

## NYS Breastfeeding Quality Improvement in Hospitals (BQIH) Collaborative Change Package

PRIMARY DRIVER 1: MOTHERS ARE EDUCATED AND RECEIVE NECESSARY SUPPORT TO INITIATE BREASTFEEDING DURING HOSPITAL STAY.	
SECONDARY DRIVERS	CHANGE IDEAS
<p>Inform all pregnant women about the benefits and management of breastfeeding, possible impacts of not breastfeeding, and risks of formula (3) <sup>3,7</sup></p>	<ol style="list-style-type: none"> <li>1. Position education resources such as posters, videos, peer counselors, and educators to present concise messages regarding benefits of breastfeeding, free of commercial advertisement or promotion of formula or bottle-feeding, in obstetric care waiting rooms, ultrasonography, laboratories, and other locations where pregnant women visit within the hospital.</li> <li>2. Ensure breastfeeding education to pregnant women in hospital-affiliated prenatal clinics and practices includes the importance of exclusive breastfeeding, early skin-to-skin contact and initiation of breastfeeding, feeding on demand, and how lactation support after delivery can assure optimal milk production, and effective positioning and attachment.</li> <li>3. Investigate and discontinue infant formula marketing in hospital-affiliated prenatal clinics and practices.</li> <li>4. Ensure that nurses, certified nurse midwives, and physicians discuss current recommendations with new mothers regarding specific medical risks of artificial infant milk for infants.</li> <li>5. Weave infant feeding education into regular prenatal care education and childbirth classes if provided, rather than offering an optional class at the end of the series.</li> <li>6. Collaborate with and invite community breastfeeding stakeholders (e.g. La Leche League, WIC, lactation consultants) to provide education on-site.</li> <li>7. Utilize NYCDHMH, NYS DOH, or NYS WIC materials to distribute through affiliated prenatal care providers.</li> <li>8. Do NOT provide educational materials which refer to proprietary product(s) or bear product logo(s), unless specific to the mother’s or infant’s needs or condition.</li> <li>9. Provide patient and family education on admission to ensure informed decision regarding infant feeding choice.</li> </ol>
<p>Mothers are supported to initiate breastfeeding within one hour of birth with consideration for patient safety (4) <sup>3,4,5,6,7</sup></p>	<ol style="list-style-type: none"> <li>1. Document infant feeding decision in medical record upon admission and mother’s knowledge of the benefits and risks of infant formula.</li> <li>2. Initiate safe skin-to skin contact immediately following birth. All infants {in the population of focus} should be placed naked, prone against their mother’s bare chest, and remain there uninterrupted for at least an hour after birth and until completion of the first feeding.</li> </ol>

	<ol style="list-style-type: none"> <li>3. Encourage mothers to breastfeed within the first hour with consideration for safety of mother and infant.</li> <li>4. During skin-to-skin contact, encourage mothers to recognize when their babies are ready to breastfeed, offering help if needed.</li> <li>5. Delay routine procedures including foot printing, weighing/measuring, bathing, eye prophylaxis, and needle sticks (including Vitamin K) until the first feeding has been accomplished and whenever possible, perform at mother’s bedside. Note: NYS hospital regulations require Vitamin K administration within 6 hours of birth.</li> <li>6. After cesarean birth, place infants in continuous, uninterrupted skin-to-skin contact as soon as the mother is responsive and alert, unless separation is medically indicated.</li> <li>7. If a mother and/or baby are separated for medical reasons, initiate skin-to-skin contact as soon as the mother and baby are reunited.</li> </ol>
<p>Show mothers how to breastfeed and how to maintain lactation, even if they are separated from their infants (5) <sup>3,7,8</sup></p>	<ol style="list-style-type: none"> <li>1. Document breastfeeding instruction, education re: feeding cues, feeding on demand for all mothers, correct positioning, and signs of a good latch and assessment of latch by skilled professional each shift.</li> <li>2. Instruct mothers about the benefits of breastfeeding, importance of colostrum, hand expression, importance of exclusive breastfeeding, infant safety concerns, the risks of formula for non-medically indicated reasons, basics of breastfeeding management, possible effect of analgesia/anesthesia on infant behavior, and rationale for early skin-to-skin contact, rooming-in, and feeding on cue. Anticipate concerns about adequacy of milk supply and infant satiety.</li> <li>3. Ensure that at least one staff member is available at all times who is qualified to assist and encourage mothers with breastfeeding. (Qualifications include CLC, IBCLC, or at minimum, the Ten Steps to Successful Breastfeeding 20-Hour Course, or equivalent training.)</li> <li>4. Instruct mothers about specific breastfeeding skills and ensure that they are able to do the following: <ol style="list-style-type: none"> <li>a. Position the infant correctly so that infant can latch at the breast with no pain during feeding;</li> <li>b. State when the infant is swallowing milk;</li> <li>c. State that the infant should receive eight or more feedings of breast milk in 24 hours, and breastfeed until satisfied;</li> <li>d. State the age-appropriate elimination patterns (at least six urinations and three to four stools) for day 4 of life;</li> <li>e. List indications for calling a physician, and</li> <li>f. Manually express milk from breasts.</li> </ol> </li> <li>5. Ensure that nursing and medical staff provides consistent, positive messages about breastfeeding to all mothers who deliver within the hospital.</li> </ol>

	<ol style="list-style-type: none"> <li>6. Provide instruction using a combination of techniques including, but not limited to, 1:1 teaching, group classes, pamphlets, and videotaped instruction. Instructional materials should reflect the cultural background, education, age, and language of the patient population.</li> <li>7. Instruct all breastfeeding mothers about method of hand expression of breast milk, use of an electric pump, and sanitary procedures for collecting and storing milk. Encourage mothers to maintain lactation if separated from their infant so that breast milk can be made available to infant.</li> <li>8. Ensure breast pumping within 6 hours of delivery when mother and infant are separated for medical indications.</li> <li>9. Arrange for trained peer counselors (e.g., WIC) to make rounds and help provide education and support for breastfeeding mothers.</li> </ol>
<p>Mothers educated on infant feeding cues and understand the importance of feeding on cue/demand (8)<sup>3,6,7,8</sup></p>	<ol style="list-style-type: none"> <li>1. Educate mothers on the “supply and demand” principle of milk production, emphasizing the importance of exclusive breastfeeding to establish and maintain the milk supply.</li> <li>2. Allow frequency and duration of breastfeeding’s to be infant-led. Non-timed feedings and cue-based offerings are the basis of mother-infant care. Tell mothers to expect eight or more feedings of breast milk in 24 hours of no particular pattern or frequency.</li> <li>3. Consider limiting visiting hours or instituting a mother/infant rest period during the day to promote mothers’ rest for night feeding, increase bonding time, and decrease infant stimulation and rest.</li> <li>4. Educate mothers during postpartum periods regarding typical infant feeding cues, normal newborn behavior, cluster feeding, and readiness to feed.</li> <li>5. Educate staff about typical infant feeding cues to ensure confidence in their ability to educate mothers respond to those cues.</li> <li>6. Encourage mothers to monitor personal signs and infant signs of adequate/inadequate intake and output.</li> </ol>
<b>PRIMARY DRIVER 2: STAFF HAVE OPTIMAL KNOWLEDGE, SKILL, COMPETENCIES, AND ACCOUNTABILITY.</b>	
<b>SECONDARY DRIVERS</b>	<b>CHANGE IDEAS</b>
<p>All staff assigned to mother/infant care are trained in the skills necessary to implement breastfeeding policy (2)<sup>3,7,8</sup></p>	<ol style="list-style-type: none"> <li>1. Require that all staff with primary responsibility for the care of breastfeeding mothers and infants complete the <i>Ten Steps to Successful Breastfeeding: 20 Hour Interdisciplinary Breastfeeding Management Course for the US</i> or equivalent and a post-test verification.</li> <li>2. Require that all physicians with primary responsibility for the care of breastfeeding mothers and infants annually complete a minimum of 3 hours of evidence-based updates to knowledge and skills for the support, promotion and protection of breastfeeding; methods may include in-service education, certification courses, skills labs, conferences, web-based training, journal articles, etc.</li> <li>3. Ensure new staff has completed required breastfeeding education by 6 months of hire</li> </ol>

	<ol style="list-style-type: none"> <li>4. Provide a one-hour orientation for all support staff to enlist them in supporting and promoting hospital breastfeeding policies and practices.</li> <li>5. Consider low-cost training modalities such as the following: integrating breastfeeding education into existing staff meetings; sending key staff to “train the trainer” programs and then offering in-house training; providing self-study training modules acquired from outside vendors, or constructed from recent journal articles; and providing web-based training.</li> </ol>
<p>Staff are prepared to give no food or drink other than breast-milk (unless medically indicated) (6) <sup>3,4,5,6,7,8</sup></p>	<ol style="list-style-type: none"> <li>1. Place a sign in infant’s bassinet to identify that the infant is breastfeeding and that no bottle-feeding of any type should be offered.</li> <li>2. Do NOT place bottles with formula in or around the breastfeeding infant’s bassinet or store formula in patient’s view.</li> <li>3. Provide no supplemental water, glucose, or formula to breastfeeding infants unless specified by a written physician order for a clinical condition, or by the mother’s documented and informed request.</li> <li>4. Implement a required physician/provider order for formula supplementation, including documenting reason(s) for the provision of formula, the route of administration (i.e. spoon, cup, syringe, etc.), the form of supplement, and the amount given in the infant’s medical chart. Prior to non-medically indicated supplementation of breastfed infants (i.e. mother’s request), educate mothers about the risks of supplementation to the infant and the establishment and success of breastfeeding. Document the mother’s decision and education provided in the medical record.</li> <li>5. Use consent form to acknowledge the informed discussion on the risks of infant formula when supplementation is requested by the breastfeeding mother. Provide <u>individual</u> training in formula preparation and feeding techniques for mothers who have chosen formula feeding or for whom breastfeeding is medically contraindicated.</li> <li>6. Utilize an alternative feeding method such as a cup (recommended), dropper, or syringe to maintain mother-infant breastfeeding skills when supplementation is medically indicated.</li> <li>7. Document all episodes of infant feeding in the medical record each shift.</li> <li>8. Create new patient documentation charting fields in EHR or paper format regarding supplementation of formula for breastfeed infants that lists what the supplement is and the indication. This could be a smart phase, a sticker format, or a stamp.</li> <li>9. Institute inventory controls for formula issuance similar to other foods, medications, and/or supplies, e.g., include formula in automated dispensing and distribution systems.</li> <li>10. Review the risk of routine or non-medically indicated formula use with all mothers including the risks to breastfeeding success as well as potential health risks to mother and infant, especially due to early weaning.</li> <li>11. Do NOT accept free formula, breast milk substitutes, bottles or nipples.</li> </ol>

<p>Pacifiers or artificial nipples are not given to breastfeeding infants (9)<sup>3,5,6</sup></p>	<ol style="list-style-type: none"> <li>1. Do NOT provide healthy breastfed infants with pacifiers or artificial nipples (There may be a role for pacifier use in the preterm or ill infant who is not able to suckle at the breast). Pacifiers or a gloved finger may be used for specific medical reasons or to decrease pain during procedures during blood sampling or circumcision but should be discontinued thereafter.</li> <li>2. Encourage mothers to hold and breastfeed infants during, or immediately following, routine painful procedures such as heel sticks and IM injections.</li> <li>3. Before providing a pacifier or artificial nipple that has been requested by the mother, the hospital should educate the mother on the possible impacts to the success of breastfeeding and discuss alternative methods for soothing her infant, and document such education.</li> <li>4. Implement skin-to-skin and rooming-in protocols to promote infant soothing opportunities. Integrate skin-to-skin and breastfeeding into relevant hospital infant care protocols including hypoglycemia, hypothermia, pain relief, and circumcision.</li> <li>5. Educate staff about soothing techniques such as skin-to-skin, breastfeeding, walking and rocking to use with infants.</li> <li>6. Institute inventory controls for pacifier issuance similar to other foods, medications, and/or supplies, e.g., include pacifiers in automated dispensing and distribution systems.</li> <li>7. Do NOT accept free or low-cost pacifiers or routinely distribute pacifiers to pregnant women, mothers or their families.</li> </ol>
<p><b>PRIMARY DRIVER 3: HOSPITAL POLICIES AND PROCEDURES ARE IN PLACE TO SUPPORT BREASTFEEDING</b></p>	
<p><b>SECONDARY DRIVERS</b></p>	<p><b>CHANGE IDEAS</b></p>
<p>A written breastfeeding policy exists that is routinely communicated with staff (1)<sup>3,7,8</sup></p>	<ol style="list-style-type: none"> <li>1. Designate at least one person who is thoroughly trained in breastfeeding physiology and management to be responsible for ensuring the implementation of an effective breastfeeding program.</li> <li>2. Provide a one-hour orientation for all support staff to enlist them in supporting and promoting hospital breastfeeding policies and practices.</li> <li>3. Create an interdisciplinary, culturally appropriate team comprised of hospital staff whose goal is to reduce institutional barriers to breastfeeding.</li> <li>4. The facility will have a detailed breastfeeding policy that is inclusive of the <i>Ten Steps to Successful Breastfeeding</i> and NYS laws and regulations.</li> <li>5. Use a Self-Appraisal Tool to examine how the current practices differ from those specified by the <i>Ten Steps to Successful Breastfeeding</i>.</li> <li>6. All hospital departments serving mothers, infants and/or children comply with the facility's breastfeeding policy.</li> </ol>

	<ol style="list-style-type: none"> <li>7. Institute methods to verify that maternity care practices are consistent with hospital breastfeeding policy.</li> <li>8. Ensure the breastfeeding policy is developed, updated, implemented and disseminated annually to staff providing maternity or newborn care.</li> <li>9. Establish a breast milk expression policy for lactating hospital employees.</li> </ol>
<p>Restrict distribution of materials from formula companies <sup>8,9,10,11,12</sup></p>	<ol style="list-style-type: none"> <li>1. Do NOT distribute marketing materials, samples or gift packs that include breast milk substitutes, bottles, nipples, pacifiers or coupons for any such items to pregnant women, mothers or their families.</li> <li>2. Do NOT use educational materials which refer to proprietary product(s) or bear product logo(s), unless specific to the mother’s or infant’s needs or condition or distribute materials that contain messages that promote or advertise infant food or drinks other than breast milk.</li> <li>3. Work with marketing to develop educational information about infant feeding and/or infant care that is free of commercial messages or logos. If the hospital wishes to distribute discharge ‘gift bags’ to patients, such bags should be free of all commercial influences.</li> <li>4. Ensure that all education media is free of commercial messages and logos used to promote formula and artificial feeding.</li> <li>5. Purchase infant formula and feeding devices in the same manner as other food and supplies and incorporate costs into insurance reimbursement contracts.</li> <li>6. Work with the purchasing department to document the actual amount of formula used (versus what is stocked) and determine its fair market price as a basis for considering the purchase of formula.</li> <li>7. Ensure that business relationships and vendor policies with formula and breastfeeding equipment companies are congruent with policies for other vendors. Work with purchasing department to understand the need and importance of ensuring corporate compliance with formula and formulas company products.</li> <li>8. Ensure all staff do not receive gifts or personal samples, or use note pads, post-its, pens, or any other incentives obtained from commercial formula companies or other companies that violate the International Code of Marketing of Breast-milk Substitutes.</li> </ol>
<p>Practice rooming-in (minimum of 23 hours a day) (7) <sup>3,4,5,6,7</sup></p>	<ol style="list-style-type: none"> <li>1. Practice rooming-in throughout the facility unless medically contraindicated or the facility does not have sufficient capacity to accommodate rooming-in requests.</li> <li>2. Do NOT separate healthy mothers and infants during the hospital stay for routine procedures or sleep time.</li> <li>3. Care for infant at mother’s bedside; use portable scales, bath equipment, etc., to provide care at mother’s bedside. Examine the routine procedures that “require” infant to be taken to the nursery. Determine which procedures could be done in mother’s room, to offer more opportunities for education during care/assessment.</li> </ol>

	<ol style="list-style-type: none"> <li>4. Equip mother’s room with items needed for pediatric assessment to encourage physicians to conduct newborn exams in the mother’s room. Keep documentation of infant vital signs, weights, and feedings with infant in mother’s room.</li> <li>5. Provide information about the benefits of rooming-in to mothers, significant others (SO) and family members prior to and when separation from their infant is requested by mother, SO, and/or family member.</li> <li>6. Feed an infant in a manner that is consistent with preserving breastfeeding (cup, dropper, or syringe) if a mother is unable or refuses to feed her infant during the night. Use hand expressed (or pumped) breast milk whenever possible. Document maternal education regarding breastfeeding supplements/complements and decision to supplement/complement in the medical record.</li> <li>7. Prioritize skin-to-skin contact and breastfeeding over other routine events such as infant bathing, circumcision, pictures, and visitors during an infant’s first day of life.</li> <li>8. Consider admission of the infant in ways that limit mother baby separation such as utilizing the nursery nurse as an admission nurse or as staff for transition care, in which nursery staff admits infant in delivery room or post-anesthesia care unit (PACU).</li> <li>9. Institute “quiet time” during the day for naps, during which visitors are not allowed and routine procedures, that are not medically necessary, are not conducted.</li> </ol>
<p>Quality Improvement (QI) efforts are utilized to improve exclusive breastfeeding rates</p>	<ol style="list-style-type: none"> <li>1. Provide/support organizational training in quality improvement methods and techniques.</li> <li>2. Conduct patient surveys routinely, and use patient and family feedback to identify challenges and improve family experience.</li> <li>3. Ask patient, family and community partners to be active members of the interdisciplinary breastfeeding committee in your hospital.</li> <li>4. Use data for learning. Use lessons learned from data to develop new Plan-Do-Study-Act cycles.</li> <li>5. Provide regular reports on performance to senior leadership, e.g. at hospital QI meetings, and have them address or remove barriers to improvement.</li> <li>6. Include community based stakeholders to enhance the reach of Steps 3 and 10.</li> </ol>
<p><b>PRIMARY DRIVER 4: SENIOR LEADERSHIP IS ENGAGED AND ARE A CHAMPION FOR CHANGE.</b></p>	
<p><b>SECONDARY DRIVERS</b></p>	<p><b>CHANGE IDEAS</b></p>
<p>Adequate staffing, equipment, and financial resources are available</p>	<ol style="list-style-type: none"> <li>1. All hospital departments serving mothers, infants and/or children, comply with the facility’s breastfeeding policy.</li> <li>2. Institute methods to verify that maternity care practices are consistent with hospital breastfeeding policy.</li> </ol>

	<ol style="list-style-type: none"> <li>3. Consider low-cost training modalities such as the following: integrating breastfeeding education into existing staff meetings; sending key staff to “train the trainer” programs and then offering in-house training; providing self-study training modules acquired from outside vendors, or constructed from recent journal articles; providing web-based training, and yearly in-service training. Ensure that all training promotes the Ten Steps to Successful Breastfeeding and is provided by World Health Organization (WHO) Code compliant entities/organizations.</li> </ol>
Performance data is shared with leadership at least quarterly	<ol style="list-style-type: none"> <li>1. Use existing meeting to provide updates: executive and management meetings, OB and Peds department/division meetings, board meetings, etc.</li> <li>2. Utilize Electronic Medical Record to support accurate documentation and data aggregation.</li> <li>3. Create an e-newsletter that goes out to all providers twice a year with updates, performance measures, QI issues, survey results, etc. Include all staff in generating ideas for improvement.</li> </ol>
Improvement efforts are dynamic and focused, with shared accountability	<ol style="list-style-type: none"> <li>1. Ensure breastfeeding work is tied to your hospital’s organization mission.</li> <li>2. Engage leadership to ensure policy and evidence-based best practice are being used by all professional staff.</li> <li>3. Create an interdisciplinary, culturally-appropriate team comprised of hospital staff whose goal is to reduce institutional barriers to breastfeeding. Consider inclusion of WIC Local Agency Breastfeeding Coordinator or Peer Counselor to address WIC population.</li> <li>4. Ensure hospital board / leadership understands this as a priority for community health (specified in NYS Prevention Agenda) and the facilitation of evidence-based practice.</li> </ol>
<b>PRIMARY DRIVER 5: FAMILIES ARE CONNECTED WITH APPROPRIATE COMMUNITY-BASED RESOURCES TO SUPPORT ONGOING BREASTFEEDING</b>	
<b>SECONDARY DRIVERS</b>	<b>CHANGE IDEAS</b>
Discharge planning focused on infant feeding choice with instructions for all mothers include post discharge supports <sup>15</sup>	<ol style="list-style-type: none"> <li>1. Focus discharge planning for breastfeeding couplets on patient safety, success, and duration of breastfeeding; include options for community support &amp; resources, which are current and culturally-appropriate.</li> <li>2. Prior to discharge, conduct a formal breastfeeding assessment to anticipate problems based on maternal and infant risk factors and create a follow-up plan of action.</li> <li>3. Assess available community breastfeeding support resources and maintain a current list of community lactation resources for specific referrals of breastfeeding mothers.</li> <li>4. Inform the mother of community services, including the Special Supplemental Nutrition Program for Women, Infants and Children (WIC), and make referrals to such community services as appropriate.</li> </ol>

	<ol style="list-style-type: none"> <li>5. Establish a WIC peer counselor program to ensure connections to available community resources for all WIC eligible mothers and newborns</li> <li>6. Provide breastfeeding mothers with telephone numbers of lactation consultants and/or community resources for breastfeeding assistance.</li> <li>7. Whenever possible, refer breastfeeding mothers to a breastfeeding support group that provides services consistent with cultural and economic needs.</li> <li>8. Arrange for evaluation of all breastfeeding newborns within 3-5 days of age, by a pediatrician or other knowledgeable health professional, as recommended by the American Academy of Pediatrics (AAP) and follow current perinatal guidelines and recommendations.</li> <li>9. Provide home visiting referrals to support the continuation of breastfeeding, especially for high-risk mothers and infants.</li> <li>10. Prior to discharge, determine that sources of nutrition for the infant and mother will be available and sufficient and if this is not confirmed, the attending practitioner and an appropriate social services agency are notified.</li> <li>11. Support coordination of follow-up care between OB, family physician, midwife, and pediatric providers for the mother and infant post-discharge.</li> </ol>
<p>Foster the establishment of breastfeeding support groups</p>	<ol style="list-style-type: none"> <li>1. Establish and schedule support groups within the hospital and the community.</li> <li>2. Ensure support groups understand and appreciate individuals from different cultures, provide bilingual staff, and address the influence culture may have on breastfeeding.</li> <li>3. Provide support to mothers/families if economic/transportation issues exist.</li> <li>4. Link with existing stakeholders, such as state or local breastfeeding coalitions, mother groups, and faith-based organizations, to promote community awareness of the benefit of breastfeeding.</li> </ol>
<p>Create partnerships with community-based organizations to promote ongoing breastfeeding support</p>	<ol style="list-style-type: none"> <li>1. Ensure all staff understands the value of community resources they are referring postpartum mothers to these resources.</li> <li>2. Have community partners present at staff meetings and at OB and Pediatric grand rounds or interdisciplinary breastfeeding committee meetings.</li> <li>3. Identify supports reflective of the patient population to ensure cultural and linguistic competency.</li> <li>4. Refer breastfeeding mothers to a breastfeeding support group.</li> </ol>

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