain. The cold pack application may be repeated, 20 minutes on, 20 minutes off.
- Breastfeed frequently, as often as the baby is willing, to empty the breasts and to keep them as comfortable as possible.
- The healthcare provider may recommend anti-inflammatory analgesics (i.e. ibuprofen) if necessary to reduce pain and inflammation.

Plugged Ducts and Mastitis

Like engorgement, plugged ducts can occur in mothers that are breastfeeding. Plugged ducts can cause tenderness, discomfort, and inflammation that can lead to maternal frustration and impact the initiation and duration of breastfeeding. Plugged ducts can be loosened; advise mothers to obtain guidance from a lactation consultant if steps taken to loosen the blockages are unsuccessful.

If a plugged duct goes unaddressed, it may lead to mastitis (breast infection). Breast infections may lead to more pronounced illness in the mother. It is important to refer mothers to their doctors if either or both breasts show evidence of infection, pus or blood is seen in the breastmilk, red streaks are visible at the affected area(s), or the symptoms progress rapidly or severely.

Jaundice

It is important to recognize that it is NOT breastfeeding alone which may lead to dangerous levels of hyperbilirubinemia, but, in most cases, insufficient intake. The physician should also be aware that not all cases of jaundice are related to feeding. A thorough evaluation is always warranted.

What to do?

- **PREVENT** any likelihood of insufficient intake:

- Support skin-to-skin, especially immediately after birth.
- Initiate breastfeeding early (preferable within the first hour of birth).
- Encourage frequent exclusive breastfeeding (8-12 times or more in 24 hours). Breastmilk has a laxative effect; therefore, breastfeeding frequently will result in more bowel movements and lower bilirubin levels.
- Assure comfortable positioning and latch (observe swallowing visually and audibly).
    - Educate mom on early feeding cues (found on page 23).

- **IDENTIFY** the dyad's risk for hyperbilirubinemia (family history of jaundiced infants, cesarean delivery, maternal diabetes, Rh sensitization, maternal BMI over 27kg/m^2, premature birth, ethnic background, specifically East Asian newborns)
- **FOLLOW UP PROMPTLY AFTER DISCHARGE** to assess progression of breastfeeding
    - ALL breastfeeding infants need to be followed up by their pediatrician no later than 2 days after discharge. An infant who has already demonstrated breastfeeding difficulties ideally should be seen one day after discharge.

If it is determined that jaundice should be assessed, laboratory rather than visual assessments, which can be highly inaccurate, are recommended. Most transcutaneous measurements are increasingly inaccurate with higher measured values. The higher the value, the lower the threshold should be for laboratory confirmation. All bilirubin values should be assessed against a tool such as the bilirubin nomogram or validated online application (such as BiliTool).

Breastfeeding infants should not be supplemented with water or glucose water. Supplementation with expressed breastmilk, banked human milk or formula (in that order) should be limited to infants with at least one of the following:

- A clear indication of inadequate intake as defined by weight loss in excess of 10% after attempts to correct breastfeeding problems. Consider checking for total and direct bilirubin and for electrolytes for any infants showing excess weight loss or evidence of dehydration.
- Evidence of dehydration defined by significant alterations in serum electrolytes, especially hypernatremia, and/or clinical evidence of significant dehydration.
- Decreased stool output. Stool output is a more sensitive indicator than urine output for dehydration in the first few days of life.
- Sleepiness or apathy/disinterest at the breast; an infant who "never cries" to be fed.
- Report of frequently needing to be awakened for feeds.
- Reported lack of audible swallowing at the breast.
- Reduced amounts of adequate breastfeeding per day (a newborn who "sleeps through the night" in the first several weeks of life may not be getting sufficient milk).
- Decreased urine output (late sign).
- Extensive jaundice (late sign).

*A depressed fontanel and decreased capillary refill may **not** be present in a dehydrated newborn, since most cases of dehydration are related to hypernatremia and not isonatremia. If a depressed fontanel or decreased capillary refill is present, it is a late sign.

Tests/Assessments:

Every patient should be carefully evaluated for assurance of adequate milk transfer. Any patient with clinically apparent jaundice should be tested for jaundice with a serum blood test. Due to lack of accuracy (especially in infants with darker skin pigment), assessment for jaundice via visual exam alone is no longer recommended.

"Providers play a critical role as a **core pillar** of [breastfeeding] support by educating families, encouraging mothers to consider breastmilk as a feeding choice, and ensuring the safe development of mothers and infants through their breastfeeding journeys."

- Dr. Rose St. Fleur, MD, FAAP, FABM, IBCLC on the role of health care providers in supporting breastfeeding

Breastfeeding Diet

There is no complex diet that will produce more milk. The removal of milk through breastfeeding is the greatest influence of how a woman's breasts produce more milk. A healthy diet contributes to mom's overall health and success with breastfeeding. However, even if mom states she is eating a diet which is lacking in nutrients, she should still be encouraged to breastfeed.

What about gassy foods?
Foods like beans, cabbage, Brussels sprouts, broccoli and cauliflower have little to no effect on mom's milk. Though many mothers believe that gassy foods can cause gassy babies, the research does not support that conclusion.

What about foods that mom had to avoid while pregnant, such as sushi, hotdogs, lunch meat, and unpasteurized dairy including imported soft cheeses?
While pregnant, the concern regarding these foods is the potential for bacteria to cross the placenta and infect the baby. There is little risk to the breastfeeding baby when eating these foods, but it is important for mom to avoid foods that pose a high risk for foodborne illnesses for her own health.

Can the breastfeeding woman safely consume coffee without affecting her baby?
Most breastfeeding mothers can drink caffeine in moderation. Some babies, particularly those under 6 months, may be more sensitive to mom's caffeine intake. Chronic consumption of caffeinated beverages or other foods or medications containing caffeine may cause agitation, irritability, poor sleeping patterns, and rapid heart rate in some infants. Lastly, there is no evidence that caffeine decreases milk supply.

How many calories should the breastfeeding mother consume?
Moms should listen to their body and eat when hungry. Women who are exclusively breastfeeding often report feeling hungry more often. Generally, an addition of 500 calories per day should meet the needs of a lactating mom. This can be achieved by eating 1-2 additional nutritional snacks throughout the day.

Total caloric needs will vary from mom to mom along with the amount of breastfeeding she is doing (exclusive vs. partial). Physical activity and pre-pregnancy health play a part in mom's caloric needs. If the mother is active, she may require more calories, and if she is less active, fewer calories. Most healthy breastfeeding women consume approximately 1800-2200 calories per day while maintaining a good milk supply.

What if the breastfeeding mother does not want to drink milk? Is she still able to breastfeed?

Drinking milk does not equate to making milk. Breastmilk is made from nutrients found in the blood stream which have been extracted from a variety of foods. However, it is important to eat calcium-rich foods and drinks while breastfeeding. The calcium recommendation for nursing women is 1,000 milligrams (mg) per day, which is in about 3-4 servings of dairy or other calcium-rich foods such as canned salmon or sardines, almonds or broccoli. If unable to obtain an adequate amount of calcium in her diet, she can add a calcium supplement.

Should the breastfeeding mother increase her fluid intake?

Many moms feel an increase in thirst when they are breastfeeding. Rule of thumb is to drink to satisfy her thirst. Many moms have water readily available when they are nursing as a reminder that when baby feeds, they might find it helpful to drink as well.

Does the breastfeeding mother need to take a vitamin D supplement?

A breastfeeding mother may need to take a vitamin D supplement if any of the following pertains to her or her baby:

- Dark skin
- Consistent coverage of skin with clothing or sunscreen when outdoors
- Live in areas where there is little sunlight for parts of the year or do not go outdoors
- Live in areas of heavy air pollution, which blocks sunlight
- Mother is vitamin D deficient

The American Academy of Pediatrics recommends that all infants receive 400 IU of vitamin D per day. Lack of vitamin D can lead to bone problems, poor immunity, and a higher risk for some cancers.

An easy way to administer vitamin D to the infant is through vitamin D drops. Though exposure to natural sunlight is another source of obtaining vitamin D, it is unrealistic to rely on sunlight to obtain daily vitamin D for the infant. An article on this topic published in the September 2015 Journal of Pediatrics (Hollis, et al.) discusses an alternative means of providing vitamin D via maternal dosing.

Can the mother consume alcohol?

Alcohol passes into breastmilk, but an occasional alcoholic beverage can probably be consumed with relatively little risk to the baby. Alcohol inhibits the release of oxytocin, which reduces milk letdown. The best practice is to minimize the amount of alcohol the mother drinks when she is breastfeeding. If a mother does drink, she should avoid breastfeeding for at least 2 hours after each standard drink* consumed.

*A standard drink contains approximately 14 grams (0.6 oz) of pure alcohol which is found in 12 ounces of 5% beer; 5 ounces of 12% wine; or 1.5 ounces of 40% (80 proof) liquor.

Breast Pumps

Generally, breast pumps do not remove milk as efficiently as a healthy full-term infant who has established a correct latch and nurses effectively. A mother's milk supply is based on the amount of milk that is removed. The more milk that is removed from the breasts, the more milk will be produced. However, access to a breast pump can be crucial to a mom's success with breastfeeding, especially if the infant is sick, premature or not breastfeeding effectively in the early weeks, if the baby needs supplement or if a mother will be separated from her infant for an extended amount of time (i.e. baby in the NICU, or mother returning to work or school).

The Affordable Care Act (ACA) makes breastfeeding more accessible and affordable for millions of women. The law requires that all new health plans must provide certain preventive services without any cost-sharing, including coverage for breastfeeding support and supplies (ex. breast pumps).

Breast Pump Suppliers	
1 Natural Way	888-977-2229, #1
Acelleron Medical Products	877-932-6327, #1
Aeroflow Breastpumps	844-867-9890
Byram Healthcare	877-773-1972
Edgepark Medical Supplies	855-504-2099
Edwards Healthcare Services	888-344-3434
McKesson Patient Care Solutions	844-727-6667
Medline	877-436-8522
Med Source	888-510-5100, #1
Pumping Essentials	866-688-4203
Yummy Mummy	855-879-8669

Note: This is a sample of the many companies that provide breast pumps through individual health insurance. Each company is specific to which health insurances they work with and various pump options.

Additionally, if the mom is participating in the WIC program, she may be eligible for a manual, single-user electric, or multi-user electric pump. WIC breastfeeding staff can help moms navigate how to get a breast pump through their health insurance. Encourage mom to contact her WIC office.

The Ocean County WIC phone number is 732-370-0122, extension 6.

Safe Storage of Human Milk

Safe handling and storage of human milk provides moms with breastfeeding flexibility if they become separated from their infants. Properly stored breastmilk preserves the unique benefits of human milk along with supporting mom's desire for her infant to be fed only breastmilk while mom and baby are separated.

- Wash hands with soap and water or use hand sanitizer. Wash in a clean bowl or basin all pump parts that come in contact with breastmilk and the storage container you are using, except the tubing that connects directly to the pump. See: https://www.cdc.gov/healthywater/hygiene/healthychildcare/infantfeeding/breastpump.html
- Storage containers vary based on preference. Avoid containers made with bisphenol A (BPA).
- If freezing, leave some space on the top of the container when filling it to allow for expansion.
- If freezing, label the container with the date in which the earliest milk was pumped.
- When removing breastmilk containers from the refrigerator or freezer, use the oldest milk first.
- Store breastmilk in varied increments, ranging from 1-4 ounces.
- Defrost frozen milk in the refrigerator overnight, running under warm water or placing the container in a warm water bath.
- NEVER microwave breastmilk to defrost or warm up.
- Expressed milk will separate when stored in the refrigerator and freezer. It's normal, just gently "swirl" the container to mix the milk for uniformity.

Breastmilk Storage Guidelines		
Location	**Temperature**	**Max. Storage Duration**
Room temperature	60-85°F	4 hours (optimal) 8 hours (very clean conditions)
Cooler pack	59°F	24 hours
Refrigerator	39°F	3 days (optimal) 8 days (very clean conditions)
Freezer	0°F	6 months (optimal) 12 months (acceptable)

Note: When placing storage containers in the freezer, place in the back of the freezer. When using the refrigerator for storage, do not store on the door. Aim for the back of the refrigerator where it's consistently colder.

Elimination Diet

Research shows that infants fed human milk appear to have lower incidence of allergic reactions to cow's milk protein than those fed cow's milk-based formula. When an exclusively breastfed baby has clinical evidence of allergic colitis, the first line of treatment is the maternal elimination diet, avoiding food containing common allergens like cow's milk protein and soy.

Often times, these infants are "well appearing" other than the presence of blood within the stool. The passage of dietary proteins into maternal milk is responsible for the majority of cases, and elimination of the offending agent from the maternal diet usually results in an improvement of symptoms within 72-96 hours, but sometimes full improvement takes up to 2-4 weeks.

Symptoms:

- Gastrointestinal (bloody stools): Usually occurring between 2 and 6 weeks of age
- Cutaneous reactions (eczema)

Main culprit:

Dietary proteins found in the mother's milk are responsible for the majority of cases and induce an inflammatory response of the rectum and distal sigmoid colon referred to as allergic proctocolitis.

Diagnosis:

- allergic colitis
- benign dietary protein proctitis
- eosinophilic proctitis
- breastmilk-induced proctocolitis
- allergic proctocolitis

Elimination Diet Plan:

- Mothers are instructed to eliminate one food or food group at a time and wait a minimum of 2 weeks and up to 4 weeks. Most cases will improve within 72-96 hours.
- If there have been no changes with the infant's symptoms in that time, the mother can usually add this food back into her diet and eliminate another food or food group from the list.
- When eliminating a food/food group from her diet, she should read the labels on food and look at ingredients in vitamins, medications and vaccinations.
- Maternal diet that eliminates a large amount of foods may put her at risk for nutritional deficiencies. The maternal risks of an extensively restrictive diet must be weighed against the potential infant benefit.
- For infants with more significant symptoms, one can place the mother on a very low-allergen diet of foods like lamb, pears, squash, and rice.
- When the infant's symptoms resolve, other foods are added back to the mother's diet one at a time, with sufficient time between additions (minimum of 1 week).

Breastfeeding and Contraceptives

There are issues to consider when deciding on the right contraception for the breastfeeding mom:

- Efficacy of contraceptive method
- Disruption in milk production
- Infant's exposure to a synthetic hormone.

It's important to make sure mother's milk supply is established before initiation of hormonal contraception. The first choice of contraception for the breastfeeding mother would be non-hormonal, such as the Lactational Amenorrhea Method (LAM), an evidence-based method with a 1-2% pregnancy risk while the following 3 criteria hold: mother is amenorrheic, baby is less than 6 months old, and breastfeeding is exclusive on demand day and night, without any regular supplemental feeds.

In addition, use of a barrier method such as a condom (which protects against STDs) or a diaphragm, can add to the efficacy of LAM.

When used correctly, condoms are an effective method that would not affect breastmilk quality or quantity. When considering a hormone contraceptive, it is recommended to delay the initiation to at least 6 weeks postpartum due to the possibility of hormones interfering with the establishment of breastfeeding.

Progestin-only contraceptives are the preferred choice for breastfeeding mothers when something hormonal is desired or necessary.

Acceptable with Breastfeeding	Avoid with Breastfeeding if Possible
Birth control injection (Depo-Provera)	Etonorgestrel/ethinyl estradiol vaginal ring (NuvaRing™)
Progestin-only pill (POP) also called the "mini-pill"	Norelgestromin/ethinyl estradiol transdermal system (OrthoEvra™ patch)
Progesterone-releasing IUD (Mirena, Skyla)	
Birth control implant (Implanon, Nexplanon, Norplant)	

Breastfeeding During a Subsequent Pregnancy

There is no evidence that a pregnant mom who continues to breastfeed will deprive her unborn baby of nutrients.

Pregnant breastfeeding mothers may experience tender nipples, decreased milk production by mid-pregnancy, infant change in behavior due to changes in the taste of milk, and/or nausea while nursing. For many mothers these effects are mild and not disruptive to breastfeeding. Pregnant breastfeeding mothers may need more calories than pregnant non-breastfeeding mothers.

Breastfeeding and Cigarette Use

Breastfeeding mothers who smoke are encouraged to quit, however breastmilk is still the optimal choice for the baby. Breastfeeding will provide the baby with antibodies and will even counteract some of the negative effects of the cigarette smoke to the infant.

Smoking may affect mom's success with breastfeeding:

- Milk production is lower
- Duration of breastfeeding is shorter
- Interference with milk ejection reflex (let-down)
- Lower levels of prolactin (the hormone that produces milk)

What should I discuss with a breastfeeding mom who smokes?

1. Ideal: QUIT.
2. Cut back and/or consider a nicotine patch.
3. Never smoke while breastfeeding or immediately before breastfeeding.
4. If mom chooses to smoke cigarettes, smoke right after a nursing session. Avoid smoking for two hours before feeding, which may improve milk let-down.
5. If mom chooses to smoke, go outside in a well-ventilated area, wear a "smoking smock," and wash hands with soap and water before interacting with her baby.
6. Infants who are routinely exposed to cigarette smoke are at a greater risk of SIDS. Discuss safe sleep with mom. Put infant on her back and remove all objects in her sleep space.
7. Refer to:
   - Mom's Quit Connection: 1-888-545-5191
   - New Jersey Quitline: 1-866-NJSTOPS (657-8677)
   - Nicotine Anonymous: 1-800-642-0666
   - RWJ's Community Medical Center Smoking Cessation & Tobacco Treatment: 1-888-724-7123

Breastfeeding and OTC Medications

Many medications are safe while breastfeeding. The risk of the medication compared to the risk of not breastfeeding should be evaluated and discussed with the patient. When necessary, identify alternative medications that are safe while breastfeeding.

Rule of Thumb:

- Do not recommend breastfeeding cessation as a first-line intervention if a mother is taking a medication. Always look up the safety profile of the medication first before giving advice. When in doubt, check it out!
- If drug is commonly prescribed to infants, it is likely safe to take while breastfeeding.
- A medication which is contraindicated during pregnancy may not necessarily be contraindicated while breastfeeding. The mechanism of drug entry into mother's milk differs significantly from that drug entry during pregnancy. Furthermore, the effects of a medication on a fetus are potentially more harmful than the effects of the same medication on an infant, which are further affected by the gestational age and the chronological age of the nursing child when the drug is taken by the mother.

Commonly used OTC drugs that are considered safe while breastfeeding	
Acetaminophen (Tylenol)	Ibuprofen (Advil, Motrin)
Cephalosporin (Keflex)	Penicillin (Amoxicillin)
Famotidine (Pepcid)	Cimetidine (Tagamet HB)
Fluconazole (Diflucan)	Loratadine (Claritin, Alavert)
Fexofenadine (Allegra)	Nyquil/Dayquil
Ranitidine (Zantac)	Cetirizine (Zyrtec)
Mylanta/Maalox/Rolaids	Lansoprazole (Prevacid)
Omeprazole (Prilosec)	Docusate (Colace)
Diphenhydramine (Benedryl)	Oxymetazoline (Afrin)

Note:

- Aspirin (Bayer): Consider ibuprofen or acetaminophen as a better choice. If using aspirin, wait 2-3 hours after consumption before breastfeeding.
- Naproxen (Aleve): Amount transferred via milk is minimal, use with caution due to long half-life.
- Medications containing pseudoephedrine (Sudafed, Zyrtec D, Robitussin) can decrease milk supply; therefore, these should be avoided if possible.

Useful Resources:

- Infant Risk Center
  Texas Tech University Health Sciences Center
  www.infantrisk.com; 1-806-352-2519
  Monday-Friday, 8am-5pm, central time
- LactMed®
  Database that contains information on drugs and other chemicals to which breastfeeding mothers may be exposed. It includes information on the levels of such substances in breastmilk and infant blood, and the possible adverse effects in the nursing infant. Suggested therapeutic alternatives to those drugs are provided, where appropriate. All data are derived from the scientific literature and fully referenced. A peer review panel reviews the data to assure scientific validity and currency.
  https://toxnet.nlm.nih.gov/newtoxnet/lactmed.htm
- AAP 2013 statement: The Transfer of Drugs and Therapeutics Into Human Breast Milk: Update on Selected Topics, found here:
  http://pediatrics.aappublications.org content/132/3/e796

Use of Mood Disorder Medications

Postpartum depression is one of the most common complications of pregnancy. Infants of depressed mothers show less engagement and eye contact, and are at risk for failure to thrive, attachment disorder, and developmental delay. As always, the risk-benefit ratio comparing medical treatment and breastfeeding should be evaluated and discussed with the patient. However, most mothers requiring anti-depressants can still breastfeed if they desire, as there are a number of anti-depressants which are relatively safe in lactation. Manage on a case-by-case basis.

Mood Disorder Medication Considerations, by Drug

(Refer to LactMed for updated information):

Drug:	Note:
Fluoxetine (Prozac)	• Effects in the newborn including crying, irritability, decreased feeding, and decreased weight gain have been documented • Breastmilk concentrations are higher compared to other SSRI's
Sertraline (Zoloft)	• Transfer to infant is minimal • Generally preferred over fluoxetine when possible
Escitalopram (Lexapro)	• The drug and its metabolite were detected at low levels in most infants tested • Infant sedation may occur especially if taken with other psychotropic drugs
Citalopram (Celexa)	• Effects in the newborn including hypotonia, colic, decreased feeding and sleep difficulties have been documented
Paroxetine (Paxil)	• Generally considered safe as milk levels are very low • Occasionally, infant restlessness and increased crying have been reported
Venlafaxine (Effexor)	• Poor feeding, jitteriness, respiratory distress and myoclonic seizure-like activity may occur, typically between birth and day 4 of life with resolution by 2-21 days of life. Close monitoring is recommended. Adverse effects may be partially relieved when venlafaxine is received through breastmilk.
Duloxetine (Cymbalta)	• Limited data is available • Infant drowsiness, maternal galactorrhea has been reported
Fluvoxamine (Luvox)	• Amounts transferred to infant with plasma levels are generally low in infants
Bupropion (Wellbutrin)	• Low transfer to infant • May suppress milk production • Infant vomiting, diarrhea, jitteriness, sleepiness, low tone and seizure reported in mothers taking bupropion + SSRI combination

Resource:

• Yad Rachel
Community based organization servicing families in Lakewood, dedicated to helping women suffering from or at risk for perinatal mood disorder.
Location: 902 E. County Line Road, Lakewood, NJ 08701
IMA line: 732-364-4462, M-Th 10am-1pm & 8pm-10pm

• "Speak Up When You're Down"
New Jersey's Postpartum Depression Helpline
1-800-328-3838

• The Center for Perinatal Mood & Anxiety Disorders
Monmouth Medical Center Southern Campus
Barnabas Health 732-923-5573

Cannabis (Marijuana)

The fact that marijuana is legal in many states may give the impression the drug is harmless during pregnancy, especially the use for nausea with morning sickness. Based on limited data, there is cause to be concerned about how the drug will impact the long-term development of children, including risk for neurodevelopmental impairments. Research does show that cannabis smoke exposure increases risk for asthmatic symptoms in the exposed infant. Parents who use cannabis also show impaired ability to execute appropriate and safe parenting behaviors. Lastly, families using cannabis are at higher risk for intervention from Child Protective Services and associated legal implications.

- Allow breastfeeding if desired, but clearly state recommendations to avoid cannabis use for at least the duration of breastfeeding, and while engaged in the care of the child for the long term thereafter.
- Consider urine toxicology screening in mothers if there is suspicion for use but mother denies.
- Recommend and encourage other therapeutic options (that are suitable for lactation) in cases where cannabis is being used to treat maternal health conditions during breastfeeding.
- Educate parents on the risk of possible adverse neurodevelopmental outcomes, asthma, and poor parenting decisions when using cannabis.
- Avoid any form of smoking, whether it is cannabis, tobacco, or other substances, in the same room with infant.
- Avoid infant's contact with clothing or other items that may have residue.

Note: Cannabis compounds, especially when consumed chronically, may appear in breastmilk for days to weeks after use and in the mother's urine and in infant's urine and feces.

Bottom line: The American Academy of Breast-feeding Medicine, the American College of Obstetricians and Gynecologists, and the American Academy of Pediatrics recommends women to avoid cannabis use while pregnant or nursing a child.

Breastfeeding and Illicit Drugs

According to the Academy of Breastfeeding Medicine, providers should "Encourage stable methadone- or buprenorphine-maintained women to breastfeed regardless of dose."

Studies show that only a small amount of methadone passes through the breastmilk to baby, even higher doses (105 mg/day). When a mother on methadone begins nursing in the hospital but has an abrupt cessation of breastfeeding, her infant may develop neonatal abstinence syndrome (NAS). About half of all infants born to mothers treated with methadone may experience withdrawal symptoms or NAS. Several studies indicate that NAS may be less frequent or less severe in women who breastfeed.

Drugs that are considered incompatible with breastfeeding:

- Cocaine
- Recreational Methamphetamine (controlled administration for treatment of ADHD is permitted)
- Heroin

What do we know about opioid medications in mothers' milk?

Presence in milk depends on certain factors such as:

- Size of drug molecule
  Drugs pass through breastmilk from mother to baby through passive diffusion. The larger the molecule, the less likely to pass through breastmilk. Methadone and buprenorphine have a higher molecular weight, thus do not transfer through so easily.

- Oral/gut availability
  Substances that are poorly absorbed via the oral route are less likely to get into the milk or into the baby via the milk. For example, buprenorphine has very poor oral availability.

- Half-life of the drug
  Choose the drug with the shorter half-life when possible (ex. Half-life for buprenorphine is 23-30 hours versus the half-life for methadone is 13-55 hours.)

- Fat solubility
  Highly fat soluble medications are more likely to enter breastmilk.

- Protein-binding
  Highly protein bound drugs pass poorly into milk (ex. methadone).

Things to consider:

Individuals who are using illicit drugs are more susceptible to:

- Impact of drug use on parenting skills
- Polysubstance and/or alcohol abuse
- Potential human immunodeficiency virus (HIV) positive status (which is contraindicated for breastfeeding)
- Hepatitis C infection (not a contraindication for breastfeeding)
- Poor nutrition
- Mental health issues (ex. depression)

What to do…

- Refer to a lactation consultant.
- Close follow-up is critical. Perform routine assessments with infant's weight gain and growth.
- Relapse in maternal illicit drug use should prompt re-evaluation of whether breastfeeding is safe for the dyad.

When NOT to Breastfeed:

The infant whose mother:

- Has been infected with HIV
- Is taking antiretroviral medications
- Is infected with human T-cell lymphotropic virus (HTLV) type I or type II
- Is using or is dependent upon an illicit drug
- Is taking prescribed cancer chemotherapy agents, such as antimetabolites that interfere with DNA replication and cell division (although it is possible to breastfeed between courses of chemotherapy if the mother wishes and feels up to it).
- Is undergoing radiation therapies; however, some nuclear medicine therapies require only a temporary interruption in breastfeeding.
    - Nuclear Medicine Therapy Information: https://www.medsmilk.com/pages/radioisotopes-in-lactation

      https://www.nrc.gov/docs/ML1728/ML17281A005.pdf

      https://www.mpcphysics.com/documents/MPCBreastFeedingReccommendations.pdf)

Other scenarios to consider:

Galactosemia: There are special considerations for the infant who has a confirmed diagnosis (which includes an evaluation from a geneticist) of galactosemia. If the geneticist puts an infant on a galactose-free formula while a complete diagnosis is confirmed, mom can pump breastmilk to keep up supply rather than complete cessation. Then, if the infant does not have galactosemia (or has a mild variant), some or all breast-feeding can be resumed.

Tuberculosis: For the mother who has active tuberculosis, the mother can express breastmilk and store it. The infant can receive the milk via a third party to avoid airborne transmission from mother to infant. Breastfeeding may be resumed once the mother is stable on anti-tubercular medications and is allowed to be with the infant.

Consultation with a trained lactation professional on how to manage the breastfeeding dyad is important so that care can be customized according to the individual situation.

Community Support Resources

Ocean County Health Department WIC Program: Conveniently located at 6 sites throughout Ocean County and is initiating mobile WIC services beginning in 2019. WIC is a supplemental nutrition program aimed at improving the nutritional status of women, infants and children. WIC provides supplemental, nutritious foods to low-income families. Additionally, WIC provides participants with access to a number of resources, including health screening, nutrition and breastfeeding counseling, immunization education and referrals to health and social services. Families may qualify for the WIC Program if they are participating in the SNAP Program or NJ Family Care.

WIC knows breastfeeding! The OCHD WIC Program has breastfeeding peer counselors and international board certified lactation consultants available to assist moms with breastfeeding education, support and consultations. Support is available on the phone, in the clinic and during home visits. WIC breastfeeding staff is available to answer questions, help moms get breastfeeding off to a good start, consultations with proper latch and positioning, information for moms returning back to work or school, obtaining a breast pump, and additional breastfeeding aids.

ZipMilk: Website that provides listings for breastfeeding resources sorted by ZIP Code. It is designed for use by consumers interested in help or support for breastfeeding, as well as by providers who want to give their clients access to such resources.

ZipMilk.org

Monmouth Ocean Breastfeeding Consortium: Find a listing of lactation professionals, breastfeeding guides in various languages, and helpful breastfeeding handouts.

http://njbreastfeeding.org/

BRICK
Brick Presbyterian Church WIC Program 111 Drum Point Road Tuesdays, 9:00am-3:00pm 732-370-0122, #6
Ocean Medical Center 425 Jack Martin Blvd 1-800-560-9990 Breastfeeding class: 'Nursing Your Newborn' Fee: $50; waived for HealthStart and Medicaid participants Time: 1st Tuesday of the month, 7pm-9:30pm For: Expectant mother and 1 support person
JACKSON
The Center for Breastfeeding at Meridian Health Village 27 South Cooks Bridge Road, Suite 2-20 Appointments: Monday 9:00am-3:00pm 732-776-3329
LAKEWOOD
Ocean County Health Department WIC Program, Northern campus 1771 Madison Ave Monday-Friday, 8:00am-4:30pm 732-370-0122, #6
Ocean Health Initiatives WIC Program 101 2nd Street Monday, Thursday, and Friday, 9:00am-3:00pm 732-370-0122, #6
Chaya Millet, IBCLC Lakewood La Leche League Phone support: 8:30pm-9:30pm 732-364-4758
Private Practice Malka Weldler, IBCLC 718-916-2437 mweldler11@gmail.com

MANAHAWKIN
Ocean County Health Department WIC Program, Southern campus 333 Haywood Rd Monday, Wednesday and Friday, 8:00am-4:30pm 732-370-0122, #6
Southern Ocean Medical Center 1140 Route 72 W, Conference Room 1 1-800-560-9990 Breastfeeding class: 'Nursing Your Newborn' Fee: $50; waived for HealthStart and Medicaid participants Time: 4th Wednesday of the month, 7:00pm-9:00pm For: Expectant mother and 1 support person
TOMS RIVER
La Leche League 2nd Tuesday of each month, 9:45am Pleasant Plaza, Gymboree 1333 Route 9 Sue: 848-448-0130 Lucia: 609-335-0399 Laura: 732-278-7771
Ocean County Health Department WIC Program, Main campus 175 Sunset Ave. Monday-Friday, 8:00am-4:30pm 732-370-0122, #6
Ocean Health Initiatives WIC Program 301 Lakehurst Rd Tuesday & Thursday, 9:00am-11:00am 732-370-0122, #6
Community Medical Center 732-557-8034 Breastfeeding class Fee: $25 Time: 3rd Tuesday of the month, 7:00pm-9:30pm
Private Practice Lactation Consultant Sue Hudler, RNC, IBCLC H: 732-270-6143 C: 848-448-0130 suehudlerrnc@gmail.com

"She needs to have cheerleaders. If the people closest to her aren't rallying for her, it's not going to work."

Mary Unagnst. IBCLC on the importance of a support system for breastfeeding mothers

@workingbirth

Breastfeeding Websites

The Academy of Nutrition and Dietetics statement:
http://www.eatrightpro.org/~/media/eatrightpro%20files/practice/position%20and%20practice%20papers/position%20papers/promotingbreastfeeding.ashx

The National Association of Pediatric Nurse Practitioners statement:
http://www.jpedhc.org/article/S0891-5245(12)00187-3/abstract

The American College of Nurse Midwives statement:
http://www.midwife.org/ACNM/files/ACNMLibraryData/UPLOADFILENAME/000000000248/Breastfeeding-statement-Feb-2016.pdf

Association of Women's Health, Obstetric, and Neonatal Nurses statement:
https://www.jognn.org/article/S0884-2175(15)31769-X/pdf

Lamaze International statement:
http://www.lamazeinternational.org/p/cm/ld/fid=123

Breastfeeding Toolkit. American College of Obstetricians and Gynecologists website. https://www.acog.org/About-ACOG/ACOG-Departments/Toolkits-for-Health-Care-Providers/Breastfeeding-Toolkit.

Medications and breastfeeding:
https://toxnet.nlm.nih.gov/newtoxnet/lactmed.htm

How to hand express:
http://med.stanford.edu/newborns/professional-education/breastfeeding/hand-expressing-milk.html

U.S. Department of Health and Human Services:
https://www.womenshealth.gov/breastfeeding/

Centers for Disease Control and Prevention:
www.cdc.gov/breastfeeding/

The Academy of Breastfeeding Medicine:
www.bfmed.org

United States Breastfeeding Committee:
www.usbreastfeeding.org/

American Academy of Family Physicians:
www.aafp.org/about/policies/all/breastfeeding-support.html

AAFP-Breastfeeding Support and Resources Toolkit:
www.aafp.org/patient-care/public-health/breastfeeding/toolkit.html

USDA FNS WIC:
www.fns.usda.gov/wic/breastfeeding-promotion-and-support-wic

Ban the Bags website: https://banthebags.org/

The American Congress of Obstetricians and Gynecologists:
www.acog.org/About-ACOG/ACOG-Departments/Breast-feeding

National Institute for Children's Health Quality (NICHQ):
https://www.nichq.org/project/best-fed-beginnings

La Leche League International: www.llli.org/

Find lactation specialist/support in your area:
www.zipmilk.org/ or www.ilca.org

Baby Friendly USA: http://www.babyfriendlyusa.org/

ACOG's "Optimizing Support for Breastfeeding as Part of Obstetric Practice":
www.acog.org/Resources-And-Publications/ Committee-Opinions/Committee-on-Obstetric-Practice/ Optimizing-Support-for-Breastfeeding-as-Part-of-Obstetric-Practice

Breastfeeding USA: https://breastfeedingusa.org/

CME
Continuing Medical Education

Access online at:

Expanding Clinicians' Roles in Breastfeeding Support
The two 1.5 hour tutorials together provide 3 hours of breastfeeding education that is aligned with the content expected for physicians providing care in Baby-Friendly Hospital facilities.

Continuing Medical Education (CME) Online Tutorial (CME#1) 1.5 CME

- Section 1: Current AAP Guidelines on Breastfeeding
- Section 2: Breastfeeding Background
- Section 3: Role of Broader Factors in Infant Feeding Decisions and Practices
- Section 4: Breastfeeding Management and Troubleshooting
- Section 5: Successful Breastfeeding Requires Support
- Section 6: Integrative Case Studies
- Section7: Resources and Posttest

Focus on Maternal & Infant Care Prenatally and During the Hospital Stay: Continuing Medical Education (CME) Online Tutorial (CME#2) 1.5 CME

- Section 1: Prenatal Activities
- Section 2: Maternity Care Practices
- Section 3: Maternity Care Challenges
- Section 4: Special Topics
- Section 5: Integrative Case Studies
- Section 6: Resources and Posttest

http://www.hriainstitute.org/breastfeedingcme/

Supporting and Promoting Breastfeeding in Health Care Settings
4 modules, via webinar

- Prenatal Care
- Hospital Care Part 1
- Hospital Care Part 2
- Early Postpartum/Postnatal Care

1 hr CME/module
Authors/affiliations: School of Public Health, University at Albany, State University of New York
Cost: free
http://www.albany.edu/sph/cphce/preventionagenda_breastfeeding.shtml

Wellstart International
FREE, download on PDF and print, read at your own pace
www.wellstart.org

Breastfeeding Friendly Performance Improvement
This activity has been approved by the American Board of Pediatrics for 10 Part 2 and 25 Part 4 Maintenance of Certification points and by the University of Virginia Office of Continuing Medical Education for a maximum of 20 PI-CME AMA PRA Category 1 Credits™. This activity has been approved by the American Board of Family Medicine for Maintenance of Certification for Family Physicians Part IV credit.

Cost $275 (no cost to Virginia residents)
Authors and affiliations: University of Virginia Health System, Virginia Department of Health, Virginia Chapter of the American Academy of Pediatrics
https://bfconsortium.org/

Lactation Education Resources
Lactation Management Training: From novice to expert. Online courses for a fee. CERPs, CPEs, RN contact hours, NICU training, BFHI training
https://www.lactationtraining.com/

Breastfeeding Essentials for Doctors
Provider information and assess breastfeeding women; Manage the breastfeeding dyad; Manage abnormal situations for the breastfeeding dyad
CME - 4 hrs
Cost: $65-$100/participant depending on the number of participants
Authors/affiliations: Wendy Brodribb, MBBS, IBCLC, PhD, and Denise Fisher, AM, MMP, BN, IBCLC and Step 2 Education
https://step2education.com/courseprice

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Ocean County Health Department

Women, Infants and Children (WIC) Division