

Workplace Accommodations to Support and Protect Breastfeeding

Introduction

This paper provides a background for understanding the role of lactation breaks in the workplace as a critical way to improve the health and productivity of working women and their children, in compliance with Section 4207 of the *Patient Protection and Affordable Care Act*.

- **Section 1** presents the public health case.
- **Section 2** explains how lactation breaks support the physical process of maintaining milk supply.
- **Section 3** discusses lactation breaks in the context of other work-family and workplace wellness issues and explores the business case for breastfeeding.
- **Section 4** reviews U.S. laws about breastfeeding and the workplace and looks ahead to unfinished business.

The **Appendix** offers a quick look at the history of infant feeding and women's work, in order to provide context for decision-makers in government and business. Many of those now in leadership positions were born at the nadir of breastfeeding in the U.S. and missed the opportunity to learn about breastfeeding as a normal part of human life when they were young.

Breastfeeding is not an issue of making a personal choice between two equally safe and effective feeding methods. It is not something "nice but not necessary." Breastfeeding is a public health issue. It is a method of caring for infants and children recommended by major health organizations as well as the federal government's health agencies. The health and economic repercussions of *not* breastfeeding are borne by everyone in our society, including the business sector. The United States Breastfeeding Committee welcomes the opportunity to provide background information for policymakers who have the power to implement change.

Section 1

The Public Health Case for Supporting Employed Women to Breastfeed

Breastfeeding is a low-tech, low-cost health promotion behavior that has received increasing support from public health authorities worldwide over the past 50 years. During that time our understanding of the scientific evidence base that supports breastfeeding has grown exponentially. It has become increasingly clear that breastfeeding is the best option for infant and young child feeding, and that *not* breastfeeding exposes mother and child to higher risks of ill health in both the short and long term. Human milk and infant formula are not equivalent and are not equally suitable options for infant feeding.

Key Points

- Breastfeeding protects infants and children from a host of significant acute and chronic diseases.
- Breastfed infants have a reduced risk of obesity throughout the life span.
- Women who breastfeed also have a reduced risk of breast cancer, ovarian cancer, type 2 diabetes, postpartum depression, and cardiovascular disease.
- \$13 billion of direct health care costs would be saved annually if 90% of women were able to breastfeed according to medical recommendations.

For more than a century, women's workforce participation has also been increasing. At first, human milk substitutes and feeding bottles seemed to offer a safe and convenient way for a mother to be away from her baby in order to take a job. People assumed that artificially-fed babies' increased susceptibility to ear and skin infections, diarrhea, and respiratory illnesses was the normal state of health for babies. Antibiotics, better public water supplies and sanitation, and the new medical specialty of pediatrics all played a role to offset the loss of health protection that breastfeeding would have provided.

However, evidence is mounting that the ill-health burden and the costs of care are significant when breastfeeding is cut short. The comprehensive review and analysis of breastfeeding research released in 2007 by the DHHS Agency for Healthcare Research and Quality (AHRQ) strongly supports the evidence demonstrated in the research¹:

- *For the child*: reduced risk of ear, skin, stomach, and respiratory infections, diarrhea, sudden infant death syndrome, and necrotizing enterocolitis; and in the longer term, reduced risk of obesity, type 1 and 2 diabetes, asthma, and childhood leukemia.
- *For the mother*: reduced risk of breast cancer, ovarian cancer, type 2 diabetes, and postpartum depression.

Current medical recommendations call for exclusive breastfeeding for the first six months of life and continued breastfeeding for at least the next six months, during which time appropriate complementary foods are added to the infant's diet. Both the duration and the exclusivity of breastfeeding are important. Exclusive breastfeeding appears to have an even stronger effect against obesity than breastfeeding combined with formula feeding.²

Studies published too late to be included in the AHRQ report have also found a decreased risk of cardiovascular disease for women who breastfeed.³ In 2010 it was estimated that \$13 billion in U.S. pediatric health care costs and over 900 infant deaths would be saved every year if 90% of families could meet the medical recommendation to breastfeed exclusively for the first six months.⁴

In 2008, 56.4% of mothers with children under one year old were participating in the labor force.⁵ The rate of exclusive breastfeeding at six months for babies born in 2006 was 13.6%; another 43.4% of mothers were partially breastfeeding at

six months.⁶ Although many factors affect breastfeeding success in our county, these numbers add evidence to women's own reports that their jobs pose a barrier to breastfeeding.

A lactating woman doesn't look any different from a non-pregnant, non-lactating woman, but she has a physical need to take about an hour out of her 8-hour workday either to feed her baby directly or to express her milk. Accommodating this invisible need poses a challenge for employers, supervisors, co-workers, and the woman herself. People are reluctant to mention breasts at the workplace because of heightened sensitivity to the possibility (or perception) of sexual harassment. Nevertheless, innovative employers who first met the challenge were pleasantly surprised to find that accommodating lactation brought bottom-line benefits. Research has shown that by supporting lactation at work, employers can reduce employee turnover, lower recruitment and new employee training costs, cut rates of absenteeism, eliminate the use of expensive temporary employees, boost morale and productivity, and reduce health care costs for covered workers and their babies. It turns out that protecting breastfeeding doesn't deplete funds from human resource and benefits programs, it *saves* money.⁷

Worksite lactation programs are now the norm among large employers, with annual savings in the hundreds of thousands of dollars. Small employers reap similar benefits as their larger counterparts, and the trend to supporting breastfeeding in small-to-mid size employers is growing.⁸

There are many reasons to support breastfeeding in all areas of modern life. Some of these reasons are the economic value of the milk itself as a food and an immune system booster; the environmental value of using milk made in the baby's own household, produced locally and just-in-time; the empowerment of women and fulfillment of their human rights; the enhancement of parent-child attachment and child development; and the provision of good care to young children. For this paper, we have chosen to focus primarily on women's and children's health, as well as the impressive return on investment for employers who accommodate lactating workers.

Section 2

The Physiological Basis for Lactation Breaks

The concept of breaks at work is familiar. Breaks give workers time to eat and drink, to use the restroom, and to rest and relax. It is recognized that breaks during the workday have a positive impact on health, well-being and productivity, and they are counted in the calculation of labor costs.⁹ Accommodations are arranged for workers with special needs, such as a diabetic who must periodically test his blood sugar and administer insulin. Smoking breaks are common and include time for workers to travel to a designated smoking area as well as to indulge their habit.

Key Points

- Breaks for lactation (pumping/storing milk) are analogous to other workplace breaks:
 - Time to eat/drink, restroom breaks, smoking breaks, accommodation for health needs.
- When mother and child are separated for more than a few hours, the woman must express milk.
- **Missing even one needed pumping session can have several undesirable consequences, including discomfort, leaking, inflammation and infection, decreased supply, and ultimately, breastfeeding cessation.**

Rest breaks for milk expression are a temporary accommodation for a subset of the labor force. These breaks ease the transition back to work after maternity leave. The need for lactation breaks coincides with the transition away from maternal-child proximity, to periodic separation. Milk expression breaks are necessary primarily in the first year after a worker gives birth, with the greatest need in the early months. Unlike absences for sickness, milk expression breaks can be scheduled and anticipated, and there is some room for flexibility.

The most effective way to maintain lactation after returning to work is to arrange time to breastfeed the baby during the workday.¹⁰ However, in the absence of contact with the baby, milk expression breaks sustain lactation and help a worker to reach her personal goals as a mother. They also help her reach the goal, shared by her employer, to be a highly functional and effective employee.

During pregnancy, a woman's breasts prepare for lactation (milk production) and begin to store small amounts of early milk. After birth comes a transition period—the milk matures, milk production increases, and mother and child learn the skills they need for effective feeding.

A lactating woman makes milk 24 hours a day. Her breasts function as both production and storage units; each woman's storage capacity is unique and cannot be determined from outward appearance. The rate of production varies, depending on the fullness of the breast. Overall output is determined by the frequency and thoroughness of milk removal, a classic model of "demand and supply." Typically, an exclusively breastfed baby (under six months) feeds between 8 and 14 times per 24 hours.¹¹ When a woman and her baby spend their time together, the baby's pattern of feeding determines the mother's rate of milk production. If mother and child are separated for more than a few hours, however, then the woman herself must express milk, both to maintain production and to ensure her own health and comfort. The milk can be stored (covered, chilled, or frozen) and fed to the baby later.

If a woman works an 8-hour day, with no access to her baby during that time, she normally will need to take two to three breaks to express milk. In a 12-hour shift, she will need three to four breaks. **Missing even one needed pumping session can have several undesirable consequences:**

- Full breasts are uncomfortable, and the milk tends to leak, which is potentially embarrassing for the employee, and not conducive to doing one's best work.
- Retained milk from missed pumping sessions can cause mastitis, a painful swelling and inflammation of the breasts. Mastitis increases the risk of breast infection, which requires physician visits, medication, and time off the job for recovery. Breast abscess, a consequence of unresolved breast infection, requires surgical treatment.
- Most critically, for all women, milk left in the breast beyond 3 to 4 hours signals the body to slow its rate of milk production and may decrease the woman's total daily output.
- If a mother's milk output drops, requiring her to resort to infant formula to meet her baby's need for food, it places the infant at higher risk for a number of diseases and conditions. A sick baby increases health claims and may cause the mother to miss work days to care for her child. Both of these situations are costly for an employer.

The health effects of combining human milk feeding with human milk substitutes are dose-related. Thus, babies who get 100% human milk (exclusive breastfeeding) are a healthier group than those who get part of their milk as formula, while those in turn are a healthier group than the babies who get no human milk at all.

Milk can be expressed by hand or by using a mechanical or electric pump made specifically for use by lactating women. (Most U.S. mothers prefer to use a pump.) Pumps vary in quality. A high-quality double electric pump is a very efficient way to remove milk from the breast when direct breastfeeding is not possible. Usually the costlier pumps work better, and it can take some experimentation for a woman to find the best pump for her needs. A few insurance plans now cover safe and efficient breast pumps as "durable medical equipment"; other plans provide a cheaper pump or no pump at all. Employers with many female employees of child-bearing age may choose to offer a good quality individual pump as part of their benefits package or else provide an on-site multi-user pump. These are hospital-grade, heavy-duty machines, quick and easy to use, with an individual kit for each user.

What does an employee do during a pumping break? She travels to the space designated for milk expression, bringing her pump equipment. Depending on whether her work environment is "dirty" or "clean" compared to the pumping place, she may have to remove or add a coverall. In any case, pumping is like preparing food, and she will wash her hands before she begins. She assembles her pump, expresses the milk, pours it into bottles or bags, stores it in a place that is cold and secure, washes her pump parts, readjusts her clothing, and returns to her work station. Pumping takes most mothers 10-15 minutes per breast, so a double pump cuts pumping time in half. The time she requires for the rest of the pumping session is a function of the space provided. Is it near her work station? Where is the nearest sink? Is a secure refrigerator provided, or will she bring her own lunch cooler with "blue ice" and keep the milk in her locker? Depending on her job duties, she may be able to "multi-task" while pumping by reading e-mail messages, writing notes, or making telephone calls.

There is also an emotional component to milk expression. Most women find it difficult if they are feeling stressed or rushed. Milk flows best when a woman feels safe and physically comfortable. A supportive worksite policy and culture, as well as a clean, private location for milk expression, can go a long way to meet these needs. In companies that employ many women, lactating employees often encourage each other with information and peer support. The skill of expressing milk usually improves with practice and by following a consistent routine. Women vary in their needs for length and frequency of breaks; thus, an employer should expect to work out an individualized plan with each lactating employee to facilitate her milk expression at work, modifying it as needed.

Lactation continues as the child starts learning to eat complementary foods, normally in the second six months of life, and mother's milk remains a valuable part of the child's diet alongside other foods. It is quite common for mothers in the U.S. to breastfeed a child past 12 months of age, a practice supported by the American Academy of Pediatrics.¹² As the baby eats more complementary foods, the proportion of milk in the baby's diet becomes smaller. The mother will be able to decrease the frequency of lactation breaks at work. Eventually she will stop them altogether.

Section 3

The Business Case for Workplace Lactation Support

Health matters to employers. One reason is that employers provide American workers with health care insurance for themselves and their families. Many employers pay for health care, too. Poor employee health can be linked to low productivity and slow economic growth.¹³ It makes good business sense for employers to pay attention to employee health.

Workers' families also matter to employers. Changing patterns of employment mean that more people are in the workforce and fewer are at home providing full-time family and domestic care. Twenty percent (20%) of American adults provide care to someone over 50. Seventy percent (70%) of families with children have either a single parent who works or two parents who both work.¹⁴ Workers may be distracted on the job by family and domestic concerns. When work-family balance is supported, however, employees experience less stress, which can lead to increased morale and productivity.

Key Points

- Lactation programs are cost-effective, showing a \$3 return on \$1 investment.
- By supporting lactation at work, employers can reduce turnover, lower recruitment and training costs, cut rates of absenteeism, boost morale and productivity, and reduce health care costs.
- Lactation accommodation is not a one-size-fits-all proposition. Flexible programs can be designed to meet the needs of both the employer and employee.

Businesses are using a range of strategies to address the challenges of work-family balance and to build a healthier workforce:

- wellness programs in the workplace, including weight loss, smoking cessation, exercise, and stress reduction;
- leave, paid and unpaid: sick leave, family leave, maternity leave, paternity leave, parental leave;
- workplace flexibility: phased return to work after leave, phased retirement, job-sharing, working from home, part-time work with a benefits package, variable start and end times for the workday;
- work-life support programs: child care at or near the workplace, policies that allow bringing babies to work, workplace concierge services.

Lactation breaks have a place on this list. In 2007, 26% of employers surveyed by the Society for Human Resource Management (SHRM) offered their workers a lactation support benefit.⁷

However, employers have a limited budget for employee benefits. A lactation program must compete with other benefits for funding.¹⁵ Before setting up a lactation support program, the employer will consider several factors:

- the **cost** of the program and expected **return on investment (ROI)**;
- the “**need**,” the proportion of employees who are women of childbearing age;
- the skill level of the employees and degree of competition with other businesses to **recruit** and **retain** the best employees.

Cost. Fortunately, lactation support programs can run the gamut from basic to comprehensive. Three essential requirements ensure that employees can successfully combine work and breastfeeding: time, space, and support. A comprehensive program also offers education.

Time: Provide a flexible work schedule with sufficient break time for feeding the baby or expressing milk.

Space: Provide a clean, comfortable, and private space for feeding the baby or expressing milk. A toilet stall is not an acceptable or hygienic option. Access to a sink for washing hands and pump parts is preferable, but alternative cleaning methods are available. Because direct feeding is more efficient and effective than milk expression, on-site or near-site child care that enables employees to breastfeed while on breaks or during lunch is extremely advantageous.

Support: Develop “mother-friendly” workplace policies. Improve staff attitudes by informing co-workers and management about the benefits that the lactation support program provides for them.

Return on investment (ROI). Lactation support programs are an opportunity to improve the bottom line. **Corporate lactation programs have demonstrated as much as a 28% decrease in absenteeism and a 36% reduction in sick child health care claims.**

- Investing in a company lactation program can result in a \$3:1 return on investment.
- One-day absences to care for sick children occur more than twice as often for mothers of formula fed infants. Absenteeism can cost more than 15% of a company’s base payroll and up to \$775 per employee. Lactation breaks can be scheduled in advance; absences to care for a sick baby cannot.
- Breastfeeding lowers insurance claims for businesses. One study showed that for every 1,000 babies not breastfed, there were over 2,000 extra physician visits, 212 extra hospitalization days, and 609 extra prescriptions to treat just three common childhood illnesses.
- Companies with lactation support programs have experienced higher productivity, employee job satisfaction, morale, and enhanced loyalty to the company.
- Companies with lactation programs enjoy an 80-90% retention rate of their childbearing employees. Employee turnover is costly, perhaps \$50,000 to replace a \$50,000 employee.
- A lactation support program can be an added recruitment incentive for female employees and can enhance a company’s image in the community.

A fast food restaurant might make a simple accommodation arrangement by scheduling a worker to take her lactation breaks in the private space where the manager counts the money. A large firm that offers a comprehensive lactation support program, complete with prenatal classes and 1:1 breastfeeding counseling, might open their education sessions and care services to the pregnant partners of male employees, knowing that having a healthy baby can benefit a father’s work performance.

One advantageous feature of a lactation support program is that some of its strongest health benefits show up soonest. It is in the first months of life that children are the most vulnerable to common infections that would bar them from day care and keep their parents home from work. Thus, the employer will see the benefits of a successful lactation support program fairly quickly.

Need. From the employer’s point of view, the need for a lactation support program varies with the number of employees who are having babies and the local community’s level of interest in breastfeeding. To an individual employee, however, the opportunity to breastfeed comes only once for each baby. Lactation accommodations allow a company to provide an equal employment opportunity to workers with family responsibilities who want to breastfeed their children. Without employer support, working mothers who breastfeed are at a greater risk of adopting behaviors that will negatively impact their company—taking an extended leave of absence, losing focus on the job, discontinuing breastfeeding prematurely, or not returning to work at all.

Recruitment and retention. There has been a marked increase in women in managerial and CEO positions in many companies over the last 20 years. Retention of highly skilled and experienced employees is a key impetus for the growing presence of workplace lactation programs in U.S. companies. A prime example comes from Wall Street's J.P. Morgan. Several senior traders who were also nursing mothers complained that they lost valuable work time by having to go several flights away from the trading floor to find a private room where they could pump milk. The company, a 150-year-old formerly male bastion, responded by setting up a room equipped with breast pumps, refrigerator, sink, and trading screens, adjacent to the trading floor. That effort, accompanied by an in-house lactation program, on-site medical care, adoption assistance and more, won the 8,000-employee firm a coveted spot on *Working Mother* magazine's "Best Companies" list.

Positive image and social benefit. We are a nation that has set a public health goal to increase the initiation, duration, and quality of breastfeeding. We pride ourselves on "family values." We strive for gender equity in the workplace as well as in other walks of life. A company that adopts a policy to support breastfeeding will receive positive attention as a model for the contribution it is making to these worthwhile goals.

Examples.¹⁶ The thousands of dollars in cost savings cited here for companies that are supportive of their breastfeeding employees is not a theoretical exercise. Large and small companies have been reaping the benefits of lactation support programs for many years.

Aetna estimated that implementing a lactation program saved the company \$1,435 in medical claims per breastfed infant during the first year of life. The total claims savings were \$108,737 per year, with a return on investment of 3 to 1.

In 1995, *Cigna* implemented a comprehensive program to eliminate worksite barriers that keep women from choosing to breastfeed and continuing to breastfeed after returning to work. The program showed these results:

- an annual savings of \$240,000 in health care expenses for breastfeeding mothers and children;
- a 77% reduction in lost work time due to infant illness, with annual savings of \$60,000;
- lower pharmacy costs due to 62% fewer prescriptions;
- increased breastfeeding rates: 72.5% at 6 months compared to the national average of 21.1% for employed mothers;
- recognition as a Workplace Model of Excellence by the National Healthy Mothers, Healthy Babies Coalition.

Mutual of Omaha was named one of the 100 best companies for working women by *Working Mother* magazine. Lactation support is one of the criteria taken into account for this recognition. Lactation support had these results:

- Hospital care costs for newborns were 2.7 times less for infants whose mothers participated in the breastfeeding support program. The total cost of additional claims for those who did not participate in the program was \$115,881 per year.
- Program participants' health care claims were \$1,269 per newborn compared to \$3,415 for non-participants.

Home Depot realized a return on investment from reduced absenteeism and increased productivity. Nationally an average new mother misses 9 days of work in the first year. Mothers in the Home Depot program reported only 3 days' absence due to infant illness. Based on a minimum cost of \$100 per day of absenteeism, Home Depot saved \$42,000.

The basic needs of breastfeeding employees are minimal and the ROI is realized quickly. Breastfeeding is not a lifestyle choice but a public health issue that calls on all sectors of society for support. Workplace support of breastfeeding is not only good for employees. It is good for the employer's bottom line, reducing unnecessary expenses through a small effort.

Section 4

Protecting Breastfeeding by Means of Law

“The theme of breastfeeding adds complexity to the issue of ‘difference’ in women’s labor market participation because, unlike pregnancy and childbirth, breastfeeding is not an inevitable biological feature of modern day maternity.”

–Judith Galtry¹⁷

Breastfeeding is a robust biological process but is subject to a number of social barriers that may cause mothers to either avoid or abandon nursing their infants. The workplace presents a particularly difficult situation for the breastfeeding woman because it usually requires mother-child separation. Lactation will continue in the absence of the infant but will be seriously diminished unless milk can be periodically removed from the breasts.

Key Points

- The lack of federal legislation addressing lactation in the workplace has resulted in a number of inconsistent state laws, as well as conflicting interpretations of existing federal laws related to pregnancy and disability.
- The U.S. is also one of the few nations with no national paid maternity leave.
- With the passage of the *Patient Protection and Affordable Care Act* of 2010 the U.S. has finally joined the more than 120 other countries whose employed women enjoy protection for lactation breaks at work. Although the law applies to only a fraction of U.S. workers, it is a start.

At its first meeting in 1919, the International Labour Organization (which was later to become a branch of the United Nations) recognized the need to protect women’s health, jobs, and income during childbearing. ILO Convention #3 called for up to 12 weeks of paid leave, including mandatory leave for six weeks after birth and an optional six weeks to rest before birth; free maternity care from a doctor or midwife; and two half-hour nursing breaks during the working day once the woman returned to the job after her leave. The leave benefits were to be paid out of public funds. By showing a medical certificate, a worker could extend her leave, and her job was protected while she was on leave.

These provisions demonstrate the early acknowledgement by the three ILO partners—employers, workers, and governments—that childbearing is not just a personal matter but calls for support from society as a whole. The work of reproduction necessitates a temporary adjustment of a woman’s workload on the job. The ILO reaffirmed maternity protection as a societal responsibility when it revised the maternity protection conventions in 1952 and 2000. They further addressed issues such as pay for nursing breaks, nursing breaks as a right not a benefit, and the prevention of discrimination against childbearing women. Consistent with its growing gender awareness, the ILO now states, “Safeguarding the health of expectant and nursing mothers and protecting them from job discrimination is a precondition for achieving genuine equality of opportunity and treatment for men and women at work and enabling workers to raise families in conditions of security.”¹⁸

The ILO’s global standards notwithstanding, the U.S. has gone its own way. The women’s movement objected to laws that protected women at work, for such laws were often used as a rationale not to hire women or to keep them in lower-paying jobs. The U.S. is one of the few nations with no national paid maternity leave policy. But in 2010, with the passage of the PPACA (*Patient Protection and Affordable Care Act* of 2010 or “health care reform bill”), America has finally joined the more than 120 other countries whose employed women enjoy a national benefit of lactation breaks at work. Section 4207 of the PPACA requires employers to provide unpaid lactation breaks and a clean and private space where women can express milk. Although the law applies to only a fraction of U.S. workers (non-exempt workers), it is a much-

needed start. Hourly workers who punch a time clock are the subset of employed mothers most likely to have been *denied* access to lactation breaks before this law was passed.

Over the decades as more and more women were joining the workforce, U.S. law has dealt in quite different ways with pregnancy and lactation, although they are the two key stages in the process of reproduction. Three laws enacted prior to the PPACA are of particular interest: the PDA (Pregnancy Discrimination Act of 1978), the ADA (Americans with Disabilities Act of 1990), and the FMLA (Family and Medical Leave Act of 1993).

The PDA amended Title VII of the Civil Rights Act of 1964, requiring employers to treat disabilities related to pregnancy the same as any other temporary disability that affects either sex. However, arguing that the PDA refers only to *medical* conditions causing disability, the courts have repeatedly expressed the opinion that lactation is not “a [medical] condition arising out of pregnancy” and is not covered by the PDA.¹⁹ The New Mothers’ Breastfeeding Promotion and Protection Act, a bill introduced in the mid-1990s by Representative Carolyn Maloney (now called the Breastfeeding Promotion Act), seeks to extend the protection of the Civil Rights Act to protect breastfeeding women from being fired or discriminated against in the workplace.²⁰

The ADA, a major achievement of the disability rights movement, defines disability as “a physical or mental impairment that substantially limits a major life activity.” Arguments have been made both for²¹ and against¹⁸ considering lactation under the ADA. Breastfeeding advocates are reluctant to classify the *normal* function of lactation as an “impairment,” even though lactation does involve a physiological need for more frequent rest breaks at work. Likewise, lactation could appear trivial and temporary when set alongside major and permanent disabling conditions like blindness and paralysis. Yet the central premise of the ADA is that “people denominated as disabled are just people.”²² If this principle were applied to lactation, it would imply that women who make milk are “just women” and have same right to function in the workplace as people with a variety of other conditions that necessitate accommodation.

Paradoxically, the Equal Employment Opportunity Commission, interpreting the ADA, has held that lactation *is* a pregnancy-related condition but that pregnancy and lactation, as normal functions, are not disabilities covered by the ADA. Contrast this opinion to court rulings on the PDA that do *not* consider lactation to be a condition arising out of pregnancy.¹⁸

The FMLA applies to workers of both sexes and provides 12 weeks of unpaid, job-protected leave for employees of large companies. The leave can be used for the employee’s own medical needs or to care for a close family member, including a newborn or newly adopted child. FMLA is helpful for new mothers, who can take time off work to recover physically from giving birth, which normally takes six to eight weeks. The process of establishing breastfeeding—a team effort between mother and baby—requires anywhere from a few days to a few months, depending on the woman’s prior experience, the child’s condition, and the support available. FMLA is definitely a step in the right direction, but since it is unpaid and applies to only the half of the workforce that works for large employers, in reality it offers breastfeeding support and protection to only a few families.

As women struggle for equality, a line is often drawn between childbearing (which is done only by women) and childrearing (which can be done by both sexes). This line may be drawn partly as a strategy to encourage men to participate more in child care. But lactation and breastfeeding are life activities with fuzzy boundaries. Lactation normally begins during pregnancy and increases after birth; logically it is a function of childbearing. Yet the process of lactation lasts as long as the mother and child continue breastfeeding (or as long as a woman continues to express her milk), and breastfeeding or providing milk seem clearly to be childrearing activities. Thus, breastfeeding is often depicted as a personal childrearing choice, treated as something that women could reasonably be expected to forego for the sake of employment. After all, alternatives to breastfeeding do exist, and for decades people believed the decision of how to feed

a baby was a choice between equivalent options. Now that the breast pump has become a common piece of parental equipment, people may have an even harder time recognizing the unique qualities of feeding a baby directly at the breast.

Those unique qualities are difficult to put into words, but in 1981 the Fifth Circuit Court in Florida made a bold attempt, saying, “Breastfeeding is the most elemental form of parental care. It is a communion between mother and child that, like marriage, is intimate to the degree of being sacred...we conclude that the Constitution protects from excessive state interference a woman’s decision respecting breastfeeding her child.”²³ An international group of human rights and breastfeeding advocates reached a similar conclusion in 2000. “...Children have the right to be breastfed, in the sense that no one may interfere with their mothers’ right to breastfeed them.” Furthermore, “women have the right to social, economic, health, and other conditions that are favorable for them to breastfeed or to deliver milk to their infants in other ways...” and “States...have an obligation to...facilitate the conditions of breastfeeding.”²⁴ These statements show why breastfeeding is a matter that is too important to be left in legal limbo.

In the absence of legal action at the national level, many states have enacted laws to protect breastfeeding. State legislatures hold jurisdiction over numerous places and situations where women need protection for the right to breastfeed. In 44 states, the District of Columbia and the Virgin Islands, laws protect women’s right to breastfeed in any public or private location. Twenty-four states have laws related to breastfeeding in the workplace.²⁵ These laws range from mandating space and time for pumping on the job, to encouraging employers to accommodate lactating workers, to requiring that employers not forbid a worker to pump during her mealtimes or breaks. Few state laws include a penalty for non-compliant employers or outline a procedure for making a complaint.

The Oregon law is the most recent and probably the best of the state laws. It details a 30-minute rest period to express milk during each four-hour work period, to be taken by the employee approximately in the middle of the work period, and if possible at the same time as the rest periods or meal periods that she otherwise would be taking. The law provides for the breaks to be paid if the break would be paid if taken for other reasons, and proposes a way she can make up the work time if the break is unpaid. A private place that is not a bathroom must be provided. Workers can call the Oregon Bureau of Labor and Industries if they need to lodge a complaint, and there is a \$1,000 penalty for each incident of non-compliance.²⁶

For a number of reasons, breastfeeding as a human activity has been largely overlooked when national laws were written in the U.S. A large proportion of American women (not to mention their babies!) would list breastfeeding as an activity that is central to “life, liberty, and the pursuit of happiness.” Now it’s time to fix that omission.

Appendix

A Brief History of Infant Feeding and Women's Work

Human beings are mammals. We are designed to get our start in life at our mother's breasts, where we receive not only food and drink but also protection and care (from the immune properties in the milk and from simply being close to a responsive adult). But throughout human history there have always been a few babies who didn't have access to their mothers' milk, because their mothers were dead, or absent, or busy with other things. Until about 150 years ago, those babies were dependent on being fed by another lactating woman, the practice called "wet nursing." Babies who had to be "hand fed" because they had no source of human milk had a poor chance of survival.

Early nutrition scientists discovered wide variation in the proportion of proteins, fats, and sugars in the milk of different mammalian species; this gave an explanation for the observation that undiluted cows' milk could kill human infants. The germ theory of disease slowly gained acceptance over the 19th century, and people saw that food for babies had to be clean, especially if it was stored for any length of time. The glass and rubber industries came up with a baby feeding bottle and teat that could be sterilized. In 1867, Justus von Liebig in Germany and Henri Nestlé in Switzerland developed recipes based on diluted cows' milk and flour that seemed to be safer for babies than previous hand feeding mixtures. Several patented baby foods soon became available; later, canned evaporated milk allowed mothers to mix their own baby milk. Home iceboxes and then refrigerators became more common. In the Western world, people began to observe that mothers and babies seemed to get along just fine without breastfeeding.

During the same time, other historical developments were affecting women's role in infant feeding. The Industrial Revolution was making factory jobs available, and mothers were going out to work long shifts away from their babies. Women began to organize their fight for equal rights, and one place they sought equality was in the workplace. Paid maternity leave and nursing breaks are a way to level the playing field between male and female workers and were a key step toward gender equity at work. In 1919, International Labour Organization (ILO) Convention # 3 set the international standard for maternity protection, which included paid maternity leave plus nursing breaks for mothers when they returned to work. ILO retained these standards when revising the Maternity Protection Conventions in 1952 and 2000.¹⁷

The U.S. has chosen not to abide by any of these global standards. Maternity protection was left to the generosity of the employer. Finally in 1993 we did take one step in that direction with the Family and Medical Leave Act, a national law that requires large employers, among other provisions, to give 12 weeks of job-protected, unpaid leave to workers with new babies. Five states provide paid leave during pregnancy out of their Temporary Disability Insurance funds, and two—California and New Jersey—now offer paid family leave for "bonding" with a newborn or newly adopted baby.

For centuries doctors had railed at mothers for "putting their babies out to nurse" instead of breastfeeding. As artificial feeding with "infant formula" became more widespread in the 19th and early 20th centuries, the new medical specialty of pediatrics devoted much attention to the artificial feeding of sick babies and young children. Gradually the incidence of formula feeding increased, and for a time it was even felt to be superior to breastfeeding because it was measurable and scientific. Coincidentally, doctors had more control over artificial feeding than over breastfeeding. They learned more about it in their medical education. Indeed, little research was done on breastfeeding, little was known about it, and little was taught about it.

All of these different trends impinged on breastfeeding for American women, and for almost a century, breastfeeding rates fell. By the 1960s fewer than one out of five American mothers even *attempted* to breastfeed, and most of those women breastfed for only a short time. Bottle feeding with commercial formula had become the *normal and expected* way to feed and nurture a baby. The American culture was losing the practical knowledge and breastfeeding skills that grandmothers, mothers, aunts, and neighbors had handed down to younger women.

The 1950s and '60s saw the founding of grassroots movements in which parents began to teach other parents about breastfeeding and childbirth. At the same time, awareness started to spread through the international consumer movement that exporting infant formula to developing countries, where poor families lacked clean water, public sanitation, accessible pediatric health care, and the money to purchase adequate quantities of this expensive food, was leading to appalling rates of infant and young child illness and death. People started to understand that breastfeeding is normally a one-way trip: milk comes in automatically after birth, but a mother who loses her milk by giving her baby too much substitute milk will have a very hard time regaining her own supply. Thus the decision of whether to breastfeed or use milk substitutes was not a typical consumer choice, like the choice between two brands of soap powder. It required a different approach to consumer information.²⁷ A global people's campaign focused on women's need to get adequate information about breastfeeding, the safe use of formula (when it is needed), and the negative effects of formula and bottle use on infant health, family resources, and breastfeeding.

As a response, the World Health Assembly (WHA) adopted the International Code of Marketing of Breast-Milk Substitutes ("the Code"). The infant formula companies and the consumer movement, including the newly-formed International Baby Food Action Network, were consulted in the drafting of the document. It was approved at the WHA in 1981 by a vote of 118 to 1 (the U.S. vote), with three abstentions. The U.S.'s "no" vote was a surprise. Throughout the deliberations in 1979 and 1980, U.S. delegates had urged that the Code take the form of a recommendation; in return they promised to press for unanimous approval. (The alternative form being considered was a regulation, a stronger legal form, but likely to be more controversial.) January 1981, however, brought the installation of a more pro-business government in the United States, and the U.S. switched sides at the last minute.²⁸

Meanwhile, scientists were beginning to look more carefully at differences between breastfed and non-breastfed babies in developed countries, too. In 1981 a New York pediatrician reviewed the health of a white, middle-class population of babies up to four months old and found a rate of 77 hospitalizations per 1,000 formula-fed babies and 5 per 1,000 breastfed babies.²⁹ Research has continued at such a pace that the April 2007 report *Breastfeeding and Maternal and Infant Health Outcomes in Developed Countries* from the Agency for Healthcare Research and Quality reviewed 9,000 English-language studies and accepted over 400 of them for analysis. The report's conclusions found evidence, for children, "that a history of breastfeeding was associated with a reduction in the risk of acute otitis media [ear infection], non-specific gastroenteritis [diarrhea], severe lower respiratory tract infections, atopic dermatitis, asthma (young children), obesity, type 1 and 2 diabetes, childhood leukemia, sudden infant death syndrome (SIDS), and necrotizing enterocolitis... For maternal outcomes, a history of lactation was associated with a reduced risk of type 2 diabetes, breast, and ovarian cancer. Early cessation of breastfeeding or not breastfeeding was also associated with an increased risk of maternal postpartum depression."¹ Studies published too late to be included in that report have also found a decreased risk of cardiovascular disease for women who breastfeed.²

In 1990 health ministers from 40 countries, representing both the "West" and the global "South," attended a meeting jointly funded by the U.S. Agency for International Development and the Swedish International Development Agency. The meeting resulted in the document known as "The Innocenti Declaration," which calls on national governments to meet four operational targets to support breastfeeding.³⁰ Target four was to "[enact] imaginative legislation protecting the breastfeeding rights of working women and [establish] means for its enforcement." Assistant Surgeon General Audrey Nora signed the Innocenti Declaration for the U.S.

Most of the "Baby Boom" generation—the people who are making the decisions now in government and business—were bottle fed as babies with infant formula. They grew up seeing babies with bottles. But the trend away from breastfeeding finally ended in the 1960s, beginning a national cultural shift, a re-discovery or reclaiming of breastfeeding by American families. That cultural shift is still going on, and a new national law that requires employers to provide lactation breaks at

work for non-exempt employees, section 4207 of the PPACA (*Patient Protection and Affordable Care Act* of 2010) signed by President Obama on March 23, 2010, is part of it.

So for 50 years, breastfeeding has been making a comeback in America, but progress has been slow, despite the growing body of research on infant feeding that shows breastfeeding is important, even for mothers and children in countries like ours with good sanitation and plenty of food. In 1979, when about half of U.S. mothers were breastfeeding at birth, the U.S. public health authorities set a goal to increase breastfeeding initiation to three out of four mothers—75%. Every 10 years, this goal has been reaffirmed. In 2010, we are nearly there. It has taken us 30 years to reach that national goal.

Of course, breastfeeding is about more than just getting started; continuing breastfeeding is also important. The effects of breastfeeding are related to the “dose.” That means that positive health outcomes are stronger for both mother and baby when breastfeeding is exclusive—100% breastfeeding, until the baby needs to begin tasting other foods at six months—and when breastfeeding continues, along with complementary foods, until the baby’s first birthday or longer. But the 75% of U.S. mothers who start breastfeeding today are having a hard time achieving exclusive breastfeeding or sustaining breastfeeding for a year.⁵ Over half of them are at work, and they need accommodation there as lactating women. Workplace support is a key intervention for the quality and duration of breastfeeding.

A recent nationwide study by the Food & Drug Administration surveyed about 2,000 mothers every month from late pregnancy until their baby’s first birthday.⁹ Forty percent (40%) of these women were both breastfeeding and working for pay. They returned to work at an average of 11 weeks after the baby’s birth, and they used several different strategies for continuing lactation. Some women breastfed only at home. They did not express milk or breastfeed their babies during their work hours, and they had the shortest duration of breastfeeding, lasting about 14 weeks after they returned to work. Pumping during the work day was the strategy used by the most women. The mothers who pumped at work continued breastfeeding almost twice as long as the mothers who breastfed only at home—continuing 26 weeks after returning to work. The most successful strategies, though, were either to breastfeed directly during the work day or to breastfeed at some times and pump at other times while at work. How did women manage to breastfeed while on the job? 1) by putting in some of their work time at home, 2) by using child care at or near the workplace (where they could visit on their lunch break), 3) by keeping the baby on the job with them, or 4) by having the baby’s caregiver bring the baby to visit them at work. Those mothers continued breastfeeding for an average of 31-32 weeks after returning to work.

What does this study tell us? It shows that:

1. Going to work does not mean that mothers have to stop breastfeeding.
2. There are several different strategies for sustaining lactation while working.
3. It’s probably best to have a range of options available.
4. Flexibility of scheduling is important.
5. Pumping at work is a commonly-used strategy, so that is probably a reasonable place to start changing the workplace environment.

Section 4207 of the PPACA is welcome because it protects some breastfeeding women at work so they can bring home a paycheck to support themselves and their families. It’s important to remember, however, that breastfeeding is about more than just getting a mom’s milk into her baby. Breastfeeding is not only a health and economic issue, not only nutrition, and not only about babies. To support breastfeeding is to support women to do something that is part of who they are as mothers—a specific behavior that is women’s birthright as mammals. Breastfeeding is worth preserving simply for itself.

About the United States Breastfeeding Committee

The United States Breastfeeding Committee (USBC) is an independent nonprofit coalition of 41 nationally influential professional, educational, and governmental organizations. Representing over half a million concerned professionals and the families they serve, the USBC and its member organizations share a common mission to improve the Nation's health by working collaboratively to protect, promote, and support breastfeeding. For more information on the USBC, visit www.usbreastfeeding.org.

References

- ¹ Ip S, Chung M, Raman G, Chew P, Magula N, DeVine D, Trikalinos T, Lau J. *Breastfeeding and Maternal and Infant Health Outcomes in Developed Countries*. Rockville, MD: Agency for Healthcare Research and Quality; 2007. Evidence Report/Technology Assessment No. 153.
- ² Gillman MW, Rifas-Shiman SL, Camargo CA, et al. Risk of overweight among adolescents who were breastfed as infants. *JAMA*. 2001;285:2461-2467.
- ³ Schwarz EB, Ray RM, Stuebe AM, Allison MA, Ness RB, Freiberg MS, Cauley JA. Duration of lactation and risk factors for maternal cardiovascular disease. *Obstet Gynecol*. 2009;113(5):972-973.
- ⁴ Bartick M, Reinhold A. The burden of suboptimal breastfeeding in the United States: a pediatric cost analysis. *Pediatrics*. 2010;125(5):e1048-e1056.
- ⁵ Labor force participation of mothers with infants in 2008: The Editor's Desk. Bureau of Labor Statistics Web site. <http://www.bls.gov/opub/ted/2009/may/wk4/art04.htm>. Accessed May 15, 2010.
- ⁶ Breastfeeding: Data and Statistics: Breastfeeding Report Card, United States: Outcome Indicators. U.S. Department of Health and Human Services, Centers for Disease Control and Prevention Web site. http://www.cdc.gov/breastfeeding/data/report_card2.htm. Accessed May 15, 2010.
- ⁷ See Part 3 for details.
- ⁸ U.S. Department of Health and Human Services, Health Resources and Services Administration, Maternal and Child Health Bureau. *Implementing the Business Case for Breastfeeding in your Community: Train the Trainer Curriculum*. Rockville, MD: U.S. Department of Health and Human Services; 2008.
- ⁹ International Labour Organization. *Report II - Measurement of Working Time - 18th International Conference of Labour Statisticians, Geneva, 24 November - 5 December 2008*. Geneva, Switzerland: International Labour Organization; 2008.
- ¹⁰ Fein SB, Mandal B, Roe BE. Success of strategies for combining employment and breastfeeding. *Pediatrics*. 2008;122(suppl 2),S56-S62.
- ¹¹ Hörnell A, Aarts C, Kylberg E, Hofvander Y, Gebre-Medhin M. Breastfeeding patterns in exclusively breastfed infants: a longitudinal prospective study in Uppsala, Sweden. *Acta Paediatr*. 1999;88(2):203-211.
- ¹² American Academy of Pediatrics Section on Breastfeeding. Breastfeeding and the use of human milk (policy statement). *Pediatrics*. 2005;115(2):496-506.
- ¹³ Executive Office of the President, Council of Economic Advisors. *Work-Life Balance and the Economics of Workplace Flexibility*. Washington, DC: Executive Office of the President; 2010.
- ¹⁴ Taubman P. *Free Riding on Families: Why the American Workplace Needs to Change and How to Do It* (issue brief). Washington, DC: American Constitution Society; 2009.
- ¹⁵ Tuttle CR, Slavitt WI. Establishing the business case for breastfeeding. *Breastfeed Med*. 2009;4(suppl 1):S59-S62.
- ¹⁶ Slavitt W, editor. *Investing in Workplace Breastfeeding Programs and Policies: An Employer's Toolkit*. Washington, DC: Center for Prevention and Health Services, National Business Group on Health; 2009.
- ¹⁷ Galtry J. Suckling and silence in the USA: the costs and benefits of breastfeeding. *Feminist Economics*. 1997;3(3):1-24.
- ¹⁸ Maternity Protection: Equality and Discrimination. International Labour Organization Web site. http://www.ilo.org/global/Themes/Equality_and_Discrimination/Maternityprotection/lang--en/index.htm. Accessed May 8, 2010.
- ¹⁹ Christrup SM. Breastfeeding in the American workplace. *Journal of Gender, Social Policy & the Law*. 2001;9(3):471-503.
- ²⁰ Breastfeeding: Legislation. Congresswoman Carolyn Maloney Web site. http://maloney.house.gov/index.php?option=com_issues&task=view_issue&issue=262&parent=21&Itemid=35. Accessed May 16, 2010.
- ²¹ Von Rohr H. Lactation litigation and the ADA solution: a response to *Martinez v. NBC*. *Washington University Journal of Law & Policy*. 2000;4:341-359.

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- ²² Von Rohr, quoting Robert L. Burgdorf.
- ²³ Christrup, quoting *Dike v. School Board of Orange County, Florida*.
- ²⁴ Kent G. Child feeding and human rights. *Int Breastfeed J*. 2006;1:27.
- ²⁵ Issues & Research: Health: Breastfeeding State Laws. National Conference of States Legislatures Web site. <http://www.ncsl.org/issuesresearch/health/breastfeedinglaws/tabid/14389/default.aspx>. Accessed May 12, 2010.
- ²⁶ Breastfeeding Promotion: Oregon Breastfeeding Law HB 2372. Oregon Department of Human Services Web site. <http://www.oregon.gov/DHS/ph/bf/hb2372.shtml>. Accessed May 12, 2010.
- ²⁷ The preamble of the WHO/UNICEF *International Code of Marketing of Breast-Milk Substitutes* states on page 7, "...in view of the vulnerability of infants in the early months of life and the risks involved in inappropriate feeding practices, including the unnecessary and improper use of breast-milk substitutes, the marketing of breast-milk substitutes requires special treatment, which makes usual marketing practices unsuitable for these products..."
World Health Organization. *International Code of Marketing of Breast-milk Substitutes*. Geneva, Switzerland: World Health Organization; 1981.
- ²⁸ Richter J. Holding Corporations Accountable: Corporate Conduct, International Codes, and Citizen Action. New York, NY: Zed Books; 2001; chapter 4.
- ²⁹ Walker M. A fresh look at the risks of artificial infant feeding. *J Hum Lact*. 1993;9(2):97-107.
- ³⁰ UNICEF in Action: Innocenti Declaration on the Protection, Promotion, and Support of Breastfeeding. UNICEF Web site. <http://www.unicef.org/programme/breastfeeding/innocenti.htm>. Accessed May 15, 2010.