Position Paper on Breastfeeding and Work

1.0. Introduction

1.1. The role of the lactation consultant is to provide care, problem-solving, education, and counseling to breastfeeding mothers and their families. These clinical services, however, make up just one part of the community system that supports women while they are breastfeeding their children. Mothers also need to be able to integrate breastfeeding with other activities, especially with the work that they do to earn income or to maintain their family and household, as well as their own self-care and leisure pursuits. In this position paper, the International Lactation Consultant Association (ILCA) expresses its endorsement for women's right to receive support for breastfeeding in the context of their paid and unpaid work. The paper also spells out the role of the Association and International Board Certified Lactation Consultants in reducing the barriers that mothers face as they seek to harmonize breastfeeding and work.

1.2. Women's conditions of work have been changing and continue to change. Throughout the 20th century, increasing numbers of women worked in jobs outside the home, and in jobs that were traditionally held by men. Worldwide, the number of households headed by women and the number of women migrating to seek better economic opportunities are increasing.[1] Many studies have shown that women who are employed while their children are young initiate breastfeeding at the same rate as unemployed women, but they stop exclusive breastfeeding sooner and wean earlier.[2 3 4 5 6 7 8 9]

1.3. In 2000, the International Labour Organization (ILO) adopted the third Maternity Protection Convention (C183) in its 81-year history. Worksite support for workers who are breastfeeding their babies has been a basic provision of maternity protection since the first Maternity Protection Convention (C3) in 1919. In 1999, ILCA was one of a group of non-governmental organizations (NGOs) that formed the Maternity Protection Coalition (MPC), aiming to retain and strengthen breastfeeding protection in C183[i]. The MPC continues to encourage and train breastfeeding advocates and others to work for strong maternity protection through the legal system, in the workplace, and throughout the community.

1.4. The provisions of C183 help to protect breastfeeding.[10] Health protection, job protection, and non-discrimination of women workers who are pregnant or lactating are key concepts of maternity protection. Maternity protection entitlements include maternity leave, maternity and newborn health care, income replacement while the worker is on leave, and the right to paid nursing breaks[ii] when she returns to work. C183's companion recommendation, R191, calls for "facilities for nursing[iii] under adequate hygienic conditions" at or near the worksite.[11] C183 is the first ILO maternity protection convention to call for these entitlements to be available to all employed women, even women employed in the informal economy.

1.5. Compared to the formal workplace, where the employers and workers pay into a national benefits system, it is more difficult to assure maternity protection for the large proportion of women who work in agriculture, in part-time, casual, or temporary jobs, in Export Processing Zones, and in the informal economy as domestic workers, self-employed vendors, or crafts-women, in illegal jobs, or as unpaid workers in family-run enterprises. Yet they and their children have the same rights to health and nutrition as the families who work in the formal economy.

1.6. Women also do the majority of the unpaid caring work that sustains their families. The workload that results from this gender-unequal division of family work[iv] affects the time and energy women have available for breastfeeding.[12]

1.7. Most child-rearing is work that can be shared with others, but it is only mothers who carry a child through pregnancy, give birth, and provide their milk to feed and protect the child. When compared to men and to women without young children, this additional work of reproduction puts childbearing women at a competitive and financial disadvantage for supporting themselves and their families. In the early 20th century, the ILO's C3 established a strategy for adjusting the workload for employed mothers of young children through the legal system. By safeguarding the mother's job, maternity protection laws help to 'level the playing field' for childbearing women in the formal economy. In addition, these laws protect the health of both mother and child.[13] Some governments provide a child benefit or tax credit, which also subsidizes the work of child-rearing. Childbearing women who work in the informal economy or as unpaid contributing family workers, and women who do unwaged work to maintain the family and household also require maternity protection. This protection can be provided by means of legal entitlements and/or through community and family support.

1.8. Children are the workforce of the future. Society can best safeguard its future by protecting breastfeeding in every situation, so that each child can reach his or her unique, inherent potential for health, growth, development, physical ability, and intellectual capacity. By providing specialized nutrients for growth and development of the nervous system, breastfeeding contributes to brain development.[14] [15] [16] By providing excellent oral exercise and reducing the incidence of ear infections, breastfeeding contributes to the development of normal speech and hearing.[17] [18] [19] [20] By reducing infection rates in young children and chronic disease throughout the life-span, breastfeeding can reduce the time lost from schooling and work because of illness.[21] [22] Healthy, well-nourished children will be able to benefit the most from opportunities for education and training.

2.0. Research

2.1. In the years before researchers understood the composition and effects of human milk, many women relied on human milk substitutes such as complementary foods and modified animal milks to cope with the challenges of combining mothering with other work. Experience and continuing research have shown that feeding infants on human milk substitutes falls short on the grounds of health, human development, emotional bonding, and economic and environmental sustainability. Complementary foods are often lacking in quantity and quality as well.[v] The toll of inadequate feeding for infants and young children is greatest in conditions of poor sanitation, contaminated water, and low family income,[23] but it is significant for families in even the most privileged conditions.[24] [25]

2.2. Many research studies show that it is possible and cost-effective to protect, promote, and support breastfeeding for women at work. Studies of the effectiveness of workplace support for breastfeeding in several U.S. corporations have demonstrated improved worker productivity, satisfaction, and loyalty, enhanced public image of the employer, lower absenteeism and employee turnover, and lower health care costs for employers who provide health care coverage.[26] [27] [28] [29] [30] [31] One company reported a conservative estimate of return on investment of 2.18 to 1 for supporting its breastfeeding employees.[32]

2.3. In addition to these benefits for the employer who actively supports breastfeeding by his or her employees, studies have shown that having an enabling environment at work can help women sustain breastfeeding. A 2005 study of women in the United States found that without support, most women discontinued breastfeeding before the end of their first month back at work.[33] Having a supportive environment, however, helps women achieve or even exceed their personal breastfeeding goals.[34] [35] [36] [37]

3.0. ILCA's Position: Affirmations

3.1. ILCA affirms that women have a human right to breastfeed and a human right to work, and that children's human rights include their rights to health, food, and care. A number of international documents support the right to breastfeed.[38] [39] [40] [41] [42] [43] Many governments have taken steps to assist childbearing women in combining breastfeeding with employment.[44] The WHO/UNICEF *Global Strategy for Infant and Young Child Feeding* calls on every nation to develop a comprehensive national policy, which must include such support.[45]

3.2. ILCA affirms that human milk substitutes fall short as a solution to the challenges of combining mothering and work.

3.3. ILCA affirms that women who are lactating must be protected from discrimination or harassment on the grounds of maternity and lactation.

3.4. ILCA affirms that mothers and infants "form a biological and social unit."[46] Women should be able to choose from a range of workload adjustment strategies that assist them to sustain breastfeeding while working. These accommodations should fit the individual needs of mother and child, changing over time as the child grows.

3.5. ILCA supports paid maternity leave and parental leave, flexible job scheduling, and paid breaks for breastfeeding or milk expression as basic elements of maternity protection. These entitlements make it economically possible for a woman to take time to recover fully from birth, establish lactation, and maintain a breastfeeding relationship with her infant(s).

3.6. The best way to protect breastfeeding is to avoid mother-baby separation. ILCA advocates the following three levels of breastfeeding protection in regard to women's work:

> 3.6.a. Strategy #1: Arrangements that keep mother and baby together. It is optimal to keep the breastfeeding baby with the mother while she is working and/or to provide income replacement while she is breastfeeding. Such arrangements include maternity leave, parental leave, working from home, and bringing the baby to the workplace with the mother.
>
> 3.6.b. Strategy #2: Intermittent contact for mother and baby by means of breastfeeding breaks. If mother and baby cannot stay together full time, then modifications in scheduling her tasks, such as part-time work, reduction in work hours, job-sharing options, on-site or near-site child care with break time at the job for the mother to visit her child, or the opportunity for the baby's care provider to bring the baby into the workplace for feeding visits, help to maintain the breastfeeding relationship.

3.6.c. Strategy #3: Provisions for milk expression during work hours, together with child care that supports the baby's breastfeeding skills. This set of options requires adequate break times and facilities for the mother to express and store her milk for later use. Mothers need training and effective equipment for milk expression and storage. Child care providers need training about the value and handling of human milk as well as how to foster the breastfeeding relationship.

3.6.d. It must be noted that Strategy # 3 involves the most labor-intensive way to breastfeed. It divides breastfeeding into two tasks: a) removing milk from the mother's breasts, plus b) feeding the mother's milk to the baby. Direct breastfeeding gets the "job" done all at one time by utilizing *the baby's* "labor" to extract the milk. In addition, some women have great difficulty sustaining adequate milk production if they have to spend several hours a day without the stimulus of the baby's suckling. They may need to change to Strategy #1 or #2.

3.7. ILCA affirms that comprehensive breastfeeding education and support help working women achieve their goals and help employers gain bottom-line benefits from providing a worksite lactation program. Education includes classes or individual consultations with an International Board Certified Lactation Consultant (IBCLC) or a trained lactation educator. Support may come from an IBCLC, as well as from employers, supervisors, work colleagues, and other employed mothers.

3.8. ILCA asserts that it is a community responsibility to build women's opportunities to care for their children, both emotionally and physically, by breastfeeding. A mother's paid labor benefits her family and her community. The family and community benefit economically when a mother's health and her child's health are protected through breastfeeding. They also benefit because money does not have to be spent to buy human milk substitutes and provide extra health care for the artificially-fed child and the lactation-suppressed mother.[47] [48] ILCA believes that the labor of childbearing women should not be exploited in ways that take away their opportunity to care for their children by breastfeeding.

4.0. ILCA's Position: Recommendations

4.1. ILCA recommends that ways be found to share the costs of protecting breastfeeding among all the parties that benefit when children are healthy and well-nourished. This includes parents, family members, community members, health insurance providers, employers and co-workers, and the nation as a whole.

4.2. ILCA respects a woman's individual responsibility to decide how to feed her child. Many times every day, a mother makes decisions about how she will feed and care for her child. While acknowledging that a woman has the right to weigh the risks and benefits of infant feeding choices and select a riskier option for her own reasons, ILCA calls on everyone in the global community to reduce the economic, social, and informational constraints which prevent women from choosing to breastfeed.

4.3. ILCA supports efforts to measure and value unwaged domestic work, including the value of human milk production. Although few nations measure the work that women do to care for their homes and the people who live there, this work clearly has economic value.[49] ILCA calls for entitlements to be provided for women's and men's domestic caregiving work, for instance tax breaks, a family allowance and/or a pension fund for family care providers. Specific entitlements should be included for breastfeeding.

4.4. ILCA encourages enterprises that have successfully instituted breastfeeding accommodations to report on their experience so that other employers and workers may benefit. Lactation consultants must acknowledge and address employers' concerns. A range of work settings requires a range of solutions.

4.5. ILCA urges governments and NGOs to explore ways to protect breastfeeding for lactating women in challenging work settings, such as mothers in the military, migrant working mothers, unorganized working mothers, and mothers working illegally. ILCA urges recognition for employers who provide conditions that allow these women to breastfeed.

5.0. ILCA's Position: Actions

5.1. The roles of the International Board Certified Lactation Consultant include protecting the breastfeeding rights of women and children; promoting breastfeeding to women workers and their employers in all work settings; assisting workers, unions, and employers who are negotiating reasonable accommodations for lactating workers; and supporting women as they strive to accommodate the demands of their work to their needs as lactating women. As the professional association for lactation consultants, ILCA will provide leadership and guidance for lactation consultants as they seek to fulfill these roles.

5.2. ILCA will engage in international advocacy and support national and local advocacy for stronger maternity protection through laws, labor regulations, and collective bargaining agreements, and through family and community support. ILCA is part of the Maternity Protection Coalition and works closely with the World Alliance for Breastfeeding Action (WABA) Women and Work Task Force. Maternity Protection at Work: A Breastfeeding Perspective, a campaign kit produced by the Maternity Protection Coalition, is available as a resource for use in advocacy for the implementation and monitoring of improved maternity protection entitlements.

5.3. ILCA will provide professional development opportunities through which individual lactation consultants can build their knowledge and skills, both to provide clinical lactation support for women at work, and to understand, advocate for, and monitor the implementation of, maternity protection measures.

5.4. ILCA will encourage, support, publish, and circulate research about the challenges, costs, and benefits of providing workplace accommodations for breastfeeding; about the value of breastfeeding to the community, employers, and the nation; about effective methods of clinical support and advocacy; and about the role of coalitions, task forces, and community support networks to make positive changes in the situation of lactating women at work.

Notes

i. ILCA's partners on the Maternity Protection Coalition (MPC) were International Baby Food Action Network (IBFAN), LINKAGES, and World Alliance for Breastfeeding Action (WABA), with technical support from International Maternal and Child Health—Uppsala, Sweden (IMCH) and United Nations Children's Fund—New York (UNICEF).

ii. The term "nursing break" is understood at the International Labour Organisation (ILO) to mean break time to breastfeed the baby and/or to express and store milk.

iii. As in the previous note, "facilities for nursing" is understood at ILO to mean a place to breastfeed and to express and store milk.

iv. "In many parts of Africa, women are expected to do domestic and public work and the men the public only. However, with the recent socio-economic changes women are increasingly occupying public responsibilities, but with no concomitant shift from men to domestic roles. The result is identity crisis for men and increase in workload for women." Reflections on the integration of men in gender and development (GAD) practice in Africa by Fatima L Adamu, Department of Sociology, Usmanu Dan Fodiyo University, Sokoto, Nigeria. Available at http://www.gwsafrica.org/african%20feminist%20thinkers/adamu/adamu%20publication6.htm. Accessed May 28, 2007.

v. "No more than 35% of infants worldwide are exclusively breastfed during the first four months of life; complementary feeding frequently begins too early or too late, and foods are often nutritionally inadequate and unsafe. Malnourished children who survive are more frequently sick and suffer the life-long consequences of impaired development… Because poor feeding practices are a major threat to social and economic development, they are among the most serious obstacles to attaining and maintaining health that face this age group." WHO/UNICEF, *Global Strategy for Infant and Young Child Feeding*, 2003:Annex, paragraph 1. Available at http://www.who.int/nutrition/publications/gs_infant_feeding_text_eng.pdf. Accessed May 28, 2007.

References (Endnotes)

1. International Labour Office. Global Employment Trends for Women, Brief, (a condensed version of the ILO working paper "Global Employment Trends for Women 2007," forthcoming 2007). Available at: http://www.ilo.org/public/english/employment/strat/download/getw07.pdf. Accessed May 28, 2007.
2. Greiner T. Factors associated with the duration of breastfeeding may depend on the extent to which mothers of young children are employed. *Acta Paediatr*. 1999:88(12): 1311-1312.
3. Lindberg LD. Women's Decisions about Breastfeeding and Maternal Employment. *Journal of Marriage and Family*. 1996:58(1):239-252.
4. McLeod D, Pullon S, Cookson T. Factors influencing continuation of breastfeeding in a cohort of women. *J Hum Lact*. 2002:18(4):335-342.
5. Novotny R, Hla MM., Kieffer EC, Park CB, Mor J, Thiele M. Breastfeeding duration in a multiethnic population in Hawaii. *Birth*. 2000:27(2):91-96.
6. Roe B, Whittington LA, Fein SB, Teisl MF. Is there competition between breast-feeding and maternal employment? *Demography*. 1999 :36(2) :157-171.
7. Taveras EM, Capra AM, Braveman PA, Jensvold NG, Escobar GJ, Lieu TA. Clinician support and psychosocial risk factors associated with breastfeeding discontinuation. *Pediatrics*. 2003:112(1):108-115.
8. Vogel A, Hutchison BL, Mitchell EA. Factors associated with the duration of breastfeeding. *Acta Paediatr*. 1999:88(12):1320-1326.
9. Yinyam S, Morrow M. Breastfeeding practices among employed Thai women in Chiang Mai. *J Hum Lac*. 1999:15(3):225-232.
10. International Labour Organization. C183 Maternity Protection Convention, 2000. Available at http://www.ilo.org/ilolex/english/convdisp1.htm Accessed May 28, 2007.
11. International Labour Organization. R191 Maternity Protection Recommendation, 2000. Available at http://www.ilo.org/ilolex/english/recdisp1.htm Accessed May 28, 2007.

12. Ramos X. Domestic work time and gender differentials in Great Britain 1992-1998: facts, value judgements and subjective fairness perceptions. Presented at the British Household Panel Survey 2003 conference, Institute for Social and Economic Research (ISER), University of Essex on July 4, 2003. Available at http://www.iser.essex.ac.uk/press/releases/releases/2003/2003-13.php. Accessed May 28,2007.

13. ILO *Maternity Protection at Work: Revision of the Maternity Protection Convention (Revised), 1952 (No. 103), and Recommendation, 1952 (No. 95) Report V (1)*. Geneva: International Labour Office; 1997:16.

14. Anderson JW, Johnstone BM, Remley DT. Breast-feeding and cognitive development: a meta-analysis. *Am J Clin Nutr*. 1999;70:525-535.

15. Lanting CI, Fidler V, Huisman M, Touwen BCL, Boersma ER. Neurological differences between 9-year-old children fed breast-milk or formula-milk as babies. *Lancet*. 1994:344:1319-1322.

16. Lucas A, Morley R, Cole TJ, Lister G, Leeson-Payne C. Breast milk and subsequent intelligence quotient in children born preterm. *Lancet*. 1992:339, 261-264.

17. Duncan B, Ey J, Holberg CJ, Wright AL, Martinez FD, Taussig LM. Exclusive breast-feeding for at least 4 months protects against otitis media. *Pediatrics* 1993:91:5:867-872.

18. Owen MJ, Baldwin CD, Swank PR, Pannu AJ, Johnson DL, Howie VM. Relation of infant feeding practices, cigarette smoke exposure, and group child care to the onset and duration of otitis media with effusion in the first two years of life. *J Pediatr*. 1993:123:702-711.

19. Neiva FCB, Cattoni DM, Ramos JLA, Issler H. Early weaning: implications to oral motor development. *Jornal de Pediatria (Brazil)*. 2003:79(1):7-12. Available at http://www.jped.com.br/conteudo/03-79-01-07/ing.pdf. Accessed May 28 ,2007.

20. Tomblin JB, Smith E, Xuyang Z. Epidemiology of specific language impairment: prenatal and perinatal risk factors. *J Commun Disord* 1997;30(4):325-44 Abstract available at http://www.sciencedirect.com/science?_ob=ArticleURL&_udi=B6T85-3RH6YBB-6&_user=10&_coverDate=08%2F31%2F1997&_rdoc=1&_fmt=&_orig=search&_sort=d&view=c&_acct=C000050221&_version=1&_urlVersion=0&_userid=10&md5=6e9ded312d407d2c8aa269a977443006. Accessed May 28,2007.

21. Ball TM & Wright AL (1999) health care costs of formula-feeding in the first year of life. *Pediatrics* 103:4, supplement 870-76.

22. Weimer J. *The Economic Benefits of Breastfeeding: A Review and Analysis* (Food Assistance and Nutrition Research Report No. 13). Washington DC: U. S. Department of Agriculture, Food and Rural Economics Division, Economic Research Service. 2001. Available at http://www.ers.usda.gov/publications/fanrr13/. Accessed May 28, 2007.

23. Jones G, Steketee R, Black R, Bhutta Z, Morris S, Bellagio Child Survival Study Group. How many child deaths can we prevent this year? *Lancet*. 2003: Jul5:362(9377):65-71.

24. Wilson AC, Forsyth JS, Greene SA, Irvine L, Hau C, Howie PW. Relation of infant diet to childhood health: seven-year follow-up of cohort of children in Dundee infant feeding study. *BMJ* 1998:316(7124):21-25.

25. Ip S, Chung M, Raman G, Chew P, Magula N, DeVine D, et al. *Breastfeeding and Maternal and Infant Health Outcomes in Developed Countries, Evidence Report/ Technology Assessment No. 153*. Agency for Healthcare Research and Quality: 2007. Available at http://www.ahrq.gov/downloads/pub/evidence/pdf/brfout/brfout.pdf. Accessed May 28, 2007.

26. Cohen R, Mrtek M. The impact of two corporate lactation programs on the incidence and duration of breastfeeding by employed mothers. *American Journal of Health Promotion*, 1994:8(6):436-441.

27. Cohen R, Mrtek M, Mrtek RG. Comparison of maternal absenteeism and infant illness rates among breast-feeding and formula-feeding women in two corporations. *American Journal of Health Promotion*, 1995:10(2):148-153.

28. Meek JY. The management of breastfeeding—breastfeeding in the workplace. *Pediatr Clin North Am*. 2001:48(2).

29. Ortiz J, McGilligan K, Kelly P. Duration of breast milk expression among working mothers enrolled in an employer-sponsored lactation program. *Pediatric Nursing*. 2004: 30(2):111-119.

30. Slusser WM, Lange L, Dickson V, Hawkes C, Cohen R. Breast milk expression in the workplace: a look at frequency and time. *J Hum Lact*. 2004:20(2), 164-169.

31. Whaley SE, Meehan K, Lange L, Slusser W, Jenks E. Predictors of breastfeeding duration for employees of the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC). *J Am Diet Assoc*. 2002:102(9), 1290-1293.

32. Bocchino C, Hodge-Bethea N, Lardy B, et al. *Advancing Women's Health: Health Plans' Innovative Programs in Breastfeeding Promotion*. 2001: 79. Available at http://www.ahip.org/content/default.aspx?bc=38|65|369|412|424 Accessed May 28, 2007.

33. Cardenas R, Major D. Combining employment and breastfeeding: utilizing a work-family conflict framework to understand obstacles and solutions. *J of Bus and Psych*. 2005: 20(1), 31-51, *citing* to Duberstein Lindberg, L. Women's decisions about breastfeeding and maternal employment. *Journal of Marriage & the Family*. 1996:58, 239–251.

34. Whaley, *op cit*, note 31.

35. Cohen, *op cit*, notes 26, 27.

36. Lewallen L P et al. Breastfeeding support and early cessation. *JOGNN* 2006:35, 166-172. *See also* Nichols M, Roux G, *JOGNN* 2004:33, 463-471

37. DiSandro D, personal communication, 2000.

38. Convention on the Rights of the Child (CRC), available at http://www.unhchr.ch/html/menu3/b/k2crc.htm. Accessed May 28, 2007.

39. International Covenant on Economic, Social and Cultural Rights (ICESCR), available at http://www.unhchr.ch/html/menu3/b/a_cescr.htm. Accessed May 28, 2007.

40. Convention on the Elimination of all Forms of Discrimination against Women (CEDAW) available at http://www.un.org/womenwatch/daw/cedaw/ Accessed May 28, 2007.

41. The ILO Maternity Protection Conventions (numbers 3, 103, and 183) and Recommendations (numbers 95 & 191), available at http://www.ilo.org/ilolex/english/ Accessed May 28, 2007.

42. WHO/UNICEF *Global Strategy on Infant and Young Child Feeding* available at http://www.who.int/nutrition/publications/gs_infant_feeding_text_eng.pdf or http://www.waba.org.my/docs/gs_iycf.pdf Accessed May 28, 2007.

43. The Innocenti Declarations of 1990 and 2005 available at http://www.usbreastfeeding.org/Innocenti.html and http://www.unicef-icdc.org/presscentre/presskit/breastfeedingweek/inno_declar_pam_localprinting_eng.pdf Accessed May 28, 2007.

44. World Alliance for Breastfeeding Action (WABA). Status of Maternity Protection by Country. Available at http://www.waba.org.my/womenwork/MaternityProtectionChart21May2006.pdf Accessed May 28, 2007.

45. WHO/UNICEF, *Global Strategy on Infant and Young Child Feeding*. Paragraph 4; Annex, paragraphs 12, 28, 34, 45, 48.

46. *Ibid*. paragraph 6.

47. Hatløy A, Oshaug A. Human milk: an invisible food resource. *J Hum Lact*. 1997:13(4): 299-305.

48. Smith JP, Ingham LH. Mothers' milk and measures of economic output. *Feminist Economics*. 2005:11(1):41-62.

49. World Alliance for Breastfeeding Action (WABA). WABA Global Forum II. Joint statement "Towards a common advocacy agenda" from theme 7, "Collaboration with women's organizations." Available at http://www.waba.org.my/gender/index.html. Accessed May 28, 2007.

ILCA

INTERNATIONAL LACTATION CONSULTANT ASSOCIATION

1500 SUNDAY DRIVE, SUITE 102 • RALEIGH, NC • 27607 • USA PHONE: 919.861.5577 • FAX: 919.787.4916 • E-MAIL: INFO@ILCA.ORG • WEB: WWW.ILCA.ORG