Promoting, Protecting and Supporting Breastfeeding

A North Carolina Blueprint for Action

2006

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North Carolina Department of Health and Human Services
Division of Public Health

Women's and Children's Health Section
Nutrition Services Branch

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Message from the Secretary

North Carolina Department of Health and Human Services

It is with great pleasure that I present this Blueprint for Action for promoting, protecting and supporting breastfeeding in North Carolina. The Blueprint for Action has been developed by the N.C. Division of Public Health in collaboration with a work group of representatives from state and community agencies and organizations.

Breastfeeding is one of the most effective ways to promote the health of our children during their early years of life. Moreover, the evidence shows that breastfeeding conveys important benefits to both the child and the mother that extend throughout the life cycle.

Promoting breastfeeding is one important way that the N.C. Department of Health and Human Services carries out its mission of protecting the public health, fostering self-reliance, and eliminating health disparities. I invite you to join with us in using this blueprint and responding to its call to action.

Community-driven, ethical, compassionate and evidence-based health and regulatory practices that promote, protect and support breastfeeding in North Carolina require that a wide range of public health programs and state and local organizations work in partnership. Our collective commitment to this process will foster the achievement of our goal of improving the health of all who live and work in North Carolina – beginning with our babies and our mothers.

Sincerely,

Carmen Hooker Odom
Secretary

Foreword

North Carolina's children are our number-one priority, and our commitment to giving them a healthy start begins with promoting, protecting and supporting breastfeeding. Breastfeeding is the best possible foundation for infant and young child feeding. Many groups, including the American Academy of Pediatrics, American Association of Family Physicians, American College of Obstetricians and Gynecologists, and Academy of Breastfeeding Medicine, recommend that infants receive their mother's milk for at least the first year of life.

North Carolina has taken many important steps forward, and effective interventions have been implemented at the state and community level to increase the initiation of breastfeeding, to make it an exclusive practice (rather than being combined with infant formula), and to increase its duration. Despite measurable progress, however, much remains to be done. North Carolina has yet to attain the Healthy People 2010 performance goals of having at least 75 percent of new mothers initiate breastfeeding, with at least 50 percent of the infants continuing to be breastfed until at least six months of age and 25 percent continuing until at least one year of age.

This blueprint incorporates input from a broad spectrum of community, state and national stakeholders and experts in the field. The document is intended to serve as a guide for North Carolina communities, health care systems, professional societies, academic and training programs, workplaces, and child care facilities to support, promote, and protect breastfeeding.

For breastfeeding to be successful, all mothers must have the broad support of their family, friends, communities, health care providers, insurers, workplaces, and policy makers. This supportive environment can empower mothers in North Carolina to breastfeed their infants.

We hope that the charge set forth through this blueprint will resonate with all North Carolinians committed to improving the health of women, infants, and children.

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A North Carolina Breastfeeding Blueprint

The Nutrition Services Branch (NSB) in the NC Division of Public Health spearheaded the development of this document, Promoting, Protecting and Supporting Breastfeeding: A North Carolina Blueprint for Action. To ensure that the blueprint would reflect the experiences and perspectives of a wide range of stakeholders and supporters of breastfeeding, the NSB invited representatives from diverse disciplines and communities across the state to participate in a public forum on September 9, 2004, entitled "Promoting, Protecting and Supporting Breastfeeding in North Carolina." The forum resulted in the specific recommendations contained in this blueprint. Appendix 6 includes information about the public forum.

The ultimate goal for North Carolina, formally adopted through the public forum, is to "increase breastfeeding initiation and duration rates by positively influencing the breastfeeding climate." To move successfully towards this goal, changes are needed in communities, the health care system, the workplace, child care facilities, the insurance industry and legislation. Ideally, these changes will come through public and private organizations working individually and collectively to seek new policies and legislation, develop programs, use the media and conduct research. Working together, we can promote and assure the opportunity for early, exclusive and continued breastfeeding for all North Carolina mothers and infants.

Refer to Appendix 1 and Appendix 5 for references used to support the discussions in this blueprint.

Vision:

North Carolina mothers will be enabled to begin their children's lives by breastfeeding - the best possible foundation for infant and young child feeding.

Breastfeeding:

A Public and Personal Health Issue

Introduction

Breastfeeding is not simply a lifestyle choice. It is universally endorsed by the world's health and scientific organizations as the best way of feeding infants. The best infant and young child feeding practices are defined internationally as early and exclusive breastfeeding for 6 months, then continuation of breastfeeding while adding age-appropriate complementary foods for two years or more. The evidence is clear that breastfeeding provides immediate and lifelong nutrition and health benefits for both mother and child, as well as larger economic, environmental and social benefits to families and communities. Breastfeeding must be considered the standard for infant feeding in the first year of life or longer.

Benefits of Breastfeeding

For infants and children

For infants and children, human mother's milk supports optimal development and provides immunities against acute and chronic illness. A mother's milk provides protection and growth factors unique to her infant and changes over time (even over the course of a day) to meet the changing nutritional needs of her infant. Human milk, unique and specific to humans, cannot be duplicated by any artificial means.

Strong evidence exists that infants fed human milk experience decreases in the incidence and/or severity of childhood infectious illnesses including bacterial meningitis, bacteremia, diarrhea, respiratory tract infections, necrotizing enterocolitis (NEC), otitis media, and urinary tract infections. Some studies suggest that breastfeeding decreases rates of sudden infant death syndrome (SIDS).

Evidence is growing that breastfeeding may reduce the incidence of a variety of chronic health issues including diabetes mellitus (type 1 and type 2), certain cancers, overweight/obesity, hypercholesterolemia, and

asthma in older children and adults. Breastfeeding also has been associated with slightly enhanced cognitive development.

For mothers

The benefits of breastfeeding are not confined to infants and children. Mothers who breastfeed within the first 30-60 minutes after the birth of their infants and who continue breastfeeding at least through the baby's first year, will gain both immediate and lifelong health benefits. The longer a woman spends breastfeeding, the greater the beneficial effect. Mothers who breastfeed experience decreased post-partum bleeding, more rapid uterine involution, and a faster return to prepregnancy weight than women who do not breastfeed. Additional benefits of continued breastfeeding include increased child spacing, a decreased risk of ovarian cancer and premenopausal breast cancer, and possibly a decreased risk of hip fractures and osteoporosis after menopause.

For family and community

Breastfeeding offers benefits to the family and community-at-large beyond those related to the improved health of mothers and children. Breastfeeding has the potential to decrease health care costs, some estimating by as much as $3.6 billion annually, although some small portion of these savings would be offset by the cost of health services to support breastfeeding (i.e., lactation consultants). With the decrease in infant illness associated with breastfeeding, there could be reduced parental absenteeism from work and/or more time for parents to spend with family and friends. Families that breastfeed may experience lower food costs, since infant formula costs upwards of $1,200 -$1,500 annually. Benefits of breastfeeding for the environment include reduced energy demands to manufacture, transport, and prepare infant formula, along with a reduced burden of disposing of infant formula packaging (i.e., bottles and cans).

Barriers to Breastfeeding in North Carolina

Why Women Are Not Breastfeeding

Some groups of women in North Carolina appear less likely than others to breastfeed. Demographic characteristics such as race, age, ethnicity, education, marital status and income have been found to be associated with the decision to breastfeed. Data suggest that women are less likely to breastfeed if they have lower income and less education, are unmarried, obese, depressed or smoke. (Source: North Carolina Pregnancy Risk Assessment and Monitoring Survey [PRAMS] data).

A common barrier for women to initiate or to continue exclusively breastfeeding is a lack of knowledge among the general population and health care professionals about the risks of not breastfeeding. Inconsistent and inaccurate information about how to breastfeed confuses mothers and often discourages them from initiating or continuing with breastfeeding. Other concerns for the new mother which may lead to early discontinuation of breastfeeding include fear of pain, fear of inadequacy of milk supply, lack of support and care for her own needs, and a perception of not having enough time to nurse. Hospital practices can interfere with early establishment of breastfeeding. Separating mother and infant diminishes a mother's chance of learning to recognize early feeding cues and of emptying her breasts frequently enough to foster optimal milk production. A hospital's casual use of infant formula to "supplement" breastfeeding without medical indication, giving pacifiers to infants, and providing samples of infant formula (which implies endorsement of them) are practices associated with shorter breastfeeding duration.

Limited family or community support for breastfeeding during the critical postpartum period can be another barrier to breastfeed-

ing, especially when there are limited role models and support systems for new mothers. New mothers need adequate food, drink, rest, and help to manage their stress. In our society, where breasts are depicted primarily as sexual rather than as the essential way of feeding and nurturing infants, there also may be psychosocial barriers associated with meeting an infant's nutritional needs through breastfeeding.

The extensive commercial promotion of infant formulas and their easy accessibility have created widespread acceptance that these products are equal to human milk and merely a lifestyle choice for the mother. The perceptions that these products are more up-to-date, convenient, or improved are false impressions created through marketing. To further exacerbate the problem, these products are frequently distributed as free samples to healthcare professionals and through direct distribution to families of young children; both practices conflict with the "International Code of Marketing of Breast-milk Substitutes." Refer to Appendix 2 for information on the International Code.

Status of Breastfeeding in North Carolina

Why We Need to Improve

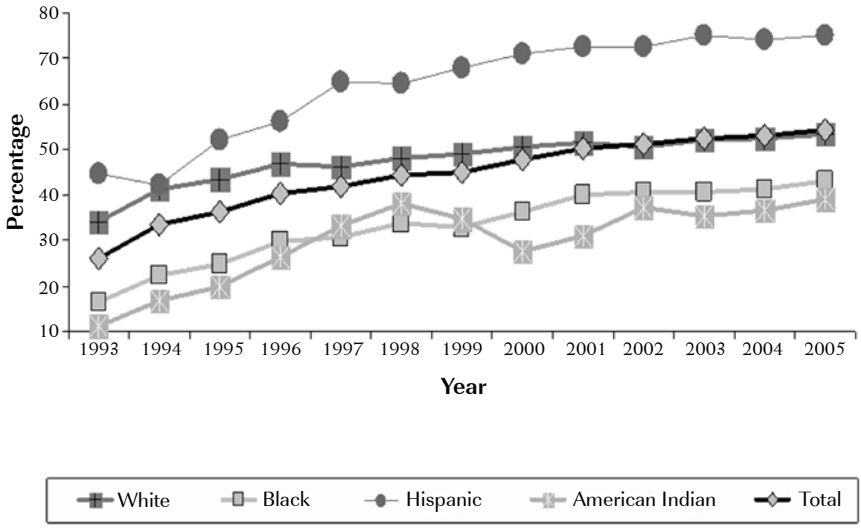
Among the 115,000 -119,000 births each year in North Carolina, there has been an increase in the number of infants who begin their lives breastfeeding: 69.9% in 2003, compared to 64.2% in 1999. Of the 69.9% of women who initiated breastfeeding in 2003, approximately 47% continued to breastfeed eight weeks or beyond, compared to 40.3% in 1999 (source: NC PRAMS).

While North Carolina has experienced an increase in breastfeeding initiation, the state remains below the Healthy People 2010 goal of having at least 75% of mothers initiate breastfeeding. With only about 47% of women still breastfeeding at eight weeks, North Carolina also falls short of the goal of having at least 50%

of the infants continuing to be breastfed until at least six months of age.

A twelve-year study (1993-2005) of infants enrolled in the N.C. Supplemental Nutrition Program for Women, Infants, and Children (WIC) shows the percent of infants who initiated breastfeeding has slowly improved, from about 26% in 1993 to 54.3% in 2005. However, the extent of changes in the percent of infants initiating breastfeeding varies with race and ethnicity. (Figure 1).

Figure 1: Breastfeeding Initiation among Infants Participating in N.C. WIC Program* by Race and Ethnicity (1993-2005)

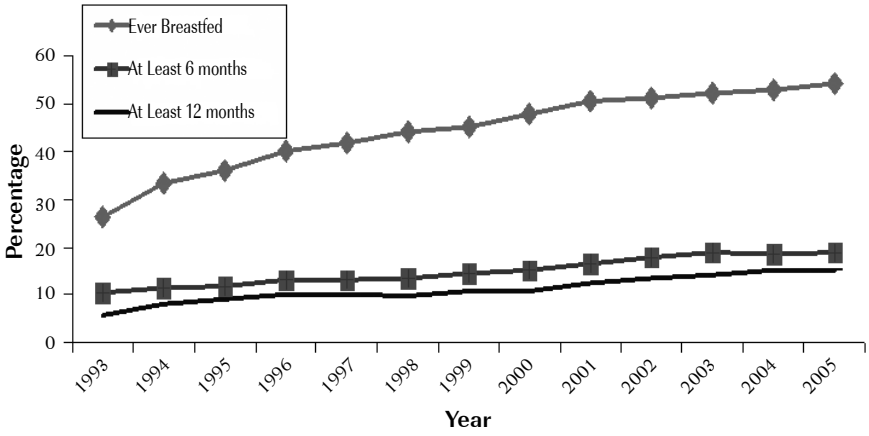


**Among infants born during the reporting period (Source: N.C. Pediatric Nutrition Surveillance System).*

Healthy People 2010 Objective: Increase the proportion of mothers who breastfeed their babies in the early postpartum period to 75%.

The number of infants breastfeeding for six months and for one year has also steadily improved, though relatively slowly over these 11 years (Figure 2).

Figure 2: Duration of Breastfeeding among Infants Participating in the N.C. WIC Program* (1993-2005)

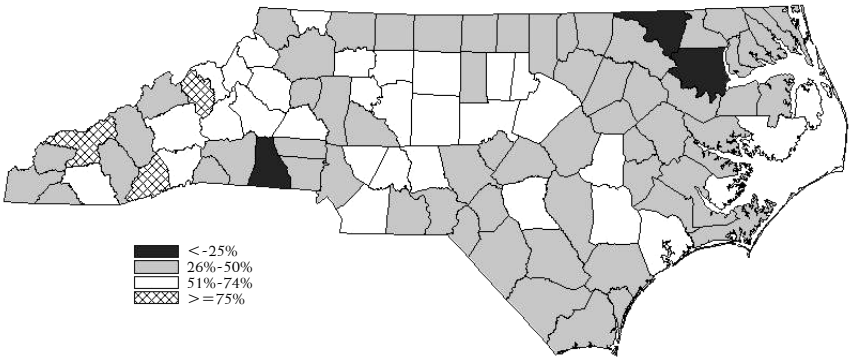


**Among infants born during the reporting period (Source: N.C. Pediatric Nutrition Surveillance System).*

Healthy People 2010 Objective: Increase the proportion of mothers who breastfeed their babies in the early postpartum period to 75%, with at least 50% of the infants continuing to be breastfed until at least 6 months of age, and 25% continuing to at least one year of age.

A map of North Carolina by county illustrates that some areas of the state are close to the Healthy People 2010 objective for breastfeeding initiation while others are not. The data suggests also that there are significant geographic disparities in the state regarding breastfeeding initiation. (Figure 3).

Figure 3: Breastfeeding Initiation Rates among Women Participating in the N.C. WIC Program, 2005



Breastfeeding Initiation Rates in Percent

Healthy People 2010 Objective: Increase the proportion of mothers who breastfeed their babies in the early postpartum period to 75%.

Key Recommendations for Promoting, Protecting and Supporting Breastfeeding in North Carolina

Participants at the 2004 Breastfeeding Forum recommended a variety of actions to improve breastfeeding by promoting, protecting and supporting breastfeeding for all North Carolina mothers and babies. Following the forum, these recommendations were assessed using relevant criteria adapted from the North Carolina Healthy Weight Initiative state plan, *Moving Our Children Toward A Healthy Weight*. The four criteria selected and systematically applied to the recommendations included in this blueprint follow:

Criterion 1. Does the recommendation have a basis in science and/or best practice — that is, has the implementation of the recommendation been shown to have a positive effect or association with breastfeeding?

Criterion 2. Does the recommendation provide the degree of specificity necessary to guide the development of effective strategies and to evaluate their impact?

Criterion 3. When considered in their entirety, do the recommendations address the most relevant variables that are associated with promoting, protecting and supporting initiation and duration of breastfeeding?

Criterion 4. When considered in their entirety, do the recommendations support (directly or indirectly) North Carolina's commitment to eliminate health disparities?

This review process resulted in the following eight key recommendations for breastfeeding:

I. Encourage the adoption of activities that create breastfeeding-friendly communities.

II. Create a breastfeeding-friendly health care system.

III. Encourage the adoption of breastfeeding-friendly workplaces.

IV. Assist child care facilities in promoting, protecting and supporting breastfeeding.

V. Advocate for insurance coverage by all third-party payers for breastfeeding care, services, and equipment when necessary.

VI. Involve media and use social marketing and public education to promote breastfeeding.

VII. Promote and enforce new and existing laws, policies and regulations that support and protect breastfeeding.

VIII. Encourage research and evaluation on breastfeeding outcomes, trends, quality of care, and best practices.

These eight key recommendations provide a framework for action to increase the number of North Carolina mothers who will be enabled to choose and succeed in breastfeeding their children. The next section of the blueprint, "From Recommendations to Action." outlines actions for each of the eight key recommendations.

In deciding which key recommendations and actions to include, given the array of possibilities and available resources, we tried to select the most appropriate and sustainable interventions for North Carolina. It was also important to incorporate actions for which effectiveness has been determined by evidence-based research. This last effort was facilitated by the fact that the Centers for Disease Control and Prevention (CDC), the American Academy of Pediatrics (AAP), and the US Breastfeeding Committee (USBC) have synthesized available research to identify activities determined to be effective.

From Recommendations to Action

The purpose of this section of the blueprint is to offer recommended actions that will interest and engage a broad spectrum of stakeholders and supporters of breastfeeding for each of the eight key recommendations.

Due to the natural overlapping of issues across the eight key recommendations, the reader is encouraged to review all eight areas to identify actions relevant to their interests, regardless of how the actions are categorized.

A cumulative effort by many, regardless of the magnitude of any single effort, will contribute towards making breastfeeding the norm for infant feeding in North Carolina. It is hoped, therefore, that leaders within communities, government, health care, business, academia, and public and private organizations will use one or more sets of recommended actions relevant to their settings to guide them in their efforts to promote, protect and support breastfeeding. It is only through a well-orchestrated combination of individual efforts, policies, environmental support and research that we will achieve the vision for North Carolina's mothers and children so clearly articulated at the breastfeeding public forum.

Communities

I. Encourage the adoption of activities that create breastfeeding-friendly communities.

Women usually understand the benefits of breastfeeding for their children, but may lack information on the benefits of breastfeeding for themselves and their families. They also may not have access to support on how to breastfeed or how to manage the problems sometimes associated with breastfeeding. Some women who would like to consider breastfeeding may hesitate to do so

when the father of their baby, their family, or the community in which they live are not supportive. Educating and supporting the whole family and the community at-large, therefore, will result in increasing breastfeeding rates. Assuring support before, during and after delivery with social networks and breastfeeding peer counselor services can positively affect a woman's decision to initiate and to continue breastfeeding.

Breastfeeding peer support is a social network that is a cost-effective approach for women of every socioeconomic background. Women tend to be influenced by other women, and new mothers are more likely to talk to other mothers about breastfeeding. Peer counselors have been effective in settings where contact with professional breastfeeding support is limited and where social networks are scarce.

Breastfeeding peer counselors are usually women with breastfeeding experience and are of similar socioeconomic status as the women to whom they offer support. Breastfeeding peer counselors are trained to help other women overcome challenges that might otherwise lead the women to not breastfeed or to wean early although breastfeeding was initiated.

Integrating peer support within the community service system and through community partnerships helps to maintain ongoing peer counseling program success. In some communities, mother-to-mother groups are already in place. Groups, such as La Leche League International, offer free and enthusiastic peer support.

Board Certified Lactation Consultants are another group that may be called upon in the community to visit homes and support new mothers. Additional information about breastfeeding peer counselors, breastfeeding educators and board certified lactation consultants can be found in Appendix 3.

Public acceptance of breastfeeding as the normal infant feeding method is not found in all parts of the society and diverse communities of North Carolina, yet public acceptance is essential to increasing the numbers of women who initiate and continue breastfeeding their infants. For some pregnant women, the social barriers are too great to even consider breastfeeding. Mothers who breastfeed often report feeling embarrassed to nurse their hungry babies when they are away from home. In North Carolina, even though it is legal to breastfeed in public, women have been asked to leave restaurants, shopping malls, and other public places because they were breastfeeding their infants.

Recommendations for Action – Communities

1. Use consistent and culturally appropriate breastfeeding promotion and support messages. Encourage and support collaboration in the development and provision of such messages among state and community agencies and organizations that provide services to young families. Such agencies and organizations include, but are not limited to, private and public health care systems (i.e., hospitals, public health departments, physicians' offices, birthing centers), educational systems, and breastfeeding support groups.

2. Develop ways to acknowledge the important role that the father of the infant and the woman's family members (e.g., parents, siblings, grandparents, other relatives) and friends play in influencing a woman's decision to breastfeed. Provide targeted and culturally appropriate support and education to each of these groups of individuals. Include ways to provide this information through community organizations.

3. Acknowledge the important role of age when influencing adolescents regarding infant feeding choices, and develop and provide appropriate and relevant messages, critical support and education targeted to their needs.

4. Provide easy access to breastfeeding resources and breastfeeding toll-free assistance by phone, in English, Spanish and TTY, with referral to 24 hour - 7 days a week support.

5. Promote interagency collaboration among private and public health care systems, educational systems and community organizations currently offering breastfeeding support. This effort could include state and local WIC programs, public health departments, school systems, hospitals, community breastfeeding support groups (such as La Leche League and Nursing Mothers), physicians' offices, Head Start, and the North Carolina Smart Start Program.

6. Assess the availability and accessibility of community breastfeeding support networks. Develop ways to increase and to integrate community breastfeeding peer counselors, educators, and experts into easily accessible community services. Establish a universal goal of providing peer-to-peer and lactation support to all new mothers, without regard to income, program eligibility or other demographic characteristics.

7. Establish links between maternity facilities and community breastfeeding support networks to establish continuous care and support to breastfeeding mothers and babies.

8. Develop ways to create a welcoming and comfortable atmosphere for breastfeeding mothers and babies for

community events and public spaces such as local shopping centers, government offices and parks.

9. Offer technical assistance to faith-based and other community organizations to encourage the development of breastfeeding-friendly practices.

10. Identify and recruit community leaders to further the progress in establishing breastfeeding as a community norm.

11. Incorporate breastfeeding information in all state and local sponsored school health education curricula, from kindergarten through higher education, to increase understanding of breastfeeding as the standard for infant feeding.

Health Care System

II. Create a breastfeeding-friendly health care system.

Attitudes toward and success with breastfeeding are greatly influenced by events during pregnancy, labor and birthing, the time immediately after birth, and during later visits with health care providers.

Education and counseling during pregnancy regarding maternal readiness, breast health and breastfeeding initiation can affect a woman's decision to breastfeed. Birthing practices can play a pivotal role in the initiation and length of time breastfeeding continues. The presence of a supportive, non-judgmental individual throughout labor and delivery both eases labor and enhances breastfeeding. Because of its relationship with the birth experience, breastfeeding must be supported throughout the maternity

hospital stay and then extended to the community after the infant and mother return home.

Breastfeeding must also be supported in all medical services that serve mothers of young children, whether surgical, infectious disease or other. Unnecessary disruption of breastfeeding is often the result of medical interventions outside the maternity or newborn setting. Board certified lactation consultants are available in many areas and can provide lactation management services and adjunct support to health care providers within the health care facility itself and/or in the home of the breastfeeding mother.

Facilities such as birthing centers, hospitals and pediatric practices that are breastfeeding-friendly typically experience an increase in breastfeeding rates. Actions taken to become a breastfeeding-friendly health facility can be part of a comprehensive set of practices such as those implemented in pursuit of World Health Organization/UNICEF Baby-Friendly Hospital Initiative (BFHI) designation. They can also be discrete, less comprehensive interventions which, over time, create a more breastfeeding-friendly environment.

North Carolina currently has no certified breastfeeding-friendly hospitals or birthing centers. Yet in 2004, North Carolina hospitals provided birthing assistance to more than 119,000 mothers. In the United States, as of April 2006, just 53 hospitals and birthing centers carry the BFHI designation, despite evidence of the improved health outcomes for infants and mothers and improved patient and staff satisfaction in BFHI facilities. It is important to note that facilities implementing fewer than the full ten steps have achieved improved maternity care and breastfeeding outcomes. Although challenging, maternity care facilities should be encouraged to strive to implement all ten steps and receive BFHI status.

Educating hospital staff and other health care professionals through training and ongoing continuing education can enhance compliance with optimal maternity and pediatric care practices, including those associated with breastfeeding support. Many clinicians indicate that they lack the skills and/or confidence to help mothers initiate normal breastfeeding or manage breastfeeding challenges. Some still have the misconception that the overall benefit of breastfeeding is small and that use of infant formulas does not create any risks.

Education to increase the knowledge, attitudes and skills of health care providers is needed regarding breastfeeding. At a minimum, this education should address the importance of exclusive breastfeeding as a health behavior with multiple benefits for both mother and child; the differences between human milk and infant formulas; and the importance of accessing a referral network to appropriately manage breastfeeding challenges.

The health care system must pay attention also to the widespread practice of advertising and distributing samples of infant formula to new mothers before, during and after the hospital stay. This practice has a negative impact on breastfeeding, with a disproportionately negative impact on mothers who are particularly vulnerable, including first-time, less educated, or nonwhite mothers, or mothers (and/or their infants) who experience illness during the postpartum period. The most common reason women give for stopping breastfeeding in the early postpartum period is a perceived lack of a sufficient milk supply. This false perception of insufficiency of breast milk can be further exacerbated when the health care system readily provides free samples of infant formula, implying product endorsement.

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 skills necessary to implement this policy.*
3. *Inform all pregnant women about the benefits and management of breastfeeding.*
4. *Help mothers initiate breastfeeding within one half-hour of birth.*
5. *Show mothers how to breastfeed and maintain lactation even if they may be separated from their infants.*
6. *Give newborn infants no food or drink other than breastmilk, unless medically indicated.*
7. *Practice rooming in - allow mothers & infants to remain together - 24 hours a day.*
8. *Encourage breastfeeding on demand.*
9. *Give no artificial teats or pacifiers (also called dummies or soothers) to breastfeeding infants.*
10. *Foster the establishment of breastfeeding support groups and refer mothers to them on discharge from the hospital or clinic.*

The World Health Organization (WHO) and United Nations International Children's Emergency Fund (UNICEF)

Recommendations for Action – Health Care Systems

1. Engage the North Carolina Hospital Association and other health professional organizations in championing the implementation of the Baby-Friendly Hospital Initiative (BFHI) in North Carolina. Develop ways to provide technical assistance and support to community-based health care facilities (i.e., community and primary health centers, local health departments, physician practices) to adopt the policies and practices defined in the Baby-Friendly Hospital Initiative (BFHI). Pursue funding to assist maternity care facilities in implementing the evidence-based practices encompassed in the BFHI Ten Steps to Successful Breastfeeding.

2. Develop and implement a North Carolina-specific method and a tool for assessing a facility's progress toward breastfeeding support and compliance with breastfeeding best practices.

3. Disseminate evidence-based information on the cost-effectiveness of breastfeeding and on effective breastfeeding-friendly practices to key decision-makers for health care institutions.

4. Develop policies, protocols and standards of practice that integrate clinical best practices throughout local health care systems and institutions, with reliance on breastfeeding authorities such as the Academy of Breastfeeding Medicine (ABM), American Academy of Pediatrics (AAP), American College of Obstetricians and Gynecologists, American Academy of Family Physicians (AAFP), and the International Lactation Consultant Association (ILCA).

5. Establish a system for publicly recognizing hospitals and other maternity care facilities that have made improvements in maternity care practices related to breastfeeding.

6. Establish breastfeeding education courses that target clinical staff of hospitals and maternity care facilities and assure financial support for staff to attend.

7. Develop and enhance the curricula of graduate and professional education programs of medicine, nursing, midwifery, public health, nutrition, and allied health to address at a minimum: the basics of human lactation, the significance of exclusive breastfeeding for the first six months of life, lactation management, and how to access and collaborate with a lactation referral network for mothers.

8. Provide breastfeeding support skills training and continuing education to community-based providers in obstetrics, family medicine, pediatrics, nursing, midwifery, nutrition, health education, and social services.

9. Develop ways to require professional licensing and board recertification to include breastfeeding education for health care providers working with pregnant or new mothers and their infants.

10. Provide up-to-date, evidence-based information to health care providers regarding the risks and benefits of different medications (including contraception) as they affect women and their infants during lactation.

Benefits of Breastfeeding to Employers

Breastfeeding makes healthier babies, and healthier babies result in mothers missing less time from work and fewer health care dollars spent.

Breastfeeding positively impacts a company's bottom line through:

- *Lower health care costs*
- *Enhanced employee productivity*
- *Improved employee satisfaction*
- *Reduced turnover rate*
- *Improved company image as family friendly*

Workplaces

III. Encourage the adoption of breastfeeding-friendly workplaces.

North Carolina is a national leader in the number of women in the work force, with mothers being the fastest-growing segment of the state labor force. Returning to work or school, however, is a commonly perceived barrier to breastfeeding.

It is often difficult for most mothers – and especially those who are breastfeeding – to see how they can return to work (or school) after the birth of a child. One in every three new mothers returns to work within three months of her child's birth; two of three return within six months. Approximately seven of ten working moms with very young children work full-time. Adolescent mothers are the least likely to breastfeed and are likely to return to school as early as ten days after giving birth, as is required in many school districts.

New mothers who work outside the home or return to school are less likely to breastfeed. Of those who do initiate breastfeeding, those who work or go back to school continue for fewer months than women who do not work outside of the home. Women living in the lower socio-economic groups tend to return to work earlier and to jobs where the work environments are not necessarily conducive to continued breastfeeding.

Workplaces can support breastfeeding by providing flexibility in the work schedule, work locations and break times, and job-sharing to accommodate breastfeeding or milk expression. Employers can utilize many different strategies to support breastfeeding,

depending upon the size and needs of the agency or organization. One of most effective ways to support breastfeeding at the workplace is having support for breastfeeding from supervisors and colleagues.

Ideally, all workplaces would offer a Nursing Mothers Room (NMR). The NMR should be centrally located with adequate lighting, ventilation, privacy, seating, a sink, an electrical outlet, a refrigerator, and a changing table. Overall, this area should be a clean, comfortable and secure space for breastfeeding or expressing milk and a safe space for storing expressed milk. Refer to Appendix 5 for additional information on workplace breastfeeding support and to www.nutritionnc.com for the resource packet "How to Become a Mother-Friendly Workplace that Supports Breastfeeding."

Recommendations for Action – Workplaces

1. Educate business and industry about the benefits of instituting breastfeeding-friendly workplace policies and practices for both employers and employees.

2. Provide technical assistance to businesses and schools about becoming breastfeeding-friendly. The technical assistance should address assuring support of employees for breastfeeding; establishing a private and safe space for on-site expression and storage of breast-milk; including breastfeeding services and equipment as a component of company benefits; and protecting breastfeeding women from harassment.

3. Disseminate information on effective breastfeeding-friendly workplace models for diverse settings including: small, medium and large businesses; businesses that are professional, technical, or

agricultural in nature; and businesses that have salaried and/or hourly employees.

4. Create a workplace recognition program to honor employers and schools who support breastfeeding employees and students.

5. Require implementation of breastfeeding-friendly policies and practices in all agencies that receive public funds.

6. Establish a model workplace lactation support program within state and local government agencies.

Child Care Facilities

IV. Assist child care facilities in promoting, protecting and supporting breastfeeding.

With increasing numbers of women returning to work or school, child care facilities are an essential setting for promoting and facilitating continuation of breastfeeding. Child care facilities can play a key role in establishing breastfeeding as the community norm for infant feeding.

Child care homes and centers are a major source of emotional and tangible support for new mothers, many of whom may have a strong desire to continue breastfeeding when they are separated from their babies. Child care providers can demonstrate support for a woman's decision to breastfeed in a variety of ways. Of greatest importance, though, is creating a breastfeeding-friendly child care environment and developing a knowledgeable and supportive staff.

Targeted information, education and training for child care providers are essential steps towards successful adoption of a child care breastfeeding protection and support policy. Such a policy should include support for the following practices: providing a place for breastfeeding mothers to nurse their babies or express milk; training staff on the importance of breastfeeding and in the proper storage and handling of human milk; providing flexible breaks to breastfeeding employees to accommodate breastfeeding or milk expression; and providing positive breastfeeding promotion messages in the home or center.

To indicate their support of breastfeeding, some child care facilities use breastfeeding-friendly symbols such as the "Breastfeeding Welcome Here" materials that were developed through USDA. The knowledge that a child care facility supports a mother's decision to breastfeed can translate into positive community recognition for the facility both as an employer and as a child care service provider. Additional information on breastfeeding and child care is available in Appendix 4 and Appendix 5.

Recommendations for Action – Child Care Facilities

1. Encourage state child care licensing and accreditation agencies and boards to reinforce the importance of breastfeeding-friendly practices by distributing evidence-based guidelines, providing technical assistance, and monitoring performance for supporting breastfeeding in child care settings.

2. Provide ongoing training opportunities for child care providers on how to support breastfeeding and to assure safe and consistent storing, handling and feeding of pumped human milk at child care facilities.

3. Provide technical assistance to community child care facilities on how to develop policy, space, incentives and programs that support breastfeeding.

4. Disseminate information and provide ongoing training opportunities for child care providers on effective child care models that support breastfeeding, while recognizing the diversity of child care settings (i.e., small, medium and large settings; center-based, at a workplace, or home-based; and provision of infant and/or toddler care).

5. Incorporate breastfeeding education and promotion into early childhood programs such as Head Start and North Carolina's More at Four and Smart Start.

Insurance Coverage

IV. Advocate for insurance coverage by all third-party payers for breastfeeding care, services, and equipment when necessary.

Increasing evidence of the cost-effectiveness of breastfeeding, including lower medical expenditures for breastfed infants as compared with never-breastfed infants, has resulted in greater attention to the role that health insurance can play in improving access to breastfeeding support and lactation services. Some states have worked in partnership with health care insurance plans to review coverage policies and to recommend provider reimbursement for prenatal, perinatal, and postpartum breastfeeding education and lactation services.

Provider reimbursement for breastfeeding and lactation support is an essential component of increasing breastfeeding initiation and

duration. Ideally, reimbursement should include community office-based visits with physicians and board certified lactation consultants, breastfeeding classes, breast pumps and pumping kits when needed, and vitamin D supplements.

Insurance coverage of breastfeeding support services requires clarification of a number of issues such as: who is the "beneficiary" (the mother or the infant); what determines medical need (i.e., universally available or only per defined medical criteria); and what constitutes the definition of a "qualified provider." Public insurance programs like Medicaid can establish the standard for best practices while ensuring that breastfeeding mothers and their infants will experience the myriad of benefits associated with having healthier babies.

Recommendations for Action – Insurance Coverage

1. Assess the availability and quality of lactation services across the state with regard to provider qualifications, service definitions and financing.

2. Conduct a survey to determine the extent to which public and private insurance companies provide coverage for breastfeeding services.

3. Compile existing data regarding costs and benefits to insurance companies that cover breastfeeding services (such as lactation services, breast pumps, Vitamin D supplements, and donor human milk for high-risk infants) and disseminate this information to health plan managers and industry leaders.

4. Work with the major health care reimbursement systems such as Medicaid, the State Employee Health Plan, and other insurance companies to develop model policies that promote adequate reimbursements for breastfeeding services.

5. Provide training and information to maternity care facilities and community providers regarding coverage policies and billing procedures for breastfeeding-related services through different plans.

6. Develop and disseminate a consumer's guide to insurance coverage of breastfeeding services.

Social Marketing Principles

The major principles of both social marketing and commercial marketing are generally known as "the four P's" of product, price, place, and promotion. The "product" is the behavior change being promoted.

In using social marketing to promote breastfeeding, marketers must find the unique appeal that makes their product, breastfeeding, more desirable than the competition, using infant formula. The price includes the emotional, psychological, physical, and social costs of breastfeeding as perceived by a target audience. The place refers to the optimal venues or locations to deliver the message to the target audience, realizing that this might differ widely from one demographic group to another. Promotion strategies must resonate with the target audience to encourage behavior change and be delivered in a well-coordinated fashion to be effective.

Media, Social Marketing, and Public Education

VI. Involve media and use social marketing and public education to promote breastfeeding.

Positive breastfeeding images, combined with factual media campaigns and social marketing, can help mothers and families make informed decisions about infant feeding. Media, social marketing, and public education initiatives can play an important role in strengthening the perception of breastfeeding as the accepted behavior for all mothers.

A media campaign typically is directed toward a wide audience and uses public channels such as television, radio, print materials and outdoor advertising. There is evidence showing that media campaigns, particularly television commercials, improve attitudes toward breastfeeding and increase initiation rates.

Social marketing goes beyond media and utilizes established commercial marketing principles to study influences on behavior and then to use the findings to encourage healthy behaviors and/or support behavior change. A social marketing campaign may encompass multifaceted approaches and will use carefully designed messages targeting specific audiences such as consumers, their support systems, health care providers, the community, and the general public. Professional endorsements, direct mail, incentive items, and sponsoring events are social marketing strategies used to address specific barriers to behavior changes such as initiation and continuation of breastfeeding. Established as an effective model for addressing a wide variety of public health issues, social marketing is being used to increase public awareness and community support for breastfeeding.

Media and social marketing approaches are used effectively in commercial infant formula advertising. The commercial marketing of infant formulas has been shown to negatively impact breastfeeding. To counteract the commercial marketing of these products, media and social marketing strategies must be used to focus on breastfeeding.

Recommendations for Action – Media, Social Marketing, and Public Education

1. Develop and implement a social marketing campaign for target audiences (and which complements actions recommended in this blueprint) to promote breastfeeding among North Carolina's diverse populations, with emphasis on increasing breastfeeding initiation and duration.

2. Partner with local media outlets (television, radio, print) and request that they broadcast existing research-based media campaigns, such as "Babies are Born to be Breastfed" (developed through US DHHS) or "Loving Support Makes Breastfeeding Work" (developed through USDA) to improve acceptance and knowledge of the importance of breastfeeding.

3. Provide promotional and educational materials/posters on breastfeeding, to be used in place of educational materials provided by commercial infant formula manufacturers, in public and private health care offices, schools and child care settings.

4. Use culturally appropriate toys, picture books, textbooks, visual aids, and room decorations that depict breastfeeding in health care offices, schools, child care settings, and workplaces.

5. Incorporate breastfeeding content into the science and health curricula of schools for preschool, primary, secondary, and postsecondary education.

6. Develop public/private partnerships at the local and state levels to promote the use of media advocacy to stimulate public discussion of breastfeeding.

7. Encourage the media to highlight advocacy efforts and activism that promotes, protects and supports breastfeeding as the community norm for feeding infants.

8. Continue support for the N.C. Family Health Resource Line (1-800-367-2229) as a primary statewide source for information and referral for breastfeeding questions and concerns.

Laws, Policies, and Regulations

VII. Promote and enforce new and existing laws, policies and regulations that support and protect breastfeeding.

Increasingly, attention is being focused on the role of federal and state legislation and regulatory action in the support and protection of breastfeeding. North Carolina was among the first states in the nation to review and amend state statutes for this purpose. In 1993, the N.C. General Assembly exempted breastfeeding from the criminal statutes, and at the same time, clarified that women have the right to breastfeed in public, even if there is exposure of the breast.

N.C. Gen. Stat. sec. 14-190.9
1993 N.C. ALS 301; 1993 N.C. Sess. Laws 301; 1993 N.C. Ch. 301; 1993 N.C. HB 1143§ 14-190.9. Indecent exposure.
(b) Notwithstanding any other provision of law, a woman may breast feed in any public or private location where she is otherwise authorized to be, irrespective of whether the nipple of the mother's breast is uncovered during or incidental to the breast feeding.

More than half of the States (39) have enacted legislation in support of breastfeeding. State laws currently in place or under review related to breastfeeding include: breastfeeding in public, enhanced maternity and lactation benefits through insurance plans, and voluntary or regulatory compliance with components of the Baby-Friendly Hospital Initiative and breastfeeding-friendly workplaces. Some states, viewing government as a major employer and a critical player in providing leadership for breastfeeding promotion and support, are considering incentives for state employers and contractors that demonstrate breastfeeding-friendly workplaces.

In 1981, the World Health Assembly adopted the World Health Organization's (WHO) International Code of Marketing of Breast-Milk Substitutes, a comprehensive set of guidelines that suggest standards for the appropriate marketing and distribution of commercial infant formulas. Generally referred to as the International Code, it addresses issues related to advertising of these products to the public, the distribution of free samples and gifts to mothers and health care workers, the promotion of infant formula products in health care facilities, and information used in the labeling and marketing of infant formulas. While challenging to fully implement, the International Code offers the opportunity for developing new and/or revising existing state policies and standards. Refer to Appendix 2 for additional information on the International Code.

It is widely recognized that breastfeeding-friendly laws, policies and regulations can be an effective way to increase societal awareness and understanding that breastfeeding is an essential health behavior that needs to be encouraged and supported. Refer to Appendix 5 for additional information on state breastfeeding legislation.

Recommendations for Action – Laws, Policies, and Regulations

1. Assess state legislation and identify ways that it could be strengthened to further promote, protect, and support breastfeeding in North Carolina.

2. Identify legislative champions and advocates most likely to sponsor improved breastfeeding policy.

3. Expand to all health clinics providing maternal and child services, the policy of the N.C. Women, Infants and Children Special Supplemental Nutrition Program (WIC) that prohibits displaying or distributing materials provided by or bearing the advertising logos of companies that manufacture infant formulas.

4. Engage state and local associations of health professionals (pediatricians, obstetrician-gynecologists, family practitioners, nutritionists, and nurses) to discourage the use of informational and educational materials provided by or bearing the advertising logos from companies that manufacture products replacing human milk and to avoid tacit endorsement by allowing sponsorship for meetings or trainings.

5. Establish public policy mandating that advertising and labels of products substituting for human milk and marketed in North Carolina be in accordance with the International Code of Marketing of Breast-milk Substitutes (ICMBS). Product labels should be easily understood by the consumer and list potential side effects and contraindications similar to those required of all pharmaceutical products.

6. Review the feasibility of North Carolina legislation to regulate advertising of products that are manufactured to replace human milk (i.e., infant formulas).

7. Monitor legislation and enactment of new laws, policies and regulations that may potentially impact policies that encourage a breastfeeding-friendly environment.

Research and Evaluation

VII. Encourage research and evaluation on breastfeeding outcomes, trends, quality of care, and best practices.

The scientific evidence for both the benefits of breastfeeding as the optimal infant feeding for human beings and for the efficacy of interventions that promote breastfeeding continues to grow more robust. Policy makers, practitioners, patients and consumers all depend on the findings of research and evaluation studies to guide individual care, collective decision making including public health decisions, and the allocation of resources. Formal evaluation studies of interventions implemented in North Carolina to increase breastfeeding initiation and duration will allow experts and the lay public alike to assess effects of the interventions and their relative contribution in achieving the state's breastfeeding goals.

Ongoing monitoring of breastfeeding initiation and duration rates can identify trends in decreasing disparities in breastfeeding and facilitate the achievement of targeted goals across all population groups. Research can identify the extent to which recommended actions are being implemented, providing baseline information for determining the effectiveness of this blueprint. Continuous data gathering, monitoring and analysis of breastfeeding trends, best practices, quality of care, and innovative state and community programs assures that the investment that North Carolina makes in breastfeeding will serve as the catalyst for future action to increase breastfeeding among North Carolina infants.

Recommendations for Action – Research and Evaluation

1. Maintain current statewide systems that collect and analyze state and population breastfeeding trend data: Pregnancy Risk Assessment Monitoring System (PRAMS), Behavioral Risk Factor Surveillance System (BRFSS), Child Health Assessment and Monitoring Program (CHAMP), Pediatric Nutrition Surveillance System (PedNSS), and Pregnancy Nutrition Surveillance System (PNSS).

2. Continue to develop trend data from statewide data studies regarding the incidence and duration of exclusive and partial breastfeeding, especially among minority and ethnic groups experiencing lower breastfeeding rates.

3. Support research studies such as:

    a. Reviewing statewide data, controlling for known variables, to gain insight on what additional factors influence breastfeeding rates.

b. Analyzing influences (social, cultural, economic, environmental, knowledge-related, attitudinal, psycho-social) on infant feeding choices, especially among minority and ethnic population groups experiencing low breastfeeding rates.

c. Assessing the array of postpartum services to the breastfeeding mother and infant and their relevance to breastfeeding initiation and duration rates.

d. Analyzing effectiveness of breastfeeding-friendly practices in maternity clinics, hospitals, workplaces, and child care facilities.

e. Determining if more cost-effective mechanisms may be developed to increase the number of baby-friendly hospitals statewide.

f. Assessing costs to the N.C. Medicaid Program for infants who are not breastfed as compared to those who are exclusively breastfed.

g. Assessing the feasibility and effectiveness of combining breastfeeding promotion with other important healthy lifestyle behavior change programs such as maternal smoking cessation, returning to pre-pregnancy weight, and family planning.

h. Assessing the impact that medications and birth control choices have on breastfeeding initiation and duration.

i. Analyzing the impact of breastfeeding on the incidence of chronic childhood diseases, including obesity.

Appendices

Appendices

1. **References**

2. **WHO/UNICEF International Code of Marketing of Breast-Milk Substitutes**

3. **A Community Continuum of Breastfeeding Support: Breastfeeding Peer Counselors, Breastfeeding Educators, and Board Certified Lactation Consultants**

4. **A Breastfeeding-Friendly Child Care Checklist**

5. **United States Breastfeeding Committee Position Statements**

   - **Benefits of Breastfeeding**
   - **Economic Benefits of Breastfeeding**
   - **Breastfeeding and Child Care**
   - **Workplace Breastfeeding Support**
   - **State Breastfeeding Legislation**

6. **Public Forum: Promoting, Protecting, and Supporting Breastfeeding in North Carolina (September 2004)**

   - **N.C. DHHS Media Release for the Breastfeeding Forum**
   - **Agenda for the Breastfeeding Forum**
   - **Organizers of the Breastfeeding Forum**
   - **Forum Participants**

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2. Breastfeeding and the Use of Human Milk. American Academy of Pediatrics Policy Statement; Section on Breastfeeding. Pediatrics, Vol. 115 No.2 February 2005. (available at http:www.aap.org)

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Additional sources of information used to support the development of this blueprint.

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http://www.aafp.org for breastfeeding position paper

12. American Academy of Pediatrics (AAP)
- http:www.aap.org for breastfeeding resources and position papers
- http://www.aap.org/breastfeeding/ for information on the AAP Breastfeeding Section and additional information on AAP breastfeeding resources and initiatives

13. American College of Obstetricians and Gynecologists (ACOG)
http://www.acog.org for breastfeeding information

14. Academy of Breastfeeding Medicine (ABM)
http://www.bfmed.org for clinical protocols for the care of breastfeeding mothers and infants

15. Baby-Friendly USA
http://www.babyfriendlyusa.org for information about breastfeeding and Baby-Friendly efforts in the United States

16. Best Start Social Marketing
www.beststartinc.org for information on social marketing and breastfeeding, including the campaign "Loving Support Makes Breastfeeding Work"

17. Centers for Disease Control and Prevention (CDC)
http://www.cdc.gov/breastfeeding/ for information and resources on breastfeeding, surveillance data, research, and new breastfeeding-related initiatives and activities

18. International Board of Lactation Consultation Examiners (IBLCE)
http:www.iblce.org for information on Board Certified Lactation Consultants

19. International Lactation Consultants Association (ILCA)
www.ilca.org for information on finding a IBCLC in your community and information about the association, World Breastfeeding Week and other breastfeeding-related activities

20. La Leche League International (LLLI)
- http://www.lalecheleague.org for information on the La Leche League and mother-to-mother breastfeeding support
- http://www.lalecheleague.org/Law/summary.html for a summary of breastfeeding legislation in the U.S.

21. Linkages
http://www.linkagesproject.org for information on worldwide projects related to infant feeding, including the Innocenti Declaration 2005 on Infant and Young Child Feeding. Linkages is managed by the Academy for Educational Development with funding provided by the Bureau of Global Health of the United States Agency for International Development.

22. National Conference of State Legislatures
www.ncsl.org/programs/health/breast50.htm for a summary of breastfeeding laws by state

23. North Carolina State Center for Health Statistics (N.C. SCHS)
http://www.schs.state.nc.us for breastfeeding data from the Pregnancy Risk Assessment Monitoring System (PRAMS)

24. North Carolina Nutrition Services Branch
www.nutritionnc.com for information and links for breastfeeding resources, educational materials, surveillance data, and the resource packet: "How to Become a Mother-Friendly Workplace that Supports Breastfeeding"

25. United Nations International Children's Emergency Fund (UNICEF)
http://www.unicef.org/programme/breastfeeding/baby.htm for information about the Baby-Friendly Hospital Initiative, the WHO/UNICEF International Code of Marketing Breast-Milk Substitutes, complementary foods and feeding

26. United States Breastfeeding Committee (USBC)
http://www.usbreastfeeding.org for breastfeeding information and issue papers *(Note: Five USBC position papers are included in Appendix 5 of this blueprint.)*

27. U. S. Department of Agriculture (USDA)
- www.ers.usda.gov for Economic Research Services reports/studies on breastfeeding
- http://www.fns.usda.gov/wic/ for information on FNS WIC Program breastfeeding activities
- www.fns.usda.gov/wicworks for a wide variety of breastfeeding resources and educational materials from WIC Programs throughout the country

28. U. S. Department of Health and Human Services (U.S. DHHS)
- www.dhhs.gov for information about research and information on breastfeeding
- www.womenshealth.gov/breastfeeding or www.4woman.gov/Breastfeeding/ for materials and resources on breastfeeding, including the National Breastfeeding Campaign
- http://www.healthypeople.gov/ for information on "The Healthy People 2010" objectives for the nation

29. Wellstart International
www.wellstart.org for information on breastfeeding education for health professionals, other breastfeeding resources, and links with other breastfeeding activities

WHO/UNICEF International Code of Marketing of Breast-Milk Substitutes (adopted in 1981)

This appendix is an abbreviated version of the International Code of Marketing of Breast-Milk Substitutes. The full-length version can be found at http://www.unicef.org/programme/breastfeeding/code.htm.

AIM: The code protects and promotes breastfeeding by ensuring appropriate marketing and distribution of human milk substitutes.

SCOPE: The code applies to human milk substitutes, when marketed or otherwise represented as a partial or total replacement for human milk. These human milk substitutes can include food and beverages such as:

- Infant formula
- Other milk products
- Vegetable mixes
- Follow-up milks
- Cereals
- Juices and baby teas
- Feeding bottles, nipples

ADVERTISING: No advertising of the above products to the public.

SAMPLES: No free samples to mothers, their families, or health care workers.

HEALTH CARE FACILITIES: No promotion of products, i.e. no product displays, posters, or distribution of promotional materials. No use of company-paid nurses or similar personnel.

HEALTH CARE WORKERS: No gifts or samples to health care workers.

SUPPLIES: No free or low-cost supplies of human milk substitutes to maternity wards and hospitals.

INFORMATION: Product information must be factual and scientific. Informational and educational materials must explain the benefits of breastfeeding, the health hazards associated with bottle feeding, and the costs of using infant formula.

LABELS: Product labels must clearly state the benefits of breastfeeding, the need for the advice of a health care worker, and a warning about health hazards. No pictures of infants, other pictures or text idealizing the use of infant formula are allowed.

PRODUCTS: Products should be of a high quality and need to consider the climatic and storage conditions of the country where they are used.

A Community Continuum of Breastfeeding Support: Breastfeeding Peer Counselors, Breastfeeding Educators, and Board Certified Lactation Consultants

A goal of all communities should be to create a continuum of breastfeeding support through the existence of peer counselors, health professional breastfeeding educators, and board certified lactation consultants. In this way, the full spectrum of support — from peer-to-peer, to generalist, to expert — would be available throughout North Carolina.

Breastfeeding Peer Counselors: Breastfeeding peer counselors are women in the community with breastfeeding experience who have been trained to provide information, assistance and support to prenatal and breastfeeding women. Their purpose is to encourage women to continue breastfeeding for as long as they chose. The breastfeeding peer counselor should have comparable life experience, socioeconomic status, and cultural background as the women to whom she is going to offer her support. The most important aspects of peer support are to serve as a role model and to be available to counsel women in the clinic, at home, in the hospital, and at community activities. Peer counselors may be volunteers or paid employees of a community agency.

Breastfeeding Educators: Breastfeeding educators are professional health care providers who assist families with breastfeeding, in addition to performing a variety of other clinical responsibilities. This level of training is intended for individuals who provide lactation management as one aspect of the health care they provide, but who do not specialize or devote the majority of time to lactation management. Lactation education prepares one to assess, plan, intervene and evaluate routine lactation management support. This training is completed during undergraduate or post-graduate education, depending on the nature of the training program and/or the individual's

situation. Peer counselors sometimes complete these courses for advanced training. Educators are aware of community resources and can refer families to lactation consultants for additional breastfeeding assistance.

International Board Certified Lactation Consultants (IBCLC):
Lactation consultants are clinical specialists whose primary clinical focus is breastfeeding assistance. They have obtained advanced lactation management education and clinical experiences and have successfully met the requirements for International Board Certification, typically referred to as "IBCLC." Lactation consultants provide in-depth, individual consultation for common and complex breastfeeding problems such as difficulty with latch-on, persistent sore nipples, premature infants, twins or triplets, infants with congenital anomalies, or infants or mothers with complications. Lactation consultants often charge separate fees for services and sometimes receive third-party reimbursement. Board certified lactation consultants are sometimes hired by health agencies to provide lactation training for staff and health professionals within the community, or to run lactation support services such as peer counselor programs or breast pump loaner programs.

A Breastfeeding-Friendly Child Care Checklist

Use this checklist to find out how breastfeeding friendly your child care center is.

- ☐ Are posters and pictures of breastfeeding moms and their babies seen throughout the child care center?
- ☐ Are brochures, pamphlets and other resources about breastfeeding displayed and made available to parents and visitors?
- ☐ Does the center provide a comfortable space for breastfeeding moms to nurse or pump (express) milk for their babies?
- ☐ Has your child care center developed any infant-feeding policies specific to breastfeeding?
- ☐ Are materials about your center's infant-feeding or breastfeeding policies included in the "Welcome" information packets?
- ☐ Do caregivers and staff willingly tell parents and visitors about the center's infant-feeding or breastfeeding policies?
- ☐ Do caregivers and staff know where to refer parents for additional breastfeeding information and resources?
- ☐ Are fathers included in discussions about breastfeeding and infant-feeding?
- ☐ Are current and prospective parents encouraged to stop by and view the center's environment?
- ☐ Does the center have an open-door policy that encourages parents to visit at their convenience?

How to Support Breastfeeding in a Child Care Center

Developed by the Mississippi State Department of Health WIC Program

This Appendix includes the following United States Breastfeeding Committee (USBC) Issue Papers, which are in the public domain and downloadable at www.usbreastfeeding.org.

- Benefits of Breastfeeding
- Economic Benefits of Breastfeeding
- Breastfeeding and Child Care
- Workplace Breastfeeding Support
- State Breastfeeding Legislation

Benefits of Breastfeeding

usbc United States Breastfeeding COMMITTEE
PROMOTING • SUPPORTING • PROTECTING

Breastfeeding is universally endorsed by the world's health and scientific organizations as the best way of feeding infants.[1–3] Years of research have shed light on the vast array of benefits not only for children but also for mothers and society.

For children, breastfeeding supports optimal development and protects against acute and chronic illness.

For mothers, breastfeeding helps with recovery from pregnancy and childbirth and provides lifelong health advantages.

For society, breastfeeding provides a range of economic and environmental rewards.

Benefits for Children

Breastfeeding offers advantages for children that cannot be duplicated by any other form of feeding. The benefits of breastfeeding begin from the first moments after childbirth and last for many years after breastfeeding ends.

Compared with formula-fed children, those who are breastfed are healthier and have fewer symptoms and shorter illnesses when they do get sick. Breastfed children:

- score higher on cognitive and IQ tests at school age, and also on tests of visual acuity[4–6]
- have a lower incidence of sudden infant death syndrome (SIDS)
- are less likely to suffer from infectious illnesses and their symptoms (e.g., diarrhea,[7] ear infections,[7,8] respiratory tract infections, meningitis[7])
- have a lower risk of the two most common inflammatory bowel diseases (Crohn's disease, ulcerative colitis)[9]
- suffer less often from some forms of cancer (e.g., Hodgkin's disease,[10] childhood leukemia)
- have a lower risk of juvenile onset diabetes, if they have a family history of the disease and are breastfed exclusively for at least 4 months[9]
- are significantly protected against asthma and eczema, if at risk for allergic disorders and exclusively breastfed for at least 4 months[11,12]
- may have a lower risk of obesity in childhood and in adolescence[13,14]
- have fewer cavities and are less likely to require braces

Breastfeeding provides benefits not just for full-term infants but also for premature and low birthweight infants.

Compared with premature infants who receive human milk, those who receive formula have future IQs that are 8–15 points lower.

For premature infants, human milk:

- significantly shortens length of hospital stay
- reduces hospital costs
- hastens brainstem maturation
- reduces the risk of life-threatening disease of the gastrointestinal system and other infectious diseases

Benefits for Mothers

Breastfeeding offers a range of benefits for mothers as well as their children.

Women who have breastfed are less likely to develop ovarian and premenopausal breast cancers.[16,17] The more months a woman has spent breastfeeding, the greater the beneficial effect.

Breastfeeding reduces osteoporosis.

Breastfeeding mothers enjoy a quicker recovery after childbirth, with reduced risk of postpartum bleeding.[16]

Mothers who breastfeed are more likely to return to their prepregnancy weight than mothers who formula feed.[16] Breastfeeding reduces the risk for long-term obesity.

Exclusive breastfeeding may reduce the risk of anemia by delaying the return of the menstrual cycle for 20 to 30 weeks.[17]

Exclusive breastfeeding for the first 6 months postpartum, in the absence of menses, is 98 percent effective in preventing pregnancy.[17]

Breastfeeding mothers are reported to be more confident and less anxious than bottle-feeding mothers.[18]

Breastfeeding contributes to feelings of attachment between a mother and her child.

Breast Milk Facts

Breast milk is an amazing substance that cannot be duplicated by any artificial means.[7,15] Unique in its composition and function, breast milk:

- contains an ideal balance of nutrients that the infant can easily digest
- changes over time, and even over the course of a day, to meet the changing needs of the growing child
- contains substances essential for optimal development of the infant's brain, with effects on both cognitive and visual function[9]
- supplies growth factors that combine to mature the infant gut
- provides the infant with immune factors manufactured to fight allergens and illnesses specific to the mother's and infant's environment

Benefits for Society

Breastfeeding offers society not only improved health of children and mothers but also economic and environmental benefits.

Breastfeeding reduces the need for costly health services that must be paid for by insurers, government agencies, or families.

Breastfeeding reduces the number of sick days that families must use to care for their sick children.

The estimated cost of artificial feeding (up to $1,200 per year for powdered formula) is four times that of breastfeeding (approximately $300 per year for increased food for a lactating woman).

Concentrated and ready-to-feed formulas are even more expensive than powdered formula. The cost of artificial feeding has increased steadily over the last 10 years.

Electricity or fuel are consumed in the preparation of infant formula.

Breastfeeding requires no packaging, and its production does not harm the environment.

What's Needed

Though any amount of breastfeeding is beneficial, exclusive breastfeeding that lasts beyond the first few weeks of life is best.

Exclusive breastfeeding for the first 6 months of life, with gradual introduction of solid foods after 6 months, is recognized as the preferred method of infant feeding.

Breastfeeding provides ideal nutrition despite any social or economic disadvantages that may exist for the child.

Greater numbers of women are choosing to initiate breastfeeding, but ethnic and social disparities persist.

Breastfeeding rates can be increased by:

- Culturally appropriate and skilled lactation support
- Worksite support for breastfeeding mothers
- Accommodation for human milk feeding in child care settings
- Appropriate legislation

For more information on breastfeeding benefits and promotion, visit the United States Breastfeeding Committee's Web site at www.usbreastfeeding.org.

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Economic Facts

Economic facts related to breastfeeding in the United States include:

- $2 billion per year is spent by families on breast milk substitutes such as infant formula
- $578 million per year in federal funds is spent by the U.S. Department of Agriculture's Special Supplemental Nutrition Program for Women, Infants and Children (WIC) to buy formula for babies who are not breastfeeding
- Every 10 percent increase in the breastfeeding rate among WIC recipients would save WIC $750,000 per year
- $1.3 billion more is spent by insurers, including Medicaid, to cover sick-child office visits and prescriptions to treat the three most common illnesses—respiratory infections, otitis media (ear infections), and diarrhea—in the first year of life for formula-fed infants versus breastfed infants.[19]
- $3.6 to 7 billion excess dollars are spent every year on conditions and diseases that are preventable by breastfeeding[20]

For Further Information

For further information, contact:

U.S. Department of Health and Human Services,
Maternal and Child Health Bureau (MCHB)
www.mchb.hrsa.gov

United States Breastfeeding Committee
www.usbreastfeeding.org

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protecting | promoting | supporting

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Economic Benefits of Breastfeeding

Years of research have confirmed the importance of breastfeeding and breast milk for the optimal health of infants, children, mothers, and society. The *absence* of breastfeeding, however, not only affects short- and long-term health outcomes but also exacts a financial toll on the U.S. economy.

- For private and government insurers, a minimum of $3.6 billion must be paid each year to treat diseases and conditions preventable by breastfeeding.[1]
- For families, the purchase of infant formula can amount to $1,200–$1,500 or more for the baby's first year.[2]
- For the nation's employers, formula feeding results in increased health claims, decreased productivity, and more days missed from work to care for sick children.

Breastfeeding and the provision of breast milk exclusively for the first 6 months, and in conjunction with appropriate foods thereafter, promises the United States improved health of both its citizens and its economy.

Medical Costs of Not Breastfeeding

The medical costs of not breastfeeding are substantial:

- Excess use of health care services attributable to formula feeding costs an HMO between $331 and $475 per never-breastfed infant for lower-respiratory illness, otitis media, and gastrointestinal illness.[3]
- Costs for hospitalization from lower-respiratory infections among 1,000 never-breastfed babies range from $26,585 to $30,750 more than for 1,000 infants exclusively breastfed.[3]
- $200,000 is spent for each case of necrotizing enterocolitis,[4] with a 10.1 percent occurrence in formula-fed babies and a 1.2 percent rate in breastfed babies.
- Additional health care costs for respiratory syncytial virus due to not breastfeeding are $225 million.[5]
- Additional health care costs for insulin-dependent diabetes mellitus (IDDM) in formula-fed children, assuming a 2–28 percent IDDM rate attributable to not breastfeeding: a low estimate of $1,185,900,000 and a high estimate of $1,301,100,000.[5]

Nonmedical Costs of Artificial Feeding

The nonmedical costs of not breastfeeding are substantial as well:

- $2 billion per year is spent by families on breast milk substitutes such as formula.
- Costs to support a breastfeeding mother in the Special Supplemental Nutrition Program for Women, Infants and Children (WIC) are about 55 percent of those for a formula-feeding mother.
- $578 million per year in federal funds is spent by WIC to buy formula for families who could be breastfeeding.
- Every 10 percent increase in breastfeeding rates among WIC recipients would save WIC $750,000 per year.

- If a parent misses 2 hours of work for the excess illness attributable to formula feeding, greater than 2,000 hours—the equivalent of 1 year of employment—are lost per 1,000 never-breastfed infants.
- 110 billion BTUs of energy ($2 million) used each year in the United States for processing, packaging, and transporting formula.

Other Costs of Not Breastfeeding

Not breastfeeding also carries intangible costs—those not associated with specific dollar amounts in research findings. Such costs include:

- Illness and death from bacteria associated with feeding powdered infant formulas, which is not sterile[6]
- 3- to 11-point IQ deficit in formula-fed babies[7]
- Less educational achievement noted with both formula-fed children[8] and throughout adulthood[9]
- Longer hospital stays in premature infants who do not receive human milk
- Slower brainstem maturation[10] and IQs 8–15 points lower in premature infants who do not receive human milk[11]
- Better vision,[12] fewer cavities in teeth,[13] and less malocclusion requiring braces[14] in children who have been breastfed
- 550 million formula cans, with 86,000 tons of metal and 800,000 pounds of paper packaging, added to U.S. landfills each year

Breastfeeding's Health Benefits

Breastfeeding is universally endorsed by the world's health and scientific organizations as the best way of feeding infants. Studies have found that not breastfeeding increases the risk for and incidence of the illnesses and conditions listed below.

For children

- respiratory syncytial virus
- sudden infant death syndrome (SIDS)
- asthma
- allergies
- lymphomas and leukemia
- autoimmune thyroid disease
- type I and type II diabetes
- ulcerative colitis and Crohn's disease
- multiple sclerosis
- poorer school performance
- lower developmental and cognitive scores
- childhood overweight and obesity

For mothers

- premenopausal breast cancer
- ovarian cancer
- thyroid cancer
- osteoporosis
- lupus

Supporting Optimal Breastfeeding Is Worth the Investment

As a preventive measure, breastfeeding promotes improved health outcomes and is cost-effective.

The U.S. government has recognized the importance of breastfeeding with three recent major policy statements on breastfeeding. These take into account the relationship between improved breastfeeding practices and our national health.

- *Healthy People 2010*
- *HHS Blueprint for Action on Breastfeeding*
- *Breastfeeding in the United States: A National Agenda*

What's Needed

Achieving our national goals for increasing the incidence and duration of breastfeeding will require:

- continued full authorization of the WIC program with improved breastfeeding support services
- inclusion of breastfeeding care and services in government health strategic plans
- coordination of breastfeeding programs among government agencies
- worksite breastfeeding protection and support incentives for employers
- insurance coverage for lactation care and services

- development of legislation that supports exclusive breastfeeding for the first 6 months of life, with gradual introduction of solids foods after 6 months
- inclusion of breastfeeding language in child health acts
- implementation of the provisions of the International Code of Marketing of Breast Milk Substitutes
- education and support for families
- education for health professionals

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protecting | promoting | supporting

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Increase protection, promotion, and support for breastfeeding mothers in the work force.

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Breastfeeding and Child Care

Research has shown that breastfeeding supports optimal growth and development for infants, and offers lifelong health advantages. Breastfeeding also contributes to the health of mothers and enhances the economic well-being of society.

Because of breastfeeding's many benefits, the U.S. Department of Health and Human Services' *Breastfeeding: HHS Blueprint for Action on Breastfeeding*[1] (November 2000) recommends that children be breastfed exclusively for the first 6 months of life, with gradual introduction of solid foods after 6 months. The *Blueprint* recommends the continuation of breastfeeding for at least the first year of life.

At the same time, in the United States millions of young children spend part or most of each day in a variety of child care settings.[2] It is estimated that 75 percent of women with children under age 3 are employed.

In just 20 years, the percentage of children enrolled in child care has soared from 30 percent (1970) to 70 percent (1993). *America's Children: Key National Indicators of Well-Being*[3] found that 51 percent of infants and toddlers from birth through age 2 are cared for by someone other than their parents for some time each day.

With so many young children enrolled in child care, child care providers can play a vital role in supporting a mother's continuation of breastfeeding.

When child care settings become strong partners and advocates in encouraging mothers to continue to breastfeed, the benefits to families are enormous. And child care settings themselves benefit from the improved health status of the children in their care.

What's Needed

Research has demonstrated that knowledgeable support is essential for helping mothers establish and continue breastfeeding as they return to work or school and make use of child care services. Responsibility for providing this support lies with both the public and the private sectors.

Governmental agencies, including licensing and regulatory sectors, can support breastfeeding by:

- providing breastfeeding support and encouragement to their own employees
- providing accurate information about the storage and handling of human milk
- continuing to provide reimbursement for feeding expressed human milk under the Child and Adult Care Food Program

National and state child care organizations can support breastfeeding in child care settings by:

- increasing current awareness of the need for protecting, promoting, and supporting breastfeeding
- initiating new training programs to improve child care providers' knowledge about breastfeeding and its importance
- participating in health promotion campaigns that disseminate information about the benefits of breastfeeding

- teaching child care providers how to store, handle, and feed mother's milk (e.g., informing child care providers that mother's milk is not a biohazard and does not require gloves for handling)

The private sector—including employers, insurance companies, and other organizations and agencies—can support breastfeeding by:

- developing health campaigns for employees that include breastfeeding promotion and protection
- considering child care settings when developing consumer education materials, breastfeeding promotion campaigns, and quality improvement initiatives
- supporting cost-effective rentals or purchase of electric breast pumps for expression of human milk when such devices are needed

Child care settings are the natural and logical place for supporting breastfeeding mothers by:

- integrating breastfeeding into plans for the design of a child care facility, its equipment and furnishings, and the training and scheduling of its staff
- providing a welcoming atmosphere that encourages mothers to initiate and continue breastfeeding after returning to work or school
- training staff to provide accurate basic breastfeeding information and referrals for skilled breastfeeding support when necessary
- designating a space for the safe expression and storage of human milk
- offering children breast milk in containers other than bottles (e.g., cups or spoons) when parents request it
- providing space for mothers to breastfeed their children on-site
- creating an environment that fosters the formation of parent support groups and the ability to share information
- empowering families to advocate at their workplaces for policies that support breastfeeding

Families themselves must be responsible for:

- establishing clear communication with the child care provider about shared responsibilities related to caring for a breastfed child and handling expressed human milk
- sharing knowledge of community resources that may be unfamiliar to the child care provider

Benefits of Breastfeeding

Breastfeeding is universally endorsed by the world's health and scientific organizations as the best way of feeding infants. Breastfed children:

- score higher on cognitive and IQ tests and also on tests of visual acuity
- have a lower incidence of sudden infant death syndrome (SIDS)
- are less likely to suffer from infectious illnesses and their symptoms (e.g., diarrhea, ear infections, respiratory tract infections, meningitis)
- have a lower risk of the two most common inflammatory bowel diseases (Crohn's disease, ulcerative colitis)
- suffer less often from some forms of cancer (e.g., Hodgkin's disease, childhood leukemia)
- have a lower risk of juvenile onset diabetes, when there is a family history of the disease and the children are breastfed exclusively for at least 4 months
- are significantly protected against asthma and eczema, when at risk for allergic disorders and breastfed exclusively for at least 4 months
- may have a lower risk of obesity in childhood and in adolescence
- have fewer cavities and are less likely to require braces

Conclusion

Integrating breastfeeding into child care settings promotes good health for the baby and mother, saves money, and contributes to the overall well-being of a community. It is not just a parent issue, a child care issue, or a health and nutrition issue, but ultimately an important public health issue that affects everyone.

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For Further Information

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U.S. Department of Agriculture (USDA)
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U.S. Department of Health and Human Services, Maternal and Child Health Bureau (MCHB)
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Workplace Breastfeeding Support

USBC United States Breastfeeding COMMITTEE
PROMOTING • SUPPORTING • PROTECTING

Women with infants and children are the fastest growing segment of the U.S. labor force.

Among employed women with children under age 3, approximately 70 percent work full time. One-third of mothers return to work within 3 months after giving birth, and two-thirds return within 6 months.[1,2]

Breastfeeding offers proven health benefits for babies and mothers, but women often find it difficult to continue breastfeeding once they return to the workplace.

Challenges include lack of break time and inadequate facilities for pumping and storing human milk.

Many of these workplace challenges can be reduced with a small investment of time, money, and flexibility.

Providing accommodations for breastfeeding offers tremendous rewards for the employer, in cost savings for health care, reduced absenteeism, employee morale, and employee retention.

Benefits for Employers

Companies that have adopted breastfeeding support programs have noted:

- cost savings of $3 per $1 invested in breastfeeding support
- less illness among the breastfed children of employees
- reduced absenteeism to care for ill children
- lower health care costs (an average of $400 per baby over the first year)
- improved employee productivity
- higher morale and greater loyalty
- improved ability to attract and retain valuable employees
- family-friendly image in the community

What's Needed

Simple strategies can allow infants, mothers, and employers to experience the benefits of workplace breastfeeding support. The strategies are feasible, safe, and relatively easy to implement, and they require only a modest budget.

These strategies have proven effective in a wide range of settings, including corporations, educational institutions, local government offices, manufacturing and sales organizations, and tribal organizations.

Develop a breastfeeding support program tailored to the company.

Each company, organization, or agency should develop a breastfeeding support program tailored to its needs and resources. Possible components of a workplace breastfeeding support program appear in Table 1.

It may be useful in larger companies to convene a task force to assess women's needs. Potential task force members include human resource specialists, company nurses, expectant mothers, an employee who is or recently was a breastfeeding mother, and a lactation consultant hired on a short-term basis.

Table 1: Components of a Workplace Breastfeeding Support Program

The table below outlines components of several levels of workplace breastfeeding support. The choice of components depends on the number of women who need support and the resources and realities of the workplace.

Adequate	Expanded	Comprehensive
	Facilities	
A clean, private, comfortable multi-purpose space (that is not a bath-room) with an electrical outlet in order to pump milk or to breastfeed.	A Breastfeeding Mothers' Break Room (BMBR) for use only by breastfeeding women.	A Breastfeeding Mothers' Break Room (or rooms) close to women's worksites.
Employee provides her own breast pump.	Employer provides one multi-user electric breast pump, and employees provide their own collection kits.	Employer provides collection kits. Additional multi-user electric pumps are provided if needed.
Table and comfortable chair.	Improved aesthetics to promote relax-ation.	Room large enough to accommodate several users comfortably.
Sink, soap, water, and paper towels. If these are very far from BMBR, extra time is allowed for cleaning hands and equipment.	Items listed in "Adequate" column are available near the BMBR.	Items listed in "Adequate" column are available in the BMBR.
Employee supplies cold packs for storage of milk.	Employer makes available refrigera-tor space designated for food near BMBR.	Employer provides a small refrigera-tor in the BMBR for storage of human milk.
	Written Company Policy	
Employer grants a 6-week unpaid maternity leave.	Employer grants 12-week unpaid maternity leave (FMLA).	Employer offers a 6- to 14-week paid maternity leave (ILO).
Employer allows creative use of accrued vacation days, personal time, sick days, and holiday pay after childbirth.	In addition, employer allows part-time work, job sharing, individualized scheduling of work hours, compressed work week, or telecommuting.	In addition, mother can bring child to work, caregiver can bring child to workplace, or on-site day care is available.
Employer allows two breaks and a lunch period during an 8-hour work day for expressing milk or breast-feeding the child.	Employer allows expanded unpaid breaks during the workday for expressing milk or breastfeeding the child.	Nursing breaks are paid and are counted as working time.
	Workplace Education	
Company breastfeeding support poli-cy is communicated to all pregnant employees.	New employees, supervisors, and coworkers all receive training on the breastfeeding support policy.	Breastfeeding education is offered to the partners of employees who are expectant fathers.
Employer provides a list of communi-ty resources for breastfeeding support.	Employer contracts with skilled lacta-tion care provider on an "as needed" basis.	Employer hires a skilled lactation care provider to coordinate a breast-feeding support program.

Key factors include the number of women who are likely to use the program, the potential available space, and the needs and priorities of potential program users. Other successful breastfeeding support programs can be used as models.

Information about types of pumps and how to obtain them can be acquired from a local hospital, a lactation consultant, a health department, or a mother's support group.

Employers can contract with breast pump manufacturers to arrange discounted rates on purchased personal-use pumps. They can also rent or purchase multi-user pumps for placement in a Breastfeeding Mothers' Break Room.

Providing key decision-makers with information on specific costs for at least two levels of breastfeeding support can facilitate the planning process.

Smooth and safe operation of the breastfeeding support program is easiest with a designated lead person, even though minimal programs generate only a few hours of work each month.

Inform all employees about the company's breastfeeding support policy.

A workplace breastfeeding support program should be governed by a written policy communicated to all employees.

The policy should spell out details of the workplace support program, such as facilities provided and time allotted for breaks.

The policy should also prohibit harassment of and discrimination against breastfeeding employees. It should include job protection for

employees during and after maternity leave, and a ban on assigning breastfeeding employees to less desirable jobs.

Consider flexible scheduling options.

Flexible work arrangements can ease new mothers' return to work following childbirth. Regardless of flexibility, there will be a period of adjustment. Examples of scheduling options that can benefit both mothers and employers include:[3]

- *part-time* work
- *earned time,* in which sick time, vacation time, and personal days are grouped into one set of paid days off work, from which workers can take time at their own discretion
- *job-sharing,* in which two workers each work part time and share the responsibilities and benefits of one job
- *phase-back,* in which workers return from leave to their full-time work load over several weeks or months
- *flex-time,* in which workers arrange to work unusual hours to accommodate their home schedules
- *compressed work week,* in which employees work more hours on fewer days
- *telecommuting,* where employees work all or part of their jobs from home

Allow women sufficient break time to breastfeed or express milk on the job, and provide space in a private, clean place (not a bathroom).

Breastfeeding or expressing milk during working hours enables a mother to keep up a good supply of milk for her child.

The number of breaks needed to breastfeed or express milk is greatest when the child is younger, then gradually decreases.

For milk safety reasons, mothers must have clean hands and must clean equipment after use. Proximity of a sink is important. In addition, secure cold storage capability is essential

(this could include coolers with cold packs, provided by employees).

Women who work in a variety of sites throughout the week or the workday have special challenges and need authorization from their employer to use creative solutions. Solutions may include expressing milk in a vehicle or in a nursing mothers' room in a shopping mall.

Provide education.

Many parents get information and support for family issues from friends and coworkers. The worksite can be a significant source of support for breastfeeding.

Information collected by the breastfeeding support program can be provided to pregnant and breastfeeding employees, as well as to new or expectant fathers, so that each family does not have to go through the same information-gathering process.

Useful information includes a list of child care facilities near the worksite and a list of resources for obtaining breast pumps.

Support and be aware of legislation and policies promoting workplace support for breastfeeding women.

Legislators and policymakers have played an important role in promoting workplace support for breastfeeding women.

More state and federal laws are needed to:

- protect breastfeeding women from discrimination
- promote adequate maternity leave
- encourage employers to accommodate the needs of breastfeeding employees (e.g., through tax incentives, mandates, honoring model practices)
- establish worksite support programs for government employees
- replicate existing model legislation and policies in new locations
- reconsider aspects of welfare-to-work legislation that have made breastfeeding more difficult
- develop systems to assist businesses wanting to improve breastfeeding support

These laws should apply to all sectors of the work force, including part-time workers and welfare-to-work participants. Particular attention is needed for disadvantaged families, who suffer the most illness, have the lowest breastfeeding rates, and often work in jobs lacking workplace breastfeeding support.

Several states have passed or are considering legislation mandating that employers make available appropriate space and sufficient time for mothers to breastfeed or express milk in the workplace.

Other states' legislation does not include mandates but offers tax incentives to companies with strong breastfeeding support.[4]

Legislators, government agencies, and business leaders are responsible for providing the vision and leadership on a national level that will support breastfeeding mothers, reward progressive and forward-thinking companies, and encourage others to join the effort.

Tax incentives for breastfeeding support, paid maternity leave, and model family support programs in government agencies are all part of this vision and leadership.

Conclusion

The majority of new parents work hard to be both dedicated, quality workers and dedicated, devoted parents. Many industries, companies, departments, and divisions work creatively to make their work environments family-friendly.

Increased initiation and duration of breastfeeding are important national and global public health goals. By falling short of these goals, we put babies and mothers at increased health risk. Breastfeeding support in the workplace is an essential component of meeting these goals and is truly a win-win-win for mothers, babies, and employers.

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Additional Resources

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Goals of the United States Breastfeeding Committee

protecting | promoting | supporting

The mission of the United States Breastfeeding Committee (USBC) is to protect, promote, and support breastfeeding in the United States. The USBC exists to ensure the rightful place of breastfeeding in society.

The USBC works to achieve the following goals:

Goal I
Ensure access to comprehensive, current, and culturally appropriate lactation care and services for all women, children, and families.

Goal II
Ensure that breastfeeding is recognized as the normal and preferred method of feeding infants and young children.

Goal III
Ensure that all federal, state, and local laws relating to child welfare and family law recognize and support the importance and practice of breastfeeding.

Goal IV
Increase protection, promotion, and support for breastfeeding mothers in the work force.

Visit us at www.usbreastfeeding.org.

This paper was funded in part by the Health Resources and Services Administration's Maternal and Child Health Bureau and the Centers for Disease Control and Prevention, U.S. Department of Health and Human Services.

Accommodations for Breastfeeding in the Workplace

Listed below are several components of breastfeeding support in the workplace. Not all of them apply to every workplace situation. They are offered as a guide to employers and employees who are considering ways to support breastfeeding as a health behavior. This checklist may be most useful when considered in conjunction with the USBC issue paper *Workplace Breastfeeding Support*.

Facilities

- ❑ Space
  - o Dedicated, private pumping/breastfeeding room
  - o Floating, multipurpose room (space available)
  - o Restroom
  - o Other (please specify) _____
- ❑ Location of facilities
  - o Within a 5 minute walk of employee work stations
  - o Within a 10 minute walk of employee work stations
  - o In another building
  - o Other (please explain) _____
- ❑ Pumps
  - o Multi-user pump provided on site
  - o Employer provides pump rental
  - o Employer subsidizes pump rental
  - o Employer subsidizes pump purchase
  - o Employee provides own pump
- ❑ Breast pump personal supplies
  - o Provided by employer
  - o Subsidized by employer
  - o Purchased by employee
- ❑ Furnishings (check all that apply)
  - o Chair, table, sink and use of a dedicated refrigerator
  - o Chair, table, sink and use of refrigerator space
  - o Chair, table and sink
  - o Chair and table
  - o Chair
  - o Other (please elaborate)

_____
_____
_____

Written company policy

- Maternity leave
  - Paid, > 12 weeks (International Labor Organization Convention 183)
  - Paid, 12 weeks
  - Paid, 6 weeks
  - Unpaid, > 12 weeks
  - Unpaid, 12 weeks (FMLA)
  - Unpaid, 6 weeks

- Other sources of leave
  - Telecommuting
  - Combined use of accrued vacation/sick leave
  - Part-time work
  - Job sharing
  - Flex time
  - Compressed work week

- Other accommodations for breastfeeding mothers
  - Mother brings child to work
  - Care giver brings child to mother for feedings
  - On-site child care with accommodation for breastfeeding
  - Contract with nearby child care center that accommodates breastfeeding mothers

- Breaks for expressing milk or breastfeeding
  - 2 breaks and a lunch period in an 8½ hour day
  - paid breaks for pumping (breaks are not deducted from work time)
  - expanded unpaid breaks

- Workplace education and clinical support
  - hire a skilled lactation care provider
  - contract with a skilled lactation care provider on an as-needed basis
  - provide a list of community resources to employees
  - offer breastfeeding education to partners as well as employees
  - offer breastfeeding education to employees
  - include protection for pregnant and breastfeeding women in company sexual harassment policy and training
  - train all employees, supervisors and co-workers on the policies
  - communicate policy to all pregnant employees

State Breastfeeding Legislation

usbc United States Breastfeeding COMMITTEE PROMOTING • SUPPORTING • PROTECTING

Breastfeeding not only benefits babies and mothers through improved health and bonding, but also contributes to society at large through economic and environmental gains. Because of the many benefits of breastfeeding, national and state objectives have been set to increase its incidence and duration.

U.S. legislatures, which recognize the importance of breastfeeding, have enacted legislation to remove some of the barriers that can affect a woman's decision to begin to breastfeed or to continue to do so. The goal of all breastfeeding legislation is to encourage more women to choose breastfeeding and to prevent harassment. Thirty-four states have enacted some form of breastfeeding legislation over the past decade:[1]

- Many states have enacted breastfeeding legislation by creating new laws that protect, clarify, and/or enforce a mother's right to breastfeed her child in various situations.
- Other states have amended various laws by adding language to existing laws that pertain to breastfeeding.
- A few states have passed Resolutions of the Legislature, encouraging the support of breastfeeding in general.

Many breastfeeding bills contain a preamble that provides information about the importance of breastfeeding for women and children and current recommendations regarding the duration of exclusive and nonexclusive breastfeeding.[2] Some states include this information directly in the actual law rather than only in the bill, so that the information can easily be seen by anyone looking at the law.[3]

Legislation focused on the areas outlined below can play an especially effective role in promoting breastfeeding.

Breastfeeding in Public

Most breastfeeding legislation in the United States today relates to a mother's right to breastfeed in public. To date, 30 states have enacted some form of legislation attempting to clarify or enforce a woman's right to breastfeed in public.[4]

Legislation is most effective when it clearly specifies that women have the right to breastfeed in any public or private place where they have the right to be, even if there is exposure of the breast. Eighteen states have created or amended their laws to expressly give women the right to breastfeed in any place where they have the right to be,[5] and eight states have provided that their laws apply even if there is exposure of the breast during or incidental to breastfeeding.[6]

Laws that merely exempt breastfeeding from criminal statutes,[7] and that do not clearly specify that women have the right to breastfeed wherever they have the right to be, may not afford sufficient protection to breastfeeding mothers. For example, because these laws do not clarify that women have the right to breastfeed

when they frequent private businesses open to the public, they may not adequately prevent businesses from engaging in practices that hinder breastfeeding.

Restrictions or limitations on the right to breastfeed are not favored, as they defeat the purpose of legislation and can discourage women from breastfeeding. Restrictions may include requiring the breastfeeding mother to be discreet or modest,[8] excepting the right to breastfeed in a private home or residence of another,[9] limiting the right to breastfeed to only those places where both a mother and her child have a right to be,[10] or defining the age of the breastfed baby or child.[11]

Note that restrictions may be unlawful or unconstitutional if they contradict existing laws (e.g., the existing law that allows women to breastfeed on any federal property).[12] Most of the states that considered putting restrictions into their laws ultimately did not do so, and the states that did include restrictions are in the minority.[13] One state that initially put a restriction into its law amended the law a year later to remove the restriction.[14]

Four states have enacted laws that not only clarify the right to breastfeed in public but clearly state that it is a discriminatory practice to stop a mother from breastfeeding.[15] One city ordinance clarifies that it is segregation to tell a woman to breastfeed in a particular place.[16]

New York was one of the first states to exempt breastfeeding from its criminal statutes (1984).[17] Apparently New York recognized that more was needed to protect breastfeeding mothers, and as a result it enacted a very strong law that created an enforceable right to breastfeed, leading the nation with its approach. New York's law, which contains no restrictions, applies to mothers wherever they may go, in public or private settings. It applies even if there is exposure of the breast during or incidental to breastfeeding.

Breastfeeding legislation can help provide mothers with a remedy for violations. To date, three states provide for civil fines or penalties for violation of their laws,[18] and one state provides for an award of reasonable attorneys' fees if a mother is forced to seek legal redress through the courts.[19] The strongest law in the nation was enacted by New York in 1994.[20] New York placed its nursing-in-public law into its civil rights statutes, thus providing breastfeeding mothers in New York with the same rights and remedies as any other people whose civil rights are violated.

The trend in nursing-in-public legislation seems to be evolving, with these various approaches combined:

- Specifying that it is a discriminatory practice to stop a woman from breastfeeding in public, and that it is segregation to tell her to go to some other location to nurse her baby.
- Clarifying that women have a right to breastfeed in any place where they have the right to be, public or private, even if there is exposure of the breast.
- Eliminating any restrictions on the right to breastfeed, such as requiring the breastfeeding mother to be discreet or modest, excepting the right to breastfeed from a private home or residence of another, limiting the right to only those places where both a mother and her child have a right to be, or defining the age of the breastfed baby or child.
- Providing mothers with a remedy for violation of the law, from civil penalties and fines to an award of attorneys' fees.

Employment Issues

Experience has shown that legislation is still necessary to protect breastfeeding mothers from discrimination in the workplace. Because working environments or conditions may discourage mothers from continuing to breastfeed once they return to work, many women see no alternative to weaning their children or quitting their jobs. Women can have difficulty in obtaining relief from the courts because of several federal court opinions that do not find discrimination against breastfeeding mothers to be actionable.[21]

Initial employment legislation only encouraged employers to provide breastfeeding support, rather requiring support, as is the more recent trend.[22] Encouragements included allowing businesses to advertise themselves as "mother-friendly"[23] or "infant-friendly"[24] if they set up lactation support that conformed to state guidelines.

To solve the problem of discrimination against breastfeeding mothers, 10 states have enacted legislation that either encourages employers to support breastfeeding mothers when they return to work, or requires the employers to take specific actions to provide this support.[25] On the federal level, a bill has been submitted but not yet enacted into law that would provide tax incentives for expending funds on lactation support.[26]

Recognizing that encouragement alone may not be enough to provide employees with adequate support, six states have enacted laws that

require employers to accommodate breastfeeding mothers when they return to work, but only two of the six states make it clear that it is discrimination to treat a breastfeeding mother differently from any other employee.[27] Five states require employers to take specific actions in accommodating breastfeeding employees.[28] Four of those states require employers to provide mothers with sufficient break time to express breast milk on the job,[29] and all five require employers to also provide a private place that is not a bathroom stall to do so.[30] The most current law of one of those states also provides for a remedy in the form of a civil penalty for violation of its laws.[31]

The sixth state has taken a different approach to supporting breastfeeding employees by clarifying in its law that it is discrimination to not allow a mother to express or breastfeed on her breaks, or to treat her differently from any other employee because she is breastfeeding or wants to express milk on her breaks.[32] Though this approach does not necessarily require employers to take any specific action, it prevents them from taking action against or discriminating against breastfeeding mothers. It also overrides the negative federal court decisions that found discrimination against breastfeeding mothers not to be actionable.

One state (Connecticut) has found that a combination of approaches provides mothers with the most comprehensive protection.[33] Its law clarifies that it is discrimination to not allow a breastfeeding mother to express milk or breastfeed on her regular breaks, and also requires employers to provide mothers with a private, sanitary place to express her milk on the job.

The trend in employment legislation seems to be evolving, with these various approaches combined:

- Specifying that it is a discriminatory practice to stop a woman from expressing milk or breastfeeding on her breaks, or to treat her differently from other employees because she is breastfeeding.
- Requiring employers to provide sufficient break time to express milk, and a private, sanitary place to do so.
- Providing mothers with a remedy for violation of the law, from civil penalties and fines to an award of attorneys' fees.

Jury Duty

Jury duty can present significant problems for the breastfeeding mother. The effect of a sudden separation can put the breastfeeding relationship between mother and infant at risk. Separation can also cause the mother to become ill if she is not able to breastfeed or to express milk regularly.

Several states have enacted laws exempting breastfeeding mothers from jury duty.[34] These laws are not at all similar in terms of their language, as they were crafted to fit in with the general jury duty laws already existing in each state.

Other states have not seen the need to enact specific legislation to exempt breastfeeding mothers, as their laws provide other avenues for protecting the breastfeeding mother and infant, such as excusing parents who are at home with a child under a certain age.[35]

If a state were contemplating enacting legislation that would exempt breastfeeding mothers from jury duty, a first step would be to see if other exemptions already exist that would solve the problem. A second step would be to look at the language of states that have already enacted specific breastfeeding legislation, and to see which approach would be most consistent with the state's own existing jury duty laws.

Family Law Situations

In situations where parents separate or divorce, decisions on custody and visitation can negatively affect or even destroy the breastfeeding relationship, as well as the bond that the child has with the mother. Because breastfeeding is such an important health choice for both the baby and the mother, courts that support breastfeeding in family law situations can contribute greatly to a family's level of health. Inappropriate, abrupt, and lengthy separations from the breastfeeding mother can result in a child prematurely weaning, becoming ill, and suffering from a variety of psychological disorders.

These difficulties can be avoided if courts consider breastfeeding when they make custody and visitation decisions. There are many court decisions from around the United States that clarify the importance of breastfeeding and require courts to consider it as a factor in deciding custody and visitation issues in family law cases.[36] Two of these cases rule that it is not discrimination to consider breastfeeding in deciding these matters.[37]

To date, only three states have addressed breastfeeding and family law by enacting legislation.[38] One of those states requires that whether a child is nursing be considered as a factor in determining the frequency, duration, and type of parenting time to be granted.[39] Another provides that an exception to its visitation guidelines is consideration of the lack of reasonable alternatives to the needs of a nursing child.[40] The third state requires courts to consider breastfeeding in deciding parental responsibility issues in divorce and separation cases.[41]

Thus, the trend in family law legislation seems to be evolving, with breastfeeding a factor to be considered in determining parenting time in divorce or separation cases.

Mothers in Prison

Mothers who are sent to prison can still be encouraged to breastfeed. Legislation, such as New York's law that allows mothers under certain circumstances to have their children with them for the first year of life, helps to ensure that their babies still receive the benefits of being breastfed.[42]

Other methods of encouraging breastfeeding could be looked at in regards to state legislation that comes from federal case law. For instance, mothers in federal prison have the right to breastfeed their babies during regular visitation periods.[43] Also, breastfeeding can be considered as a factor in federal sentencing proceedings.[44]

Education, Training, and Licensure

In order to promote breastfeeding, some states require hospitals and providers of care to women and families to offer the services of a lactation consultant and/or information on breastfeeding and its benefits to infant and mother.[45] Several state laws that administer maternal and child health programs require promotion of breastfeeding as well as availability of breastfeeding services and support.[46] Also, some public service and education campaigns produced by health departments include the promotion of breastfeeding.[47]

The role of states may include licensing or registering lactation consultants, and setting forth requirements for qualifications, as one state has done.[48] Additionally, states may require the education of health professionals to include specific breastfeeding content.

Milk Banks

There is currently no legislation regulating the use of donor human milk. Medicaid and insurance third-party payers can and do cover processing fees for circumstances in which donor human milk is prescribed.

International Code of Marketing of Breast-milk Substitutes

Another issue that has arisen in the United States is the enactment of legislation to enforce the *International Code of Marketing of Breast-milk Substitutes*. While the United States joined numerous other countries in signing the *Code,* only one state has attempted to enact legislation designed to enforce it.[49] Such laws would prohibit a manufacturer of infant formula from engaging in marketing activities that violate the *Code*. While there are no state laws at the present time pertaining to the *Code,* Massachusetts and New York have a provision in their perinatal guidelines that require a physician prescription or a request by the mother before a formula discharge bag can be distributed.

Breastfeeding Equipment and Supplies

Another method of supporting breastfeeding is to enact legislation that provides for the payment or reimbursement of breastfeeding equipment

and supplies essential for successfully maintaining lactation, such as breast pumps and shields. This could be done through maternal and child health programs (such as WIC programs) and through requirements for third-party payers to cover such items, as well as the services of a lactation consultant. State health insurance codes can be modified to facilitate third-party reimbursement for breastfeeding care and services.

Breastfeeding equipment and supplies can be treated as medical supplies and thus be made exempt from sales tax, as has been done in one state.[50]

Conclusion

For states wishing to offer the greatest possible support of breastfeeding, the United States Breastfeeding Committee recommends enacting or amending laws as suggested in this paper. Though each state will need to consider its specific situation, all efforts will assist the United States in attaining its goals for breastfeeding incidence and duration, and for the optimal health of infants, children, and mothers.

Endnotes

1. See chart entitled "State by State Listing of Enacted Breastfeeding Legislation As of 1/29/03"; see also "A Current Summary of Breastfeeding Legislation in the U.S." at www.lalecheleague.org/LawBills.html.
2. AK, DE, FL, MT, NH, NJ, NY.
3. LA, NV.
4. AK, CA, CT, DE, FL, GA, HI, IL, IA, LA, ME, MI, MN, MO, MT, NV, NH, NJ, NM, NY, NC, OR, RI, SD, TX, UT, VT, VA, WA, WI.
5. CA, FL, HI, IA, LA, ME, MN, MO, MT, NV, NJ, NM, NY, NC, OR, TX, UT, VT.
6. FL, MI, MN, MT, NV, NY, NC, UT.
7. AK, IL, MI, RI, SD, VA, WA, WI.
8. MO.
9. CA.
10. CA, GA, MN, VT.
11. Colorado attempted to pass such legislation but it failed; Massachusetts has a pending bill with this restriction, 2001 Bill Tracking MA H.B. 4401.
12. Right to Breastfeed Act (H.R. 1848).
13. CA, GA, MN, MO, VT.
14. GA.
15. CT, LA, HI, NH.
16. PA City of Philadelphia City Ordinance 9-1105.
17. NY CLS § 245.012 245.02.
18. CT, HI, NJ.
19. HI.
20. 1994 NY ALS 98, NY CLS Civ R § 79-e.
21. *Fortier v. Steel Group,* 2002 U.S. Dist. LEXIS 11788; *Martinez v. N.B.C. Inc.,* 49 F. Supp. 2d 305 (1999); *Bond v. Sterling,* 997 F. Supp. 306 (1998); *Wallace v. Pyro Mining,* 789 F. Supp. 867 (1990); *Pendrix-Wang v. Director, Employment Security Department,* 42 Ark. App. 218 (1993); *Barrash v. Bowen,* 846 F.2d 927 (1988).
22. GA, FL, TX, WA.
23. TX.
24. WA.
25. CA, CT, FL, HI, GA, IL, MN, TN, TX, WA.
26. Breastfeeding Promotion and Employers' Tax Incentive Act (H.R. 1163).
27. CT, HI.
28. CA, CT, IL, MN, TN.
29. CA, IL, MN, TN.
30. CA, CT, IL, MN, TN.
31. CA.
32. HI.
33. CT.
34. CA, OR, IA, ID.
35. For example, several states exempt parents at home with children under a certain age. OCGA § 15-12-1, 2002; Fla Stat §40.013, 2002; 705 ILCS 305/10.2, 2002; Mass Ann Laws ch. 234 § 1, 2002; SC Code Ann 14-7-860, 2002.
36. For example, see *Faber v. Faber,* 159 A.D.2d 676 (1990); *Presutti v. Presutti,* 1990 Ohio App. LEXIS 3987; *Ford v. Ford,* 108 Idaho 443 (1985); *In re: The Marriage of Norton and Norton,* 640 P.2d 254 (Col. Ct. App. 1981); *Lester v. Lennane,* 84 Cal. App. 4th 536 (Ca Ct. App. 2000); *Kerstetter v. Kerstetter,* 1993 West Law 98040 (Ohio App. 4 Dist); *Goose v. Goose,* 406 NW 2d 4 (Minn.).
37. *Lester,* 84 Cal. App. 4th 536; *In re: The Marriage of Norton and Norton,* 640 P.2d 254.
38. ME, MI, UT.
39. MI.
40. UT.
41. ME.
42. NY CLS Correc § 611, 2001.
43. *Barrios v. Richard Thornberg, etc., et al.,* 716 F. Supp. 987 (1989).
44. *U.S. v. Dyce,* 320 U.S. App. D.C. 1; 91 F.3d 1462 (1996).
45. CA, FL, MO.
46. FL, IL, MT.
47. CA, IL, MN.
48. LA.
49. Cal Assembly Bill 2447, 2001 CA AB 2447.
50. MD.

State by State Listing of Enacted Breastfeeding Legislation as of 1/29/03

Alaska

Ak SB 297, 1998 AK ALS 78, Ak Stat §01.10.060, §29.25.080 (Nursing in Public)

California

Cal AB 977, 1995 Cal ALS 463, Cal Health & Saf Code §123360 and §123365 (Information Campaign, Health Program)

Cal AB 157, 1997 Cal ALS 59, Stats 1997 Ch 59,Cal Civ Code §43.3; (Nursing in Public)

Cal Assembly Concurrent Resolution 155, 1998 (Employment)

Cal AB 1814, 2000 Cal ALS 266, Stats 2000 Ch 266, Cal Code Civ Proc §210.5 (Jury Duty)

Cal AB 1025, 2001 Cal ALS 821, Stats 2001 Ch 821, Cal Lab. Code §1030, 1031, 1032, 1033, 2001 (Employment)

Connecticut

Ct SB 260, 1997 Ct ALS 210, Conn Gen Stat §46a-64, and §53-34b (Nursing in Public)

Ct HB 5656, 2001 Ct ALS 182 (Employment)

Delaware

Del HB 31, 1997 Del ALS 10, 71 Del Laws 10, 31 Del C. §310 (Nursing in Public)

Florida

Fl HB 231, 1993 Fl ALS 4, 1993 Fla Laws ch. 4, Stat. §383.015, §800.02–800.04, §847.001 (later 827.071) (Nursing in Public)

Fl SB 1668, 1994 Fl ALS 217, 1994 Fla Laws Ch 217, Stat §363.318, §383.015, §383.016, §383.311, §383.318 (Employment, Health Program)

Georgia

Ga SB 29, 1999 Ga ALS 304, 1999 Ga Laws 304, (Nursing in Public) (Later amended by Ga SB 221, 2001, OCGA §31-1-9)

OCGA §34-1-6 (Employment)

Hawaii

Hi HB 2280, 1990 Hi ALS 326 (WIC)

Hi HB 2774, 1999, HRS §489-21, HRS 489-22, 2002 (Nursing in Public)

Hi HB 266, 1999 Hi ALS 172, HRS 378-10.2, 2002, HRS §378-2, 2002 (Employment)

Idaho

Ida SB 1468, 1996 Ida. ALS 189, 1996 Ida Ch189, Ida Code §2-212, 2002 (Jury Duty)

Illinois

Ill SB 190, 1995 Ill ALS 59, 1995 Ill Laws 59, 720 ILCS 5/11-9, 2002 (Nursing in Public)

Ill SB 404, 1997 Ill ALS 244,1997 Ill Laws 244, 20 ILCS 2310/2310-442, 2002 (Information Campaigns)

Ill SB 619, 1997 Ill ALS 290, 1997 Ill Laws 290 (WIC)

Ill SB 542, 2001 Ill ALS 68, 2001 Ill Laws 68 (Employment)

Iowa

Ia HF 2350, 1994 Ia ALS 1196, 1994 Ia Ch 1196, 1994 Ia LAWS 1196, Ia Code §607A.5, 2002 (Jury Duty)

Ia SF 2302, 2000 Ia. ALS 1140, 2000 Ia. Ch 1140, 2000 Ia. LAWS 1140, Iowa Code §135.30A, 2002 (Nursing in Public)

Louisiana

La HB 377, 2001 La. ALS 576, 2001 La. ACT 576. 777, La RS 51:2247.1, 2002 (Nursing in Public)

La RS 40:2213, 2002 (Consultant qualifications)

Maine

Me SP 888, 1999 Me ALS 702, 1999 Me Laws 702, 1999 Me Ch 702, 19-A MRS §1653, 2001 (Family Law)

Me HP 1039, 2001 Me ALS 206, 2001 Me Laws 206, 2001 Me Ch. 206, 5 MRS §4634, 2001 (Nursing in Public)

Maryland

Md SB 252, 2001 Md. ALS 137, 2001 Md. Chap 137, Md Code Ann §11-211,2002 (Tax exemption)

Michigan

Mi SB 107-109, 1994 Mi ALS 313-315, 1994 Mi P.A. 313-315, MCLS §41.181, §67.1, 17.4i,§117.5h (Nursing in Public)

Michigan Complied Laws § 25.312(7a) Ch 722, Children, Child Custody Act of 1970

MCLS §722.27a (Family Law)

Minnesota

Minn SF 2621,1990 Minn ALS 568, 1990 Minn Ch Law 568, Minn Stat §145.894,2002 (Information Campaign)

Minn SF 2751, 1998 Minn ALS 369, 1998 Minn Ch Law 369, Minn Stat.§181.939, 617.23 (Employment)

Minn SF 3346, 1998 Minn ALS 407, 1998 Minn Ch Law 407, Minn Stat. §145.905 (Nursing in Public)

Missouri

Mo SB 8, 1999, R.S.Mo §191.915, §191.918 (Health Program, Nursing in Public)

Montana

Mt SB 398, 1999 Mt ALS 299, 1999 Mt Laws 299, 1999 Mt Ch. 299, Mont Code Anno. §50-19-501(Nursing in Public)

Mt HJR 3, 1991 (WIC)

Nevada

Nev SB 317, 1995 Nev ALS 105, 1995 Nev Stat 105, 1995 Nev Ch 105, Nev Rev Stat Ann. §201.210, § 201.220, §201.232 (Nursing in Public)

Nev SB 416, 1995 Nev ALS 443, 1995 Nev Stat 443 (Nursing in Public)

New Hampshire

NH HB 441, 1999, 10 RSA 132:10-d (Nursing in Public)

New Jersey

NJ SN 1212, 1997 NJ ALS 101, 1997 NJ Laws 101, 1997 NJ Ch 101, NJ Stat. §26:4B-4 (Nursing in Public)

New Mexico

NM SB 545, 1999 NM ALS 117, 1999 NM Laws 117, 1999 NM Ch 117, NM Stat Ann §28-20-1 (Nursing in Public)

New York

NY SN 3999, 1994 NY ALS 98, 1994 NY LAWS 98, NY CLS Civ R §79-e (Nursing in Public)

NY CLS §245.01, 245.02, 1984 (Nursing in Public)

NY CLS Correc §611 2001, Correction Law (Nursing in Prison)

North Carolina

NC HB 1143, 1993 NC ALS 301, 1993 NC Sess. Laws 301, 1993 NC Ch. 301, Gen. Stat. Sec. 14-190.9, 1993 (Nursing in Public)

Oregon

Ore SB 744, 1999, Ore ALS 306, 1999 Ore Laws 306, ORS §109.001 (Nursing in Public)

Ore SB 1304, 1999 Ore ALS 1085, 1999 Ore Laws 1085, ORS §10.050 (Jury Duty)

Pennsylvania: City of Philadelphia Only

Pennsylvania: City of Philadelphia City Ordinance 9-1105, 1997

Rhode Island

RI SB 2319, 1997, RI Gen Laws §11-45-1 (Nursing in Public)

South Dakota

SD SB 184, 2002 SD ALS 109, 2002 SD Ch 109, SD Cod Laws §22-22-24.1, 2002 (Nursing in Public)

Tennessee

Tn SB 1856, 1999 Tn ALS 161, 1999 Tn Pub Acts 161, Tenn Code Ann §50-1-305 (Employment)

Texas

Tex HB 359 & 340, 1995 Tex ALS 599-600, 1995 Tex Gen Laws 599-600, 1995 Tex Ch 599-600, Code §165.001 – 165.005, 165.031 – 165.034 (Nursing in Public, Employment)

Utah

Ut HB 262, Ut Code Ann §10-8-41, §10-8-50, §17-15-25, §76-9-702, §76-10-1229.5 (Nursing in Public)

Ut SB 33, 1997 Ut ALS 80, 1997 Utah Laws 80, 1997 Ut Ch. 80, Utah Code Ann §30-3-34 (Family Law)

Vermont

Vt SB 156, 2002 Vt ALS 117, 2002 Vt Laws 117, 2002 Vt Act 117, 9 VSA §4502, 2002 (Nursing in Public)

Virginia

Va HB 1188, 1994 Va ALS 398, 1994 Va Acts 398, 1994 Va Ch. 398, Va Code Ann §18.2-387 (Nursing in Public)

Va H J R 248, 1994 (Supplies for Medicaid)

Washington

Wa HB 1590, 2001 Wa ALS 88, 2001 Wa Ch. 88, RCW 43.70.640, 9A.88.010 (Nursing in Public, Employment)

Wisconsin

Wis AB 154,1995 Wis ALS 165, 1995 Wis Act 165, 1995 Wis Laws 165, Wis Stat.§944.17, § 944.20, §948.10 (Nursing in Public)

Goals of the United States Breastfeeding Committee

protecting | promoting | supporting

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Ensure access to comprehensive, current, and culturally appropriate lactation care and services for all women, children, and families.

Goal II
Ensure that breastfeeding is recognized as the normal and preferred method of feeding infants and young children.

Goal III
Ensure that all federal, state, and local laws relating to child welfare and family law recognize and support the importance and practice of breastfeeding.

Goal IV
Increase protection, promotion, and support for breastfeeding mothers in the work force.

Visit us at www.usbreastfeeding.org.

This Appendix includes the following information about the "Public Forum: Promoting, Protecting, and Supporting Breastfeeding in North Carolina (September 2004)"

- NC DHHS Media Release for the Breastfeeding Forum
- Agenda for the Breastfeeding Forum
- Forum Organizers
- Forum Participants

Michael F. Easley
Governor

Carmen Hooker Odom
Secretary

State of North Carolina
Department of Health and Human Services

For Release: Immediate
Contact: Carol Schriber

Date: Sept. 7, 2004

MEDIA ADVISORY

Groups' goal would significantly advance breastfeeding as the best foundation for infant and young child feeding

RALEIGH – Not enough North Carolina infants are being fed breast milk, and many of those that receive its benefits are weaned far too early, says a group of specialists. The state needs a blueprint to turn those numbers around.

WHAT: The North Carolina Division of Public Health, in collaboration with representatives from non-governmental and public agencies, will hold a **public forum** on "Promoting, Protecting and Supporting Breastfeeding in North Carolina."

WHO: Presenters include Dr. Peter Morris, MD, president of N.C. Pediatric Society; Molly Pessl, director, Evergreen Perinatal Education, Seattle, Wash.; Alice Lenihan, head, Nutrition Services Branch, N.C. Division of Public Health; Ginger Sall, La Leche League International representative to the UNICEF and the Department Public Information, of the United Nations, New York, NY; Dr. Miriam Labbock, MD, senior advisor, Infant and Young Child Feeding and Care, UNICEF, United Nations, New York, NY.

WHY: The forum will address barriers and opportunities in health care systems, insurance, educational institutions, community organizations, individuals and families and identify strategies to help North Carolina develop a state plan and meet the National Healthy People 2010 Goals: Promoting, Protecting and Supporting Breastfeeding.

WHEN: Thursday, Sept. 9, 8:00 a.m. to 4:30 p.m.

WHERE: William and Ida Friday Center for Continuing Studies, Chapel Hill, N.C.

BACKGROUND: In 2002, about 51 percent of lower income mothers in North Carolina initiated breastfeeding, 18 percent continued at six months, and 14 percent breastfed at 12 months, according to CDC's Pediatric Nutrition Surveillance. The Healthy People 2010 Objectives for breastfeeding are for 75 percent of mothers to initiate breastfeeding, 50 percent to breastfeed for six months, and for 25 percent to breastfeed for one year.

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Debbie K. Crane
Director

Agenda
September 9, 2004

Promoting, Protecting and Supporting Breastfeeding In North Carolina: A Public Forum

8:00 am — Registration and Poster Sessions

8:45 — Welcome and Introduction in the Grumman Auditorium

Recognizing the Challenge
Peter Morris, MD, MPH
President of North Carolina Pediatric Society, and Medical Director

Focusing on the Issues
Molly Pessl, BSN, IBCLC
Director of Evergreen Perinatal Education, Seattle, WA

A Look at Breastfeeding in North Carolina
Alice Lenihan, MPH, RD, LDN
Branch Head of Nutrition Services Branch, North Carolina Division of Public Health, Raleigh, NC

10:00 — Break and Poster Sessions

10:30 — Panel Discussion to Explore the Issues: Public Policy, Public Awareness, Community Organizations and Families
Moderator – Mary Rose Tully, MPH, IBCLC, Director of Lactation Services, University of North Carolina, Women's and Children's Hospital, Chapel Hill, NC

Panel Members

- *Ruth Sheehan, Columnist, Raleigh News and Observer, Raleigh, NC*
- *Janice Payne, Breastfeeding Counselor, Forsyth County Health Department, Winston-Salem, NC*
- *Elizabeth Julye, BS, Nutritionist and Breastfeeding Coordinator, Granville-Vance Health Department, Granville, NC*

- *Nancy Register, FNP, IBCLC, Family Nurse Practitioner, SAS Institute, Cary, NC*
- *Jean Holliday, Supervisor, NC Department of Insurance, Raleigh, NC*
- *David Weismiller, MD, ScM, Associate Professor, The Brody School of Medicine at ECU, Greenville, NC*
- *Miriam Labbock, MD, MPH, Senior Advisor, Infant and Young Child Feeding and Care, UNICEF, New York, NY*

12:15pm **Networking Lunch and Poster sessions** (lunch is provided)

1:30 **Facilitated Discussion Groups** (choose one)

Room – Bellflower AB
(A-1) Public Awareness: Health Care Systems, Insurance, Educational Institutions

Room – Windflower AB
(A-2) Public Awareness: Community Organizations and Families

Room – Dogwood A
(B-1) Public Policy: Health Care Systems, Insurance, Educational Institutions

Room – Dogwood B
(B-2) Public Policy: Community Organizations and Families Room – Mountain Laurel AB

(C-1) Community Organizations and Families: Individuals and Families

Room – Azalea AB

(C-2) Community Organizations and Families: Organizations and Work-sites

3:00 **Break and Poster Sessions**

3:30	**Going for the Gold** Findings and Recommendations from the Discussion Groups
	Closing Remarks *Miriam Labbock, MD, MPH,* *and* *Ginger Sall, BA* *La Leche League International Representative to the UNICEF and Department of Public Information of the United Nations*
4:30	**Adjourn**

Forum Organizers

A special thank you is extended to the members of the Breastfeeding Work Group in collaboration with the North Carolina Division of Public Health who worked tirelessly to organize the breastfeeding public forum. Their vision for the children of North Carolina is that they start life breastfeeding, the best possible foundation for optimal infant and young child feeding. The forum members are listed below.

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