Maternity Protection Resource Package

From Aspiration to Reality for All

International Labour Organization

PART TWO

Module 10

Breastfeeding arrangements at work

GIFA IBFAN unicef World Health Organization ITC International Training Centre UN WOMEN UNFPA

INTERNATIONAL LABOUR ORGANIZATION

Maternity Protection Resource Package

From Aspiration to Reality for All

Module 10:
Breastfeeding arrangements at work

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Module 10:
Breastfeeding arrangements at work[1]

If women are both to work and to have children in decent and healthy conditions, maternity protection is a necessity. One of the five essential elements of maternity protection is enabling mothers to continue breastfeeding upon returning to work.

Key contents

This module discusses the importance of breastfeeding, the challenges of continuing breastfeeding upon return to work, legislation and practical tools that can help to facilitate continued breastfeeding for mothers returning to paid work. It includes the following:

- The benefits of breastfeeding for mothers and their babies, employers and society
- International standards and national legislation supporting breastfeeding for mothers in paid work
- Practical measures for supporting breastfeeding for mothers in paid work
- Considerations regarding breastfeeding and HIV and the roles that workplace stakeholders can play in diminishing the transmission of HIV to infants through breastfeeding (PMTCT)

Breastfeeding is an unequalled way of providing ideal food and care for the healthy growth and physical and psychological development of infants. It is also an integral part of the reproductive process with important implications for the health of mothers. The World Health Organization (WHO) and UNICEF have set out two global public health recommendations.[2] First, infants should be exclusively breastfed for the first six months of life to achieve optimal growth, development and health. Second, to meet their evolving nutritional requirements, infants older than six months should receive nutritionally adequate and safe complementary foods while continuing to breastfeed up to 2 years of age or beyond.[3] Not breastfeeding presents both short- and long-term risks for mothers and children. Exclusive breastfeeding

[1] This chapter draws primarily from the Maternity Protection Coalition (MPC) (IBFAN, ILCA, IMCH, LLLI, WABA): *Maternity Protection Campaign Kit: A Breastfeeding Perspective* (Malaysia, WABA, 2003, re-edited 2008).

[2] For an overview and links to the WHO/UNICEF *Global Strategy on Infant and Young Child Feeding*, see http://www.who.int/nutrition/topics/infantfeeding_recommendation/en/.

[3] World Health Assembly Resolution 55.15 (*Global Strategy on Infant and Young Child Nutrition*, 2002) states: "As a global public health recommendation, infants should be exclusively breastfed for the first six months of life to achieve optimal growth, development and health. Thereafter, to meet their evolving nutritional requirements, infants should receive nutritionally adequate and safe complementary foods while breastfeeding continues for up to two years of age or beyond".

from birth is possible except for a very few medical conditions, and unrestricted exclusive breastfeeding results in ample milk production. Exclusive breastfeeding is also a suitable option for many HIV-positive mothers, especially in the presence of antiretroviral drugs (ARVs) (see the section on Breastfeeding and HIV, in this module).[4]

Breastfeeding should be initiated within the first hour after birth[5] and over the following weeks a routine needs to be established. The longer the maternity leave, the more settled the routine. Returning to work after giving birth is a major change for a woman and in her family's life. Returning to work while still breastfeeding is even more of a challenge and it is one of the main reasons that women stop breastfeeding. For example, in the United States women working fulltime start breastfeeding in hospital at about the same rate as all mothers, but after six months they are less than half as likely to still be breastfeeding as mothers who do not return to work. Even women who work part-time breastfeed for nearly nine weeks longer than their full-time counterparts.[6]

A number of factors impact the duration of breastfeeding once women return to their paid work. They include:

- working fulltime (as opposed to working part-time or staying at home);
- returning to work less than two months postpartum;[7]
- factors such as travel time and distance to work, employment conditions and workplace arrangements;[8]
- support at the workplace, in the form of breastfeeding breaks, breastfeeding facilities, and the attitudes of employer's and colleagues towards breastfeeding workers;
- support at home and in the community.

During the first six months of exclusive breastfeeding and the period of complementary feeding, when a child consumes soft, semi-solid or solid foods alongside breast milk, a sudden reduction in the frequency of feeds due to a return to work can lower milk production. An insufficient milk supply is frequently reported by mothers as a reason for stopping breastfeeding, especially when going back to work. Therefore, it is very important that working conditions enable the continuation of frequent breastfeeding or milk expression, in order to maintain sufficient milk production to cover the baby's needs.

For many women, the lack of workplace support for breastfeeding makes working incompatible with breastfeeding (see **Box 10.1** on how breastfeeding works and why not breastfeeding at work can mean not breastfeeding at all). Stakeholders (i.e. government, trade unions and employers) need to better understand the importance of breastfeeding, as their support is central to enabling women to follow the recommendations of the WHO/UNICEF *Global Strategy on Infant and Young Child Feeding*, already mentioned.

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4 WHO: *Guidelines on HIV and infant feeding* (Geneva, 2010).

5 Pan American Health Organization (PAHO): Early initiation of breastfeeding: The key to survival and beyond, in *Technical Bulletin* (Washington, D.C., 2010).

6 S.B. Fein and B. Roe: "The Effect of Work Status on Initiation and Duration of Breast-feeding" in *American Journal of Public Health* (1998, Vol. 88, No. 7), pp. 1042-1046.

7 M.H. Kearney and L. Cronenwett: "Breastfeeding and Employment" in *Journal of Obstetric, Gynecologic & Neonatal Nursing* (1991, Vol. 20, No. 6), pp. 471-480.

8 Galtry, 2003, and Quandt, 1995, cited in P. Smith and M. Ellwood: "Where does a mother's day go? Preliminary estimates from the Australian Time Use Survey of New Mothers", in *Australian Centre for Economic Research on Health,* Research Report 1 (Canberra, 2006).

Box 10.1 How does breastfeeding work? And why "not breastfeeding at work" can mean "not breastfeeding at all"

For a woman who is at work for more than a couple of hours per day, if she cannot take breaks to breastfeed or express, her supply will diminish and she may no longer be able to produce enough milk for her baby. This is because breast-milk production depends on adequate and regular stimulation of the breasts. The baby's suckling at the breast stimulates a hormonal response that activates the production and release of milk. It is a true supply-and-demand relationship: the more milk removed from the breast, the more milk produced. When a woman who is breastfeeding returns to paid work, she can ensure that she produces as much milk as her baby needs either by breastfeeding her baby at the workplace or by expressing milk while she is away, and storing it for later use.

Source: Australia Department of Employment: *Workplace Guide to Work and Family*, Work and Family Resources, Work and Family Unit, Workplace Relations and Small Businesses (Canberra, 1996) Part 4, pp. 3-4.

One of the provisions that can help to improve breastfeeding rates and duration is to ensure that the minimum standards set by the International Labour Organization (ILO) are implemented at the workplace; namely, making sure that breastfeeding breaks are established and used. Setting up breastfeeding facilities is another step in the same direction.[9]

As early as 1919, the ILO acknowledged that breastfeeding was an integral part of motherhood and of reproduction, and thus deserved protection at the workplace. It included breastfeeding breaks in Convention No. 3, and has maintained them in subsequent maternity protection Conventions. Over the past 90 years, social and economic changes, including wide-spread marketing of breast-milk substitutes, have led to lower breastfeeding rates in many countries around the world, and in turn to a loss of the shared understanding about the practice of breastfeeding. Since the 1980s, the trend is slowly changing and practices are generally improving, as recent UNICEF data indicate.[10] With the entry of more and more women of childbearing age into the workforce, it is essential that support for breastfeeding be reinforced.

[9] Other breastfeeding-friendly measures include reduced working hours, part-time work, flexible working hours and working from home. See **Module 11** for more information.

[10] UNICEF: Child nutrition statistics: Breastfeeding, **http://www.childinfo.org/breastfeeding_progress.html** [accessed 20 Oct. 2011].

Why breastfeeding at work?

The changing composition of the workforce, especially women's increased participation rates, has made it imperative to find ways for breastfeeding to be compatible with paid work. Research shows that women who choose to breastfeed are more likely than others to return to the paid workforce, and that many want to continue breastfeeding.[11]

Advantages of breastfeeding

Over the past 30 years, and especially since the beginning of this century, the protection, promotion and support of breastfeeding have become part of national and international health policy for compelling medical reasons. The *Global Strategy for Infant and Young Child Feeding* was endorsed at the World Health Assembly by Member States in 2002 and establishes breastfeeding as the norm and the natural way to feed infants and young children. It provides a comprehensive framework for the protection, promotion and support of breastfeeding, explicitly defining the obligations and responsibilities of governments, international organizations and other concerned parties with regard to providing mothers and families the support they need to carry out their crucial roles.

Exclusive and continued breastfeeding significantly reduces the incidence, severity and duration of common illnesses among newborns. Research is also showing long-term health benefits for children, into adolescence and adulthood, and on their psychological and motor development. The health benefits of breastfeeding for mothers are also being increasingly recognized. While these health benefits are important in themselves, they are matched by economic returns at the national and enterprise levels as well as in the family budget. At the national level, the economic impact is mainly felt in reduced demand for curative health services for mothers and babies and the productivity gains derived from a healthy labour force.

In recent years, attention has also focused on the economic costs, both direct and indirect, of breast-milk substitutes, both for the national economy and for the individual family. While breastfeeding is environmentally friendly, a sustainable resource and an important element of food security, artificial milks and their production and distribution are not.

See ***RESOURCE SHEET 10.1*** for a comprehensive list of the benefits of breastfeeding.

The business case for breastfeeding-friendly workplaces

Workplace lactation programmes, which provide prenatal counselling and workplace support for breastfeeding, are increasingly seen as a cost-effective investment to increase employee morale, minimize absenteeism and reduce turnover (see **Box 10.2**). In addition, such programmes are viewed by many employees as supportive of their efforts to balance professional and family responsibilities.

Supporting breastfeeding among employees is generally a low cost intervention for employers involving minimal workplace disruption.[12] Research also indicates that there are potential benefits for employers associated with supporting breastfeeding. These include:

[11] K. Auerbach: "Assisting the employed breastfeeding mother", in *Journal of Nurse-Midwifery* (1990, Vol. 35, No. 1), pp. 26-34.

[12] Commonwealth of Australia: *Balancing breastfeeding and work: Important information for workplaces* (Canberra, 2000). K. Tyler: "Got milk?", in *HR magazine* (1999, Vol. 44, No. 3), pp. 68-73.

- improved retention of female employees after maternity leave, thereby retaining valuable employee skills and experience and lessening recruitment and retraining costs;
- earlier return to work by some new mothers;
- easier transition back to work following maternity leave;
- lower employee absenteeism rates on account of improved child health;
- lower and fewer health-care costs associated with healthier breastfed infants;
- improved employer–employee relations and greater employee loyalty;
- improved company image;
- higher job productivity, employee satisfaction and morale;
- added recruitment incentives for women;
- healthier workforce for the future.[13]

Box 10.2 Benefits to employers of workplace breastfeeding support, United States

Kaiser Permanente research

In enterprises that have instituted family-friendly policies and practices, the economic benefits can be measured in terms of reduced health insurance costs. The results of internal research carried out by Kaiser Permanente, a major health maintenance organization in the United States, anticipated that policies to support breastfeeding in the workplace would not only optimize the long-term health of the infants and mothers concerned. They would also significantly reduce health costs by reducing the need for medical consultation, prescription drugs and hospitalization of infants in the first year of life.

Los Angeles Department of Power and Water

The Los Angeles Department of Power and Water has provided breastfeeding support to workers, including three onsite lactation rooms, flexible scheduling for milk expression, the loan of a hospital-grade electric breast pump, and free pump attachment kits. A multifaceted education programme includes breastfeeding, childbirth, and parenting classes. A lactation specialist is available on call to assist new families with breastfeeding questions. A formal evaluation of the programme has found a significant impact on health-care savings, lower absenteeism rates, lower turnover rates, and improved employee loyalty and productivity. The company reports that as a result of the programme, health-care claims are 35 per cent lower, 33 per cent of new mothers return to work sooner than anticipated, absenteeism rates are 27 per cent lower, 71 per cent take less time off since participating in the programme, 67 per cent worry less about family concerns on the job, 83 per cent are more positive about the company, and 67 per cent intend to make the company their long-term employer.

[13] R. Cohen and M.B. Mrtek: "The impact of two corporate lactation programs on the incidence and duration of breast-feeding by employed mothers" in *American Journal of Health Promotion* (1994, Vol. 8), pp. 436-441. R. Cohen, M.B. Mrtek and R.G. Mrtek: "Comparison of maternal absenteeism and infant illness rates among breastfeeding and formula-feeding women in two corporations", in *American Journal of Health Promotion* (1995, Vol. 10), pp. 148-153. D. Shalowitz: "Lactation program speeds mothers' return to work", in *Business Insurance* (1993, Vol. 27), p. 2. J. Smith: "How employers can profit from breastfeeding: Estimates of financial gains to employers supporting breastfeeding by mothers in employment" (Vermont Breastfeeding-Friendly Employer Project, 2003), unpublished manuscript.

Why support for breastfeeding is an important equal employment opportunity (EEO) consideration for employers, Australia

The need to accommodate breastfeeding in the workplace is an important equal employment opportunity and anti-discrimination consideration for employers for the following reasons:

- Women's labour market participation rates have been increasing over recent decades. One of the biggest changes in recent years has been the rise in employment among women with young children.
- Through smoothing the transition back to work, the introduction of workplace policies and provisions to support breastfeeding may positively influence new mothers' workforce participation.
- In the absence of workplace support for breastfeeding many new mothers may decide not to return to work following maternity leave/parental leave. This is potentially costly for both employers and the women concerned.
- Sometimes women take longer periods of maternity leave to breastfeed because their workplaces do not accommodate breastfeeding. This may be costly both for women in terms of possible loss of income, seniority and opportunities for promotion and for employers, in terms of finding and training temporary replacements.
- It is generally recognized that organizations that recognize and support diversity potentially benefit from a range of skills and experience. In its diversity survey, EEO Trust identified formal policies and practices to support breastfeeding at work as among a range of measures that encourage a diverse workforce within organizations. The EEO Trust has also published information on how employers might best support breastfeeding.

Sources:
Australian Equal Opportunity for Women in the Workplace Agency (EOWA): *Employment matter guidelines: Arrangements for dealing with pregnancy, potential pregnancy and breastfeeding* (2002)
EEO Trust: "Breast milk is best: How can workplaces help?", in *Work & Life Bulletin*, Dec. 2002.
—: *EEO Trust Diversity Index 2002 Summary.* (Auckland, 2002).
J. Galtry: *Policies and practices to support breastfeeding in the workplace*, background paper prepared for the WHO/UNICEF Technical Consultation on Infant and Young Child Feeding, 13-17 March 2000 (Geneva, WHO, 1999).
J. Galtry and M. Annandale: *Guidelines for Supporting Breastfeeding in the Workplace*, Equal Employment Opportunities' Contestable Fund Project (New Zealand, 2003).
Statistics New Zealand: *New Zealand now - Women (Census 96) (1998) - Reference reports.* (Wellington, 1999).
U.S. Department of Health and Human Services (DHSS): *The Business Case for Breastfeeding: Employer Spotlights*, http://www.womenshealth.gov/breastfeeding/government-programs/business-case-for-breastfeeding/employe-spotlights.pdf [accessed 27 Sep. 2011].

Support for breastfeeding at work

As maternity leave periods typically expire before the WHO recommended period of exclusive breastfeeding, workplace arrangements to enable women to continue to breastfeed upon return to work are important to meet international recommendations and are in the best health interests of mother and child.

Important elements in an approach to supporting breastfeeding women in the workplace are:

- legal provisions for paid breastfeeding breaks at work;
- support in the workplace which makes it easier for women employees to combine work and breastfeeding, such as:
  - ➔ paid breastfeeding breaks;
  - ➔ a breastfeeding room/facility;
  - ➔ a workplace breastfeeding policy statement to promote the organization's provisions to employees and managers;
  - ➔ a supportive workplace climate.

Breastfeeding breaks[14]

Breastfeeding or nursing breaks are short periods that are reserved during the workday to breastfeed one's child or express milk to be fed later to the child. They are usually consigned to breastfeeding mothers, who in some cases must prove by means of a medical certificate that they are in fact breastfeeding.

International labour standards and legislation

Since the first Convention on maternity protection (No. 3, 1919), nursing breaks for breastfeeding mothers during working hours have been part of the international standards on maternity protection. Convention No. 183 leaves it to national laws and regulations to decide the number and duration of breastfeeding breaks, as long as at least one break is provided. It also introduces the possibility of transforming breaks into a daily reduction of hours of work (see **Box 10.3**). These breaks are not intended to be part of or substitutes for lunch breaks or other breaks, but can be combined with them.

Box 10.3 Breastfeeding Breaks

Convention No. 183. Article 10

(1) *A woman shall be provided with the right to one or more daily breaks or a daily reduction of hours of work to breastfeed her child.*

(2) *The period during which nursing breaks or the reduction of daily hours of work are allowed, their number, the duration of nursing breaks and the procedures for the reduction of daily hours of work shall be determined by national law and practice. These breaks or the reduction of daily hours of work shall be counted as working time and remunerated accordingly.*

Recommendation No. 191

Paragraph 7: *On production of a medical certificate or other appropriate certification as determined by national law and practice, the frequency and length of nursing breaks should be adapted to particular needs.*

Paragraph 8: *Where practicable and with the agreement of the employer and the woman concerned, it should be possible to combine the time allotted for daily nursing breaks to allow a reduction of hours of work at the beginning or at the end of the working day.*

National laws in more than 90 countries provide for breastfeeding breaks in some form (see **Boxes 10.4** and **10.5**). The issues concerning breaks include:

- the number of nursing breaks allowed in a given time period;
- their frequency and length;
- the length of time after birth that a worker may take nursing breaks;
- whether breaks are paid or unpaid; whether breaks are counted as working time;
- whether a worker loses income because she takes nursing breaks (e.g. a worker paid by the piece, not by the hour, or who earns a bonus based on productivity).

[14] See ILO: *Maternity at work: A review of national legislation*, Second Edition (Geneva, 2010) and MPC, 2003, op. cit.

Box 10.4 Expanded Breastfeeding Act, the Philippines

On 6 March 2010, the Philippines adopted the Expanded Breastfeeding Promotion Act of 2009 (No. 10028) which establishes breastfeeding facilities at the workplace as well as breastfeeding breaks.

The Act states:
Section 2: *The State shall likewise protect working women by providing safe and healthful working conditions, taking into account their maternal functions...*
Section 11: *Establishment of lactation stations: It is hereby mandated that all health and non-health facilities, establishments or institutions shall establish lactation stations.*
Section 12: *Lactation periods: Nursing employees shall be granted break intervals in addition to the regular time off for meals to breastfeed or express breast milk.*

The Act is the result of several years of lobbying and advocacy on behalf of women's groups, grassroots groups, breastfeeding advocates, trade unions, concerned congressmen and women and senators as well as UNICEF and the WHO.

Source: Congress of the Philippines: *Expanded Breastfeeding Promotion Act of 2009*, No. 10028, 14th Congress, 3rd Regular Session, Manila, 2009.

Box 10.5 Workplace breastfeeding support provision in health care reform, USA

In 2010, the passage of the healthcare reform package included the breastfeeding support provision in the Affordable Care Act (ACA). The provision states that employers shall provide reasonable, unpaid break time and a private, non-bathroom place for an employee to express breast milk for her nursing child for one year after the child's birth. Employers with less than 50 employees are not subject to the requirement if it would cause "undue hardship".

Medical experts agree with the US Department of Health and Human Services (DHHS) in recommending exclusive breastfeeding for six months and continued breastfeeding for the first year of life and beyond. But returning to work can be a major hurdle for new mothers struggling to balance working and breastfeeding without the simple support measures this law ensures.

The Business Case for Breastfeeding, published in 2008 by the DHHS, demonstrates an impressive return on investment for employers that provide workplace lactation support, including lower health-care costs, absenteeism and turnover rates. Employees whose companies provide breastfeeding support consistently report improved morale, better satisfaction with their jobs and higher productivity.

Currently, 24 US states, the District of Columbia and Puerto Rico have legislation related to breastfeeding in the workplace. The new federal provision will provide a minimum level of support in all states, but it will not pre-empt a state law that provides stronger protections.

A recent report by the Institute for Women's Policy Research (IWPR) shows that provisions in the ACA will increase the number of working mothers who breastfeed their children up to the age of six months, particularly among lower income and hourly employees. The report estimates that the legislation will result in an annual increase of 165,000 women who breastfeed their children, and will affect more than one million mothers and their children over the course of the next six years.

In February 2011, the Internal Revenue Service (IRS) announced it would reverse a ruling that denies equipment used to help women breastfeed from being covered as a health-care expense. Breastfeeding equipment will be allowed as medical tax deduction and reimbursed by flexible health-spending accounts.

This measure combined with the effective implementation of the ACA by the US Department of Labour is expected to further promote breastfeeding and thus help to meet the target of 60.5 per cent of mothers breastfeeding at six months, established by the DHHS' Healthy People 2020 Goals.

Sources:
Drago et al.: *Better health for mothers and children: Breastfeeding accommodations under the Affordable Care Act* (Washington, IWPR, 2010).
United States Breastfeeding Committee (USBC): *USBC applauds workplace breastfeeding support provision in health care reform*, 1 Apr. 2010.
For more information, visit the websites of The National Women's Health Information Center **http://www.womenshealth.gov/** and USBC **http://www.usbreastfeeding.org**.

In Convention No. 183, breastfeeding breaks are a right available only to breastfeeding women. However, in some countries the scope of eligibility appears to be broader. For example, in Estonia, a person raising a child under 18 months of age is granted additional breaks of not less than 30 minutes each for feeding the child at least every three hours. In Mongolia, women employees and single fathers are entitled to additional breaks for childcare or feeding. Breastfeeding breaks may also be available to the father under certain conditions: for instance if the mother dies or is unable to attend to the child because of a serious illness. In Spain, mothers and fathers have the same right to take "nursing" breaks.

Length and frequency of breastfeeding breaks

Physiologically, the length of individual breastfeeds and their frequency change over time. The length of feeds also varies between babies, some being more "efficient" feeders than others. Generally, the needs are more frequent but for shorter periods at the beginning of an infant's life, and may become less frequent as the child gets older. Some countries take this into account when legislating, but most do not, and give a fixed period of time and frequency for breastfeeding breaks.

In general, many countries include entitlements in legislation for mothers to have two 30-minute breaks per day in every eight-hour working day for a period of approximately six to 12 months. Sometimes the breaks are more frequent, in which case a number of countries provide for less than 30 minutes. In other cases, the nursing woman can choose how to distribute the total duration of the daily breastfeeding breaks. In some countries, the number of nursing breaks depends on the working hours. This is the case in Belgium, where a woman who works a minimum of four hours a day has the right to one break of 30 minutes. If she works at least 7.5 hours a day, she can take two nursing breaks of 30 minutes each (see **Box 10.6**).

Box 10.6 Breastfeeding breaks in Belgium

A maternity protection law came into force in Belgium in July 2002. It specifies in great detail a breastfeeding woman's rights at the workplace, with seven chapters and eleven articles solely on breastfeeding breaks. Since trade unionists in many European countries report that breastfeeding breaks are a barrier to ratification of ILO Convention No. 183, the Belgian model may point toward a solution. However, some details of the Belgian law, for instance the monthly medical certificate and the limitation of breastfeeding breaks to the first seven months after birth, would be too restrictive for countries where they are already well-accepted features of maternity protection at work.

The Belgian *Labour Collective Agreement No. 80* gives women working under contract in the private and the public sector the right to breastfeed or to express their milk during work hours. Breastfeeding breaks are paid by the national health insurance at the same rate as maternity leave (82 per cent of salary). They are considered work time, meaning that employees do not lose their rights to seniority, advancement, etc. The worker is entitled to breastfeed and/or to express her milk in specific premises set up by the employer. The premises have to be private, well ventilated, well lit, clean, appropriately heated and equipped for the mother to lie down to rest. They are generally located in or very close to the undertaking, but in certain circumstances, they can be in the employer's home. In shopping centres, the premises can be shared by the employees of several employers.

Each breastfeeding break lasts 30 minutes. Employees are entitled to a 30-minute break for a period of at least four hours of work; and to two periods of 30 minutes each or one period of 60 minutes after at least 7.5 hours of work. Employees, together with the employer, can decide when to take these breaks. Workers are allowed to take breastfeeding breaks for a total of seven months from the time of the infant's birth (this period can be extended in exceptional circumstances). Employees must inform their employer of their intention to take the breaks and must prove by means of a monthly medical certificate that they are still breastfeeding. From the time the employee announces her intention to take the breaks until one month after she is no longer entitled to them, she cannot be dismissed for reasons linked either to her health or to the fact that she is breastfeeding.

Source: MPC, 2003, op. cit., Sect. 7, pp. 3-4.

Some countries grant longer and/or more frequent breaks in the case of particular needs. In Colombia, the employer is bound to grant rest periods more often than the usual two breaks of 30 minutes each, if the female employee produces a medical certificate indicating the reasons why she requires more frequent breaks. In Estonia, the duration of a break granted for feeding two or more children up to 18 months of age shall be at least one hour, instead of the normal duration of 30 minutes. In some countries, nursing breaks may also be extended if there are no nursing facilities at the workplace.

In nearly all countries allowing breastfeeding breaks, the entitlement extends until the child is 6 months old, the age at which **exclusive breastfeeding** is no longer recommended; some countries grant breastfeeding breaks for up to two years, in accordance with the WHO recommendation that breastfeeding be continued at least until the child is 2 years old.

The period during which breastfeeding breaks are allowed may be indicated by such general expressions as "for the period of lactation", "until the child is weaned", or "as necessary"; in some countries, no period is set at all.

Daily reduction of working hours

Convention No. 183 offers the possibility for member States to choose whether breastfeeding women should be provided with a right to daily breaks or to a daily reduction of hours of work. In many countries, nursing breaks can be converted into a reduction of working time to allow for late arrival or early departure from the workplace. This is the case in Guatemala where, during the breastfeeding period, a woman worker may accumulate the two breaks of 30 minutes each and either come to work an hour later than normal or leave an hour earlier. In Ecuador, in enterprises or workplaces where there is no nursery, a nursing mother's workday is reduced to six hours for the first nine months after confinement.

Some women opt for shorter working hours in order to be with their infant for longer periods before or after work. They also may breastfeed and/or express their milk during the lunch break.

Paid breaks

Both Convention No. 103 and Convention No. 183 stipulate that interruptions of work for the purpose of nursing are to be counted as working time and remunerated accordingly. This is usually also the case in countries that offer breastfeeding breaks, with legislation in more than two-thirds of these countries explicitly providing for payment.

Even in countries where maternity leave is not paid, breastfeeding breaks may nevertheless be paid as normal working time. This is the case in Lesotho, where a woman is entitled to paid breaks of up to one hour a day for six months immediately after her return from unpaid maternity leave. In Papua New Guinea, a female employee is entitled to two nursing breaks of 30 minutes each, counted as working hours without implying a reduction in wages. In some countries, remuneration is handled through collective bargaining. Other countries provide for payment under the social security regime, thus avoiding a direct cost to the employer.

Breastfeeding breaks in practice

If a mother brings her baby to the workplace, it is important to ensure it is safe and not exposed to harmful substances or to unhygienic conditions. Even where the workplace is safe, some working arrangements can be a problem for breastfeeding women. The timing, length and flexibility of shifts and breaks are all important. For example, lack of nursing breaks may prevent continued breastfeeding on return to work with health risks to mother and child.

When the baby cannot be brought to work and is not nearby, women may use breastfeeding breaks to express their milk at work. In this way they can both continue to offer their babies breast milk and maintain the milk supply by regular expression. In fact it is essential for breastfeeding mothers to continue stimulating the milk supply during the day by expressing their milk if it is not possible for the child to accompany her mother to work. If milk production is interrupted during long periods every day, the supply is reduced and will eventually cease completely. Breastfeeding only early in the morning and in the evening is not sufficient to maintain the supply, especially if the infant is just a few weeks or months old (See **Box 10.7**).

Box 10.7 Why are breastfeeding breaks needed?

Breaks enable mothers to keep up a good supply of breast milk. A lactating mother makes milk 24 hours a day. Normally, her baby breastfeeds around the clock as well, and her breasts respond to the baby's demand by making the amount of milk that the baby takes, for the times the baby usually takes it. If her baby begins to space feedings farther apart (and thus sleeps for longer periods at night), her body will adjust by making less milk at those times.

When the mother's job takes her away at a time the baby normally breastfeeds, her baby can drink milk that she has expressed (by hand or with a pump) and left with the caregiver. In order to continue making enough milk for her baby's needs, the mother must also express the milk that gathers in her breasts during the time that she and her baby are apart. In addition, a woman who expresses milk is taking care of her own health, relieving pressure in her breasts and protecting them from infections.

A breastfeeding mother invests time and energy providing food and care for her family. This is rewarding but also stressful. Milk expression in particular becomes more difficult when women are under stress. A supportive attitude from the employer, supervisors, union and co-workers can lessen the stresses of balancing job and family needs.

Source: MPC, 2003, op. cit.

Breastfeeding breaks and facilities offer advantages to the mother and baby and also to employers (see the first section of this module).

Breastfeeding facilities

Breastfeeding facilities or nursing rooms are simply places where a worker can feed her baby or express her milk. The requirements are similar to those for preparing safe food: that they are clean and have clean water available for washing hands and cleaning utensils.[15] Many women request that the facility offer a certain degree of privacy.

International labour standards and legislation

Convention No. 183 does not set out requirements for breastfeeding facilities. However Recommendation No. 191 calls for the provision of such facilities (see **Box 10.8**).

Box 10.8 Recommendation No. 191, Paragraph 9

Where practicable, provision should be made for the establishment of facilities for nursing under adequate hygienic conditions at or near the workplace.

Regulations on the provision of a special nursing room have been identified in more than 20 countries, mainly in Africa, Asia and Latin America, as set forth in Recommendation No. 191: for example, Belgium, Costa Rica, Latvia, the Netherlands, Nicaragua, Niger and the Philippines (see **Boxes 10.6** and **10.9**).

Such regulations usually apply to all sectors of activity, but often only to those enterprises employing a minimum number of women. The minimum may be as high as 100 but is

[15] WHO, 2000, cited in MPC, op. cit., Sect. 1, p. 8.

generally set at 25, 30 or 50 female workers. A number of countries adapt the length of time allowed for nursing breaks to the presence or absence of nursing facilities on-site.

In a limited number of countries, a special quiet room is to be provided only for pregnant women or nursing mothers. Even where legislation does not require employers to provide nursing facilities, many enterprises choose to maintain an on-site nursery or a quiet room, where nursing mothers can express their milk during the workday for later use at home. Unless nursing facilities are clearly designated and appropriately situated, nursing mothers may suffer a lack of privacy and security from unwarranted intrusion.

Few workplaces provide such facilities, but a recent trend is that more workplaces are providing facilities in which mothers express their milk and save it to feed their child at home later.

Box 10.9 Legislation on breastfeeding facilities

Law on Breastfeeding facilities at the workplace, Peru
From 23 August 2006, a supreme decree states that all institutions belonging to the public sector employing at least 20 women of reproductive age, have to set up a facility of around 10 square metres for the sole use of expressing milk. This is intended to harmonize family and work life. There are presently 180 such facilities in Peru.

Lactation Stations Act, Brazil
Brazil has recently approved the "Norms and Rules" to implement lactation facilities at the workplace. This is to enable working women to express their milk in hygienic conditions, to store it and take it home safely to feed their babies. This is not a law but a "sanitary rule".

For the past year, advocates in Brazil have been identifying employers who have set up such lactation facilities. On 26 April 2010, a campaign to make the new norms known was launched throughout the country. A large gathering assembling entrepreneurs and decision-makers took place in Sao Paulo on that day.

Health experts call for more breastfeeding support for working mothers, the United Arab Emirates
Health experts are urging the government to double the amount of time that working mothers are allowed to breastfeed their babies. The call for longer statutory breaks – from one hour per day to two for the first 18 months after giving birth – was among 12 recommendations submitted to the government. They also called for an extension of paid maternity leave, from 45 days to at least 14 weeks.

One 25-year old mother started feeding her baby formula when she returned to her job as an executive assistant at Al Ain Hospital. She found that an office environment was not conducive to breastfeeding. There is no nursery for staff members in the hospital and there are no hygienic and private places where she could express milk. She was allowed to leave work one hour early so that she could feed her three-month-old son. "My son needs to be fed four or five times a day and I give him formula", she said. "I would take more time off if it was possible".

Her first two sons were breastfed, but her work schedule now does not allow her time to express her milk. Although she has her own office, she found the idea of using it to express milk embarrassing. She also disliked the idea of locking herself in a bathroom stall. "I feel too shy to do it during work hours", she said, "We should have a special place".

Sources:
Lactancia de madres trabajadoras es promovida por empresas publicas, June 2008, **http://radio.rpp.com.pe/saludenrpp/lactancia-de-madres-trabajadoras-es-promovida-por-empresas-publicas/** [accessed 27 Sep. 2011]
A. McMeans: "UAE: Government urged to double work breaks for breastfeeding mothers", in *The National*, Dec. 2009.
Ministério da Saúde: Portaria Nº 193, de 23 Fev. de 2010.

Setting up a facility

Many people assume that breastfeeding facilities are complicated to set up, expensive and hardly worthwhile given the few workers likely to use them. However, a basic breastfeeding facility is simply a small, clean space with a chair. There should be a screen, curtain or door for privacy, access to clean water and secure storage space for expressed milk. It should be located near the workers who use it, so their limited break time is not wasted in travel. More elaborate facilities offer a refrigerator or an electric outlet for an electric breast pump. **Box 10.10** describes a typical breastfeeding facility and **Box 10.11** gives an example from Mozambique.

Even if the facilities needed for a nursing room are minimal, workplaces often lack adequate hygienic conditions for breastfeeding. As a result, nursing mothers may be forced to choose between weaning their infants earlier than recommended or using the facilities available, even if they are not satisfactory.

Box 10.10 Facilities for expressing breast milk

To set up an appropriate place for employees who are breastfeeding requires:

- a private, clean, quiet, warm room or space – such as a screened off area (spaces don't need to be sterile, just clean), which needs to be big enough to manoeuvre a pram;
- a low comfortable chair .

To ensure privacy, windows or glass walls may need to be screened. If an employee is expressing breast milk, in addition to the things listed above the following are needed:

- a lockable door;
- a washbasin;
- a refrigerator or cooler for storing expressed breast milk;
- a table;
- a clean space to store equipment (e.g. a small locker or cupboard);
- the availability of electricity (if using an electric breast pump).

Toilets are not acceptable places to breastfeed or express breast milk. Toilets are not only unsanitary, but are also inappropriate for all cultures.

A breastfeeding facility is not expensive or complicated to set up
Basic cleanliness, accessibility and security are the most important features of a breastfeeding facility. A worker needs to know that the space will be available when she needs it. More than one mother can use the space at the same time, if all agree. In fact, they may find it helpful for mutual encouragement.

The level of cleanliness is similar to that needed for preparing and eating food, thus, a toilet is not an appropriate location. Although a refrigerator is useful, it is not essential. The mother or the employer can provide a small coolbox or thermos flask.

Breast milk can be expressed into a cup, glass, jug or jar that has been thoroughly washed with water and soap, and then stored in a glass with a cover indicating the time and date. Expressed Breast Milk (EBM) can be safely stored for eight hours at room temperature, or in a refrigerator for 24 to 48 hours. If deep freezing is available, EBM can also be stored for three months

Sources:
M. Hamosh et al.: "Breastfeeding and the working mother" in *Pediatrics* (1996, Vol. 97, No. 4), pp. 492-498.
MPC, 2003, op. cit.
New Zealand Department of Labour: *Breastfeeding in the workplace: A guide for employers* (n.d.).
WHO: *Infant and young child feeding. Model chapter for text books for medical students and allied health professionals* (Geneva, 2009), p. 32.

Box 10.11 WISE-R family-friendly programme in a hotel complex in Mozambique: setting up a breastfeeding room

Breastfeeding and emergency childcare. Managers of *Complexo Palhota*, a hotel complex in Mozambique, participated in a training event on improving working conditions in small and medium enterprises, hosted by the Ministry of Labour, CTA (an organization for the tourism industry) and the ILO. The training methodology, Work Improvements for Small Enterprises (WISE) encourages low-cost workplace actions that improve the quality of life in the workplace while also increasing productivity. As part of their action plan, the company decided to allocate one hotel room as a breastfeeding room to meet a key need of the largely female workforce. Employees who are breastfeeding now have access to clean water and a refrigerator if needed. Because reliable childcare is also a pressing concern for workers, the hotel also permits employees to bring their babies to work when no other alternatives are available. Such low-cost measures can go far in meeting the practical needs of workers while reducing absenteeism and improving productivity for the enterprise.

Source: ILO: WISE+ in *Mozambique: Success Stories, Complexo Palhota*, Minutes of WISE+ Evaluation Workshop, unpublished, pp.*1-2.*

Other factors supporting breastfeeding at work

Besides breastfeeding breaks and facilities, other elements can support workers in successfully combining breastfeeding and employment.

Information

Information can be prepared, collected and made available to all workers. It could include specifications on pay and leave entitlements, announcements concerning potential flexible work options, strategies for returning to work, childcare information and options, specific arrangements and facilities to support breastfeeding on return to work. Such information can be in special kits or packages, or be included in general personnel resource materials, safety manuals or new employee orientation flyers. Information should be available before the woman starts her leave because the decision to breastfeed is usually taken in the prenatal period, as well as the decision to return or not to work.

Support by employer and colleagues

Employers may circulate information about the requirements of breastfeeding mothers, available options at the workplace, benefits to the firm, the mother, the baby and the importance of their support and respect for breastfeeding workers. Managers can be encouraged to be considerate when planning meetings or other work events so as to include breastfeeding workers. Breastfeeding may be included in discussions on other issues, such as sexual harassment. The more employers and colleagues learn about breastfeeding, the more they will accept breastfeeding arrangements at the workplace and feel supportive.

Flexible work arrangements

Flexible work arrangements – which are often important for both men and women with family responsibilities – can be especially important when a woman first returns to work. Such arrangements allow an easier transition period and flexibility in changing the schedule of both mother and child. Flexible working arrangements include: part-time

employment, job sharing, career break schemes, flexible hours, home-based or telework, flexible leave arrangements, leave without pay and the flexible use of annual leave (see **Module 11**).

Childcare facilities

Centres in the workplace or nearby can facilitate breastfeeding, especially for children under 12 months (see **Module 11**).

Box 10.12 describes a tool that may be used to assess the workplace situation in terms of breastfeeding support.

Box 10.12 Evaluation of breastfeeding support at the workplace

An instrument, Employees' Perceptions of Workplace Breastfeeding Support – Questionnaire (EPBS-Q), has been developed that can be used at the workplace level to understand why women who return to work discontinue breastfeeding sooner than the general population.

Use of the tool reveals that the main influences include:

- space for breastfeeding (physical environment);
- company policies (organization structure);
- managers and co-workers (human dimension);
- supportiveness for breastfeeding (social climate).

Elements of the workplace environment that may encourage breastfeeding include flexible scheduling, having a place for expressing breast milk that provides sufficient privacy, adequacy of breaks, availability of storage for expressed breast milk, knowledge that other employees or managers have breastfed at the workplace, and company-provided accommodation for expressing milk (e.g. lactation programmes, pumping rooms and pumping equipment). Manager and co-worker attitudes and support play an important role in whether or not women continue to breastfeed after returning to work.

Sources:
S. Greene and B. Olson: "Development of an Instrument Designed to Measure Employees' Perceptions of Workplace Breastfeeding Support", in *Breastfeeding Medicine* (2008, Vol. 3, No. 3), pp 151-157.
S. Greene, B. Olson and W. Wolfe: "Assessing the Validity of Measures of an Instrument Designed to Measure Employees' Perceptions of Workplace Breastfeeding Support", in *Breastfeeding Medicine* (2008, Vol. 3, No. 3), pp. 159-163.

Breastfeeding policy at the workplace

Another supporting factor for breastfeeding is for the employer to have a policy that supports breastfeeding at work (see **Box 10.13**). Developing and disseminating such a policy statement will help to demonstrate the employer's commitment to the workplace provisions. The policy should:

- help to reassure women that participation in the paid workforce is compatible with their reproductive function including breastfeeding, and that the employer supports it;
- outline workplace provisions to enable women to maintain breastfeeding (e.g. breastfeeding breaks, facilities and promotion of work-based child care);

- highlight the employer's commitment to helping both men and women workers to better balance their paid work with family responsibilities through flexible working arrangements such as teleworking, job-sharing, part-time work and flexitime (see **Module 11**).

This policy could be part of the company's competitive recruiting package offered to potential employees along with general information about parental leave entitlements and other family-friendly measures, which all men and women should receive when they start work.

Box 10.13 Guidance for developing a policy to support breastfeeding in the workplace

- Businesses need to consider adopting a breastfeeding policy that meets the needs of employees while also taking account of workplace conditions.
- This policy could be made available in the same way as other workplace policies, such as those concerning family-friendly provisions and sexual harassment.
- Human resources personnel, managers and immediate supervisors need to be educated about and made aware of the policy.
- This policy could also be made available, along with general information about parental leave entitlements and other work-family balancing measures, to all employees announcing their pregnancy (rather than at the start of maternity leave) so that they can plan accordingly.
- The policy may need to be tailored to meet the specific conditions of the workplace, but would ideally include appropriate provisions for the three essential components for breastfeeding support: time, space and support.
- Breastfeeding/breast milk expression breaks may need to be negotiated with regard to both their frequency and whether they are paid or not. This may require negotiations between the employer and an employee or their representative that takes account of both employee and organizational needs.
- Breastfeeding breaks are commonly for 30 minutes twice daily or 20 minutes three times daily. However, some employees may prefer to opt for a longer lunch break combined with another shorter break.
- The policy might also include various employment flexibility options to enable the employee to phase back to full-time work following leave, including part-time work, job sharing and/or flexitime.
- Businesses may wish to consider translating the policy into other languages spoken by those in the workplace.

Source: J. Galtry and M. Annandale, 2003, op. cit., pp. 4-5.

Box 10.14 shows a model policy (*Balancing Breastfeeding and Work*) for workplaces produced by the Australian government.

Box 10.14 Model breastfeeding policy statement for workplaces

This organization_____ recognizes the importance of breastfeeding for both mother and infant and supports, protects and promotes breastfeeding.

This organization provides facilities and the support necessary to enable mothers in our employment to balance breastfeeding/breast milk expression with their work.

Provision of facilities and support includes:
Breastfeeding/breast milk expression breaks. There is flexibility for mothers to take breaks for breastfeeding/expressing breast milk during their workday. They can be negotiated between the mother (or her employee representative) and her supervisor.

A clean private room with electricity, lockable door, a comfortable chair, a table, hand washing facilities, (where possible a refrigerator), and breast pump storage area.

Access to breastfeeding resources:
Employees who are pregnant or considering pregnancy will be provided with information about this policy along with policies on maternity leave/parental leave and about balancing breastfeeding and work.

Flexible work options:
A mother (or her employee representative) can negotiate flexible work options (such as flexitime, part-time, home-based work) with her supervisor taking into account both the employee's and the organization's needs.

All staff are made aware of this policy.

Source: J. Galtry and M. Annandale, 2003, op. cit., pp. 4-5.

Once developed, the policy has to be implemented. Mechanisms have to be put in place, and the policy must be monitored and evaluated on a regular basis. All employees, managers, supervisors, resource staff and other workers will probably need to discuss the needs of breastfeeding mothers and should all be aware of the in-house policy, including the benefits breastfeeding can bring to the different people concerned.

More guidance for making workplaces more breastfeeding-friendly

There are several options for making workplaces friendlier for mothers who want to work and to continue breastfeeding. **Box 10.15** provides some general guidance while **Box 10.16** describes success stories in various firms and awards presented to breastfeeding-friendly workplaces.

Box 10.15 Towards making a workplace "breastfeeding-friendly"

Time:

- Provide statutory paid maternity leave for women who qualify.
- Provide paternity and parental leave.
- Offer flexible work hours so that breastfeeding mothers can take extended lunch breaks to express milk or breastfeed their baby.
- Provide a breastfeeding break of at least one hour per day if the baby can be brought to work.
- Be attentive to parents' needs regarding children's schedules.

Space:

- Provide comfortable, private facilities for expressing breast milk; the woman's toilet is not suitable; also provide access to a refrigerator to store expressed breast milk.
- Keep the work environment clean and safe from dangerous waste products and chemicals – for both female and male workers.
- Provide day care facilities, if feasible, and a playroom for older children.

Support:

- Provide a clear policy in support of breastfeeding and of family-related entitlements.
- Inform all workers about maternity benefits and provide information on women's health.
- Encourage a staff support network.
- Organize discussions and information sessions on breastfeeding, maternity and family-friendly measures.
- Consult with workers to learn about their family-related needs.
- Make sure that parents are not discriminated against when it comes to job and promotion opportunities when they apply or return to work after a family-related leave.

Source: Lanarkshire Breastfeeding Initiative, cited in MPC, 2003, op. cit., Sect. 5.

Box 10.16 Family-friendly and baby-friendly initiatives

Childcare centre in South Africa

In 2008, the First National Bank of South Africa, one of the country's largest commercial banks, opened its first childcare centre. In order to compete in an international market it is important to attract and retain skilled personal. An efficient way to do so is through a comprehensive benefit scheme, namely a childcare centre for mothers to be able to reconcile their work obligations with their family responsibilities. The bank assigned childcare professionals to run the centre and worked closely with trade unions in order to ensure maximum efficiency. The daycare centre was filled rapidly, taking in children from three months to six years of age.

Community crèche in Kenya
In 2006, Red Land Roses and Pollen Ltd. in Kenya opened its first childcare centre for children aged two months to four years. The children are provided with proper nutrition and health care, including treatment of HIV and AIDS. The centre is subsidized by public–private partnerships, and financed by the profits of the company. Those who wish to put their children in the centre only pay 10 per cent of the effective care costs. Also, the centre expands its services free of charge to some of the poorest families in the area. Since this programme has been implemented, the company has seen a substantial increase in productivity as well as a decrease in absenteeism. It has been particularly effective since women constitute around 60 per cent of the workforce.

When women bring their babies to work, India
Mobile Crèches approaches builders at potential construction sites with a view to opening a centre for the children of its workers. If the builders agree, they provide accommodation, electricity and water. The crèche only lasts as long as construction on the site. The infant section looks after newborn babies and infants and mothers are encouraged to breastfeed regularly. Older children are prepared for admission to regular schools. To date, Mobile Crèches has trained 6,000 childcare workers and run 600 day care centres.

Source: C. Hein and N. Cassirer: *Workplace solutions for childcare* (Geneva, ILO, 2010).
For more information, see: **http://www.redlandsroses.com/index.php**, **www.mobilecreches.org** and **http://www.bpni.org/mp/Ws40-BPNI1-Mridula_Bajaj.pdf**

Small businesses sometimes face their own challenges when establishing breastfeeding facilities given that very few employees may need such support at any given time. **Box 10.17** provides some ideas for meeting these challenges.

Box 10.17 Ideas for smaller businesses

Small businesses can face additional challenges when considering initiatives to support breastfeeding, particularly those that have confined spaces. If you have a small business, some creative ideas that other small employers have already used might work for you:

- If you cannot provide the space, can you provide the time e.g. flexible working hours, reduced hours, longer lunch hours and working from home?
- Make one or more offices available at intervals during the day. They might need blinds installed for privacy, or a comfortable chair added.
- A number of different businesses in a mall, or in the vicinity of a mall, or in a single building, could pool resources to lease and equip a family room for staff.
- If a room is not available, look at the different spaces you have and consider whether anything could be reorganized or stored off-site to create a suitable space, even if this is only temporary.
- Could a sick room be adapted?
- Use screens and "do not disturb" notices to make a cubicle private.
- Contact a breastfeeding advocate to work with your organization one-on-one.

Source: New Zealand Department of Labour: *Breastfeeding in the workplace: A guide for employers* (Auckland, 2010).

Breastfeeding and HIV

HIV can be transmitted by an HIV-positive woman to her baby during pregnancy, delivery or breastfeeding. This is usually referred to as mother-to-child-transmission (MTCT). Antiretroviral (ARV) drugs and other measures can dramatically reduce the risk of transmission. Pregnant women and lactating mothers need to know their HIV status in order to benefit from prevention and care interventions.

Workplaces can facilitate access to voluntary and confidential testing, access to treatment to prevent MTCT and access to information on infant feeding options for HIV-positive women. In settings where mothers living with HIV are encouraged to breastfeed as the option likely to lead to the best outcome for their infants, continued breastfeeding after returning to work is even more critical. For more information concerning breastfeeding and HIV, see **Module 8**.

Knowing one's status

In order to protect their own health and the health of their infants, all women should know their HIV status and take appropriate action accordingly. In many countries, women are disproportionately affected (see **Box 10.18**). However, in 2009 only 26 per cent of the estimated numbers of pregnant women living in low- and middle-income countries were tested for HIV. Thus, the majority of pregnant women are unable to access appropriate preventive measures if HIV-negative, or treatment and support if HIV-positive.

Box 10.18 Women, HIV and AIDS

Globally, about half of all people living with HIV are female, with variation within regions, countries and communities. In low- and middle-income countries, rates range from a low of 31 per cent in Eastern Europe and Central Asia to approximately 60 per cent in sub-Saharan Africa. Rates also vary by age: in the Caribbean, where women comprise 48 per cent of people living with HIV, young women are approximately 2.5 times more likely to be infected with HIV than young men. In southern Africa, girls are two to 4.5 times more likely to become infected with HIV than boys, compounding other vulnerabilities such as poverty, humanitarian and food crises and the increased economic and care needs of AIDS-affected households.

Regional differences can be quite stark: two-thirds (66 per cent) of women with HIV live in only ten countries (Ethiopia, India, Kenya, Malawi, Mozambique, Nigeria, South Africa, the United Republic of Tanazania, Zambia and Zimbabwe). In the epicentre of the epidemic, nine Southern African countries account for over 40 per cent of the world's HIV-positive women. In Latin America, women constitute 33.5 per cent of people living with HIV, up from 25 per cent in 1999. In the United States today, women account for more than one-quarter of HIV-positive people, up from seven per cent in 1986.

Source: UNAIDS: *UNAIDS Action Framework, Addressing Women, Girls, Gender Equality and HIV* (Geneva, 2009).

Women who are living with HIV and become pregnant may face additional health risks themselves. In the most-affected countries, AIDS-related illnesses are the leading cause of maternal mortality.[16] Maternal deaths worldwide could be reduced by 60,000 per year if women received appropriate HIV diagnosis and treatment.

[16] M. Hogan et al.: "Maternal mortality for 181 countries, 1980-2008: A systematic analysis of progress towards Millennium Development Goal 5", in *The Lancet* (2010, Vol. 376, No. 9750, 23 Oct.), p. 1389.

It is recommended that women who are HIV-infected are assessed for treatment, which is becoming increasingly available and affordable in many places. Women living with HIV, who are followed medically, and if necessary, on treatment according to medical guidelines, may not require any special considerations regarding their work during pregnancy beyond those for other pregnant women. Medical benefits that cover the costs of medical care before and/or during and/or after childbirth should also cover services for the prevention of mother-to-child transmission of HIV (PMTCT).[17]

Ideally, all pregnant women and women who have just given birth should know their HIV status in order to protect their health and make informed decisions about infant feeding. Workplaces can facilitate this by providing information on HIV-testing and prevention, and sometimes by offering testing onsite, as long as confidentiality is maintained.

Preventing mother-to-child transmission (PMTCT) of HIV

A woman living with HIV can transmit the virus to her infant during pregnancy, delivery or breastfeeding. Nearly all of these risks can be eliminated through the appropriate use of antiretroviral drugs as well as safer birthing and feeding practices.

The WHO's guiding principles and recommendations on HIV and infant feeding issued in 2010 aim to achieve the best outcomes for HIV-exposed infants. National or sub-national health authorities should decide whether health services will principally counsel and support mothers known to be HIV-infected to either:

- breastfeed and receive ARV interventions,
  or,
- avoid all breastfeeding, as the strategy that will most likely give infants the greatest chance of HIV-free survival.

This decision should be based on international recommendations and consideration of the:

- socio-economic and cultural contexts of the populations served by maternal and child health services;
- availability and quality of health services;
- local epidemiology including HIV prevalence among pregnant women; and,
- main causes of maternal and child under-nutrition and infant and child mortality.

Where national authorities promote breastfeeding and ARVs, mothers known to be HIV-infected are now recommended to breastfeed their infants until at least 12 months of age. Breastfeeding should only stop once a nutritionally adequate and safe diet without breast milk can be provided.

The WHO recommends that mothers living with HIV avoid breastfeeding and use replacement feeding **only** when **all** of the following conditions have been met:

- Safe water and sanitation are assured at the household level and in the community.
- The mother, father or other caregiver can reliably provide sufficient infant formula milk to support normal growth and development of the infant.

[17] According to the *UNAIDS Terminology Guidelines* (2011), some countries use the term "parent-to-child transmission" or "vertical transmission" in order to avoid stigmatizing pregnant women and to encourage male involvement in HIV prevention.

- The mother, father or caregiver can prepare it cleanly and frequently enough so that it is safe and carries a low risk of diarrhoea and malnutrition.
- The mother, father or caregiver can, in the first six months, exclusively give infant formula milk.
- The family is supportive of this practice.
- The mother, father or caregiver can access health care that offers comprehensive child health services.

PMTCT and the workplace

Women living with HIV who wish to breastfeed and work face the same problems as other working women; support at the workplace is essential for all. As returning to economic activities is a major reason women stop breastfeeding, support for economically active women to continue breastfeeding after their return to work is required. In settings where mothers living with HIV are encouraged to breastfeed as the option which is likely to lead to the best outcome for their infants, continued breastfeeding after returning to work is even more critical.

PMTCT at the workplace is essential in scaling up prevention, in particular in ensuring children do not become infected, and in contributing to women's access to maternal health facilities. PMTCT is not only the woman's concern but also that of the man. The workplace can offer an entry point for male involvement in PMTCT and contribute to their understanding of and support for counseling and testing, best infant feeding practices and other services. Male peer programmes on PMTCT are increasingly being organized at the workplace with the following objectives:

- Contribute to better ARV adherence rates among HIV-infected pregnant women and their infants, and access to care for those with AIDS-defining conditions.
- Increase the number of male partners participating and active in PMTCT programmes.
- Increase the number of male partners trained to support women in target communities.
- Increase the number of workplaces and homes receiving outreach from peer males.

Box 10.19 Male partner involvement in PMTCT in the Kenyan Armed Forces

In 2004 a programme was implemented to integrate PMTCT services within the Kenyan Armed Forces Medical Services.

Civilian and non-civilian health community enrolled nurses from the Kenyan Armed Forces Medical Services were trained about PMTCT and HIV testing and then provided with the required consumables to initiate PMTCT services in their respective duty stations.

Nine months after programme initiation, supportive supervision that included face-to-face meetings and site visits were introduced.

Fourteen health facilities spread throughout Kenya initiated PMTCT services. These services included health education regarding PMTCT, counselling, testing, modification of delivery services, infant-feeding counselling and the provision of the drug Nevirapine (NVP).

In addition, community mobilization that included the provision of information on PMTCT at soldiers' meetings, informal discussions during military exercises, as well as door-to-door visits in some of the barracks was carried out. In the first 18 months of the programme, 1,303 women were counselled, 69.8 per cent accepted testing and 45.7 per cent of the women identified as positive received NVP. The supportive supervision visits helped to identify gaps in the implementation of the recommendations.

Conclusions: It is feasible to provide PMTCT services through largely male workplace health facilities. High HIV test uptake was achieved with moderate uptake of NVP. Regular supportive supervision strengthens the skills of health workers who have had limited PMTCT training and also provides oversight of widely scattered services.

Source: O.I. Ekesa et al.: *Increasing access to PMTCT services through work-place facilities: Experiences from the Kenya Armed Forces Medical Services*, 15th International Conference on AIDS, Bangkok, 11-16 July 2004.

Key points

- Returning to paid work is a major reason for women to stop breastfeeding before the internationally recommended duration of six months of exclusive breastfeeding and continued breastfeeding until two years or beyond.
- Breastfeeding is the norm for feeding babies and supporting breastfeeding at work produces major health and economic advantages with benefits for the child, the mother, the employer and society.
- Among the benefits reported by employers who support breastfeeding at the workplace are lower health-care costs, less absenteeism, and higher productivity.
- International labour standards set out breastfeeding breaks or a daily reduction of working time – that are counted as working time and remunerated accordingly – for mothers returning from maternity leave. National legislation typically provides for one hour, usually divided into two 30-minute breaks per day.
- Breastfeeding facilities at the workplace are inexpensive and easy to set up.
- More and more employers understand the advantages of being breastfeeding-friendly, mother-friendly, and family-friendly – and are making the effort to become so, including through developing in-house policies.
- It is necessary to raise the awareness of policy-makers, trade unions, employers and others on the need to support breastfeeding mothers, both in terms of time and financial allocations. Men as fathers and decision-makers have a critical role to play in supporting these efforts.
- HIV can be transmitted to infants through pregnancy, childbirth and breastfeeding. WHO has specific recommendations regarding the prevention of transmission through breastfeeding. The workplace has a critical role to play in preventing mother-to-child- transmission and in supporting breastfeeding practices in accordance with international guidelines.

Key resources

WHO: Guidelines on HIV and infant feeding (Geneva, 2010).

The WHO has recently published guidelines on prevention of mother-to-child transmission of HIV through breastfeeding. These guidelines are particularly useful when elaborating breastfeeding practices, especially in those countries most affected by the epidemic. They can be used for training and awareness-raising purposes, but also directly by women infected with HIV.

Available at: http://whqlibdoc.who.int/publications/2010/9789241599535_eng.pdf

C. Hein and N. Cassirer: Workplace solutions for childcare (Geneva, ILO, 2010).

This ILO publication goes over the importance of providing childcare solutions for working women, including breastfeeding. It provides examples of good practices put in place by various employers, governments and trade unions in various types of companies around the world. Stakeholders testify of their experience with workplace childcare options, their costs and benefits, as well as lessons learned on how to implement them effectively. It can serve as a basis for any employer wishing to provide breastfeeding options for employees, and also outlines the important role governments and trade unions have to play in this process.

Available at:
http://www.ilo.org/wcmsp5/groups/public/@dgreports/@dcomm/@publ/documents/publication/wcms_110397.pdf

WHO: Evidence on the long term effects on breastfeeding, systematic review and analysis (Geneva, 2007).

This publication carries out a systematic review and meta-analysis of studies to assess the association between breastfeeding and blood pressure, diabetes and related indicators, serum cholesterol, overweight and obesity, and intellectual performance. The study found that subjects who were breastfed experienced lower mean blood pressure and total cholesterol, as well as higher performance in intelligence tests. Prevalence of overweight/obesity and Type-2 diabetes was lower among breastfed subjects. All effects were statistically significant but for some outcomes their magnitude was relatively modest.

Available at:
http://www.who.int/child_adolescent_health/documents/9241595230/en/index.html

WHO/UNICEF: Global Strategy and Infant and Young Child Feeding (Geneva, 2003).

This strategy was adopted by WHA member States almost 10 years ago and has since been implemented at country level more or less successfully. It aims to improve breastfeeding rates worldwide and, more specifically, exclusive breastfeeding rates at six months of age. It encourages a comprehensive package of measures, from legislation and national policy to local and community efforts. It lists the important international instruments on which it is based, and defines the roles of each of the actors involved in the health and nutrition of babies, including obligations related to maternity protection.

Available at:
http://www.who.int/nutrition/publications/infantfeeding/9241562218/en/index.html

Maternity Protection Coalition, Maternity (IBFAN, ILCA, IMCH, LLLI, WABA): Protection Campaign Kit: A breastfeeding perspective (Malaysia, 2003, re-edited 2008).

This action kit, prepared by a coalition of worldwide breastfeeding networks to strengthen Convention No. 183 ratification campaigns, presents a comprehensive understanding of maternity protection from a breastfeeding angle. It underlines how breastfeeding is an important component of maternity protection, addressing all stakeholders on the matter. It gives examples of progressive legislation and actions worldwide, including on setting up breastfeeding facilities at the workplace.

Available at: http://www.waba.org.my/whatwedo/womenandwork/mpckit.htm

ILO Conditions of Work and Employment Programme (TRAVAIL)

The ILO recognizes the importance of breastfeeding for the health care of women and children, and gives attention to this issue in the most recent ILO Convention and Recommendation on Maternity Protection. More information on the ILO approach to maternity protection can be found on the ILO Conditions of Work and Employment Programme (TRAVAIL) website.

Available at: http://www.ilo.org/travail

WHO website on breastfeeding

The WHO has issued a set of information on healthy breastfeeding practices, as well as the importance of breastfeeding. All of this information can be found on their website.

Available at: http://www.who.int/topics/breastfeeding/en/

International Baby Food Action Network (IBFAN)

IBFAN, the International Baby Food Action Network, aims to protect and promote breastfeeding in particular by monitoring and implementing the WHA/UNICEF International Code of Marketing of Breast-milk Substitutes (1981) at country level. The code includes approximately 200 groups in almost 100 countries worldwide, working on infant health and nutrition issues such as child rights, maternity protection, infant feeding in emergency situations, infant feeding and HIV, sponsorship and implementation of the Global Strategy.

Available at: http://www.ibfan.org

International Lactation Consultant Association (ILCA)

The International Lactation Consultant Association (ILCA) is the professional association for International Board Certified Lactation Consultants (IBCLCs) and other health-care professionals who care for breastfeeding families. Its vision is a worldwide network of lactation professionals and its mission is to advance the profession of lactation consulting worldwide. ILCA has more than 5,000 members from 81 nations, including a wide variety of health professionals, midwives, nurses, physicians and medical practitioners, childbirth educators and dieticians. Amongst numerous other activities, ILCA has developed a Worksite Lactation Support Directory that lists IBCLCs who assist business lactation support programmes. One of their aims is to set up tailored breastfeeding programmes at worksites.

Available at: http://www.ilca.org

World Alliance for Breastfeeding Action (WABA)

The World Alliance for Breastfeeding Action (WABA) is a global network of individuals and organizations concerned with the protection, promotion and support of breastfeeding worldwide. WABA's action is based on the *Innocenti* Declarations, the Ten Links for Nurturing the Future and the WHA Global Strategy for Infant and Young Child Feeding. Its core members include international breastfeeding networks such as the Association of Breastfeeding Medicine (ABM), IBFAN, ILCA, La Leche League International (LLLI) as well as Wellstart International. Its goal is to foster a strong and cohesive breastfeeding movement, which will act on the various international instruments to create an enabling environment for mothers – including at the workplace – thus contributing to increasing optimal breastfeeding and infant and young child feeding practices.

Available at: http://www.waba.org.my

Resource and tool sheets

Resource Sheet 10.1: Benefits of breastfeeding

Breastfeeding plays an important role in providing short- and long-term health benefits for children, adults and society in general, including employers. Extensive and continuing research into the nature of breast milk and its effects on the developing infant has documented many health and psychological benefits for the infant and the mother.

Breastfeeding benefits for children

Before the baby is born, he or she is protected in the mother's womb from most of the germs to which the mother is exposed. After birth, the mother's breast milk continues to protect against many of the viruses, bacteria and parasites to which the baby is now exposed. Several substances in breast milk prevent diseases and stimulate and strengthen the development of the baby's immune system. This results in better health, even years after breastfeeding has ended. For these and other reasons based on scientific evidence, the World Health Organization recommends exclusive breastfeeding for babies until the age of six months and continued breastfeeding, coupled with the introduction of solid, semi-solid or soft foods, for children of up to two years of age or beyond.

Breastfeeding promotes child survival:
According to UNICEF, *"If all babies were fed only breast milk for the first six months of life, the lives of an estimated 1.5 million infants would be saved every year and the health and development of millions of others would be greatly improved."*

The WHO similarly estimates that non-exclusive breastfeeding in the first six months of life results in 1.4 million deaths annually and constitutes 10 per cent of the disease burden in children younger than five years.[18]

Reviews of studies in developing countries show that infants who are not breastfed are six to ten times more likely to die in the first months of life than infants who are breastfed.[19] In resource-poor settings, exclusive breastfeeding may be the best option for HIV-positive mothers.[20]

Breastfeeding is an essential means of **providing food security** for millions of infants worldwide, particularly in developing countries and regions coping with conflict, population displacement, natural disasters or economic crises. Under-nutrition is associated with at least 35 per cent of child deaths.[21]

[18] WHO: "Infant and young child feeding", Model chapter for textbooks for medical students and allied health professionals (Geneva, 2009).
[19] WHO, 2009, op. cit.
[20] For recommendations on HIV and infant feeding, see WHO, UNAIDS, UNFPA and UNICEF: *Guidelines on HIV and infant feeding,* 2010, http://whqlibdoc.who.int/publications/2010/9789241599535_eng.pdf.
[21] WHO, 2009, op. cit.

Breastfeeding can reduce the incidence of infectious diseases:

Otitis media: Middle ear infections are one of the most frequent reasons for seeing the doctor. In a US study, infants from birth to 12 months who were not breastfed had twice as many ear infections as babies who were exclusively breastfed for about four months.[22]

Diarrhoea: The antibodies in a mother's milk protect her baby from the germs causing diarrhoea. The cycle of illness, dehydration and malnutrition weakens the child, often fatally. A study from Belarus shows that infants exclusively breastfeeding at three months have 40 per cent less risk of developing gastrointestinal infections.[23]

Pneumonia: Worldwide, pneumonia is one of the leading causes of death in children under five years of age. A study in Brazil showed that the risk of hospitalization for pneumonia among non-breastfed infants was 17 times greater than that for breastfed infants.[24]

Breastfeeding reduces the risk of asthma and other allergies:

In Australia, the risk of childhood asthma decreases by at least 40 per cent in infants who are breastfed for four months.[25] Exclusive breastfeeding has been shown to reduce the risk of asthma by 30 per cent, and showed still better results (48 per cent) in families with a history of asthma-related illnesses.[26]

Breastfeeding improves child development outcomes:

A meta-analysis of 20 studies showed scores of cognitive function on average 3.2 points higher among children who were breastfed compared with those who were formula fed. The difference was greater (5.18 percentage points) among children born with low birth weight.[27]

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22 B. Duncan et al.: "Exclusive breastfeeding for at least 4 months protects against *otitis media"* in *Pediatrics* (1993, Vol. 91, No. 5), pp. 867-872.
WHO, 2009, op. cit.

23 M.S. Kramer et al.: "A Randomized Trial in the Republic of Belarus. Promotion of Breastfeeding Intervention Trial (PROBIT)" in *JAMA* (2001, Vol. 285), pp. 413-420.
S. Arfeen et al.: "Exclusive breastfeeding reduces acute respiratory infection and diarrhea among infants in Dhaka slums" in *Pediatrics* (2001, Vol. 108), p. e67.
I. De Zoysa, M. Rea and J. Martines: "Why promote breast feeding in diarrhoeal disease control programmes?" in *Health Policy and Planning* (1991, Vol. 6), pp. 371–379.

24 J.A. Cesar et al.: "Impact of Breast Feeding on Admission for Pneumonia during Post-neonatal Period in Brazil: nested case-control study" in *British Medical Journal* (1999, Vol. 318), pp. 1316-1320,
C.J. Chantry, C.R. Howard and P. Auinger: "Full breastfeeding duration and associated decrease in respiratory tract infection in US children" in *Pediatrics* (2006, Vol. 117), pp. 425-432.
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25 W.H. Oddy et al: "Association between breast feeding and asthma in the 6-year old child: findings of a prospective cohort study" in *British Medical Journal* (1999, Vol. 319), pp. 815-818.

26 M. Gdalevich, D. Mimouni and M. Mimouni: "Breastfeeding and the Risk of Bronchial Asthma in Childhood: a systematic review with meta-analysis of prospective studies" in *Journal of Pediatrics*, (2001, Vol. 139), pp. 261-266.
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A.L. Wright et al.: "Factors Influencing the Relation of Infant Feeding to Asthma and Recurrent Wheeze in Childhood" in *Thorax* (2001, Vol. 56), pp. 192-197.
I. Kull et al.: "Breast feeding and allergic diseases in infants: A prospective birth cohort study" in *Archives of Disease in Childhood* (2002, Vol. 87), pp. 478-481.

27 J.W. Anderson, B.M. Johnstone and D.T. Remley: "Breastfeeding and cognitive development: a meta-analysis", in *American Journal of Clinical Nutrition* (1999, Vol. 70), pp. 525–535.

Increased duration of breastfeeding has been associated with greater intelligence in late childhood.[28] A recent study in Denmark showed that breastfeeding affected brain development as measured in the child's ability to crawl, to grip and to babble in polysyllables: the longer the duration of breastfeeding, the higher the child's capacities.[29]

Long-term effects of breastfeeding on child health outcomes:

Bone mass: In the United Republic of Tanzania, a study demonstrated a significant association between breastfeeding and higher bone mineral density in comparison with children that had not been breastfed.[30]

Haemophilus influenzae meningitis: In Sweden, a study showed that low breastfeeding rates were followed by increased meningitis rates five to ten years later.[31]

Non-communicable diseases: Breastfeeding also has long term effects on non-communicable diseases such as lower blood pressure, lower levels of cholesterol and diabetes.[32]

Obesity: In a number of countries (e.g. the Czech Republic, Germany, the UK and the USA) research demonstrates that breastfeeding reduces the risk of obesity and being overweight.[33]

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28 M.C. Daniels and L.S. Adair: "Breast-feeding influences cognitive development in Filipino children", in *The Journal of Nutrition* (2005, Vol. 135), pp. 2589–2595.

29 M. Vestergaard et al.: "Duration of Breastfeeding and Developmental Milestones during the Latter Half of Infancy" in *Acta Paediatrica* (1999, Vol. 88), pp. 1327-1332.
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30 G. Jones, M. Riley and T. Dwyer: "Breastfeeding in early life and bone mass in prepubertal children: A longitudinal study", in *Osteoporos International* (2000, Vol. 11), pp. 146-152.

31 S.A. Silfverdal, L. Bodin and P. Olcen: "Protective effect of breastfeeding: An ecologic study of *Haemophilus influenzae* meningitis and breastfeeding in a Swedish population", in *International Journal of Epidemiology*, (1999, Vol. 28), pp. 152-156.

32 WHO: Evidence on the long term effects on breastfeeding: Systematic review and analysis (Geneva, 2007).

33 R. Kries et al.: "Breastfeeding and obesity: Cross sectional study", in *British Medical Journal*, (1999, Vol. 319), pp. 1547-150.
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C.G. Owen et al: "Effect of infant feeding on the risk of obesity across the life course: a quantitative review of published evidence", in *Pediatrics* (2005, Vol. 115), pp. 1367-1377.
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Urinary infection: S. Marild et al.: "Protective effect of breastfeeding against urinary tract infection", in *Acta Paediatrica*, (2004, Vol. 93), pp. 164-168.

Benefits for Mothers

Breastfeeding results in the reduction of anaemia:
In the first hours and days after birth, early breastfeeding brings about uterine contractions, preventing excessive blood loss. Over the months to come, breastfeeding reduces the frequency and severity of anaemia by delaying the return of menstruation and by building iron reserves.[34]

Long-term effects of breastfeeding on mothers' health:[35]
Breast cancer: Studies from China, Japan, Mexico, New Zealand, the United Kingdom and the United States show that women who breastfed their children have a reduced risk of developing breast cancer and that the risk declines with increased duration of breastfeeding.[36]

Ovarian cancer: Breastfeeding for at least two months per child decreases the mother's risk of developing epithelial ovarian cancer.[37]

Osteoporosis: The risk of hip fracture amongst women over 65 is reduced by half for those who have breastfed. It decreases by another quarter for those who have breastfed each of their children for at least nine months.[38]

Mental and emotional well-being:
Breastfeeding develops a mother's confidence in her physical and emotional capacities.[39]

Benefits for Families

Breastfeeding strengthens family ties:
Studies have highlighted the emotional and psychological importance, as well as the bonding effects of breastfeeding, to both mother and child. The importance of bonding is even greater when mothers return to work.[40]

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34 American Academy of Pediatrics: "Breastfeeding and the use of human milk", in *Pediatrics* (1997, Vol. 100), pp. 1035-1039.

35 A. Dermer: "A well-kept secret: Breastfeeding's benefits to mothers", in *New Beginnings* (2001, Vol. 18, No. 4), pp.124-127.

36 United Kingdom National Case-Control Study Group: "Breastfeeding and Risk of Breast Cancer in Young Women" in *British Medical Journal* (1993, Vol. 307), pp. 17-20.
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38 R.G. Commings and R.J. Klineberg: "Breastfeeding and Other Reproductive Factors in the Risk of Hip Fracture in Elderly Women", in *International Journal of Epidemiology* (1993, Vol. 2, No. 4), pp. 684-691.
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39 M. Locklin: "Telling the world: Low income women and their breastfeeding experiences" in *Journal of Human Lactation* (1995, Vol. 11, No. 4), pp. 285-291.

40 K. Uvnas-Moberg: "Breastfeeding: physiological, endocrine and behavioural adaptations caused by oxytocin and local neurogenic activity in the nipple and mammary gland", in *Acta Paediatrica* (1996, Vol. 5, No. 5), pp. 525-530.

Family planning:
As long as a mother breastfeeds exclusively or nearly exclusively and as long as menstruation has not recommenced, her protection against pregnancy during the first six months is 98 per cent.[41] This family planning method is called the Lactational Amenorrhea Method (LAM).

Breastfeeding brings economic benefits and helps to save time:
- Saving in time and money for the purchase of breast-milk substitutes and other feeding equipment.
- Less spent on medical care and medication.
- Less time preparing bottles, including fetching water, fuel and cleaning utensils.

Benefits for Employers

Breastfeeding reduces staff absenteeism:
Studies have shown that breastfed babies have fewer episodes of illness than formula-fed infants and that rates of absenteeism were lower for mothers of breastfed babies (only 25 per cent of one-day maternal absences) than for mothers of bottle-fed babies.[42]

Reduction in work–family conflict:
Family-friendly interventions and workplace support mechanisms for working mothers and parents are also likely to reduce the incidence of work–family conflict. "Available research suggests that workplace breastfeeding support has positive ramifications, including decreased health care costs".[43] In addition, employees supported by such interventions will have greater loyalty to and respect for their employer, which enhances morale and commitments.[44]

Increase in employee retention:
Research shows that women who choose to breastfeed are more likely than others to return to the paid workforce and many want to continue breastfeeding upon their return.[45]

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41 K.I. Kennedy and C.M. Visness: "Contraceptive Efficacy of Lactational Amenorrhea", in *The Lancet* (1992, Vol. 339), pp. 227-230
M. Labbok: "The Lactational Amenorrhea Method (LAM): Another choice for mothers", in *Breastfeeding Abstracts* (1993, Vol. 13, No. 1), pp. 3-4.
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42 R. Cohen, M.B. Mrtek and R.G. Mrtek: "Comparison of maternal absenteeism and infant illness rates among breastfeeding and formula-feeding women in two corporations", in *American Journal of Health Promotion* (1995, Vol. 10, No. 2), pp. 148-153.

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44 G.H. Seijits: "Milking the organization? The effect of breastfeeding accommodation on perceived fairness and organizational attractiveness", in *Journal of Business Ethics* (2002, Vol. 40), pp. 1-13.

45 K. Auerbach, 1990, op. cit.

Higher worker satisfaction:
Case studies that record the experiences of women who have combined work and breastfeeding show that many women report "feelings of personal satisfaction and pleasure in the commitment that they made to their baby and to their job".[46]

Benefits for Society

Breastfeeding helps to protect the environment:

- Ecological in its production, consumption and disposal, it is a natural and renewable resource.
- Less industrial production, transportation, packaging and disposal pollution: breastfeeding produces hardly any waste.

Breastfeeding results in overall economic benefits:
Nations can save substantial amounts on the purchase and distribution of commercial breast-milk substitutes (often in foreign exchange). In India for example, women nationally produce approximately 3,900 million litres of milk over a two-year period (which corresponds to the usual lactation period of Indian mothers). If tinned cows' milk had been purchased instead, it would have cost close to US$3 billion, more than three times the combined budgets of the Departments of Education, Health and Family Welfare, and Science and Technology during that same period. In Guatemala, annual spending on breast-milk substitutes amounted to approximately US$ 48 million in 1999.[47]

Societies can save on health-care expenses for preventable acute and chronic illnesses. A recent study estimated that if 90 per cent of US mothers complied with medical breastfeeding recommendations, the nation could save US$13 billion and avoid 911 deaths per year.[48] Although somewhat dated, a 1997 Australian study calculated that if breastfeeding until three months of age increased in prevalence from 60 per cent to 80 per cent, Australian $3.7 million would be saved on treating gastro-intestinal diseases alone.[49]

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46 K. Auerbach, 1990, op. cit.

47 A. Gupta and K. Khanna: "Economic Value of Breastfeeding in India" in *National Medical Journal of India*, (1999, Vol. 12, No. 3), pp. 123-127.
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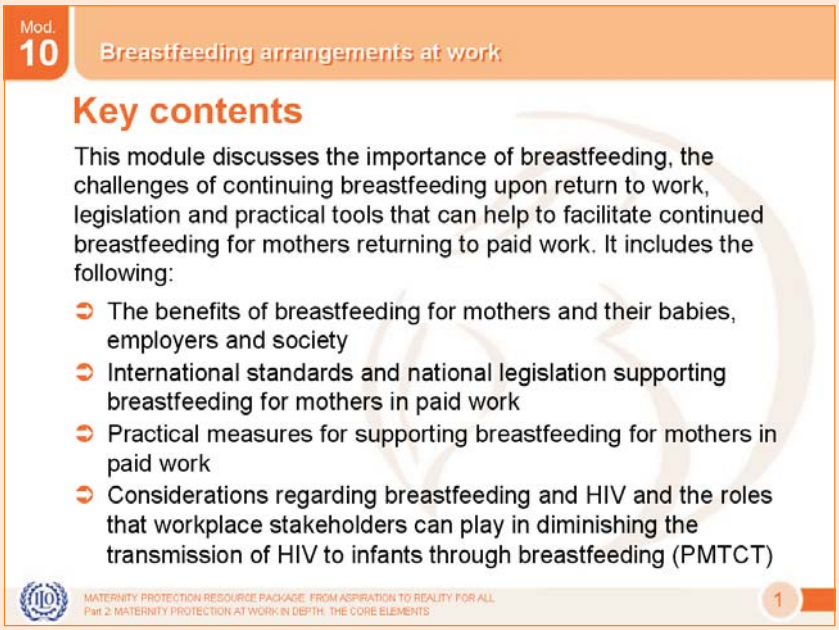
48 M. Bartick and A. Reinhold: "The burden of sub optimal breastfeeding in the United States: A pediatric cost analysis", in *Pediatrics* (2010, Vol. 125, No. 5), pp. 1048-1056.

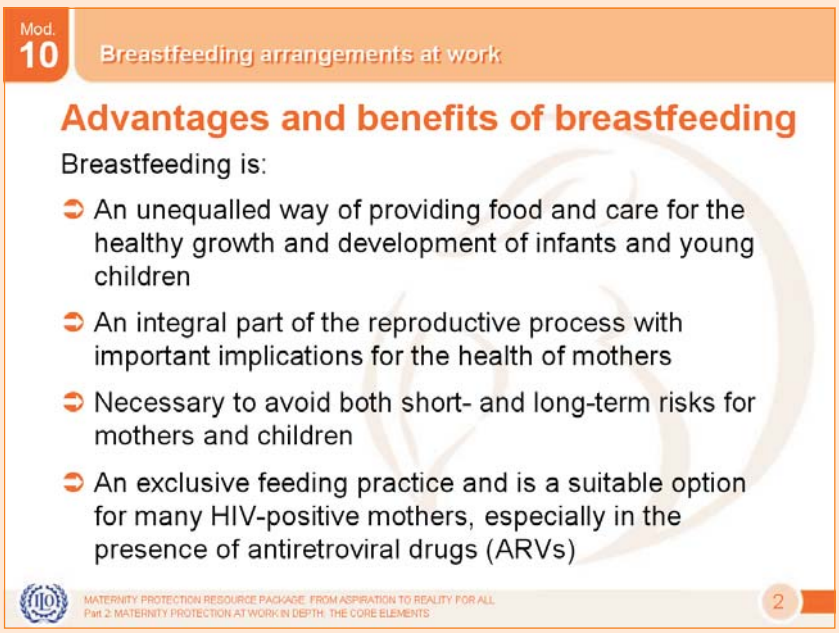
49 D. Drane: "Breastfeeding and Formula Feeding: a preliminary economic analysis", in *Breastfeeding Review,* (1997, Vol. 5, No. 1), pp. 7-17.

Visual presentation model

SLIDE 1: Key contents



SLIDE 2: Advantages and benefits of breastfeeding



SLIDE 3: Breastfeeding after returning to work

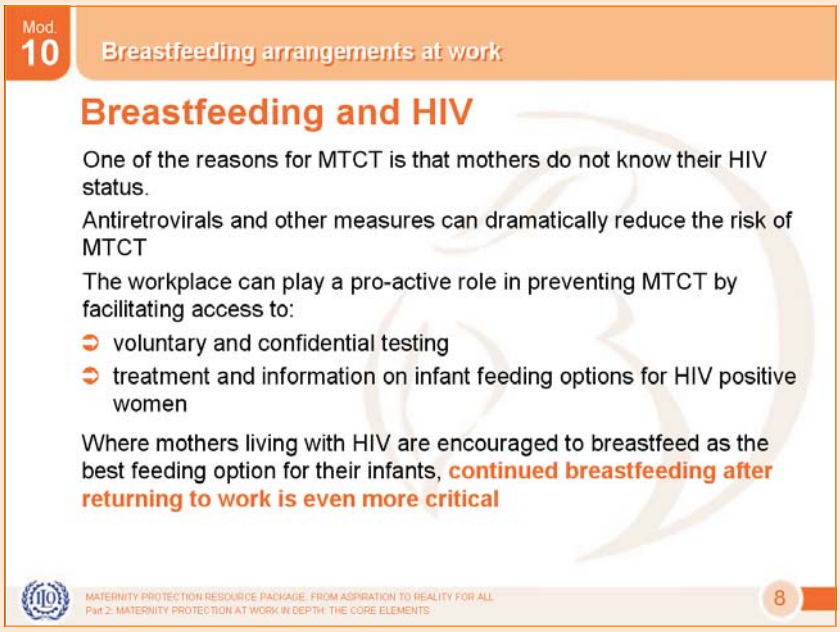
SLIDE 4: Supporting breastfeeding and work: Breastfeeding breaks

SLIDE 5: Supporting breastfeeding and work: Breastfeeding facilities

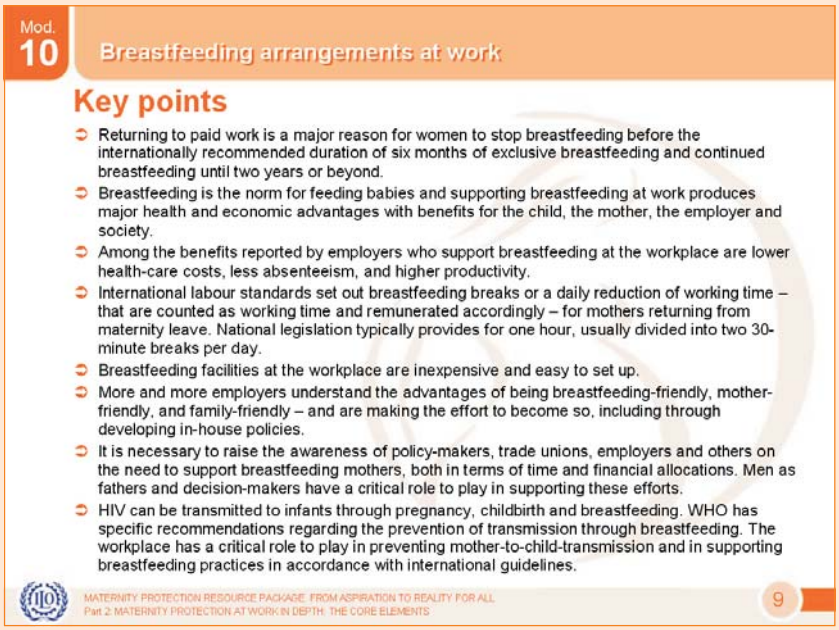
SLIDE 6: Other ways to support breastfeeding and work

SLIDE 7: How to make the workplace breastfeeding-friendly

SLIDE 8: Breastfeeding and HIV



SLIDE 9: Key points



- Part 1: Maternity Protection at work: The basics
- Part 2: Maternity Protection at work in depth: The core elements
- Part 3: Taking action on Maternity Protection at work

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