☞ 07hr_sb0030_SC-PHSILTCP_pt02

WISCONSIN STATE LEGISLATURE ... PUBLIC HEARING COMMITTEE RECORDS

2007-08

(session year)

Senate

(Assembly, Senate or Joint)

Committee on Public Health, Senior Issues, Long Term Care and Privacy

(SC-PHSILTCP)

(FORM UPDATED: 07/02/2010)

COMMITTEE NOTICES ...

- Committee Reports ... **CR**
- Executive Sessions ... **ES**
- Public Hearings ... **PH**
- Record of Comm. Proceedings ... **RCP**

INFORMATION COLLECTED BY COMMITTEE FOR AND AGAINST PROPOSAL ...

- Appointments ... **Appt**
  - ☞ **Name:**
- Clearinghouse Rules ... **CRule**
- Hearing Records ... bills and resolutions (ab / ar / ajr) (sb / sr / sjr)
- Miscellaneous ... **Misc**
  - ☞ **Details:**

SB 307

Position of the American Dietetic Association: Promoting and Supporting Breastfeeding

ABSTRACT

It is the position of the American Dietetic Association (ADA) that exclusive breastfeeding provides optimal nutrition and health protection for the first 6 months of life, and breastfeeding with complementary foods for at least 12 months is the ideal feeding pattern for infants. Breastfeeding is also a public health strategy for improving infant and child health survival, improving maternal morbidity, controlling health care costs, and conserving natural resources. ADA emphasizes the essential role of dietetics professionals in promoting and supporting breastfeeding by providing up-to-date, practical information to pregnant and postpartum women, involving family and friends in breastfeeding education and counseling, removing institutional barriers to breastfeeding, collaborating with community organizations and others who promote and support breastfeeding, and advocating for policies that position breastfeeding as the norm for infant feeding. ADA also emphasizes its own role by providing up-to-date information to the public, encouraging empirical research, providing continuing education opportunities, providing cultural sensitivity and cultural competence training to dietetics professionals, and encouraging universities to review and update undergraduate and graduate training programs.

J Am Diet Assoc. 2005;105:810-818.

POSITION STATEMENT

It is the position of the American Dietetic Association (ADA) that exclusive breastfeeding provides optimal nutrition and health protection for the first 6 months of life, and breastfeeding with complementary foods for at least 12 months is the ideal feeding pattern for infants. Breastfeeding is also a public health strategy for improving infant and child health survival, improving maternal morbidity, controlling health care costs, and conserving natural resources.

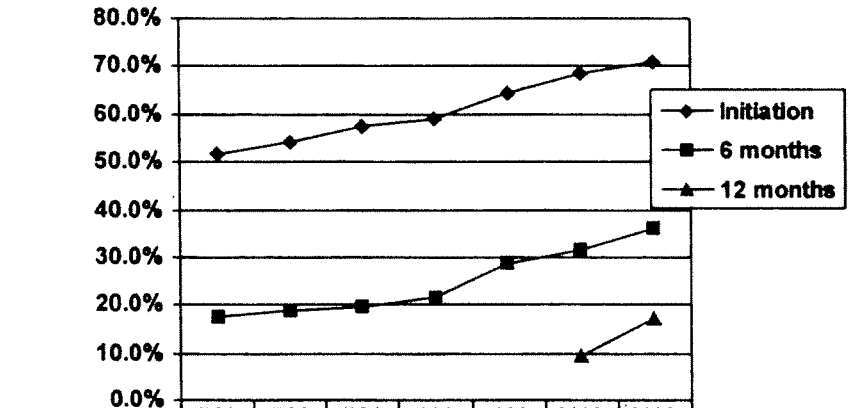
0002-8223/05/10505-0020$30.00/0
doi: 10.1016/j.jada.2005.03.015

reastfeeding, or lactation, is the ideal method of feeding and nurturing infants. The Bellagio Child Survival Study Group identified breastfeeding in the first year as one of the most important strategies for improving child survival (1-3). Health professionals in the United States recommend that infants be exclusively breastfed for the first 6 months of life, and then be breastfed with complementary foods for at least the first year (4-8). Internationally, the World Health Organization recommends that breastfeeding be continued up to 2 years of age or beyond, with appropriate supplementation of solid foods (9,10). Breastfeeding involves primary, and to a lesser extent, secondary prevention of acute and chronic diseases. Achieving the Healthy People 2010 objectives (4) for breastfeeding could lead to a significant decrease in pediatric health care costs in the United States (11). The benefits of breastfeeding are well recognized and include decreased infant and child morbidity and mortality, protection against common childhood infections, and decreased risk of certain acute and chronic diseases. There are also extensive health benefits for mothers who breastfeed (4,10).

BREASTFEEDING TRENDS IN THE UNITED STATES

Breastfeeding rates in the United States are lower than in most nations. Globally, about 79% of infants are breastfed for 12 months, compared with 17% to 20% in the United States (10,12,13). In colonial America, almost all infants were breastfed. By the 1880s, mothers began to supplement breastfeeding with raw cow's milk (some starting soon after giving birth) and to wean their infants before they were 3 months old. Infants fed raw cow's milk died at much higher rates than breastfed infants until the 1920s, when pasteurization made cow's milk safer and readily available for infant feeding. Over the next 50 years, breastfeeding rates declined sharply because of the widespread belief that pasteurized cow's milk eliminated the differences between human and cow's milk feeding (14). The decline continued when other milk substitutes (evaporated cow's milk and infant formula) became widely available. These were promoted as being more convenient for the mothers and being more nutritious than human milk. Breastfeeding rates reached an all-time low in the United States in 1971, with only 24% of mothers initiating breastfeeding (15).

As a result, the US Department of Health and Human Services (HHS) set goals for breastfeeding initiation and duration rates in the late 1970s. The United States has since seen a steady increase in breastfeeding rates (4). Breastfeeding initiation rates increased from a low of about 24% in the early 1970s to a high of 61.9% in 1982 (15,16). After a decline in breastfeeding rates through 1990, breastfeeding initiation rates have increased yearly, exceeding 70% in 2002 (12,13) (Figure 1). Breastfeeding rates are expected to continue increasing as a result of several national efforts, including the *HHS Blueprint for Action on Breastfeeding* (5), the US Department of Agriculture (USDA)/Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) *Loving Support Makes Breastfeeding Work* campaign (17), the HHS *Breastfeeding Awareness Campaign* (18), and the US Breastfeeding Committee's strategic



	1990	1992	1994	1996	1998	2000	2002
Initiation	51.5%	54.2%	57.4%	59.2%	64.3%	68.4%	70.9%
6 months	17.6%	18.9%	19.7%	21.7%	28.6%	31.4%	36.2%
12 months	NA [a]	NA	NA	NA	NA	9.6%	17.2%

Figure 1. US breastfeeding rates (1990 to 2002). 1990 to 2000 data from reference (12). 2002 data from reference (13). [a]NA=not available.

plan for breastfeeding (19). The US Breastfeeding Committee's strategic plan is endorsed by HHS and more than 20 other professional and public health organizations.

According to National Immunization Survey data, 14 states have achieved the national Healthy People 2010 objective for 75% of mothers initiating breastfeeding (Figure 2), and the national goal seems to be within reach (13). Breastfeeding initiation rates continue to be highest among women who are white, college educated, older than 30 years, employed part-time, not enrolled in WIC, and living in the Mountain or Pacific regions (12,13). Although all demographic groups reported increases in breastfeeding initiation since 1990, the largest increases occurred among mothers who have historically been less likely to breastfeed—women who are black, Hispanic, less educated, employed full-time, less than 24 years old, living in the South Atlantic region, participating in WIC, and with low-birth-weight infants (12).

Considerable work remains to achieve the two Healthy People 2010 goals for breastfeeding duration—50% of infants breastfeeding at 6 months of age and 25% breastfeeding at 12 months of age (4). Six states have achieved the objective for breastfeeding duration at 6 months of age (see Figure 2). However, nationally only 33.2% to 36% of all infants are breastfeeding at 6 months of age (12,13). The largest increases in breastfeeding duration rates have occurred among New England residents, Hispanic mothers, and non-WIC participants (12). Eight states have achieved the objective for breastfeeding duration at 12 months of age (see Figure 2). Nationally, only 17% to 20% of all infants are breastfeeding at their first birthday (12,13). Worldwide, 79% of infants are still breastfeeding at 12 months of age (10).

US breastfeeding initiation rates are much higher than breastfeeding exclusivity rates. Despite the limited data about breastfeeding exclusivity and the variety of definitions of exclusivity used across studies, the available data provide important insight. Exclusive breastfeeding in hospitals has remained steady over the last 4 years, but significant differences exist by demographic segments. For example, mothers with a college education are more likely to have exclusively breastfed their infants than mothers without a college education. Non-WIC mothers exclusively breastfed their infants at higher rates than WIC mothers, and white mothers exclusively breastfed at a rate nearly double that of black mothers. At 6 months of age, similar gaps existed for these same demographic segments (12,13).

The primary source of breastfeeding data in the United States since 1955 has been proprietary data collected by Ross Products Division of Abbott Laboratories. The Ross Mothers Survey (12) collects data through an ongoing mail survey periodically sent to a nationally representative sample of new mothers. The data have been relied on to monitor breastfeeding rates by state, by geographic region, and nationally. Another data source for monitoring breastfeeding trends was instituted in 2003 by the Centers for Disease Control and Prevention and the National Center for Health Statistics (13). Breastfeeding questions were incorporated into the National Immunization Survey, which uses random-digit dialing to survey households with children ages 19 to 35 months. Breastfeeding initiation, duration, and exclusivity of breastfeeding rates are reported for the overall population, states, and selected geographic areas within states. Trend data from the latter survey will be critical for monitoring breastfeeding rates in the future.

HEALTH BENEFITS TO INFANTS

According to the American Academy of Pediatrics, the breastfed infant is the reference against which all alternative feeding methods must be measured with regard to growth, health, development, and other outcomes (6). Human milk has many beneficial effects on the health of infants (including premature and low-birth-weight infants) and young children. These benefits are magnified with exclusive breastfeeding and breastfeeding beyond 6 months of age (3,10).

Human milk is uniquely superior to all other milk substitutes and is specifically tailored to meet the nutritional needs of the human infant. It has the appropriate balance of nutrients provided in easily digestible and bioavailable forms (4,10,20). The milk changes its composition, from colostrum for the newborn to mature milk for the older infant, to meet the nutrient needs of the growing infant. It provides generous amounts of carbohydrates, essential fatty acids, saturated fatty acids, medium-chain triglycerides, long-chain polyunsaturated fatty acids, and cholesterol. The relatively low protein content presents a relatively modest nitrogen load to the immature kidney. The protein is largely α-lactalbumin, a whey protein that forms a soft, easily di-

75% Breastfeeding initiation	50% Breastfeeding at 6 months	25% Breastfeeding at 12 months
Alaska	Hawaii	Alaska
Arizona	Idaho	California
California	Oregon	Hawaii
Colorado	Utah	Idaho
Hawaii	Vermont	Oregon
Idaho	Washington	Utah
Kansas		Vermont
Minnesota		Washington
Montana		
Nevada		
Oregon		
Utah		
Vermont		
Washington		

Figure 2. States achieving national Healthy People 2010 breastfeeding objectives. Source: Centers for Disease Control and Prevention. 2003 National Immunization Survey.

Benefits for infant	Benefits for mother
• Provides optimal nutrition for infant	• Promotes faster shrinking of the uterus
• Guarantees safe, fresh milk	• Reduces postpartum bleeding
• Enhances immune system	• Decreases risk of breast and ovarian cancer
• Protects against infectious and non-infectious diseases	• Delays resumption of the menstrual cycle
• Protects against allergies and intolerances	• Improves bone density
• Decreases risk of diarrhea and respiratory infections	• Decreases risk for hip fracture
• Promotes correct development of jaws, teeth, and speech patterns	• Improves glucose profile in gestational diabetics
• Decreases risk of childhood obesity	• Strengthens bond with the infant
• Increases cognitive function	• Enhances self-esteem in the maternal role
• Reduces risk for heart disease	• Eliminates the need for preparing and mixing formula
• Increases bonding with mother	• Saves money not spent on formula

Figure 3. Benefits of breastfeeding.

gestible curd. Human milk has a relatively low sodium content, allowing the fluid requirements of the exclusively breastfed infant to be met while keeping the renal solute load low. Minerals in breast milk are largely protein bound and balanced to enhance bioavailability. The 2:1 calcium-to-phosphorus ratio is ideal for the absorption of calcium, phosphorus, and magnesium. The limited amount of iron and zinc is highly absorbable (21). Given the nutrient content of human milk and decreased exposure to sunlight, a vitamin D supplement is recommended for all breastfed infants until they consume at least 500 mL per day of vitamin D–fortified infant formula (or milk for infants after their first birthday) (22). Breastfed infants who are 6 months and older may need a fluoride supplement if the total amount of fluoride from the local water supply or other sources available to the infant is inadequate (23).

Breastfeeding, especially exclusive breastfeeding, during the first 6 months of life is an important factor in reducing infant and childhood morbidity and mortality (9). Breastfeeding decreases the risk for a large number of acute and chronic diseases (Figure 3). Breastfeeding decreases the incidence and severity of diarrhea and gastrointestinal illnesses (24,25), lower respiratory infection (26), otitis media (24,25,27), bacterial meningitis (28,29), necrotizing enterocolitis (30), malocclusions or misalignment of teeth (31), allergic diseases (30), childhood asthma (32), childhood leukemia (33), childhood obesity (34), and Sudden Infant Death Syndrome (SIDS) (35). Evidence continues to accumulate confirming the benefits of breastfeeding in reducing the risk for cardiovascular diseases and type 1 diabetes (36). Breastfeeding also has been linked with enhancement of cognitive development, with some studies showing evidence that these cognitive developmental benefits increased with the duration of breastfeeding (37) and extended through the school-age years (38,39).

Studies relating to the benefits of breastfeeding have been criticized for methodological and analytical flaws including lack of control for confounding factors, poorly designed tools, varying definition of breastfeeding, and researcher bias (11,40). However, professional health organizations stand behind their recommendations for promoting breastfeeding as the optimal food for human infants.

HEALTH BENEFITS TO WOMEN, FAMILY, AND SOCIETY

Maternal Benefits

Women choose to breastfeed for many reasons. Although women may be aware of the health benefits to infants, they may not be fully aware of the wide range of health benefits for themselves (see Figure 3). The degree to which some of these health benefits may be realized depends on breastfeeding duration, frequency, exclusivity, and other personal factors (41). Breastfeeding increases oxytocin levels, resulting in less postpartum bleeding and greater uterine involution (shrinking) (42). Lactation amenorrhea (delayed menstrual cycle) causes less menstrual blood loss, which conserves iron stores (42). Other benefits of breastfeeding include a decreased risk for postmenopausal hip fractures (43), bone remineralization to levels exceeding those present before pregnancy (44), an improved glucose profile for those with gestational diabetes (45), a decreased risk of type 2 diabetes (41), a decreased risk for ovarian cancer (46), a decreased risk for premenopausal breast cancer (47), and increased weight loss and fat loss (48-50).

The studies on breastfeeding and weight loss have produced mixed findings. In the short term, breastfeeding women experience greater weight and fat loss than nonbreastfeeding women (48,49). Women who breastfeed for more than 6 months and those who do so exclusively are more likely to achieve maximum weight loss. However, the weight difference may not be sustained past 18 months (50). It should be noted that weight loss and body composition changes are highly variable among postpartum women (50,51). In addition, prepregnancy weight and total pregnancy weight greatly impact postpartum weight loss (50).

Economic Benefits

Breastfeeding provides significant economic benefits to the family and society. Breastfeeding allows the family to save the money that otherwise would be spent on infant formula, other milk substitutes, and feeding equipment. It also improves household food security and saves the family's disposable income for food for older children and adults. Families that do not breastfeed spend close to $700 for standard formulas in the first year. Other direct family savings include the defrayed or reduced health care–related expenses. (11,52,53). Indirect costs to the family include time and income lost from work to take care of a sick child (11).

There also would be economic benefits to the nation if more women would breastfeed. The USDA estimates that at least $3.6 billion could be saved in health care costs if breastfeeding rates were increased from current levels to those recommended by the US Surgeon General. The savings could be much higher because this figure only represents cost savings from the treatment of three childhood illnesses (otitis media, gastroenteritis, and necrotizing enterocolitis) (11). It is also estimated that $30 million would be saved if all of the women in WIC breastfed for 1 month. An additional $48 million could be saved if 75% of the mothers in WIC breastfed for 3 months (11,52,53). In addition to the savings in direct medical costs, data are emerging that document the economic benefits of breastfeeding support to employers, including lower maternal absenteeism attributable to infant illness, increased employee loyalty, improved productivity, and enhanced public image (11,54). Breastfeeding is a cost-effective and socially beneficial health practice that should be encouraged and supported.

Environmental Benefits

Breastfeeding contributes to the health of the environment in numerous ways (55,56). Human milk is a natural resource that is renewable with each pregnancy. It is produced and delivered to the consumer without using and wasting other resources, and it creates no pollution. In contrast to infant formula, human milk does not require manufacturing, packaging, shipping, disposing of containers, or extensive advertising. It also conserves natural resources such as fossil fuels. By delaying the return of menses (57), breastfeeding suppresses fertility and increases birth spacing, improving maternal and child health while limiting population growth.

BARRIERS TO BREASTFEEDING

Despite the many benefits of breastfeeding, many women still choose not to do so. The reasons include inadequate knowledge of the benefits of breastfeeding (58), embarrassment and social reticence (59,60), lack of interest or negative perception of breastfeeding (59,61,62), lack of support from partner and family members (59,60,62), partner's negative perception of breastfeeding (63), mother not breastfed as a child (63), the need to work or go to school (59,62), other family responsibilities (59), perceived decrease in father-child bond (59), and aggressive marketing by infant formula companies (64).

Although the majority of American mothers initiate breastfeeding, less than one third continue to breastfeed at 6 months postpartum. Reasons for early termination of breastfeeding include inconvenience (62), perceived restriction of freedom and independence (59), the need to work or go to school (59), embarrassment and societal disapproval (59,60), discomfort about breastfeeding in public (59,60), short or unpaid maternity leave (59,60), unsupportive work environment (59), lack of public and workplace facilities to breastfeed comfortably (59), early supplementation with formula or other milk substitutes (65), pacifier use (65), unsupportive health care environment (65), inconsistent implementation of breastfeeding promotion policies (66), and limited availability of lactation consultant services, especially after hospital discharge (65). Providing samples of infant formula in physician offices, in clinics, and on hospital discharge promotes maternal-infant separation, undermines maternal confidence, and contributes to early mixed feedings that interfere and sometimes interrupt establishing an adequate milk supply (63,64).

SPECIAL CONSIDERATIONS

The advantages of breastfeeding and the use of human milk are particularly salient for premature and low-birth-weight infants. If these infants are unable to nurse, the mother's milk can be administered through various feeding routes, although fortification may be needed to achieve adequate growth (21,67). Human

milk has also been successfully used with infants with cleft palate, cystic fibrosis (with pancreatic enzyme replacement), Down syndrome, and inborn errors of metabolism, especially phenylketonuria (with careful supplementation of low-phenylalanine formula) (21). In each of these situations, mothers need support from health care providers to achieve and maintain an adequate milk supply. Health care providers should provide anticipatory support and be alert to early signs or symptoms of feeding difficulties so that effective early intervention can be initiated.

Despite the many benefits of breastfeeding, there are some situations in which the infant should not be breastfed. These include galactosemia (6) and the infant whose mother uses illegal drugs (68), has active tuberculosis (6,69), is infected with the human immunodeficiency virus (HIV), has acquired immunodeficiency syndrome, or has other diseases in which the immune system is compromised (6,70). In countries with a high prevalence of HIV/acquired immunodeficiency syndrome, the infant mortality risks associated with not breastfeeding may be greater than the risk of acquiring HIV (71).

Medical advances have improved the health outcomes of many pregnant women with chronic diseases such as type 1 diabetes mellitus, systemic lupus erythematosus, and hypothyroidism. However, few data exist to provide guidance to these women if they choose to breastfeed (21). Guidelines are available regarding the advisability of breastfeeding in women with infectious diseases and other maternal conditions (21). The key to successful breastfeeding for these women is the appropriate choice of medications, treatments, and lactation support from the early prenatal to the postpartum period.

Most prescribed and over-the-counter medications are safe for the breastfed infant, and resources are available to assist in evaluating the safety of drug use in lactation (21,68,72). However, there are a few medications that mothers may need to take that may make it necessary to interrupt breastfeeding. They include radioactive isotopes, antimetabolites, cancer chemotherapy agents, lithium, ergotamine, and a small number of other medications (68). Breastfeeding mothers should be encouraged to discuss any use of prescription drugs, over-the-counter drugs, and herbal medications with their primary care providers. Although herbal products are widely used in the United States, data are lacking about the safety of their use during lactation.

With the exception of maternal chemical poisoning, human milk remains a safe feeding method for infants and young children. Contamination of breast milk with environmental pollutants is a concern when mothers have had specific exposure to heavy metals or insecticides (73). In situations in which maternal exposure and probability of transfer in breast milk lipids are determined to be significant, analysis of milk is recommended, with decisions regarding safety being made from estimated average intake. Environmental contaminants get into human milk when mothers have had geographic, occupational, or accidental exposure. Dioxins produced during industrial processes and organochlorine pesticides and polychlorinated biphenyls are of greatest concern because of their long half-lives and their contribution to the mother's and infant's overall body burden of contaminants (74). Research shows that the greatest risk period for adverse effects from exposure is prenatally (75).

Breastfeeding mothers should be encouraged to reduce their own exposure to known chemical contaminants. For example, women who may become pregnant, who are pregnant, or who are breastfeeding should reduce their exposure to methylmercury (76). Large bottom-dwelling fish are the most common food source of methylmercury, so the Food and Drug Administration and the Environmental Protection Agency recommend the following guidelines for eating fish:

- Avoid shark, swordfish, mackerel, and tilefish.
- Eat up to 12 oz of other kinds of fish every week, with a maximum of 6 oz of albacore (white) tuna per week.
- Check local advisories about eating locally caught fish. If no advice is posted, limit intake of locally caught fish to 6 oz per week and consume no other fish in that same week (77).

ROLE OF DIETETICS PROFESSIONALS IN PROMOTING AND SUPPORTING BREASTFEEDING

As experts in food and nutrition throughout the life cycle, it is the responsibility of dietetics professionals to promote and support breastfeeding for its short-term and long-term health benefits. The ADA emphasizes the essential role of dietetics professionals in promoting breastfeeding as the norm for infant feeding; supporting local, state, and national efforts to increase breastfeeding initiation, duration, and exclusivity rates; reducing individual, social, and institutional barriers to breastfeeding; and increasing access to lactation care and services. The ADA recommends the following strategies to promote and support breastfeeding:

Counsel and Educate Prenatal and Postpartum Women

- Recognize and respect that breastfeeding is a personal decision. Effective educational strategies that strike a balance of support and education result in informed decisions about infant feeding, not guilt.
- Provide women with practical information about breastfeeding that addresses their specific questions and concerns. This patient-centered approach may help dietetics professionals identify breastfeeding problems early and prevent unnecessary or premature weaning.
- Target women who are less likely to breastfeed (eg, racially and ethnically diverse groups, low education levels, adolescents) and counsel in a culturally relevant and sensitive manner. Adolescents need to hear that breastfeeding strengthens the bond with their infants.
- Identify mothers who are at risk for early cessation. The first 6 weeks are especially crucial. Predictors of early cessation include education level, working intentions, workplace support, social support, and previous breastfeeding experience (77).
- Encourage overweight and obese women to achieve a healthful weight before pregnancy. Overweight and obese women who are lactating may have a lower prolactin response, which may result in decreased milk production and

Every facility providing maternity services and care for newborn infants should:

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 1 hour of birth.
5. Show mothers how to breastfeed and how to maintain lactation, even if they are separated from their infants.
6. Give newborn infants no food or drink other than breast milk, unless *medically* indicated.
7. Practice "rooming in"—allow mothers and infants to remain together 24 hours a day.
8. Encourage unrestricted breastfeeding.
9. Give no artificial teats or pacifiers to breastfeeding infants.
10. Foster the establishment of breastfeeding support groups and refer mothers to them on discharge from the hospital or clinic.

Figure 4. Ten steps to successful breastfeeding for hospitals. World Health Organization and United Nations Children's Fund, 1989. Source: reference (81) Baby Friendly USA, www.babyfriendlyusa.org.

early cessation of breastfeeding (78).

- Provide appropriate and timely information on weaning. The decision to wean should be based on the desires and needs of each breastfeeding dyad. Ideally, weaning should be gradual and solid foods should be offered based on the age and developmental stage of the child.
- Encourage women who are returning to work or school to explore their options for continuing to breastfeed. Discuss on-site arrangements to express and store milk for later use. For women who cannot pump or hand express on site, discuss how to supplement breastfeeding with formula while apart and breastfeed when with the infant.
- Evaluate client education materials and service delivery sites for product bias. Changes should be made to the counseling environment to clearly communicate that breastfeeding is the norm for infant feeding.

Involve Family and Friends

- Identify support networks as early in pregnancy as possible, and develop programs and materials aimed at partners, parents, and grandparents.
- Include partners and grandmothers in breastfeeding education and counseling sessions. Support from a woman's partner and her mother significantly increase her chances of breastfeeding and continuing to breastfeed. Partners need to learn how to be part of a successful breastfeeding family.

Enhance Professional Development

- Participate in continuing education programs to keep up-to-date with the art and science of lactation. Intensive courses in lactation training and education are available through various organizations.
- Consider completing the requirements to obtain the voluntary credential (International Board Certified Lactation Consultant), through the International Board of Lactation Consultant Examiners (79,80).
- Participate in continuing education programs on cultural competence. The low prevalence of breastfeeding among racial/ethnic minority groups demands ongoing training in cultural competence. Dietetics professionals must ask questions and invite dialogue to identify and understand the specific barriers for a group, then design or refine services and messages to address those barriers. Focusing on hands-on interventions, skill building, and problem solving can begin the process of social change.
- Conduct critical internal reviews of undergraduate and graduate dietetics training programs to ensure that nutrition and lactation, lactation physiology, breastfeeding management, and cultural competence are incorporated into curricula. This will ensure that dietetics professionals entering the field understand the health implications of breastfeeding. There also is a need to recruit more racially and ethnically diverse students into dietetics training programs.

Initiate Institutional Change

- Initiate and create institutional and organizational policies to reduce or eliminate institutional bias (eg, hospitals, clinics) for infant formula and incorporate appropriate lactation promotion and support policies in their place. Dietetics professionals must present the breastfed infant as the standard against which infants fed human milk substitutes are compared.
- Encourage hospitals and birthing centers to adopt The Ten Steps to Successful Breastfeeding for Hospitals as outlined by the United Nations Children's Fund/World Health Organization and promoted by Baby-Friendly USA (81). (See Figure 4.)

Collaborate with Others Who Promote Breastfeeding

- Participate in professional and volunteer activities. Collaborative opportunities exist for ADA members to work with the International Lactation Consultant Association, La Leche League International, Nursing Mothers' Counsel, Healthy Mothers Healthy Babies coalitions, state and local WIC programs, the National WIC Association, the African American Breastfeeding Alliance, and breastfeeding task forces at all levels to promote and support breastfeeding.

Initiate and Support Breastfeeding Campaigns

- Work with pro-breastfeeding organizations to promote breastfeeding as the social norm.
- Support extending the reach of

breastfeeding promotion campaigns to men, grandmothers, and adolescent mothers.
- Initiate campaigns that promote breastfeeding exclusivity and breastfeeding beyond 6 months. Breastfeeding is more than meeting the nutrition needs of young infants. It offers health, physical, and psychological benefits to infants that influence health outcomes later in life. Breastfeeding must be part of a broader strategy to reduce existing health disparities.

Advocate for Policy Change

- Support legislation to eliminate barriers to breastfeeding. More than half of the states have enacted legislation to address breastfeeding in public, on the job, and on jury duty (82).
- Advocate for other policy changes affecting a woman's ability to continue breastfeeding, including longer family leave, facilities for child care and breastfeeding at the worksite or nearby in the community, paid lactation or milk expression breaks, flexible employment arrangements, breastfeeding support personnel/lactation consultation, and third-party reimbursement for lactation consultation and management services.
- Encourage school boards to review curriculum to ensure that breastfeeding is presented as the norm in texts, other resources, and classroom discussion at elementary and secondary schools. Dietetics professionals can volunteer to work with curriculum committees and science fair committees, and can guest lecture in classes such as social studies, life management, and science.
- Advocate for adequate facilities and breaks for mothers who are students and those who are teachers.

Conduct Empirical Research

- Take the initiative to conduct empirical research. Research is needed on topics such as cultural influences on infant feeding, social marketing of breastfeeding, effectiveness of breastfeeding promotion programs, cost-effectiveness, hospital/clinic use rates, eliminating barriers to extended breastfeeding, and nutrient needs for women and children with special needs. Research should be theory-based and have policy implications. Larger-scale studies with better designs are needed.
- Develop and/or advocate for a consistent definition of breastfeeding in research studies to improve the understanding of the benefits of exclusive breastfeeding.
- Support a national policy to track breastfeeding trends using nonproprietary data. Policies are also needed to centralize national infant and child morbidity and mortality data.

References

1. Black RE, Morris SS, Bryce J. Child survival I: Where and why 10 million children die every year? *Lancet.* 2003;361:2226-2234.
2. Jones G, Steketee R, Black R, Bhutta Z, Morris S, and the Bellagio Child Survival Study Group. Child survival II: How many child deaths can we prevent this year? *Lancet.* 2003;362:65-71.
3. Bellagio Child Survival Study Group. Child Survival V: Knowledge into action for child survival. *Lancet.* 2003;362:323-327.
4. US Department of Health and Human Services. *Healthy People 2010: Conference Edition—Volumes I and II.* Washington, DC: US Department of Health and Human Services; 2000.
5. US Department of Health and Human Services. *HHS Blueprint for Action on Breastfeeding.* Washington, DC: US Department of Health and Human Services, Office on Women's Health; 2000.
6. American Academy of Pediatrics. Breastfeeding and the use of human milk. *Pediatrics.* 1997;100:1035-1039.
7. American Dietetic Association. Position of the American Dietetic Association: Breaking the barriers to breastfeeding. *J Am Diet Assoc.* 2001;101:1213-1220.
8. National WIC Association. *Breastfeeding Promotion and Support in the WIC Program* (position paper). Washington, DC: National WIC Association; 2004
9. World Health Organization. *Community-based strategies for breastfeeding promotion and support in developing countries.* Geneva, Switzerland: World Health Organization; 2003.
10. World Health Organization, United Nations Children's Fund. *Global Strategy for Infant and Young Child Feeding.* Geneva, Switzerland: World Health Organization; 2003.
11. Weimer J. *The economical cost of breastfeeding: A review and an analysis.* ERS Food Assistance and Nutrition Research Report No. 13. Washington, DC: Economic Research Services, US Department of Agriculture; 2001.
12. Abbott Laboratories. *Mothers Survey.* Abbott Park, IL: Ross Products Division; 2002.
13. Centers for Disease Control and Prevention. 2003 National Immunization Survey. Available at: http://www.cdc.gov/breastfeeding/NIS_data. Accessed December 16, 2004.
14. Wolf JH. Low breastfeeding rates and public health in the United States. *Am J Public Health.* 2003; 93:2000-2010.
15. Ryan AS, Rush D, Krieger FW. Recent declines in breastfeeding in the United States, 1984 through 1989. *Pediatrics.* 1991;88:719-727.
16. Ryan AS. The resurgence of breastfeeding in the United States. *Pediatrics.* 1997;99:E12.
17. US Department of Agriculture. *Loving Support Makes Breastfeeding Work.* Available at: http://www.fns.usda.gov/wic/Breastfeeding/lovingsupport.htm. Accessed December 16, 2004.
18. US Department of Health and Human Services. Breastfeeding awareness campaign. Available at: http://www.adcouncil.org/campaigns/breastfeeding/. Accessed February 10, 2005.
19. US Breastfeeding Committee. *Breastfeeding in the United States: A national agenda.* Rockville, MD: US Department of Health and Human Services, Health Resources and Services Administration, Maternal and Child Health Bureau; 2001.
20. Riordan J. *Breastfeeding and Human Lactation.* Boston, MA: Jones and Bartlett; 2004.
21. Lawrence RA, Lawrence RM. *Breastfeeding. A Guide for the*

Medical Profession. St Louis, MO: Mosby; 1999.
22. American Academy of Pediatrics. Prevention of rickets and vitamin D deficiency: New guidelines for vitamin D intake. *Pediatrics*. 2003;111:908-910.
23. American Academy of Pediatrics. *Pediatric Nutrition Handbook*. Elk Grove Village, IL: American Academy of Pediatrics; 2004.
24. Dewey KG, Heinig MJ, Nommsen-Rivers LA. Differences in morbidity between breast-fed and formula-fed infants. *J Pediatr*. 1995;126:696-702.
25. Beaudry M, Dufour R, Marcoux S. Relation between infant feeding and infection during the first six months of life. *J Pediatr*. 1995;126:191-197.
26. Wright A, Holberg C, Martinez F. Breastfeeding and lower respiratory tract illness in the first year of life. *BMJ*. 1989;299:945-949.
27. Monobe H, Ishibashi T, Fujishiro Y, Shinogami M, Yano J. Factors associated with poor outcome in children with acute otitis media. *Acta Otolaryngol*. 2003;123:564-568.
28. Cochi S, Flemming D, Hightower A. Primary invasive haemophilius influenza type B disease: A population-based assessment of risks. *J Pediatr*. 1986;101:804-805.
29. Istre G, Conner J, Broome C, Broome C, Hightower A, Hopkins R. Risk factors of invasive haemophilius influenza disease among children. *J Pediatr*. 1985; 115:694-701.
30. Lucas A, Cole T. Breastmilk and neonatal necrotizing enterocolitis. *Lancet*. 1990;336:1519-1523.
31. Palmer B. The influence of breastfeeding on the development of the oral cavity: A commentary. *J Hum Lact*. 1998;14:93-98.
32. Chan-Yeung M, Manfreda J, Dimich-Ward H, Ferguson A, Watson W, Becker A. A randomized controlled study of the effectiveness of a multifaceted intervention program in the primary prevention of asthma in high-risk infants. *Arch Pediatr Adolesc Med*. 2000;154:657-663.
33. Shu XO, Linet MS, Steinbuch M, Wen WQ, Buckley JD, Neglia JP, Potter JD, Reaman GH, Robison LL. Breast-feeding and risk of childhood acute leukemia. *J Natl Cancer Inst*. 1999;91:1765-1772.
34. Fisher JO, Birch LL, Smiciklas-Wright H, Picciano MF. Breastfeeding through the first year predicts maternal control in feeding and subsequent toddler energy intakes. *J Am Diet Assoc*. 2000;100:641-646.
35. McVea KLSP, Turner PD, Peppler DK. The role of breastfeeding in Sudden Infant Death Syndrome. *J Hum Lact*. 2000;16:13-20.
36. Singhal A, Cole TJ, Fewtrell M, Lucas A. Breastmilk feeding and lipoprotein profile in adolescents born preterm: Follow-up of a prospective randomized study. *Lancet*. 2004;363:1571-1577.
37. Smith MM, Durkin M, Hinton VJ, Bellinger D, Kuhn L. Influence of breastfeeding on cognitive outcomes at age 6-8 years: Follow-up of very low birth weight infants. *Am J Epidemiol*. 2003; 158:1075-1082.
38. Horwood LJ, Darlow BA, Mogridge N. Breast milk feeding and cognitive ability at 7-8 years. *Arch Dis Child Fetal Neonatal Educ*. 2001;84:F23-F27.
39. Horwood LJ, Fergusson DM. Breastfeeding and later cognitive and academic outcomes. *Pediatrics*. 1998;101:E9.
40. Workgroup on Breastfeeding Science and Society. *Breastfeeding: Science and Society*. Vatican City, Italy: Pontificia Acemica Sientiarum; 1996.
41. Steyn NP, Mann J, Bennett PH, Temple N, Zimmet P, Tuomilehto J, Lindstrom J, Louheranta A. Diet, nutrition and the prevention of type 2 diabetes. *Public Health Nutr*.2004;7:147-167.
42. Heinig MJ, Nommsen-Rivers LA, Peerson JM, Dewey KG. Factors related to duration of postpartum amenorrhea among USA women with prolonged lactation. *J Biosoc Sci*. 1994;26:517-527.
43. Cumming RG, Klinieberg RJ. Breastfeeding and other reproductive factors and the risk of hip fractures in elderly women. *Int J Epidemiol*. 1993;22:884-891.
44. Kalkwarf HJ, Specker BL. Bone mineral loss during lactation and recovery after weaning. *Obstet Gynecol*. 1995;86:26-32.
45. Kjos SL, Henry O, Lee RM, Buchanan TA, Michell DR. The effect of lactation on glucose and lipid metabolism in women with recent gestational diabetes. *Obstet Gynecol*. 1993;82:451-455.
46. Rosenblatt KA, Thomas DB. Lactation and the risk of epithelial ovarian cancer. The WHO Collaborative Study of Neoplasia and Steroid Contraceptives. *Int J Epidemiol*. 1993;22:192-197.
47. Newcomb PA, Storer BE, Longnecker MP, Mittendorf R, Greenberg ER, Clapp RW, Burke KP, Willett SC, MacMahon B. Lactation and a reduced risk of premenopausal breast cancer. *N Engl J Med*. 1994;330:81-87.
48. Kac G, Benicio M, Velasquez-Melendez G, Valente J, Struchiner CJ. Breastfeeding and postpartum weight retention in a cohort of Brazilian women. *Am J Clin Nutr*. 2004;79:487-493.
49. Rooney BL, Schauberger CW. Excess weight gain and long-term obesity: One decade later. *Obstet Gynecol*. 2002;100:245-252.
50. Sichieri R, Field AE, Rich-Edwards J, Willett WC. Prospective assessment of exclusive breastfeeding in relation to weight change in women. *Int J Obes Relat Metab Disord*. 2003;27:815-820.
51. Butte NF, Hopkinson JM. Body composition changes during lactation are highly variable among women. *J Nutr*. 1998;128(suppl 2):S381-S385.
52. Montgomery DL, Splett PL. The economic benefit of breast-feeding infants in the WIC program. *J Am Diet Assoc*. 1997;97:379-385.
53. Splett PL, Montgomery DL. *The Economic Benefits of Breastfeeding an Infant in the WIC Program: Twelve Month Follow-up Study*. Final Report submitted to USDA Food and Consumer Service. March 1998.
54. Cohen R, Mrtek MB, Mrtek RG. Comparison of maternal absenteeism and infant illness rates among breastfeeding and formula-feeding women in two corporations. *Am J Health Promot*. 1995; 10:148-153.
55. Radford A. *The ecological impact of breastfeeding*. Baby Milk Action Coalition, XIII IOCU World Congress: Hong Kong; 1991.

56. Institute for Reproductive Health/ IMPACT. *Breastfeeding: Protecting a Natural Resource.* Washington, DC; 1990.
57. Geerling JH. Natural family planning. *Am Fam Physician.* 1995;52:149-156.
58. Shepherd CK, Power KG, Carter H. Examining the correspondence of breastfeeding and bottle-feeding couples' infant feeding attitudes. *J Adv Nurs.* 2000;31:651-600.
59. Stewart-Knox B, Gardiner K, Wright M. What is the problem with breast-feeding? A qualitative analysis of infant feeding perception. *J Hum Nutr Diet.* 2003;16:265-273.
60. Guttman N, Zimmerman D. Low-income mother's view on breastfeeding. *Soc Sci Med.* 2000;10: 1457-1473.
61. Scott JA, Shaker I, Reid M. Parental attitudes toward breastfeeding: Their association with feeding outcome at hospital discharge. *Birth.* 2004;31:125-131.
62. Brownell K, Hutton, L, Hartman J, Dabrow S. Barriers to breastfeeding among African American adolescent mothers. *Clin Pediatr.* 2002;4:669-673.
63. James DC, Jackson RT, Probart CK. Factors affecting breast-feeding prevalence and duration among international students. *J Am Diet Assoc.* 1994;94:194-196.
64. Novotny R, Hla MM, Kieffer EC, Park CB, Mor J, Thiele M. Breastfeeding duration in a multiethnic population in Hawaii. *Birth.* 2000;27:91-96.
65. Howard C, Howard F, Lanphear B, Eberly S, deBlieck E, Oakes D, Lawrence R. Randomized clinical trial of pacifier use and bottle-feeding or cup-feeding and their effect on breastfeeding. *Pediatrics.* 2003;111:511-518.
66. Cropley L, Herwehe JC. Evaluation of institutional support for breastfeeding among low income women in the metropolitan New Orleans area. *J Am Diet Assoc.* 2002;102:94-96.
67. Schanler RJ. The use of human milk for premature infants. *Pediatr Clin North Am.* 2001;48:207-219.
68. American Academy of Pediatrics. The transfer of drugs and other chemicals into human milk. *Pediatrics.* 2001;108:776-789.
69. American Academy of Pediatrics, Committee on Pediatric AIDS. Human milk, breastfeeding, and transmission of human immunodeficiency virus in the United States. *Pediatrics.* 1995;96:977-979.
70. Read J, Committee on Pediatric AIDS. Human milk, breastfeeding, and transmission of human immunodeficiency virus type 1 in the United States. *Pediatrics.* 2003;112:1196-1205.
71. World Health Organization Collaborative Study Team on the Role of Breastfeeding on the Prevention of Infant Mortality. Effect of breastfeeding on infant and child mortality due to infectious diseases in less developed countries: A pooled analysis. *Lancet.* 2000;355:451-455.
72. Hale T. *Medications and Mothers' Milk.* Amarillo, TX: Pharmasoft Medical Publishing; 2004.
73. Etzel RA, ed. *Handbook of Pediatric Environmental Health.* Elk Grove Village, IL: American Academy of Pediatrics; 1999.
74. International Lactation Consultant Association. *Position on Breastfeeding, Breast Milk, and Environmental Contaminants.* October 2001. Available at: http://www.ilca.org/pubs/EnvironContPP.pdf. Accessed February 10, 2005.
75. Przyrembel H, Heinrich-Hirsch B, Vieth B. Exposition to the health effects of residues in human milk. In: Koletzko B, Michaelsen KF, Nernell O, eds. Short and long term effects of breastfeeding on child health. *Advances in Experimental Medicine and Biology.* Volume 478. New York, NY: Kluwer Academic/Plenum Publishers; 2000.
76. Food and Drug Administration. Backgrounder for the 2004 FDA/ EPA Consumer Advisory: What You Need to Know About Mercury in Fish and Shellfish. Available at: http://www.fda.gov/oc/opacom/hottopics/mercury/backgrounder.html. Accessed December 16, 2004.
77. Kronborg H, Vaeth M. The influence of psychosocial factors on the duration of breastfeeding. *Scand J Public Health.* 2004;32:210-216.
78. Rasmussen K, Kjolhede CL. Prepregnant overweight and obesity diminish the prolactin response to suckling in the first week postpartum. *Pediatrics.* 2004;113:465-471.
79. International Board of Lactation Consultant Examiners. Certification information available at: http://www.iblce.org. Accessed December 16, 2004.
80. Diamond L. Lactation consulting: Is it for you? *J Am Diet Assoc.* 1997;97:591-592.
81. Baby-Friendly USA. UNICEF Baby-Friendly Hospital Initiative materials. Available at: http://www.babyfriendlyusa.org. Accessed December 16, 2004.
82. Baldwin EN, Friedman KA. A current summary of breastfeeding legislation in the United States. Available at: http://www.lalecheleague.org/Law/summary.html. Accessed December 16, 2004.

ADA position adopted by the House of Delegates on March 16, 1997, and reaffirmed on September 12, 1999, and June 6, 2003. The update will be in effect until December 31, 2008. The ADA authorizes republication of the position, *in its entirety,* provided full and proper credit is given. Requests to use portions of this position must be directed to ADA Headquarters at 1-800-877-1600, ext 4835, or ppapers@eatright.org. *Authors:* Delores C. S. James, PhD, RD (University of Florida, Gainesville, FL); Brenda Dobson, MS, RD (Iowa Department of Public Health, Des Moines, IA). *Reviewers:* Jessica Donze Black, MPH, RD (ADA, Washington, DC); Dietetic Technicians in Practice Dietetic Practice Group (Josie Klein, DTR, Mount Olivet Careview, Minneapolis, MN, and Connie Urich, DTR, Children's Mercy Hospital, Kansas City, MO); Deborah Krauter, RD (Massachusetts Department of Public Health, Boston, MA); Esther Myers, PhD, RD (ADA, Chicago, IL); Judith B. Roepke, PhD, RD (Ball State University, Muncie, IN); Jane V. White, PhD, RD, FADA (University of Tennessee-Knoxville, Knoxville). APC Workgroup: Ida Laquatra, PhD, RD (chair); Cynthia Taft Bayerl, MS, RD; Rachelle Lessen, MS, RD (content advisor).


FORWARD

Breastfeeding stories in Wisconsin

SB 30 ?

These stories have been collected for educational purposes. The women have shared these stories in hopes that someday there will be a protected right to breastfeed and pump breastmilk for their babies.

JC Penney West, Madison, August 2006 – Alicia Butz
I was told by an employee that the bathrooms are a more appropriate place to breastfeed.

Dane County YMCA East, Madison, July 2006 – Jessica Grant
Last summer at the YMCA a friend and I were watching our older boys play at Jack Splash and were nursing our babies. A lifeguard came up to us and said, "It's OK to do that here, you just need to cover up." We were too surprised to say anything, so we tried to cover up as best we could. I went back later to talk with the Aquatic Director about their policy on breast feeding. We were basically told that their policy is what the lifeguard said. It's OK to nurse but you need to be "discreet" because the Y is a family place. It's terribly ironic that this business sees breastfeeding as not compatible with family activities when I was there with my family. It was a good thing that my child was done nursing, because she wouldn't have nursed in the heat while covered up.

Victoria's Secret, Burlington, June 22, 2006 – Rebecca Cook
I was shopping at a Victoria's Secret on June 22, 2006 with a friend, I couldn't find anything that I liked, and my friend was shopping around their fragrance section when my daughter got restless. There weren't any benches outside of the store, so I went to the back to find a dressing room (so I wouldn't have to go in search of a place to sit down.) I asked the attendant for one to nurse my baby and she said they were all full. There was enough room in the area where you wait for a dressing room that I just said I'd settle down on the floor and nurse her there, that I'm not shy. Another one of the women working there said, "No, you'll need to use the restroom," and proceeded to unlock the employee bathroom. I firmly said, "No! I don't eat in the restroom. She's not going to eat in the restroom!" At that moment, a woman came out of a dressing room, so I went into it. While I was in the dressing room, the employees were standing outside of my door talking about how they were in the middle of their biggest sale and needed to get people in and out of dressing rooms as quickly as possible (to each other, not to me.) Their talking was distracting my daughter, so we left.

I called the manager to complain that one of the employees asked me to go to the bathroom to nurse and she said, "Well, she was probably concerned that a patron would be offended at the sight of your breast." After that, I told the woman that their models and mannequins show more flesh than the average nursing mom, and that it's inappropriate to ask a nursing mother to use the restroom, and if a patron complains, they can politely tell them to look the other way. I then called the corporate customer service line, and the customer service rep said that they don't allow people to try on clothing in the middle of the sales floor, and that's why they wouldn't allow me to nurse on the sales floor.

After telling my story on mothering.com, another woman in Boston was harassed at a Victoria's Secret the very next day. We helped organize a modest nationwide nurse-in at Victoria's Secret and generate a bit of media attention about the problem.

Limited Too, Mayfair Mall, Milwaukee, April 2006 – Carrie Bondioli
My 11-year-old daughter received some clothing from her aunt that didn't fit. We decided to exchange them at the Limited Too store where the clothing was originally purchased. My daughter went into the dressing room, and as my sister-in-law and I sat on some nice oversized chairs nearby, my nursling decided it was time for lunch. No one seemed to notice. My older daughter came out and she and my sister-in-law went to the back of the store to deal with the exchanges while I finished up. Suddenly a store clerk in her early 20's approached and said, "Ma'am, could I ask you to nurse in a fitting room?"
I looked in the room which had a tiny three legged stool and decided "no" to the uncomfortable accommodations.
She then replied, "Well, this is a little girl's store and that is gross."
To this I responded, "What better way then, to show girls that 'breast is best' for their babies?"
The clerk attempted again, "But could you just go?"
After my nursling finished up about a minute later, we all left the store. What really hit me was that this store encourages girls to be sexy prematurely, when they are still too young to know what kind of messages they are sending. Breasts are already being portrayed as sexual objects, not means of nurturance. The act of nursing my daughter is more offensive to the general public than fastening messages on a young girl's butt to call attention to passersby, or selling thong-styled, lacy underwear for a 10-year-old. The fact that she used the word "gross" to describe an innate human behavior that has existed for women and babies since the beginning of time really says something about the current ideas and philosophies

of our society. I can think of all kinds of things that are "gross," like commercializing and marketing sex to preteens and detaching girls from the natural powers of their bodies.

UW Medical Foundation, Madison, March 31, 2006 – Fran Weintraub, MD, FAAP
I had computer training for 8 hours in a UW Medical foundation administration type of building. I asked the woman at the front desk where I could pump and she directed me to a shower stall within the bathroom. I told her it was not acceptable to pump in a restroom and made a tiny bit of fuss. Later she said they could find an empty conference room but by then I had called my husband to bring the baby for me to nurse.

WPS, Madison, January 2006 – Anonymous
I was told that I'm only allowed to use the unisex bathroom at work to pump. I think it's disgusting that I have to pump in there. There needs to be incentives for employers to set up something, anything, better than a bathroom for women to pump in.

St. Aloysius Church, Sauk City, Winter 2005 – Mary Fabian
We moved here from Minnesota in 2001. In the past 5 years, I have experienced more harassment for my breastfeeding in America's Dairyland than I ever did in The Land of 10,000 lakes! You'd think with all the dairy farmers, breastfeeding would be more accepted in this state. It's not! Our homeschooling group was attending a daily Mass, on a weekly basis (Thursday mornings) and several of the Moms in the group were breastfeeding children. The Pastor contacted me after Mass one day to tell me that he had received several complaints about the "breastfeeding during Mass" being very distracting and was it possible to feed our children before we came to Mass instead. I explained to him that there are LOTS of distractions during Mass that are far more irreverent (cell phones going off, immodest dress, etc.) Getting up to leave Mass to nurse our children and then coming back in would be more distracting than simply quietly nursing during the Mass itself. I also pointed out that The Blessed Virgin Mary nursed Jesus for at least 2 years! Nothing officially happened...except we all felt uncomfortable nursing our children from that point forward. This incident took place in the winter of 2005.

East Towne Mall, Madison, July 2005 – Karissa Andrews
When my baby was just 3 weeks old, I was harassed at the East Towne mall by an employee that told me to leave, cover up, and that she had alerted security. Two security officers circled around me, intimidating me until I finally decided to go nurse him in my hot van. It was a horrible experience no one should ever have to endure.

Neenah Public Pool, June 2005 -- Amy Weinsheim
When Lola was just 5 weeks old, I was at the Neenah Public Pool with my entire family. I was fully clothed (skirt & t-shirt...NOT in a bathing suit) sitting on a chaise lounge in a corner of the deck nursing my infant when a lifeguard approached and asked me to please "do that" someplace else because this is a family pool. She asked me 3 times and 3 times I told her very pleasantly that I would not leave as I was there with my family. The pool manager then came over (a large man, quite overweight). He repeatedly told me that this was a family pool and everyone could tell what I was doing and they wanted me to do it someplace else...why couldn't I go in the bathroom to "do that". He stood within a couple inches of me with his arms folded looking down and even with my husband there would not leave me alone. After several minutes of him staring at me I said I was not going to be bullied into leaving and he finally left. After I was done nursing, I asked him how to get a refund for my season pass as I could not believe the way I had been treated and he ran out of the office blocking the door and yelled at me. I made a formal complaint to the City and contacted La Leche League and the ACLU. Unfortunately, nobody was willing to do more than tell me that this happens a lot. The Park & Rec dept. Manager eventually contacted me via e-mail to say she was sorry I had been offended and that they would do some education with their staff. Thankfully, I was not a brand new mother and had the backbone to stand up to this. It was the very first time I had ever been approached while nursing one of my children and I still get upset when I think about it. Both of those staff people should have been reprimanded and, at the very least, I should have received a formal apology from both of them.

Manawa, 2005 – Chris Solheim
I had a negative NIP experience at my child's daycare center. I was told I could not nurse in my child's classroom and would have to go elsewhere. The staff break room. This is after I had nursed in my older son in his classroom for months when the center had another director. "People weren't comfortable." "Other children might see your breast." Any child that had been there for more than 18 months would have already seen me nurse my older son.

I'm getting all worked up again this again (this was over a year ago). To make a long story short a compromise was worked out although I did it only because I had no other childcare readily available and my older son was very happy there. I'm so glad that we are not there anymore.

UW Hospital, Madison, September 2004 – Anonymous
I was not allowed to pump at work. I only got a one hour break while at work for 9 hours. I needed to pump more than just once in order to supply my 3 month old baby with enough breastmilk while I was away from him. However, my supervisor would not allow me to split up my break time in order to pump more than once in order to keep up my supply of milk. I was only able to pump 2-4 oz/per time and my baby was taking 6-8 oz./day while I was away. This was terribly frustrating for me since I wanted to exclusively breastfeed my son.

Lakeside Nursing Home, Chippewa Falls, November 2004 – Christa Emberts
I was in Lakeside nursing home in Chippewa Falls, WI. My baby and I were nursing discreetly when the supervisor of that floor approached me and asked me not to nurse in any vicinity where food was. Although I quietly obliged, I assured her that Wisconsin law stated that where I was allowed to be, my baby was allowed to nurse (even though I'm not sure if that was true, I wanted her to know that she was in the wrong, but I complied anyway).

Dane County YMCA, 2004 – Lisa Yeager
I was kicked out of the YMCA pool for breastfeeding Nick about 2 years ago. I was told that I shouldn't expose myself in an area where young children were swimming. She said it would be more appropriate to do so in the change rooms and cover with a shawl. Then when I gave her some (polite) backchat ie: " this is ridiculous...," the manager on duty cornered me on the way out as well. She said there was to be no eating or drinking in the pool area and that included breastfeeding Nick!

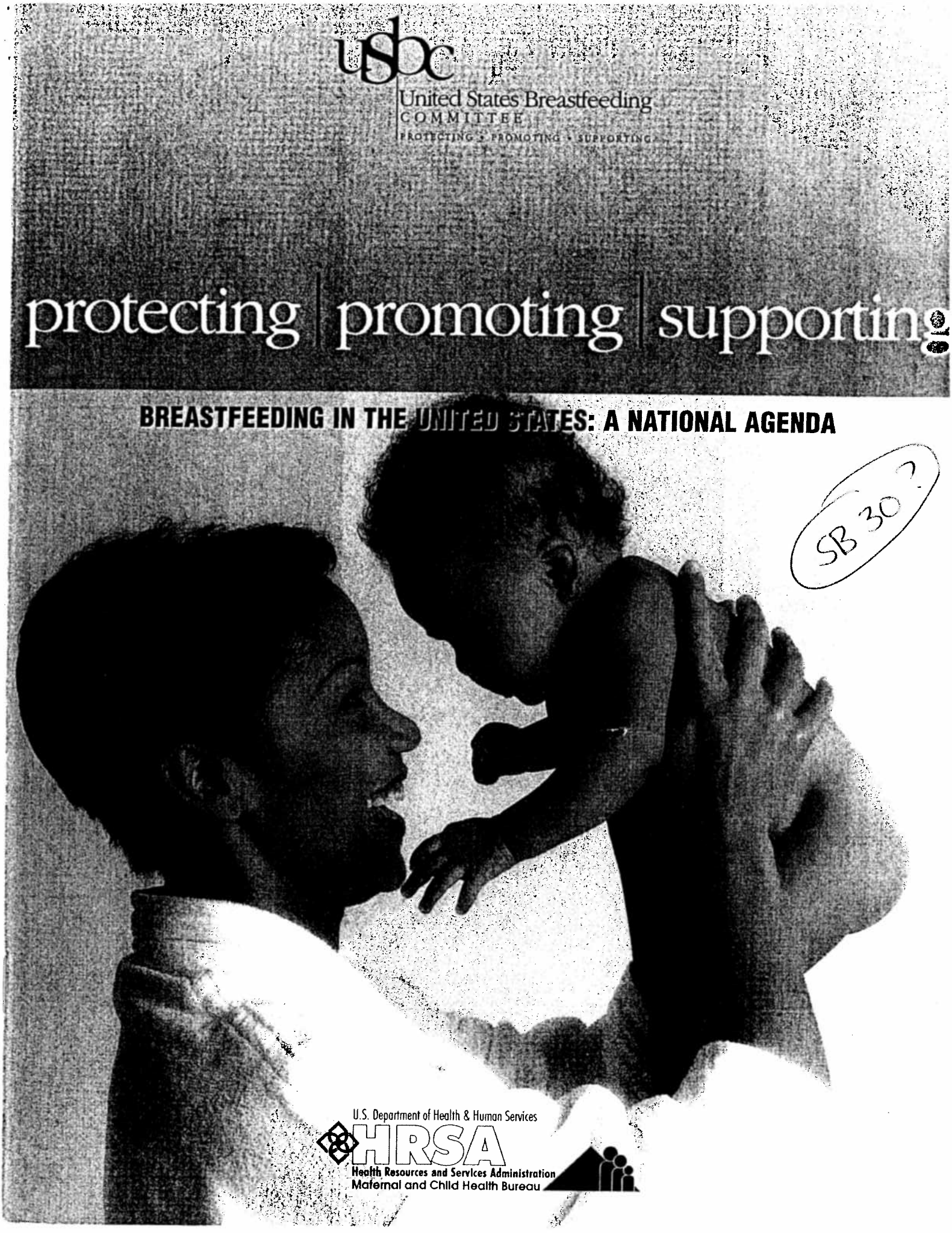
Waukesha/Hartland County, Fall 2003 – Kristin Sanden
I volunteered to help reshelve books in my children's school library when my youngest was a few months old. I thought this would be a nice way to help out with my baby rocked to sleep in a sling while I reached up and down to put books away. Sometimes my baby did need to nurse and I either stopped to nurse her in a chair or continued to nurse her in the sling. It did work well and I enjoyed the quiet time as I worked in the library when there were no classes in there. Occasionally a student came in to return a book; otherwise the only other person there was the library assistant. After a few weeks, I got a call from the head librarian asking me not to nurse my baby in the library. She stated she was supportive of breastfeeding and nursed her own babies, but that it wasn't appropriate in the school when children were around. She said she was concerned that she was going to start getting a bunch of calls from concerned parents. She suggested I nurse in the bathroom if needed (aren't there children in there?) or leave the baby at home. I did attempt to discuss counter-arguments and admitted that I might not have been as discrete as I normally would be since the library was typically empty, but I eventually decided to stop volunteering as the damage was already done and it wasn't worth the fight. I was surprised at my reaction which was of a sense of shame and a feeling that I did something "naughty". I felt like a kid getting reprimanded by a teacher. I was upset that I had to chose between my baby's needs and my desire (and what I felt was my responsibility) to help in my children's school. It was even more surprising that nursing was considered "taboo" in a supposedly child-centered institution.

Princeton Club East, Madison, July 2003 – Alicia Butz
I was feeding my daughter when an employee came up to me to tell me that a member had complained and the Princeton Club would like me to leave. I said that I needed to feed my daughter. He then told me that breastfeeding was disgusting and should only be done in the bathrooms. I told him I was staying and that if he'd like to throw me out, I needed to see the manager. I was not thrown out, but had been reduced to tears. I later found out that this experience was not uncommon at the club.

YMCA, Oshkosh, Nov/Dec. 2002 – Maggie Payne
A teacher had breastfed her children in a sling for years while she taught her class. No one had ever commented that she knew of. She was relatively certain that most folks didn't even know she was breastfeeding. The YMCA acquired a new female director who happened upon her class one day. Upon seeing the baby in the sling and breastfeeding she suspended the teacher for inappropriate behavior in a classroom and made a blanket policy that children of an instructor could not be present during a class even if the child was participating in the class as a member. All instructors' children, no matter what age, must either be left at home or put in drop off care. This policy then was extended to include anyone breastfeeding in the YMCA. The new policy read that breastfeeding must be done in the facilities provided for such activities, i.e. the family changing room...back to feeding in the *bathroom*. This policy did not include bottlefed babies, just those that are breastfed.

American Family Insurance, Madison, November 2002 – Anonymous
The pump in the lactation room at work was broken and I wanted to have my partner bring my child into work to nurse. I was told that because there was a no visitors policy that my child could not briefly breastfeed to help keep up my supply. My son is 13 weeks old and I'm not allowed to breastfeed at work. I just didn't know what to do with this situation.


FORWARD


usbc
United States Breastfeeding
COMMITTEE
PROTECTING • PROMOTING • SUPPORTING
protecting | promoting | supporting
BREASTFEEDING IN THE UNITED STATES: A NATIONAL AGENDA
SB 30?
U.S. Department of Health & Human Services
HRSA
Health Resources and Services Administration
Maternal and Child Health Bureau

Please cite this document as: United States Breastfeeding Committee. (2001). Breastfeeding in the United States: A national agenda. Rockville MD: U.S. Department of Health and Human Services, Health Resources and Services Administration, Maternal and Child Health Bureau.

The Strategic Plan of the United States Breastfeeding Committee reflects a collective statement and is not necessarily representative of its individual member organizations.

Prepared by the United States Breastfeeding Committee in cooperation with the National Alliance for Breastfeeding Advocacy and with support from the Maternal and Child Health Bureau, Health Resources and Services Administration, Department of Health and Human Services.

usbc
United States Breastfeeding
COMMITTEE
PROTECTING • PROMOTING • SUPPORTING

protecting | promoting | supporting

BREASTFEEDING IN THE UNITED STATES: A NATIONAL AGENDA

U.S. Department of Health & Human Services
HRSA
Health Resources and Services Administration
Maternal and Child Health Bureau

foreword

The United States Breastfeeding Committee composed of representatives from health professional associations and relevant government departments and non-governmental organizations developed the following *Strategic Plan.*

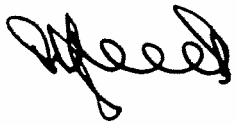
The Health Resources and Services Administration's Maternal and Child Health Bureau has a long history of protecting, promoting and supporting breastfeeding in the United States. A landmark activity was the Surgeon General's Workshop in 1984, which identified six major areas for the breastfeeding initiative:

- **Improve professional education in human lactation and breastfeeding;**
- **Develop public education and promotion efforts;**
- **Strengthen the support for breastfeeding in the health care system;**
- **Develop a broad range of support services in the community;**
- **Initiate a national breastfeeding promotion effort directed at working women; and**
- **Expand research on human lactation and data collection on breastfeeding.**

Over the years there have been numerous other significant events that have culminated with the establishment of the United States Breastfeeding Committee in 1998. This committee, composed of representatives from health professional associations and relevant government departments and non-governmental organizations, developed the following *Strategic Plan.* Through this plan we will hopefully see the recommendations from the Surgeon General's Workshop on Breastfeeding and Human Lactation fully implemented.

The timing of this *Strategic Plan* is fortuitous as the Surgeon General has released the *HHS Blueprint for Action on Breastfeeding.* The Blueprint is a comprehensive framework for increasing breastfeeding and for promoting optimal breastfeeding practices. Linking the *Blueprint* with the *Strategic Plan* of the U.S. Breastfeeding Committee provides a synergistic approach that will benefit America's mothers and children.

We thank our partners, especially those at the Centers for Disease Control and Prevention's Maternal and Child Nutrition Branch, who have supported us in this momentous effort, and we look forward to our continued collaboration as we work together to implement this *Strategic Plan for Protecting, Promoting, and Supporting Breastfeeding in the United States.*



Peter C. Van Dyck, M.D., M.P.H.
Associate Administrator for Maternal and Child Health

introduction

Starting in 1995, a small group of breastfeeding advocates met to discuss the need for coordination of breastfeeding activities in the U.S.

The development of the Strategic Plan, *Protecting, Promoting and Supporting Breastfeeding in the United States*, was one of four objectives developed by the National Breastfeeding Leadership Roundtable, the organizational precursor to the United States Breastfeeding Committee. Starting in 1995, a small group of breastfeeding advocates met to discuss the need for coordination of breastfeeding activities in the U.S. After conducting an intensive needs assessment, the National Alliance for Breastfeeding Advocacy (NABA) was formed to address needs not being met by organizations, government agencies or individuals. NABA convened the first National Breastfeeding Leadership Roundtable (NBLR) in January 1996 to determine if another organization was needed to move breastfeeding forward in this country. Working on the international model, the formation of this committee, if successful, would satisfy one of the four operational targets set forth by the 1990 Innocenti Declaration. This was to establish a multi-sectoral national breastfeeding committee composed of representatives from relevant government departments, non-governmental organizations, and health professional associations in every country.

It was agreed at that meeting of nineteen breastfeeding leaders to do four things. First, to support ongoing breastfeeding projects in the U.S. Second, to develop a strategic plan for breastfeeding in the U.S. Third, to formalize NBLR into the U.S. Breastfeeding Committee (USBC). And finally, to establish the organization of the USBC and its leadership, the NBLR continued to meet twice a year and in January 1998 voted to declare itself, with the encouragement of Assistant Surgeon General Dr. Audrey Nora, the United States Breastfeeding Committee.

The USBC is a collaborative partnership of organizations. The mission of the committee is to protect, promote and support breastfeeding in the U.S. The USBC exists to assure the rightful place of breastfeeding in society. To these ends, the USBC, supported by the Maternal and Child Health Bureau, developed this *Strategic Plan* for breastfeeding in the United States.

Breastfeeding in the United States: Strategic Plan

The formation of the USBC is among the most salient and distinguishing features of the progress that has occurred in the breastfeeding community since 1984.

Since the Surgeon General's Workshop in 1984, much has happened to advance the protection, promotion and support of breastfeeding for U.S. families. These efforts include the American Academy of Pediatrics 1997 policy statement, *Breastfeeding and the Use of Human Milk*, the introduction of the Maloney Bill in 1998, the Maternal and Child Health State Performance Measures, the 1998 National Breastfeeding Policy Conference and, facilitated by the National Alliance for Breastfeeding Advocacy, the establishment of the United States Breastfeeding Committee (USBC).

The policy recommendations from the National Breastfeeding Policy Conference, held in Washington, D.C. in November of 1998, provided a framework for setting a national policy agenda to protect, promote and support breastfeeding well into the 21st century. The mandate from this conference transferred the policy agenda to the USBC. The Federal Government, through the Health Resources and Services Administration's Maternal and Child Health Bureau, asked the committee to provide a strategic plan to implement this policy agenda.

The formation of the USBC is among the most salient and distinguishing features of the progress that has occurred in the breastfeeding community since 1984. It satisfies one of the four operational targets set forth by the 1990 Innocenti Declaration which was to establish a multi-sectoral national breastfeeding committee composed of representatives from relevant government departments, non-governmental organizations, and health professional associations.

The health of our Nation is one of our most important resources. Breastfeeding, a relatively basic, simple, and cost-effective measure, can have a significant impact on establishing the foundation for a lifetime of optimal health and can result in reduced health care spending. In recognition of this, the USBC has developed this strategic plan for breastfeeding in the United States.

mission

To improve the Nation's health by working collaboratively to protect, promote, and support breastfeeding.

vision

In order to achieve optimal health, enhance child development, promote knowledgeable and effective parenting, support women in breastfeeding, and make optimal use of resources, we envision breastfeeding as the norm for infant and child feeding throughout the U.S.

goals | objectives

Accomplishing our mission requires setting forth concrete and challenging goals. These revolve around improvement in breastfeeding initiation and duration, reduction and removal of barriers to breastfeeding, equitable access to lactation care and services, and portrayal and acceptance of breastfeeding as the cultural norm for infant and child feeding. The overarching breastfeeding goal of Healthy People 2010 is a 75 percent initiation rate, a 50 percent continuation rate to 6 months, and a 25 percent rate at 1 year. To that end, we recommend the following:

GOAL I

ASSURE ACCESS TO COMPREHENSIVE, CURRENT, AND CULTURALLY APPROPRIATE LACTATION CARE AND SERVICES FOR ALL WOMEN, CHILDREN AND FAMILIES.

GOAL STATEMENT:

All U.S. mothers should have the opportunity to breastfeed their infants and all infants should have the opportunity to be breastfed. By ensuring access to comprehensive, interdisciplinary, culturally appropriate lactation and breastfeeding care and services from preconception through weaning, all women will be empowered to breastfeed their infants exclusively for about 6 months and continue through the first year of life and beyond while introducing appropriate weaning foods.

OBJECTIVE A: Identify and disseminate evidence-based best practices and policies throughout the health care system.

STRATEGY 1: Develop a single overall national breastfeeding policy statement grounded on a foundation of evidence-based practice. The statement will be culturally appropriate, aim to eliminate disparities in care, and include all babies whether full term or preterm, healthy or sick.

ACTIVITIES:

a) Fund and convene a national breastfeeding subcommittee to draft an evidence-based U.S. breastfeeding policy statement that will be submitted to member organizations for universal adoption.
b) Encourage institutions including third party payers, hospitals, health care agencies, health professional organizations and others to adopt these policies.
c) Encourage health professional associations, institutions, organizations and agencies to develop and implement practice guidelines congruent with the U.S. breastfeeding policy statement.
d) Disseminate the policy statement to the general public and governmental agencies through governmental and non-governmental channels using the media, Internet sites, newsletters, bulletins, electronic mailing lists, meetings, and conferences.

STRATEGY 2: Ensure that every facility providing maternity services will offer effective, evidence-based breastfeeding care.

ACTIVITIES:

a) Encourage the USBC member organizations to promote best hospital practices to their members such as those identified in the WHO/UNICEF Baby-Friendly Hospital Initiative.
b) Encourage the U.S. Department of Health and Human Services [DHHS] to issue a statement urging all maternity care facilities to provide effective, evidence based breastfeeding practices such as those identified in the WHO/UNICEF Baby-Friendly Hospital Initiative.
c) Encourage the utilization of measurable breastfeeding outcomes for facilities providing maternity services and encourage health care accrediting agencies to include these outcomes in their evaluation.
d) Inform hospital administrators, members of Congress, health management companies and third party payers about the best maternity practices such as those identified in the Baby-Friendly Hospital Initiative.

OBJECTIVE B: Educate all health care providers and payers regarding appropriate breastfeeding and lactation support.

STRATEGY 1: Establish minimum competency-based standards of breastfeeding knowledge and skills for all maternal-child health care providers.

ACTIVITIES:

a) Urge organizations responsible for accreditation of health professional education programs to require the use of relevant competency-based curricula on breastfeeding and lactation management.
b) Ensure the development and dissemination of competencies and competency-based lactation management curricula for use in the training and education of health professionals.
c) Urge private, state and national licensure and certification agencies to include questions regarding breastfeeding protection, promotion and support on their examinations.

STRATEGY 2: Encourage health care plans and other provider organizations to educate their providers, administrators, managers, and consumers about the importance of breastfeeding as part of an overall preventive health strategy.

ACTIVITIES:

a) Support the expansion of continuing education (e.g., CME, CEU and CERP) and staff development programs pertaining to breastfeeding issues.
b) Foster the integration of breastfeeding education and services into conferences, meetings, and written literature that are accessed by top levels of management companies and hospital administrators.

OBJECTIVE C: Ensure that all women have access to appropriate breastfeeding support within the family and/or community.

STRATEGY 1: Comprehensive and seamless lactation support programs will be encouraged between hospitals and communities.

ACTIVITIES:

a) Ensure that all women have access to skilled lactation care.
b) Facilitate the formation of mother-to-mother support groups and breastfeeding peer-counselor programs to help eliminate disparities in breastfeeding initiation and duration.
c) Ensure that all women have access to referral services, "hot lines" and "warm lines" as needed.
d) Develop and disseminate a valid and reliable community assessment tool that identifies referral services.

STRATEGY 2: Encourage third party health care payers to adequately reimburse for lactation and breastfeeding services and medically advised equipment.

ACTIVITIES:

a) Create a task force to study the health care spending costs, employer costs, and family costs of breastfeeding and not breastfeeding.
b) Encourage federally funded programs and all other third party payers to pay for breastfeeding equipment when medically advised.

OBJECTIVE D: Ensure the routine collection and coordination of breastfeeding data by federal, state, and local government and other organizations and foster additional research on breastfeeding.

STRATEGY 1: Collect timely breastfeeding initiation and duration data through existing and new channels.

ACTIVITIES:

a) Encourage the federal government to explore and implement the collection of ongoing statistics of breastfeeding initiation, continuation, and exclusivity through survey, surveillance systems and program statistics.
b) Encourage federal funding for breastfeeding surveillance at both Federal and State levels.
c) Encourage all states to participate in breastfeeding data collection.
d) Encourage development of incentives for participation in data collection.
e) Propose and promulgate breastfeeding data elements for Health plan Employer Data Information Systems (HEDIS) and Consumer Assessment of Health Plans (CAHPS) including measurement for special and high-risk populations such as preterm infants.

STRATEGY 2: Encourage funding for clinical, epidemiological, programmatic, and other research on breastfeeding and human lactation.

ACTIVITIES:

a) Contact governmental and private funding agencies, and encourage funding of breastfeeding research.
b) Encourage the inclusion of evidence-based breastfeeding practices into databases such as the Cochrane database.
c) Encourage the expansion of breastfeeding research to encompass issues such as program effectiveness, cost/benefit analysis, and emerging medical concerns.
d) Convene a technical meeting on the cost-benefit of breastfeeding and the cost of artificial feeding.

All U.S. mothers should

have the opportunity to

breastfeed  their infants

and all infants should have

the opportunity to be breastfed.

GOAL II

ENSURE THAT BREASTFEEDING IS RECOGNIZED AS THE NORMAL AND PREFERRED METHOD OF FEEDING INFANTS AND YOUNG CHILDREN.

GOAL STATEMENT:

Breastfeeding should become the normative method of infant and young child feeding and should be woven into the foundation of society and family life.

OBJECTIVE A: Develop a positive and desirable image of breastfeeding for the American public.

STRATEGY 1: Develop and implement a national comprehensive and coordinated marketing program which portrays breastfeeding as normal, desirable and achievable.

ACTIVITIES:

a) Conduct breastfeeding marketing research that is independent of formula company marketing research to provide data for a national breastfeeding campaign.
b) Secure adequate funding for a national breastfeeding promotion campaign.
c) Enlist the support of the National Ad Council or similar organizations to design a national campaign that creates positive breastfeeding images and eliminates the bottle as a symbol of infancy.
d) Target specific populations for marketing, including but not limited to health care providers, hospitals, third party payers, business leaders, government, labor and education agencies, private sector labor organizations, women's groups, social welfare organizations, religious groups, judicial systems, and consumer groups.
e) Develop white papers on selected breastfeeding topics for routine distribution to members of Congress and policy makers.
f) Expand the Breastfeeding Media Watch to encompass all States and territories, and catalog acceptable and unacceptable breastfeeding images that appear in all forms of the media. Respond to both positive and negative publicity with issue letters and white papers.
g) Provide the Federal Trade Commission and the Federal Communications Commission with guidelines and recommendations for acceptable advertising.
h) Encourage publication of articles in advertising and trade journals that suggest ways to portray breastfeeding in a positive light and ways to eliminate bottles as the representative symbol of infancy.
i) Establish a unified project to promote and recognize businesses supportive of breastfeeding mothers and families.
j) Designate a Presidential (or Surgeon General's) Award program for a variety of breastfeeding support programs.
k) Expand and financially support a rapid response system for both public relations and damage control.
l) Establish and fund a national breastfeeding web site of the USBC with frequent updating for the media to access for correct breastfeeding information and hyperlinks to all member organizations.

m) Establish a speakers bureau of breastfeeding experts and market this bureau to appropriate audiences.

STRATEGY 2: Develop and implement an educational curriculum relating to breastfeeding as the normal and preferred method of feeding infants and young children that is age appropriate for pre-Kindergarten through grade 12.

ACTIVITIES:

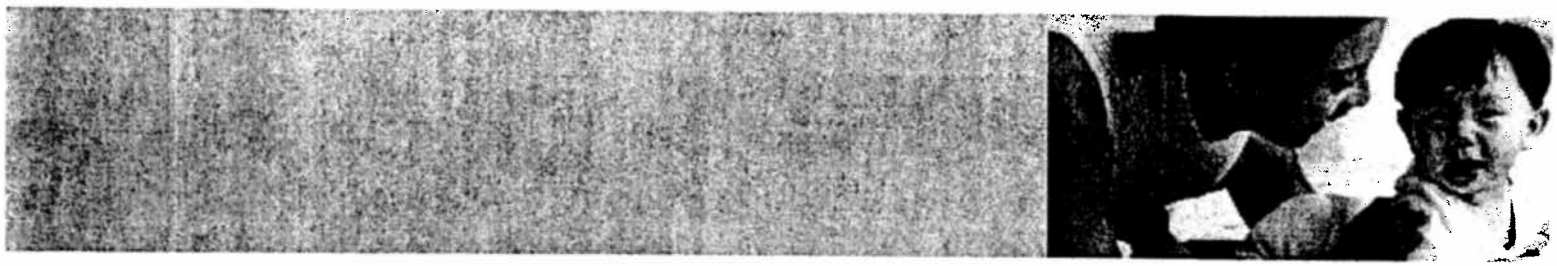
a) Collect and review samples of existing curricula from around the country for different age groups.
b) Develop a national curriculum in consultation with the U.S. Department of Education and educational experts.
c) Disseminate the curriculum to all State and territorial departments of education, national teachers' groups, parent-teacher associations, and media services involved with children's education.
d) Develop and implement a training program that will facilitate the use of the curriculum.

OBJECTIVE B: Reduce the barriers to breastfeeding posed by the marketing of breastmilk substitutes.

STRATEGY 1: Encourage the implementation of the International Code of Marketing of Breastmilk Substitutes.

ACTIVITIES:

a) Form a multidisciplinary task force to explore the implementation of the International Code of Marketing of Breastmilk Substitutes (The Code) and all relevant WHO and UNICEF resolutions. Include marketing experts, lobbying experts, attorneys, and congressional staff on this task force.
b) Gather systematic data on the state of The Code in the U.S. and publish and disseminate a report.
c) Target education related to The Code (including the report mentioned above) to professional organizations, legislators, non-governmental organizations, the general public, the business community, hospitals, attorneys, and national women's organizations.
d) Adapt the International Code language and documentation to fit the U.S. legal system.
e) Create a panel to monitor and enforce The Code within the U.S.



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 STATEMENT:

Lawmakers and policymakers will recognize breastfeeding as vital to the health, social and economic well-being of women, children, and families.

OBJECTIVE A: Ensure that all lawmakers and government officials at Federal, State, and local levels are aware of the importance of protecting, promoting, and supporting breastfeeding.

STRATEGY 1: Inform lawmakers and governmental officials to consider breastfeeding when addressing any policy or practice that has an impact on women or children.

ACTIVITIES:

a) Identify breastfeeding issues that require action by lawmakers.
b) Identify and train breastfeeding advocates to inform lawmakers.
c) Develop legislative fact sheets for government and non-government agencies, especially those involved with underserved and special populations.
d) Establish a database of legislation, policies, regulations, and legal precedents with implications for breastfeeding.
e) Establish liaisons with the American Bar Association and other legal organizations and law schools to educate and work with attorneys and judges in supporting breastfeeding.

GOAL IV

INCREASE PROTECTION, PROMOTION AND SUPPORT FOR BREASTFEEDING MOTHERS IN THE WORK FORCE.

GOAL STATEMENT:

Every woman, regardless of her employment status, will have the opportunity to breastfeed and/or provide breast milk to her child. Breastfeeding will be protected, promoted, and supported in the workplace through political, sociocultural, economic, and legal means in a way that protects family health and economic viability.

OBJECTIVE A: The rights of women in the workplace will be recognized in public and private sectors.

STRATEGY 1: Raise awareness in both the public and private sectors about the need to establish the rights of breastfeeding women in the workplace.

ACTIVITIES:

a) Create and disseminate an overview of labor laws, regulations, gender equity issues, policies, agency declarations, or statements (e.g., Occupational Safety and Health Administration) where breastfeeding should be addressed.
b) Educate the public about the legal rights of breastfeeding mothers, whether in the formal or informal workplace, paid or unpaid, through print, radio, and televised and electronic media in broad circulation.

OBJECTIVE B: Ensure that all mothers are able to seamlessly integrate breastfeeding and employment.

STRATEGY 1: Codify policy, legislation, and regulations that will enable parents to have flexibility in adapting their work schedules and employment arrangements for at least one year after birth to facilitate breastfeeding and/or the provision of breastmilk to their child.

ACTIVITIES:

a) Convene a Technical Advisory Group to explore paid maternity leave, implementation of the recommendations of the International Labor Organization (ILO) conventions, the Family Medical Leave Act, and other pertinent legislation regarding employment.
b) Develop and maintain relationships with key legislators in order to provide information that will enable them to initiate and support legislation related to breastfeeding and the workplace.
c) Devise and disseminate education and outreach activities individualized for business and labor groups.

d) Introduce into the employment arena existing recommendations including proceedings from ILO Conventions of 1919 and 1952, the Surgeon General's Workshop, the Quezon City Declaration, Healthy People 2010, Call to Action-Maternal and Child Health Inter-Organizational Nutrition Group (MCHING), Beijing Platform for Action, the Innocenti Declaration, and the National Breastfeeding Policy Meeting.
e) Ensure representation for breastfeeding at conferences related to women in the workplace such as AFL-CIO Working Woman 2000.
f) Ensure representation at policy development meetings related to women in the workplace.
g) Incorporate breastfeeding into the Civil Rights Act, Pregnancy Discrimination Act, and other Federal regulations and legislation where appropriate.
h) Incorporate breastfeeding into State-based legal protections for working women.

STRATEGY 2: Increase the number of work site environments that are modified or adapted to be supportive of breastfeeding employees.

ACTIVITIES:

a) Encourage employers through education and outreach to offer a variety of flexible work programs such as earned time, part-time, job sharing, graduated return to work, flex time, compressed work week, telecommuting, and onsite childcare.
b) Identify and showcase demonstration projects, successful models, or better practices for breastfeeding in the workplace.
c) Conduct research at local, state, or national levels to determine the needs of all mothers returning to work.
d) Encourage employers to conduct needs assessments of their breastfeeding employees or employees of reproductive age, and develop programs supportive of the breastfeeding mother.
e) Create innovative situational models for different types of work settings relative to time, space, and the breastfeeding needs of the work force.
f) Educate the workforce on the economic costs of artificial feeding in the working community according to work site needs.

The United States Breastfeeding Committee, Inc. is comprised of Governmental, Educational and Not-For-Profit organizations that share the common mission of protecting promoting and supporting breastfeeding in the United States.

member organizations

Academy of Breastfeeding Medicine

Academy for Educational Development

American Academy of Pediatrics

American College of Nurse Midwives

American College of Obstetricians and Gynecologists

American College of Osteopathic Pediatricians

American College of Preventive Medicine

American Public Health Association

Assoication of State and Territorial Public Health Nutrition Directors

Association of Women's Health, Obstetrics and Neonatal Nurses

Baby-Friendly USA

Best Start Social Marketing

Centers for Disease Control/Maternal and Child Nutrition Branch

Center on Budget and Policy Priorities

Coalition for Improving Maternity Services

Department of Health and Human Services/Food and Drug Administration

Department of Health and Human Services/Health Resources Services Administration/Maternal and Child Health Bureau

Healthy Children 2000

Human Milk Banking Association of North America

International Board of Lactation Consultant Examiners

International Lactation Consultant Association

Keck School of Medicine, University of Southern California

La Leche League International

Lamaze International

Morgan State University

National Alliance for Breastfeeding Advocacy

NABA
Research, Education and Legal

National Association of Pediatric Nurse Associates and Practitioners

National Association of WIC Directors

National Commission on Donor Milk Banking

National Healthy Mothers, Healthy Babies Coalition

Office on Women's Health, Department of Health and Human Services

United States Department of Agriculture/Food and Nutrition Services/WIC

University of California Los Angeles School of Public Health

University of Rochester, School of Medicine and Dentistry

Wellstart International

Women's International Public Health Network

GOAL I

Assure 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.

United States Breastfeeding COMMITTEE
PROTECTING • PROMOTING • SUPPORTING

U.S. Department of Health & Human Services
HRSA
Health Resources and Services Administration
Maternal and Child Health Bureau

United States Breastfeeding Committee
2025 M Street, NW, Suite 800
Washington, DC 20036
Phone: 202.367.1132 • Fax: 202.367.2132
E-mail: office@usbreastfeeding.org