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Breastfeeding and the Use of Human Milk
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POLICY STATEMENT

Breastfeeding and the Use of Human Milk

SECTION ON BREASTFEEDING

KEY WORDS

breastfeeding, complementary foods, infant nutrition, lactation, human milk, nursing

ABBREVIATIONS

AAP—American Academy of Pediatrics
AHRQ—Agency for Healthcare Research and Quality
CDC—Centers for Disease Control and Prevention
CI—confidence interval
CMV—cytomegalovirus
DHA—docosahexaenoic acid
NEC—necrotizing enterocolitis
OR—odds ratio
SIDS—sudden infant death syndrome
WHO—World Health Organization

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abstract

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Breastfeeding and human milk are the normative standards for infant feeding and nutrition. Given the documented short- and long-term medical and neurodevelopmental advantages of breastfeeding, infant nutrition should be considered a public health issue and not only a lifestyle choice. The American Academy of Pediatrics reaffirms its recommendation of exclusive breastfeeding for about 6 months, followed by continued breastfeeding as complementary foods are introduced, with continuation of breastfeeding for 1 year or longer as mutually desired by mother and infant. Medical contraindications to breastfeeding are rare. Infant growth should be monitored with the World Health Organization (WHO) Growth Curve Standards to avoid mislabeling infants as underweight or failing to thrive. Hospital routines to encourage and support the initiation and sustaining of exclusive breastfeeding should be based on the American Academy of Pediatrics-endorsed WHO/UNICEF “Ten Steps to Successful Breastfeeding.” National strategies supported by the US Surgeon General’s Call to Action, the Centers for Disease Control and Prevention, and The Joint Commission are involved to facilitate breastfeeding practices in US hospitals and communities. Pediatricians play a critical role in their practices and communities as advocates of breastfeeding and thus should be knowledgeable about the health risks of not breastfeeding, the economic benefits to society of breastfeeding, and the techniques for managing and supporting the breastfeeding dyad. The “Business Case for Breastfeeding” details how mothers can maintain lactation in the workplace and the benefits to employers who facilitate this practice. *Pediatrics* 2012;129:e827–e841

INTRODUCTION

Six years have transpired since publication of the last policy statement of the American Academy of Pediatrics (AAP) regarding breastfeeding.¹ Recently published research and systematic reviews have reinforced the conclusion that breastfeeding and human milk are the reference normative standards for infant feeding and nutrition. The current statement updates the evidence for this conclusion and serves as a basis for AAP publications that detail breastfeeding management and infant nutrition, including the *AAP Breastfeeding Handbook for Physicians*,² *AAP Sample Hospital Breastfeeding Policy for Newborns*,³ *AAP Breastfeeding Residency Curriculum*,⁴ and the *AAP Safe and Healthy Beginnings Toolkit*.⁵ The AAP reaffirms its recommendation of exclusive breastfeeding for about 6 months, followed by continued breastfeeding as complementary foods are introduced, with continuation

of breastfeeding for 1 year or longer as mutually desired by mother and infant.

EPIDEMIOLOGY

Information regarding breastfeeding rates and practices in the United States is available from a variety of government data sets, including the Centers for Disease Control and Prevention (CDC) National Immunization Survey,⁶ the NHANES,⁷ and Maternity Practices and Infant Nutrition and Care.⁸ Drawing on these data and others, the CDC has published the “Breastfeeding Report Card,” which highlights the degree of progress in achieving the breastfeeding goals of the Healthy People 2010 targets as well as the 2020 targets (Table 1).^{9–11}

The rate of initiation of breastfeeding for the total US population based on the latest National Immunization Survey data are 75%.¹¹ This overall rate, however, obscures clinically significant sociodemographic and cultural differences. For example, the breastfeeding initiation rate for the Hispanic or Latino population was 80.6%, but for the non-Hispanic black or African American population, it was 58.1%. Among low-income mothers (participants in the Special Supplemental Nutrition Program for Women, Infants, and Children [WIC]), the breastfeeding initiation rate was 67.5%, but in those

with a higher income ineligible for WIC, it was 84.6%.¹² Breastfeeding initiation rate was 37% for low-income non-Hispanic black mothers.⁷ Similar disparities are age-related; mothers younger than 20 years initiated breastfeeding at a rate of 59.7% compared with the rate of 79.3% in mothers older than 30 years. The lowest rates of initiation were seen among non-Hispanic black mothers younger than 20 years, in whom the breastfeeding initiation rate was 30%.⁷

Although over the past decade, there has been a modest increase in the rate of “any breastfeeding” at 3 and 6 months, in none of the subgroups have the Healthy People 2010 targets been reached. For example, the 6-month “any breastfeeding” rate for the total US population was 43%, the rate for the Hispanic or Latino subgroup was 46%, and the rate for the non-Hispanic black or African American subgroup was only 27.5%. Rates of exclusive breastfeeding are further from Healthy People 2010 targets, with only 13% of the US population meeting the recommendation to breastfeed exclusively for 6 months. Thus, it appears that although the breastfeeding initiation rates have approached the 2010 Healthy People targets, the targets for duration of any breastfeeding and exclusive breastfeeding have not been met.

Furthermore, 24% of maternity services provide supplements of commercial infant formula as a general practice in the first 48 hours after birth. These observations have led to the conclusion that the disparities in breastfeeding rates are also associated with variations in hospital routines, independent of the populations served. As such, it is clear that greater emphasis needs to be placed on improving and standardizing hospital-based practices to realize the newer 2020 targets (Table 1).

INFANT OUTCOMES

Methodologic Issues

Breastfeeding results in improved infant and maternal health outcomes in both the industrialized and developing world. Major methodologic issues have been raised as to the quality of some of these studies, especially as to the size of the study populations, quality of the data set, inadequate adjustment for confounders, absence of distinguishing between “any” or “exclusive” breastfeeding, and lack of a defined causal relationship between breastfeeding and the specific outcome. In addition, there are inherent practical and ethical issues that have precluded prospective randomized interventional trials of different feeding regimens. As such, the majority of published reports are observational cohort studies and systematic reviews/meta-analyses.

To date, the most comprehensive publication that reviews and analyzes the published scientific literature that compares breastfeeding and commercial infant formula feeding as to health outcomes is the report prepared by the Evidence-based Practice Centers of the Agency for Healthcare Research and Quality (AHRQ) of the US Department of Health Human Services titled *Breastfeeding and Maternal and Infant Health Outcomes in Developed Countries*.¹³ The following sections summarize and update the AHRQ meta-analyses and provide an expanded analysis regarding health outcomes. Table 2 summarizes the dose-response relationship between the duration of breastfeeding and its protective effect.

Respiratory Tract Infections and Otitis Media

The risk of hospitalization for lower respiratory tract infections in the first year is reduced 72% if infants breastfed exclusively for more than 4 months.^{13,14} Infants who exclusively breastfed for 4

TABLE 1 Healthy People Targets 2010 and 2020(%)

	2007 ^a	2010 Target	2020 Target
Any breastfeeding			
Ever	75.0	75	81.9
6 mo	43.8	50	60.5
1 y	22.4	25	34.1
Exclusive breastfeeding			
To 3 mo	33.5	40	44.3
To 6 mo	13.8	17	23.7
Worksite lactation support	25	—	38.0
Formula use in first 2 d	25.6	—	15.6

^a 2007 data reported in 2011.¹⁰

TABLE 2 Dose-Response Benefits of Breastfeeding^a

Condition	% Lower Risk ^b	Breastfeeding	Comments	OR ^c	95% CI
Otitis media ¹³	23	Any	—	0.77	0.64–0.91
Otitis media ¹³	50	≥3 or 6 mo	Exclusive BF	0.50	0.36–0.70
Recurrent otitis media ¹⁵	77	Exclusive BF ≥6 mo ^d	Compared with BF 4 to <6 mo ^d	1.95	1.06–3.59
Upper respiratory tract infection ¹⁷	63	>6 mo	Exclusive BF	0.30	0.18–0.74
Lower respiratory tract infection ¹³	72	≥4 mo	Exclusive BF	0.28	0.14–0.54
Lower respiratory tract infection ¹⁵	77	Exclusive BF ≥6 mo ^d	Compared with BF 4 to <6 mo ^d	4.27	1.27–14.35
Asthma ¹³	40	≥3 mo	Atopic family history	0.60	0.43–0.82
Asthma ¹³	26	≥3 mo	No atopic family history	0.74	0.6–0.92
RSV bronchiolitis ¹⁶	74	>4 mo	—	0.26	0.074–0.9
NEC ¹⁹	77	NICU stay	Preterm infants Exclusive HM	0.23	0.51–0.94
Atopic dermatitis ²⁷	27	>3 mo	Exclusive BF ^{negative} family history	0.84	0.59–1.19
Atopic dermatitis ²⁷	42	>3 mo	Exclusive BF ^{positive} family history	0.58	0.41–0.92
Gastroenteritis ¹³⁻¹⁴	64	Any	—	0.36	0.32–0.40
Inflammatory bowel disease ³²	31	Any	—	0.69	0.51–0.94
Obesity ¹³	24	Any	—	0.76	0.67–0.86
Celiac disease ³¹	52	>2 mo	Gluten exposure when BF	0.48	0.40–0.89
Type 1 diabetes ¹³⁻⁴²	30	>3 mo	Exclusive BF	0.71	0.54–0.93
Type 2 diabetes ¹³⁻⁴³	40	Any	—	0.61	0.44–0.85
Leukemia (ALL) ¹³⁻⁴⁶	20	>6 mo	—	0.80	0.71–0.91
Leukemia (AML) ¹³⁻⁴⁵	15	>6 mo	—	0.85	0.73–0.98
SIDS ¹³	36	Any >1 mo	—	0.64	0.57–0.81

ALL, acute lymphocytic leukemia; AML, acute myelogenous leukemia; BF, breastfeeding; HM, human milk; RSV, respiratory syncytial virus.

^a Pooled data.

^b % lower risk refers to lower risk while BF compared with feeding commercial infant formula or referent group specified.

^c OR expressed as increase risk for commercial formula feeding.

^d Referent group is exclusive BF ≥6 months.

to 6 months had a fourfold increase in the risk of pneumonia compared with infants who exclusively breastfed for more than 6 months.¹⁵ The severity (duration of hospitalization and oxygen requirements) of respiratory syncytial virus bronchiolitis is reduced by 74% in infants who breastfed exclusively for 4 months compared with infants who never or only partially breastfed.¹⁶

Any breastfeeding compared with exclusive commercial infant formula feeding will reduce the incidence of otitis media (OM) by 23%.¹³ Exclusive breastfeeding for more than 3 months reduces the risk of otitis media by 50%. Serious colds and ear and throat infections were reduced by 63% in

infants who exclusively breastfed for 6 months.¹⁷

Gastrointestinal Tract Infections

Any breastfeeding is associated with a 64% reduction in the incidence of nonspecific gastrointestinal tract infections, and this effect lasts for 2 months after cessation of breastfeeding.^{13,14,17,18}

Necrotizing Enterocolitis

Meta-analyses of 4 randomized clinical trials performed over the period 1983 to 2005 support the conclusion that feeding preterm infants human milk is associated with a significant reduction (58%) in the incidence of necrotizing enterocolitis (NEC).¹³ A more recent

study of preterm infants fed an exclusive human milk diet compared with those fed human milk supplemented with cow-milk-based infant formula products noted a 77% reduction in NEC.¹⁹ One case of NEC could be prevented if 10 infants received an exclusive human milk diet, and 1 case of NEC requiring surgery or resulting in death could be prevented if 8 infants received an exclusive human milk diet.¹⁹

Sudden Infant Death Syndrome and Infant Mortality

Meta-analyses with a clear definition of degree of breastfeeding and adjusted for confounders and other known risks for sudden infant death syndrome (SIDS) note that breastfeeding is associated with a 36% reduced risk of SIDS.¹³ Latest data comparing any versus exclusive breastfeeding reveal that for any breastfeeding, the multivariate odds ratio (OR) is 0.55 (95% confidence interval [CI], 0.44–0.69). When computed for exclusive breastfeeding, the OR is 0.27 (95% CI, 0.27–0.31).²⁰ A proportion (21%) of the US infant mortality has been attributed, in part, to the increased rate of SIDS in infants who were never breastfed.²¹ That the positive effect of breastfeeding on SIDS rates is independent of sleep position was confirmed in a large case-control study of supine-sleeping infants.^{22,23}

It has been calculated that more than 900 infant lives per year may be saved in the United States if 90% of mothers exclusively breastfed for 6 months.²⁴ In the 42 developing countries in which 90% of the world's childhood deaths occur, exclusive breastfeeding for 6 months and weaning after 1 year is the most effective intervention, with the potential of preventing more than 1 million infant deaths per year, equal to preventing 13% of the world's childhood mortality.²⁵

Allergic Disease

There is a protective effect of exclusive breastfeeding for 3 to 4 months in

reducing the incidence of clinical asthma, atopic dermatitis, and eczema by 27% in a low-risk population and up to 42% in infants with positive family history.^{13,26} There are conflicting studies that examine the timing of adding complementary foods after 4 months and the risk of allergy, including food allergies, atopic dermatitis, and asthma, in either the allergy-prone or nonatopic individual.²⁶ Similarly, there are no convincing data that delaying introduction of potentially allergenic foods after 6 months has any protective effect.^{27–30} One problem in analyzing this research is the low prevalence of exclusive breastfeeding at 6 months in the study populations. Thus, research outcomes in studies that examine the development of atopy and the timing of introducing solid foods in partially breastfed infants may not be applicable to exclusively breastfed infants.

Celiac Disease

There is a reduction of 52% in the risk of developing celiac disease in infants who were breastfed at the time of gluten exposure.³¹ Overall, there is an association between increased duration of breastfeeding and reduced risk of celiac disease when measured as the presence of celiac antibodies. The critical protective factor appears to be not the timing of the gluten exposure but the overlap of breastfeeding at the time of the initial gluten ingestion. Thus, gluten-containing foods should be introduced while the infant is receiving only breast milk and not infant formula or other bovine milk products.

Inflammatory Bowel Disease

Breastfeeding is associated with a 31% reduction in the risk of childhood inflammatory bowel disease.³² The protective effect is hypothesized to result from the interaction of the immunomodulating effect of human milk and the underlying genetic

susceptibility of the infant. Different patterns of intestinal colonization in breastfed versus commercial infant formula-fed infants may add to the preventive effect of human milk.³³

Obesity

Because rates of obesity are significantly lower in breastfed infants, national campaigns to prevent obesity begin with breastfeeding support.^{34,35} Although complex factors confound studies of obesity, there is a 15% to 30% reduction in adolescent and adult obesity rates if any breastfeeding occurred in infancy compared with no breastfeeding.^{13,36} The Framingham Offspring study noted a relationship of breastfeeding and a lower BMI and higher high-density lipoprotein concentration in adults.³⁷ A sibling difference model study noted that the breastfed sibling weighed 14 pounds less than the sibling fed commercial infant formula and was less likely to reach BMI obesity threshold.³⁸ The duration of breastfeeding also is inversely related to the risk of overweight; each month of breastfeeding being associated with a 4% reduction in risk.¹⁴

The interpretation of these data is confounded by the lack of a definition in many studies of whether human milk was given by breastfeeding or by bottle. This is of particular importance, because breastfed infants self-regulate intake volume irrespective of maneuvers that increase available milk volume, and the early programming of self-regulation, in turn, affects adult weight gain.³⁹ This concept is further supported by the observations that infants who are fed by bottle, formula, or expressed breast milk will have increased bottle emptying, poorer self-regulation, and excessive weight gain in late infancy (older than 6 months) compared with infants who only nurse from the breast.^{40,41}

Diabetes

Up to a 30% reduction in the incidence of type 1 diabetes mellitus is reported for infants who exclusively breastfed for at least 3 months, thus avoiding exposure to cow milk protein.^{13,42} It has been postulated that the putative mechanism in the development of type 1 diabetes mellitus is the infant's exposure to cow milk β -lactoglobulin, which stimulates an immune-mediated process cross-reacting with pancreatic β cells. A reduction of 40% in the incidence of type 2 diabetes mellitus is reported, possibly reflecting the long-term positive effect of breastfeeding on weight control and feeding self-regulation.⁴³

Childhood Leukemia and Lymphoma

There is a reduction in leukemia that is correlated with the duration of breastfeeding.^{14,44} A reduction of 20% in the risk of acute lymphocytic leukemia and 15% in the risk of acute myeloid leukemia in infants breastfed for 6 months or longer.^{45,46} Breastfeeding for less than 6 months is protective but of less magnitude (approximately 12% and 10%, respectively). The question of whether the protective effect of breastfeeding is a direct mechanism of human milk on malignancies or secondarily mediated by its reduction of early childhood infections has yet to be answered.

Neurodevelopmental Outcomes

Consistent differences in neurodevelopmental outcome between breastfed and commercial infant formula-fed infants have been reported, but the outcomes are confounded by differences in parental education, intelligence, home environment, and socioeconomic status.^{13,47} The large, randomized Promotion of Breastfeeding Intervention Trial provided evidence that adjusted outcomes of intelligence scores and teacher's ratings are significantly greater in breastfed infants.^{48–50} In

addition, higher intelligence scores are noted in infants who exclusively breastfed for 3 months or longer, and higher teacher ratings were observed if exclusive breastfeeding was practiced for 3 months or longer. Significantly positive effects of human milk feeding on long-term neurodevelopment are observed in preterm infants, the population more at risk for these adverse neurodevelopmental outcomes.^{51–54}

PRETERM INFANTS

There are several significant short- and long-term beneficial effects of feeding preterm infants human milk. Lower rates of sepsis and NEC indicate that human milk contributes to the development of the preterm infant's immature host defense.^{19,55–59} The benefits of feeding human milk to preterm infants are realized not only in the NICU but also in the fewer hospital readmissions for illness in the year after NICU discharge.^{51,52} Furthermore, the implications for a reduction in incidence of NEC include not only lower mortality rates but also lower long-term growth failure and neurodevelopmental disabilities.^{60,61} Clinical feeding tolerance is improved, and the attainment of full enteral feeding is hastened by a diet of human milk.^{51,52,59}

Neurodevelopmental outcomes are improved by the feeding of human milk. Long-term studies at 8 years of age through adolescence suggest that intelligence test results and white matter and total brain volumes are greater in subjects who had received human milk as infants in the NICU.^{53,54} Extremely preterm infants receiving the greatest proportion of human milk in the NICU had significantly greater scores for mental, motor, and behavior ratings at ages 18 months and 30 months.^{51,52} These data remain significant after adjustment for confounding factors, such as maternal age, education, marital status, race, and infant morbidities.

These neurodevelopmental outcomes are associated with predominant and not necessarily exclusive human milk feeding. Human milk feeding in the NICU also is associated with lower rates of severe retinopathy of prematurity.^{62,63} Long-term studies of preterm infants also suggest that human milk feeding is associated with lower rates of metabolic syndrome, and in adolescents, it is associated with lower blood pressures and low-density lipoprotein concentrations and improved leptin and insulin metabolism.^{64,65}

The potent benefits of human milk are such that all preterm infants should receive human milk (Table 3). Mother's own milk, fresh or frozen, should be the primary diet, and it should be fortified appropriately for the infant born weighing less than 1.5 kg. If mother's own milk is unavailable despite significant lactation support, pasteurized donor milk should be used.^{19,66} Quality control of pasteurized donor milk is important and should be monitored. New data suggest that mother's own milk can be stored at refrigerator temperature (4°C) in the NICU for as long as 96 hours.⁶⁷ Data on thawing, warming, and prolonged storage need updating. Practices should involve protocols that prevent misadministration of milk.

MATERNAL OUTCOMES

Both short- and long-term health benefits accrue to mothers who breastfeed. Such mothers have decreased postpartum blood loss and more rapid involution of the uterus. Continued breastfeeding leads to increased child spacing secondary to lactational amenorrhea. Prospective cohort studies have noted an increase in postpartum depression in mothers who do not breastfeed or who wean early.⁶⁸ A large prospective study on child abuse and neglect perpetuated by mothers found, after correcting for potential

TABLE 3 Recommendations on Breastfeeding Management for Preterm Infants

- All preterm infants should receive human milk.
 - Human milk should be fortified, with protein, minerals, and vitamins to ensure optimal nutrient intake for infants weighing <1500 g at birth.
 - Pasteurized donor human milk, appropriately fortified, should be used if mother's own milk is unavailable or its use is contraindicated.
- Methods and training protocols for manual and mechanical milk expression must be available to mothers.
- Neonatal intensive care units should possess evidence-based protocols for collection, storage, and labeling of human milk.¹⁵⁰
- Neonatal intensive care units should prevent the misadministration of human milk (http://www.cdc.gov/breastfeeding/recommendations/other_mothers_milk.htm).
- There are no data to support routinely culturing human milk for bacterial or other organisms.¹⁵¹

confounders, that the rate of abuse/neglect was significantly increased for mothers who did not breastfeed as opposed to those who did (OR: 2.6; 95% CI: 1.7–3.9).⁶⁹

Studies of the overall effect of breastfeeding on the return of the mothers to their pre-pregnancy weight are inconclusive, given the large numbers of confounding factors on weight loss (diet, activity, baseline BMI, ethnicity).¹⁵ In a covariate-adjusted study of more than 14 000 women postpartum, mothers who exclusively breastfed for longer than 6 months weighed 1.38 kg less than those who did not breastfeed.⁷⁰ In mothers without a history of gestational diabetes, breastfeeding duration was associated with a decreased risk of type 2 diabetes mellitus; for each year of breastfeeding, there was a decreased risk of 4% to 12%.^{71,72} No beneficial effect for breastfeeding was noted in mothers who were diagnosed with gestational diabetes.

The longitudinal Nurses Health Study noted an inverse relationship between the cumulative lifetime duration of breastfeeding and the development of rheumatoid arthritis.⁷³ If cumulative duration of breastfeeding exceeded 12

months, the relative risk of rheumatoid arthritis was 0.8 (95% CI: 0.8–1.0), and if the cumulative duration of breastfeeding was longer than 24 months, the relative risk of rheumatoid arthritis was 0.5 (95% CI: 0.3–0.8).⁷³ An association between cumulative lactation experience and the incidence of adult cardiovascular disease was reported by the Women's Health Initiative in a longitudinal study of more than 139 000 postmenopausal women.⁷⁴ Women with a cumulative lactation history of 12 to 23 months had a significant reduction in hypertension (OR: 0.89; 95% CI: 0.84–0.93), hyperlipidemia (OR: 0.81; 95% CI: 0.76–0.87), cardiovascular disease (OR: 0.90; 95% CI: 0.85–0.96), and diabetes (OR: 0.74; 95% CI: 0.65–0.84).

Cumulative lactation experience also correlates with a reduction in both breast (primarily premenopausal) and ovarian cancer.^{13,14,75} Cumulative duration of breastfeeding of longer than 12 months is associated with a 28% decrease in breast cancer (OR: 0.72; 95% CI: 0.65–0.8) and ovarian cancer (OR: 0.72; 95% CI: 0.54–0.97).⁷⁶ Each year of breastfeeding has been calculated to result in a 4.3% reduction in breast cancer.^{76,77}

ECONOMIC BENEFITS

A detailed pediatric cost analysis based on the AHRQ report concluded that if 90% of US mothers would comply with the recommendation to breastfeed exclusively for 6 months, there would be a savings of \$13 billion per year.²⁴ The savings do not include those related to a reduction in parental absenteeism from work or adult deaths from diseases acquired in childhood, such as asthma, type 1 diabetes mellitus, or obesity-related conditions. Strategies that increase the number of mothers who breastfeed exclusively for about 6 months would be of great economic benefit on a national level.

DURATION OF EXCLUSIVE BREASTFEEDING

The AAP recommends exclusive breastfeeding for about 6 months, with continuation of breastfeeding for 1 year or longer as mutually desired by mother and infant, a recommendation concurred to by the WHO⁷⁸ and the Institute of Medicine.⁷⁹

Support for this recommendation of exclusive breastfeeding is found in the differences in health outcomes of infants breastfed exclusively for 4 vs 6 months, for gastrointestinal disease, otitis media, respiratory illnesses, and atopic disease, as well as differences in maternal outcomes of delayed menses and postpartum weight loss.^{15,18,80}

Compared with infants who never breastfed, infants who were exclusively breastfed for 4 months had significantly greater incidence of lower respiratory tract illnesses, otitis media, and diarrheal disease than infants exclusively breastfed for 6 months or longer.^{15,18} When compared with infants who exclusively breastfed for longer than 6 months, those exclusively breastfed for 4 to 6 months had a four-fold increase in the risk of pneumonia.¹⁵ Furthermore, exclusively breastfeeding for 6 months extends the period of lactational amenorrhea and thus improves child spacing, which reduces the risk of birth of a preterm infant.⁸¹ The AAP is cognizant that for some infants, because of family and medical history, individual developmental status, and/or social and cultural dynamics, complementary feeding, including gluten-containing grains, begins earlier than 6 months of age.^{82,83} Because breastfeeding is immunoprotective, when such complementary foods are introduced, it is advised that this be done while the infant is feeding only breastmilk.⁸² Mothers should be encouraged to continue breastfeeding through the first

year and beyond as more and varied complementary foods are introduced.

CONTRAINDICATIONS TO BREASTFEEDING

There are a limited number of medical conditions in which breastfeeding is contraindicated, including an infant with the metabolic disorder of classic galactosemia. Alternating breastfeeding with special protein-free or modified formulas can be used in feeding infants with other metabolic diseases (such as phenylketonuria), provided that appropriate blood monitoring is available. Mothers who are positive for human T-cell lymphotropic virus type I or II⁸⁴ or untreated brucellosis⁸⁵ should not breastfeed nor provide expressed milk to their infants. Breastfeeding should not occur if the mother has active (infectious) untreated tuberculosis or has active herpes simplex lesions on her breast; however, expressed milk can be used because there is no concern about these infectious organisms passing through the milk. Breastfeeding can be resumed when a mother with tuberculosis is treated for a minimum of 2 weeks and is documented that she is no longer infectious.⁸⁶ Mothers who develop varicella 5 days before through 2 days after delivery should be separated from their infants, but their expressed milk can be used for feeding.⁸⁷ In 2009, the CDC recommended that mothers acutely infected with H1N1 influenza should temporarily be isolated from their infants until they are afebrile, but they can provide expressed milk for feeding.⁸⁸

In the industrialized world, it is not recommended that HIV-positive mothers breastfeed. However, in the developing world, where mortality is increased in non-breastfeeding infants from a combination of malnutrition and infectious diseases, breastfeeding may outweigh the risk of the acquiring HIV infection

from human milk. Infants in areas with endemic HIV who are exclusively breastfed for the first 3 months are at a lower risk of acquiring HIV infection than are those who received a mixed diet of human milk and other foods and/or commercial infant formula.⁸⁹ Recent studies document that combining exclusive breastfeeding for 6 months with 6 months of antiretroviral therapy significantly decreases the postnatal acquisition of HIV-1.^{90,91}

There is no contraindication to breastfeeding for a full-term infant whose mother is seropositive for cytomegalovirus (CMV). There is a possibility that CMV acquired from mother's milk may be associated with a late-onset sepsis-like syndrome in the extremely low birth weight (birth weight <1500 g) preterm infant. Although not associated with long-term abnormalities, such a syndrome may warrant antiviral therapy.⁹² The value of routinely feeding human milk from seropositive mothers to preterm infants outweighs the risks of clinical disease, especially because no long-term neurodevelopmental abnormalities have been reported.⁹³ Freezing of milk reduces but does not eliminate CMV.⁹⁴ Heating, either as Holder pasteurization (heating at 62.5°C for 30 minutes) or high-temperature short pasteurization (72°C for 5–10 seconds) eliminates the viral load from the milk but also affects bioactive factors and nutrients.⁹⁵ Thus, fresh mother's own milk is preferable for routinely feeding all preterm infants.

Maternal substance abuse is not a categorical contraindication to breastfeeding. Adequately nourished narcotic-dependent mothers can be encouraged to breastfeed if they are enrolled in a supervised methadone maintenance program and have negative screening for HIV and illicit drugs.⁹⁶ Street drugs such as PCP (phencyclidine), cocaine, and cannabis can be detected in human

milk, and their use by breastfeeding mothers is of concern, particularly with regard to the infant's long-term neurobehavioral development and thus are contraindicated.⁹⁷ Alcohol is not a galactagogue; it may blunt prolactin response to suckling and negatively affects infant motor development.^{98,99} Thus, ingestion of alcoholic beverages should be minimized and limited to an occasional intake but no more than 0.5 g alcohol per kg body weight, which for a 60 kg mother is approximately 2 oz liquor, 8 oz wine, or 2 beers.¹⁰⁰ Nursing should take place 2 hours or longer after the alcohol intake to minimize its concentration in the ingested milk.¹⁰¹ Maternal smoking is not an absolute contraindication to breastfeeding but should be strongly discouraged, because it is associated with an increased incidence in infant respiratory allergy¹⁰² and SIDS.¹⁰³ Smoking should not occur in the presence of the infant so as to minimize the negative effect of secondary passive smoke inhalation.¹⁰⁴ Smoking is also a risk factor for low milk supply and poor weight gain.^{105,106}

MATERNAL DIET

Well-nourished lactating mothers have an increased daily energy need of 450 to 500 kcal/day that can be met by a modest increase in a normally balanced varied diet.^{107–109} Although dietary reference intakes for breastfeeding mothers are similar to or greater than those during pregnancy, there is no routine recommendation for maternal supplements during lactation.^{108,109,110} Many clinicians recommend the continued use of prenatal vitamin supplements during lactation.¹⁰⁹

The mother's diet should include an average daily intake of 200 to 300 mg of the ω -3 long-chain polyunsaturated fatty acids (docosahexaenoic acid [DHA]) to guarantee a sufficient concentration of preformed DHA in the

milk.^{111,112} Consumption of 1 to 2 portions of fish (eg, herring, canned light tuna, salmon) per week will meet this need. The concern regarding the possible risk from intake of excessive mercury or other contaminants is offset by the neurobehavioral benefits of an adequate DHA intake and can be minimized by avoiding the intake of predatory fish (eg, pike, marlin, mackerel, tile fish, swordfish).¹¹³ Poorly nourished mothers or those on selective vegan diets may require a supplement of DHA as well as multivitamins.

MATERNAL MEDICATIONS

Recommendations regarding breastfeeding in situations in which the mother is undergoing either diagnostic procedures or pharmacologic therapy must balance the benefits to the infant and the mother against the potential risk of drug exposure to the infant. There are only a limited number of agents that are contraindicated, and an appropriate substitute usually can be found. The most comprehensive, up-to-date source of information regarding the safety of maternal medications when the mother is breastfeeding is LactMed, an Internet-accessed source published by the National Library of Medicine/National Institutes of Health.¹¹⁴ A forthcoming AAP policy statement on the transfer of drugs and other chemicals into human milk will provide additional recommendations, with particular focus on psychotropic drugs, herbal products, galactagogues, narcotics, and pain medications.¹¹⁵ In general, breastfeeding is not recommended when mothers are receiving medication from the following classes of drugs: amphetamines, chemotherapy agents, ergotamines, and statins.

There are a wide variety of maternally administered psychotropic agents for which there are inadequate pharmacologic data with regard to human milk and/or nursing infant's blood

concentrations. In addition, data regarding the long-term neurobehavioral effects from exposure to these agents during the critical developmental period of early infancy are lacking. A recent comprehensive review noted that of the 96 psychotropic drugs available, pharmacologic and clinical information was only available for 62 (65%) of the drugs.¹¹⁶ In only 19 was there adequate information to allow for defining a safety protocol and thus qualifying to be compatible for use by lactating mothers. Among the agents considered to be least problematic were the tricyclic antidepressants amitriptyline and clomipramine and the selective serotonin-reuptake inhibitors paroxetine and sertraline.

Detailed guidelines regarding the necessity for and duration of temporary cessation of breastfeeding after maternal exposure to diagnostic radioactive compounds are provided by the US Nuclear Regulatory Commission and in medical reviews.^{117–119} Special precaution should be followed in the situation of breastfeeding infants with glucose-6-phosphate-dehydrogenase deficiency. Fava beans, nitrofurantoin, primaquine, and phenazopyridine should be avoided by the mother to minimize the risk of hemolysis in the infant.¹²⁰

HOSPITAL ROUTINES

The Sections on Breastfeeding and Perinatal Pediatrics have published the Sample Hospital Breastfeeding Policy that is available from the AAP Safe and Healthy Beginnings Web site.^{3,5} This sample hospital policy is based on the detailed recommendations of the previous AAP policy statement “Breastfeeding and the Use of Human Milk”¹ as well as the principles of the 1991 WHO/UNICEF publication “Ten Steps to Successful Breastfeeding” (Table 4)¹²¹ and provides a template for developing a uniform hospital policy for support of breastfeeding.¹²² In particular,

emphasis is placed on the need to revise or discontinue disruptive hospital policies that interfere with early skin-to-skin contact, that provide water, glucose water, or commercial infant formula without a medical indication, that restrict the amount of time the infant can be with the mother, that limit feeding duration, or that provide unlimited pacifier use.

In 2009, the AAP endorsed the Ten Steps program (see Table 4). Adherence to these 10 steps has been demonstrated to increase rates of breastfeeding initiation, duration, and exclusivity.^{122,123} Implementation of the following 5 postpartum hospital practices has been demonstrated to increase breastfeeding duration, irrespective of socioeconomic status: breastfeeding in the first hour after birth, exclusive breastfeeding, rooming-in, avoidance of pacifiers, and receipt of telephone number for support after discharge from the hospital.¹²⁴

The CDC National Survey of Maternity Practices in Infant Nutrition and Care has assessed the lactation practices in more than 80% of US hospitals and noted that the mean score for implementation of the Ten Steps was only 65%.^{34,125} Fifty-eight percent of hospitals erroneously advised mothers to limit suckling at the breast to a specified length of time, and 41% of the hospitals gave pacifiers to more than some of their newborns—both practices that have been documented to lower breastfeeding rates and duration.¹²⁶ The survey noted that in 30% of all birth centers, more than half of all newborns received supplementation commercial infant formula, a practice associated with shorter duration of breastfeeding and less exclusivity.^{34,125} As indicated in the benefits section, this early supplementation may affect morbidity outcomes in this population. The survey also reported that 66% of hospitals

TABLE 4 WHO/UNICEF 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 the skills necessary to implement this policy.
3. Inform all pregnant women about the benefits and management of breastfeeding.
4. Help mothers initiate breastfeeding within the first 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 breast milk, unless medically indicated.
7. Practice rooming-in (allow mothers and infants to remain together) 24 h a day.
8. Encourage breastfeeding on demand.
9. Give no artificial nipples or pacifiers to breastfeeding infants.^a
10. Foster the establishment of breastfeeding support groups and refer mothers to them on discharge from hospital.

^a The AAP does not support a categorical ban on pacifiers because of their role in SIDS risk reduction and their analgesic benefit during painful procedures when breastfeeding cannot provide the analgesia. Pacifier use in the hospital in the neonatal period should be limited to specific medical indications such as pain reduction and calming in a drug-exposed infant, for example. Mothers of healthy term breastfed infants should be instructed to delay pacifier use until breastfeeding is well-established, usually about 3 to 4 wk after birth.

reported that they distributed to breastfeeding mothers discharge packs that contained commercial infant formula, a practice that has been documented to negatively affect exclusivity and duration of breastfeeding.¹²⁷ Few birth centers have model hospital policies (14%) and support breastfeeding mothers after hospital discharge (27%). Only 37% of centers practice more than 5 of the 10 Steps and only 3.5% practice 9 to 10 Steps.³⁴

There is, thus, a need for a major conceptual change in the organization of the hospital services for the mother and infant dyad (Table 5). This requires that medical and nursing routines and practices adjust to the principle that breastfeeding should begin within the first hour after birth (even for Cesarean deliveries) and that infants must be continuously accessible to the mother by rooming-in

arrangements that facilitate around-the-clock, on-demand feeding for the healthy infant. Formal staff training should not only focus on updating knowledge and techniques for breastfeeding support but also should acknowledge the need to change attitudes and eradicate unsubstantiated beliefs about the supposed equivalency of breastfeeding and commercial infant formula feeding. Emphasis should be placed on the numerous benefits of exclusive breastfeeding. The importance of addressing the issue of the impact of hospital practices and policies on breastfeeding outcomes is highlighted by the decision of The Joint Commission to adopt the rate of exclusive breast milk feeding as a Perinatal Care Core Measure.¹²⁷ As such, the rate of exclusive breastfeeding during the hospital stay has been confirmed as a critical variable when measuring the quality of care provided by a medical facility.

Pacifier Use

Given the documentation that early use of pacifiers may be associated with less successful breastfeeding, pacifier use in the neonatal period should be limited to specific medical situations.¹²⁸ These include uses for pain relief, as a calming agent, or as part of structured program for enhancing oral motor function. Because pacifier use has been associated with a reduction in SIDS incidence, mothers of healthy term infants should be instructed to use pacifiers at infant nap or sleep time after breastfeeding is well established, at approximately 3 to 4 weeks of age.^{129–131}

Vitamins and Mineral Supplements

Intramuscular vitamin K₁ (phytonadione) at a dose of 0.5 to 1.0 mg should routinely be administered to all infants on the first day to reduce the risk of hemorrhagic disease of the newborn.¹³² A delay of administration

until after the first feeding at the breast but not later than 6 hours of age is recommended. A single oral dose of vitamin K should not be used, because the oral dose is variably absorbed and does not provide adequate concentrations or stores for the breastfed infant.¹³²

Vitamin D deficiency/insufficiency and rickets has increased in all infants as a result of decreased sunlight exposure secondary to changes in lifestyle, dress habits, and use of topical sunscreen preparations. To maintain an adequate serum vitamin D concentration, all breastfed infants routinely should receive an oral supplement of vitamin D, 400 U per day, beginning at hospital discharge.¹³³

Supplementary fluoride should not be provided during the first 6 months. From age 6 months to 3 years, fluoride supplementation should be limited to infants residing in communities where the fluoride concentration in the water is <0.3 ppm.¹³⁴ Complementary food rich in iron and zinc should be introduced at about 6 months of age. Supplementation of oral iron drops before 6 months may be needed to support iron stores.

Premature infants should receive both a multivitamin preparation and an oral iron supplement until they are ingesting a completely mixed diet and their growth and hematologic status are normalized.

GROWTH

The growth pattern of healthy term breastfed infants differs from the existing CDC "reference" growth curves, which are primarily based on data from few breastfeeding infants. The WHO multicenter curves are based on combined longitudinal data from healthy breastfed infants from birth to 24 months and cross-sectional data from 2 to 5 years of the same children from 6 diverse geographical areas

TABLE 5 Recommendations on Breastfeeding Management for Healthy Term Infants

1. Exclusive breastfeeding for about 6 mo
 - Breastfeeding preferred; alternatively expressed mother's milk, or donor milk
 - To continue for at least the first year and beyond for as long as mutually desired by mother and child
 - Complementary foods rich in iron and other micronutrients should be introduced at about 6 mo of age
2. Peripartum policies and practices that optimize breastfeeding initiation and maintenance should be compatible with the AAP and Academy of Breastfeeding Medicine Model Hospital Policy and include the following:
 - Direct skin-to-skin contact with mothers immediately after delivery until the first feeding is accomplished and encouraged throughout the postpartum period
 - Delay in routine procedures (weighing, measuring, bathing, blood tests, vaccines, and eye prophylaxis) until after the first feeding is completed
 - Delay in administration of intramuscular vitamin K until after the first feeding is completed but within 6 h of birth
 - Ensure 8 to 12 feedings at the breast every 24 h
 - Ensure formal evaluation and documentation of breastfeeding by trained caregivers (including position, latch, milk transfer, examination) at least for each nursing shift
 - Give no supplements (water, glucose water, commercial infant formula, or other fluids) to breastfeeding newborn infants unless medically indicated using standard evidence-based guidelines for the management of hyperbilirubinemia and hypoglycemia
 - Avoid routine pacifier use in the postpartum period
 - Begin daily oral vitamin D drops (400 IU) at hospital discharge
3. All breastfeeding newborn infants should be seen by a pediatrician at 3 to 5 d of age, which is within 48 to 72 h after discharge from the hospital
 - Evaluate hydration (elimination patterns)
 - Evaluate body wt gain (body wt loss no more than 7% from birth and no further wt loss by day 5: assess feeding and consider more frequent follow-up)
 - Discuss maternal/infant issues
 - Observe feeding
4. Mother and infant should sleep in proximity to each other to facilitate breastfeeding
5. Pacifier should be offered, while placing infant in back-to-sleep-position, no earlier than 3 to 4 wk of age and after breastfeeding has been established

(Brazil, Ghana, India, Norway, Oman, and the United States).¹³⁵ As such, the WHO curves are “standards” and are the normative model for growth and development irrespective of infant ethnicity or geography reflecting the optimal growth of the breastfed infant.¹³⁶ Use of the WHO curves for the first 2 years allows for more accurate monitoring of weight and height for age and, in comparison with use of the CDC reference curves, results in more accurate (lower) rates of undernutrition and short stature and (higher) rates of overweight. Furthermore, birth to 6-month growth charts are available where the curves are magnified to permit monitoring of weight trajectories. As such, the WHO curves serve as the best guide for assessing lactation performance because they minimize mislabeling clinical situations as inadequate breastfeeding and identify more accurately and promptly overweight and obese infants. As of September 2010, the CDC, with the concurrence of the AAP, recommended the use of the WHO curves for all children younger than 24 months.^{137,138}

ROLE OF THE PEDIATRICIAN

Pediatricians have a critical role in their individual practices, communities, and society at large to serve as advocates and supporters of successful breastfeeding (Table 6).¹³⁹ Despite this critical role, studies have demonstrated lack of preparation and knowledge and declining attitudes regarding the feasibility of breastfeeding.¹⁴⁰ The AAP Web site¹⁴¹ provides a wealth of breastfeeding-related material and resources to assist and support pediatricians in their critical role as advocates of infant well-being. This includes the Safe and Healthy Beginnings toolkit,⁵ which includes resources for physician’s office for promotion of breastfeeding in a busy pediatric practice setting, a pocket

TABLE 6 Role of the Pediatrician

1. Promote breastfeeding as the norm for infant feeding.
2. Become knowledgeable in the principles and management of lactation and breastfeeding.
3. Develop skills necessary for assessing the adequacy of breastfeeding.
4. Support training and education for medical students, residents and postgraduate physicians in breastfeeding and lactation.
5. Promote hospital policies that are compatible with the AAP and Academy of Breastfeeding Medicine Model Hospital Policy and the WHO/ UNICEF “Ten Steps to Successful Breastfeeding.”
6. Collaborate with the obstetric community to develop optimal breastfeeding support programs.
7. Coordinate with community-based health care professionals and certified breastfeeding counselors to ensure uniform and comprehensive breastfeeding support.

guide for coding to facilitate appropriate payment, suggested guidelines for telephone triage of maternal breastfeeding concerns, and information regarding employer support for breastfeeding in the workplace. Evidence-based protocols from organizations such as the Academy of Breastfeeding Medicine provide detailed clinical guidance for management of specific issues, including the recommendations for frequent and unrestricted time for breastfeeding so as to minimize hyperbilirubinemia and hypoglycemia.^{4,142,143} The critical role that pediatricians play is highlighted by the recommended health supervision visit at 3 to 5 days of age, which is within 48 to 72 hours after discharge from the hospital, as well as pediatricians support of practices that avoid non-medically indicated supplementation with commercial infant formula.¹⁴⁴

Pediatricians also should serve as breastfeeding advocates and educators and not solely delegate this role to staff or nonmedical/lay volunteers. Communicating with families that breastfeeding is a medical priority that is enthusiastically recommended by their personal pediatrician will build

support for mothers in the early weeks postpartum. To assist in the education of future physicians, the AAP recommends using the evidence-based Breastfeeding Residency Curriculum,⁴ which has been demonstrated to improve knowledge, confidence, practice patterns, and breastfeeding rates. The pediatrician’s own office-based practice should serve as a model for how to support breastfeeding in the workplace. The pediatrician should also take the lead in encouraging the hospitals with which he or she is affiliated to provide proper support and facilities for their employees who choose to continue to breastfeed.

BUSINESS CASE FOR BREASTFEEDING

A mother/baby-friendly worksite provides benefits to employers, including a reduction in company health care costs, lower employee absenteeism, reduction in employee turnover, and increased employee morale and productivity.^{145,146} The return on investment has been calculated that for every \$1 invested in creating and supporting a lactation support program (including a designated pump site that guarantees privacy, availability of refrigeration and a hand-washing facility, and appropriate mother break time) there is a \$2 to \$3 dollar return.¹⁴⁷ The Maternal and Child Health Bureau of the US Department of Health and Human Services, with support from the Office of Women’s Health, has created a program, “The Business Case for Breastfeeding,” that provides details of economic benefits to the employer and toolkits for the creation of such programs.¹⁴⁸ The Patient Protection and Affordable Care Act passed by Congress in March 2010 mandates that employers provide “reasonable break time” for nursing mothers and private non-bathroom areas to express

breast milk during their workday.¹⁴⁹ The establishment of these initiatives as the standard workplace environment will support mothers in their goal of supplying only breast milk to their infants beyond the immediate postpartum period.

CONCLUSIONS

Research and practice in the 5 years since publication of the last AAP policy statement have reinforced the conclusion that breastfeeding and the use of human milk confer unique nutritional and nonnutritional benefits to the infant

and the mother and, in turn, optimize infant, child, and adult health as well as child growth and development. Recently, published evidence-based studies have confirmed and quantitated the risks of not breastfeeding. Thus, infant feeding should not be considered as a lifestyle choice but rather as a basic health issue. As such, the pediatrician's role in advocating and supporting proper breastfeeding practices is essential and vital for the achievement of this preferred public health goal.³⁵

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REFERENCES

- Gartner LM, Morton J, Lawrence RA, et al; American Academy of Pediatrics Section on Breastfeeding. Breastfeeding and the use of human milk. *Pediatrics*. 2005;115(2):496–506
- Schanler RJ, Dooley S, Gartner LM, Krebs NF, Mass SB. *Breastfeeding Handbook for Physicians*. Elk Grove Village, IL: American Academy of Pediatrics; Washington, DC: American College of Obstetricians and Gynecologists; 2006
- American Academy of Pediatrics Section on Breastfeeding. Sample Hospital Breastfeeding Policy for Newborns. Elk Grove Village, IL: American Academy of Pediatrics; 2008
- Feldman-Winter L, Barone L, Milcarek B, et al. Residency curriculum improves breastfeeding care. *Pediatrics*. 2010;126(2):289–297
- American Academy of Pediatrics. *Safe and Health Beginnings: A Resource Toolkit for Hospitals and Physicians' Offices*. Elk Grove Village, IL: American Academy of Pediatrics; 2008
- Centers for Disease Control and Prevention. Breastfeeding Among U.S. Children Born 1999–2006, CDC National Immunization Survey. Atlanta, GA: Centers for Disease Control and Prevention; 2010
- McDowell MM, Wang C-Y, Kennedy-Stephenson J. Breastfeeding in the United States: Findings from the National Health and Nutrition Examination Surveys, 1999–2006. NCHS Data Briefs, no. 5. Hyattsville, MD: National Center for Health Statistics; 2008
- 2007 CDC National Survey of Maternity Practices in Infant Nutrition and Care. Atlanta, GA: Centers for Disease Control and Prevention; 2009
- Office of Disease Prevention and Health Promotion; US Department of Health and Human Services. Healthy People 2010. Available at: www.healthypeople.gov. Accessed June 3, 2011
- Centers for Disease Control and Prevention. Breastfeeding report card—United States, 2010. Available at: www.cdc.gov/breastfeeding/data/reportcard.htm. Accessed June 3, 2011
- U.S. Department of Health and Human Services. Maternal, infant, and child health. Healthy People 2020; 2010. Available at: <http://healthypeople.gov/2020/topicsobjectives2020/overview.aspx?topicid=26>. Accessed December 12, 2011
- Centers for Disease Control and Prevention. Racial and ethnic differences in breastfeeding initiation and duration, by state National Immunization Survey, United States, 2004–2008. *MMWR Morb Mortal Wkly Rep*. 2010;59(11):327–334
- Ip S, Chung M, Raman G, et al; Tufts-New England Medical Center Evidence-based Practice Center. Breastfeeding and maternal and infant health outcomes in developed countries. *Evid Rep Technol Assess (Full Rep)*. 2007;153(153):1–186
- Ip S, Chung M, Raman G, Trikalinos TA, Lau J. A summary of the Agency for Healthcare Research and Quality's evidence report on breastfeeding in developed countries. *Breastfeed Med*. 2009;4(suppl 1):S17–S30
- Chantry CJ, Howard CR, Auinger P. Full breastfeeding duration and associated decrease in respiratory tract infection in US children. *Pediatrics*. 2006;117(2):425–432
- Nishimura T, Suzue J, Kaji H. Breastfeeding reduces the severity of respiratory syncytial virus infection among young infants: a multi-center prospective study. *Pediatr Int*. 2009;51(6):812–816
- Duijts L, Jaddoe VW, Hofman A, Moll HA. Prolonged and exclusive breastfeeding reduces the risk of infectious diseases in infancy. *Pediatrics*. 2010;126(1). Available at: www.pediatrics.org/cgi/content/full/126/1/e18
- Quigley MA, Kelly YJ, Sacker A. Breastfeeding and hospitalization for diarrheal and respiratory infection in the United Kingdom Millennium Cohort Study. *Pediatrics*. 2007;119(4). Available at: www.pediatrics.org/cgi/content/full/119/4/e837
- Sullivan S, Schanler RJ, Kim JH, et al. An exclusively human milk-based diet is associated with a lower rate of necrotizing enterocolitis than a diet of human milk and bovine milk-based products. *J Pediatr*. 2010;156(4):562–567, e1
- Hauck FR, Thompson JMD, Tanabe KO, Moon RY, Vennemann MM. Breastfeeding and reduced risk of sudden infant death syndrome: a meta-analysis. *Pediatrics*. 2011;128(1):1–8
- Chen A, Rogan WJ. Breastfeeding and the risk of postneonatal death in the United States. *Pediatrics*. 2004;113(5). Available at: www.pediatrics.org/cgi/content/full/113/5/e435
- Task Force on Sudden Infant Death Syndrome. SIDS and other sleep-related infant deaths: expansion of recommendations for

- a safe infant sleeping environment. *Pediatrics*. 2011;128(5):1030–1039
23. Vennemann MM, Bajanowski T, Brinkmann B, et al; GeSID Study Group. Does breastfeeding reduce the risk of sudden infant death syndrome? *Pediatrics*. 2009;123(3). Available at: www.pediatrics.org/cgi/content/full/123/3/e406
 24. Bartick M, Reinhold A. The burden of sub-optimal breastfeeding in the United States: a pediatric cost analysis. *Pediatrics*. 2010;125(5). Available at: www.pediatrics.org/cgi/content/full/125/5/e1048
 25. Jones G, Steketee RW, Black RE, Bhutta ZA, Morris SS; Bellagio Child Survival Study Group. How many child deaths can we prevent this year? *Lancet*. 2003;362(9377):65–71
 26. Greer FR, Sicherer SH, Burks AW; American Academy of Pediatrics Committee on Nutrition; ; American Academy of Pediatrics Section on Allergy and Immunology. Effects of early nutritional interventions on the development of atopic disease in infants and children: the role of maternal dietary restriction, breastfeeding, timing of introduction of complementary foods, and hydrolyzed formulas. *Pediatrics*. 2008;121(1):183–191
 27. Zutavern A, Brockow I, Schaaf B, et al; LISA Study Group. Timing of solid food introduction in relation to atopic dermatitis and atopic sensitization: results from a prospective birth cohort study. *Pediatrics*. 2006;117(2):401–411
 28. Poole JA, Barriga K, Leung DYM, et al. Timing of initial exposure to cereal grains and the risk of wheat allergy. *Pediatrics*. 2006;117(6):2175–2182
 29. Zutavern A, Brockow I, Schaaf B, et al; LISA Study Group. Timing of solid food introduction in relation to eczema, asthma, allergic rhinitis, and food and inhalant sensitization at the age of 6 years: results from the prospective birth cohort study LISA. *Pediatrics*. 2008;121(1). Available at: www.pediatrics.org/cgi/content/full/121/1/e44
 30. Nwaru BI, Erkkola M, Ahonen S, et al. Age at the introduction of solid foods during the first year and allergic sensitization at age 5 years. *Pediatrics*. 2010;125(1):50–59
 31. Akobeng AK, Ramanan AV, Buchan I, Heller RF. Effect of breast feeding on risk of coeliac disease: a systematic review and meta-analysis of observational studies. *Arch Dis Child*. 2006;91(1):39–43
 32. Barclay AR, Russell RK, Wilson ML, Gilmour WH, Satsangi J, Wilson DC. Systematic review: the role of breastfeeding in the development of pediatric inflammatory bowel disease. *J Pediatr*. 2009;155(3):421–426
 33. Penders J, Thijs C, Vink C, et al. Factors influencing the composition of the intestinal microbiota in early infancy. *Pediatrics*. 2006;118(2):511–521
 34. Perrine CG, Shealy KM, Scanlon KS, et al; Centers for Disease Control and Prevention (CDC). Vital signs: hospital practices to support breastfeeding—United States, 2007 and 2009. *MMWR Morb Mortal Wkly Rep*. 2011;60(30):1020–1025
 35. U.S.Department of Health and Human Services, The Surgeon General's Call to Action to Support Breastfeeding. Available at: www.surgeongeneral.gov/topics/breastfeeding/ Accessed March 28, 2011
 36. Owen CG, Martin RM, Whincup PH, Smith GD, Cook DG. Effect of infant feeding on the risk of obesity across the life course: a quantitative review of published evidence. *Pediatrics*. 2005;115(5):1367–1377
 37. Parikh NI, Hwang SJ, Ingelsson E, et al. Breastfeeding in infancy and adult cardiovascular disease risk factors. *Am J Med*. 2009;122(7):656–663, e1
 38. Metzger MW, McDade TW. Breastfeeding as obesity prevention in the United States: a sibling difference model. *Am J Hum Biol*. 2010;22(3):291–296
 39. Dewey KG, Lönnerdal B. Infant self-regulation of breast milk intake. *Acta Paediatr Scand*. 1986;75(6):893–898
 40. Li R, Fein SB, Grummer-Strawn LM. Association of breastfeeding intensity and bottle-emptying behaviors at early infancy with infants' risk for excess weight at late infancy. *Pediatrics*. 2008;122(suppl 2):S77–S84
 41. Li R, Fein SB, Grummer-Strawn LM. Do infants fed from bottles lack self-regulation of milk intake compared with directly breastfed infants? *Pediatrics*. 2010;125(6). Available at: www.pediatrics.org/cgi/content/full/125/6/e1386
 42. Rosenbauer J, Herzig P, Giani G. Early infant feeding and risk of type 1 diabetes mellitus—a nationwide population-based case-control study in pre-school children. *Diabetes Metab Res Rev*. 2008;24(3):211–222
 43. Das UN. Breastfeeding prevents type 2 diabetes mellitus: but, how and why? *Am J Clin Nutr*. 2007;85(5):1436–1437
 44. Bener A, Hoffmann GF, Afify Z, Rasul K, Tewfik I. Does prolonged breastfeeding reduce the risk for childhood leukemia and lymphomas? *Minerva Pediatr*. 2008;60(2):155–161
 45. Rudant J, Orsi L, Menegaux F, et al. Childhood acute leukemia, early common infections, and allergy: The ESCALE Study. *Am J Epidemiol*. 2010;172(9):1015–1027
 46. Kwan ML, Buffler PA, Abrams B, Kiley VA. Breastfeeding and the risk of childhood leukemia: a meta-analysis. *Public Health Rep*. 2004;119(6):521–535
 47. Der G, Batty GD, Deary IJ. Effect of breast feeding on intelligence in children: prospective study, sibling pairs analysis, and meta-analysis. *BMJ*. 2006;333(7575):945–950
 48. Kramer MS, Fombonne E, Iqumov S, et al; Promotion of Breastfeeding Intervention Trial (PROBIT) Study Group. Effects of prolonged and exclusive breastfeeding on child behavior and maternal adjustment: evidence from a large, randomized trial. *Pediatrics*. 2008;121(3). Available at: www.pediatrics.org/cgi/content/full/121/3/e435
 49. Kramer MS, Aboud F, Mironova E, et al; Promotion of Breastfeeding Intervention Trial (PROBIT) Study Group. Breastfeeding and child cognitive development: new evidence from a large randomized trial. *Arch Gen Psychiatry*. 2008;65(5):578–584
 50. Kramer MS, Chalmers B, Hodnett ED, et al; PROBIT Study Group (Promotion of Breastfeeding Intervention Trial). Promotion of Breastfeeding Intervention Trial (PROBIT): a randomized trial in the Republic of Belarus. *JAMA*. 2001;285(4):413–420
 51. Vohr BR, Poindexter BB, Dusick AM, et al; NICHD Neonatal Research Network. Beneficial effects of breast milk in the neonatal intensive care unit on the developmental outcome of extremely low birth weight infants at 18 months of age. *Pediatrics*. 2006;118(1). Available at: www.pediatrics.org/cgi/content/full/118/1/e115
 52. Vohr BR, Poindexter BB, Dusick AM, et al; National Institute of Child Health and Human Development National Research Network. Persistent beneficial effects of breast milk ingested in the neonatal intensive care unit on outcomes of extremely low birth weight infants at 30 months of age. *Pediatrics*. 2007;120(4). Available at: www.pediatrics.org/cgi/content/full/120/4/e953
 53. Lucas A, Morley R, Cole TJ. Randomised trial of early diet in preterm babies and later intelligence quotient. *BMJ*. 1998;317(7171):1481–1487
 54. Isaacs EB, Fischl BR, Quinn BT, Chong WK, Gadian DG, Lucas A. Impact of breast milk on intelligence quotient, brain size, and white matter development. *Pediatr Res*. 2010;67(4):357–362
 55. Furman L, Taylor G, Minich N, Hack M. The effect of maternal milk on neonatal morbidity of very low-birth-weight infants. *Arch Pediatr Adolesc Med*. 2003;157(1):66–71

56. Lucas A, Cole TJ. Breast milk and neonatal necrotizing enterocolitis. *Lancet*. 1990;336(8730):1519–1523
57. Sisk PM, Lovelady CA, Dillard RG, Gruber KJ, O'Shea TM. Early human milk feeding is associated with a lower risk of necrotizing enterocolitis in very low birth weight infants. *J Perinatol*. 2007;27(7):428–433
58. Meinen-Derr J, Poindexter B, Wrage L, Morrow AL, Stoll B, Donovan EF. Role of human milk in extremely low birth weight infants' risk of necrotizing enterocolitis or death. *J Perinatol*. 2009;29(1):57–62
59. Schanler RJ, Shulman RJ, Lau C. Feeding strategies for premature infants: beneficial outcomes of feeding fortified human milk versus preterm formula. *Pediatrics*. 1999;103(6 pt 1):1150–1157
60. Hintz SR, Kendrick DE, Stoll BJ, et al; NICHD Neonatal Research Network. Neurodevelopmental and growth outcomes of extremely low birth weight infants after necrotizing enterocolitis. *Pediatrics*. 2005;115(3):696–703
61. Shah DK, Doyle LW, Anderson PJ, et al. Adverse neurodevelopment in preterm infants with postnatal sepsis or necrotizing enterocolitis is mediated by white matter abnormalities on magnetic resonance imaging at term. *J Pediatr*. 2008;153(2):170–175, e1
62. Hylander MA, Strobino DM, Dhanireddy R. Human milk feedings and infection among very low birth weight infants. *Pediatrics*. 1998;102(3). Available at: www.pediatrics.org/cgi/content/full/102/3/e38
63. Okamoto T, Shirai M, Kokubo M, et al. Human milk reduces the risk of retinal detachment in extremely low-birthweight infants. *Pediatr Int*. 2007;49(6):894–897
64. Lucas A. Long-term programming effects of early nutrition—implications for the preterm infant. *J Perinatol*. 2005;25(suppl 2):S2–S6
65. Singhal A, Cole TJ, Lucas A. Early nutrition in preterm infants and later blood pressure: two cohorts after randomised trials. *Lancet*. 2001;357(9254):413–419
66. Quigley MA, Henderson G, Anthony MY, McGuire W. Formula milk versus donor breast milk for feeding preterm or low birth weight infants. *Cochrane Database Syst Rev*. 2007;(4):CD002971
67. Slutzah M, Codipilly CN, Potak D, Clark RM, Schanler RJ. Refrigerator storage of expressed human milk in the neonatal intensive care unit. *J Pediatr*. 2010;156(1):26–28
68. Henderson JJ, Evans SF, Straton JA, Priest SR, Hagan R. Impact of postnatal depression on breastfeeding duration. *Birth*. 2003;30(3):175–180
69. Strathearn L, Mamun AA, Najman JM, O'Callaghan MJ. Does breastfeeding protect against substantiated child abuse and neglect? A 15-year cohort study. *Pediatrics*. 2009;123(2):483–493
70. Krause KM, Lovelady CA, Peterson BL, Chowdhury N, Østbye T. Effect of breastfeeding on weight retention at 3 and 6 months postpartum: data from the North Carolina WIC Programme. *Public Health Nutr*. 2010;13(12):2019–2026
71. Stuebe AM, Rich-Edwards JW, Willett WC, Manson JE, Michels KB. Duration of lactation and incidence of type 2 diabetes. *JAMA*. 2005;294(20):2601–2610
72. Schwarz EB, Brown JS, Creasman JM, et al. Lactation and maternal risk of type 2 diabetes: a population-based study. *Am J Med*. 2010;123(9):863.e1–e6
73. Karlson EW, Mandl LA, Hankinson SE, Grodstein F. Do breast-feeding and other reproductive factors influence future risk of rheumatoid arthritis? Results from the Nurses' Health Study. *Arthritis Rheum*. 2004;50(11):3458–3467
74. Schwarz EB, Ray RM, Stuebe AM, et al. Duration of lactation and risk factors for maternal cardiovascular disease. *Obstet Gynecol*. 2009;113(5):974–982
75. Stuebe AM, Willett WC, Xue F, Michels KB. Lactation and incidence of premenopausal breast cancer: a longitudinal study. *Arch Intern Med*. 2009;169(15):1364–1371
76. Collaborative Group on Hormonal Factors in Breast Cancer. Breast cancer and breastfeeding: collaborative reanalysis of individual data from 47 epidemiological studies in 30 countries, including 50302 women with breast cancer and 96973 women without the disease. *Lancet*. 2002;360(9328):187–195
77. Lipworth L, Bailey LR, Trichopoulos D. History of breast-feeding in relation to breast cancer risk: a review of the epidemiologic literature. *J Natl Cancer Inst*. 2000;92(4):302–312
78. World Health Organization. The optimal duration of exclusive breastfeeding: report of an expert consultation. Available at: http://www.who.int/nutrition/publications/optimal_duration_of_exc_bfeeding_report_eng.pdf. Accessed December 12, 2011
79. Institute of Medicine. Early childhood obesity prevention policies. June 23, 2011. Available at: www.iom.edu/obesityyoungchildren. Accessed December 12, 2011
80. Kramer MS, Kakuma R. Optimal duration of exclusive breastfeeding [review]. *The Cochrane Library*. January 21, 2009. Available at: <http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD003517/full>. Accessed December 12, 2011
81. Peterson AE, Peñez-Escamilla R, Labbok MH, Hight V, von Hertzen H, Van Look P. Multi-center study of the lactational amenorrhea method (LAM) III: effectiveness, duration, and satisfaction with reduced client-provider contact. *Contraception*. 2000;62(5):221–230
82. Agostoni C, Decsi T, Fewtrell M, et al; ESPGHAN Committee on Nutrition. Complementary feeding: a commentary by the ESPGHAN Committee on Nutrition. *J Pediatr Gastroenterol Nutr*. 2008;46(1):99–110
83. Cattaneo A, Williams C, Pallás-Alonso CR, et al. ESPGHAN's 2008 recommendation for early introduction of complementary foods: how good is the evidence? *Matern Child Nutr*. 2011;7(4):335–343
84. Gonçalves DU, Proietti FA, Ribas JG, et al. Epidemiology, treatment, and prevention of human T-cell leukemia virus type 1-associated diseases. *Clin Microbiol Rev*. 2010;23(3):577–589
85. Arroyo Carrera I, López Rodríguez MJ, Sapiña AM, López Lafuente A, Sacristán AR. Probable transmission of brucellosis by breast milk. *J Trop Pediatr*. 2006;52(5):380–381
86. American Academy of Pediatrics. Tuberculosis. In: Pickering LK, Baker CJ, Kimberlin DW, Long SS, eds. Red Book: 2009 Report of the Committee on Infectious Diseases. 28th ed. Elk Grove Village, IL: American Academy of Pediatrics; 2009:680-701
87. American Academy of Pediatrics. Varicella-zoster infections. In: Pickering LK, Baker CJ, Kimberlin DW, Long SS, eds. Red Book: 2009 Report of the Committee on Infectious Diseases. 28th ed. Elk Grove Village, IL: American Academy of Pediatrics; 2009:714-727
88. Centers for Disease Control and Prevention. 2009 H1N1 Flu (Swine Flu) and Feeding your Baby: What Parents Should Know. Available at: http://www.cdc.gov/h1n1flu/infantfeeding.htm?s_cid=h1n1flu_outbreak_155. Accessed January 22, 2010
89. Horvath T, Madi BC, Iuppa IM, Kennedy GE, Rutherford G, Read JS. Interventions for preventing late postnatal mother-to-child transmission of HIV. *Cochrane Database Syst Rev*. 2009;21(1):CD006734
90. Chasela CS, Hudgens MG, Jamieson DJ, et al; BAN Study Group. Maternal or infant antiretroviral drugs to reduce HIV-1 transmission. *N Engl J Med*. 2010;362(24):2271–2281

91. Shapiro RL, Hughes MD, Ogwu A, et al. Antiretroviral regimens in pregnancy and breast-feeding in Botswana. *N Engl J Med*. 2010;362(24):2282–2294
92. Hamele M, Flanagan R, Loomis CA, Stevens T, Fairchok MP. Severe morbidity and mortality with breast milk associated cytomegalovirus infection. *Pediatr Infect Dis J*. 2010; 29(1):84–86
93. Kurath S, Halwachs-Baumann G, Müller W, Resch B. Transmission of cytomegalovirus via breast milk to the prematurely born infant: a systematic review. *Clin Microbiol Infect*. 2010;16(8):1172–1178
94. Maschmann J, Hamprecht K, Weissbrich B, Dietz K, Jahn G, Speer CP. Freeze-thawing of breast milk does not prevent cytomegalovirus transmission to a preterm infant. *Arch Dis Child Fetal Neonatal Ed*. 2006;91(4):F288–F290
95. Hamprecht K, Maschmann J, Müller D, et al. Cytomegalovirus (CMV) inactivation in breast milk: reassessment of pasteurization and freeze-thawing. *Pediatr Res*. 2004;56(4):529–535
96. Jansson LM; Academy of Breastfeeding Medicine Protocol Committee. ABM clinical protocol #21: Guidelines for breastfeeding and the drug-dependent woman. *Breastfeed Med*. 2009;4(4):225–228
97. Garry A, Rigourd V, Amirouche A, Fauroux V, Aubry S, Serreau R. Cannabis and breastfeeding. *J Toxicol*. 2009;2009:596149
98. Little RE, Anderson KW, Ervin CH, Worthington-Roberts B, Clarren SK. Maternal alcohol use during breast-feeding and infant mental and motor development at one year. *N Engl J Med*. 1989;321(7):425–430
99. Mennella JA, Pepino MY. Breastfeeding and prolactin levels in lactating women with a family history of alcoholism. *Pediatrics*. 2010;125(5). Available at: www.pediatrics.org/cgi/content/full/125/5/e1162
100. Subcommittee on Nutrition During Lactation, Institute of Medicine, National Academy of Sciences. *Nutrition During Lactation*. Washington, DC: National Academies Press; 1991:113–152
101. Koren G. Drinking alcohol while breast-feeding. Will it harm my baby? *Can Fam Physician*. 2002;48:39–41
102. Guedes HT, Souza LS. Exposure to maternal smoking in the first year of life interferes in breast-feeding protective effect against the onset of respiratory allergy from birth to 5 yr. *Pediatr Allergy Immunol*. 2009;20(1):30–34
103. Liebrechts-Akkerman G, Lao O, Liu F, et al. Postnatal parental smoking: an important risk factor for SIDS. *Eur J Pediatr*. 2011; 170(10):1281–1291
104. Yilmaz G, Hizli S, Karacan C, Yurdakök K, Coskun T, Dilmen U. Effect of passive smoking on growth and infection rates of breast-fed and non-breast-fed infants. *Pediatr Int*. 2009;51(3):352–358
105. Vio F, Salazar G, Infante C. Smoking during pregnancy and lactation and its effects on breast-milk volume. *Am J Clin Nutr*. 1991; 54(6):1011–1016
106. Hopkinson JM, Schanler RJ, Fraley JK, Garza C. Milk production by mothers of premature infants: influence of cigarette smoking. *Pediatrics*. 1992;90(6):934–938
107. Butte NF. Maternal nutrition during lactation. *Pediatric Up-to-Date*. 2010. Available at: http://www.uptodate.com/contents/maternal-nutrition-during-lactation?source=search_result&search=maternal+nutrition&selectedTitle=2%7E150. Accessed October 29, 2010
108. Zeisel SH. Is maternal diet supplementation beneficial? Optimal development of infant depends on mother's diet. *Am J Clin Nutr*. 2009;89(2):685S–687S
109. Picciano MF, McGuire MK. Use of dietary supplements by pregnant and lactating women in North America. *Am J Clin Nutr*. 2009;89(2):663S–667S
110. Whitelaw A. Historical perspectives: perinatal profiles: Robert McCance and Elsie Widdowson: pioneers in neonatal science. *NeoReviews*. 2007;8(11):e455–e458
111. Simopoulos AP, Leaf A, Salem N Jr. Workshop on the essentiality of and recommended dietary intakes for omega-6 and omega-3 fatty acids. *J Am Coll Nutr*. 1999; 18(5):487–489
112. Carlson SE. Docosahexaenoic acid supplementation in pregnancy and lactation. *Am J Clin Nutr*. 2009;89(2):678S–684S
113. Koletzko B, Cetin I, Brenna JT; Perinatal Lipid Intake Working Group; ; Child Health Foundation; ; Diabetic Pregnancy Study Group; ; European Association of Perinatal Medicine; ; European Association of Perinatal Medicine; ; European Society for Clinical Nutrition and Metabolism; ; European Society for Paediatric Gastroenterology, Hepatology and Nutrition, Committee on Nutrition; ; International Federation of Placenta Associations; ; International Society for the Study of Fatty Acids and Lipids. Dietary fat intakes for pregnant and lactating women. *Br J Nutr*. 2007;98(5):873–877
114. Drugs and Lactation Database. 2010. Available at: <http://toxnet.nlm.nih.gov/cgi-bin/sis/htmlgen?LACT>. Accessed September 17, 2009
115. Committee on Drugs, American Academy of Pediatrics. The transfer of drugs and other chemicals into human milk. *Pediatrics*. 2011, In press
116. Fortinguerra F, Clavenna A, Bonati M. Psychotropic drug use during breast-feeding: a review of the evidence. *Pediatrics*. 2009;124(4). Available at: www.pediatrics.org/cgi/content/full/124/4/e547
117. US Nuclear Regulatory Commission. Control of access to high and very high radiation areas in nuclear power plants. USNRC Regulatory Guide 8.38. June 1993. Available at: www.nrc.gov/reading-rm/doc-collections/reg-guides/occupational-health/rg/8-38/08-038.pdf.
118. International Commission on Radiological Protection. Doses to infants from ingestion of radionuclides in mother's milk. ICRP Publication 95. *Ann ICRP*. 2004;34(3–4):1–27
119. Stabin MG, Breitz HB. Breast milk excretion of radiopharmaceuticals: mechanisms, findings, and radiation dosimetry. *J Nucl Med*. 2000;41(5):863–873
120. Kaplan M, Hammerman C. Severe neonatal hyperbilirubinemia. A potential complication of glucose-6-phosphate dehydrogenase deficiency. *Clin Perinatol*. 1998;25(3):575–590, viii
121. World Health Organization. *Evidence for the Ten Steps to Successful Breastfeeding*. Geneva, Switzerland: World Health Organization; 1998
122. World Health Organization; United Nations Children's Fund. *Protecting, Promoting, and Supporting Breastfeeding: The Special Role of Maternity Services*. Geneva, Switzerland: World Health Organization; 1989
123. Philipp BL, Merewood A, Miller LW, et al. Baby-friendly hospital initiative improves breastfeeding initiation rates in a US hospital setting. *Pediatrics*. 2001;108(3):677–681
124. Murray EK, Ricketts S, Dellaport J. Hospital practices that increase breastfeeding duration: results from a population-based study. *Birth*. 2007;34(3):202–211
125. Centers for Disease Control and Prevention. Breastfeeding-related maternity practices at hospitals and birth centers—United States, 2007. *MMWR Morb Mortal Wkly Rep*. 2008;57(23):621–625
126. Dewey KG, Nommsen-Rivers LA, Heinig MJ, Cohen RJ. Risk factors for suboptimal infant breastfeeding behavior, delayed onset of lactation, and excess neonatal weight loss. *Pediatrics*. 2003;112(3 pt 1):607–619
127. The Joint Commission: Specifications Manual for Joint Commission National Quality Core Measures. Available at: <http://manual.jointcommission.org/releases/TJC2011A/>. Accessed January 12, 2011
128. O'Connor NR, Tanabe KO, Siadaty MS, Hauck FR. Pacifiers and breastfeeding:

- a systematic review. *Arch Pediatr Adolesc Med*. 2009;163(4):378–382
129. Hauck FR, Omojokun OO, Siadaty MS. Do pacifiers reduce the risk of sudden infant death syndrome? A meta-analysis. *Pediatrics*. 2005;116(5). Available at: www.pediatrics.org/cgi/content/full/116/5/e716
 130. American Academy of Pediatrics Task Force on Sudden Infant Death Syndrome. The changing concept of sudden infant death syndrome: diagnostic coding shifts, controversies regarding the sleeping environment, and new variables to consider in reducing risk. *Pediatrics*. 2005;116(5):1245–1255
 131. Li DK, Willinger M, Petitti DB, Odouli R, Liu L, Hoffman HJ. Use of a dummy (pacifier) during sleep and risk of sudden infant death syndrome (SIDS): population based case-control study. *BMJ*. 2006;332(7532):18–22
 132. American Academy of Pediatrics Committee on Fetus and Newborn. Controversies concerning vitamin K and the newborn. *Pediatrics*. 2003;112(1 pt 1):191–192
 133. Wagner CL, Greer FR; American Academy of Pediatrics Section on Breastfeeding; ; American Academy of Pediatrics Committee on Nutrition. Prevention of rickets and vitamin D deficiency in infants, children, and adolescents. *Pediatrics*. 2008;122(5):1142–1152
 134. American Academy of Pediatric Dentistry. Guidelines for Fluoride Therapy, Revised 2000. Available at: <http://www.aapd.org/pdf/fluoridetherapy.pdf>. Accessed September 17, 2009
 135. Garza C, de Onis M. Rationale for developing a new international growth reference. *Food Nutr Bull*. 2004;25(suppl 1):S5–S14
 136. de Onis M, Garza C, Onyango AW, Borghi E. Comparison of the WHO child growth standards and the CDC 2000 growth charts. *J Nutr*. 2007;137(1):144–148
 137. Grummer-Strawn LM, Reinold C, Krebs NF; Centers for Disease Control and Prevention. Use of World Health Organization and CDC growth charts for children aged 0–59 months in the United States. *MMWR Recomm Rep*. 2010;59(RR-9):1–15
 138. Grummer-Strawn LM, Reinold C, Krebs NF; Centers for Disease Control and Prevention. Use of World Health Organization and CDC growth charts for children aged 0–59 months in the United States. *MMWR Recomm Rep*. 2010;59(RR-9):1–15
 139. Schanler RJ. The pediatrician supports breastfeeding. *Breastfeed Med*. 2010;5(5):235–236
 140. Feldman-Winter LB, Schanler RJ, O'Connor KG, Lawrence RA. Pediatricians and the promotion and support of breastfeeding. *Arch Pediatr Adolesc Med*. 2008;162(12):1142–1149
 141. American Academy of Pediatrics. American Academy of Pediatrics Breastfeeding Initiatives. 2010. Available at: <http://www.aap.org/breastfeeding>. Accessed September 17, 2009
 142. Academy of Breastfeeding Medicine Protocol Committee. Clinical Protocols. Available at <http://www.bfmed.org/Resources/Protocols.aspx>. Accessed January 22, 2010
 143. American Academy of Pediatrics Subcommittee on Hyperbilirubinemia. Management of hyperbilirubinemia in the newborn infant 35 or more weeks of gestation. *Pediatrics*. 2004;114(1):297–316
 144. American Academy of Pediatrics, Committee on Practice and Ambulatory Medicine and Bright Futures Steering Committee. Recommendations for preventive pediatric health care. *Pediatrics*. 2007;120(6):1376
 145. Cohen R, Mrtek MB, Mrtek RG. Comparison of maternal absenteeism and infant illness rates among breast-feeding and formula-feeding women in two corporations. *Am J Health Promot*. 1995;10(2):148–153
 146. Ortiz J, McGilligan K, Kelly P. Duration of breast milk expression among working mothers enrolled in an employer-sponsored lactation program. *Pediatr Nurs*. 2004;30(2):111–119
 147. Tuttle CR, Slavit WI. Establishing the business case for breastfeeding. *Breastfeed Med*. 2009;4(suppl 1):S59–S62
 148. US Department of Health and Human Services Office on Women's Health. Business case for breast feeding. 2010. Available at: www.womenshealth.gov/breastfeeding/government-in-action/business-case-for-breastfeeding. Accessed September 24, 2010
 149. Patient Protection and Affordable Care Act 2010, Public Law 111-148. Title IV, §4207, USC HR 3590, (2010)
 150. Hurst NM, Myatt A, Schanler RJ. Growth and development of a hospital-based lactation program and mother's own milk bank. *J Obstet Gynecol Neonatal Nurs*. 1998;27(5):503–510
 151. Schanler RJ, Fraley JK, Lau C, Hurst NM, Horvath L, Rossmann SN. Breastmilk cultures and infection in extremely premature infants. *J Perinatol*. 2011;31(5):335–338

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