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Why Breastfeeding is (Also) a Legal Issue

Corey Silberstein Shdaimah*

I. INTRODUCTION

To many people, it is not clear why breastfeeding is an issue of public debate. Isn't breastfeeding just another means for providing nutrition for babies—a choice open to whoever opts for this method? In order to assess the need for public encouragement and support for breastfeeding, one must first understand the social, economic and medical factors that contribute to the current atmosphere in the United States. This natural and free source of child nutrition, nurturing and health benefits has become an anomaly in the United States and has greatly declined throughout the world. This Article examines how the legal system has responded to address breastfeeding in a variety of contexts.

The first part of this Article will give a brief summary of the health issues involved in choosing whether or not to breastfeed. The following sections will address some of the social and economic factors which influence the decline in breastfeeding rates and duration in the United States and other countries. After addressing these important background issues, I will give a critical survey of how the United States legal system has responded to breastfeeding issues. This will be followed by a discussion of some of the important international conventions and documents that address breastfeeding, and how these have been accepted or rejected by the United States. I will conclude with some analytical remarks.

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II. HEALTH BENEFITS OF BREASTFEEDING

A growing body of literature attests to the medical benefits of breastfeeding to both the mother and the child. A partial list of benefits to breastfed children includes immune protection, better neurological development, higher IQs, and decreased incidence in Sudden Infant Death Syndrome, intestinal disorders (pediatric and adult), juvenile diabetes, childhood cancers and allergies. Mothers also benefit from breastfeeding.


2. Throughout this paper I will refer to the mother. However, it must be noted that many (but not all) of the issues raised here will be applicable to the nursing of a child by a woman other than its mother.

3. Some also speak of the health risks of not breastfeeding. Put this way, the same statement carries greater import.

4. The AAP Statement asserts:

   Extensive research, especially in recent years, documents diverse and compelling advantages to infants, mothers, families, and society from breastfeeding and the use of human milk for infant feeding. These include health, nutritional, immunologic, developmental, psychological, social, economic, and environmental benefits.

   Human milk is uniquely superior for infant feeding and is species-specific; all substitute feeding options differ markedly from it.

   Epidemiologic research shows that human milk and breastfeeding of infants provide advantages with regard to general health, growth, and development, while significantly decreasing risk for a large number of acute and chronic diseases. Research in the United States, Canada, Europe, and other developed countries, among predominantly middle-class populations, provides strong evidence that human milk feeding decreases the incidence and/or severity of diarrhea, lower respiratory infection, otitis media, bacteremia, bacterial meningitis, botulism, urinary tract infection, and necrotizing enterocolitis. There are a number of studies that show a possible protective effect of human milk feeding against sudden infant death syndrome, insulin-dependent diabetes mellitus, Crohn's disease, ulcerative colitis, lymphoma, allergic diseases, and other chronic digestive diseases. Breastfeeding has also been related to possible enhancement of cognitive development.

   There are also a number of studies that indicate possible health benefits for mothers. It has long been acknowledge that breastfeeding increases level of oxytocin, resulting in less postpartum bleeding and more rapid uterine involution. Lactational amenorrhea causes less menstrual blood loss over the months after delivery. Recent research demonstrates that lactating women have an earlier return to prepregnant weight, delayed resumption of ovulation with increased child spacing, improved bone remineralization postpartum with reduction in hip fractures in the postmenopausal period, and reduced risk of ovarian cancer and premenopausal breast cancer. AAP Statement, supra note 1, at 1036 (emphasis in original).

5. See Jo L. Freudenheim et al., Exposure to Breastmilk in Infancy and the Risk of Breast Cancer, EPIDEMIOLOGY, May 1994, at 324; see also Polly A. Newcomb et al., Lactation and a Reduced Risk of Premenopausal Breast Cancer, NEW ENG. J. MED., Jan.
in that it facilitates contraction of the uterus immediately postpartum\(^7\) and is associated with a reduced incidence of breast cancer,\(^8\) osteoporosis, diabetes and a delayed return to fertility. There is no doubt the great health benefits\(^9\) appurtenant to breastfeeding result in direct economic benefits due to fewer health problems which reduce medical expenses and employee absenteeism.\(^10\) Among the groups that have recognized the beneficial effects of breastfeeding are the American Academy of Pediatrics\(^11\) and the American College of Obstetricians and Gynecologists.\(^12\)

III. CULTURAL CONTEXT

Even many who concede that breastfeeding is the optimal form of nutrition and nurturing for infants and children do not understand the need for measures to promote and encourage breastfeeding. It is not always clear why any woman who chooses to breastfeed her child may have difficulty doing so. The role of the state in the promotion of breastfeeding should include educating the public as to the benefits thereof, providing support to the breastfeeding family in the way of protective and proactive legislation, educational health programs and incentives. In order to define what that role should be it is important to understand the existing barriers to breastfeeding.

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\(^7\) This is the process by which the uterus returns to its shape and size after pregnancy.

\(^8\) See Breastfeeding Reduces Breast Cancer Risk, INFACT CANADA NEWSLETTER, Fall, 1993, at 1. INFACT stands for Infant Feeding Action Coalition, a breastfeeding advocacy group based in Toronto, Ont., Canada.

\(^9\) See Cynthia Washam, Is the Breast Still Best?, E MAG., Nov./Dec., 1995, at 46-47 (discussing concerns that have been raised about the transmission of HIV and toxic chemicals). However, these risks obviously do not apply to all women and breastfeeding advocates still say that in some cases the benefits outweigh the risks. See also AAP Statement, supra note 1, at 1036. For a critique of the way in which HIV transmission has been determined and emerging policy on the local, national and international levels, see Celia Farber, HIV and Breastfeeding; The Fears. The Misconceptions. The Facts., 90 MOTHERING 65 (1998).

\(^10\) See AAP Statement, supra note 1, at 1036.

\(^11\) See id.

\(^12\) See AMERICAN C. OBSTETRICIANS & GYNECOLOGISTS, EXECUTIVE BOARD STATEMENT ON BREASTFEEDING (Sept. 1994) (on file with author). The American College of Obstetricians and Gynecologists (ACOG) officially endorsed breastfeeding and called for “its Fellows and other health professionals caring for women and their infants, hospitals and employers to support women in choosing to breastfeed their infants.” Id.
A. SOCIAL ATTITUDES

The social mores that interfere with breastfeeding are illustrated by newspaper accounts across the country of women who have been asked to leave public spaces when breastfeeding their infants or young children.13 People who oppose breastfeeding in public routinely compare it to sexual acts or defecation to convey the message that, while it may be natural or necessary, it should never be public.14 However, the fact of the matter is that a breastfeeding infant has little regard for the distinction between public and private, nor does it care to recognize the sexual characterization of the breast. If women and young children are to be allowed outside the confines of their homes, then public breastfeeding must be accepted.15 Such acceptance is also crucial to curb declining breastfeeding rates.16

The message that this basic act of love and nurture in feeding one’s child is inappropriate, sexual or shameful also contributes to declining rates of breastfeeding. Increasing emphasis on the breast as a sexual organ in Western society has been correlated to a decline in breastfeeding.17 It is obvious from the little existing legislation addressing breastfeeding that the stated concern with public nursing is the possibility that the women’s breast or nipple will be exposed incident to feeding her child. This emphasis underscores the preoccupation with the breast as a sexual organ.18 It also serves to undermine a woman’s confidence in, and comfort with, her own body and her special physiological capacity to care for her children. In one extreme case, University of Texas anthropologist Katherine Dettwyler relates an exchange which took place in a class in which she discussed breastfeeding.19 During the class discussion regarding the function of the

15. For expanded discussion see infra, Section IV.
16. See BAUMSLAG & MICHELS, supra note 5, at xvii. See also, ROSS LABORATORIES, RECENT TREND IN BREASTFEEDING, ROSS LABORATORIES MOTHERS’ SURVEYS (on file with author). According to Ross Laboratories statistics, breastfeeding rates in the United States declined from the 1950s through the 1970s. In the mid-1970s breastfeeding rates began to climb, reaching highs in the early 1980s. Rates again began to decline in the mid-1980s and are only now, in the late 1990s, reaching their peaks of the early 1980s. Statistics for 1997 show that while 62.4% of mothers are breastfeeding their children in the hospital, only 26% are still breastfeeding at six months and 14.5% are breastfeeding at twelve months. These figures include women who are not exclusively breastfeeding, i.e. are giving their infants supplemental formula. Id. See also Olson, supra note 6, at 270–71 n.11, 14 (noting that current rates of breastfeeding fall behind goals set by the U.S. Department of Health and Human Services in 1984 and 1990).
17. See BAUMSLAG & MICHELS, supra note 5, at 6.
breast, a student expressed her confusion and disbelief. "With obvious shock and disgust evident in her voice she asked, 'You mean women's breasts are like a cow's udder?'" This female college student did not even know that the breast is a utilitarian organ specially designed to feed and nurture human infants and children.

B. BREASTFEEDING IS A LEARNED ART

Although breastfeeding is natural, it is a technique that needs to be learned. Across many cultures, women passed on breastfeeding knowledge to each other through various social networks of family and community. Girls grew up in an environment where their female relatives and other women routinely breastfed infants and young children. Not only did this convey the attitude that breastfeeding is the acceptable and natural way to feed children, but it also functioned as environmental education in issues such as how often to feed and how to position a breastfeeding infant or child. Midwives also played a central role in breastfeeding education as well as helping to solve breastfeeding difficulties such as breast infections and/or blocked milk ducts. The declining role of midwives and women's networks, due to increasing medicalization and changing social

20. Id. at 198.
Lactation is the very core of our identity; the process evolved even before gestation and each mammal has evolved, over the millennia, a milk unique to its requirements, its behavior and its environment. It is such a spectacular survival strategy that we call ourselves, after the mammary gland, mammals... animals that suckle their young.

Id.

22. See BAUMSLAG & MICHELS, supra note 5, at xxiv.
23. See id. at ch.5.
24. See Dettwyler, supra note 19, at 197. The loss of the repository of this practical knowledge and societal support is also underscored by the history of La Leche League International (LLI). LLI was started in the 1956 by a group of mothers who formed a grassroots support group of mothers helping mothers when they found little support or information from childcare professionals. Today, La Leche League and its leaders have become one of the main sources of support and advocacy for breastfeeding worldwide. See LA LECHE LEAGUE INTERNATIONAL, THE WOMANLY ART OF BREASTFEEDING, THIRTY-FIFTH ANNIVERSARY EDITION xiii–xxxii, 391-93, 398-404, 405-09 (5th rev. ed. 1991).
25. See, e.g., LAUREL THATCHER ULRICH, A MIDWIFE'S TALE: THE LIFE OF MARTHA BALLARD, BASED ON HER Diary, 1785-1812 (1st ed. 1990) (referring to this type of help as part of Ballard's midwifery practice).
Reasons given for the decrease in breastfeeding in this century have been reviewed by sociologists. Urbanization and technological advances have affected social, medical, and dietary trends throughout the world. The social influences include the changing pattern of family life—smaller, isolated families that are separated from the previous generation. In medicine, the emphasis has been on disease and its treatment, especially as it relates to laboratory study and hospital care. The science of nutrition has developed a
and family structures, has contributed to the difficulty in passing on breastfeeding knowledge.

Today it is widely recognized that successful breastfeeding often demands expertise. It has been well documented that successful and continued breastfeeding is highly correlated with receiving breastfeeding support, particularly in the early initiation stages. Medical doctors often lack the knowledge and skills to aid breastfeeding couples and often cause more harm than good to the breastfeeding relationship. Breastfeeding is not part of the routine medical or nursing school curriculum, nor has it been routinely required of obstetrical/gynecological hospital staff. It is amazing that several generations of overt and covert attacks on breastfeeding could lead to a climate in which a natural practice as old as humanity itself, and so widely recognized as vital to its survival, is threatened with extinction. However, healthcare providers' lack of knowledge is one of the chief factors in the failure of breastfeeding attempts by new mothers.

reliance on measurement and technology, which has led to the conclusion that prepared foods are superior because they can be measured and calculated to meet precise dietary requirements.

_Id._ at 11 (footnote omitted).

27. See, _e.g._, the "Recommended Breastfeeding Practices" section of the AAP Statement, _supra_ note 1, at 1035-36.


[A] study in the Journal of the American Medical Association reports that doctors most likely to come into contact with breast-feeding mothers and babies—pediatricians, obstetricians and family physicians—don't know much about the mechanics of breast-feeding.

More than half the practicing physicians surveyed said their training was poor; a similar number of doctors-in-training said they had had only one lecture on breast-feeding in medical school. Many doctors in both groups gave incorrect answers to common questions, answers that could lead a mother to needlessly stop nursing.

_Id._ at C3.

The AAP itself cites "physician apathy and misinformation" and "disruptive hospital policies" as one of the "[o]bstacles to the initiation and continuation of breastfeeding." _AAP Statement, supra_ note 1, at 1037.

29. Breastfeeding is not in the standard curricula for residency programs, nor is it a component required by the Accreditation Council of Graduate Medical Education for obstetrics/gynecology and family medicine programs. _See_ Olson, _supra_ note 6, at 277 n.70, _citing_ Gary L. Freed et al., _National Assessment of Physicians Breast-feeding Knowledge, Attitudes, Training, and Experience_, 273 JAMA 472, 476 (1995).

30. _See_ LAWRENCE, _supra_ note 26, at vii. John H. Kennell and Marshall H. Klaus state:

There would have been little need for this book had it been written at the beginning of the century, when more than 50% of the mothers in the United states breastfed infants beyond 1 year, and a wealth of experience, cultural beliefs, and information about breastfeeding was shared by young mothers, their families, and their physicians. There has, however, been so little breastfeeding in the United States for the past 4 decades that the repository of cultural information about lactation has almost disappeared. Fortunately,
IV. CURRENT LEGAL TREATMENT OF BREASTFEEDING

Until recently, breastfeeding was not a subject discussed in the law. With the growing awareness that breastfeeding is beneficial to mother and baby, breastfeeding has raised its profile in many contexts. There are several areas of law which have responded to emerging issues surrounding breastfeeding in our culture. In this section, I will discuss how this issue has surfaced in the legal system and how the law has responded. I will focus on breastfeeding in public and the employment arena, and follow with a brief discussion of case law in other areas such as custody and incarceration. I will end this section with a discussion of attempts to encourage breastfeeding through the federal program of supplemental nutrition for women, infants and children.31

A. 'LEGALIZATION' OF BREASTFEEDING

Breastfeeding is not illegal under any federal or local legislation and has in fact been recognized by one federal court of appeals as a constitutional right.32 However, many women who have attempted to breastfeed their children in public places have been confronted and told that they are not allowed to do so. This has happened at shopping malls,33 museums34 and libraries.35 In one case a woman was confronted by a police officer while nursing her infant in her car in a parking lot.36 Any breastfeeding mother can tell you that children, especially infants, have little regard for public standards of decency or decorum, nor do they see any necessity in timing their nursing so as not to inconvenience anyone (including their mother). Beyond this, in the early stages of the nursing relationship, nursing on demand is important in establishing the milk feeding of human milk is once again returning to its proper position of preeminence, and the lack of practical information on breastfeeding available to parents-to-be and healthcare professional is being keenly felt.

Id.

32. See Dike v. Orange County Sch. Bd., 650 F.2d 783 (5th Cir. 1981) (basing its reasoning in part on the right to privacy on a par with marriage as recognized in Griswold v. Conn., 381 U.S. 479, 486 (1965)).
33. See Evelyn Nieves, Public Furor Over Nursing Baby in a Car, N.Y. TIMES, Sept. 15, 1996, at 45 (noting an incident which took place in a Florida mall).
34. See Anna Quindlen, To Feed or Not to Feed, N.Y. TIMES, May 25, 1994, at A21. The author writes of her experience breastfeeding: The closest I came to arrest was when a security guard suggested that I might want to take my modest state of undress into the ladies' room. Intimidated, I complied, despite the fact that there were more nudes on the walls of the museum I was visiting than in your average health club locker room.
36. See Nieves, supra note 33, at 45.
supply. Interference or attempts at regulating this can be harmful to the success of continued nursing. 37 The same is true of introducing bottles, especially if they contain formula rather than "expressed" 38 breast milk. While delayed feeding may be a 'considerate,' or more likely embarrassed, mother's concession to public (in)sensitivities, it may in fact result in a premature end or add difficulty to her attempts to breastfeed her child. As Elizabeth Baldwin points out:

[w]e know that breastfeeding reduces both the mother's and the baby's risk of serious illnesses. And we know that if mothers don't nurse on demand or give bottles in the early weeks, that breastfeeding can be jeopardized. Would we want even one mother or baby to have an increased risk of illness just because someone didn't want to see it? 39

The resultant public outcry to the incidences described above prompted some state legislatures to amend indecent exposure statutes so that they explicitly provided that the exposure of a breast 40 during or incidental to breastfeeding would not be considered indecent exposure, nudity or lewd behavior. 41 While the need for such statutes may be questioned, current social mores allow for interpretation of existing statutes in ways that criminalize breastfeeding in public or quasi-public places. This type of ambiguity is fed by the social climate that sees breastfeeding as shameful, deviant and indecent.

It is obvious why such attitudes, enforced by statutes interpreted (even incorrectly) by the public and law enforcement officials, 42 are obstacles for women who want to breastfeed their children. They also conflict with increasing awareness that breastfeeding is the optimal way to nurture and feed children, particularly during infancy. Furthermore, it segregates women who want to breastfeed. The message is that women with young children should stay at home with them, and if they have to venture out, it should be for a short time only and any breastfeeding that has to be done in

37. See DORA HENSCHEL & SALLY INCH, BREASTFEEDING: A GUIDE FOR MIDWIVES 60 (1996). Section 3 of "Recommended Breastfeeding Practices" outlined in the AAP Policy Statement states, "newborns should be nursed whenever they show signs of hunger, such as increased alertness or activity, mouthing, or rooting. Crying is a late indicator of hunger. . . . Appropriate initiation of breastfeeding is facilitated by continuous rooming-in." AAP Statement, supra note 1, at 1037 (emphasis in original).
38. The term "express" is used to indicate extraction of breast milk from the breast, either manually or by mechanical means such as a pump.
40. Some state legislatures specified the nipple and/or areola. See, e.g., FLA. STAT. ANN. § 847.001(5) (West 1998).
42. See, e.g., supra notes 32–34.
public places should be done in the bathroom. When the message of the benefits of breastfeeding intermingles with the lack of acceptance of breastfeeding in public, this creates the anti-woman, anti-feminist message that a good mother must breastfeed and a breastfeeding mother must stay home, i.e., a good mother must stay home.

The decision whether or not to breastfeed is one that must be based upon informed choice in a climate in which women can realistically implement their decisions. The benefits of breastfeeding and risks of bottle-feeding must be honestly and openly conveyed to women who must be recognized as intelligent adults capable of making informed choices based on relevant information rather than societal conceptions of proper public behavior. Furthermore, social mores and impediments need to be removed so women will not have to choose between erroneous concepts of modesty and their decision to breastfeed. Societal and legal concepts of what is possible are what need to change so that women do not have to make this false choice.43

Another example of legislative shortcoming is that some protective statutes specifically refer to babies or infants.44 These statutes have yet to be interpreted by the courts, but narrow language which may be construed to protect only mothers of young infants does not go far enough to combat social stigmas and ignorance. Furthermore, statutes that limit breastfeeding protection to early infancy are in direct contradiction with medical findings and the recommendations of organizations such as the American Academy of Pediatrics and the United States Department of Agriculture. These institutions recommend breastfeeding for a minimum of a year.45 Even

43. The same is true for breastfeeding in the workplace, which will be discussed infra, Section IV(B). Katherine Dettwyler posits that what needs to change is our misconceptions of women's roles as "mothers" as rendering them "unprofessional."

Rather than concluding that an advocacy of breastfeeding means a return to the days of 'a woman's place is in the home,' one can argue that an advocacy of breastfeeding means a change in a culture's valuation of child rearing as an activity, and a change in the valuation of the important contributions that only women can make to the social reproduction of a society.

Dettwyler, supra note 19, at 204 (footnote omitted).

44. See Gordon G. Waggett & Rega Richardson Waggett, Breast is Best: Legislation Supporting Breast-feeding is an Absolute Bare Necessity—A Model Approach, 6 MD. J. CONTEMP. LEGAL ISSUES 71, 109 (1994-95) (pointing to this problem in (then) proposed Texas legislation which refers to a "baby"). See, e.g., FLA. STAT. ANN. § 383.015 (West 1997) (referring to a "baby"); 720 ILL. COMP. STAT. ANN. 5/11-9 (West 1997) (referring to an "infant."). C.f. Virginia and Delaware statutes which refer to a "child." VA. CODE ANN. § 18.2-387 (Michie 1997); DEL. CODE ANN. tit. 31, § 310 (1997). Another issue that might arise in this context would be wetnursing because these statutes on their face would not protect a woman nursing another's child. Although it is hard to imagine such a distinction having practicable application, it has some import as these statutes are largely declaratory and intended to bring about social change. As such they do not go so far as to imagine the possibility of wetnursing.

45. See “Recommended Breastfeeding Practices” section 6 of the AAP Policy Statement,
these recommendations are conservative compared to the international guidelines, which recommend a minimum of two years breastfeeding.\textsuperscript{46} It is important to remember that enacted and proposed legislation do not force a woman to breastfeed for that long (or for any length of time), nor do most even explicitly encourage breastfeeding. Rather, they serve as a minimal protection. For the mother who chooses to breastfeed her child in accordance with national or international guidelines or based upon her own notions of child-rearing, surely that protection should extend to protect a mother’s choice.

In light of the above, the state statutes have mainly been intended as instruments of clarification and social change.\textsuperscript{47} Most of them are declaratory in nature, excluding breastfeeding from the definition of offenses which might be construed as including breastfeeding.\textsuperscript{48} Despite the increasing number of state laws that protect a mother’s right to breastfeed her child,\textsuperscript{49} there are some interpretative issues that have yet to be addressed and the language of the statutes signal some of the remaining prejudices.

Additionally, it is unclear how far-reaching the protective statutes actually are. To date, only the state of New York has gone so far as to declare breastfeeding a civil right.\textsuperscript{50} Another progressive approach which would give breastfeeding protection more teeth in this context is Pennsylvania’s proposed Breastfeeding Rights Act.\textsuperscript{51} The Bill would confer upon a woman “an absolute right to breastfeed in any location, public or private, where she is otherwise authorized to be.”\textsuperscript{52} Furthermore, the Bill deems that “any violation of this statute shall be unlawful

\textsuperscript{46} See Breastfeeding in the 1990s: A Global Initiative (visted Mar. 26, 1998) <http://www.gn.apc.org/libfan/innocenti.html>. These are the recommendations in numerous international documents, for example, the Innocenti Declaration On the Protection, Promotion and Support of Breastfeeding, produced and adopted by participants at the WHO/UNICEF policy makers’ meeting on Breastfeeding in the 1990s: A Global Initiative, co-sponsored by the United States Agency for International Development and the Swedish International Development Authority held at the Spedale degli Innocenti, Florence, Italy, on July 30–Aug. 1, 1990.

\textsuperscript{47} See Baldwin, supra note 39, at 2.

\textsuperscript{48} See Waggett & Waggett, supra note 44, for a broad survey of proposed and enacted legislation.

\textsuperscript{49} Such legislation has also been enacted in local government. See Elizabeth N. Baldwin & Kenneth A. Friedman, A Current Summary of Breastfeeding Legislation in the U.S. (visited Jan. 11, 1999) <http://www.lalecheleague.org/LawBills.html>. Baldwin and Friedman noted one of the more progressive city ordinances enacted in Philadelphia which “not only prohibited discriminating against breastfeeding mothers, but also prohibited segregating breastfeeding mothers.” Id.

\textsuperscript{50} See N.Y. CIV. RIGHTS LAW § 79(e) (McKinney 1998).

\textsuperscript{51} See 1997 PA. S.B. 290 (SN). The proposed legislation was introduced on January 31, 1997 and referred to Public Health and Welfare.

\textsuperscript{52} Id. at § 3 (emphasis added).
discrimination on the basis of sex. The proposed legislation also provides a breastfeeding woman who is discriminated against with remedies available under the Pennsylvania Human Relations Act. This act allows complaints to be submitted directly to the Pennsylvania Human Relations Committee which may impose monetary sanctions and recovery of damages, both actual and in the form of mental anguish and embarrassment, as well as injunctive relief and legal fees.

B. EMPLOYMENT

With a few exceptions, the issue of breastfeeding mothers in the employment context is an area largely untouched by law and left to the discretion of individual employers. It would seem that benefits associated with working mothers who breastfeed should be enough to convince employers that policies encouraging and facilitating this practice are in their own good interest. Even if economic persuasion fails, there are societal concerns that dictate that the workplace should not be left entirely to the discretion of the employer.

Perhaps the most frequently cited case in the employment context is Dike v. School Board of Orange County, Florida. This case illustrates the status of breastfeeding and some of the ironies inherent in current legal attitudes towards breastfeeding. Janice Dike was a kindergarten teacher who wanted to breastfeed her son upon returning to work after his birth. Dike sought a means to breastfeed her son "that would not disrupt the education of children attending the school or interfere with her discharge of work responsibilities." To this end, she had her husband bring the infant to her workplace during her lunch break where she nursed him behind a locked door. After three trouble-free months of this routine, the principal

53. Id. at § 5.
54. See id. at §§ 7–8. Section 8 of the proposed legislation provides for immediate injunctive relief if so required.
55. See PA. STAT. ANN. tit. 43, § 959 (West 1998).
56. See TEX. HEALTH & SAFETY CODE ANN. § 165.003 (West 1997). The state of Texas created employer incentive to accommodate breastfeeding women by allowing them to use the designation "mother-friendly" if they comply with a policy designed to encourage breastfeeding within the outline stipulated in the law. In Puerto Rico, the House of Representatives passed a bill which would grant women one hour of paid leave daily for a year post-partum in order to breastfeed or express milk. P. de la C. 127, approved by the House of Representatives June 23, 1997. Minn. Stat. § 181.939 (1998) (emphasis added).
57. Some of the most frequently cited benefits are decreased absenteeism and less worry over sick children. See, e.g., AAP Statement, supra note 1, at 1036.
58. 650 F.2d 783 (5th Cir. 1981).
59. Dike, 650 F.2d at 784.
60. Id. at 784–85.
61. See id. at 785. The court also notes that when Dike was asked to perform school
ordered Dike to stop under threat of discipline. After Dike conformed with the principal’s order her baby developed an allergy to formula, which he was given in lieu of the midday breastfeeding, and all attempts at feeding the infant expressed breastmilk resulted in “observable psychological changes” in the infant. She made a petition to the principal—offering alternatives such as breastfeeding in a camper-van in the school parking lot or going to other nearby off-campus locations during non-duty hours to feed her baby. However, the principal did not accept any of Dike’s proffered compromises, citing general school board policy that school teachers may not leave the school during the day nor may they bring their children (or have them brought) onto the premises. As a result of this inflexibility, and her baby’s refusal to take the bottle, Dike was forced to take unpaid leave for the remainder of the school year.

The district court dismissed Dike’s claims as frivolous. However, the appellate court accepted Dike’s claim that breastfeeding is entitled to constitutional protection and that it is a fundamental right resting on the privacy doctrine protected under the Ninth and Fourteenth amendments of the U.S. Constitution:

Breastfeeding is the most elemental form of parental care. It is communion between mother and child that, like marriage, is ‘intimate to the degree of being sacred’ Nourishment is necessary to maintain the child’s life, and the parent may choose to believe that breastfeeding will enhance the child’s psychological as well as physical health. In light of the spectrum of interests that the Supreme Court has held specially protected we conclude that the constitution protects from excessive state interference a woman’s decision respecting breastfeeding her child.

The classification of breastfeeding as a fundamental right requires that any state interference with this right be based upon compelling reasons. Furthermore, when such state interference significantly interferes with a fundamental right, the compelling state interest will be subject to strict scrutiny. The appellate court found that the school board had a

duties during her lunch hour she would return the baby to her husband or the baby-sitter and carry out any such duty.

62. See id.
63. Id.
64. See id.
65. See id.
66. See id.
67. See id. at 784.
69. Dike, 650 F.2d at 787 (citations omitted) (quoting from Griswold v. Connecticut, 381 U.S. 479, 486 (1965)).
70. See id.
presumably legitimate interest "in avoiding disruption of the educational process, in ensuring that teachers perform their duties without distraction, and in avoiding potential liability for accidents."\(^{72}\) The case was remanded to the trial court to make a factual determination as to whether the school board's stated reasons "or other interests are strong enough to justify the school board's regulations, and whether the regulations are sufficiently narrowly drawn."\(^{73}\) The case was returned to the trial court on remand and the judge upheld the school board regulations; however, when this decision was also appealed the school board settled with Dike and "she received back pay and she was reinstated in her job."\(^{74}\)

Even though Dike recognized breastfeeding as a fundamental right subject to strict scrutiny, the court did not actually apply this test.\(^{75}\) A careful reading shows that the Dike court itself looked to the state's legitimate interest, which is a lower threshold than required by strict scrutiny.\(^{76}\) In another case before the Fifth Circuit, the court again weighed the state's legitimate goals against a woman's fundamental right to breastfeed.\(^{77}\) In a handful of cases, other federal courts concurred with the Fifth Circuit's ruling in Dike but used different tests to weigh the competing interests at hand. In one case, a Kentucky district court required the state authority to show a compelling interest to justify interference with a woman's right to breastfeed.\(^{78}\) A D.C. circuit court also recognized the holding in Dike but distinguished it in that matter.\(^{79}\)

The lower court's decision on remand in Dike also illustrates that even when the decision to breastfeed is recognized as an essential element within the ambit of parental authority, implementation does not always conform to the lofty declarations of public officials and the higher courts.\(^{80}\) This notion has yet to 'trickle down'; and until there is a larger effort at informing the public, changing attitudes\(^{81}\) and making clear and effective

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72. Dike, 650 F.2d at 787.
73. Id.
74. DIANE MASON & DIANE INGERSOLL, BREASTFEEDING AND THE WORKING MOTHER 179 (1986).
75. See generally Dike, 650 F.2d 783.
76. See id. at 785.
77. See Southerland v. Thigpen, 784 F.2d 713 (5th Cir. 1986). In this case, a female prison inmate filed for a temporary injunction to prevent the State's interference in her breastfeeding relationship with her infant son. The court ruled that her interest in maintaining this relationship was outweighed by the legitimate goals of the state penal system, even after considering the special medical needs of her son. See id.
79. See U.S. v. Dyce, 94 F.3d 1462 (D.C. Cir. 1996) (a convicted woman's desire to breastfeed her child, though a relevant consideration, was not an "extraordinary" enough circumstance to justify a departure from sentencing guidelines).
80. See discussion of Dike, supra notes 58–76 and accompanying text (comparing declarations of the appeals court to the actions of the school board and the treatment of the case by the lower court in its original decision and on remand).
81. The case of Linda Eaton is illustrative of the social change that must go hand in hand
legislation protecting working mothers who choose to breastfeed, there will be little bite to the more general statement of principles. Isabelle Schallreuter Olson comments on the Fifth Circuit’s failure to recognize breastfeeding in a medical context: “in the Court’s opinion, a woman’s decision to breastfeed her child is purely a parenting decision unrelated to any actual health benefits for the child.” As noted above, the claim in Dike was raised exclusively under the privacy doctrine of the Ninth and Fourteenth amendments. It is possible that in light of the documentation of medical benefits that have grown significantly since 1981, such claims, if raised today, would be considered more significant.

However, it appears that even in the context of claims under the Pregnancy Discrimination Act of 1978 (PDA), where medical concerns are relevant, the courts do not sufficiently address the significant medical benefits related to breastfeeding. The PDA amended Title VII and extended protection against employment discrimination by expanding its definition: “[t]he terms ‘because of sex’ or ‘on the basis of sex’ include, but are not limited to, because of or on the basis of pregnancy, childbirth, or related medical conditions.”

In Wallace v. Pyro Mining Company, the court held that “[b]reastfeeding and weaning are natural concomitants of pregnancy and childbirth, they are not ‘medical conditions’ related thereto.” Based on a review of the legislative history, the court concluded it was: “Congress’ intent that ‘related medical conditions’ be limited to incapacitating conditions for which medical care or treatment is usual and normal. Neither breastfeeding and weaning, nor difficulties arising therefrom, constitute such conditions.” In Barrash v. Bowen, the court denied a disparate impact claim based on denial of breastfeeding leave. Here, the court also

with legal action. Linda Eaton, a firefighter, won her appeal to the Iowa Civil Rights Commission to breastfeed her son on the job. See Linda Eaton v. City of Iowa City Fire Dep’t., No. 46454, slip op. at 30 (Iowa May 13, 1981), discussed in Mason & Ingersoll, supra note 74, at 180–83. However, after her victory she was harassed and threatened to an unbearable and life-threatening extent. The court denied her suit in a subsequent harassment action, dismissing the behavior which included vandalizing her fire-fighting protection equipment as “horseplay and rough language.” Id. at 179 (pointing out that in Dike, and in Bd. of Sch. Dir. of Fox Chapel v. Rossetti, 387 A.2d 957, 957–58, 959 (Pa. Commw. Ct. 1978), rev’d 411 A.2d 486 (Pa. 1979), the issue was more starkly brought home because they were relatively rare cases where the babies were allergic to formula so there was no question as to the necessity to breastfeed—those cases where breastfeeding is ‘merely’ the mother’s choice and not a medical imperative will be even tougher).

82. Id. at 179.
83. Olson, supra note 6, at 302.
85. See Olson, supra note 6, at 302–05.
88. Id. at 869.
89. 846 F.2d 927 (4th Cir. 1988).
interpreted the PDA as applicable only to incapacitating illness. In addition to the questionable accuracy of the above courts’ factual determination, which ignored medical implications of breastfeeding, it is also unclear whether the PDA was not intended to have broader application. The wording clearly states that the PDA is not limited to the conditions set forth in the statute. Furthermore, just as pregnancy is a condition specific to women, so is breastfeeding. It would appear that recognizing breastfeeding, which only women can do, as a condition similar (and usually related) to pregnancy would be consistent with congressional intent in enacting the PDA.

In a similar vein, the Pennsylvania Supreme Court ruled that the Pennsylvania Humans Relation’s Act, a state statute analogous to Title VII in relevant part, did intend to cover breastfeeding in prohibition of unlawful sex discrimination. Cheryl Rossetti, another teacher, was denied an extension of leave to breastfeed her child who was prone to allergies, refused to take a bottle and would require feeding intravenously or through a stomach tube failing her being able to breastfeed him. The school board then fired Ms. Rossetti based upon her refusal to return to her teaching position upon termination of her maternity leave. After reviewing the Human Relations Act case law, the Commonwealth Court upheld Rossetti’s claim of sex discrimination, concluding:

None of these cases suggest that a pregnancy related disability extends beyond a woman’s own physical disability to a disability arising out of the special needs of her child. However, since the development of the law in this area has been based upon the unique position of the female confronted with the prospect of childbirth, it follows that the request for additional leave for breastfeeding purposes under the circumstances of this case is merely a logical and natural extension of that concept.

90. See id. at 931.
92. It is relevant to note that the PDA was enacted in response to what Congress saw as the courts erroneous and overly narrow interpretation of Title VII. Congress rejected the Supreme Court’s literal equal treatment approach which focuses on sameness rather than a broader approach based on equal opportunity for women which would take into account gender differences. Thus the PDA served as a remedial clarification of the intent of Title VII, declaring the necessity to account for this difference in a manner consistent with providing equal employment opportunities for men and women. See id.
96. See id. at 959.
97. Id.
The Pennsylvania Supreme Court reversed the lower court’s decision, giving the Human Relations Act a narrow interpretation focusing on similarity. The court compared whether the school board would have granted leave to a man who had to remain home to care for a disabled infant, concluding that such a man would have been treated no differently.

It is important to note that even in the Commonwealth Court’s finding of unlawful sex discrimination in Rossetti, the court put great emphasis on the woman’s decision to breastfeed as a condition related to childbirth as distinguished from a child-rearing decision. This characterization is decidedly at odds with the Dike classification of breastfeeding under the privacy doctrine. Furthermore, the Commonwealth Court emphasized the unique medical situation of Rossetti and her son which questions broader applicability even had it not been reversed.

Proposed federal legislation would apply the scope of PDA protection to include breastfeeding. The Findings section of the proposed New Mother’s Breastfeeding Promotion and Protection Act states, inter alia:

Although title VII of the Civil Rights Act of 1964 (42 U.S.C. 2000e et. eq.) was amended by the Pregnancy Discrimination Act in 1978, to prohibit discrimination on the basis of pregnancy, childbirth, or related medical condition, courts have not interpreted this amendment to include breastfeeding despite the intent of Congress to include it.

To this end, proposed section 3(1) of the proposed legislation would amend section 701(k) of the Civil Rights Act of 1964 by adding the word “breastfeeding” to the definition of “because of sex” or “based on sex.”

While it is true that only women can breastfeed, there is a fear that a policy which recognizes and accommodates difference can be dangerous ground. Accounting for difference may undermine a claim that it is only artificial barriers that stand in the way of women’s achievement in the employment context in that it forces special treatment for a special condition. While I do not make light of these concerns, it is important to

98. See Rossetti, 411 A.2d at 489.
100. See id.
102. See id. at § 2(13) (finding of fact).
103. Id.
105. Id. See also supra note 86 and accompanying text.
106. Many of the concerns which were raised in including protecting pregnancy within the employment discrimination context are relevant to breastfeeding. For a deconstruction and analysis of the problems with considering difference in general, see Martha Minow, The Supreme Court 1986 Term: Justice Engendered, 101 HARV. L. REV. 10 (1987).
recognize that breastfeeding need not interfere with a woman’s capacity to do her job.\textsuperscript{107} The Civil Rights Act does not protect people without the relevant qualifications for the jobs they seek or hold but rather seeks to combat discrimination based on specific biases, including sex.\textsuperscript{108}

In this context, we must also recognize that in protecting breastfeeding, we are not only protecting the interests of those particular women or a class of women who choose to breastfeed but also breastfed children, their fathers, taxpayers, the environment and society as a whole. If we as a society recognize the importance of a woman’s choice to breastfeed her child and the necessary support she requires, including in the workplace, then we must provide the accommodations necessary for facilitating this choice. We must bear this burden as a society and not see such an accommodation as being solely a women’s issue.

One additional problem with the PDA, even if expanded as proposed in the New Mothers Breastfeeding Act,\textsuperscript{109} is the statute’s linkage of pregnancy, childbirth and breastfeeding with a medical condition and disability. This is not the best solution to combat societal mores and misconceptions. Breastfeeding is a natural and healthy function that a woman may choose to perform, and should be characterized as such. The case law cited in this section illustrates the difficulty of classifying breastfeeding within existing doctrines that focus on one aspect of the issue while ignoring the others. Classifying breastfeeding solely as a medical disability or health issue obscures the powerful privacy claims which provide women with the right to rear their children and use their bodies as they choose.\textsuperscript{110} On the other hand, ignoring medical concerns fails to recognize our duty as a society to support and encourage breastfeeding as a viable option, even at the expense of interference in the private workplace.

The recommended duration of the breastfeeding relationship is such that it is also a more long-term prospect than what is considered either by the present disability-related construction of the PDA or by the Family Medical and Leave Act (FMLA).\textsuperscript{111} On the other hand, it is much easier for the employer to make accommodations for breastfeeding women, as

\textsuperscript{107} For example in a fact pattern like Dike, see supra text accompanying notes 59–66.
\textsuperscript{108} See, e.g., McDonald v. Santa Fe Trail Transportation Co., 427 U.S. 273 (1976). Although the discussion of historical congressional intent is focused on racial equality, it makes clear that the intention of the Civil Rights Act was not to favor any one group, but rather to remove stumbling blocks in the way of equal opportunity.
\textsuperscript{109} See discussion at supra text accompanying notes 101-03.
\textsuperscript{110} The title of Pregnancy Disability Act as well as the wording of 42 U.S.C § 2000(e)(k) speaks of pregnancy and other “related medical conditions.”
\textsuperscript{111} The Family Medical and Leave Act of 1993 (FMLA), 29 U.S.C.A. § 2601 (West 1998) applies to employers of a minimum of 50 employees. It requires them to allow employees to take up to 12 weeks vacation in order to care for a sick family member or in relation to pregnancy and as such can be used for at least the initial stages of breastfeeding. However, Olson points out that the minimum employee requirement makes the statute applicable to less than 50% of employees. See Olson, supra note 6, at 307.
most will be able to be fully employed while breastfeeding once the initial nursing relationship and milk supply is established. This is not necessarily the case with a disability or a medical condition. This is the rationale for the amendment to the FMLA in the proposed federal legislation which would require employers to provide one hour of paid leave per day to breastfeed or pump breastmilk for the duration of the woman's breastfeeding. 112 A similar accommodation is being considered under demonstration projects or feasibility studies, such as those established by Texas and Florida, as well as those voluntarily run by private employers. 113 These programs assess accommodations for women who are generally separated from their children during working hours, such as providing private rooms in which to pump, two breaks during the day (not much longer than a smoking break) and proper storage facilities (a small refrigerator). Another possibility is on-site day care where women could go to breastfeed their children throughout the workday. 114

Under proposed federal legislation, employers would also be granted tax incentives to institute regimens designed to encourage and support breastfeeding among its employees. 115 This would go a long way in making a normative statement and adding a 'carrot' to sway employers who are not persuaded by economic incentives of reduced absenteeism and healthier children to voluntarily accommodate breastfeeding employees. This would also diffuse any burden, real or perceived, incurred by such accommodation.

C. OTHER AREAS OF LAW

Breastfeeding has surfaced in the area of family law in cases concerning custody and visitation issues. 116 Breastfeeding is only one of the many factors that may be considered by the courts. There are some courts which refuse to put it into the balancing equation at all, while there are others who will give it weight but will not allow it to trump concerns of children bonding with their fathers. 117 A Colorado appeals court upheld the lower court’s consideration of the breastfeeding relationship, rejecting the...

112. See H.R. 3531, 105th Cong. § 6(a) (1998).
113. See Fla. Stat. Ann § 383.011 (West 1997). The Texas legislature makes a strong declaration: "The legislature recognizes a mother’s responsibility to both her job and her child when she returns to work and acknowledges that a woman’s choice to breast-feed benefits the family, the employer, and society." TEX. HEALTH & SAFETY CODE ANN. § 165.031 (West 1997). Another section establishes a demonstration project to assess the benefits of various employer accommodation for breastfeeding women such as provision of private rooms or breaks. TEX. HEALTH & SAFETY CODE ANN § 165.032 (West 1997).
114. This is not a component of either of the demonstration projects mentioned above, nor of the proposed federal legislation.
116. See Baldwin, supra note 39, at 5.
117. See id. For a more in depth discussion of this matter see Olson, supra note 6, at 296–97 and cases cited therein.
father’s claim of sex discrimination in awarding custody based on the mother’s breastfeeding of their child. The appeals court rejected the father’s claim as frivolous.

Some courts have expressed their disapproval of the breastfeeding relationship. In *Shunk v. Walker*, the court awarded custody to the father, noting, inter alia, that the mother was breastfeeding beyond when it should have been continued. In another case, an appellate court corrected prejudices and misconceptions about breastfeeding in the lower courts, stating that the “[c]ourt’s initial decision was predicated not on findings about the interests of the child, but rather on its apparent disdain for the mother’s educational ambitions and on her continued breast feeding the child.” The Court awarded custody to the mother, noting that the jointly-selected expert cited the mother’s occasional nursing as “evidence of substantiality of the relationship.” The expert further noted that

[w]hether one would argue that she needs to nurse (the child) or not, it’s clear that by her description and just based on some observations that I had of (the child) that this is a very comforting and reassuring activity and is probably useful to dissipate certain stressful times.

Breastfeeding has also been discussed in the custody context in social welfare cases where women’s children have been taken from them by the state and among the charges leveled against them were extended breastfeeding and/or low weight gain. However, in these cases the

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119. See id. The court also emphasized that the award was for as long as the child continued to breastfeed and subject to review. Also, in *Moran v. Moran*, 612 A.2d 1075 (Pa. Super. Ct. 1992), the appellate court remanded the case so that a hearing could be held to determine whether partial physical custody would adversely interfere with the child’s breastfeeding schedule.
122. *Id.* at 1050.
123. *Id.*
124. Katherine Dettwyler recounted a custody case in which she testified where the judge determined that breastfeeding was detrimental to the child’s health when it was found that the child was under the 50th percentile for growth! Katharine Dettwyler, A Time to Wean, Lecture at the Conference and Annual Meeting of the International Lactation Consultant’s Association: Breastfeeding, the Crosscultural Connection (Kansas City, MO, July 11-14, 1996) (on file with author) (This would mean that a full half of all children in the standard range would be under-developed, 50% is the average of all children and some are obviously more and less developed.). Often overlooked is that growth charts and many other standard measures of child development over the last several decades have been based on bottle-fed children. See LAWRENCE supra note 26, at 275; HENSCHEL & INCH, supra note 37, at 65 (noting differences in growth rates of breastfed and bottle-fed babies). The AAP statement notes that breastfed infants should be the standard of measurement: “The breastfed infant is the reference of normative model against which all alternative feeding methods must be measured with regard to growth, health, development, and all other short- and long-term outcomes.” AAP Statement, supra note 1, at 1035. See also Baldwin, supra note 39, at 3.
breastfeeding issues have only formed part of the charges and no court has found that breastfeeding is abuse or neglect, except in the case of mothers who were breastfeeding while using controlled substances.125

Another area in which breastfeeding has been discussed in a legal context are incarcerated mothers. This is one area in which the constitutional right to breastfeed, even if recognized, can be infringed upon when weighed against other concerns. In one case, a pregnant woman convicted of embezzling over three hundred and fifty dollars was sentenced to five years imprisonment.126 Her son had a high hereditary risk of allergies and diabetes,127 both of which occur in reduced incidences in breastfed children.128 Here the court agreed with the holding in Dike that breastfeeding is a fundamental right but nevertheless refused to grant delayed sentencing in order for the convicted mother to breastfeed her child.129 The court determined that many rights are infringed upon as a result of incarceration, which is often incompatible with motherhood and that incarceration “presupposes disruption of . . . personal relations.”130 Based upon the district court’s findings, the appellate court determined that such an interruption of the breastfeeding relationship did not necessarily pose a serious health threat to the woman’s son nor did she show that other sources of human milk were not available.131 However logical this may appear on its face, such a blanket determination does not make good sense. If incarceration is rehabilitative, it would seem that fostering a caring relationship through breastfeeding would be positive. If, on the other hand, the goal of incarceration is retributive, then why should the infant be punished,132 especially when the infant belongs to a higher risk health group? While the court paid lip service to these considerations, it did not hold them to be persuasive, even though the accommodation requested was not to forego the prison sentence but to delay it.133

In another case, a prison refused to provide refrigerator or freezer space for prisoners to store their breastmilk so that it could be fed to their infants by another and prohibited breastfeeding during normal visitation, even though inmates were allowed to bottle-feed their infants during such

125. See Baldwin, supra note 39, at 2-3, 7 (referring to cases in which women were convicted of child endangerment, and in one case, second degree murder for use of amphetamines while breastfeeding, even though there was no evidence that the babies’ deaths were caused by the mothers’ drug use).
126. See Southerland v. Thigpen, 784 F.2d 713, 714 (5th Cir. 1986).
127. See id. at 713–14.
129. See Southerland, 784 F.2d at 716–18.
130. Id. at 717.
131. See id. at 718.
132. Not only are the mother and infant effectively punished, but so is society in the form of increased medical expenses and other less costs which may be quantitative.
133. See Southerland, 784 F. 2d at 717.
times.\textsuperscript{134} The court upheld the prisoner’s appeal in part, holding that the prison had no compelling interest in refusing to allow Berrios-Berrios to breastfeed during normal visitation hours.\textsuperscript{135} However, the court denied Berrios-Berrios’ request that the prison be ordered to accommodate her in providing her son with expressed milk.\textsuperscript{136} The court determined that the fundamental right to breastfeed was outweighed by the prison’s compelling security concerns and logistic difficulties.\textsuperscript{137} One other important issue which was raised in \textit{Berrios-Berrios} was the court’s allowance of the plaintiff’s claim even though she had not exhausted all remedies through the prison appeals system—which would have taken at least 60 days.\textsuperscript{138} The court recognized the importance of immediate resolution of the matter in light of the threat to Berrios-Berrios’ ability to breastfeed, should she have been forced to exhaust all other remedies.\textsuperscript{139}

States have also grappled with jury duty requirements for breastfeeding mothers. Most states have no explicit recognition of release from jury duty on such a ground.\textsuperscript{140} However, there are several states which currently have legislation in place which can serve as a protection for the breastfeeding mother. Iowa exempts “stay-at-home” breastfeeding mothers.\textsuperscript{141} Idaho legislation specifically exempts breastfeeding mothers from jury duty so long as she continues to nurse her child: “The court shall provide that a mother nursing her child shall have service postponed until she is no longer nursing the child.”\textsuperscript{142} In most other cases, an exemption of a breastfeeding mother is determined by other exemption criteria and largely left up to the discretion of the court. The enacted legislation is a step in recognizing that breastfeeding women need accommodations.

It is important to distinguish breastfeeding jury duty exemptions from earlier, more general, exemptions for women.\textsuperscript{143} Breastingfeeding would not

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\item[135.] \textit{See id.} at 990 (reasoning: “It would appear that prison officials would be more concerned with the minimal security risks posed by allowing a prisoner to handle bottle-feeding paraphernalia than the nonexistent security risk posed by allowing a prisoner to merely handle her child and her own breasts.”).
\item[136.] \textit{See id.} Berrios-Berrios requested that the prison provide her with refrigerator storage for milk that she had expressed. She further requested that the prison give the stored milk to a friend who was willing and able to come to the prison each day to retrieve the milk and feed it to Berrios-Berrios’ son.
\item[137.] \textit{See id.} at 990 (referring to the fact that the prison held 1300 inmates, approximately 50 of whom are pregnant at any one time).
\item[138.] \textit{See id.} at 989. This estimate was conceded by the defendant.
\item[139.] \textit{See id.}
\item[140.] \textit{See} Baldwin \textit{supra} note 39, at 2.
\item[141.] Iowa exempts breastfeeding women who meet the dual requirements that they are not regularly employed outside the home and they are responsible for the daily care of their child. \textsc{iowa code, ann.} § 607A.5 (West 1997).
\item[142.] \textsc{Idaho code} § 2-209 (West 1997).
\item[143.] Some states entirely exempted women, only calling women for jury duty if they had taken the proactive step of signing an exemption waiver. This exemption, purportedly for the paternalistic protection of women and their “special duties,” effectively acted as a
constitute a blanket exemption status for all women or all mothers but rather may be invoked by the breastfeeding mother should she so choose. However, the legislation does not address the breastfeeding woman who wants to serve as a juror but would require on-site accommodation such as child-care or an appropriate place to express and store her milk. If we want to allow breastfeeding women (and the same applies to mothers of young children) to take part in the American democratic process, which includes jury duty, then such accommodations are necessary.

D. LEGISLATIVE PROMOTION OF BREASTFEEDING

In 1972, Congress launched a pilot project to serve the basic nutritional needs of low income women who qualified as being “at nutritional risk.” The pilot project, which became permanent in 1975, was entitled the Special Supplemental Nutrition Program for Women, Infants and Children (WIC) and was administered by the United States Department of Agriculture Food and Consumer Service (USDAlFCS). WIC allocates federal funds to be distributed to the states that would be responsible for implementation on the state and local levels. Those eligible for supplemental nutrition are children under the age of five, pregnant women, postpartum mothers who breastfeed their infants up to the age of one year and non-breastfeeding mothers up to six month postpartum who meet specific federal income and “nutritional risk” guidelines.

By way of providing vouchers for breastmilk substitutes to mothers for their young children, the United States has become the single largest consumer of breastmilk substitutes in the world. In 1996 alone, the United States spent 620 million dollars on infant formula in 1996 for distribution in the WIC framework. Statistics compiled in 1996 show that: “[a]bout 98 percent of all eligible infants receive WIC benefits. Of all the eligible women, infants, and children, the program serves about 60 percent. Of all infants born in the United States, about 45 percent receive WIC benefits.”

With the growing awareness and recognition of breastfeeding as the optimal way to nurture and feed infants, WIC also became involved in the promotion and encouragement of breastfeeding among WIC-eligible women. It has done so through requiring states to allocate some portion of


145. Id.
146. See id.
147. See id.
148. Id.
149. See WIC Fact Sheet, provided by Alice Lockett, Program Analyst at the USDA/FCS WIC Program (on file with author) (hereinafter WIC Fact Sheet).
150. Id.
their WIC funds\textsuperscript{151} to breastfeeding promotion and support, and by requiring state agencies to designate a breastfeeding coordinator.\textsuperscript{152}

WIC's promotion and encouragement of breastfeeding has been an important first step. However, there are several problems with the program, and its administration, that should be addressed. First, the supervisory and compliance mechanisms employed by the federal sponsors are very minimal, relying mainly upon self-reporting by the states receiving federal WIC funds.\textsuperscript{153} This, combined with a broad range of discretion given to the state WIC agencies in implementing the program, results in a very uneven level of breastfeeding promotion and support.\textsuperscript{154} For example, part of the WIC program for 1998 includes a media campaign in support of breastfeeding, using materials prepared and developed by the USDA that states can purchase. However, states are not actually required to use the materials or funds allocated for breastfeeding promotion towards such a campaign and not all states are using them.\textsuperscript{155} One twenty-year old WIC mother related her experience:

\[\text{upon arriving at my first appointment, I found that I was the only one out of 10 young mothers to be breastfeeding. At the time my son was three months old and we were having a class on what types of things they should be doing (eating cereal, drinking juice, etc.). My son did none of these, and still does not eat much solid food. . . .}\]

\textsuperscript{151} To understand how small this figure is in comparison to WIC spending, compare an allotted $8 million for breastfeeding in 1989 against 1990 fiscal year cost of $2.1 billion. \textit{Id.} Today, WIC offices must allot $23 per pregnant woman to breastfeeding spending. Under federal law the amount was set up as $21 and is adjusted annually for inflation. \textit{See} 42 U.S.C. § 1786(h)(3)(e) (1998). The current figure was provided by Alice Lockett. \textit{See} Telephone Interview with Alice Lockett, Program Analyst, USDA/FCS WIC Program (Mar. 30, 1998).

\textsuperscript{152} \textit{See} 42 U.S.C. § 1786(h)(3)(e) (1998). This coordinator does not have to be a certified lactation consultant nor does she need to have any demonstrated knowledge or expertise in breastfeeding issues whatsoever. This is clear from the legislation, which does not specify requirements and was confirmed by Mary Beth Haas, a certified lactation consultant and Professor at the Lasalle Nursing School. She was the first breastfeeding coordinator for WIC in Philadelphia and started the breastfeeding promotion program there. \textit{See} Telephone Interview with Mary Beth Haas (Apr. 9, 1998).


\textsuperscript{154} \textit{See} Interview with Mary Beth Haas, \textit{supra} note 152.

\textsuperscript{155} \textit{See} Interview with Alice Lockett, \textit{supra} note 151. Many of the WIC programs have developed their own materials. This is the case in Philadelphia. In this context, it is also important to note that not all materials are appropriate to all targeted audiences. For example, the materials developed for Philadelphia were found by some other Pennsylvania WIC offices to be too explicit in wording or images. \textit{See} Interview with Mary Beth Haas, \textit{supra} note 152. This phenomenon also draws attention to some of the social issues raised earlier in the paper and the difficulty of promoting and aiding women in breastfeeding when the breast cannot be shown or mentioned, further underscoring the need for coordinated efforts that go beyond legal action.
[I] then received my coupons for the month only to find ones for cereal and juice! At three months old! No wonder these young mothers aren’t breastfeeding. I began to think that if WIC were promoting what is nutritionally best for babies, then why are all these other babies drinking formula and eating solid food already? After talking to a friend, I found out why—WIC gives away free formula!

Upon leaving my appointment, I was almost in tears and while the other moms were socializing while feeding their babies from a bottle, I noticed a sign that read, “Breastfeeding rooms available upon request.” I couldn’t believe it! I had to ask for a room to nurse my baby in while they sat having a good time! Instead, I went out to my car and sat in the back seat and nursed mine in the middle of the winter. . . .

What is obvious from this one woman’s experience is that not all WIC offices fully support breastfeeding. Even in those offices where support for breastfeeding is very high, the fact that WIC distributes free formula and supplements can be a barrier to breastfeeding. For example, the highly-praised Philadelphia WIC program is the only one in the country that has a Breastfeeding Department. It is comprised of 22 employees and run by a board-certified lactation consultant. They offer a broad range of services to assist breastfeeding mothers, and provide outreach to communities and medical personnel. Despite this, one peer counselor, Poncilla Cousins, in the Philadelphia WIC jurisdiction noted that many mothers cited the offering of free formula as a reason not to breastfeed. In 1996, “WIC state agencies spent $620 million on infant formula, after rebate savings totaling $1.18 billion.” It is difficult to combat the mixed message that WIC patrons receive, especially when WIC also meets the needs of women who choose not to breastfeed. More advertising, promotion, educational programs and videos, particularly directed to WIC participants, would go far in conveying unambiguous encouragement of breastfeeding.

156. Letter from Reader, COUPLE TO COUPLE LEAGUE FAMILY FOUNDATIONS, November-December 1997, at 18 (on file with author).
157. See Telephone Interview with Suzi Garrett, Director of the Philadelphia WIC Program (April 17, 1998). Many of the services are provided to mothers regardless of whether they are WIC beneficiaries.
158. See Videotape: Breastfeeding Peer Counselors Share Their Thoughts (Thomas Jefferson University Video, Joan U. Bretschneider prod.) (on file with author) [hereinafter Thomas Jefferson Video]. All the peer counselors interviewed gave birth in and later worked at the Jefferson University Hospital peer counseling program.
159. WIC Fact Sheet, supra note 149, at § 8.
160. See Thomas Jefferson Video, supra note 158 (Erta Wilkins suggested that instead of the soap operas, which are sometimes shown in WIC waiting rooms, educational videos might be helpful in promoting breastfeeding among WIC participants.).
support during mothers' hospital stay and family or community-oriented programs designed to create a supportive network for women who choose to breastfeed would also be beneficial. All of this would increase resources dedicated to breastfeeding support and promotion.\textsuperscript{161}

A critical review of the WIC literature also reveals that its target groups are family and community—no mention is made of employers. Campaign promotion materials for WIC's media effort planned for 1997, entitled "Loving Support," also fails to address breastfeeding in the employment context.\textsuperscript{162} This failure to explicitly address employers is even more inexplicable in light of the USDA's own program to encourage employee breastfeeding\textsuperscript{163} which would seem to be a recognition of the importance of such cooperation. The WIC program, including its breastfeeding component, operates in a vacuum. There is no interdepartmental cooperation on the federal level, nor is cooperation between state agencies required on the state level.\textsuperscript{164} This is particularly questionable in light of new Welfare to Work policies which most likely affect many eligible WIC recipients.\textsuperscript{166} WIC is working to promote

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161. The proposed federal legislation would provide increasing funding to WIC for this purpose. See H.R. 3531, 105th Cong. § 6(a) (1998).
162. See USDA, RELEASE NO. 0229.97, GICKMAN PROCLAIMS WIC NATIONAL BREASTFEEDING WEEK (1997).
163. WIC has always actively promoted breastfeeding, but we realized that we needed a national campaign to make everyone aware—mothers, fathers, families, and health care providers—that breastfeeding can bring great benefits to both the mother and the baby.\textit{Id., quoting} Mary Ann Keeffe (acting Under Secretary for Food, Nutrition, and Consumer Services).
164. In Secretary of Agriculture of the United States of America Dan Glickman's proclamation declaring WIC National Breastfeeding Week he calls upon public and private health professionals to celebrate with appropriate ceremonies and activities that acknowledge efforts of breastfeeding mothers, fathers, their families, and the health and medical professionals, peer counselors and others who provide support, encouragement and help so mothers succeed with breastfeeding.
165. See Interview with Alice Lockett, \textit{ supra} note 151.
166. See \textit{The Personal Responsibility and Work Opportunity Reconciliation Act of 1996, Pub. L. No. 104-193, 110 STAT. 2105} (requiring states to develop programs intended to force welfare recipients into the workforce, often without adequate provisions for or attention to childcare needs). For a good discussion of the childcare issues this creates see
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breastfeeding especially among low-income women, many of who may be unemployed.\textsuperscript{167} If welfare beneficiaries will be encouraged or compelled to go to work under recent welfare reforms, then a concerted effort to make breastfeeding truly feasible in the workplace is needed. It is particularly important to take this into account in the overall implementation of welfare and employment policies since lack of cooperation can effectively thwart a well-meaning but non-comprehensive policy. Failure to address this issue gives women a mixed message—it is an inherently inconsistent ‘no-win’ policy, undermining women’s determination to breastfeed as well as their self-esteem.

Furthermore, while WIC covers children up to five years of age, it does not confer benefits to lactating mothers beyond one year, even though their breastfed children are eligible for benefits. This policy is contradictory, especially in light of the health benefits of continued nursing which might offset some of the problems associated with children at nutritional risk—the WIC target group. This is also contradictory to international guidelines which recommend breastfeeding for a minimum of two years.

In its promotion of breastfeeding WIC may also have a conflict of interest arising from its relationship with the manufacturers of breast-milk substitutes. As the single largest purchaser of such substitutes, WIC is engaged in an ongoing relationship with these companies in order to receive subsidized formula and rebates.\textsuperscript{168} From the “Loving Support” literature, it also appears that the USDA relies on information generated by formula manufacturers. For example, Ross Laboratories, one of the largest international manufacturers of breast-milk substitutes, provided statistics cited in WIC promotion materials.\textsuperscript{169} While there is no specific cause to believe that the information is biased or incorrect, formula companies have

ref: Clare Huntington, \textit{Welfare Reform and Child Care: A Proposal for State Legislation}, 6 \textit{CORNELL J.L. \\& PUB. POL'y} 95 (1996). The poverty criteria established for WIC eligibility makes it likely that mothers who are being encouraged to breastfeed under the WIC program will also be required to return to work. \textit{See} 7 C.F.R. \S 246.2 (1998).

\textsuperscript{167.} One of the criteria for WIC eligibility is that applicants must have met standards of inadequate income. The poverty income criteria are set by the Department of Human Services. In 1997, to be eligible on the basis of income, the applicant’s income had to fall below a percentage of the United States Poverty Income Guidelines. \textit{See} 7 C.F.R. \S 246.2; WIC fact sheet, \textit{supra} note 149.

\textsuperscript{168.} See figures for the purchase of breast-milk substitutes and rebates, \textit{supra} note 159 and accompanying text.

\textsuperscript{169.} \textit{See supra} note 163 (statistics compiled by Ross Laboratories are cited.). Ross Laboratories are the manufacturers of breastmilk substitutes Similac and Isomil. In fairness, these statistics are widely used, even by breastfeeding advocates such as La Leche League International. I myself referred to them because they are the most comprehensive statistics available. \textit{See supra} note 16.

been known to exert influence in insidious ways. It would therefore seem more appropriate that FDCS and WIC remain independent of any possible influence, particularly when it is not overt or direct and hence, not open to debate.

There are other difficulties in promoting breastfeeding among low-income women. Breastfeeding can only be performed by a woman (usually the child’s mother), therefore many women view it as just one more chore that someone is telling them that they must perform. The promotion of breastfeeding can therefore be met with great resistance, especially when the mother is a single parent or is solely or chiefly responsible for other health and welfare concerns of her children. Furthermore, there can be mistrust and lack of understanding between healthcare workers and mothers who are of different ethnic, economic or social backgrounds. Women may then view the message that ‘breast is best’ with suspicion, especially if that message is conveyed without proper regard to the ethnic and cultural context of the recipient. This is especially true where the surrounding culture views bottle feeding as preferable, a view which is often strongly enforced in cultures where community mores play a strong role.

Research has also shown that different ethnic or socioeconomic groups will respond differently to breastfeeding and that different methods and approaches must be tailored to meet the various needs and concerns involved.

V. INTERNATIONAL CODES AND GUIDELINES

The international community has recognized the health, economic

171. See Interview with Nancy Elfant, Maternity Care Coalition in Philadelphia, Pa. (Feb. 20, 1998) (on file with author). Maternity Care Coalition (MCC) is a non-profit organization that provides nutrition to low-income pregnant and lactating women and their children. MCC also works to encourage breastfeeding among its patrons and has encountered this reaction. Because MCC provides a parallel service largely to WIC eligible mothers and children, I believe that many of the reactions and concerns encountered by MCC shed light on some of the difficulties with the WIC program.
172. For a good review of some of the factors effecting different attitudes toward breastfeeding in different cultural, ethnic and socioeconomic contexts see Bretschneider, supra note 169. Bretschneider notes that studies indicate that low-income black women rely on their social system in making decisions on feeding their children. See id. at 26.
173. I am grateful to Nancy Elfant for this insight. See Interview with Nancy Elfant, supra note 171.
174. See Bretschneider, supra note 169. In Bretschneider’s work with Chinese immigrants, she noted that immigrant status and identification of bottle-feeding as part of American culture can also be a deterrence to breastfeeding, even when it was accepted in the country of origin. See id.
175. Countries as well as non-governmental organizations, particularly the United Nations International Children’s Education Fund (UNICEF) and the World Health Organization (WHO), are concerned with breastfeeding. In this Article, I refer to these together as “the international community.” In discussing specific documents or debates, I specify the
and environmental benefits of breastfeeding and has actively promoted breastfeeding in the international arena for over twenty years. A body of international conventions, some of which are outlined below, promote breastfeeding by promulgating guidelines for hospitals, protecting breastfeeding mothers and regulating the marketing of breast-milk substitutes. However, these conventions are not binding on member countries and most have failed to enact internal legislation necessary to incorporate them into local law.

Many of the health benefits appurtenant to breastfeeding are not confined to developing countries nor are they correlated with poverty and maternal malnutrition. This Article contends that the United States has been slow to recognize breastfeeding as an important part of maternal and infant health and as a woman’s fundamental choice worthy of support. In 1997, the United States had one of the lowest breastfeeding rates and one of the highest infant mortality rates. Even though breastfeeding as a viable choice has been recognized, rarely has the judiciary or the legislature backed such recognition with the warranted interpretation, regulation and support. Any minimal steps have been aimed toward breastfeeding infants and virtually nothing has been done to encourage long-term breastfeeding.

A. BREASTFEEDING AS A PRIORITY

In response to the declining rates of breastfeeding and the accompanying health ramifications, some of which may be particularly harmful in developing nations, the international community has recognized and promoted the importance of breastfeeding. The World Health organization has adopted a number of resolutions which declare breastfeeding as the optimal, and exclusive, source of infant nutrition throughout the first six months of life. Breastfeeding is to be combined with appropriate complementary foods for a minimum of two years.

Breastfeeding has been recognized as a critical component of various relevant constituents of this group.

176. See BAUMSLAG & MICHELS, supra note 5, at xxix.
177. See id. at 164–65.
178. See AMERICAN ACADEMY OF PEDIATRICS, POLICY STATEMENT § 100(6), at 1035 (Dec. 1997) (specifically noting health benefits recognized in studies conducted in developed countries); see also supra note 1 and accompanying text.
180. Most states do not have legislation protecting the rights of mothers to breastfeed, nor have legislative or judicial accommodations been made in the employment context. See supra, section IV. The United States has also declined to implement the Baby Friendly Hospital Initiative and has failed to implement any or all of the provisions of the International Code for the Marketing of Breast Milk Substitutes. See infra section V(B) and (C).
182. See supra section IV.A.
social and economic platforms. Article 24(e) of The Convention on the Rights of the Child adopted by the United Nations General Assembly in 1989 confirms that the member governments will take steps ["t]o ensure that all segments of society, in particular parents and children, are informed, have access to education and are supported in the use of basic knowledge of child health and nutrition, the advantages of breastfeeding, hygiene and environmental sanitation and the prevention of accidents." This declaration, ratified by all but two nations of the world, the United States and Somalia, recognized the fact that access to breastfeeding information and support is an integral part of ensuring children’s health and welfare.

In addition, breastfeeding has been recognized as a necessary component to women’s rights and empowerment. In the Report of the Fourth World Conference on Women, which emerged from the Conference in Beijing, breastfeeding was mentioned in several contexts. Article 107 of the document called for action

[B]y governments, in collaboration with non-governmental organizations and employers’ and workers’ organizations and with the support of international institutions

[to p]romote public information on the benefits of breast-feeding; examine ways and means of implementing fully the WHO/UNICEF International Code of Marketing of Breast-Milk Substitutes, and enable mothers to breast-feed their infants by providing legal, economic, practical and emotional support.

The Conference further recognized that the interference with a working woman’s right to breastfeed was discrimination and recognized the necessity to combat this formidable obstacle in order to provide women with a true choice to breastfeed. Article 165(c) of the document called for governments to

[e]liminate discriminatory practices by employers and take appropriate measures in consideration of women’s reproductive role and functions, such as denial of employment and dismissal due to pregnancy or breast-feeding, or requiring proof of contraceptive

184. id.
185. See id.
187. id.
188. See id. § 167(e)
use, and take effective measures to ensure that pregnant women, women on maternity leave or women reentering the labor market after childbearing are not discriminated against.189

Article 181 (c) also calls for the “facilitation of breast-feeding for the working mother.”190

Breastfeeding promotion has also been seen as a weapon in the fight against world hunger. The Rome Declaration on World Food Security and World Summit Plan of Action [hereinafter “The Plan”] adopted objectives to eliminate world hunger.191 Objective 1.4 in article 17 of the declaration concerns the provision of “equal opportunity for all, at all levels, in social, economic and political life, particularly in respect of vulnerable and disadvantaged groups and persons.”192 One of the ways in which the Plan proposes to achieve the goal stated above is through legislation to provide opportunities for youth and the enhancement of the special contribution that women can make to ensure family and child nutrition with due emphasis on the importance of breastfeeding.193

What is most striking about the international community's focus is the integrated nature of its approach. Breastfeeding is not an isolated issue of infant nutrition or a purely medical issue. Rather, the international community recognizes the importance of breastfeeding in a social, economic and gender context. This integrated approach calls for taking action on different fronts.

This is very different from the United States approach. In Dike,194 for example, even though the importance of breastfeeding per se was recognized, this was ineffective without the legislative and judicial backing which would give teeth to declared sentiment. In contrast to the United States’ approach, the Fourth World Conference on Women specifically categorized discrimination of a breastfeeding mother as sex discrimination, something which the state and federal judiciary of the United States has not yet done.195

B. THE BABY FRIENDLY HOSPITAL INITIATIVE

It is not only in approach and outlook that the United States differs from the holistic international approach to breastfeeding. The United

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189. Id.
190. Id.
192. Id. at § 17(c).
193. See id.
195. With the exception of the trial court in Rossetti, which was overturned, only the proposed federal and Pennsylvania legislation would do this, the former in the employment category and the latter in the context of public breastfeeding. See H.R. 3531 § 3(1) (1998); 1997 Pa. S.B. 290 (SN).
States has failed to discuss the ramifications of the marketing of breast-
milk substitutes.

There are two leading international instruments which focus on the
marketing and the encouragement of what is commonly referred to as
infant formula. The Baby Friendly Hospital Initiative (BFHI) specifically
addresses the promotion of infant formulas in health care facilities to new
mothers. Based upon a 1989 document published by WHO in Geneva in
1989 entitled "Ten Steps to Successful Breastfeeding,"\(^{196}\) BFHI is a joint
effort of the World Health Organization and UNICEF. These ten steps
were considered essential for the successful promotion of breastfeeding in
hospitals and for the removal of institutional barriers to breastfeeding
within the maternity care setting.\(^{197}\)

BFHI was implemented as an incentive program for hospitals aspiring
to receive the designation of a Baby-Friendly institution. In many
countries, this title is conferred by a government supervisory panel, which
ascertains whether the hospital has complied and continues to comply with
all ten steps. Governmental cooperation in this process is crucial because it
provides an impetus for seeking endorsements and places its stamp of
approval on the international requirements.

The United States Department of Agriculture (USDA) investigated the
feasibility of implementing the BFHI. An Expert Work Group (EWG)
which met three times throughout 1993 rejected the original ten steps but
adopted a modified version. The EWG entitled the plan, the Breastfeeding
Health Initiative, and gave it the acronym “BfHI.”\(^{198}\) Subsequently, the

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\(^{196}\) The full text of the global Ten Steps is as follows:

1. Have a written breastfeeding policy that is routinely communicated to all
   healthcare 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 a half-hour of birth.
5. Show mothers how to breastfeed, and how to maintain lactation even if
   they should be separated from their infants.
6. Give newborn infants no food or drink other than breastmilk, unless
   medically indicated.
7. Practice rooming-in: allow mothers and infants to remain together 24
   hours a day.
8. Encourage breastfeeding on demand.
9. Give no artificial teats or pacifier (also called dummies or soothers) to
   breastfeeding infants.
10. Foster the establishment of breastfeeding support groups and refer
    mothers to them on discharge from the hospital or clinic.

Protecting, Promoting and Supporting Breastfeeding, the Special Role of Maternity
Services, A Joint WHO/UNICEF Statement, 1989, (visited October 23,

\(^{197}\) See Heiser, supra note 170, at 2.

\(^{198}\) The use of such a closely related name and acronym has been criticized by one of the
Expert World Group (EWG) members, Barbara Heiser. See Heiser, supra note 170. A
U.S. Committee for UNICEF and Wellstart International decided that the program would best be pursued by an independent organization. The implementation and supervision of the BFHI has been taken up by a non-profit organization named Baby-Friendly USA. 199

C. MARKETING OF BREASTMILK SUBSTITUTES

UNICEF and the World Health Organization have also joined forces to produce guidelines for the marketing of infant formula and other breast milk substitutes and supplements. 200 Some of the documented maladies associated by the promotion of breast-milk substitutes are: illnesses due to unsafe hygiene when sanitary conditions and water supplies do not permit safe mixing and feeding of the formulas to infants; malnutrition caused by formula dilution in order to “stretch it” which prevents infants from receiving sufficient nutrients; increased diarrhea illness which often proves fatal when combined with lack of medical care. 201 In addition, mothers who are given free formula samples immediately postpartum lose their breast-milk supply which can only be established and maintained by nursing. Many mothers who subsequently cannot afford to buy breast-milk substitutes have no means by which to feed their children. The discovery of these practices led advocacy groups to take active measures, the most famous of which was the Nestle boycott. 202

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202. For a full discussion on the marketing of infant formula substitutes in the United States and throughout the world, see BAUMSLAG & MICHELS, supra note 5, at 147–88. See also Nancy E. Zelman, The Nestle Infant Formula Controversy: Restricting the Marketing Practice of Multinational Corporations in the Third World, 3 TRANSNAT'L L. 697 (1990).
As a result of the direct and indirect implications of breast-milk substitute marketing strategies leading to death, sickness, and severe malnutrition of infants in developing countries, the World Health Assembly (WHA) adopted The International Code of Marketing of Breastmilk Substitutes. For many years, the United States remained the only member of the WHA out of 122 states which rejected the Code—it was not until 1994 that President Clinton finally endorsed it. The Code contains guidelines for marketing products which, inter alia, require warning labels, prohibits the use of infant pictures and the distribution of samples to pregnant or lactating mothers, and disallows gifts to hospital and other health care personnel.

The international community has not rejected breastmilk substitutes entirely and in fact has recognized the important role that they can have: considering that when mothers do not breastfeed, or only do so partially, there is a legitimate market for infant formula and for suitable ingredients from which to prepare it; that all these products should accordingly be made accessible to those who need them through commercial or noncommercial distribution systems; and that they should not be marketed or distributed in ways that may interfere with the protection and promotion of breastfeeding.

In fact, manufacturers and distributors of breastmilk substitutes were involved in negotiating the Code and agreed to conform to its principles. Nevertheless, there have been many alleged violations of the Code on their part, some of which have been recently documented by a study commissioned by the Interagency Group on Breastfeeding Monitoring conducted in Bangladesh, Poland, South Africa and Thailand.

The World Health Organization has clarified and reconfirmed the Code every two years since 1982. Levels of compliance with the Code are in


205. See BAUMSLAG & MICHEL, supra note 5, at 169.

206. See id.

207. LOVING SUPPORT, supra note 163, at 1.

208. See id. at 2.

209. A detailed summary and findings of the study is published in CRACKING THE CODE, supra note 201.

210. The International Code of Marketing of Breastmilk Substitutes, otherwise known as the Code, has been clarified and revised every two years since 1982 by the WHA. See
four categories. Sixteen countries are classified in category one for enacting legislation or other legally enforceable measures implementing all aspects of the Code.\footnote{\textsuperscript{211}} Only nine countries have been classified as category four. These countries have taken no action whatsoever to implement the Code. The United States is one of the nine.\footnote{\textsuperscript{212}}

VI. CONCLUDING ANALYSIS

The declining rates of breastfeeding in the United States and in the world are alarming. This phenomenon has been documented as a contributing factor in poor infant, adult and maternal health in all social and economic strata.\footnote{\textsuperscript{213}} However, characterization of this issue solely as a health imperative also misses a fundamental point. Breastfeeding is not merely a nutritional or health decision, but is also a fundamental element of how a woman chooses to raise her child. Lack of support and encouragement by governmental agencies has led to a hostile climate which impedes a woman’s decision to breastfeed her children.

I believe that nurturing a child from a woman’s own body is an empowering experience. It allows a woman to reclaim her body and take control of how she chooses to use/and or relate to her own reproductive and physical capacities. However, I am also aware of the dilemma that promoting breastfeeding presents for feminists who hesitate to add breastfeeding to a woman’s ‘must do’ list. It may be contended that enacting legislation to support and promote breastfeeding will only serve to further limit women’s choices and will be used as a weapon to curtail women’s freedom, limiting employment and other opportunities. In examining the context for the decline in breastfeeding, it becomes clear that it is not so much the result of choice, but has been shaped by misguided social forces and inaccurate and incomplete information. Women need to make the decision whether or not to breastfeed based upon accurate and complete information. Furthermore, they must be supported by the community, by employers, by law and by family in their decision. This can only be achieved through concerted educational efforts and the curbing of unfettered manufacturing and distribution practices which mislead and misinform; together with legislation ensuring protection of a woman’s right to breastfeed wherever and whenever she happens to be with her infant or child.

The international instruments discussed above have achieved a balance

\textsuperscript{211} See Barrington-Ward, supra note 203, at 70.
\textsuperscript{212} See id. at 71.
\textsuperscript{213} See supra text accompanying note 1, in which it is pointed out that the benefits due to breastfeeding in reduced incidences of diseases accrue to developed as well as developing nations.
which recognizes women’s choice but also recognizes the need for
government intervention to insure true choice through the provision of
accurate information and fair marketing practices. The United States
should take its cue from these instruments and take greater steps in
securing their implementation and the complementary social and
educational action required for full acceptance of breastfeeding. The
international community has also recognized that mere encouragement of
breastfeeding is not enough and that an integrated approach is required.
Without proper employee accommodations, for example, breastfeeding
encouragement remains an empty promise. The United States must
integrate its programs and take a more holistic approach to breastfeeding in
its various contexts in order to insure that women who choose this option
will have the full range of support for their choice.

214. See, e.g., The International Code for the Marketing of Breastmilk Substitutes, supra
note 200.

215. This can be demonstrated by the range of fronts and contexts in which breastfeeding
is addressed. See supra note 196 (maternal healthcare facilities by the Ten Steps); supra
note 200 (in the commercial arena by the International Code for the Marketing of
Breastmilk Substitutes); supra note 186 (in the employment and healthcare arenas by the
Fourth World Conference Platform for Action). See also Innocenti Declaration (visited on

Efforts should be made to increase women’s confidence in their ability to
breastfeed. Such empowerment involves the removal of constraints and
influences that manipulate perceptions and behaviour towards breastfeeding,
often by subtle and indirect means. This requires sensitivity, continued
vigilance, and a responsive and comprehensive communications strategy
involving all media and addressed to all levels of society. Furthermore,
obstacles to breastfeeding within the health system, the workplace and the
community must be eliminated.

Id.