



2015

Hospital Breastfeeding Laws in the U.S.: Paternalism or Empowerment?

Jennifer Bernstein

The Network for Public Health Law

Lainie Rutkow

Johns Hopkins Bloomberg School of Public Health

Follow this and additional works at: <http://scholarworks.law.ubalt.edu/ublr>



Part of the [Health Law and Policy Commons](#), and the [Law and Gender Commons](#)

Recommended Citation

Bernstein, Jennifer and Rutkow, Lainie (2015) "Hospital Breastfeeding Laws in the U.S.: Paternalism or Empowerment?," *University of Baltimore Law Review*: Vol. 44: Iss. 2, Article 2.

Available at: <http://scholarworks.law.ubalt.edu/ublr/vol44/iss2/2>

This Article is brought to you for free and open access by ScholarWorks@University of Baltimore School of Law. It has been accepted for inclusion in University of Baltimore Law Review by an authorized administrator of ScholarWorks@University of Baltimore School of Law. For more information, please contact snolan@ubalt.edu.

HOSPITAL BREASTFEEDING LAWS IN THE U.S.:
PATERNALISM OR EMPOWERMENT?

*Jennifer Bernstein, JD, MPH**

*Lainie Rutkow, JD, PhD, MPH***

TABLE OF CONTENTS

I. INTRODUCTION	164
II. BENEFITS OF BREASTFEEDING.....	165
III. BREASTFEEDING RATES IN THE U.S. AND HEALTHY PEOPLE GOALS.....	168
IV. BREASTFEEDING AS A WHITE, UPPER-CLASS PHENOMENON.....	171
V. BREASTFEEDING IN THE HOSPITAL SETTING	173
VI. NEW YORK.....	178
VII. CALIFORNIA.....	181
VIII. CROSS-CASE ANALYSIS.....	184
Provision of Breastfeeding Information.....	184
Standards for Breastfeeding Consultants	184
Choice of Breastfeeding Policy	185
Declining Breastfeeding Information	185
Non-English Speakers.....	186
IX. DISCUSSION.....	186
A. Public Health and the Charge of Paternalism	186
B. Breastfeeding, Feminism, and Public Health	189
C. Hospital Breastfeeding Law as Reproductive Choice.....	192
D. Considerations for Marginalized Women	195
E. Using Law to Ensure Breastfeeding Success	197
X. CONCLUSION.....	199

* Senior Attorney, Network for Public Health Law, Mid-States Region, University of Michigan School of Public Health

** Assistant Professor, Department of Health Policy and Management, Johns Hopkins Bloomberg School of Public Health

I. INTRODUCTION

In the United States, hospital breastfeeding law is surfacing as a new area for maternal and child health legislation,¹ with recent laws passed in California and New York.² Joining legislation concerning breastfeeding in public and in workplaces,³ these laws aim to increase the number of infants that are breastfed exclusively during the first 6 to 12 months of life, as recommended by the U.S. Surgeon General and the World Health Organization.⁴ Healthy People 2020 seeks to have 25.5 percent of U.S. infants breastfed exclusively through six months of age by 2020.⁵

Hospital breastfeeding laws have faced resistance from the media and feminist groups who claim that the laws are paternalistic and that the state, acting through its public health authority, is limiting

-
1. *Breastfeeding State Laws*, NAT'L CONF. STATE LEGIS. (June 11, 2014), <http://www.ncsl.org/research/health/breastfeeding-state-laws.aspx#State> (providing a detailed listing of each state's breastfeeding laws, including laws that allow women to breastfeed in public and in the workplace).
 2. Hospital Infant Feeding Act, CAL. HEALTH & SAFETY CODE § 123366(c) (West 2012); Breastfeeding Mothers' Bill of Rights, N.Y. PUB. HEALTH LAW § 2505-a(3)(1)–(3) (McKinney 2012).
 3. *Breastfeeding in Public: Are You Protected?*, MOTHERING.COM, <http://files.mothering.com/sites/resources/laws.pdf> (last updated Mar. 16, 2010) (providing map of U.S. states with and without laws that allow mothers to breastfeed in public); U.S. DEP'T OF LABOR, FACT SHEET #73: BREAK TIME FOR NURSING MOTHERS UNDER THE FLSA (Aug. 2013), *available at* <http://www.dol.gov/whd/regs/compliance/whdfs73.pdf> (explaining that the Fair Labor Standards Act requires employers to provide nursing mothers with a reasonable break time for one year after birth).
 4. U.S. DEP'T HEALTH & HUMAN SERVS., THE SURGEON GENERAL'S CALL TO ACTION TO SUPPORT BREASTFEEDING 4 (2011) [hereinafter SURGEON GENERAL SUPPORT BREASTFEEDING], *available at* <http://www.surgeongeneral.gov/library/calls/breastfeeding/calltoactiontosupportbreastfeeding.pdf>; *Global Strategy on Infant and Young Child Feeding*, WORLD HEALTH ORG. 7–8 (2003), *available at* <http://www.who.int/nutrition/publications> (“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.”) (footnote omitted).
 5. Healthy People 2020, *Maternal, Infant, and Child Health*, HEALTHYPEOPLE.GOV, <https://www.healthypeople.gov/2020/topics-objectives/topic/maternal-infant-and-child-health/objectives> (last visited Jan. 11, 2015) (“Increase the proportion of infants who are breastfed exclusively through 6 months[.]”).

women's infant feeding choices by overzealously advocating that "breast is best."⁶

This paper first examines the current state of breastfeeding in the United States, including in the hospital setting, in Parts II–V. Next, in Parts VI–VIII, we compare the New York and California hospital breastfeeding laws to determine their possible influence on diverse populations of women, especially with regard to adequately addressing the circumstances and needs of vulnerable and minority groups. Finally, in Part IX, we examine the role of the state in relation to the rights of women to make choices about infant feeding and consider whether hospital breastfeeding laws are an appropriate mechanism to increase exclusive breastfeeding rates.

II. BENEFITS OF BREASTFEEDING

Scientific research has clearly documented the benefits of exclusive breastfeeding throughout the first six months of life.⁷ Evidence supports the claim that breastfeeding protects against a wide range of immediate and longer-term adverse health effects.⁸ Health benefits extend to both the infant and mother, potentially decreasing disease burden and increasing positive health outcomes.⁹

There is considerable epidemiological evidence demonstrating the benefits of breastfeeding to infants against a range of illnesses and infections.¹⁰ Studies have shown that breastfeeding is protective against infectious diseases such as upper and lower respiratory tract infections,¹¹ gastrointestinal illness,¹² and middle ear infections

6. See WENDY KLINE, *BODIES OF KNOWLEDGE: SEXUALITY, REPRODUCTION, AND WOMEN'S HEALTH IN THE SECOND WAVE* 159 (2010).

7. SURGEON GENERAL SUPPORT BREASTFEEDING, *supra* note 4, at 1.

8. Arthur I. Eidelman & Richard J. Schanler, *Breastfeeding and the Use of Human Milk*, 129 *PEDIATRICS* e827, e837 (2012) ("Research and practice . . . have reinforced the conclusion that breastfeeding and the use of human milk confer unique nutritional and nonnutritional benefits to the infant and the mother and, in turn, optimize infant, child, and adult health as well as child growth and development.").

9. See *infra* notes 11–25.

10. See *infra* notes 11–18.

11. *E.g.*, Caroline J. Chantry et al., *Full Breastfeeding Duration and Associated Decrease in Respiratory Tract Infection in US Children*, 117 *PEDIATRICS* 425, 428, 431 (2006) (finding an increased risk of respiratory tract infections among children breastfed for four versus six months); Alice H. Cushing et al., *Breastfeeding Reduces Risk of Respiratory Illness in Infants*, 147 *AM. J. EPIDEMIOLOGY* 863, 867–68 (1998) (finding that breastfeeding was associated with a reduced duration of respiratory illnesses in infants).

12. *E.g.*, Liesbeth Duijts et al., *Prolonged and Exclusive Breastfeeding Reduces the Risk of Infectious Diseases in Infancy*, 126 *PEDIATRICS* e18, e24 (2010) (finding

during infancy and beyond.¹³ In addition, evidence also suggests that “[f]ollowing breastfeeding termination there may be prolonged protection against certain infections.”¹⁴ Observational studies have shown that breastfeeding, relative to formula feeding, reduces the risk for obesity in later life even after adjustment for biological and sociodemographic confounders.¹⁵ The association was the strongest among children who had been breastfed exclusively for prolonged periods.¹⁶ Moreover, breastfeeding has been associated with increased neurodevelopmental scores for infants.¹⁷ One study indicated a positive effect throughout early childhood when controlling for confounding variables such as maternal intelligence.¹⁸

There is compelling evidence that breastfeeding has profound protective maternal health benefits as well.¹⁹ Studies have shown that breastfeeding protects against developing premenopausal breast cancer.²⁰ Additional evidence also supports a possible protective

breastfeeding until four months of age is associated with reduced gastrointestinal illness); Peter W. Howie et al., *Protective Effect of Breast Feeding Against Infection*, 300 BRIT. MED. J. 11, 15 (1990) (finding that breastfeeding during the first four months of life is associated with protection against gastrointestinal illnesses).

13. E.g., Linda C. Duffy et al., *Exclusive Breastfeeding Protects Against Bacterial Colonization and Day Care Exposure to Otitis Media*, 100 PEDIATRICS e7, e7 (1997) (finding that breastfeeding protects against otitis media); Maryvonne L. Sassen et al., *Breast-feeding and Acute Otitis Media*, 15 AM. J. OTOLARYNGOLOGY 351, 356 (1994) (finding that risk of otitis media is associated with number of months during which infants are breastfed).
14. Wendy H. Oddy, *Breastfeeding Protects Against Illness and Infection in Infants and Children: A Review of the Evidence*, 9 BREASTFEEDING REV. 11, 15 (2001).
15. E.g., Thomas Harder et al., *Duration of Breastfeeding and Risk of Overweight: A Meta-Analysis*, 162 AM. J. EPIDEMIOLOGY 397, 401–02 (2005) (finding an association between increased duration of breastfeeding and decreased risk of being overweight later in life).
16. Christopher G. Owen et al., *Effect of Infant Feeding on the Risk of Obesity Across the Life Course: A Quantitative Review of Published Evidence*, 115 PEDIATRICS 1367, 1374 (2005).
17. E.g., M. Vestergaard et al., *Duration of Breastfeeding and Developmental Milestones During the Latter Half of Infancy*, 88 ACTA PÆDIATRICA 1327, 1329 (1999) (finding that breastfeeding is associated with benefits for neurodevelopment).
18. Manuela Gómez-Sanchiz et al., *Influence of Breast-Feeding and Parental Intelligence on Cognitive Development in the 24-Month-Old Child*, 43 CLINICAL PEDIATRICS 753, 756–57 (2004).
19. Miriam H. Labbok, *Effects of Breastfeeding on the Mother*, 48 PEDIATRIC CLINICS OF N. AM. 143, 143–44 (2001).
20. *Id.* at 143, 146–48; see also Polly A. Newcomb et al., *Lactation and a Reduced Risk of Premenopausal Breast Cancer*, 330 NEW ENG. J. MED. 81, 81, 85 (1994) (finding a reduced risk of developing premenopausal breast cancer among women who had breastfed).

effect against postmenopausal breast cancer.²¹ Other studies have indicated that breastfeeding may protect against ovarian cancer.²² Studies have shown that hormonal changes linked with breastfeeding increase recovery time after childbirth and increase the period of postpartum infertility, resulting in increased child spacing.²³ Breastfeeding has also been associated with an increase in postpartum weight loss, since lactation burns between 500 to 640 daily calories.²⁴ In almost all instances, scientists have linked the extent of protection to a dose response effect—meaning protection is dependent on the frequency, intensity, and duration of breastfeeding.²⁵

In addition to infant and maternal health benefits, some studies have shown the economic and social benefits to breastfeeding. Infant mortality in the United States is the highest among economically developed countries.²⁶ Increased breastfeeding rates could help reduce mortality among full-term births by preventing infant illness and death.²⁷ A detailed pediatric cost analysis based on a report by the Agency for Healthcare Research and Quality concluded that “[i]f 90 percent of U.S. families comply with the medical recommendation

-
21. Collaborative Grp. Hormonal Factors in Breast Cancer, *Breast Cancer and Breastfeeding: Collaborative Reanalysis of Individual Data from 47 Epidemiological Studies in 30 Countries, Including 50,302 Women with Breast Cancer and 96,973 Women Without the Disease*, 360 LANCET 187, 191 (2002); see also Shelley M. Enger et al., *Breastfeeding Experience and Breast Cancer Risk Among Postmenopausal Women*, 7 CANCER EPIDEMIOLOGY, BIOMARKERS & PREVENTION 365, 367 (1998).
 22. Marina F. Rea, *Benefits of Breastfeeding and Women's Health*, 80 J. PEDIATRICS S142, S142 (2004) (“[B]reastfeeding provides important benefits for women’s health, such as reduced risk of breast and ovarian cancer, decreased risks of hip fractures and contribution to the increase of birth spacing.”).
 23. E.g., Labbok, *supra* note 19, at 143, 150–51 (discussing multiple health benefits that breastfeeding confers on mothers such as reduced risk of postpartum loss of blood, premenopausal breast cancer, ovarian cancer and an increase in child spacing); P.W. Howie & A.S. McNeilly, *Effect of Breast-Feeding Patterns on Human Birth Intervals*, 65 J. REPRODUCTIVE FERTILITY 545, 546–47 (1982) (noting that breastfeeding provides a natural method to ensure adequate time between births).
 24. E.g., Jennifer L. Baker et al., *Breastfeeding Reduces Postpartum Weight Retention*, 88 AM. J. CLINICAL NUTRITION 1543, 1547–50 (2008) (finding that breastfeeding was associated with reduced postpartum weight).
 25. See, e.g., Rea, *supra* note 22, at S143–44.
 26. UN Inter-Agency Group for Child Mortality Estimation, *Mortality Rate, Infant (per 1,000 live births)*, WORLD BANK, <http://data.worldbank.org/indicator/SP.DYN.IMRT.IN> (last visited Jan. 11, 2015).
 27. See generally Miriam H. Labbok, *Breastfeeding: Population-Based Perspectives*, 60 PEDIATRIC CLINICS N. AM. 11, 12–13 (2013) (discussing extensive benefits of breastfeeding for infants).

to breastfeed exclusively for 6 months, the United States could save \$13 billion/year and prevent an excess 911 [infant] deaths annually.”²⁸ Additionally, breastfeeding may have a personal economic impact for mothers and families, influenced by a number of factors, including reduced infant feeding costs, reduced medical costs, and reduced lost wages or sick child care costs.²⁹ “Families who follow optimal breastfeeding practices can save about \$1,200 to \$1,500 in expenditure on infant formula in the first year alone.”³⁰

Because of these health benefits to both mothers and children and the resulting societal benefits, a number of national and international health organizations have made recommendations on optimal breastfeeding duration. The American Academy of Pediatrics recommends exclusive breastfeeding for six months, followed by continued breastfeeding for at least 12 months as complementary foods are introduced.³¹ The World Health Organization recommends six months of exclusive breastfeeding, with continued breastfeeding along with appropriate complementary foods “up to two years of age or beyond.”³²

III. BREASTFEEDING RATES IN THE U.S. AND HEALTHY PEOPLE GOALS

The prevalence of breastfeeding initiation and duration in the United States has increased over the previous decade.³³ In 2010, more than 75 percent of U.S. mothers breastfed their infants at some point, but only 16.4 percent breastfed exclusively through six months of age.³⁴ California has the highest rate of infants who were breastfed

28. Melissa Bartick & Arnold Reinhold, *The Burden of Suboptimal Breastfeeding in the United States: A Pediatric Cost Analysis*, 125 PEDIATRICS e1048, e1052 (2010).

29. Thomas M. Ball & David M. Bennett, *The Economic Impact of Breastfeeding*, 48 PEDIATRIC CLINICS N. AM. 253, 256–58 (2001).

30. *Surgeon General Support Breastfeeding: Fact Sheet*, SURGEONGENERAL.GOV (Jan. 20, 2011), <http://www.surgeongeneral.gov/library/calls/breastfeeding/factsheet.html> (citations omitted).

31. Eidelman & Schanler, *supra* note 8, at e827–28.

32. *Exclusive Breastfeeding*, WORLD HEALTH ORG., http://www.who.int/nutrition/topics/exclusive_breastfeeding/en/ (last visited Jan. 11, 2015).

33. *Breastfeeding Among U.S. Children Born 2001–2011*, CDC National Immunization Survey, CTRS. FOR DISEASE CONTROL & PREVENTION, http://www.cdc.gov/breastfeeding/data/NIS_data/index.htm (last updated Nov. 18, 2014) [hereinafter *National Immunization Survey*] (documenting U.S. breastfeeding trends from 2001 to 2011).

34. *See id.*

exclusively through six months of age at 27.4 percent.³⁵ Tennessee has the lowest rate, with just 4.1 percent of infants being breastfed exclusively through six months of age.³⁶

These low rates of breastfeeding continuation and exclusivity indicate that women face barriers to exclusive breastfeeding.³⁷ The 2011 Surgeon General's Call to Action to Support Breastfeeding identifies some potential barriers to breastfeeding, including lack of knowledge and skills, social norms, poor family and social support, embarrassment, lactation problems, employment, child care, and barriers related to health services.³⁸ Evidence has shown that targeted hospital programs can increase exclusive breastfeeding rates and duration by overcoming some of the barriers women face.³⁹

Healthy People 2020 provides evidence-based, 10-year national objectives in a broad spectrum of determinants of health.⁴⁰ The goal of Healthy People 2020 is to provide measurable outcomes for improving the health of all Americans. Healthy People 2020 has three main hospital breastfeeding-related objectives.⁴¹ Table 1 summarizes the relevant Healthy People 2020 objectives as well as breastfeeding rates in California, New York, and nationally. It

35. Nat'l Ctr. for Chronic Disease Prevention & Health Promotion, *Breastfeeding Report Card*, CTRS. FOR DISEASE CONTROL & PREVENTION 4 (2013), available at <http://www.cdc.gov/breastfeeding/pdf/2013BreastfeedingReportCard.pdf> [hereinafter *Breastfeeding Report Card*].

36. *Id.*

37. SURGEON GENERAL SUPPORT BREASTFEEDING, *supra* note 4, at 7–9.

38. *Id.* at 10–15.

39. *E.g.*, Anne Merewood et al., *Breastfeeding Rates in US Baby-Friendly Hospitals: Results of a National Survey*, 116 PEDIATRICS 628, 628–29 (2005) (finding that, throughout the U.S., rates of initiation and duration of breastfeeding increased in hospitals participating in the Baby-Friendly Hospital Initiative); Erin K. Murray et al., *Hospital Practices that Increase Breastfeeding Duration: Results from a Population-Based Study*, 34 BIRTH 202, 204–07 (2007) (finding that implementation of hospital-based practices, including breastfeeding within the first hour, feeding only breast milk exclusively, and withholding the pacifier, were associated with increased breastfeeding duration); Barbara L. Philipp et al., *Baby-Friendly Hospital Initiative Improves Breastfeeding Initiation Rates in a US Hospital Setting*, 108 PEDIATRICS 677, 677–79 (2001) (finding improvements in breastfeeding initiation and duration after implementation of baby-friendly practices at Boston Medical Center).

40. Healthy People 2020, *About Healthy People*, HEALTHYPEOPLE.GOV, <http://www.healthypeople.gov/2020/about/default.aspx> (last updated Jan. 6, 2015) (“Healthy People 2020 continues in this tradition with the launch on December 2, 2010 of its ambitious, yet achievable, 10-year agenda for improving the Nation’s health. Healthy People 2020 is the result of a multiyear process that reflects input from a diverse group of individuals and organizations.”).

41. Healthy People 2020, *supra* note 5.

should be noted that in California, 24.82 percent of live births occur in Baby-Friendly Hospitals and California exceeds Healthy People 2020 objectives across the board.⁴² New York is generally above or in line with current national rates, but well below 2020 U.S. targets.⁴³

Table 1

Healthy People 2020 Objective	2010 U.S. Rate	2010 CA Rate	2010 NY Rate	2020 U.S. Target
MICH- 21: Increase the proportion of infants who are breastfed				
MICH-21.1: Ever	76.5%	91.6%	82.6%	81.9%
MICH-21.2: At 6 months	49.0%	71.3%	52.6%	60.6%
MICH-21.3: At 1 year	27.0%	45.3%	28.4%	34.1%
MICH-21.4: Exclusively through 3 months	37.7%	56.8%	32.1%	46.2%
MICH-21.5: Exclusively through 6 months	16.4%	27.4%	16.5%	25.5%
MICH-23: Reduce the proportion of breastfed newborns who receive formula supplementation within the first 2 days of life	24.4%	16.9%	34.7%	14.2%
MICH-24: Increase the proportion of live births that occur in facilities that provide recommended care for lactating mothers and their babies	7.2%	24.8%	4.9%	8.1%

Source: Nat'l Ctr. for Chronic Disease Prevention & Health Promotion, *Breastfeeding Report Card*,

42. Though the higher rate of baby friendly hospitals has not been causally linked to higher breastfeeding rates in California, some studies have linked baby friendly hospitals with longer periods of exclusive breastfeeding. See Merewood et al., *supra* note 39, at 628–29, 633. California's long history of legal interventions to encourage and protect women's right to breastfeed probably contributes to higher breastfeeding rates, including the state's laws covering breastfeeding in public, CAL. CIV. CODE § 43.3 (West 2007), lactation accommodation in employment, CAL. LAB. CODE §§ 1030–33 (West 2011), and paid family leave, CAL. GOV'T CODE §§ 12945, 12945.2 (West 2011 & Supp. 2014).

43. *Breastfeeding Report Card*, *supra* note 35, at 4.

CTRS. FOR DISEASE CONTROL & PREVENTION 6 (2013), <http://www.cdc.gov/breastfeeding/pdf/2013BreastfeedingReportCard.pdf>.

IV. BREASTFEEDING AS A WHITE, UPPER-CLASS PHENOMENON

In addition to demographic differences in breastfeeding rates,⁴⁴ racial and ethnic differences in breastfeeding have also been observed.⁴⁵ In a study conducted by the Centers for Disease Control and Prevention (CDC), there was a significant increase between 2000 and 2008 that occurred in the percentages of all infants who had ever breastfed, but a significant gap existed between black infants and white and Hispanic infants.⁴⁶ Although 74.6 percent of infants overall were ever breastfed in 2008, only 58.9 percent of black infants were ever breastfed.⁴⁷ The percentage of black infants that were still breastfed (but not exclusively) at six months was only 30.1 percent compared to 44.4 percent of infants overall. Black infants consistently had the lowest rates of breastfeeding initiation and duration across all study years.⁴⁸

Some characteristics that are associated with lower breastfeeding prevalence among women include being unmarried, younger, having a lower income, and less education.⁴⁹ Among low-income participants in the Women, Infants, and Children (WIC) program, the breastfeeding initiation rate was 66.1 percent, but in women ineligible for WIC due to a higher income, the initiation rate was 82.2 percent.⁵⁰ The breastfeeding initiation rate was the lowest for low-

44. *Provisional Breastfeeding Rates by Socio-Demographic Factors, Among Children Born in 2007*, CTRS. FOR DISEASE CONTROL & PREVENTION, http://www.cdc.gov/breastfeeding/data/NIS_data/2007/socio-demographic_any.htm (last visited Jan. 11, 2015).

45. *Id.*; see also *National Immunization Survey*, *supra* note 33 (including tables of information about any breastfeeding rate, exclusive breastfeeding rate, and formula supplementation rate by socio-demographic characteristics).

46. Ctrs. for Disease Control & Prevention, *Progress in Increasing Breastfeeding and Reducing Racial/Ethnic Differences—United States, 2000–2008 Births*, 62 MORBIDITY MORTALITY WKLY. REP. 77, 78–80 (2013).

47. *Id.*

48. *Id.* at 78–79.

49. Ruowei Li & Laurence Grummer-Strawn, *Racial and Ethnic Disparities in Breastfeeding Among United States Infants: Third National Health and Nutrition Examination Survey, 1988–1994*, 29 BIRTH 251, 251–57 (2002).

50. Ctrs. for Disease Control & Prevention, *Racial and Ethnic Differences in Breastfeeding Initiation and Duration, by State—National Immunization Survey, United States, 2004–2008*, 59 MORBIDITY & MORTALITY WKLY. REP. 327, 328 (2010).

income black mothers at just 37 percent.⁵¹ Similar age-related disparities exist.⁵² “[M]others younger than 20 years initiated breastfeeding at a rate of 59.7 percent, compared with the rate of 79.3 percent in mothers older than 30 years.”⁵³ Non-Hispanic black mothers less than 20 years old had lower rates of breastfeeding initiation, at 30 percent.⁵⁴

Cultural norms seem to play a role in the breastfeeding rate among black women.⁵⁵ A textual analysis study, conducted on 53 fictional television breastfeeding representations with a worldwide range of genres and audiences, found that breastfeeding depictions have increased over time and are generally affirmative, but are limited to depictions of educated, mature, white women.⁵⁶ The depictions also fail to address issues related to barriers to breastfeeding or challenges.⁵⁷ Some other theories as to the existence of this persistent gap in breastfeeding rates between black women and women of other races include unsupportive cultural norms, perceptions that breastfeeding is inferior to formula feeding, lack of partner support, and an unsupportive work environment.⁵⁸

The large disparity in breastfeeding rates between black women and women of other races and ethnicities means that breastfeeding-related programs and legislation must be examined from an anti-essentialist, intersectionality perspective.⁵⁹ When developing laws, it

51. Eidelman & Schanler, *supra* note 8, at e828.

52. *Id.*

53. *Id.*

54. *Id.*

55. Margaret E. Bentley et al., *Breastfeeding Among Low Income African-American Women: Power, Beliefs, and Decision Making*, 133 J. HUM. NUTRITION 305S, 308S (2003).

56. Katherine A. Foss, “*That’s Not a Beer Bong, It’s a Breast Pump!*” *Representations of Breastfeeding in Prime-Time Fictional Television*, 28 HEALTH COMM. 329, 329 (2013).

57. *Id.* at 333–34 (“The obstacles of breastfeeding were limited in these representations to initial problems with nursing and focused on individual problems.”).

58. See, e.g., Bentley et al., *supra* note 55, at 308S (2003) (“We posit that macrolevel factors, such as the media, aggressive marketing of breastmilk substitutes, welfare reform, hospital policy and breastfeeding programs and policy, *interact with* microlevel factors to influence a woman’s decision to breastfeed. These microlevel factors include features of the community, neighborhoods, workplaces that support or discourage breastfeeding, social and personal networks and cultural norms and individual beliefs.”).

59. Maneesha Deckha, *Is Culture Taboo? Feminism, Intersectionality, and Culture Talk in Law*, 16 CAN. J. WOMEN & L. 14, 51 (2004) (“While my proposal for feminist engagement with law is relativist in that it encourages the recognition of cultural differences and accepts the invariable degree of essentialism that will accompany such

is important to consider the multiple intersections or identities that exist for all women, not just based on gender but also race, class, age, sexuality, and culture. Breastfeeding cannot truly be a choice for all women when protective laws are based on the experiences of 30-something, white, heterosexual, middle class women.

V. BREASTFEEDING IN THE HOSPITAL SETTING

In the health care system, both passive and active barriers exist to prevent women from breastfeeding. Passive barriers include the tacit acceptance of formula company advertising,⁶⁰ a lack of clinician education on breastfeeding support skills,⁶¹ and a lack of support for breastfeeding among all patients.⁶² Active barriers include a lack of clarity in reimbursement for breastfeeding support services⁶³ and an

recognition, it definitely does not condone a belief in reified or totalizing cultural differences or the presumption of neatly separated distinct cultures Put simply, culture matters. Humans are cultural beings. My proposal recognizes this ‘acceptable’ universal to denounce grand generalizations that expressly subordinate some members of the group being generalized about in order to sustain the power of others, while supporting or tolerating other generalizations that potentially subvert cultural hegemonies.”); Trina Grillo, *Anti-Essentialism and Intersectionality: Tools to Dismantle the Master’s House*, 10 BERKELEY J. GENDER L. & JUST. 16, 30 (1995) (“Anti-essentialism and intersectionality are checks on us; they help us make sure that we do not speak for those we cannot speak for or ask others to share our agenda while they patiently wait for their own.”).

60. See, e.g., Deborah L. Kaplan & Kristina M. Graff, *Marketing Breastfeeding—Reversing Corporate Influence on Infant Feeding Practices*, 85 J. URBAN HEALTH 486, 497 (2008) (“Institutional practices, implemented in the setting of marketing by the formula industry, are pervasive in three phases of perinatal care associated with reduced rates of breastfeeding initiation, duration and exclusivity: providing women in prenatal care with formula company-produced infant feeding information and free formula offers; giving mothers free formula at hospital discharge; and hospitals’ non-medically indicated use of formula with breastfeeding infants.”).
61. See Xena Grossman et al., *Hospital Education in Lactation Practices (Project HELP): Does Clinician Education Affect Breastfeeding Initiation and Exclusivity in the Hospital?*, 36 BIRTH 54, 57 (2009) (“The finding that professional education alone directly increases breastfeeding initiation in the hospital is a valuable addition to the current, sparse literature.”).
62. See Nathan Christopher Nickel et al., *The Extent that Noncompliance with the Ten Steps to Successful Breastfeeding Influences Breastfeeding Duration*, 29 J. HUM. LACTATION 59, 59–60, 68 (2013).
63. Cf. Jennifer R. Thomas & Ulfat Shaikh, *Electronic Communication with Patients for Breastfeeding Support*, 23 J. HUM. LACTATION 275, 275 (2007) (“Physicians have expressed qualms about electronic communication with patients due to patient privacy, malpractice liability, time, and reimbursement issues.”).

inattention to the importance of breastfeeding by health providers.⁶⁴ For example, during the first 48 hours post-birth commercial infant formula is typically provided at 24 percent of maternity hospitals.⁶⁵ Studies of hospital practices have found that, regardless of the population, “disparities in breastfeeding rates are also associated with variations in hospital routines.”⁶⁶

Studies have shown that the implementation of quality of care practices in hospitals can reduce barriers and increase breastfeeding rates.⁶⁷ This is likely due to several factors, including hospital policies and practices that discourage the use of formula and encourage women to breastfeed within a few hours after birth. Studies have indicated that the key to long-term breastfeeding success is early initiation, within the first two hours after birth and no formula supplementation unless medically necessary.⁶⁸

The Baby-Friendly Hospital Initiative (BFHI) is a global evidence-based standard for hospitals to provide an “optimal level of care for infant feeding.”⁶⁹ The World Health Organization and the United Nations’ Children’s Fund launched the BFHI in 1991 as a way to recognize and encourage hospitals to meet the standard.⁷⁰ Obtaining recognition as a Baby-Friendly Hospital means a facility has successfully implemented the Ten Steps to Successful Breastfeeding⁷¹ and the International Code of Marketing of Breast-Milk Substitutes.⁷² Today, 199 U.S. hospitals and birthing centers, out of over 3,000 facilities, in 45 states and the District of Columbia have received the

64. See Elsie M. Taveras et al., *Clinician Support and Psychosocial Risk Factors Associated with Breastfeeding Discontinuation*, 112 PEDIATRICS 108, 113 (2003) (“Our results are in accordance with previous studies that suggest that clinicians and other health care providers may have an influential role in breastfeeding initiation and continuation.”).

65. Eidelman & Schanler, *supra* note 8, at e828.

66. *Id.*

67. Eugene Declercq et al., *Hospital Practices and Women’s Likelihood of Fulfilling Their Intention to Exclusively Breastfeed*, 99 AM. J. PUB. HEALTH 929, 933 (2009); Ann M. DiGirolamo et al., *Effect of Maternity-Care Practices on Breastfeeding*, 122 PEDIATRICS S43, S46–48 (2008).

68. See, e.g., Philipp et al., *supra* note 39, at 678–79, 681.

69. *Baby-Friendly Hospital Initiative*, BABY-FRIENDLY USA, <http://www.babyfriendlyusa.org/about-us/baby-friendly-hospital-initiative> (last visited Jan. 11, 2015).

70. *Id.*

71. *The Ten Steps to Successful Breastfeeding*, BABY-FRIENDLY USA, <https://www.babyfriendlyusa.org/about-us/baby-friendly-hospital-initiative/the-ten-steps> (last visited Jan. 11, 2015).

72. WORLD HEALTH ORG., INTERNATIONAL CODE OF MARKETING OF BREAST-MILK SUBSTITUTES 4 (1981), available at http://www.who.int/nutrition/publications/code_english.pdf.

Baby-Friendly designation.⁷³ There are over 20,000 hospital and birthing centers in 150 countries designated as Baby-Friendly.⁷⁴

The Ten Steps to Successful Breastfeeding set the foundation for the standards of a Baby-Friendly Hospital.⁷⁵ The first step is for the hospital to “[h]ave a written breastfeeding policy that is routinely communicated to all health care staff.”⁷⁶ The policy should address all ten steps and protect the rights of breastfeeding mothers.⁷⁷ Essential policy elements include “general sections on aims and objectives,” “any national or international guidelines . . . which provide the basis of the hospital policy,” “national and local data on breastfeeding rates,” “the *Ten Steps to Successful Breastfeeding*,” “details of practice related to the local situation,” and “technical information and references.”⁷⁸

The second step is to “[t]rain all health care staff in skills necessary to implement this [breastfeeding] policy.”⁷⁹ Studies show that health professionals’ knowledge, attitudes, and practices are often not supportive of breastfeeding.⁸⁰ “All health care staff who have any contact with mothers, infants and/or children must receive instruction on the implementation of the breastfeeding policy.”⁸¹ The training “should be at least 18 hours in total with a minimum of 3 hours of supervised clinical experience and cover at least 8 steps.”⁸²

The third step is to “[i]nform all pregnant women about the benefits and management of breastfeeding.”⁸³ This step aims to provide women with enough information to make an informed decision about

73. *Find Facilities*, BABY-FRIENDLY USA, <http://www.babyfriendlyusa.org/find-facilities> (last visited Jan. 11, 2015).

74. *BFHI Worldwide*, BABY-FRIENDLY USA, <http://www.babyfriendlyusa.org/about-us/baby-friendly-hospital-initiative/bfhi-worldwide> (last visited Jan. 11, 2015).

75. *Ten Steps to Successful Breastfeeding*, BABY-FRIENDLY HOSPITAL INITIATIVE, <http://tensteps.org/> (last visited Jan. 11, 2015).

76. *Ten Steps to Successful Breastfeeding: Step 1*, BABY-FRIENDLY HOSPITAL INITIATIVE (June 16, 2014), <http://tensteps.org/step-1-successful-breastfeeding.shtml>.

77. *See id.*

78. WORLD HEALTH ORG., EVIDENCE FOR THE TEN STEPS TO SUCCESSFUL BREASTFEEDING 10 (1998), available at http://whqlibdoc.who.int/publications/2004/9241591544_eng.pdf.

79. *Ten Steps to Successful Breastfeeding: Step 2*, BABY-FRIENDLY HOSPITAL INITIATIVE (Aug. 15, 2013), <http://tensteps.org/step-2-successful-breastfeeding.shtml>.

80. *See Taveras et al.*, *supra* note 64, at 108, 113.

81. *Ten Steps to Successful Breastfeeding: Step 2*, *supra* note 79.

82. EVIDENCE FOR THE TEN STEPS TO SUCCESSFUL BREASTFEEDING, *supra* note 78, at 15.

83. *Ten Steps to Successful Breastfeeding: Step 3*, BABY-FRIENDLY HOSPITAL INITIATIVE (Aug. 15, 2013), <http://tensteps.org/step-3-successful-breastfeeding.shtml>.

their infant feeding plans.⁸⁴ Breastfeeding counseling should be given in combination with antenatal services, if affiliated with the hospital.⁸⁵ The information “should cover the importance of exclusive breastfeeding for the first 4–6 months, the benefits of breastfeeding, and basic breastfeeding management.”⁸⁶

The fourth step is to “[h]elp mothers initiate breastfeeding within one hour of birth.”⁸⁷ Mothers in a maternity ward who have had uncomplicated vaginal deliveries or mothers who have had uncomplicated caesarean deliveries, once able to respond, should be “given their babies to hold with skin contact, for at least 30 minutes.”⁸⁸ They should also be “offered help by a staff member to initiate breastfeeding.”⁸⁹

The fifth step is to “[s]how mothers how to breastfeed and how to maintain lactation, even if they [are] separated from their infants.”⁹⁰ Breastfeeding is not entirely instinctive, and thus requires that the techniques are taught and new mothers are helped.⁹¹ “[S]taff should offer further assistance with breastfeeding within six hours of delivery and mothers should be shown how to express their milk or be given written information on expression and/or advised where they could get [further] help”⁹² Moreover, “[s]taff should [also] teach mothers positioning/attachment and techniques for manual expression of breast milk.”⁹³

The sixth step is to “[g]ive newborn infants no food or drink other than breast milk unless medically indicated.”⁹⁴ The practice of giving “formula, glucose water, or plain water to newborns . . . is associated

84. *Id.*

85. *Id.*

86. EVIDENCE FOR THE TEN STEPS TO SUCCESSFUL BREASTFEEDING, *supra* note 78, at 23.

87. *The Ten Steps to Successful Breastfeeding*, *supra* note 71. In the U.S. these are the same as the WHO/United Nations Children’s Fund (UNICEF) Ten Steps to Successful Breastfeeding except for step 4, which in the U.S. says mothers should initiate breastfeeding within one hour of birth, compared to 30 minutes elsewhere. Compare *id.* (noting that the U.S. recommends breastfeeding one hour after birth), with *Ten Steps to Successful Breastfeeding: Step 4*, BABY-FRIENDLY HOSPITAL INITIATIVE (Aug. 15, 2013), <http://tensteps.org/step-4-successful-breastfeeding.shtml> (noting that WHO/UNICEF recommend breastfeeding a half hour after birth).

88. See *Ten Steps to Successful Breastfeeding: Step 4*, *supra* note 87.

89. EVIDENCE FOR THE TEN STEPS TO SUCCESSFUL BREASTFEEDING, *supra* note 78, at 31.

90. *Ten Steps to Successful Breastfeeding: Step 5*, BABY-FRIENDLY HOSPITAL INITIATIVE (Aug. 15, 2013), <http://tensteps.org/step-5-successful-breastfeeding.shtml>.

91. EVIDENCE FOR THE TEN STEPS TO SUCCESSFUL BREASTFEEDING, *supra* note 78, at 40.

92. *Id.*

93. *Id.*

94. *Ten Steps to Successful Breastfeeding: Step 6*, BABY-FRIENDLY HOSPITAL INITIATIVE (Aug. 15, 2013), <http://tensteps.org/step-6-successful-breastfeeding.shtml>.

with early termination of breastfeeding.”⁹⁵ Any supplementation should have an acceptable medical reason.⁹⁶ Additionally, “[n]o promotion for infant foods or drinks,” such as infant formula, “should be displayed or distributed to mothers, staff, or the facility.”⁹⁷

The seventh step is to “[p]ractice rooming -in -allow mothers and infants to remain together - 24 hours per day.”⁹⁸ Nursery care increases the risk of cross-infection and staphylococcal skin disease among newborns.⁹⁹ It also prevents breastfeeding on demand and discourages bonding between mothers and their infants.¹⁰⁰ Mothers with healthy babies “should stay with them in the same room day and night, except for periods of up to an hour for [necessary] hospital procedures”¹⁰¹

The eighth step is to “[e]ncourage breastfeeding on demand.”¹⁰² “[T]he number of episodes and the total duration of suckling per 24 hours, varies widely between mother-infant pairs and over time, so truly unrestricted breastfeeding cannot follow guidelines”¹⁰³

Mothers of normal babies (including caesareans) who are breastfeeding should have no restrictions placed on the frequency or length of their babies’ breastfeeds. They should be advised to breastfeed their babies whenever they are hungry or as often as the baby wants and they should also wake their babies for breastfeeding if the babies sleep too long or the mother’s breasts are overfull.¹⁰⁴

The ninth step is to “[g]ive no artificial teats or pacifiers . . . to breastfeeding infants.”¹⁰⁵ “There is growing evidence that the use of artificial teats and pacifiers is associated with early cessation of breastfeeding as well as some other problems.”¹⁰⁶ Pacifiers and

95. EVIDENCE FOR THE TEN STEPS TO SUCCESSFUL BREASTFEEDING, *supra* note 78, at 48.

96. *Id.*

97. *Id.*

98. *Ten Steps to Successful Breastfeeding: Step 7*, BABY-FRIENDLY HOSPITAL INITIATIVE (Aug. 15, 2013), <http://tensteps.org/step-7-successful-breastfeeding.shtml>.

99. EVIDENCE FOR THE TEN STEPS TO SUCCESSFUL BREASTFEEDING, *supra* note 78, at 62.

100. *Id.*

101. *Id.*

102. *Ten Steps to Successful Breastfeeding: Step 8*, BABY-FRIENDLY HOSPITAL INITIATIVE (Aug. 15, 2013), <http://tensteps.org/step-8-successful-breastfeeding.shtml>.

103. EVIDENCE FOR THE TEN STEPS TO SUCCESSFUL BREASTFEEDING, *supra* note 78, at 70.

104. *Ten Steps to Successful Breastfeeding: Step 8*, *supra* note 102.

105. *Ten Steps to Successful Breastfeeding: Step 9*, BABY-FRIENDLY HOSPITAL INITIATIVE (Aug. 15, 2013), <http://tensteps.org/step-9-successful-breastfeeding.shtml>.

106. EVIDENCE FOR THE TEN STEPS TO SUCCESSFUL BREASTFEEDING, *supra* note 78, at 78.

artificial teats may carry infection and reduce time spent suckling at the breast.¹⁰⁷

The tenth step is to “[f]oster the establishment of breastfeeding support groups and refer mothers to them on discharge from the hospital or clinic.”¹⁰⁸ The nursing officer in charge should be prepared to share information about breastfeeding support groups in the local area.¹⁰⁹ “Alternatively, [staff] should be able to describe a system of follow-up support for all breastfeeding mothers after they are discharged, such as (early postnatal or lactation clinic checkup, home visits, telephone call).”¹¹⁰

The CDC’s Maternity Practices in Infant Nutrition and Care (mPINC) survey assesses and scores how well maternity care practices at hospitals and birth centers support breastfeeding, on a scale of 0 to 100, with a higher score indicating better practices.¹¹¹ The national average mPINC score rose from 65 to 70 between 2009 and 2011.¹¹² But currently, only 6 percent of U.S. births take place in a Baby-Friendly Hospital.¹¹³ As these indicators suggest, national hospital maternity care has improved, but the majority of hospitals do not meet the BFHI standards, leaving many mothers without the care that could best help them to follow their intentions for breastfeeding.¹¹⁴

VI. NEW YORK

In 2009, New York passed the Breastfeeding Mothers’ Bill of Rights (BFMBR).¹¹⁵ The legislation was designed to be educational so that new mothers could make informed decisions about infant feeding choices.¹¹⁶ The statute specifies the rights of pregnant

107. *Id.* at 74.

108. *Ten Steps to Successful Breastfeeding: Step 10*, BABY-FRIENDLY HOSPITAL INITIATIVE (Aug. 15, 2013), <http://tensteps.org/step-10-successful-breastfeeding.shtml>.

109. *Id.*

110. EVIDENCE FOR THE TEN STEPS TO SUCCESSFUL BREASTFEEDING, *supra* note 78, at 82.

111. *Maternity Practices in Infant Nutrition and Care (mPINC) Survey*, CTRS. FOR DISEASE CONTROL & PREVENTION, <http://www.cdc.gov/breastfeeding/data/mpinc/index.htm> (last visited Jan. 11, 2015).

112. *Breastfeeding Report Card—United States, 2012*, CTRS. FOR DISEASE CONTROL & PREVENTION, <http://www.cdc.gov/breastfeeding/data/reportcard/reportcard2012.htm> (last visited Jan. 11, 2015).

113. *Id.*

114. *Id.*

115. N.Y. PUB. HEALTH LAW § 2505-a (McKinney 2012).

116. *Id.* § 2505-a(3) (“Choosing the way you will feed your new baby is one of the important decisions you will make in preparing for your infant’s arrival. Doctors agree that for most women breastfeeding is the safest and most healthy choice. It is

women and new mothers “to be informed about the benefits of breastfeeding” and to obtain support from health care providers and health care facilities during pregnancy, during and after delivery, and upon discharge.¹¹⁷ It also requires that information received is free of commercial interests.¹¹⁸

Prior to passage of the BFMBR, all hospitals that provide maternity care services in New York State were required to develop and implement written policies and procedures related to breastfeeding in accordance with the New York Codes, Rules & Regulations on Perinatal Services, passed in 1988.¹¹⁹ The Perinatal Services regulations are promulgated under the New York Public Health Law and derive mostly from general public health authority.¹²⁰

The Perinatal Services regulations mirror several Baby-Friendly Hospital requirements, but they do not explicitly mention the Ten Steps to Successful Breastfeeding.¹²¹ For example, under the Perinatal Services regulations, facilities must implement rooming-in procedures at the request of all patients unless “medically contraindicated” or the facility cannot accommodate all requests due to inadequate resources.¹²² Hospitals are required to provide assistance to patients who have chosen to breastfeed, including access to a trained breastfeeding consultant to help ensure successful breastfeeding initiation.¹²³ Hospitals must also “provide information on the advantages and disadvantages of breastfeeding to women who are undecided as to the feeding method for their infants.”¹²⁴ The

your right to be informed about the benefits of breastfeeding and have your health care provider and maternal health care facility encourage and support breastfeeding. You have the right to make your own choice about breastfeeding.”)

117. *Id.* § 2505-a(1)–(3).

118. *Id.* § 2505-a(3)(1) (“You have the right to receive information that is free of commercial interests . . .”).

119. N.Y. COMP. CODES R. & REGS. tit. 10, § 405.21(c)(1)(v), (f)(3) (2011).

120. N.Y. PUB. HEALTH LAW § 2803.

121. *Compare* N.Y. COMP. CODES R. & REGS. tit. 10, § 405.21(f)(3)(i)(a)–(c) (requiring staff to assist breastfeeding mothers, inform mothers of the pros and cons, develop written procedures to help mothers with breastfeeding which should include on demand feeding, dietary guidance, and additional information that ought to be provided to the mother upon discharge), *with The Ten Steps to Successful Breastfeeding*, *supra* note 71 (encouraging hospitals to have a written policy for staff, train staff properly, inform women about the advantages to breastfeeding, provide only breast-milk unless medical concerns dictate otherwise, encourage on demand breastfeeding, and recommend mothers to breastfeeding support groups).

122. N.Y. COMP. CODES R. & REGS. tit. 10, § 405.21(c)(1)(iii).

123. *Id.* § 405.21(f)(3)(i)(a).

124. *Id.* § 405.21(f)(3)(i).

regulations also require written policies on immediate skin-to-skin contact, restrictions on supplemental formula feedings, on-demand feeding schedules, and a provision on discharge packs of infant formula.¹²⁵ Under the regulations, mothers may opt for supplemental feedings and the receipt of a discharge pack.¹²⁶ The regulations seem to address steps one through eight of the Ten Steps to Successful Breastfeeding, at least in part, but the regulations are not as detailed and could be applied differently than intended by the Ten Steps to Successful Breastfeeding. The regulations do not seem to address step nine, regarding artificial pacifiers or step ten, regarding breastfeeding support groups, at all. Also, under the regulations, hospitals must prohibit standing orders for anti-lactation drugs,¹²⁷ a provision not included in the Ten Steps to Successful Breastfeeding.

In contrast, the BFMBR contains a list of 22 enumerated rights that women may exercise during pregnancy, during and after delivery, and upon discharge.¹²⁸ The law requires that the BFMBR be conspicuously posted in all maternal care facilities and included in maternity information leaflets.¹²⁹ Most of the rights provided for in the BFMBR are reflected in hospital requirements under the Perinatal Regulations, though some are completely new.¹³⁰ For example, the BFMBR provides that newborns have the right not to receive any pacifiers.¹³¹ It also provides women the right to be informed if medical staff “advis[es] against breastfeeding before any feeding decisions are made” and the right to obtain information about community breastfeeding resources.¹³² These provisions seem to address the previous gaps between the Perinatal Regulations and the Ten Steps to Successful Breastfeeding.

The BFMBR does not create a private right of action for patients, but it does direct patients to file complaints if their rights are violated by contacting the New York State Department of Health (NYDOH) or the hospital complaint hotline.¹³³ The statute also authorizes the commissioner to adopt any rules and regulations reasonably

125. *Id.* § 405.21(f)(3)(i)(b).

126. *Id.* § 405.21(f)(3)(i)(b)(5).

127. *Id.* § 405.21(f)(3)(i)(b)(1).

128. N.Y. PUB. HEALTH LAW § 2505-a(3)(1)–(3) (McKinney 2012).

129. *Id.* § 2505a-(1). In 1989, New York passed legislation requiring hospitals to provide maternity patients with a maternity information leaflet that includes facility performance data. *Id.* § 2803-j(1)–(2). This is provided to new mothers when admission arrangements are made. *Id.*

130. *See id.* § 2505-a; N.Y. COMP. CODES R. & REGS. tit. 10, § 405.21(f)(3)(b).

131. N.Y. PUB. HEALTH LAW § 2505-a(3)(2).

132. *Id.* § 2505-a(3)(2)–(3).

133. *Id.* § 2505-a(3).

necessary to implement the law and ensure compliance, but no rules or regulations have been promulgated under the statute.¹³⁴

Implementation efforts for the Perinatal Regulations started in 1992 with the initiation of a series of biennial voluntary hospital surveys, conducted up to 2002, aimed at both increasing hospital awareness of the regulations and evaluating compliance.¹³⁵ Results from the surveys were reported to the hospitals, which compared practice scores between facilities.¹³⁶

With the passage of the BFMBR in 2009, the NYDOH started including more traditional enforcement actions to ensure compliance.¹³⁷ NYDOH developed a State Model Hospital Breastfeeding Policy that includes 28 provisions required under both the Perinatal Regulations and the BFMBR, along with many additional recommended provisions, including some from the Ten Steps to Successful Breastfeeding.¹³⁸ In September 2009, NYDOH requested hospitals' written breastfeeding policies; five months later, NYDOH contacted hospital administrators to explain aspects of their policies that did not comply with the Perinatal Regulations.¹³⁹ NYDOH repeated this process in 2011 and found that only 7 of 132 hospitals were in complete compliance with the Perinatal Regulations and the BFMBR.¹⁴⁰ NYDOH planned to initiate enforcement proceedings against hospitals that failed to achieve complete compliance within 12 weeks.¹⁴¹ By 2013, 75 percent of hospitals were in full compliance.¹⁴²

VII. CALIFORNIA

Like New York, California has a long history of laws supporting breastfeeding in the hospital setting. In 1995, California passed a law that required hospitals to make available a breastfeeding consultant or

134. *Id.* § 2505-a(4).

135. Timothy D. Lytton, *Promoting Breastfeeding through Transparency: A Case Study of How Mandatory Disclosure Laws Influence Government Regulators and Maternity Care Providers* 12 & n.37 (Sept. 4, 2014) (unpublished manuscript) (on file with author).

136. *Id.*

137. *Id.* at 1–2.

138. N.Y. STATE DEP'T HEALTH, NEW YORK STATE MODEL HOSPITAL BREASTFEEDING POLICY 2, 5 (2011), available at http://www.health.ny.gov/community/pregnancy/breastfeeding/docs/model_hospital_breastfeeding_policy_implementation_guide.pdf.

139. Lytton, *supra* note 135, at 14.

140. *Id.* at 14–15.

141. *Id.* at 15.

142. *Id.*

provide information to mothers about where they can access breastfeeding information.¹⁴³ Although legally binding, this law has a low potential impact since hospitals can comply with the law by merely directing women to breastfeeding information rather than having a breastfeeding consultant on staff to assist women.¹⁴⁴ Furthermore, even if a breastfeeding consultant were available, the law does not require hospitals to inform women of the availability of this accommodation.¹⁴⁵

In 2007, California passed a law requiring the California State Department of Public Health to “recommend training . . . for general acute care hospitals that . . . have exclusive patient breastfeeding rates in the lowest 25 percent [of the state].”¹⁴⁶ This includes at least eight hours of training for administrative and supervisory staff about the hospital’s policies to promote exclusive breastfeeding.¹⁴⁷ The training is voluntary, rather than mandatory, and hospitals that meet the criteria in the Healthy People Guidelines for exclusive breastfeeding rates are excluded from the recommended training requirements.¹⁴⁸ An additional provision of California’s Health and Safety Code requires the California State Department of Public Health to create an eight-hour course about hospital policies to promote exclusive breastfeeding, and to indicate which hospital staff should receive the training.¹⁴⁹ The training materials should be shared with hospitals upon request.¹⁵⁰

In 2011, California passed the Hospital Infant Feeding Act.¹⁵¹ It requires all general acute care hospitals and special hospitals that provide maternity care to have an infant feeding policy that draws upon guidance from the Baby-Friendly Hospital Initiative or the State Department of Public Health Model Hospital Policy

143. CAL. HEALTH & SAFETY CODE § 123365 (West 2012).

144. *See id.* § 123365(a).

145. *Id.* (“All general acute care hospitals . . . and all special hospitals providing maternity care . . . shall make available a breast feeding consultant or alternatively, provide information to the mother on where to receive breast feeding information.”).

146. CAL. HEALTH & SAFETY CODE § 1257.9(a)(1) (West 2008).

147. *Id.*

148. *Id.*

149. CAL. HEALTH & SAFETY CODE § 123360(b) (West 2012).

150. *Id.* The California State Department of Public Health 8-hour training, entitled *Increasing Exclusive Breastfeeding Rates in California Hospitals: A Workshop for Hospital Administrators and Key Decision Makers*, available at <http://www.cdph.ca.gov/HealthInfo/healthyliving/childfamily/Pages/IncreasingExclusiveBFRates.aspx> (last visited Jan. 11, 2015).

151. Hospital Infant Feeding Act, CAL. HEALTH & SAFETY CODE § 123366 (West 2012).

Recommendations (State Policy).¹⁵² Hospitals are required to post the policy in the perinatal unit or on the hospital website.¹⁵³ They are also required to routinely communicate the policy to perinatal staff.¹⁵⁴

The State Policy is very similar to the Baby-Friendly Hospital Initiative's Ten Steps to Successful Breastfeeding.¹⁵⁵ Unlike the Ten Steps to Successful Breastfeeding, the State Policy calls for performance of a breast exam on all pregnant women and all breastfeeding mothers prior to discharge with preventive guidance on any conditions that might adversely affect breastfeeding.¹⁵⁶ The State Policy also calls for initiation of breastfeeding and skin-to-skin contact within two hours after birth, rather than within one hour as promoted by the Ten Steps to Successful Breastfeeding.¹⁵⁷ Though the Hospital Infant Feeding Act represents a large step forward towards ensuring hospitals in California adopt the Ten Steps to Successful Breastfeeding, the language of the bill only requires hospitals to "utiliz[e] guidance" from the Ten Steps to Successful Breastfeeding (or the State Policy), rather than adopt them in whole.¹⁵⁸ The Hospital Infant Feeding Act took effect on January 1, 2014, so implementation is in the early stages.¹⁵⁹

As a follow-up to the Hospital Infant Feeding Act, California passed a law that requires all hospitals to "adopt the 'Ten Steps to Successful Breastfeeding,' . . . or an alternate process . . . that includes evidenced-based policies and practices and targeted outcomes, or the Model Hospital Policy Recommendations" by January 1, 2025.¹⁶⁰ This law recognizes the shortfall in the language

152. *Id.* § 123366(c).

153. *Id.* § 123366(d).

154. *Id.*

155. See Inland Empire Breastfeeding Coal. & Inland Cnty. Reg'l Perinatal Program, *Providing Breastfeeding Support: Model Hospital Policy Recommendations*, CAL. DEP'T OF PUB. HEALTH 8 (2005) [hereinafter *Model Hospital Policy Recommendations*], available at http://www.mch.dhs.ca.gov/documents/pdf/Model_Hospital_Policy_Recommendations.pdf; see also *Baby-Friendly Hospital Initiative*, *supra* note 69.

156. *Breastfeeding Hospital Policy Recommendation Policy #3*, CAL. DEP'T OF PUB. HEALTH, <http://www.cdph.ca.gov/HealthInfo/healthyliving/childfamily/Pages/BFP-MdlHospToolkitPolicy3.aspx> (last visited Jan. 11, 2015).

157. *Breastfeeding Hospital Policy Recommendation Policy #5*, CAL. DEP'T OF PUB. HEALTH, <http://www.cdph.ca.gov/HealthInfo/healthyliving/childfamily/Pages/BFP-MdlHospToolkitPolicy5.aspx> (last visited Jan. 11, 2015); see *Baby-Friendly Hospital Initiative*, *supra* note 69.

158. CAL. HEALTH & SAFETY CODE § 123366(c).

159. See *id.* § 123366(f).

160. CAL. HEALTH & SAFETY CODE § 123367(b) (West Supp. 2014).

of the Hospital Infant Feeding Act by making adoption of the policy mandatory, but it also gives hospitals over a decade to comply with the standards.¹⁶¹

VIII. CROSS-CASE ANALYSIS

New York and California each present a very different model for instituting hospital breastfeeding policies, but both aim to increase exclusive breastfeeding rates. New York provides broad mandates through the Perinatal Regulations and the BFMBR, leaving implementation measures largely to the hospital's discretion.¹⁶² In contrast, California gives much more detailed guidance by requiring hospitals to use specific model policies for guidance and ultimately adopt those model policies in whole by 2025.¹⁶³ Specific provisions of each state's policies are compared below.

Provision of Breastfeeding Information

In California, hospitals have a choice between providing a breastfeeding consultant or providing information to mothers about where to receive breastfeeding information.¹⁶⁴ In the California State Policy, hospitals should provide information to women "prior to birth, following birth, and before discharge."¹⁶⁵ In New York, the provision of breastfeeding information is treated as separate from access to a breastfeeding consultant.¹⁶⁶ Additionally, the BFMBR must be posted in each maternal care facility and published in the maternal information leaflet provided at the time of pre-booking or admission.¹⁶⁷ In contrast, California requires the hospital breastfeeding policy to be posted either in the maternal care facility or on the facility's website.¹⁶⁸

Standards for Breastfeeding Consultants

In California, the law states that breastfeeding consultants may be registered nurses, but does not require them to be.¹⁶⁹ The California State Policy recommends that nurses "should receive standardized

161. *See id.*

162. N.Y. PUB. HEALTH LAW § 2505-a (McKinney 2012); N.Y. COMP. CODES R. & REGS. tit. 10 § 405.21 (2011).

163. CAL. HEALTH & SAFETY CODE §§ 123365–123367 (West 2012 & Supp. 2014).

164. CAL. HEALTH & SAFETY CODE § 123365(a) (West 2012).

165. *Model Hospital Policy Recommendations*, *supra* note 155, at 14.

166. N.Y. PUB. HEALTH LAW § 2505-a.

167. *Id.*

168. CAL. HEALTH & SAFETY CODE § 123366(d).

169. *Id.* § 123365(b).

education and training on [lactation] support and management,” both as part of orientation and on-going training.¹⁷⁰ In New York, the law states that breastfeeding consultants are “someone trained to help you in breastfeeding.”¹⁷¹ The New York State Policy recommends that at least one hospital maternity staff member be an International Board Certified Lactation Consultant.¹⁷²

Choice of Breastfeeding Policy

In California, all hospitals with a perinatal unit are required to have a breastfeeding policy that uses guidance from either the World Health Organization’s Baby-Friendly Hospital Initiative or a policy developed by the California Department of Public Health.¹⁷³ The California State Policy has very specific measures for each of the ten overarching policies that mirror the Ten Steps to Successful Breastfeeding.¹⁷⁴ In New York, all hospitals are required to develop written policies that implement the Article 28 provisions within the perinatal regulations and BFMBR,¹⁷⁵ but the requirements are very broad and minimal legal guidance exists to implement such measures.

Declining Breastfeeding Information

California allows mothers to decline a breastfeeding consultation or the provision of breastfeeding information.¹⁷⁶ In contrast, New York requires all mothers to receive the BFMBR, which includes wording stating that women have a choice in breastfeeding decisions.¹⁷⁷ It also states, “You have the right to complete information about the benefits of breastfeeding for yourself and your baby.”¹⁷⁸ The Perinatal Regulations require hospitals to provide information regarding breastfeeding to women who have not decided on an infant

170. *Model Hospital Policy Recommendations*, *supra* note 155, at 10.

171. N.Y. PUB. HEALTH LAW § 2505-a(3)(2); *see also* N.Y. COMP. CODES R. & REGS. tit. 10, § 405.21(f)(3)(a) (2011).

172. N.Y. STATE MODEL HOSPITAL BREASTFEEDING POLICY, *supra* note 138, at 4.

173. CAL. HEALTH & SAFETY CODE § 123366(b)–(c).

174. *See Model Hospital Policy Recommendations*, *supra* note 155, at 8; *Ten Steps to Successful Breastfeeding*, *supra* note 75.

175. N.Y. PUB. HEALTH LAW § 2505-a; N.Y. COMP. CODES R. & REGS. tit. 10, § 405.21(f)(3)(i)(b).

176. CAL. HEALTH & SAFETY CODE § 123365(d).

177. N.Y. PUB. HEALTH LAW § 2505-a.

178. *Id.* § 2505-a(3)(1).

feeding method.¹⁷⁹ It is unclear if women choosing to formula feed may decline the provision of additional breastfeeding information.

Non-English Speakers

California does not mention any accommodations for non-English speakers.¹⁸⁰ In New York, the BFMBR is made available in the top six languages spoken in New York State in addition to English.¹⁸¹ Also, the BFMBR states that the hospital must provide an interpreter, if needed, to convey information about breastfeeding.¹⁸²

IX. DISCUSSION

As states such as California begin to require hospitals to institute evidence-based policies to support breastfeeding,¹⁸³ important considerations arise about the impact of these laws. Public health laws are sometimes viewed as constraining personal liberties and inappropriately increasing state influence over matters traditionally reserved to the private sphere.¹⁸⁴ Many women make infant feeding decisions in the context of a variety of factors that are often unrelated to public health, such as cultural norms or personal convenience.¹⁸⁵ Tensions escalate when government intercedes in matters traditionally left to personal choice and arguments of paternalism and the “Nanny State” arise.¹⁸⁶

A. Public Health and the Charge of Paternalism

Public health interventions have long been vulnerable to the charge of paternalism.¹⁸⁷ The core mission of public health is to protect and

179. N.Y. COMP. CODES R. & REGS. tit. 10, § 405.21(f)(3)(i).

180. See CAL. HEALTH & SAFETY CODE §§ 123365-123366.

181. N.Y. PUB. HEALTH LAW § 2505-a(2).

182. *Id.* § 2505-a(3).

183. See CAL. HEALTH & SAFETY CODE § 123366; S.B. 502, Cal. 2011-2012 Reg. Sess. (Cal. 2011).

184. James Colgrove & Ronald Bayer, *Manifold Restraints: Liberty, Public Health, and the Legacy of Jacobson v Massachusetts*, 95 AM. J. PUB. HEALTH 571, 575 (2005) (“We think it is crucial to acknowledge that tensions exist between collective good and individual rights precisely because such rights are always vulnerable to erosion. This is especially true in the case of paternalistic measures, which may have their own moral justification but are typically put forth in the name of preventing third-party harms.”).

185. See *supra* Part IV.

186. Lindsay F. Wiley et al., *Who’s Your Nanny? Choice, Paternalism and Public Health in the Age of Personal Responsibility*, 41 J. LAW MED. ETHICS (SUPPLEMENT) 88, 88–89 (2013).

187. Colgrove & Bayer, *supra* note 184, at 575.

promote the health of populations.¹⁸⁸ The foundation of public health authority comes from police powers, the inherent authority of a state to protect the public's health, safety, and welfare.¹⁸⁹ Police powers provide government with the means to carry out public health's mission by exercising authority, allocating funding, and implementing a range of legal interventions.¹⁹⁰ In turn, individual rights such as autonomy, privacy, and liberty limit public health authority.¹⁹¹ Over the past century, a social shift has created a greater focus on the ideals of individualism, freedom, and personal responsibility.¹⁹² These ideals are often at odds with public health's core values of government responsibility, population health promotion, community participation, and social justice.¹⁹³ This shift seems to be causing concerns over governmental public health authority, and paternalism is being used as a tool to push back against public health law interventions, both in the courtroom and through public opinion.¹⁹⁴

Arguments of paternalism play a role in political and legal challenges to the adoption and implementation of new public health laws, especially those that target self-regarding behaviors such as smoking, unhealthy eating, or exercise habits.¹⁹⁵ Nowhere has seen more resistance than New York City in response to the plethora of public health law initiatives developed under former Mayor Michael Bloomberg.¹⁹⁶ Mayor Bloomberg's legal initiatives included a trans-fat ban,¹⁹⁷ menu labeling,¹⁹⁸ sugary drink portion limits,¹⁹⁹ HIV and

188. LAWRENCE O. GOSTIN, *PUBLIC HEALTH LAW: POWER, DUTY, RESTRAINT* 17 (2000).

189. *Id.* at 11.

190. *Id.* at 91–95.

191. Lawrence O. Gostin, *Public Health Law in a New Century: Part II: Public Health Powers and Limits*, 283 *JAMA* 2979, 2979 (2000).

192. *Id.* at 2981–82.

193. *Id.*

194. Wiley et al., *supra* note 186, at 88.

195. *Id.* at 89.

196. Lawrence O. Gostin, *Bloomberg's Health Legacy: Urban Innovator or Meddling Nanny?*, 43 *HASTINGS CTR. REP.* 19, 19 (2013) (“The public health community views [Mayor Bloomberg] as an urban innovator—a rare political and business leader willing to fight for a built environment conducive to healthier, safer lifestyles. To his detractors, Bloomberg epitomizes a meddling nanny—an elitist dictating to largely poor and working-class people about how they ought to live their lives.”).

197. Charisse Jones & Nanci Hellmich, *NYC Bans Trans Fats in Restaurants*, *USA TODAY* (Dec. 6, 2006, 7:50 AM), http://usatoday30.usatoday.com/news/health/2006-12-04-trans-fat-ban_x.htm.

198. Ray Rivera, *New York City Reintroduces Calorie Rule*, *N.Y. TIMES* (Oct. 25, 2007), <http://www.nytimes.com/2007/10/25/nyregion/25calories.html>.

diabetes surveillance,²⁰⁰ and smoke-free laws.²⁰¹ These types of laws are directly restrictive for consumers, but they are also potentially damaging to the industries that profit from such negative behaviors.²⁰² In many instances, the industry has become a vigorous opponent to public health laws and initiatives, with deep pockets and powerful connections.²⁰³

Breastfeeding has not gone unscathed in the court of public opinion.²⁰⁴ In 2012, the New York City Department of Health and Mental Hygiene launched a voluntary hospital campaign, Latch On NYC, aimed at increasing exclusive breastfeeding rates.²⁰⁵ In the initiative's background literature, it indicated that 93 percent of New York City births occur in hospitals that provide supplementation with infant formula and that New York was ranked second nationally for breastfed infants receiving supplementary formula while in the hospital.²⁰⁶

Hospitals that volunteered for the program agreed to enforce the Perinatal Regulations prohibiting formula supplementation unless medically indicated, to document feeding method on the patient's medical chart, to limit hospital staff access to infant formula, to discontinue the practice of distributing free infant formula, and to prohibit the display of infant formula promotional materials in hospitals.²⁰⁷ As of September 2012, 29 of the 40 hospitals in New

-
199. Michael M. Grynbaum, *New York Plans to Ban Sale of Big Sizes of Sugary Drinks*, N.Y. TIMES (May 30, 2012), <http://www.nytimes.com/2012/05/31/nyregion/bloomberg-plans-a-ban-on-large-sugared-drinks.html?pagewanted=all>.
 200. Janlori Goldman et al., *New York City's Initiatives on Diabetes and HIV/AIDS: Implications for Patient Care, Public Health, and Medical Professionalism*, 98 AM. J. PUB. HEALTH 807, 807 (2008).
 201. *Existing Legislation*, N.Y. CITY COALITION FOR A SMOKE-FREE CITY, <http://nycsmokefree.org/existing-legislation> (last visited Jan. 11, 2015).
 202. Wiley et al., *supra* note 186, at 89–90.
 203. *Id.* at 90 (“Companies that sell tobacco, alcohol, junk food, and other products that are harmful to the public’s health have an obvious incentive to oppose public health measures that threaten their profits.”).
 204. See generally, Kelly Bonyata, *Handling Criticism About Breastfeeding*, KELLYMOM (July 26, 2011), <http://kellymom.com/bf/concerns/mother/criticism/> (discussing how to deal with criticism of breastfeeding).
 205. *Breastfeeding: Latch On NYC*, N.Y. CITY DEP’T HEALTH & MENTAL HYGIENE, <http://www.nyc.gov/html/doh/pregnancy/html/after/breast-feeding-latchon.shtml> (last visited Jan. 11, 2015).
 206. *Initiative Description*, N.Y. CITY DEP’T HEALTH & MENTAL HYGIENE, <http://www.nyc.gov/html/doh/downloads/pdf/ms/initiative-description.pdf> (last visited Jan. 11, 2015).
 207. *Latch On NYC: A Hospital-Based Initiative to Support A Mother’s Decision to Breastfeed*, N.Y. CITY DEP’T HEALTH & MENTAL HYGIENE,

York City that provide maternity care services had signed up to participate in the campaign.²⁰⁸

Public backlash was immediate, with several news articles conjuring images of “Nanny Bloomberg” and evoking more paternalistic language to describe the program.²⁰⁹ Misinformation pervaded media coverage, including a misconception that in order to limit hospital staff access to infant formula, hospitals were required to lock up and track their inventory, as they would do with medication.²¹⁰ A *New York Daily News* opinion piece painted a disparaging picture of new hospital procedures: “If a new mom begs hard enough, the put-upon nurse is allowed to dole out a swig of the Devil’s brew.”²¹¹ The New York City Department of Health and Mental Hygiene had to amend its website to include a “Latch on NYC Initiative – Myths & Facts” section to combat widespread negative misconceptions.²¹²

B. Breastfeeding, Feminism, and Public Health

Evoking the “Nanny State” to describe the activities of public health and breastfeeding advocates summons many negative

<http://www.nyc.gov/html/doh/downloads/pdf/ms/latchon-hosp-commitments.pdf> (last visited Jan. 11, 2015).

208. *Id.*

209. See, e.g., Dan Childs, *NYC Hospitals’ Baby Formula Plan Rankles Mommy Bloggers*, ABC NEWS (July 31, 2012, 5:29 PM), <http://abcnews.go.com/blogs/health/2012/07/31/nyc-hospitals-baby-formula-plan-rankles-mommy-bloggers/> (“‘This isn’t morphine,’ Carroll said. ‘I’m not a drug addict that needs to be kept away from a drug. I just want to feed my baby.’”); Inae Oh, *Bloomberg’s Breastfeeding Program, ‘Latch on NYC,’ Wants Hospitals to Change Baby Formula Protocol*, HUFFINGTON POST (July 30, 2012, 10:34 AM), http://www.huffingtonpost.com/2012/07/30/bloombergs-breast-feeding-latch-on-nyc-hospitals-hide-baby-formula_n_1718664.html (“Starting in September, Mayor Bloomberg’s push to encourage breastfeeding will incorporate a new program urging hospitals to keep baby formula under lockdown.”); Mary Kay Linge, *Mayor Bloomberg Pushing NYC Hospitals to Hide Baby Formula So More New Moms Will Breast-Feed*, N.Y. POST (July 29, 2012, 4:00 AM), <http://nypost.com/2012/07/29/mayor-bloomberg-pushing-nyc-hospitals-to-hide-baby-formula-so-more-new-moms-will-breast-feed/> (“The nanny state is going after moms.”).

210. Linge, *supra* note 209 (“Mayor Bloomberg is pushing hospitals to hide their baby formula behind locked doors so more new mothers will breast-feed.”).

211. Lenore Skenazy, *Sucking the Choice Out of Parenting*, N.Y. DAILY NEWS (Aug. 1, 2012, 3:48 AM), <http://www.nydailynews.com/opinion/sucking-choice-parenting-article-1.1125979>.

212. *Latch On NYC Initiative – Myths & Facts*, N.Y. CITY DEP’T HEALTH & MENTAL HYGIENE, http://www.nyc.gov/html/om/pdf/2012/latch_myth_fact.pdf (last visited Jan. 11, 2015).

associations, such as adults being treated like children, not letting individuals make their own decisions, and the attribution of social problems to a few individuals' failure to take personal responsibility.²¹³ In contrast, feminism is focused on women's rights—as a woman, as an individual, as a patient, as a consumer.²¹⁴ The language of allegedly paternalistic public health policies seems to be at direct odds with feminist ideologies.

The concepts of self-determination and autonomy are so deeply intertwined with the feminist movement²¹⁵ that an issue such as breastfeeding would seem to be naturally implicated within its discourse. Yet second wave liberal feminist theory has been seen as contributing to the alienation of women from breastfeeding.²¹⁶ Breastfeeding was not included in the narrowly constructed agenda of women's reproductive rights, which was limited to issues of contraception and abortion.²¹⁷ Early feminist efforts that sought gender equality conceptualized the male body as the norm and strove to assimilate into that paradigm rather than shifting the paradigm to include women's reproductive functions as normal.²¹⁸ Feminists fought against biology as destiny, ultimately alienating women from motherhood.²¹⁹ Finally, there was a feeling among women that by

213. Wiley et al., *supra* note 186, at 90.

214. See KLINE, *supra* note 6, at 155.

215. See Jennifer Nedelsky, *Reconceiving Autonomy: Sources, Thoughts and Possibilities*, 1 YALE J.L. & FEMINISM 7, 7–9 (1989).

216. KAREN M. KEDROWSKI & MICHAEL E. LIPSCOMB, BREASTFEEDING RIGHTS IN THE UNITED STATES 6 (2008); see also KLINE, *supra* note 6, at 1.

217. Paige Hall Smith, "Is It Just So My Right" *Women Repossessing Breastfeeding*, 3 INT'L BREASTFEEDING J. 12 (2008) ("I highly protest when people say [breastfeeding] is not [a reproductive right] because I think that you cannot detach it from the whole experience of reproduction at all, because it is that natural cycle of what's supposed to happen, and I think that one of the problems is that we do not talk about it as part of that whole feminist model of abortion rights, conceptive, pregnancies, safe childbirth, breastfeeding. Breastfeeding seems like a natural end, but a lot of people want to cut it off which is very surprising to me because I mean [feminism] is a realm that is used to dealing with controversy; so, I cannot believe that breastfeeding would be that controversial that they would not want to deal with it.") (alteration in original).

218. *Id.*

219. *Id.*

Oh, definitely. Definitely. I even got into a debate with a friend who is not a mom, is in graduate school. And I was talking about breastfeeding in public as a feminist issue. And she said, 'Oh, come on; don't even link those two together. There's no such thing. It's a public health issue, breastfeeding in public because of the exchange of bodily fluids.' And she didn't see it as when you make a mother feel uncomfortable about her choice to breastfeed out in public chances are she is going to be isolated. If she is

advocating for breastfeeding, feminists would be disrespecting the choices of women fighting for gender equality by giving up the traditional roles of wife, mother, and caregiver.²²⁰

Feminism still struggles with the role of breastfeeding within the movement. Some feminists advocate for greater choice in the birth experience, including practices that encourage breastfeeding.²²¹ Other feminists see breastfeeding advocates as overzealous, pushing a perspective that is disrespectful of a woman's right to make her own choice about how to feed her infant.²²² A large volume of recent feminist literature examines the relationship between infant feeding practices, breastfeeding advocacy, and maternal guilt.²²³

Though public health law may seem at odds with the feminist ideologies of autonomy and self-determination, it has historical ties to the first wave feminist movement.²²⁴ It also has “deep historical roots and strong public support”²²⁵ that has led to some of the greatest decreases in morbidity and mortality over the past century.²²⁶ In the early twentieth century, social justice feminists focused on the use of police powers to improve the welfare of society at large, by targeting labor reforms for women, including healthier working conditions.²²⁷

isolated she will stop breastfeeding and then she won't get the benefits of breastfeeding for herself or her child. So, it really is a feminist issue because of women's health and children's health is a feminist issue.

Id.

220. *Id.*

221. KLINE, *supra* note 6, at 154–55.

222. *Id.* at 159 (“An example of the high standards, judgment, and expectations arising from the ‘new momism’ is the ‘breast is best’ phenomenon. Dr. Amy Tuteur, who calls herself the ‘skeptical OB,’ writes on the publishing platform opensalon.com about the disturbing quest of ‘lactivists’—breastfeeding activists—to condemn bottle feeders.”).

223. See, e.g., Kate Williams et al., *Discursive Constructions of Infant Feeding: The Dilemma of Mothers’ ‘Guilt’*, 23 FEMINISM & PSYCHOLOGY 339 (2013); Michele L. Crossley, *Breastfeeding as a Moral Imperative: An Autoethnographic Study*, 19 FEMINISM & PSYCHOLOGY 71 (2009).

224. Kristin Kalsem & Verna L. Williams, *Social Justice Feminism*, 18 UCLA WOMEN’S L.J. 131, 152–54 (2010).

225. GOSTIN, PUBLIC HEALTH LAW: POWER, DUTY, RESTRAINT, *supra* note 188, at 39.

226. See Anthony D. Moulton et al., *Perspective: Law and Great Public Health Achievements*, in LAW IN PUBLIC HEALTH PRACTICE 3–21 (Richard A. Goodman ed., 2d ed. 2007).

227. Kalsem & Williams, *supra* note 224, at 154. For early feminist activists, focusing on individual rights was problematic. *Id.*

Florence Kelley objected to the courts’ interpretation of the Due Process Clause of the Fourteenth Amendment as emphasizing

Much later, feminist legal theorists looked to the concept of social justice to articulate an alternative to liberal feminism, which seeks equality under a framework that relies on “white males as the norm” and assumes the existence of a “universal woman.”²²⁸ Theorists argue that feminist social justice is superior to liberal feminism because it recognizes important considerations outside of individual liberty, such as the social and political structures of white privilege, heterosexism, able-ism, and classism that support patriarchy.²²⁹ Social justice feminist work helps to highlight issues that liberal feminism has ignored, such as the intersection between gender, race, and class on health outcomes by looking at issues such as the effect of fast food on obesity.²³⁰

C. *Hospital Breastfeeding Law as Reproductive Choice*

Social justice feminism puts into question traditional notions of autonomy and self-determination, recognizing the role of the state and public health in addressing inequalities. Rather than limiting women’s reproductive choices, hospital breastfeeding laws actually increase women’s ability to make choices about infant feeding practices.²³¹ Hospital breastfeeding laws expand the reproductive rights of women by mandating that hospitals provide infant feeding policies for women and guidelines for employees. They provide women with greater knowledge about the benefits of breastfeeding and encourage women who want to breastfeed through increased support such as lactation consultants, in-rooming, and ensuring early

freedom of contract and individual rights. Such a reading only helped the propertied and those in power; moreover, it was “a formidable barrier to [her] plan to use the police power—the inherent power of the state to pass laws that protect the health, safety, and welfare of its citizens—to enact laws that served the interests of working people, and women and children in particular.

Id. (alteration in original) (footnotes omitted).

228. *Id.* at 156.

229. *See id.* at 157 (“[U]nder feminist social justice, liberty is not merely a negative concept, in the sense of being free from governmental interference. Indeed, elsewhere, Roberts has written that liberty should be construed as a positive right in certain contexts.”) (footnotes omitted).

230. *Id.* at 159–60 (“[S]he uncovers the class inequalities that facilitate obesity among urban people of color by highlighting the prevalence of ‘hunger and food insecurity,’ the lack of healthy alternatives to fast food, and the limited access to recreational outlets that would promote physical activity. In Austin’s work, we see how gender, race, and class conspire to affect even the most basic decisions and have serious health implications.”) (footnotes omitted).

231. *See supra* Parts VI–VII.

breastfeeding initiation.²³² The laws also respect women's choice to make their own decisions about infant feeding by providing formula feeding for women who choose it.²³³ In the past, the majority of women in California and New York did not have the option to utilize accommodations that support breastfeeding, imposing only a single infant feeding model—formula. The role of the state in relation to the rights of women to make choices about infant feeding is appropriate and does not unduly limit personal freedom or women's autonomy.²³⁴ Evidence has shown the efficacy of initiatives such as the Baby-Friendly Hospital Initiative to increase breastfeeding rates.²³⁵ Hospital breastfeeding laws, in so far as they institutionalize better maternal care and infant feeding practices, are an appropriate mechanism to increase exclusive breastfeeding rates. These laws actually work to exchange paternalism for empowerment by allowing women more choices in infant feeding.

There have been many voluntary initiatives to reform maternal care practices and institute policies that increase breastfeeding rates.²³⁶ Many states are working to have hospitals voluntarily implement various parts of the Baby-Friendly Hospital Initiative, but the largest focus seems to be on free formula giveaways upon discharge from the hospital.²³⁷ This is likely due to the view that the influence of

232. *E.g.*, N.Y. PUB. HEALTH LAW § 2505-a (McKinney 2012); N.Y. COMP. CODES R. & REGS. tit. 10 § 405.21 (2011); CAL. HEALTH & SAFETY CODE §§ 123365–123366 (West 2012).

233. *See, e.g.*, N.Y. PUB. HEALTH LAW § 2505-a.

234. *See id.*

It is your right to be informed about the benefits of breastfeeding and have your health care provider and maternal health care facility encourage and support breastfeeding. You have the right to make your own choice about breastfeeding. Whether you choose to breastfeed or not you have the following basic rights regardless of your race, creed, national origin, sexual orientation, gender identity or expression, or source of payment for your health care. Maternal health care facilities have a responsibility to ensure that you understand these rights.

Id.

235. *See supra* Part V.

236. *See The CDC Guide to Breastfeeding Interventions*, U.S. DEP'T OF HEALTH & HUMAN SERVS. (2005), <http://www.cdc.gov/breastfeeding>.

237. *E.g.*, *What is the "Ban the Bags" Campaign?*, MD. BREASTFEEDING COALITION, <http://www.marylandbreastfeedingcoalition.org/BanTheBags.php> (last visited Jan. 11, 2015); *Ban the Bags*, N.C. BREASTFEEDING COALITION, http://www.ncbfc.org/index.php?option=com_content&view=category&id=40&Itemid=83 (last visited Jan. 11, 2015); *Formula Sample-Free Hospitals*, BREASTFEEDING COALITION OF OR.,

commercial interests has no place in the hospital setting.²³⁸ For example, in fall 2011, Rhode Island's 11 birthing hospitals stopped formula giveaways, making it the first state to eliminate the practice and be "goody bag-free."²³⁹ Massachusetts quickly followed suit in the summer of 2012, becoming the second state in which all 49 birthing hospitals voluntarily banned infant formula goody bags.²⁴⁰ Ban the Bags, a larger, nationwide movement, has received pledges from 851 hospitals and birth centers across the United States to voluntarily eliminate formula goody bag giveaways.²⁴¹ This accounts for 26 percent of all hospitals and birth centers nationwide.²⁴²

Though these voluntary measures are a respectable start, they fall short in several ways compared to the legal frameworks that exist in California and New York. First, these initiatives seem to focus on a single aspect of infant feeding policy (i.e., "goody bags") and create a piecemeal approach to maternal care reform, rather than working to apply all evidence-based policies that promote breastfeeding.²⁴³ Second, the state has no power of enforcement in a voluntary scheme and hospitals can choose to withdraw participation, fail to enforce their policies, or only selectively enforce policies (with possible discriminatory effect) with few consequences.²⁴⁴ Third, voluntary

<http://www.breastfeedingor.org/healthcare/formula-bag-free-hospitals/> (last visited Jan. 11, 2015).

238. *About*, BAN THE BAGS, <http://banthebags.org/about/> (last visited Jan. 11, 2015) ("The campaign grew out of efforts in Massachusetts to stop aggressive formula company marketing tactics in hospitals. Multiple studies have shown that formula sales campaigns undermine mothers who choose to breastfeed, and coopt medical professionals to promote expensive brand-name formula.").
239. David Klepper, *Free Infant Formula: No More at Rhode Island Hospitals*, HUFFINGTON POST, (Nov. 29, 2011, 1:56 PM), http://www.huffingtonpost.com/2011/11/29/free-infant-formula_n_1119042.html?ref=health-news&ir=Health%20News.
240. Deborah Kotz, *All Massachusetts Maternity Hospitals Now Ban Infant Formula Gift Bags*, BOST. GLOBE (July 13, 2012), <http://www.bostonglobe.com/lifestyle/health-wellness/2012/07/12/all-massachusetts-maternity-hospitals-now-ban-infant-formula-gift-bags/6MociHyPZH76Un3EfNsIUO/story.html>.
241. *Bag-Free Hospitals and Birth Centers*, BAN THE BAGS, <http://banthebags.org/bag-free-hospitals/> (last visited Jan. 15, 2015).
242. *Id.*
243. See generally Eva Seidelman, *Public Citizen, Successful Initiatives to Limit Formula Marketing in Health Care Facilities: Strategic Approaches and Case Studies*, PUBLIC CITIZEN 6–17 (Karilyn Gower & Angela Bradbery eds., 2014), <http://www.citizen.org/documents/report-successful-initiatives-formula-marketing.pdf> (discussing various state initiatives which primarily center around the Ban the Bags campaign).
244. See *id.* at 17–18 (recognizing that when "[t]he regulations were not being fully implemented and hospitals were working around loopholes," New York legislators took action and passed the Breastfeeding Mothers' Bill of Rights in July of 2009).

measures create a disparity in the care provided between hospitals in the same state or even within the same community, disadvantaging women who live in communities with hospitals failing to participate.²⁴⁵ A statewide legal framework ensures greater consistency and should be the model for states pursuing increased breastfeeding rates.

D. Considerations for Marginalized Women

Not all women's experiences are the same or even similar, especially with regard to decisions of maternal care and infant feeding.²⁴⁶ Social and economic factors play a large role in shaping women's infant feeding decisions, especially for low-income women and minority women.²⁴⁷ It is important to consider hospital breastfeeding laws from a social justice perspective, to ensure that they reflect and meet the needs of more than just the "universal woman"—white, middle class, and heterosexual.

The number of African American women who give birth in a Baby-Friendly Hospital is very low.²⁴⁸ Though requiring the adoption of hospital breastfeeding policies based on the Baby-Friendly Hospital Initiative will likely increase breastfeeding rates for all hospitals serving all populations of women, the New York and California laws still fall short in addressing specific needs of minority women. The laws do little to address the problem of women's lack of self-efficacy due to social and cultural pressures.²⁴⁹ They also fail to highlight cultural misconceptions about breastfeeding that are inherent in

245. See Rita Henley Jensen, 'Baby-Friendly' Hospitals Bypass Black Communities, CHI. BUREAU (Aug. 30, 2013), <http://www.chicago-bureau.org/wenews-baby-friendly-hospitals-bypass-black-communities/>; see also SURGEON GENERAL'S CALL TO SUPPORT BREASTFEEDING, *supra* note 4, at 15.

246. *Progress in Increasing Breastfeeding and Reducing Racial/Ethnic Differences – United States, 2000-2008 Births*, *supra* note 6, at 79.

247. See SURGEON GENERAL SUPPORT BREASTFEEDING, *supra* note 4, at 6–7; see also *supra* Part IV.

248. Jensen, *supra* note 245 ("Less than 5 percent of the 166 U.S. hospitals meeting criteria for the WHO'S Baby-Friendly Hospital Initiative are in the nine states plus District of Columbia with the highest concentrations of black Americans; areas home to one-third of the country's black population.").

249. See Deborah McCarter-Spaulding & Rebecca Gore, *Social Support Improves Breastfeeding Self-Efficacy in a Sample of Black Women*, 3 CLINICAL LACTATION 114, 116 (2012); Karen M. Robinson & Leona VandeVusse, *African American Women's Infant Feeding Choices: Prenatal Breast-Feeding Self-Efficacy and Narratives from a Black Feminist Perspective*, 25 J. PERINATAL & NEONATAL NURSING 320, 326–27 (2011).

various cultural, racial, and ethnic minorities.²⁵⁰ More targeted support to address these issues must be reflected either in the laws themselves or in the regulatory guidance, such as the State Policies.

The 2011 Surgeon General's *Call to Action to Support Breastfeeding* identified several potential initiatives to address the needs of minority women.²⁵¹ It called for increasing support for nonprofit organizations that promote breastfeeding in minority communities.²⁵² Under the Ten Steps to Successful Breastfeeding, hospitals are supposed to "foster the establishment of breastfeeding support groups and refer mothers to them on discharge from the hospital."²⁵³ Hospitals should be guided to foster the establishment of support groups that address the needs of different groups of women, including minority women, working mothers, and low-income women.

The 2011 Surgeon General's *Call to Action to Support Breastfeeding* also called for an increase in the number of International Board Certified Lactation Consultants from minority communities.²⁵⁴ Evidence has shown that the provision of peer support is important to maintaining exclusive breastfeeding.²⁵⁵ International Board Certified Lactation Consultants from minority communities can act as both peers and lactation experts.²⁵⁶ Sharing various characteristics with a lactation consultant, such as race or language, helps reinforce breastfeeding recommendations in a socially and culturally appropriate context.²⁵⁷ Peer counselors also serve as role models, which can be important when a woman lacks a breastfeeding model among family and friends.²⁵⁸

250. SURGEON GENERAL'S CALL TO SUPPORT BREASTFEEDING, *supra* note 4, at 11–12.

251. *Id.* at 38–57.

252. *Id.* at 40–43.

253. *Ten Steps to Successful Breastfeeding*, *supra* note 71.

254. SURGEON GENERAL SUPPORT BREASTFEEDING, *supra* note 4, at 48.

255. *E.g.*, Alex K. Anderson et al., *A Randomized Trial Assessing the Efficacy of Peer Counseling on Exclusive Breastfeeding in a Predominantly Latina Low-Income Community*, 159 ARCHIVES PEDIATRIC ADOLESCENT MED. 836, 840 (2005) ("Findings from this study indicate that the use of trained community-based peer counselors, within the context of a Baby Friendly Hospital, is a very efficacious approach to promote [exclusive breast feeding] in the United States."); *cf.* Jolly Nankunda et al., *"She Would Sit with Me": Mothers' Experiences of Individual Peer Support for Exclusive Breastfeeding in Uganda*, 5 INT'L BREASTFEEDING J. 6, 10 (2010) ("The women generally felt that the peer counselor visits were useful to them. Some even felt that peer counseling had empowered them to make decisions about how to feed their babies since they now had the knowledge.").

256. *See* SURGEON GENERAL SUPPORT BREASTFEEDING, *supra* note 4, at 20.

257. *Id.* at 20.

258. *See id.*

E. Using Law to Ensure Breastfeeding Success

Though hospital breastfeeding law lays an important foundation for breastfeeding success at the most crucial time for breastfeeding initiation, it cannot address additional barriers that women face after leaving the hospital. Most states have specific laws that protect a woman's right to breastfeed in public,²⁵⁹ but additional legal protections for breastfeeding are less common.²⁶⁰ Twenty-nine states and the District of Columbia exempt breastfeeding from public indecency laws.²⁶¹ Twenty-five states and the District of Columbia have laws relating to breastfeeding in the workplace.²⁶² Sixteen states exempt breastfeeding mothers from jury duty.²⁶³ Federally, the Patient Protection and Affordable Care Act requires employers to provide break time and a place for hourly paid workers to express breast milk at work, but it only covers employers with more than 50 employees.²⁶⁴

Though these laws increase women's chances to breastfeed exclusively, they do not provide a legal framework to fully protect and support women's infant feeding choices. These laws do not address several additional barriers that women face to exclusive breastfeeding. A truly comprehensive legal framework to sustain breastfeeding throughout the first 12 months of life requires increased protections, especially for working mothers. States can utilize many creative legal interventions to support breastfeeding, including taxing and spending, alteration of the socioeconomic environment, alteration of the informational environment, and direct regulation of health care providers, employers, and businesses.²⁶⁵ Laws that address social and

259. *Breastfeeding State Laws*, *supra* note 1. The District of Columbia, the Virgin Islands and forty-six states have specific laws protecting mothers who breastfeed in public, including: Alabama, Alaska, Arizona, Arkansas, California, Colorado, Connecticut, Delaware, Florida, Georgia, Hawaii, Illinois, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Minnesota, Mississippi, Missouri, Montana, Nebraska, Nevada, New Hampshire, New Jersey, New Mexico, New York, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, Pennsylvania, Rhode Island, South Carolina, Tennessee, Texas, Utah, Vermont, Washington, West Virginia, Wisconsin and Wyoming.

260. *See id.*

261. *Id.*

262. *Id.*

263. *Id.*

264. Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 4207, 124 Stat. 119, 577-78 (2010).

265. GOSTIN, PUBLIC HEALTH LAW: POWER, DUTY, RESTRAINT, *supra* note 188, at 238-39.

economic barriers to breastfeeding will most benefit poor and minority women.

Hospital breastfeeding laws should be the foundation for a strong legal framework aimed at supporting women's right to breastfeed throughout a child's first 12 months of life by providing support during the crucial initiation period. New laws should also address barriers in childcare settings. Returning to work often signals the end to breastfeeding for many women.²⁶⁶ Supportive workplace policies are important and have received a lot of attention, especially since passage of the Patient Protection and Affordable Care Act workplace breastfeeding provisions.²⁶⁷ But even with a supportive workplace environment, many women face challenges in the child care setting.²⁶⁸

Currently, only two states have statutes regarding breastfeeding requirements for licensed childcare facilities. Mississippi law requires child care facilities to provide breastfeeding mothers with a non-toilet stall, sanitary space to breastfeed or express milk, to provide a refrigerator to store expressed milk, to train staff in the safe storage and proper handling of breast milk, and to display breastfeeding promotion information to the clients of the facility.²⁶⁹ Louisiana has a law that prohibits any childcare facility from discriminating against breastfed children.²⁷⁰

266. Claire McCarthy, *The Top Four Reasons Moms Stop Breastfeeding—And What We Can Do About Them*, BOSTON.COM (June 4, 2012, 11:09 AM), http://www.boston.com/lifestyle/health/mdmama/2012/06/the_top_four_reasons_moms_stop_breastfeeding—and_what_we_can_do_about_them.html?s_campaign=8315 (“But finding the time and place to pump (and affording the pump in the first place), as well as transporting and storing breast milk, can be stressful. Add that to the general stress of going back to work, throw in a less-than-supportive workplace, and there goes the exclusive breastfeeding plan.”).

267. *Health Care Law's Impact on Jobs, Employers, and the Economy: Hearing Before the House Comm. on Ways and Means*, 112th Cong. 177–79 (2011) (statement of Debra L. Ness, President, Nat'l Partnership for Women & Families & Robin W. Stanton, Chair, U.S. Breastfeeding Comm.) (“The *Affordable Care Act* (ACA) gives millions of nursing moms the support and protection they need. The law is an important step in making sure the nation's workplaces meet the needs of working women and their families.”).

268. *Cf. id.* (discusses the support employers can provide to breastfeeding mothers in the workplace).

269. MISS. CODE ANN. § 43-20-31 (2009).

270. LA. REV. STAT. ANN. § 46:1407(F) (repealed) (2010 & Supp. 2014) (“Discrimination by child care facilities and child-placing agencies on the basis of race, color, creed, sex, national origin, disability as defined by R.S.51:2232(11), ancestry, or whether the child is being breastfed is prohibited.”).

State laws should also work to eliminate financial barriers to breastfeeding. Maryland has a unique law that exempts the sale of breastfeeding supplies, such as breast pumps, breast pump hook-up kits, breast shells, nursing shields, feeding tubes, breast milk storage bags, finger feeders, and purified lanolin, from state sales tax.²⁷¹

Additionally, state laws should ensure insurance coverage for all breastfeeding services, including access to breastfeeding supplies, such as breast pumps and all accessories. Under the Patient Protection and Affordable Care Act, insurance plans are required to cover comprehensive lactation support and counseling and the cost of a breast pump, but plans may offer to cover either a rental or a new pump for patients to keep.²⁷² The law's recommendations are vague, so in practice coverage varies widely from health plan to health plan.²⁷³ For example, some health plans cover the purchase of manual pumps only while other plans exclude hospital-grade pumps.²⁷⁴ Most plans place restrictions on the types of pumps women can obtain by only covering limited designated vendors,²⁷⁵ which may limit women's choice of model and in turn may discourage some women from continuing to breastfeed.

X. CONCLUSION

A large majority of women intend to breastfeed exclusively for three months or more, but only one-third of women actually achieve their expected period of breastfeeding.²⁷⁶ Feminists should recognize women's right to choose their own infant feeding method, seek passage of public health laws that provide for effective maternal care practices and infant feeding support, and combat misconceptions that hospital breastfeeding laws are paternalistic.²⁷⁷ Feminism and public health are not mutually exclusive, but rather are both rooted in the ideology of social justice.²⁷⁸ The opportunity to breastfeed should be afforded to all women, regardless of age, race, ethnicity, economic

271. MD. CODE ANN., TAX-GEN. § 11-211(b)(19) (LexisNexis 2010).

272. Ann Carns, *Breast Pump Coverage Under New Law Varies in Practice*, N.Y. TIMES (Jan. 28, 2013, 4:09 PM), http://bucks.blogs.nytimes.com/2013/01/28/breast-pump-coverage-under-new-law-varies-in-practice/?_php=true&_type=blogs&_php=true&_type=blogs&_r=1.

273. *Id.*

274. *Id.*

275. *Id.*

276. Cria G. Perrine et al., *Baby-Friendly Hospital Practices and Meeting Exclusive Breastfeeding Intention*, 130 PEDIATRICS 1, 1 (2012).

277. *See supra* Part IX.B.

278. *See supra* Part IX.B.

status, or sexuality. Though not perfect, the New York and California hospital breastfeeding laws lay a foundation for a comprehensive legal framework to support breastfeeding.²⁷⁹ The laws also provide a good starting point for other states to experiment with a variety of legal mechanisms to increase breastfeeding rates. Ultimately, hospital breastfeeding laws will empower women and decrease the proportion of women who are unable to meet their exclusive breastfeeding intentions, by providing evidence-based interventions to support their infant feeding decisions.

279. Hospital Infant Feeding Act, Cal. HEALTH & SAFETY CODE § 123366 (West 2012); N.Y. PUB. HEALTH LAW § 2505-a (McKinney 2012).