State Breastfeeding Worksite Statutes.... Breastfeeding Rates...and.....

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Abstract

Background: State worksite breastfeeding statutes are thought to play a role in increasing rates of breastfeeding duration, which remain below Healthy People 2010 goals. As of 2010 24 states including the District of Columbia had such worksite statutes. Of these only 18 required both break time and a site. This preliminary analysis assessed if infants born in states with worksite breastfeeding statutes had longer breastfeeding duration.

Methods: Using the 2009 National Immunization Survey we analyzed infants comparing breastfeeding duration at 6 months with type of worksite breastfeeding statute in place, while adjusting for year enacted and other state characteristics (years since founding of state breastfeeding coalition, breastfeeding supportive hospital practices). Other covariates included maternal and infant characteristics. Only those infants whose mothers were at least 18 years old and who had not changed state of residence since birth were included ($n=16,145$).

Results: Although requiring a site and/or break time for breastfeeding increased the likelihood of breastfeeding at 6 months (odds ratio, 1.20; 95% confidence interval, 1.07–1.35; $p=0.002$), after accounting for other factors this relationship remained positive but was not significant (adjusted odd ratio, 1.07; 95% confidence interval, 0.92–1.24). Because all mothers, not just those in or returning to the workforce, were included in the analysis this relationship could be underestimated. Breastfeeding at 6 months was associated with being from a state that had had a breastfeeding coalition for a longer period of time (adjusted odds ratio, 1.25; 95% confidence interval, 1.04–1.49; $p<0.001$).

Conclusions: State worksite breastfeeding statutes alone may not directly affect breastfeeding duration. Analysis of breastfeeding duration using the multiple levels of the social-ecological model is a potentially useful approach to understanding the impact of state breastfeeding statutes. The impact of state breastfeeding coalitions warrants further study.

Introduction

ALTHOUGH INITIATION OF BREASTFEEDING has increased (and in some areas exceeded the Healthy People 2010 goals), rates of duration and exclusive breastfeeding at 6 months continue to lag and are well below Healthy People 2010 goals.¹ Breastfeeding is an individual behavior assessed at the individual level, but from the perspective of the social-ecological model other factors also contribute, including those at the interpersonal, community, institutional, and policy and systems level.² Achieving and sustaining Healthy People 2020 targets can only occur through coordinated efforts across the spectrum of the social-ecological model. Much of the emphasis to improve breastfeeding rates has been at the individual and interpersonal level, whereas there are significant gaps in both

evidence and implementation at the institutional and policy/systems levels.

Consistent with the social-ecological approach, the *Surgeon General's Call to Action* issued in 2011³ outlines a multiplicity of concurrent, multisector efforts necessary to achieve and sustain increases in breastfeeding rates. Support for lactating mothers in the workplace is one of the report's 20 initiatives. Over 56.5% of 2009 births occurred in a state with a worksite breastfeeding statute, but only 25% of worksites provided an on-site lactation/mother's room.⁴ The Health Resources and Services Administration's Business Case for Breastfeeding has been available since 2008,⁵ but evidence-based lactation support programs are lacking,⁶ and voluntary participation has been slow. For the first time, Healthy People 2020 established a goal to increase the proportion of worksites with lactation support programs; the 2020 target is 38%.⁴ Key to achieving

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this goal is the establishment and enforcement of regulations that specifically support the working mother who seeks to continue providing breastmilk to her infant.⁷

As of 2010, 24 states and the District of Columbia had statutes that addressed worksite support of lactating mothers.⁸ The Patient Protection and Affordable Care Act of 2010 (ACA) made changes to the Fair Labor Standards Act of 1938 and established federal provisions for worksite support that include both a requirement for break time and a site for mothers to pump breastmilk while at work. The federal regulations do not cover all employees (e.g., exempt employees, elementary and secondary school teachers, agricultural workers), and there is a hardship provision for smaller employers (those with <50 employees), but all states are now covered by some worksite lactation regulation. The federal regulations supplement but do not override state statutes that have stronger provisions.⁸ Assessing the extent to which state laws have contributed to increases in breastfeeding rates, prior to the ACA implementation, provides important information on what might be expected as the federal provisions move forward.

State laws about worksite lactation support vary (Table 1).⁷ Although the majority ($n=18$) *require* both break time and a designated site to pump, one only requires break time, and six *encourage*, rather than require, break time and a site. Details are well described by Murtagh and Moulton.¹⁰ In addition, six

states (and the District of Columbia) have anti-employment discrimination laws specific to lactating mothers. Although the laws differ, all but one state (West Virginia) specifically protects breastfeeding in public.⁸

Breastfeeding rates from 2000–2007, based on the aggregate state report card data from the Centers for Disease Control and Prevention (CDC),¹ were examined to identify trends. For illustrative purposes two states with worksite statutes in place prior to 2000, two with statutes enacted in 2005, and three states with statutes in place after 2007 were compared (Table 2). Ranks for each state were calculated based on their percentage of mothers breastfeeding at 6 months. To demonstrate relative changes across the period of time both percentages for each year 2000–2007 and the 2000 and 2007 ranking are presented. No consistent trends after enactment of a workplace statute are apparent.

In assessing whether worksite breastfeeding statutes impact breastfeeding rates, other factors must be considered. These include support for breastfeeding initiation from hospitals, other state regulations (e.g., family medical leave) and availability services (e.g., Women, Infants, and Children peer counseling), actual employers' practices, and advocacy efforts such as through state-based breastfeeding coalitions. These coalitions play an important role in advocacy (for establishment and enforcement) and awareness raising (among employers and employees).^{11,12}

We examined whether enacting worksite statutes led to improvements in state breastfeeding duration rates. Specifically, we analyzed the relationship between breastfeeding duration at 6 months and the presence of a worksite breastfeeding statute in the infant's birth state.

Methods

Individual-level and state-level data drawn from several sources were used for these analyses. For individual infant data we accessed the 2009 National Immunization Survey (NIS).¹³ The NIS is obtained annually from a nationally representative sample ($n=25,241$ children) by the CDC. It is a list-assisted random-digit-dialing telephone survey followed by a mail survey to participating children's immunization providers. It provides estimates of immunization coverage, weighted to represent children between the ages of 19 and 35 months, nationally, and by region, state, and select metropolitan areas using a complex sampling design.¹³ Questions about breastfeeding were included starting in 2001. The 2009 dataset includes infants born between February 2006 and May 2008. We eliminated infants whose mothers were 18 years old or under because the worksite statutes were not thought to affect their breastfeeding decisions. Furthermore, we omitted infants who by the time of the survey had relocated to a different state, resulting in 16,145 infants for analysis. Maternal variables included sociodemographic characteristics associated with breastfeeding (e.g., age, race), parity, and infant gender. Data on maternal birthplace (e.g., not born in the United States) were not available. We used whether the interview was conducted in Spanish as a proxy for non-U.S. maternal birthplace. Given the exploratory nature of this analysis we used the data as provided by the CDC, not modifying or collapsing any variable, except for the outcome variable, breastfeeding duration, recoded from continuous (days) to categorical (e.g., <6 months or ≥ 6 months).

TABLE 1. STATE CHARACTERISTICS

<i>Characteristic</i>	
Worksite statutes ^a	
None ^b	32
Time/site encouraged	4
Time to pump only	1
Both time/site required	14 ^c
When established (year law went into effect)	
After January 1, 2008	5
2005–2007	8
Prior to 2005	11
Breastfeeding coalition established ^d	
After January 1, 2008	25
2005–2007	8
Prior to 2005	14
mPINC score ^e	
National mean	65
Range	51–81
% births at BFHI hospital ^f	
National average	3.78
Range	0–21.7

Worksite statutes, when established, and breastfeeding coalition established data are number of states.

^aData are from the National Conference of State Legislatures as of 2010.⁷

^bAs of January 1, 2008. Five states had statutes enacted after January 1, 2008.

^cIncludes the District of Columbia.

^dData are from the United States Breastfeeding Committee (personal communication, 2011, Megan Renner).

^emPINC, Maternity Practices in Infant Nutrition and Care. Data are from the Centers for Disease Control and Prevention 2010 Breastfeeding Report Card.⁹ The potential score is 0–100.

^fBFHI, Baby-Friendly Hospital Initiative. Data are from the Centers for Disease Control and Prevention 2010 Breastfeeding Report Card.⁹

TABLE 2. BREASTFEEDING RATES IN 2000–2007 AND STATE RANKINGS FOR SELECTED STATES

State	2000 rank	Percentage breastfeeding at 6 months								2007 rank
		2000	2001	2002	2003	2004	2005	2006	2007	
U.S. national average		34.2	36.9	37.6	39.1	41.5	43.1	43.4	43.0	
Worksite law implemented in 1999										
Georgia	31	31.3	31	28.3	30.5	38	43.5	36.4	33.5	43
Hawaii	28	34.1	48.3	49.3	55.4	50.5	54.5	56.3	60.4	3
Worksite law implemented in 2005										
Rhode Island	25	35.7	39	33.4	35.1	31.2	49.3	40.4	45.1	26
Wyoming	8	47.4	42.7	44.4	42.1	42.9	46.6	50.8	52.5	12
Worksite law implemented after 2007										
Colorado	15	40.7	42.4	46.4	47.1	42	48.2	59.5	57.7	7
Vermont	2	47.5	47.5	47.2	55.9	55.3	53.8	59.5	58.4	5
Indiana	40	27.3	27.3	30.2	37.1	34.6	35.7	37.2	37.8	38

Rankings were calculated based on percentage of mothers breastfeeding at 6 months compared with other states (1=highest percentage). Data are from the Centers for Disease Control and Prevention National Immunization Survey.¹

The main exposure of interest was the presence of a state statute about worksite breastfeeding.⁷ This variable (Table 1) was coded into three categories: No statute in place by 2008 ($n=32$), break time and/or pumping site encouraged ($n=6$), or break time and/or pumping site required ($n=15$). For the purposes of these analyses the District of Columbia was considered the 51st state. We also categorized the length of time the law had been in effect similar to the methodology of Kogan et al.¹⁴ Because we did not have month of birth we created three categories of length based on year only: Prior to 2005 ($n=11$), between January 1, 2005 and January 1, 2008 ($n=8$), and none or after January 1, 2008 ($n=32$).

Other data in Table 1 were drawn from publicly available sources and included measures at the institutional level (e.g., hospitals) and system/policy level. Each state's average Maternity Practices in Infant Nutrition and Care (mPINC) in 2007 score was included to represent the influence of hospital practices on initiation of breastfeeding.⁹ (2009 mPINC scores were not available.) The mPINC is a biennial CDC-mailed survey of all U.S. state and territorial hospitals and birth centers with registered maternity beds.¹⁵ Begun in 2007, each hospital reports on 34 items representing various practices that may affect infant feeding. Over 80% returned the 2007 survey representing 2,687 facilities. Facility responses were tallied into subscales and total score (range 0–100).¹⁶ The average 2007 mPINC score was 65.⁹ We included the proportion of births at Baby-Friendly Hospital Initiative (BFHI)–designated hospitals as an additional institutional-level characteristic. Facilities are designated BFHI after a rigorous external review process that affirms full implementation of specific breastfeeding friendly practices.¹⁷ We included this item given the Healthy People 2020 goal to increase the proportion of births occurring at BFHI designated hospitals (from 2007 baseline of 2.9% to 8.1%).⁴ Policy and system-level variables were obtained from the National Conference of State Legislatures⁷ including other statutes pertinent to breastfeeding such as employment discrimination and protecting breastfeeding in public.

The final system level characteristic included was the presence of a State Breastfeeding Coalition (Table 1). Although by 2010 all states had a coalition, they were established at varying times during the prior two decades. To be consistent we classified their founding dates (provided by the United States

Breastfeeding Committee; personal communication, 2011, Megan Renner) in a manner similar to how the state statute dates were coded (pre-2005; 2005–2007; 2008 or later).

Because our interest was whether the presence of state worksite statutes increased breastfeeding duration, our main outcome variable—any breastfeeding at 6 months—was modeled to examine who was still breastfeeding (rather than who had stopped). We selected 6-month breastfeeding duration because it is a common maternal goal, it is beyond the time period when most women return to work, and it is consistent with the Healthy People 2020 objectives.

In our analyses we first modeled the prevalence of breastfeeding at 6 months by states with different types of statutes. We then ran six logistic regression models of any breastfeeding at 6 months, first including just the presence of the type of statute, then adding length of time the statute had been in effect, other state statutes pertinent to supporting lactating women, when state coalition was founded, and lastly variables depicting state implementation of breastfeeding supportive hospital practices. The final model included individual-level maternal and infant covariates.

Results

From the 2009 NIS weighted sample more than half of the infants' mothers were at least 30 years of age (63.8%), nearly one-quarter were below the poverty level (26.1%), and less than 20% had not finished high school (16.9%), whereas over a third were college graduates (36.1%) (Table 3). Non-Hispanic whites represented just over half of respondents (52.3%), with non-Hispanic blacks and Hispanics representing 8.9% and 30.2%, respectively. Nearly three-quarters were married (72.2%), and nearly half (45.4%) were primiparous.

Overall, 57.5% of mother reported breastfeeding for at least 6 months. Half of the mothers lived in states with no worksite breastfeeding statute (49.9%); a third were from states that *required* both a site and break time (35.0%). Among mothers from states without worksite breastfeeding statutes, 55.5% breastfed for at least 6 months. This was the same for mothers from states with statutes that *encouraged*, rather than required, lactation support. Among mothers from states *requiring* a site and/or break time, 60.0% were still breastfeeding at 6 months.

TABLE 3. CHARACTERISTICS OF RESPONDENTS (N=16,145)

Characteristic	n	Weighted %
Maternal age		
20–29 years	4,871	36.23
≥30 years	11,274	63.77
Household income		
Above poverty		
>\$75,000	6,446	30.41
≤\$75,000	6,369	38.11
Below poverty	2,585	26.11
Unknown	745	5.37
Maternal education		
<12 years	1,264	16.88
12 years	2,405	27.06
>12 years, non-college grad	4,269	19.93
College grad	8,207	36.13
Race/ethnicity		
Hispanic	2,790	30.18
Non-Hispanic white only	10,556	52.3
Non-Hispanic black only	1,289	8.85
Non-Hispanic other/multiple race	1,510	8.65
Marital status		
Married	1,3173	72.22
Language spoken during interview		
English	14,732	81.01
Spanish	1,241	17.40
Other	172	1.59
Child is first born		
Yes	7,490	45.38
Child's gender		
Male	8,295	51.18
Breastfeeding status		
<6 months	6,385	42.47
≥6 months	9,760	57.53
Worksite law in state of residence		
None	9,255	49.90
Law encouraged site/break time	2,285	15.11
Law required site/break time	4,605	34.98

Data are from the 2009 National Immunization Survey.¹³

For our analyses, we combined the one state that only required break time with those that required both site and break time. Our unadjusted model demonstrated that states *requiring* a site and/or break time had more mothers breastfeeding at 6 months (odds ratio, 1.20; 95% confidence interval, 1.07–1.35; $p=0.002$) compared with mothers from states without a worksite breastfeeding statute (Table 4, Model 1). No statistically significant difference was found between mothers from states that *encouraged* worksite lactation support and mothers from states with no such statute. Three of the five adjusted models are presented in Table 4.

After adjusting for length of time since statute implementation, the adjusted odds ratio increased to 1.33 (95% confidence interval, 0.92–1.92) (Table 4, Model 2), but the relationship was no longer statistically significant. Additional adjustments for other state laws, breastfeeding coalition founding year, and state hospital practices (Table 4, Model 3) as well as inclusion of maternal and infant characteristics (Model 4) reduced the strength of the workplace statute variable. Of note is that the addition of the maternal and child characteristics resulted in negligible changes between the parameters of Model 3 and Model 4. Although mothers giving

birth in states with worksite breastfeeding statutes were more likely to still be breastfeeding at 6 months (adjusted odds ratio, 1.07; 95% confidence interval, 0.92–1.24), the difference was not statistically significant.

Mothers who gave birth in states with a breastfeeding coalition founded before 2005 were more likely to be breastfeeding at 6 months compared with those from states with no coalition (adjusted odds ratio, 1.25; 95% confidence interval, 1.04–1.49; $p<0.001$). This statistically significant relationship was not found for coalitions more recently founded, although the adjusted odds ratio was positive (adjusted odds ratio, 1.15; 95% confidence interval, 0.95–1.39).

Maternity care practices at birthing facilities as captured by the mean state mPINC scores were small but positive and significant (adjusted odds ratio, 1.03; 95% confidence interval, 1.01–1.04; $p<0.0001$) such that higher scores were associated with more mothers breastfeeding at 6 months. The percentage of births at BFHI-certified hospitals was not significant.

Discussion

This preliminary analysis of this nationally representative data set of over 16,000 infants demonstrated that for those whose mothers were over 18 years of age and lived in states with breastfeeding worksite statutes that *required* either a site and/or a break time were 20% more likely to be breastfeeding at 6 months than those from states with no statutes. Although the relationship between statutes was not statistically significant after adjusting for other available state, infant, and maternal characteristics, the relationship remained positive. No differences were found between states with no statutes and those with a worksite statute that encouraged workplace support of breastfeeding.

This is not entirely surprising. First, the dataset included infants regardless of maternal employment status, so some unknown number of mothers that was not working prenatally would not likely have returned to work postpartum. Yet others who were working prenatally would not be returning to work. Thus, worksite lactation statutes would not have been an influencing factor on their decision to breastfeed to 6 months. Including the infants of these women in the analysis likely diminished the effect of any worksite lactation support on state breastfeeding rates.

Furthermore, although workplace laws have the potential for broad reach, the establishment of a regulation does not result in automatic or universal compliance. Given that a third of states have laws requiring lactation support, but only 25% of employers provide support, there is a gap in adoption and, likely, enforcement. Implementation of regulations is often affected by court cases. So far there have been few such cases challenging employer compliance with state worksite breastfeeding statutes; two in California were won by the plaintiff (employed lactating mother).^{18,19} Should additional cases accrue, adoption of worksite lactation support would likely increase. Additionally, given the changes made to the Fair Labor Standards Act in 2010 and the Healthy People 2020 goal to increase lactation support in the worksite, the rate of adoption may accelerate.

We found a small significant relationship with state mean mPINC scores but no relationship with proportion of births in BFHI-designated hospitals. The latter's low prevalence may preclude any broad impact. Additionally, because the mPINC

TABLE 4. LOGISTIC REGRESSION MODELS OF STATE WORKSITE BREASTFEEDING LAWS ON WHETHER MOTHERS ARE STILL BREASTFEEDING AT 6 MONTHS

Effect	Model 1	p value	Model 2	p value	Model 3	p value	Model 4 ^a	p value
Type of worksite breastfeeding statute (reference: none ^b)								
Break time and site encouraged	1.00 (0.85–1.17)	NS	1.04 (0.77–1.42)	NS	1.01 (0.74–1.39)	NS	0.97 (0.80–1.18)	NS
Break time and/or site required	1.21 (1.06–1.39)	0.0042	1.33 (0.92–1.92)	NS	1.08 (0.76–1.63)	NS	1.07 (0.92–1.24)	NS
Date when worksite breastfeeding statute implemented (reference: none ^b)								
Prior to 2005			0.97 (0.69–1.35)	NS	0.98 (0.68–1.40)	NS	0.98 (0.67–1.42)	NS
From 2005 to January 1, 2008			0.81 (0.56–1.16)	NS	0.81 (0.58–1.29)	NS	0.94 (0.62–1.42)	NS
State has an anti-employment discrimination law specific to breastfeeding (reference: none ^b)								
Yes					1.18 (0.94–1.42)	NS	1.16 (0.93–1.43)	NS
When was state breastfeeding coalition established (reference: none ^b)								
Prior to 2005					1.27 (1.06–1.50)	0.006	1.25 (1.04–1.49)	<0.0001
From 2005 to January 1, 2008					1.17 (0.97–1.41)	NS	1.15 (0.95–1.39)	NS
mPINC score					1.03 (1.02–1.04)	<0.0001	1.03 (1.01–1.04)	<0.0001
% births at Baby-Friendly hospitals					1.01 (0.99–1.02)	NS	1.01 (0.99–1.02)	NS

Data for Model 1 are odds ratio (95% confidence interval). Data for Models 2, 3, and 4 are adjusted odds ratio (95% confidence interval).

^aAdjusted for maternal age, household income, maternal education, race, marital status, language in which the interview was conducted, parity (i.e., first born), and child's gender.

^bNone or passed after January 1, 2008. Total $n=16,145$.

mPINC, Maternity Practices in Infant Nutrition and Care; NS, not significant.

scores capture the BFHI characteristics, there may be redundancy, although re-analyzing and omitting the BFHI variable resulted in only negligible changes. The small impact of hospital practices on state breastfeeding rates may be due to the likely intra-state variability of mPINC scores from hospital to hospital. The fact that any significant difference was found at all may be noteworthy given all of the other factors that influence breastfeeding at 6 months.

The presence of a state breastfeeding coalition emerged as a significant factor in breastfeeding at 6 months even when controlling for maternal factors typically associated with longer breastfeeding such as maternal age, race, and income. The use of coalitions to promote positive change is well established^{20,21} and has become increasingly prominent in perinatal and breastfeeding initiatives.^{11,22,23} Given their range of potential activities from policy advocacy to providing resources to individual mothers, coalitions often work across the social-ecological spectrum. This may help explain our finding of their positive impact on breastfeeding rates. Additionally, because they may have been the organization that lobbied for the statute it is possible that the presence of statutes increases the impact of state breastfeeding coalitions.

This preliminary study has several strengths. We included factors across the individual interpersonal, institutional, and system levels of the social-ecological model. Our analysis predates implementation of changes resulting from enactment of the 2010 ACA. Our analysis speaks to one of the priorities from the *Surgeon General's Call to Action*.³ We also identified an understudied area warranting further research: state breastfeeding coalitions.

This preliminary analysis also has several limitations. Individual-level factors known to be associated with breast-

feeding were not available for inclusion in these analyses, specifically, whether the mother had paid maternity leave, whether the mother intended or actually returned to work (and whether this was full or part time), if the mother was foreign born, if there were infant factors that precluded breastfeeding, and how long the mother intended to breastfeed. Interpersonal factors (other than marital status) and community factors were also not readily available. Other institutional variables, such as participation in WIC or other programs that might influence breastfeeding, were not available. At the state level support for family medical leave, beyond that provided for by the federal statute, was also not included. By using broad classification categories we may have lost some detail. There was no measure of enforcement of uptake by employers to assess the extent to which the laws were even being followed. As a result there may be unmeasured confounding.

Conclusions

This preliminary analysis raises some important questions. To what extent is the impact of worksite breastfeeding statutes determined by other factors either directly or indirectly related to worksite efforts to support breastfeeding. Additional analytical work is warranted to explore this and better understand the impact of coalitions on breastfeeding rates. Analysis of impacts on initiation and on longer duration of breastfeeding (e.g., 12 months) as well as subgroups should also be undertaken along with multilevel analyses. Research about effective worksite programs is also needed.

Into the future it will be important to watch for other changes that may affect worksite breastfeeding statutes, their establishment and enforcement, and employer adoption. The

impact of the federal-level worksite breastfeeding provisions is one important step as will be increases in the number of states with their own statutes specific to support of the lactating mother (including not only at the worksite but also family medical leave). Court challenges will help drive the adoption of worksite practices that support the lactating mother as well. Lastly, efforts of state breastfeeding coalitions and where worksite breastfeeding support resides in their priorities for advocacy and awareness raising will likely play a major role in progress.

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