

SAMPLE LACTATION POLICY

for Clinics and Medical Offices

[Practice / Office Name]

Breastfeeding Family Friendly Communities

breastfeedingcommunities.org

Contributors

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Aligned with the recommendations of the American Academy of Family Physicians, the Academy of Breastfeeding Medicine, the World Health Organization, and the National Academies' 2024 report Breastfeeding in the United States.

HOW TO USE THIS TEMPLATE

Replace every bracketed field with your practice's information. Where this template offers alternative wordings, they appear in labeled OPTION boxes — choose the one that fits your practice and delete the others. The green IN PLAIN LANGUAGE boxes translate policy provisions for quick staff reference; keep them, adapt them, or remove them as you prefer. A patient-facing summary designed for your waiting room accompanies this template as a separate one-page document.

A lactation policy should always start with the why — why does your practice believe in this work? A comprehensive lactation policy addresses equity and inclusive language in the practice: how you reduce the structures that create barriers for families of color to provide human milk, how you identify inequities to ensure adequate lactation support, how you use in-clinic skilled lactation support or determine referrals, and how you decide when formula is medically necessary.

RECOGNITION OF THE HEALTH ADVANTAGES

In recognition of the well-documented health advantages of chest/breastfeeding and the particularly important role of the medical provider in supporting, promoting, and protecting chest/breastfeeding, [Office] observes the following policy to ensure a supportive environment and practices that can optimize breastfeeding success for our patients. This includes breastfeeding, chestfeeding, other forms of human milk feeding, and body feeding (all of which may be referred to as “breastfeeding,” for simplicity, in this policy). This plan is aligned with the recommendations of the American Academy of Family Physicians (AAFP), the Academy of Breastfeeding Medicine (ABM), and the World Health Organization (WHO).

PHILOSOPHY

OPTION A — OPENING STATEMENT

Human milk feeding has been shown to be the preferred form of infant nutrition. Alternate forms of infant feeding carry known health, social, and economic risks to both parent and baby. To support families who are human milk feeding — whether breastfeeding, chestfeeding, or feeding expressed human milk — [Office] subscribes to the following policy:

OPTION B — OPENING STATEMENT

Because chest/breastfeeding has been shown to be the superior form of infant nutrition, and because alternate forms of infant feeding carry significant health, social, and economic risks to both parent and baby, [Office] subscribes to the following policy:

- We will make a deliberate and diligent effort to be inclusive and welcoming of all patients, starting with our terminology. Human milk feeding is a gender- and anatomically-neutral term, while maintaining medical accuracy. We support all human milk feeding, breastfeeding, and chestfeeding families inclusive of their race, ethnicity, immigration status, nationality, creed, age, sexual orientation, gender identity, family structure, primary language, ability, or class. Every service described in this policy is provided under a universal access and inclusive design model: it is available to every patient and family, and no service is denied to anyone, or conditioned on any demographic characteristic, on the basis of race, color, ethnicity, national origin, immigration status, religion or creed, age, sex, pregnancy or lactation status, sexual orientation, gender identity, family structure, primary language, ability or disability, veteran or military status, or socio-economic status.
- We recognize that nursing families are vulnerable during the early days and weeks, and that suggesting formula use or promoting formula through free samples and advertisements can undermine the parent's confidence that they can successfully meet their nursing goals.
- We support the right of all parents to make informed decisions about infant feeding — breastfeeding, chestfeeding, and other forms of human milk feeding — and all of our staff will support families in their decisions. We protect human milk feeding by allowing no advertising or distribution of formula or feeding supplies within our office.

- The WHO and AAFP recommend exclusive chest/breastfeeding for the first 6 months, and continued chest/breastfeeding with complementary foods until 12 months and beyond, for as long as parent and baby desire; the WHO recommends breastfeeding for two years or beyond. We will support families in achieving their own breastfeeding successes, whatever those may be.

IN PLAIN LANGUAGE

Every family is welcome, every service is for everyone, and our job is to help each family meet their own feeding goals — never to judge them.

PROMOTING LACTATION — ACTIVELY AND PASSIVELY

Active Promotion

Obstetric patients will receive comprehensive and accurate information regarding human milk feeding — including the benefits of human milk, establishing and maintaining milk supply, the benefits of skin-to-skin contact, and the health and mental-health benefits for the feeding dyad. Printed material must NOT be sponsored by or contain advertisements for formula. Clinicians providing prenatal care, individually and via Centering, will be trained to include discussion of feeding modalities throughout pregnancy, with educational materials and community resources distributed during each trimester.

Passive Promotion

No formula samples, literature, or promotional items from formula companies shall be visible to patients — including posters, cups, pens, pads of paper, lanyards, and name badges. This clinic shall maintain a supportive human milk feeding environment.

ALWAYS WELCOME AND RESPECTED

Within our clinic, parents may chest/breastfeed their children in any location in which they are comfortable. If they request a more private location, they may use an unoccupied exam room or the clinic's designated space. At [Office], families are always welcome and respected. They will never be treated poorly, asked to stop breastfeeding or human milk feeding, or asked to cover up or move.

LACTATING EMPLOYEES

OPTION A

All lactating employees are allowed breaks to express milk or nurse their children. Our office provides access to a private space for expressing milk or nursing. The space is not a bathroom, is lockable and shielded from view, includes an electrical outlet, and has hand hygiene available.

OPTION B

Lactating staff may schedule breaks for milk expression. A designated space — not a bathroom or toilet stall — is available during the workday. Milk may be stored in the kitchen refrigerator or a personal cooler. Other arrangements or concerns can be addressed with [Dr. Name].

OPTION C

Staff members who are human milk feeding will have access to a private space, distinct from the lavatory, to feed or express milk with sufficient time for pumping or feeding. The space includes an electric outlet and access to hand hygiene, and a staff-only refrigerator is available for safe milk storage.

FORMULA USE AND THE WHO CODE

OPTION A

We protect human milk feeding by allowing no advertising or coupons for formula to families. The clinic shall comply with the WHO International Code of Marketing of Breast-milk Substitutes. No formula samples or formula-company gift packs shall be distributed to pregnant patients or new parents, and we do not distribute formula or other feeding supplies within our office.

OPTION B

The clinic will comply with the WHO International Code of Marketing of Breast-milk Substitutes. No formula samples or gift packs shall be distributed to pregnant or lactating persons, and human milk feeding will be passively promoted by keeping formula samples, literature, and promotional materials out of the clinic entirely. If formula is required in the clinic for medical reasons, it will be purchased by the clinic — never obtained through free samples from formula companies.

IN PLAIN LANGUAGE

If a baby medically needs formula, we buy it ourselves and discuss all the options with the family — formula companies get no marketing channel through this office.

STAFF RESPONSIBILITIES

OPTION A

Physicians, advanced practice providers, and nurses are expected to maintain accurate and current knowledge regarding the benefits of human milk feeding, normal infant feeding patterns, human milk feeding as it relates to mental health, and the basics of feeding problems. Copies of resources should be made available in the clinic and all staff members, including clerical staff, should be familiar with these resources. All physicians, advanced practice providers, nurses and CMAs who are serving pregnant or postpartum patients, infants and children will complete an annual 3-hour online human milk feeding training. This includes all staff who interact with this patient population through direct care, clinical supervision, triage, education, and in-clinic encounters. New staff and providers will complete this training within 3 months of hire.

OPTION B

Physicians and nurses are expected to maintain accurate, current knowledge regarding all forms of lactation and human milk feeding. Copies of resources are available in the clinic and are familiar to all staff members, including clinical and clerical staff. References for telephone triage of human milk feeding questions are available and should be consulted when answering patient concerns. Designate a qualified staff person(s) to be available to answer questions or provide patient assistance.

Staff is responsible for:

- Reading and understanding this policy.
- Attending appropriate lactation training according to one's role in the office.
- Providing a welcoming attitude and environment for breastfeeding/chestfeeding/human milk feeding families.
- Providing follow-up and referrals, as indicated.

Leadership

A point person ([Dr. Name]) within [Office] has been identified to oversee the details of this Policy and will facilitate communication and modifications as necessary.

Training Topics

Each member of our staff receives regular lactation training and updates according to their role, covering: basic lactation management; supply and demand; building a milk supply; latch and positioning; hand expression; feeding cues; newborn behavior; expectations by age; resources and referrals; using a breast pump; triage protocol; and cultural considerations.

Triage

Human milk feeding clinical questions will be triaged and answered promptly — same day during business hours. Patients calling about feeding problems are given an appointment within 24 hours or the next business day. Telephone triage references are available and consulted when answering patient concerns, and qualified staff are designated to answer questions and provide assistance. The triage protocol is reviewed regularly and updated as necessary.

- New or established patients who request appointments for acute human milk feeding concerns (pain, fever, concerns about supply and baby's weight gain, etc.) or for newborns discharged from the hospital or birthing center, will be triaged by a medical assistant to determine when to schedule them. If there are questions regarding the urgency, the MA will discuss the situation with [Dr. Name] to determine appropriate scheduling and, if indicated, measures to try before the appointment.
- Most patients with acute need will be scheduled within 24 hours with [Dr. Name] or another provider who can consult with [Dr. Name] if needed.
- Newborn human milk feeding infants will be given an appointment within the first three days of discharge from the birthing facility (or sooner if discharge instructions specify this, or parents have acute concerns).
- New or established patients who wish to discuss inducing lactation, re-lactating, or chestfeeding may be able to wait a few days or weeks for an appointment, if they anticipate having at least several months before the baby is due. If the baby has already been born, or there is less than 5–6 months before the baby is due, an appointment with [Dr. Name] will be made within a week.

Triage tools for MAs and providers include:

- The Outpatient Breastfeeding Champion triage book
- Nancy Mohrbacher's book or app
- Lactation Associated Pain Protocol
- Mastitis Not Responding To Antibiotics / Suspected Abscess guidance
- Medications in Lactation
- Radiologic Imaging of Pregnant or Lactating Patients

IN PLAIN LANGUAGE

A feeding crisis cannot wait a week. Same-day answers, next-day appointments, and a newborn visit within three days of discharge.

PATIENT EDUCATION

Educational and support resources to promote human milk feeding will be available to patients. All clerical personnel will be familiar with these documents and how to locate them within the clinic. A comprehensive educational packet and community resource list will be available and updated annually. This will include factsheets, links to websites and videos about human milk feeding, as well as local organizations that support human milk feeding and young families. Funding will be obtained to maintain a stock of electric pumps and other feeding supplies, pillows, storage containers, pads, etc. for those who are human milk feeding and do not have other means to obtain these resources (i.e., insurance, WIC, other community organizations).

- Education: breastfeeding, chestfeeding, and human milk feeding education and resources are provided to patients during pregnancy, the adoption process, postpartum, and/or well-baby/child visits according to the scope of practice of this medical office. Education follows a [periodicity table or other protocol (see appendix)] to optimize messages, and resources are based on families' needs.
- Classes: all human milk feeding families are provided with information and referrals for classes and support groups, as locally available.
- Environment: [Office] has fostered an environment in the waiting area, exam rooms, and other spaces that is fully supportive of and optimizes chest/breastfeeding success for our patients. This clinic will maintain a supportive human milk feeding environment for both patients and staff.
- Patients within our clinic may feed their children in any location in which they are comfortable. If they request a more private location, they may use the clinic's designated space. Staff will be trained to never ask lactating patients to cover up, move, or stop feeding.

- Visual cues to support and welcome human milk feeding in our office will include signs and posters in the waiting area as well as in exam rooms and lavatories. Signs and posters will be representative of the patient population we serve, so patients are able to see images that look like them.
- Formula: we protect chest/breastfeeding by allowing no visible display of formula messaging from formula companies. We do not provide formula samples or free gifts that are provided by formula companies.

EVALUATION AND SUSTAINABILITY

- Documentation: [Office] documents breastfeeding information in electronic medical records to understand our population's breastfeeding rates and improve office policies and practices.
- Billing: lactation education and services are billed with appropriate ICD-10-CM codes following best practices for optimal reimbursement; the billing specialist receives regular lactation training, and patients are notified of our billing practices.

CONTINUITY OF CARE

- Follow-up: a protocol ensures follow-up for the breastfeeding infant within the first three days of discharge from the birthing facility (see Appendices 1 and 2).
- Referrals: [Office] maintains a regularly updated list of lactation management professionals and specialists in our community to facilitate referrals (in Durham, see breastfeeddurham.org).
- References: lactation-related reference books and materials are available within [Office] and replaced as updates are released, with special attention to lactation management, medications, and triage protocols.

Together, these provisions connect our clinical care to community support — the continuity of care described in NACCHO's Continuity of Care in Breastfeeding Support: A Blueprint for Communities — so no family loses support in the handoff from hospital to office to home.

SOURCES

The following Lactation Policy was adapted from the following sources:

- Academy of Breastfeeding Medicine Protocols
- Academy of Breastfeeding Medicine Clinical Protocol #2: Guidelines for Birth Hospitalization Discharge of Breastfeeding Dyads, Revised 2022
- ABM Clinical Protocol #14: Breastfeeding-Friendly Physician's Office — Optimizing Care for Infants and Children
- ABM Clinical Protocol #19: Breastfeeding Promotion in the Prenatal Setting, Revision 2015
- ABM Clinical Protocol #33: Lactation Care for Lesbian, Gay, Bisexual, Transgender, Queer, Questioning, Plus Patients
- The Historical, Psychosocial, and Cultural Context of Breastfeeding in the African American Community
- Breastfeeding, Family Physicians Supporting (Position Paper) | AAFP
- Making Breastfeeding Work for Medical Offices Colorado — A Six-Point Plan
- Adapted from the Mississippi Breastfeeding Coalition's Building Breastfeeding Friendly Communities project by the Wisconsin Department of Health and Family Services in collaboration with the Wisconsin Breastfeeding Coalition, Division of Public Health

APPENDIX 1 — SPECIFIC RECOMMENDATIONS FOR CLINICAL MANAGEMENT

Preconception and Prenatal Education

- Ensure that all discussions take place in a culturally sensitive manner.
- Address the infant feeding decision before conception or as early in pregnancy as possible. Prenatal intention to breastfeed affects initiation and duration of breastfeeding. Continue to bring up the issue of infant feeding and express support for breastfeeding throughout the prenatal period. Provide appropriate education and anticipatory guidance to encourage breastfeeding and determine what support is needed to make and carry out this decision.
- Elicit any factors in the family medical history that may make breastfeeding especially important (e.g., atopic diseases, diabetes, obesity, cancers) and provide counseling and advice specific to these factors.
- Elicit any risk factors for potential breastfeeding problems and any medical contraindications to lactation. Provide appropriate support and education.
- For previous births, document the duration of lactation for each infant, reasons for weaning, and any problems that occurred (if possible, document this history and include the labor history of each infant). For the current pregnancy (or pending adoption, if appropriate), document a plan for intervention, including lactation consultation if indicated, on the patient's record.
- Encourage the participation of the patient's support network and educate them as appropriate. Remember that anyone present during a patient's prenatal visits or hospital stay is likely to have influence over breastfeeding and other health care decisions.
- Recognize the feelings of relatives who did not breastfeed or who weaned prematurely. Encourage them to learn what is known about breastfeeding for the optimal health of the parent and baby.
- Encourage the parent and people from their support network to attend breastfeeding classes and/or support group meetings during the prenatal period.
- Provide accurate, noncommercial breastfeeding literature and recommend accurate lay breastfeeding resources (e.g., books, websites).
- Provide education regarding potential breastfeeding problems associated with the use of intrapartum analgesia and anesthesia. Encourage the use of a labor support person, such as a doula.

Early Postpartum Education and Support

- Advocate for 24-hour rooming-in for the breastfeeding parent and baby.
- Involve family members and others from the support network in breastfeeding education and enlist their support for breastfeeding.
- Ensure that breastfeeding is being adequately assessed on a regular basis by qualified professionals. Advocate for lactation consultation services at all hospitals where maternal and infant care is provided.
- Educate parents about the importance of frequent, unrestricted breastfeeding with proper positioning and latch.
- Help parents recognize the baby's early feeding cues (e.g., rooting, lip smacking, sucking on fingers or hands, rapid eye movements) and explain that crying is a late sign of hunger. It is also important to help them recognize signs that the baby is satisfied at the end of a feeding (e.g., relaxed body posture, unclenching of fists).
- If separation of the parent and infant is necessary, assist with maintenance of breastfeeding and/or ensure that the parent receives assistance with expressing milk. Encourage expression of milk within two hours after being separated from the infant.
- Educate patients about the risks of unnecessary supplementation. The decision to use a pacifier should be based on personal preferences, as the use of pacifiers has not been associated with an increased risk of not breastfeeding in motivated parents.
- Develop an appropriate follow-up plan for any identified problems or concerns.
- Provide the family with information about breastfeeding support groups or other providers who support breastfeeding in the community — including but not limited to lactation consultants, speech therapists who assess infant sucking skills, physicians and dentists who perform frenotomy, and chiropractors and other body workers who are trained to help breastfeeding families. (In Durham see breastfeeddurham.org and Appendix 5.)

Ongoing Support and Management

- Provide evaluation within 24–72 hours after hospital discharge to assess adequacy of milk intake, newborn jaundice, and any breastfeeding concerns. Evaluation may need to occur within 24 hours after hospital discharge if breastfeeding was not going well in the hospital.

- Continue to support breastfeeding throughout the first year of life and beyond at well-child and other visits. Encourage exclusive breastfeeding for the first six months of life.
- Be knowledgeable about prevention and management of common breastfeeding challenges.
- Educate office staff on breastfeeding topics so that they can provide optimal breastfeeding triage and support.
- Develop a working relationship with professionals who have expertise in lactation issues, such as International Board Certified Lactation Consultants (IBCLCs). Consult when breastfeeding concerns exceed your level of expertise.
- Encourage parents who are returning to work to continue to breastfeed.
- Encourage partial breastfeeding for as long as possible if exclusive breastfeeding is not feasible.

Substance Use

See ABM Clinical Protocol #21: Guidelines for Breastfeeding and Substance Use or Substance Use Disorder, Revised 2015. [Complete for your practice, addressing each of the following:] Nicotine · Alcohol · Marijuana · Cannabis (THC) · Methadone · Buprenorphine · Other opioids · The parent with a substance use disorder who has successfully initiated breastfeeding.

APPENDIX 2 — SPECIFIC RECOMMENDATIONS FOR ETHNICITY AND CULTURE CLINICAL MANAGEMENT

This appendix provides historical and clinical-education context so that staff can serve every family well. Nothing in it creates, or should be read as creating, any demographic eligibility criterion; all care and lactation support under this policy is provided to all patients on a universal access basis.

There are a number of complex factors that influence the decision to initiate and continue breastfeeding, including those “external” to families, such as cultural beliefs. The cultural context and environment of decision making are illuminated through the prism of traditions and historical and cultural events. The ideology and sentiment of breastfeeding, chestfeeding, and human milk feeding have changed during the course of history and have evolved within the culture communities. Throughout the evolution of infant feeding practices, historical aftermaths have contributed to the legacy and emotional context of infant feeding trends. First-generation immigrants from countries where breastfeeding is the norm are more likely to breastfeed than are second- and later-generation parents. This may be because of convenience, belief in modern food technology, and/or attempts to acculturate into a society where bottle feeding is perceived to be the norm. Thus, breastfeeding role models are lost with successive generations. Additionally, accurate breastfeeding information is less available in the languages of ethnic minorities with smaller U.S. populations.

- **Aware of Personal Biases:** being aware of the impact of the physician's own personal cultural attitudes and implicit biases when interacting with patients.
- **Native Language:** providing all information and instruction, whenever possible, in the patient's native language in a culturally relevant manner and assessing for literacy level, when appropriate.
- **Trauma-Informed Care:** the decision to breastfeed and the act of breastfeeding may remain deeply affected by generational trauma. (1) We talk about how echoes of past oppression create an environment that is ripe for aversion to medical establishment recommendations. (1) We think about how this historical context lends itself to a psychosocial response to infant feeding decision making that is simultaneously steeped in familial or community influence on formula feeding. (1)
- **Moderating Support That Families Need:** data suggest that a family's desires alone are not enough — multiple and complex barriers exist, thus moderating support that families need from health care providers, public health professionals, family members, society, their community, and employers is paramount to meet their breastfeeding goals. (1) We engage all family members in the first few discussions: parents need to be supported by their partner, family, health care providers, and the community to be able to provide their infant the best preventative medicine for a healthy start to life, as well as promoting the critical bonding experiences. We learn about the family structure of our patients — support from key family members may assist greatly in the promotion of breastfeeding.
- **Respectful Care:** promoting respectful care is recognized by [Office] as a critical element to improve the quality of maternity care and add a humanistic approach to patient education and care. (1) Respectful care can be defined as “an approach to care that emphasized the fundamental rights of parents, newborns, and families and that promotes equitable access to evidence-based care, while recognizing the unique needs and preference of both parents and newborns.” (2) Respectful care is touted through education, quality of care, shared decision making, informed consent, dignity, and nondiscrimination, and supports parents in being active decision makers in their birth experience and plans for feeding their infant. (3)
- **Several themes emerge in providing a typology of respectful maternal care,** including being free from harm and mistreatment, maintaining privacy and confidentiality, preserving the family's dignity, prospective provision of information and seeking informed consent, ensuring continuous access to family and community support, enhancing the quality of the physical environment and resources, providing equitable maternity care, engaging with effective communication, respecting families' choices that strengthen their capabilities to give birth, availability of competent and motivated human resources, and provision of efficient and effective care and continuity of care. (2)
- **Respecting cultural traditions and taboos associated with lactation and adapting cultural beliefs to facilitate optimal breastfeeding,** while also sensitively educating patients about traditions that may be detrimental to breastfeeding. There are a number of complex factors that influence the decision to initiate and continue breastfeeding, including those external to families, such as cultural beliefs. (4)

- Ensuring that parents from diverse cultures and family structures understand the importance of breastfeeding to their children's growth and development. Encouraging exclusive lactation in the hospital, when possible, in a culturally sensitive manner. (5)
- Black Families: medical exploitation is one of the many nuanced cultural barriers that denies Black families and infants the many health benefits of breastfeeding. (1) We ensure that staff and providers are informed about the historical influences such as subjugation and marginalization of Black Americans that can contribute to implicit biases when it comes to making health decisions, not necessarily limited to infant feeding. (1) We know that establishing and supporting breastfeeding are critical to success; however, many Black parents decline to breastfeed their infants, possibly considering cultural and historical influences. Thus, the history of breastfeeding and abuse by the medical establishment are critical to the conversation on reproductive justice and birth equity, highlighting the rights of families in both the private and public sphere. (1)
- LGBTQ+ Community: members of the LGBTQ+ community also face significant obstacles to breastfeeding/chestfeeding/human milk feeding. LGBTQ+ communities have been marginalized and experienced discrimination, both inside and outside health care settings. These experiences have led to both psychological pain and disparate health outcomes — most extreme in areas of sexual, reproductive, and mental health. Providing affirming health care, including using correct names and pronouns, and recognizing each person's unique family and community, can help to improve outcomes. (8)

Appendix 2 References

Appendix 2 was adapted from The Historical, Psychosocial, and Cultural Context of Breastfeeding in the African American Community, and the following references: (1) The Historical, Psychosocial, and Cultural Context of Breastfeeding in the African American Community · (2) Respectful Maternity Care: Country Experiences · (3) New York City Department of Health and Mental Hygiene Sexual and Reproductive Justice Community Engagement Group, New York City Standards for Respectful Care at Birth · (4) Factors That Influence Breastfeeding Initiation Among African American Women · (5) ABM Clinical Protocol #2: Guidelines for Birth Hospitalization Discharge of Breastfeeding Dyads, Revised 2022 · ABM Clinical Protocol #14: Breastfeeding-Friendly Physician's Office · ABM Clinical Protocol #19: Breastfeeding Promotion in the Prenatal Setting · (8) ABM Clinical Protocol #33: Lactation Care for Lesbian, Gay, Bisexual, Transgender, Queer, Questioning, Plus Patients.

APPENDIX 3 — PATIENT-FACING POLICY SUMMARY

The patient-facing summary is provided as a separate one-page companion document (BFFC Patient-Facing Lactation Policy), formatted for printing and display in your waiting room. Make it available to patients, and keep the full policy available on request.

APPENDIX 4 — THE TEN STEPS TO SUCCESSFUL BREASTFEEDING

(This does not need to be part of your office policy; the policy uses many of these principles.) The Ten Steps to Successful Breastfeeding were developed by a team of global experts and consist 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. The Ten Steps are:

- Have a written breastfeeding policy that is routinely communicated to all health care staff, and comply fully with the International Code of Marketing of Breast-milk Substitutes.
- Train all health care staff in the skills necessary to implement the breastfeeding policy.
- Inform all pregnant people and their families about the benefits and management of breastfeeding.
- Facilitate immediate and uninterrupted skin-to-skin contact and help families initiate breastfeeding or chestfeeding as soon as possible after birth.
- Show families how to breastfeed and how to maintain lactation, even if they are separated from their infants.
- Give infants no food or drink other than breast milk, unless medically indicated.
- Practice rooming-in — allow parents and infants to remain together 24 hours a day.
- Encourage breastfeeding on demand and support families to recognize and respond to their infant's cues for feeding.
- Give no pacifiers or artificial nipples to breastfeeding infants.
- Foster the establishment of breastfeeding support groups, and refer families to them on discharge from the hospital or birth center.

APPENDIX 5 — RESOURCE LIST

[This resource list will always need to be updated using the Breastfeed Durham website (breastfeeddurham.org). Attune the information below to the culture of your patients, and localize it for your community.]

Support Groups

- Durham-wide list: breastfeeddurham.org/mec-category/parent-information/

Finding Local Providers / Community Resources

- Find a local Lactation Consultant directory: ilca.org/main/why-ibclc/falc
- Locate WIC offices for any state: fns.usda.gov/wic/wic-contacts
- Breastfeeding resources by county: ncbfc.org/perinatal-region-map
- Breastfeed Durham: breastfeeddurham.org
- Breastfeeding support for families of color: breastfeeddurham.org/black-breastfeeding/ (many resources here)
- LGBTQ+ lactation / human milk feeding support: breastfeeddurham.org/lgbtq-human-milk-feeding/ (many resources here)

Mental Health Support

- Postpartum Support International: postpartum.net/get-help/
- Moms Supporting Moms

Milk Bank

- WakeMed Mothers' Milk Bank (to donate or purchase human milk): wakemed.org/mothers-milk-bank

General Information

- Lymphatic drainage of the breast — illustration/instructions (Maya Bolman handout, linked from the online version of this policy)
- Medication safety during pregnancy and lactation — InfantRisk Center: infantrisk.com
- Safety of medications/drugs during lactation — LactMed: ncbi.nlm.nih.gov/books/NBK501922/

Videos

- Hand expression, maximizing pumping results, and more: med.stanford.edu/newborns/professional-education/breastfeeding.html
- Flange fitting · latching, positioning, and hunger cues · asymmetric latch and sandwich hold · paced bottle feeding · reverse pressure softening (video links maintained in the online version of this policy)

Infant Feeding Classes

- breastfeeddurham.org/support-for-families/lactation-support/groups-classes/
- Carolina Global Breastfeeding Institute, online classes: sph.unc.edu/cgbi/ready-set-baby-live-online-classes/
- [Add your local hospital and birth-center classes — e.g., Duke, UNC, WakeMed, WBWC]

Doulas

- breastfeeddurham.org/durhams-ten-steps/breastfeeding-welcome-here/#doulas

Tongue Tie Resources

- [Add your local tongue-tie evaluation and treatment providers]

Lactation Consultants (Specific)

- breastfeeddurham.org/support-for-families/lactation-support/
- [Be specific — name individual lactation consultants your practice refers to]

Chiropractors

- Donna Hedgepeth · Alicia Davis · Lauren Scott · Keystone Chiropractic · Triangle Chiropractic and Rehabilitation Center

Craniosacral Therapists

- [Add your local craniosacral therapists familiar with lactation]

Adapt this policy to your practice. · Breastfeeding Family Friendly Communities · breastfeedingcommunities.org