3-1-2015

Becoming Baby-Friendly

Harvard Law School Mississippi Delta Project

Becoming Baby-Friendly: Recommendations for Mississippi

Harvard Law School Mississippi Delta Project

Spring 2015

TABLE OF CONTENTS

I. INTRODUCTION 2

II. BENEFITS OF BREASTFEEDING 2
A. Health Benefits to Babies 3
B. Health Benefits to Mothers 4
C. Economic Benefits of Breastfeeding 5
D. Health Indicators in Mississippi 6

III. THE BABY-FRIENDLY HOSPITAL INITIATIVE 7
A. Background 7
B. Why go Baby-Friendly? 10

IV. IMPLEMENTING THE BABY-FRIENDLY HOSPITAL INITIATIVE – STATE SUCCESSES 12
A. Five Step Implementation – Colorado, Arizona, Connecticut 12
1. Colorado 12
2. Arizona 17
3. Connecticut 20
B. Separate Designation Program – Texas 24
C. Monetary Incentive Program – South Carolina 27
D. Legislative Mandate 30
1. California 30
2. Illinois 34

V. RECOMMENDATIONS FOR MISSISSIPPI 34
A. Collaboration 34
1. Local, Community Organizations 34
2. Other Government Departments 35
3. Hospital Administrators and Staff 36
4. Facilitating Hospital Networks 36
B. Resources and Training 37
C. Community Support 38

VI. CONCLUSION 39

I. INTRODUCTION[1]

"*For nearly all infants, breastfeeding is the best source of infant nutrition and immunologic protection, and it provides remarkable health benefits to mothers as well.*"[2]

- U.S. Surgeon General

This report is written in collaboration with the Mississippi State Health Department's Office of Preventative Health in order to assist them in their mission to increase breastfeeding rates in the state of Mississippi. The health department has received a grant from the Center for Disease Control and Prevention, in order to increase breastfeeding rates in the state of Mississippi through the use of the Baby-Friendly Hospital model. The Baby-Friendly Hospital Initiative is an initiative created by the World Health Organization (WHO) and the United Nations Children's Fund (UNICEF) to encourage hospitals to promote and become a supportive environment for breastfeeding.[3] The Office of Preventative Health is using the framework created by the Baby-Friendly Hospital Initiative (BFHI) to address Mississippi's low breastfeeding rates. Through these efforts, they aim to increase not breastfeeding rates in Mississippi as well as works towards creating a more supportive breastfeeding culture within the state.

This report addresses methods and programs that other state health departments have used to implement the Baby-Friendly Hospital Initiative within their state, with particular attention to how these might apply to Mississippi. This report first addresses the practice of breastfeeding and its benefits and the Baby-Friendly Hospital Initiative and then examines six other state models that represent a variety of ways to implement BFHI.

II. BENEFITS OF BREASTFEEDING

Health experts and public health organizations across the nation have broadly recognized the importance of breastfeeding and the many health, economic, and environmental benefits that breastfeeding can bring to infants, mothers, and communities. In 2011, The Surgeon General of the United States declared that "breastfeeding is the best source of infant nutrition and immunologic protection," citing

---

[1] This report was prepared by Anna Byers, Margaret Hazuka, Susana Cervantes, Amanda Bakowski, Joseph Goldsmith, and Alice Reichman, members of the Harvard Law School Mississippi Delta Project, under the supervision of Desta Reff, Harvard Delta Clinical Fellow.

[2] THE SURGEON GENERAL'S CALL TO ACTION TO SUPPORT BREASTFEEDING, U.S. DEP'T OF HEALTH AND HUMAN SERVICES, v (2011), *available at* http://www.surgeongeneral.gov/library/calls/breastfeeding/calltoactiontosupportbreastfeeding.pdf [hereinafter THE SURGEON GENERAL'S CALL TO ACTION].

[3] *Baby-friendly Hospital Initiative,* WORLD HEALTH ORGANIZATION, http://www.who.int/nutrition/topics/bfhi/en/ (last visited April 15, 2015).

at least six medical professional associations[4] that recommend breastfeeding most infants for twelve months, with the first six months dedicated to exclusive breastfeeding (no foods or liquids other than breast milk).[5] Breastmilk provides optimal nutrition for infants right from the start and contains all of the necessary vitamins and nutrients babies need to develop and thrive. Breastfeeding strengthens immunities against common childhood illnesses and diseases, such as asthma and childhood diabetes.[6] Mothers also receive health benefits from breastfeeding, including a decreased risk of postpartum bleeding, possible lowered risk of arthritis and diabetes, and a reduced risk of ovarian and breast cancer.[7] Breastfeeding is also free, organic, and sustainable.

A. Health Benefits to Babies

Breastfeeding has numerous health benefits for infants. Infants who are at least partially breastfed show significantly lower rates of both common infections, like diarrhea[8] and ear infections,[9] as well as more serious conditions, like lower respiratory infections,[10] and leukemia,[11] than infants who are exclusively formula-fed for the first six months. Formula fed infants are 250% more likely to be hospitalized for lower respiratory infection before reaching one year, than babies who are exclusively breastfed for the first four months or longer.[12] Acute ear infection rates double among formula-fed infants over babies who exclusively breastfeed for the first six months.[13] Perhaps most striking is the fact that sudden infant death syndrome is 56% more likely to occur in infants that have been exclusively formula fed than infants who have experienced at least some breastfeeding.[14]

A number of studies have also shown that breastfeeding reduces risks of crippling chronic conditions, such as diabetes, obesity, and asthma.[15] Breastfeeding is

---

[4] Particularly, the Surgeon General noted the American Academy of Pediatrics (AAP), American Academy of Family Physicians, American College of Obstetricians and Gynecologists, American College of Nurse Midwives, American Dietetic Association, and American Public Health Association.
[5] THE SURGEON GENERAL'S CALL TO ACTION, *supra* note 2, at v.
[6] *Id*. at 1.
[7] *Benefits of Breastfeeding for Mom*, HEALTHY CHILDREN, (July 10, 2014), http://www.healthychildren.org/English/ages-stages/baby/breastfeeding/Pages/Benefits-of-Breastfeeding-for-Mom.aspx.
[8] Maria A. Quigley et. al. *Breastfeeding and Hospitalization for Diarrheal and Respiratory Infection in the United Kingdom Millennium Cohort Study*, 119 PEDIATRICS 2006, 2006-7 (2007).
[9] Chung M Ip S et al. *Breastfeeding and Maternal and Infant Health Outcomes in Developed Countries: Evidence Report/ technology assessment no. 153*, AGENCY FOR HEALTHCARE RESEARCH AND QUALITY (2007), *available at* http://www.ncbi.nlm.nih.gov/books/NBK38333/#B106792.
[10] Quigley, *supra* note 8.
[11] Marilyn L. Kwan, *Breastfeeding and the Risk of Childhood Leukemia: a Meta-Analysis*, 119 PUBLIC HEALTH REP. 521, 521–535 (2004).
[12] THE SURGEON GENERAL'S CALL TO ACTION, *supra* note 2 at 1.
[13] *Id*.
[14] Christopher G. Owen et al., *Does Breastfeeding Influence Risk of Type 2 Diabetes in Later Life? A quantitative analysis of published evidence*, 84 AMERICAN JOURNAL OF CLINICAL NUTRITION 1043 (2006).
[15] *Chung, supra* note 9.

also associated with the development of healthy dietary behaviors as research has found that breastfed children consume more water, fruits, and vegetables than formula-fed children.[16] Some studies have even shown a positive association between breastfeeding and higher cognitive performance.[17] A recent study has found that breastfeeding for a year or more can have a positive effect on increased intelligence in adulthood, longer schooling, and higher adult earnings.[18] Further, many mothers find breastfeeding to help them bond with their child.

INFANT HEALTH RISK REDUCTION DUE TO BREASTFEEDING[19]	
Health Outcome	Reduction of Risk in Full Term Infants
Asthma	27-40%*
Childhood Obesity	24%
Type II Diabetes	39%
Childhood Leukemia	19%
Sudden Infant Death Syndrome	56%
Lower Respiratory Tract Illness	72%

* Variation due to duration of breastfeeding and family history

B. Health Benefits to Mothers

Breastfeeding has also been shown to have significant benefits for the mother. Breastfeeding is associated with decreased postpartum bleeding,[20] increased child spacing,[21] and a reduction in obesity through increased postpartum weight loss.[22]

[16] Cria G. Perrine et al., *Breastfeeding Duration Is Associated With Child Diet at 6 Years*, 134 PEDIATRICS 550, 550-555 (2014).
[17] American Academy of Pediatrics, *Breastfeeding and the Use of Human Milk*, 115 PEDIATRICS 496, 497 (2005).
[18] Cesar G. Victora et al., *Association between Breastfeeding and Intelligence, Educational Attainment, and Income at 30 years of Age: a Prospective Birth Cohort Study from Brazil*, 3 THE LANCET GLOBAL HEALTH 199 (2015).
[19] Desta Reff, *Increasing Breastfeeding Rates in Mississippi*, HARVARD FOOD AND POLICY CLINIC, 2 (2015), *available at* http://www.champsbreastfeed.org/uploads/3/7/9/4/37948891/policy_brief_by_desta_reff.pdf.
[20] S. Chua et al., *Influence of breastfeeding and nipple stimulation on postpartum uterine activity*, 101 BRITISH JOURNAL OF OBSTETRICS AND GYNAECOLOGY 804-5 (1994).
[21] Jen O'Quinn. *Natural Child Spacing and Breastfeeding*, 34 LEAVEN 128 (1998).

Studies have shown that women who breastfeed can reduce their risk of breast cancer by up to 28%, and also have significantly lower risk of ovarian cancer.[23] Breastfeeding mothers also have lower risks in the long term of Type II diabetes and osteoperosis.[24] The longer a woman breastfeeds, the greater many of these benefits are, specifically the reduction in her risk of breast cancer.[25] Indeed, women who breastfed for a cumulative two years enjoy double the reduction in risk that those women who only breastfed for one year.[26] Moreover, many women find breastfeeding emotionally rewarding in that it helps them create a stronger attachment with their children.[27] Research also and indicates that women who breastfeed are less likely to suffer from postpartum depression.[28]

C. Economic Benefits of Breastfeeding

In addition to the emotional, psychological, and health benefits, experts have also highlighted significant economic benefits created by increased rates of breastfeeding. In a state with the highest poverty rate in the country, this is an enormous boon.[29] Formula is highly expensive. A seminal 1999 study showed that the average family spent between $1200-1500 on formula during an infant's first year, or a shocking $1680-$2100 when adjusted for inflation.[30] Another study showed that during an infant's first year, the increased health care costs for an infant never breastfed were between $331 and $475.[31] On a larger, national level, increasing breastfeeding rates has significant economic implications for the United States and its healthcare costs. A 2001 study

---

[22] Kathryn G. Dewey et al., *Maternal Weight-Loss Patterns During Prolonged Lactation*, 58 AMERICAN JOURNAL CLINICAL NUTRITION 162, 165 (1993).
[23] *Breastfeeding and the Use of Human Milk*, 129 PEDIATRICS 827, 832 (2012).
[24]. Healthy Milk, Healthy Baby: Benefits of Breastfeeding, NATIONAL RESOURCES DEFENSE COUNCIL, http://www.nrdc.org/breastmilk/ (last visited April 25, 2014)

[25] COLLABORATIVE GROUP ON HORMONAL FACTORS IN BREAST CANCER, *Breast Cancer and Breastfeeding: Collaborative Reanalysis of Individual Data from 47 Epidemiological Studies in 30 Countries, including 50302 Women with Breast Cancer and 96,973 Women Without the Disease*, 360 LANCET 187, 187-95 (2002).
[26] *Id.*
[27] Y.K. Bai et al., *Psychosocial Factors Underlying the Mother's Decision to Continue Exclusive Breastfeeding for 6 Months: an Elicitation Study*, 22 JOURNAL OF HUMAN NUTRITION AND DIETETICS 134, 137 (2009).
[28] *See e.g.* F. Mancini et al., *Use of the Postpartum Depression Screening Scale in a Collaborative Obstetric Practice*, 52 J MIDWIFERY WOMEN'S HEALTH 429, 429-434 (2007); K. Green et al., *Postnatal Depression Among Mothers in the United Arab Emirates: Socio-cultural and Physical Factors*, 11 PSYCHOLOGY, HEALTH & MEDICINE 425, 425-431 (2006); R. Jardri et al., *Predictive Validation Study of the Edinburgh Postnatal Depression Scale in the First Week after Delivery and Risk Analysis for Postnatal Depression*, 93 JOURNAL OF AFFECTIVE DISORDERS 169, 169-176 (2006).
[29] *Poverty,* USDA ECONOMIC RESEARCH SERVICE, http://www.ers.usda.gov/data-products/county-level-data-sets/poverty.aspx (last visited April 25, 2014).
[30] THE SURGEON GENERAL'S CALL TO ACTION, *supra* note 2.
[31] T.M. Ball, *Health Care Costs of Formula-Feeding in the First year of Life*, 103 PEDIATRICS 870, 870-6 (1999).

found that if only 50% of women followed recommended breastfeeding practices of breastfeeding to six months, a net savings of $3.6 billion in reduced healthcare costs would result.[32] If 90% compliance was reached, the U.S. could save nearly $13 billion in healthcare costs per year.[33]

Mississippi's economy would benefit greatly from increased breastfeeding rates. First and foremost, increasing breastfeeding rates would result in significant reduction in healthcare costs to the state. Based on population, using the numbers above, Mississippi could save an estimated $36-130 million per year in healthcare costs by increasing breastfeeding rates - likely much more considering the state's negative health indicators.[34] There are also further positive economic benefits to increased breastfeeding rates in Mississippi, such as decreased employee absenteeism and increased worker productivity.[35] With child health improving through breastfeeding, parents will be absent less from work due to sick children. Further, as parental work attendance increases, higher productivity results from more hours and more continuity.[36]

D. Health Indicators in Mississippi

Mississippi's breastfeeding rates continue to be among the lowest in the country.[37] The CDC's 2014 "Breastfeeding Report Card" reported that only 61.5% of babies in Mississippi are ever breastfed which is 47th in the country and significantly lower that the national average of 79.2%.[38] By six months, only 10.1% of babies in Mississippi are exclusively breastfed, which is about half of the national average.[39] Compare this to states such as California (with a state-wide Baby-Friendly mandate) where 92.8% of babies are breastfed and 25.4% are still exclusively breastfed at six months,[40] or Colorado, another state which has strongly encouraged breastfeeding, with rates of 81.0% of babies ever being breastfed, and 25.8% exclusively breastfed at six

[32] JON WEIMER, FOOD AND RURAL ECONOMICS DIVISION, ECONOMIC RESEARCH SERVICE, U.S. DEPT. OF AGRICULTURE, THE ECONOMIC BENEFITS OF BREASTFEEDING: A REVIEW AND ANALYSIS, FOOD ASSISTANCE AND NUTRITION RESEARCH REPORT NO. 13, iii-iv (2001).
[33] Melissa Bartick & Arnold Reinhold, *The Burden of Suboptimal Breastfeeding in the United States: a Pediatric Cost Analysis*, 125 PEDIATRICS 1048 (2010).
[34] Reff, *supra* note 19 at 2.
[35] *Id*.
[36] HEALTH SERVICE EXECUTIVE, BREASTFEEDING AND WORK 4 (2007), *available at* http://www.healthpromotion.ie/hp-files/docs/HPM00365.pdf.
[37] Though Mississippi has risen from 50th to 47th in the country in breastfeeding in the last year, there is much work to be done to expand and sustain this upward trend. *Compare* BREASTFEEDING REPORT CARD U.S. 2014, CTRS. FOR DISEASE CONTROL AND PREVENTION 4 (2014), *with* BREASTFEEDING REPORT CARD U.S. 2013, CTRS. FOR DISEASE CONTROL AND PREVENTION, 4 (2013).
[38] BREASTFEEDING REPORT CARD U.S. 2014, CTRS. FOR DISEASE CONTROL AND PREVENTION , 4 (2014) [hereinafter BREASTFEEDING REPORT CARD 2014].
[39] *Id*.
[40] *Id*.

months.[41] Without these specific and proven interventions, Mississippi's breastfeeding number will continue to lag behind.

Increasing breastfeeding rates is particularly important for the state, given Mississippi's significant health problems. Mississippi has the highest rate of infant mortality of any state.[42] Only Louisiana surpasses Mississippi in obesity and overweight among children[43]. Mississippi has the third highest rate of diabetes with 12.9% of people with a diagnosis of diabetes [44] as well as the highest child death rate in the country.[45] Breastfeeding significantly reduces the risk of these negative health issues, and increasing breastfeeding rates within the state would be a strong, cost-effective start for Mississippi to address these crippling health problems.

III. THE BABY-FRIENDLY HOSPITAL INITIATIVE

A. Background

The Baby-Friendly Hospital Initiative was created by the World Health Organization and the United Nations International Children's Emergency Fund in 1991 to encourage hospitals to implement best practices designed to increase global breastfeeding rates.[46] The Initiative helps hospitals give mothers the information and skills necessary to begin and successfully continue breastfeeding their babies, and acknowledges hospitals that have done so.[47] The Initiative recognizes and designates hospitals and birthing facilities that successfully implement *The Ten Steps to Successful Breastfeeding,* a list of evidence-based best practices created by international experts, shown to encourage breastfeeding initiation and duration.[48] The Ten Steps are:

1. Have a written breastfeeding policy that is routinely communicated to all health care staff.
2. Train all health care staff in the skills necessary to implement this policy.
3. Inform all pregnant women about the benefits and management of breastfeeding.
4. Help mothers initiate breastfeeding within one hour of birth.

---

[41] *Id*.
[42] *Infant Mortality Rate (Deaths per 1,000 Live Births)*, THE HENRY J. KAISER FAMILY FOUND., http://kff.org/other/state-indicator/infant-death-rate/ (last visited Apr. 6, 2015).
[43] *Percent of Children (ages 10-17) Who are Overweight or Obese*, THE HENRY J. KAISER FAMILY FOUND., http://kff.org/other/state-indicator/overweightobese-children/ (last visited Apr. 6, 2015).
[44] *Percent of Adults Who Have Ever Been Told by a Doctor the They Have Diabetes*, THE HENRY J. KAISER FAMILY FOUND., http://kff.org/other/state-indicator/adults-with-diabetes/ (last visited Apr. 6, 2015).
[45] *Rate of Child Deaths (1-14) per 100,000 Children*, THE HENRY J. KAISER FAMILY FOUND., http://kff.org/other/state-indicator/child-death-rate/ (last visited Apr. 6, 2015).
[46] *Baby-Friendly Hospital Initiative,* BABY-FRIENDLY USA, https://www.babyfriendlyusa.org/about-us/baby-friendly-hospital-initiative (last visited Mar. 24, 2015).
[47] *Id*.
[48] *The Ten Steps to Successful Breastfeeding,* BABY-FRIENDLY USA, https://www.babyfriendlyusa.org/about-us/baby-friendly-hospital-initiative/the-ten-steps (last visited Mar. 24, 2015).

5. Show mothers how to breastfeed and how to maintain lactation, even if they are separated from their infants.
6. Give infants no food or drink other than breast-milk, unless medically indicated.
7. Practice rooming in - allow mothers and infants to remain together 24 hours a day.
8. Encourage breastfeeding on demand.
9. Give no pacifiers or artificial nipples to breastfeeding infants.
10. Foster the establishment of breastfeeding support groups and refer mothers to them on discharge from the hospital or birth center.[49]

Mothers who give birth at Baby-Friendly hospitals are more likely to exclusively breastfeed and sustain breastfeeding at six months.[50] To get certified as Baby-Friendly, a hospital or birthing center must go through the "4-D pathway" to designation and pass an on-site assessment.[51] The process requires "verification of policies, curriculum, action plans, quality improvements projects, staff training, and competency verification, as well as a readiness interview and an on-site survey."[52] Once a hospital has passed the on-site assessment they can use the Baby-Friendly certification mark.[53] The phases of the 4-D pathway are:

D1 – Discovery: During this phase the hospital must complete three tasks - (1) "register with Baby-Friendly USA" (2) submit a letter from the CEO declaring administrative support to undertake the process of becoming Baby-Friendly and "(3) complete and submit a Facility Data Sheet and Self-Appraisal tool."[54] There is no fee during this phase.[55]

D2 – Development: During the development phase, hospitals are given a set of tools to help in executing the *Ten Steps.*[56] There are six main tasks that must be accomplished during this stage, including developing a task force, a work plan, an infant feeding plan that supports breastfeeding, teaching plans for prenatal and postpartum care, and creating a data collection plan.[57] Plans are then reviewed by

[49] *Id*.
[50] *Why Seek Designation?,* BABY-FRIENDLY USA, https://www.babyfriendlyusa.org/faqs/why-seek-designation (last visited Mar. 24, 2015).
[51] *Get Started,* BABY-FRIENDLY USA, https://www.babyfriendlyusa.org/get-started (last visited Mar. 24, 2015).
[52] *Id*.
[53] *Id*.
[54] *D1 Discovery,* BABY-FRIENDLY USA, https://www.babyfriendlyusa.org/get-started/d1-discovery (last visited Mar. 24, 2015).
[55] *Fee Schedule,* BABY-FRIENDLY USA (May 1, 2014), *availale at* https://www.babyfriendlyusa.org/get-started/fee-schedule.
[56] *D2 Development,* BABY-FRIENDLY USA, https://www.babyfriendlyusa.org/get-started/d2-development (last visited Mar. 24, 2015).
[57] *Id*.

Baby-Friendly USA.[58] The fee during this phase is $3,600 for hospitals or $2,800 for facilities with fewer than 500 births a year.[59]

D3 – Dissemination Phase: During this phase, hospitals implement the plans that they developed during the D2 phase and collect data to measure their progress.[60] A hospital has successfully completed this phase when all audit results indicate the facility is meeting all the requirements of the *Ten Steps.*[61] The fee during this phase is $3,900 for hospitals or $3,000 for facilities with fewer than 500 births a year.[62]

D4 – Designation Phase: During this last phase facilities are assessed by Baby-Friendly USA, who sends an on-site assessment team to the facility after completion of a phone assessment.[63] This is dependent on the hospital achieving a system of fair market value for any infant feeding supplies.[64] If the facility is deemed to have fully implemented the *Ten Steps* they will be given a license to use the Baby-Friendly certification.[65] If they do not pass, they can correct the problems and apply for a re-assessment.[66] The fee during this phase is $4,200 for hospitals or $3,200 for facilities with fewer than 500 births a year.[67]

After earning the designation, all facilities must follow the *Baby-Friendly USA Guidelines and Evaluation Criteria* in order to retain their designation.[68] To do this each facility must complete an Annual Quality Improvement Project[69] and pay an annual fee of $1,250.[70] The Baby-Friendly Designation is for five years and following the fifth year all facilities must be re-designated through an on-site assessment.[71]

Since the Baby-Friendly Hospital Initiative's inception, over 15,000 hospitals in 134 countries have achieved Baby-Friendly status, resulting in higher breastfeeding rates

[58] *Id*.
[59] *Fee Schedule, supra* note 55. Note: These fees assume a facility will not take longer than a year per phase. If a facility does take longer than a year to complete a phase, there will be an additional fee, equal to the fee for that phase.
[60] *D3 Dissemination,* BABY-FRIENDLY USA, https://www.babyfriendlyusa.org/get-started/d3-dissemination (last visited Mar. 24, 2015).
[61] *Id*.
[62] *Fee Schedule, supra* note 55.
[63] *D4 Designation,* BABY-FRIENDLY USA, https://www.babyfriendlyusa.org/get-started/d4-designation (last visited Mar. 24, 2015).
[64] *Id*.
[65] *Id*.
[66] *Id*.
[67] *Fee Schedule*, *supra* note 55.
[68] *Maintaining your Designation*, BABY-FRIENDLY USA, https://www.babyfriendlyusa.org/get-started/maintaining-your-designation (last visited Mar. 24, 2015).
[69] *Id*.
[70] *Annual Fees for Designated Facilities*, BABY-FRIENDLY USA (May 1, 2014), *available at* https://www.babyfriendlyusa.org/get-started/fee-schedule.
[71] *Id*.

and better child health.[72] For example, since implementing the BFHI in over 6,000 hospitals, rural China has increased breastfeeding rates from 29% to 68% in just two years.[73] In Cuba, exclusive breastfeeding rates at four months rose from 25% to 72% in six years with 49 of 56 birthing centers being BF.[74] Overall, the BFHI has been shown to be very effective in increasing breastfeeding initiation, exclusive breastfeeding and breastfeeding duration in many countries, as well as improving mother's experiences and reducing rates of infant abandonment.[75]

B. Why go Baby-Friendly?

Studies continue to confirm that participation in the Baby-Friendly Hospital Initiative increases breastfeeding rates in U.S. hospitals.[76] In a 2005 study, the mean breastfeeding initiation rate for the 28 Baby-Friendly Hospitals studied was 83.8%, compared with the U.S. breastfeeding initiation rate of 69.5%.[77] The average rate of exclusive breastfeeding while at the hospital was 78.4%, compared a national average of 46.3%.[78] Another study showed 3.8% more women with lower education levels began breastfeeding at BFHs compared to non-BFHs.[79]

Becoming Baby-Friendly shows that a hospital is eager to meet the persistent national call to increase breastfeeding. Meeting Baby-Friendly Hospital Initiative goals will bring hospitals into compliance with the U.S. Department of Health and Human Services Health Healthy People 2020 breastfeeding goals[80], and will help improve their U.S. Center for Disease Control's Maternity Practices in Infant Nutrition and Care (MPINC) scores[81]. Hospitals have also noted the following reasons to participate in the Baby-Friendly Hospital Initiative:

---

[72] *The Baby-Friendly Hospital Initiative,* UNICEF, http://www.unicef.org/programme/breastfeeding/baby.htm (last visited Mar. 24, 2015).
[73] *Id*.
[74] *Id*.
[75] B.L. Philipp, A. Radford, *Baby□Friendly: Snappy Slogan or Standard of Care?*, 91 ARCHIVES OF DISEASE IN CHILDHOOD, FETAL, AND NEONATAL ED. F145, F145–F149 (2006).
[76] See e.g. B.L. Philipp et al., *Baby-Friendly Hospital Initiative Improves Breastfeeding Initiation Rates in a US Hospital Setting*, 108 PEDIATRICS 677, 677-81 (2001); B.L. Philipp et al., *Sustained Breastfeeding Rates at a US Baby-Friendly Hospital*, 112 PEDIATRICS 234, 234-6 (2003); B.L. Philipp and A. Merewood, *The Baby-Friendly Way: the Best Breastfeeding Start*, 51 PEDIATRIC CLINICS NORTH AMERICA 761, 761-83 (2004); A. Merewood et al., *Breastfeeding rates in US Baby-Friendly Hospitals: Results of a National Survey*, 116 PEDIATRICS 628, 628-34 (2005).
[77] A. Merewood et al., *Breastfeeding Rates in US Baby-Friendly Hospitals: Results of a National Survey*, 116 PEDIATRICS 628, 628-34 (2005).
[78] *Id*.
[79] S.S. Hawkins et al., *Evaluating the Impact of the Baby-Friendly Hospital Initiative on Breast-Feeding Rates: a Multi-State Analysis*, 14 PUBLIC HEALTH NUTRITION 1, 1-9 (2014).
[80] *Maternal, Infant and Child Health*, HEALTHPEOPLE.GOV, https://www.healthypeople.gov/2020/topics-objectives/topic/maternal-infant-and-child-health/objectives (last visited Apr. 10, 2015).
[81] *Maternity Practices in Infant Nutrition and Care (mPinc) Survey*, CTRS. FOR DISEASE CONTROL AND PREVENTION, http://www.cdc.gov/breastfeeding/data/mpinc/index.htm (last visited Apr. 10, 2015).

- "Deliver patient-centered care": The Baby-Friendly Initiative is just what it sounds like – friendly. It ensures that each mother and child get the support they need through education, outpatient care, and information to achieve their breast-feeding goals.[82]
- "Improve health outcomes for mothers and babies": As discussed above, the act of breastfeeding is a huge health boon for mother and child.[83]
- "Improve patient satisfaction"[84]: Numerous studies have shown that patients are happier in Baby-Friendly hospitals.[85]
- "Elevate the national reputation and standards of their birthing facility" by receiving a globally prestigious certification: A WHO and UNICEF designed project brings international prestige to the facility.[86]
- "Develop a professional environment of competence among staff": BFHI requires high levels of training among the staff: This not only provides them with more resources, but also has been shown to increase staff satisfaction.[87]
- Build leadership and teamwork skills among staff: The training allows staff to come together to achieve a common goal. As well, leadership among staff members emerges in various models with BFHI captains, nurses in leadership positions, etc.[88]

Evidence also suggests that the costs associated with becoming Baby-Friendly are not overly burdensome. A cost comparison study of Baby-Friendly facilities and non-Baby-Friendly facilities showed that while the costs of nursery service were slightly higher at the Baby-Friendly hospital, the difference was not statistically significant.[89] While costs can rise by around 2% at the beginning of implementation, as breastfeeding rates increase, this number decreases.[90] This relative stability in the cost of regular operations, when considered along with the many gains to be made in other health, staff, and patient satisfaction areas, should incentivize hospitals to implement practices

[82] *For Facilities,* BABY-FRIENDLY USA, https://www.babyfriendlyusa.org/faqs/for-facilities (last visited Apr. 6, 2015).
[83] *Id.*; *Supra* II.A and II.B.
[84] *For Facilities*, *supra* note 82.
[85] *See e.g.* Becky Law, *The Journey to Becoming a Baby-Friendly™ Hospital,* TEXAS HEALTH, 21 (Sept. 2011) , *available at* http://www.seton.net/locations/clinical_education_center_at_brackenridge/perinatal_education_conference/The_Journey_to_Becoming_a_Baby_Friendly_Hospital-Law.pdf (last visited Apr. 10, 2015); Jim Langabeer II et al., *An Economic Cost-Analysis of Becoming a Baby-Friendly Hospital,* THE UNIVERSITY OF TEXAS HEALTH SCIENCES CENTER AT SAN ANTONIO, 22 (2009), *available at* http://www.breastfeedingor.org/wp-content/uploads/2012/10/baby_friendly_cost_analysis.pdf.
[86] *For Facilities, supra* note 82.
[87] *For Facilities, supra* note 82; JIM LANGABEER II ET AL., *supra* note 87 at 22.
[88] *For Facilities, supra* note 82.
[89] Jami DelliFraine et al., *Cost Comparison of Baby-Friendly and Non−Baby-Friendly Hospitals in the United States*, 127, 989 PEDIATRICS e989, e991 (2011).
[90] JIM LANGABEER II ET AL., *supra* note 87, *supra* note 82 at 25-6.

that support breastfeeding despite potential extra expenditures at the outset of implementation.

IV. Implementing the Baby-Friendly Hospital Initiative – State Successes

States across the country have developed a variety of methods to assist hospitals in adopting the Baby-Friendly Hospital Initiative. Many states, like Colorado, have chosen to implement the Baby-Friendly Hospital Initiative in stages by helping hospitals achieve five of the *Ten Steps to Successful Breastfeeding* and encouraging further implementation.[91] Others, such as Texas, have created separate designation programs that closely mirror the BFHI, but result in state certification as opposed to official BFHI designation.[92] As the process of achieving Baby-Friendly designation comes with noted costs, some states, such as South Carolina, provided monetary incentives to offset these added expenses and motivate hospitals to become Baby-Friendly.[93] Still other states, like California and Illinois, have passed state legislation mandating BFHI designation and adoption of the Ten Steps.[94] The following section will explore these methods and extrapolate recommendations for Mississippi.

A. Five Step Implementation – Colorado, Arizona, Connecticut

1. Colorado

Colorado launched an initiative to make its hospitals more baby-friendly in 2008.[95] The idea behind the *Colorado Can Do 5!* campaign was to make the process of becoming baby-friendly more manageable by introducing hospitals to just five of the ten official BFHI steps.[96]

The momentum behind this campaign began building as early as 2003: at that time, Colorado already boasted breastfeeding rates higher than the national average.[97] 85% of all mothers in Colorado initiated breastfeeding shortly after delivery, surpassing the rate of 75% established as a Healthy People 2010 goal by the United States Department of Health and Human Services.[98] However, when the Colorado Department of Public Health and Environment ("CDPHE") began to look more closely at the data, they noticed some shortcomings. Despite their high rates of breastfeeding

---

[91] *Infra* p. 12.
[92] *Infra* p. 24.
[93] *Infra* p. 27.
[94] *Infra* p. 30-34.
[95] Telephone Interview with Jennifer Dellaport, Former Breastfeeding Specialist, Colo. Dep't of Pub. Health and Env't (Nov. 26, 2014) (Interview Notes filed with the Interviewer).
[96] *Id*.
[97] Erin Murray et al., Getting it Right After Delivery: Five Hospital Practices That Support Breastfeeding, Colo. Dep't of Pub. Health and Env't, i. (2007), *available at* https://www.colorado.gov/pacific/sites/default/files/PF_MCH_Getting-it-Right-After-Delivery.pdf [hereinafter Getting it Right After Delivery].
[98] *Id.* at 4, 7.

initiation, duration rates in Colorado fell far below national objectives.[99] The Healthy People goal was that by 2010, 50% of mothers nationwide would continue breastfeeding six months after delivery.[100] In contrast, only 33% of Colorado's mothers were still breastfeeding at four months after delivery.[101] Aware of the many health benefits of continued breastfeeding and concerned that they were not meeting national goals, CDPHE began to investigate ways it could influence hospital practices in order to improve duration rates.[102]

CDPHE began by collecting data on current hospital practices. Since 1997, Colorado has collected data on pregnant and breastfeeding women through the Pregnancy Risk Assessment Monitoring System (PRAMS), a statewide survey of women who have recently given birth.[103]In 2002 and 2003, CDPHE added questions to the survey to determine the kind of supportive breastfeeding practices that mothers were experiencing in the hospital.[104] Seven of these questions directly reflected seven of the ten Baby-Friendly steps (for example: "My baby used a pacifier in the hospital. [Yes or No]").[105] An analysis of the data revealed that five hospital practices were particularly effective in producing statistically significant improvements in breastfeeding duration rates:

1. Infant is breastfed in the first hour after birth.

2. Infant is fed only breast milk in the hospital.

3. Infant stays in the same room with the mother in the hospital.

4. Infant does not use a pacifier in the hospital.

5. Hospital staff gives mother a telephone number to call for help with breastfeeding.[106]

Moreover, the combination of all five factors appeared to be more effective than any one practice on its own.[107] Indeed, 63% of mothers who experienced all five successful hospital breastfeeding practices were still breastfeeding at four months, compared to only 48% of mothers who experienced zero to four of the practices.[108]

---

[99] *Id*. at 4.
[100] *Id*.
[101] *Id.* at 7.
[102] *Id*. at i.
[103] *Pregnancy Risk Assessment Monitoring System (PRAMS)*, COLO. DEP'T OF PUB. HEALTH AND ENV'T, https://www.colorado.gov/pacific/cdphe/pregnancysurvey (last visited Mar. 3, 2015).
[104] GETTING IT RIGHT AFTER DELIVERY, *supra* note 97 at 6.
[105] *Id*. at 16.
[106] *Id*. at 21.
[107] *Id*.
[108] *Id*. at 22.

Additionally, this correlation between the five practices and increased duration rates existed across different socioeconomic groups.[109]

In 2007, CDPHE published these findings in a report called "Getting it Right After Delivery: Five Hospital Practices That Support Breastfeeding."[110] In order to disseminate this report, CDPHE's WIC and Physical Activity and Nutrition Program partnered with the Colorado Breastfeeding Coalition (CBC) in 2008 to tour the state's hospitals and conduct trainings.[111] The CDPHE reached out to the state's 55 hospitals, describing the report and offering to deliver a presentation to any hospital that agreed to host them.[112] Hosting hospitals had to promise to advertise the event among staff, administrators, and local public health programs; arrange for staff to have the option of receiving continuing medical education credits where possible; provide refreshments for the event; and complete a one page evaluation after the training.[113]

Twenty-one hospitals agreed to host the training in the first year.[114] At these trainings, volunteers from WIC and CBC delivered a presentation on the five hospital practices that support breastfeeding.[115] They also provided staff at the hospital with a resource kit that "contained a letter from the health department's Chief Medical Director, the report ["Getting it Right After Delivery"], a CD with a PowerPoint presentation about the report; the DVD From Bottles to Breasts to Baby-Friendly, the Challenge of Change;[116] training and technical assistance resources; and a Model Hospital Self-Assessment."[117]

Following the first year, CDPHE received grants, primarily from the CDC, that allowed them to continue delivering the presentation to hospitals across the state.[118] They were also fortunate to be able to contract with Dr. Marianne Neifert, aka "Dr. Mom," a Colorado native and renowned expert on breastfeeding support and management.[119] The charismatic and knowledgeable Dr. Neifert became a key

---

[109] *Id*. at 22-24.
[110] *GETTING IT RIGHT AFTER DELIVERY, supra* note 97.
[111] *Colorado Can Do 5! Initiative Raising Awareness for the Baby-Friendly Ten Steps*, COLO. DEP'T OF PUBLIC HEALTH AND ENV'T, 1, https://www.colorado.gov/pacific/sites/default/files/PF_BF_Colorado-Can-Do-5-Initiative.pdf (last visited Mar. 3, 2015) [hereinafter *Initiative Raising Awareness*].
[112] Telephone Interview with Jennifer Dellaport, *supra* note 95.
[113] *Initiative Raising Awareness*, *supra* note 111 at 2.
[114] *Id*. at 1.
[115] *Id*.
[116] *From Bottles to Breasts to Baby-Friendly* is a DVD created by the Boston Medical Center, outlining their experience in becoming the first Baby-Friendly hospital in Massachusetts. The DVD operates as an "informative guide" to any hospital looking to become Baby-Friendly certified. The DVD is available for purchase here: http://injoyvideos.com/from-bottles-to-breasts-to-babyfriendly-1.html.
[117] *Initiative Raising Awareness, supra* note 111 at 1.
[118] Telephone Interview with Jennifer Dellaport, *supra* note 95; *Initiative Raising Awareness*, *supra* note 111 at 1.
[119] Telephone Interview with Jennifer Dellaport, *supra* note 95.

spokesperson for the program, which became known as *Colorado Can Do 5!.* The name of the program came from the general hospital staff reactions at how easy and manageable the Colorado five step approach seemed compared to the daunting requirements of becoming fully Baby-Friendly certified. "We can do these five steps," was the general consensus.[120]

By the end of 2010, CDPHE had delivered its *Colorado Can Do 5* presentation to 50 out of the state's 55 hospitals.[121] The only hospitals that declined to host a training were Colorado's two hospitals that were already baby-friendly certified and three hospitals that did not typically provide maternity services.[122] After the training, adoption of the steps was wholly voluntary; hospitals were free to implement the steps or not, as they saw fit.[123] In 2011, CDPHE emailed a survey to the state's 52 hospitals providing maternity services to determine what practices the hospitals were implementing.[124] At the same time, CDPHE invited hospitals to apply for a BEST award (Breastfeeding Excellence Starts Today) by submitting any written policies they had encompassing the *Colorado Can Do 5!* practices.[125] Hospitals with strong written policies were recognized as *Colorado Can Do 5!* hospitals.[126]

The results of the survey administered in 2011 revealed that the number of Colorado mothers experiencing all five of the recommended supportive hospital practices had increased from one in five to one in four.[127] The actual effect that the increased implementation of the five steps has had on breastfeeding initiation and duration rates is inconclusive at this time, but appears positive. According to PRAMS data, breastfeeding initiation rates increased from 85.3% in 2003 to 92.8% in 2010, and the percentage of mothers still breastfeeding at five months increased from 31% in 2003 to 47% in 2010.[128] These numbers are heartening, though CDPHE cautions that these increases may not all be directly due to the *Colorado Can Do 5!* campaign, as other

[120] *Id.*; *Colorado Can Do 5!: Offers Hospitals Specific Strategies to Extend Breastfeeding Duration,* COLO. DEP'T OF PUB. HEALTH AND ENV'T, 1, https://www.colorado.gov/pacific/sites/default/files/PF_BF_Colorado-Can-Do-5-Fact-Sheet.pdf (last visited Mar. 3, 2015) [hereinafter *Specific Strategies*].
[121] *Initiative Raising Awareness*, *supra* note 111 at 2.
[122] *Id.*; Telephone Interview with Jennifer Dellaport, *supra* note 95.
[123] Telephone Interview with Jennifer Dellaport, *supra* note 95.
[124] *Colorado Can Do 5! B.E.S.T. Awards Fact Sheet*, COLO. DEP'T OF PUB. HEALTH AND ENV'T, https://www.colorado.gov/pacific/sites/default/files/PF_BF_Colorado-Can-Do-5-BEST-Awards-Fact-Sheet.pdf (last visited April 25, 2015).
[125] *Id.*
[126] *Id.*
[127] *Specific Strategies*, *supra* note 120, at 1.
[128] *Colorado Breastfeeding Rates*, COLO. DEP'T OF PUB. HEALTH AND ENV'T, https://www.colorado.gov/pacific/sites/default/files/PF_BF_Colorado-Breastfeeding-Rates.pdf (last visited Mar. 3, 2015).

factors and collaborations may also have had an effect.[129] More data and greater study in this area is needed.

Since the successful roll-out of the *Colorado Can Do 5!* campaign, a number of hospitals in the state have expressed interest in going further and actually achieving Baby-Friendly status.[130] CDPHE has provided support to these hospitals by creating the Baby-Friendly Collaborative, a network of eighteen hospitals who applied by completing the first stage of the Baby-Friendly certification process (discovery).[131] CDPHE is not able to offer any financial support to the hospitals, but the collaborative has served a useful role as a forum for hospitals to troubleshoot problems together, usually through webinars hosted by CDPHE.[132] Today, most of the hospitals in the collaborative are already in the third phase of the certification process (dissemination).[133]

Colorado Analysis: Strengths and Challenges

Colorado's focus on five steps provides a strong example of how data can be used to implement targeted and manageable reforms that will nonetheless have significant effects, allowing the state to "get the most bang for its buck."[134] Other strong points of Colorado's model include the use of a locally respected, charismatic expert as a spokesperson for the campaign and the creation of an award to recognize hospitals that were making meaningful strides towards effective implementation of the five steps. A representative from CDPHE noted three difficulties that the department faced during its campaign: (1) having the CDPHE spearhead the initiative, although the organization did not have experts in lactation or "Baby-Friendly" procedures; (2) gaining access to certain parts of the Baby-Friendly Health Initiative website that are only accessible to hospital administrators; and (3) measuring the results of the campaign through effective data.[135] Creating effective partnerships with experts and with hospital administrators that can pass on key information whenever possible should help other states address the first two problems, while the third problem suggests the importance of developing a plan for how results will be measured before training even begins. Hospitals participating in the program also noted the need for more training and educational

[129] Telephone Interview with Jennifer Dellaport, *supra* note 95.
[130] *Id*.
[131] *Id.; see Colorado Baby Friendly Hospital Collaborative*, COLO. DEP'T OF PUB. HEALTH AND ENV'T (2015), *available at* https://www.colorado.gov/pacific/cdphe/colorado-baby-friendly-hospital-collaborative.
[132] Telephone Interview with Jennifer Dellaport, *supra* note 95.
[133] *Id*.
[134] *Id*.
[135] *Id*.

opportunities from CDPHE, sample policies and grants to use as models, and help in developing media to educate Colorado communities about breastfeeding.[136]

2. Arizona

In 2010, Arizona began an initiative called Baby Steps for Breastfeeding Success (AzBSBS) in order to increase breastfeeding rates and breastfeeding duration within the state. While the state had a high percentage of mothers initiating breastfeeding, many stopped within days of starting.[137] Indeed, while 78.8% of mothers initiated breastfeeding, only 49.6% were still breastfeeding at six months, and only 12.7% were breastfeeding exclusively at 6 months.[138] Though these numbers are not exceptional nationally, they similarly failed to meet the national Healthy People 2010 targets.[139] Aware that many of the health benefits of breastfeeding only come with extended, exclusive breastfeeding and concerned that its numbers were falling below national targets, Arizona began a campaign to increase breastfeeding duration rates, as well as the rates of exclusive breastfeeding.[140]

Arizona modeled its program after Colorado's successful *Colorado Can Do 5!* Initiative, focusing on encouraging hospitals to implement just five of the ten Baby-Friendly steps that have been shown to increase breastfeeding duration rates:[141]

> "1.Initiate breastfeeding within the first hour after birth.
> 2. Avoid giving infants fluids or solids other than breast milk unless medically necessary.
> 3. Promote 24-hour rooming-in, encouraging the family to recognize and respond to infant's cues
> 4. Avoid using pacifiers or artificial nipples with infants during the hospital stay.
> 5. Foster the establishment of breastfeeding support groups and refer mothers to them on discharge from the hospital or birth center through giving them a telephone number to help them with breastfeeding and breastfeeding issues."[142]

---

[136] *Colorado Hospital Breastfeeding Policy Survey*, COLO. DEP'T OF PUB. HEALTH AND ENV'T, 2 (2012) *available at* https://www.colorado.gov/pacific/sites/default/files/PF_BF_Hospital-Policies-Survey-Fact-Sheet.pdf.

[137] *Baby Steps for Breastfeeding Success: Health Professionals*, ARIZ. DEP'T OF HEALTH SERVS., http://www.azdhs.gov/phs/bnp/gobreastmilk/healthPro.htm (last visited Mar. 3, 2015) [hereinafter *Health Professionals*].

[138] *Breastfeeding Report Card 2010,* CTRS. FOR DISEASE CONTROL AND PREVENTION, http://www.cdc.gov/breastfeeding/data/reportcard/outcome2010.htm (last updated Aug. 1, 2011).

[139] *Healthy People 2020: Breastfeeding Objectives*, UNITED STATES BREASTFEEDING COMM., http://www.usbreastfeeding.org/LegislationPolicy/FederalPoliciesInitiatives/HealthyPeople2020BreastfeedingObjectives/tabid/120/Default.aspx (last visited Mar. 3, 2015).

[140] *Health Professionals*, *supra* note 137.

[141] *Baby Steps to Breastfeeding Success*, ASS'N OF MATERNAL AND CHILD HEALTH PROGRAMS: INNOVATION STATION, 1, http://www.amchp.org/programsandtopics/BestPractices/InnovationStation/ISDocs/Baby-Steps-to-Breastfeeding.pdf (Jul. 2012) [hereinafter *Baby Steps to Breastfeeding Success*].

In order to bolster buy-in for its program, the Arizona Department of Health ("ADHS") partnered with the Arizona Perinatal Trust ("APT") to make implementation of the five practices part of the APT certification process.[143] APT runs a voluntary certification program designed to guide hospitals through a process of self-assessment and self-improvement to meet quality standards of care.[144] Because the program has been running for thirty years, it is highly recognized in the state, and most birthing hospitals seek out APT certification.[145] With APT's certification being so pervasive and desirous, this collaboration helped to widely promote Arizona's Baby-Friendly program and more rapidly induce the implementation of these steps.[146]

APT also agreed to help provide training and support for hospitals as they modified their policies in alignment with the new certification standards.[147] Together with APT, ADHS developed a training program to assist targeted hospitals in the implementation of the five recommended practices. In 2010, ADHS emailed the 41 APT certified hospitals a letter of introduction and an invitation to apply to participate in the AzBSBS initiative by completing an online survey.[148] Based on the survey responses, 20 hospitals were selected to take part in the training program.[149] Ultimately, 25 hospitals agreed to implement the five steps.[150] Together these 25 hospitals accounted for approximately 80% of Arizona's births.[151]

From fall 2010 to fall 2011, ADHS organized free trainings led by International Board Certified Lactation Consultants for each of the participating hospitals.[152] Each training session involved both a pre-training and a post-training component.[153] A pre-training assessment was conducted to determine the stage that each hospital was at in its implementation, so that the training could be shaped to best support each hospital's particular needs.[154] A post-training evaluation was used to identify areas of improvement for future sessions.[155] Trainers also met with hospital administrators in

---

[142] *Id*.
[143] *Baby Steps to Breastfeeding Success*, *supra* note 141, at 1.
[144] *About Us*, ARIZ. PERINATAL TRUST, https://www.azperinatal.org/About_Us.html (last visited Mar. 3, 2015).
[145] *30th Anniversary Recognition*, ARIZ. PERINATAL TRUST, https://www.azperinatal.org/uploads/30th_Anniversary_Recognition.pdf (Jul. 7, 2010); *Certified Hospitals*, ARIZ. PERINATAL TRUST, https://www.azperinatal.org/Certified_Hospitals.html (last visited Mar. 3, 2015).
[146] *Baby Steps to Breastfeeding Success*, *supra* note 141, at 1.
[147] *Id*.
[148] *Id*. at 2.
[149] *Id*. at 2.
[150] *Id*. at 1.
[151] *Id*.
[152] *Id*. at 2.
[153] *Id*.
[154] *Id*.
[155] *Id*.

follow-up meetings to check in on the implementation process and to help troubleshoot and offer technical assistance where needed. [156]

In addition to the trainings, ADHS created a range of Arizona-specific educational materials, and provided those materials for free to administrators, staff, and patients.[157] Chief among these materials was the AzBSBS Model Hospital Policy Guide, which contained "sample policies, position statements, a self-appraisal tool to review policies and practices, and other online resources."[158] Overall this program cost a total of $246,000 (including $46,000 for personnel), adding up to a little more than $3 per mother served.[159] Most of the costs were funded by grants from the CDC.[160]

Post-training surveys indicated that all participating hospitals made "good-faith efforts to comply" with all five steps, and all wanted to work on becoming more baby-friendly.[161] The program did not officially include data collection on the rates of breastfeeding after training, but at least one hospital indicated that the rate of mothers exclusively breastfeeding at the time of discharge more than tripled within the first six months of implementation, from 3% to 10%.[162] Moreover, Arizona's breastfeeding rates appear to have increased slightly overall since 2010, though the data is mixed. In 2014, 81.6% of mothers initiated breastfeeding, up from 78.8% in 2010.[163] The percentage of mothers breastfeeding at six months actually dropped slightly, from 49.6% in 2010 to 48.8% in 2014, though the number of mothers exclusively breastfeeding at six months increased significantly, from 12.7% to 18%.[164] Arizona's mPINC score (a measure of the quality of maternity care practices with respect to supporting breastfeeding) increased from 64 (out of 100) in 2009 to 75 in 2013.[165] Ultimately, more long-term data collection and study is necessary to see what effect these practices are having breastfeeding rates and infant health outcomes.

Arizona Analysis: Strengths and Challenges

---

[156] *Id*.
[157] *Id*. at 1-2.
[158] *Id*.
[159] *Id*. at 2.
[160] *Baby Steps for Breastfeeding Success: Home*, ARIZ. DEP'T OF HEALTH SERVS. http://www.azdhs.gov/phs/bnp/gobreastmilk/BFAzBabySteps.htm (last visited Mar. 3, 2015).
[161] *Baby Steps to Breastfeeding Success*, *supra* note 141, at 2.
[162] *Id*.
[163] BREASTFEEDING REPORT CARD 2014*, supra* note 38, at 4; *Breastfeeding Report Card 2010, supra* note 140.
[164] *Id*.
[165] *Maternity Practices in Infant Nutrition and Care in Arizona—2009 mPINC Survey*, CTRS. FOR DISEASE CONTROL AND PREVENTION, 2 (2009) *available at* http://www.cdc.gov/breastfeeding/pdf/mpinc/states/mpinc_2009_arizona.pdf; *CDC Survey of Maternity Practices in Infant Nutrition and Care: Arizona Results Report*, CTRS. FOR DISEASE CONTROL AND PREVENTION, 1 (2013) *available at* http://www.cdc.gov/breastfeeding/pdf/mpinc/states/2013/arizonampinc13_508tagged.pdf.

Since the completion of the training program, ADHS has continued to support hospitals in becoming more baby-friendly by creating an online training course.[166] This reflects one of the overall strengths of Arizona's campaign, which has been to provide thorough, on-going training to hospitals. Resources include in-person trainings with planned follow-up sessions as well as a wealth of easily accessible supportive online materials. Another major strength of Arizona's model was its partnership with the Arizona Perinatal Trust, a credible authority on maternity practices in the state, which helped ensure buy-in from birthing hospitals. One major shortcoming of its implementation that ADHS identified was its failure to adequately reach out to OB/GYNs during training.[167] Hospitals reported in their post-training surveys that OB/GYN practitioners were not actively promoting breastfeeding practices.[168] Because the OB/GYN is such an important point of contact for mothers, earning their full investment in the program is an important step in reaching full implementation. ADHS has suggested that future campaigns take greater efforts to educate physicians, rather than simply focus on nurses and other staff. One way to do this may be to identify and coordinate with a "champion" physician or nurse at each facility who can continue to provide hands-on training to others after the state training.[169]

3. Connecticut

The Connecticut Department of Public Health received a grant from the Centers for Disease Control and Prevention to implement Baby-Friendly steps in hospitals that were typically under-resourced and served underserved groups. The Department recognized the need for implementation of the BFHI in 2009 when studies showed that only 10.3% of maternity facilities in the state were certified as Baby-Friendly.[170] In 2010, the Department contracted with the Connecticut Breastfeeding Coalition to implement the Connecticut Breastfeeding Initiative (CBI), which served the goal of helping ten Connecticut maternity facilities achieve five of ten steps of the Baby-Friendly Hospital Initiative. [171]

Like Colorado, the Connecticut Department of Public Health worked with its state Breastfeeding Coalition to accomplish this goal.[172] The Connecticut Breastfeeding Coalition was formed through the Department of Public Health and consists of representatives from local health departments, Special Supplemental Nutrition Program

[166] *Arizona Baby Steps to Breastfeeding Success: Online Course*, ARIZ. DEP'T. OF HEALTH SERVS. ADHS Breastfeeding Program, http://azdhsmedia.com/wic/live/babysteps/ (last visited Mar. 3, 2015).
[167] *Baby Steps to Breastfeeding Success*, *supra* note 141, at 3.
[168] *Id*.
[169] *Id*.
[170] MELISSA CHAPMAN HAYNES ET AL., CONN. DEP'T PUBLIC HEALTH, CONNECTICUT BREASTFEEDING INITIATIVE FINAL EVALUATION REPORT, 13, (2012), *available at* http://www.breastfeedingct.org/images/cbi%20final%20evaluation%20report.pdf [hereinafter CONNECTICUT FINAL EVALUATION].
[171] *Id*. at 8.
[172] *Id*. at 4.

for WIC, American Academy of Pediatrics, hospitals, and other stakeholders like nurses and lactation specialists.[173]

The Connecticut Breastfeeding Coalition, with the help of the CDC grant, put together a 5-Step breastfeeding initiative based on steps from the Baby-Friendly Initiative. Connecticut selected the following steps, based closely on steps from BFHI:

1. Have a written breastfeeding policy that is routinely communicated to all health care staff.
2. Train all health care staff in skills necessary to implement this policy.
3. Help mothers initiate breastfeeding within one hour of birth (skin to skin contact).
4. Practice "rooming-in" 23 to 24 hours a day.[174]
5. Foster the establishment of breastfeeding support groups and refer mothers to them.[175]

These steps were selected based on level of importance in achieving certification, difficulty of achievement, and requirement of external technical assistance. Colorado states that the "purpose of selecting five of the Ten Steps was also to aid evaluation of project outcomes."[176] According to the final evaluation survey, most hospitals found these five steps a helpful first benchmark, although some hospitals found it difficult to do the five steps "without looking at all Ten."[177]

Because of the limited funding of the grant and in order to most effectively reach women in need of breastfeeding education and assistance, an application process was set up for the state's 29 hospitals with maternity units.[178] A series of events was held to promote the program, including a dinner symposium for maternity facilities hosted by Coalition and a teleconference to answer questions.[179] The Connecticut Hospital Association also distributed a newsletter about the CBI.[180] Thirteen hospitals applied and were then sent an assessment to assist the Department of Public Health in selecting which hospitals would participate in the pilot project.[181] The assessment included questions regarding the hospitals' existing policies and procedures as well as

[173] *History,* CONN. BREASTFEEDING COAL., http://www.breastfeedingct.org/ (last visited Apr. 14. 2015).
[174] Connecticut chose to change some of the Ten Steps based on "level of importance, need for external assistance, perceived difficulty, likelihood of being achieved within a 2-year timeframe, purposes of project evaluation, and CDC recommendation." Because hospitals generally noted significant difficulty with the rooming-in requirement, Connecticut's rooming-in step attempted to alleviate some of the burden by reducing the requirement from 24 to 23 hours a day. Connecticut Breastfeeding Initiative Overview, CTR. TRT, http://www.centertrt.org/?p=intervention&id=1006&section=2 (last visited Apr. 6, 2015).
[175] CONNECTICUT FINAL EVALUATION, supra note 170, at 8.
[176] *Id*.
[177] *Id*. at 30.
[178] *Id*. at 9.
[179] *Id*.
[180] *Id*.
[181] *Id*.

community resources, such as peer support groups.[182] Other questions sought to determine the hospital's commitment to the process, for example: "Has your facility considered a Baby-Friendly designation in the past?"[183] Since the Department of Public Health sought to maximize the project's reach to low-income and underserved groups, the number of annual births and the percentage of "public pay" births were also considered.[184]

Through its grant, the Initiative was able to provide each hospital selected for participation with $2,000 for Baby-Friendly USA fees and $750 for materials for staff and patient breastfeeding education.[185] The Initiative also provided a 15-hour workshop for hospital staff that satisfied the BFHI training requirements for accreditation, and 40 hours of consultation with a Connecticut Breastfeeding Initiative staff member.[186]

According to the 2012 final evaluation report, the Connecticut Initiative was very successful. When the Initiative began in 2009, only 3 of Connecticut's 29 facilities (10.3%) were "Baby-Friendly."[187] The 10 hospitals selected for the Initiative successfully achieved Baby-Friendly status by 2012, and the remaining hospitals have since worked to achieve Baby-Friendly status or are in the process of doing so.[188] After the Initiative, at least 44.8% of maternity facilities in Connecticut were "Baby-Friendly" or working towards such a designation.[189] Additionally, staff reported that they felt more confident in educating and encouraging mothers to practice healthy breastfeeding practices and more knowledgeable of the benefits of the 10 steps.[190] Connecticut is now second in the nation for the percentage of births that occur in a Baby-Friendly facility.[191]

Connecticut Analysis: Strengthens and Challenges

Based on the experience and results of the Connecticut initiative, members of the CBI emphasized the importance of five actions for successful implementation: forming an interdisciplinary task force, educating staff and patients, networking with other hospitals, getting administrators on board, and planning ahead for extra staff support.[192] Nurses, physicians, neonatologists, pediatricians, obstetricians, nurse midwives,

---

[182] *Id*.
[183] *Id*.
[184] *Id*.
[185] *Id*. at 4.
[186] *Id*.
[187] *Id*. at 13.
[188] *Id*.
[189] *Id*.
[190] *Id.* at 29.
[191] BREASTFEEDING REPORT CARD U.S. 2014*, supra* note 38 at 4.
[192] Telephone Interview with Michele Griswold, Chair of Connecticut Breastfeeding Coalition, and Marilyn Lonczak, WIC Breastfeeding Coordinator (Nov. 23, 2014)(Interview Notes filed with the Interviewer).

management staff, clinic staff, and staff from social services should all be considered for inclusion when planning a task force or committee.

Leaders of the coalition expressed that having the local WIC program as part of the team helped bridge the community gap and provide more consistent messages around the initiative, specifically about skin-to-skin and rooming in expectations.[193] Additionally, the partnership between WIC and the Department of Public Health increased the visibility of the campaign both throughout the Department and the larger community. This allowed the Commissioner to get press for breastfeeding as a preventative strategy to address short and long-term health issues. Leaders also expressed that collaborating allowed the team to build on their project successes when other state funds became available.[194] Rather than re-invent projects, collaboration allowed the Department of Public Health to invest in successful initiatives that were already in progress but would benefit from more resources, such as the Baby-Friendly Initiative.[195]

Providing resources for the healthcare staff and greater community allowed for greater clinician confidence and made many steps easier. Surveys indicated that additional resources such as funding, staff, and consultant help were most needed.[196] These included adding staff to allow the delivery nurse time with the new delivered mother and baby, continued support from a BFHI consultant, a statewide media campaign supporting breastfeeding to change norms in the community, and technology to show educational videos to new mothers.[197] Leaders suggested using existing Baby-Friendly materials to save time and money, though a hospital that is not working towards designation but still attempting to implement some of the steps may not be able to use Baby-Friendly USA materials as most are proprietary.[198]

While all the hospitals made substantial progress in becoming baby-friendly, the rooming-in requirement resulted in a great deal of pushback, as only 4 of the 10 hospitals achieved this step.[199] There was concern over safety and pressure from parents who had other children as well as the need for tired parents to get some rest.[200] Overall, staff showed lower confidence levels in responding to mothers who requested that their babies be placed in the nursery.[201] Interviews indicated that education about practicing rooming-in is needed, and that the most effective tool against this was

[193] *Id*.
[194] *Id*.
[195] *Id*.
[196] CONNECTICUT FINAL EVALUATION, *supra* note 170, at 43.
[197] *Id*.
[198] Telephone Interview with Michele Griswold and Marilyn Lonczak, *supra* note 192.
[199] CONNECTICUT FINAL EVALUATION, *supra* note 170, at 6.
[200] *Id*. at 26-27.
[201] *Id*.

training and presence of someone who knew the benefits of rooming in.[202] This was especially true for some parents who had previously given birth because they had the expectation that their child would sleep in the nursery.[203] Hospitals found it useful to distribute scripts for staff to use in approaching these situations to increase confidence.[204]

B. Separate Designation Program – Texas

The Texas Department of State Health Services launched the Texas Ten Step Program in 1999 to encourage birthing centers to become Baby Friendly.[205] Texas' program is directly based on the Baby Friendly Hospital Initiative, and the Texas Ten Steps are identical to the WHO and UNICEF Ten Steps.[206] Indeed, the goal of the Texas Ten Step Program is to encourage hospitals to make progress towards achieving Baby Friendly Hospital designation by providing a free framework and designation program that tracks the BFHI Ten Steps. However, participation in the Texas Ten Step Program does not certify hospitals as Baby Friendly.[207] Instead, Texas encourages involvement in a separate "designation" awarded by the Ten Step Program upon scoring 85% or higher on a self-reported policy and facility evaluation that tracks the Texas Ten Steps.[208]

The program is free and voluntary, and "there are no external audits or site visits."[209] First, birthing centers are encouraged to form a task force (with recommended members including hospital administrators, lactation specialists, nursing staff and WIC local agency staff) to begin the application and review the current state of the facility's policy and practices related to breastfeeding.[210] The program offers a Texas Ten Step Scorecard Evaluation Tool to assist newly formed task forces in assessing a facility's readiness.[211]

Next, to become designated as a Texas Ten Step Hospital, hospitals must submit documents outlining their infant-feeding policies, their staff and community breastfeeding training plans, breastfeeding resources lists, patient education resources,

---

[202] *Id*. at 27.
[203] *Id*. at 26-27.
[204] *Id*. at 27.
[205] *Texas 10 Step Program*, TEX. TEN STEP PROGRAM, http://texastenstep.org (last visited Mar. 4, 2015).
[206] *Texas 10 Step Program—Scorecard Tool,* TEX. TEN STEP PROGRAM, http://texastenstep.org/wp-content/uploads/2012/09/Texas-Ten-Step-Scorecard.pdf (last visited Apr. 14, 2015); *Ten Steps to Successful Breastfeeding*, BABY-FRIENDLY USA, http://www.babyfriendlyusa.org/about-us/baby-friendly-hospital-initiative/the-ten-steps (last visited Apr. 12, 2015).
[207] *Baby Friendly Hospital* Initiative, TEX. TEN STEP PROGRAM, http://texastenstep.org/star-achiever/baby-friendly-designation/ (last visited Apr. 14, 2015).
[208] *Become Texas Ten Step*, TEX. TEN STEP PROGRAM, http://texastenstep.org/texas-ten-step-program/become-texas-ten-step/ (last visited Apr. 14, 2015).
[209] *Id*.
[210] *Id*.
[211] *Texas 10 Step Program—Scorecard Tool, supra* note 206.

and proof that they are using current WIC publications and resources.[212] Ten Step Administrators score hospitals based on their application materials, and hospitals that score an 85% or higher receive the Ten Step designation.[213] Hospitals that fail to achieve initial designation are encouraged to leverage their task forces to improve practices, develop policy, and reapply, using the Texas Ten Step evaluation scorecard as a framework.[214] Hospitals must apply for re-designation every two years to maintain their status.[215] There is no specific funding available for hospitals to participate in Texas' program.[216] However, free and low-cost training for hospital staff is available by request.[217] A range of training opportunities is available for physicians, nurses, and other health care professionals. Free training includes courses on breastfeeding management, breastfeeding compromised infants, a physician's breastfeeding course, all meant to provide staff with the most up to date scientific research-based practices to support successful breastfeeding.[218] For a small registration fee, two separate, two-day training programs are available to teach principles of lactation management and lactation counseling.[219] These two-day courses were designed to meeting the training requirements of the Baby-Friendly Hospital Initiative, and are given numerous times a year at hospitals throughout the state.[220]

Since the Texas Ten Step Program was launched in 1999, over 100 hospitals have earned the Texas Ten Step Designation.[221] Of those hospitals, 8 have since achieved Baby-Friendly status, and over 30 are currently pursuing Baby-Friendly designation.[222] The Texas Ten Step Program has not tracked breastfeeding data among

---

[212] The Texas WIC uses an online ordering system to provide hospitals with brochures, flyers, handouts, posters, forms, training materials, and informational DVD to assist in educating mothers and encouraging breastfeeding. The Texas WIC Catalog of resources can be found at http://www.onlineordersff.com/ffcontent/main/main.asp. In the application to become designated as a Texas Ten Step Hospital, hospitals must include the revision date and publication stock number of the publications they use to ensure that each hospital is using the current version of the publication. *How to Apply,* TEX. TEN STEP PROGRAM, http://texastenstep.org/texas-ten-step-program/how-to-apply/ (last visited Mar. 24, 2015).
[213] *Become Texas Ten Step*, *supra* note 208.
[214] *Id*.
[215] *Redesignation*, TEX. TEN STEP PROGRAM, http://texastenstep.org/texas-ten-step-program/redesignation/ (last visited Apr. 12, 2015).
[216] *Become Texas Ten Step*, *supra* note 208.
[217] Telephone Interview with Veronica Hendrix, Coordinator, TEX. TEN STEP PROGRAM (Dec. 1, 2014)(Interview Notes filed with Interviewer).
[218] *Breastfeeding Courses Available by Request*, TEXAS DEP'T OF STATE HEALTH SERVS., http://www.dshs.state.tx.us/wichd/lactate/addtrain.shtm (last visited Mar. 24, 2015).
[219] *Breastfeeding Courses,* TEX. DEP'T OF STATE HEALTH SERVS, http://www.dshs.state.tx.us/wichd/lactate/courses.shtm#general (last visited Mar. 24, 2015).
[220] *Id*.
[221] *Texas Ten Step Directory*, TEX. TEN STEP PROGRAM, http://texastenstep.org/texas-ten-step-program/directory/ (last visited Apr. 6, 2015).
[222] *Id*.

hospitals that have completed the program, making it difficult to assess how successful the program has been.

In 2012, the Texas Department of State Health Services launched the Texas Ten Step Star Achiever Initiative to expand on the work accomplished by the Texas Ten Step Program.[223] The initiative offers additional web-based training resources, such as a comprehensive toolkit providing resources for each of the ten steps.[224] The initiative also partnered with the National Institute for Children's Health Quality to create the Star Achiever Learning Collaborative, meant to engage hospitals motivated to improve their compliance with the ten steps and achieve Baby-Friendly designation.[225] The five-year program brings together hospitals within designated public health regions and offers the opportunity to share information and best practices.[226] Hospitals benefit from "virtual learning meetings, monthly conference calls, and an online collaboration tool," allowing them work together, address barriers, share strategies, and celebrate successes.[227] The Collaborative is broken into regional cohorts of 20 - 27 hospitals that applied and were chosen to participate.[228] Overall, 81 hospitals will benefit from the program.[229] The first cohort was formed from the northern region of Texas, chosen because hospitals in the area were most ready to implement the ten steps and improve their policies.[230] A number of the hospitals were already designated as Baby-Friendly, and were therefore able to provide guidance to those who were seeking designation in the cohort.[231] The first cohort will then serve as mentors for future cohorts in other regions. Overall, 81 hospitals will benefit from the program.[232] Results from the first Learning Collaborative cohort have been promising. Within 18 months, the overall breastfeeding rate rose from 84 to 88% in participating hospitals, and the percentage of mothers receiving referrals for support to continue breastfeeding when discharged rose from 49 to 73%.[233]

---

[223] *Breastfeeding Rates through the Learning Collaborative Model*, NAT'L INST. FOR CHILDREN'S HEALTH QUALITY (Mar. 6, 2015), http://www.nichq.org/blog/2015/march/veronicahendrix. [hereinafter *Improving Statewide Breastfeeding Rates*]

[224] *See Texas Ten Step Star Achiever Training Toolkit*, TEX. TEN STEP PROGRAM, http://texastenstep.org/starachiever-texastenstep/Star_Achiever_Ten_Step_Modules/resources-and-tools/ (last visited Mar. 25, 2015).

[225] *Texas Ten Step Star Achiever Breastfeeding Learning Collaborative*, NAT'L INST. FOR CHILDREN'S HEALTH QUALITY, http://breastfeeding.nichq.org/solutions/texas-breastfeeding-collaborative (last visited Apr. 6, 2015).

[226] *Improving Statewide Breastfeeding Rates*, *supra* note 223.

[227] *Id*.

[228] Memorandum from Linda Brumble to WIC Regional and Local Agency Directors, *Texas Ten Step Star Achiever Breastfeeding Learning Collaborative* 1 (Nov. 12, 2012).

[229] *Id*.

[230] *Improving Statewide Breastfeeding Rates, supra* note 225.

[231] *Id*.

[232] *Id*.

[233] *Id*.

The Texas Ten Step Program has one full time coordinator, who partners with the Texas Department of State Health Services' WIC program.[234] The Texas WIC funds Texas Ten Step and the Star Achiever Initiative, and WIC employees typically function as the "foot soldiers" for the programs. They deliver information and assist in training for hospitals and mothers.[235] In implementation, the Program has collaborated with coordinators from Colorado and Louisiana, and the coordinator attends the Carolina Global Breastfeeding Institute, which hosts various state representatives in North Carolina to learn from other programs.[236]

Texas Analysis: Strengths and Challenges

The Texas Ten Step Program Coordinator noted internal program funding as a principal roadblock to the success of the program.[237] The program lacked a full time director from 1999-2011 due to lack of funding.[238] During that time, hospitals complained that the program lacked structure, and that there was no consistent point of contact responsible for overseeing the program.[239] The State WIC provided funding for a full time director in 2011, aiding in the program's organization and overall success.[240] Funding was also the most commonly reported challenge from hospitals.[241] However, hospital administrators have noted that free staff education, training, and materials can be helpful incentives to encourage participation.[242] Trainings given by the Texas Health Department were useful ways for hospitals to meet training requirements when seeking Baby-Friendly designation.

In addition, there was a lack of awareness and information around the benefits of breastfeeding. The Ten Step Program has been successful in removing those roadblocks through creating a multipronged information campaign that targets moms and healthcare providers, utilizing television and online ads to help generate support for breastfeeding initiatives. The Program also created the Texas Mother-Friendly Website to raise awareness of breastfeeding initiatives and workplace lactation policies.[243]

C. Monetary Incentive Program – South Carolina

A common barrier, frequently noted by hospitals, to becoming a Baby-Friendly facility is cost. In addition to the official fees for the process of designation, there are further, and often greater, costs associated with implementing the policies and

[234] Telephone Interview with Veronica Hendrix, *supra* note 217.
[235] *Id*.
[236] *Id*.
[237] *Id*.
[238] *Id*.
[239] *Id*.
[240] *Id*.
[241] *Id*.
[242] *Id*.
[243] *Id*.

procedures maternal care facilities must undertake to become Baby-Friendly. In response to this, some state departments have used purely monetary incentives to encourage implementation of the Baby-Friendly Hospital Initiative. The South Carolina Department of Health and Human Services (SCDHHS) created the "Race to the Date" program in 2013 to incentivize birthing hospitals to become BFHI certified.[244] Hospitals were eligible for a maximum payout of $200,000 if they were able to certify their facilities as Baby-Friendly within one year.[245] SCDHHS provided the funding for the total incentive pool of $1,000,000.[246] Four hospitals received certification in time to meet the state's deadline, all of which had begun the process of baby-friendly certification prior to announcement of the incentive program.[247] Since the deadline passed, three additional hospitals have received certification.[248] Since the "Race to the Date" project was implemented, the total number of babies born in Baby-Friendly Hospitals in South Carolina increased from 0% to 24%, as compared to the national average of 8.4%.[249]

The "Race to the Date" Initiative was a project developed by the South Carolina Birth Outcomes Initiative (SCBOI).[250] In July 2011, SCDHHS, partnering with 125 key stakeholders (including the March of Dimes and Blue Cross Blue Shield of South Carolina), created the SCBOI in order to improve outcomes for newborns throughout the state.[251] The Birth Outcomes Initiative has six core objectives relating to improving overall newborn health, one of which is "promoting Baby-Friendly Certified hospitals and breastfeeding."[252] Members of the Birth Outcomes Initiative work to achieve core objectives by creating initiatives and facilitating on workgroups.[253] In addition to the "Race to the Date" initiative, the SCBOI has used similar tactics to focus on reducing the number of early labor inductions, decreasing the number of infants in neonatal intensive care units, and implementing universal screening for pregnant women to assess risk factors like substance use, mental health issues, and domestic violence.[254]

---

[244] *Baby-Friendly Hospital Initiative – "Race to the Date"*, S.C. DEP'T OF HEALTH AND HUMAN SERVS., https://www.scdhhs.gov/press-release/baby-friendly-hospital-initiative-race-date (last visited Apr. 6, 2015).
[245] *Id*.
[246] *Id*.
[247] Telephone Interview with BZ Giese, Director, South Carolina Birth Outcomes Initiative (Nov. 13, 2014).
[248] *Id*.
[249] *Id*.
[250] *Id*.
[251] *Id*.
[252] *South Carolina Birth Outcomes Initiative*, S.C. DEP'T OF HEALTH AND HUMAN SERVS., https://www.scdhhs.gov/organizations/boi (last visited Apr. 6, 2015).
[253] Nicole Perelman et al., *Using Education, Collaboration, and Payment Reform to Reduce Early Elective Deliveries: A Case Study of South Carolina's Birth Outcomes Initiative*, CATALYST FOR PAYMENT REFORM, 4 (Nov. 2013), *available at* http://www.milbank.org/uploads/documents/reports/South_Carolina_Birth_Outcomes_Case_Study.pdf.
[254] S.C. INST. OF MEDICINE & PUB. HEALTH, *South Carolina Birth Outcomes Initiative Celebrates Success* (Jan. 2014) http://imph.org/south-carolina-birth-outcomes-initiative-celebrates-success/.

The biggest roadblock to implementation came from hospital administrators, specifically Chief Financial Officers, who were hesitant to accept the change because of projected losses based on estimated changes in formula expenses.[255] One hospital, for example, estimated the program would cost their facility $1.3 million in increased formula costs.[256] Typically, hospitals receive discounts from manufacturers and vendors on their formula products. Once hospitals become Baby-Friendly, they are required to refuse these formula discounts and purchase formula at market prices.[257] Accordingly, administrators often assume that they will incur significant costs in purchasing more expensive formula, even if the demand for formula decreases. However, based on information from the seven hospitals in South Carolina that are Baby-Friendly, these numbers have been dramatically overcast.[258] Indeed, the same hospital that predicted a $1.3 million loss actually incurred only $20,000 in additional formula costs the year following certification.[259] This is likely attributable to the fact that Baby-Friendly Hospitals use much less formula. Previously, hospitals kept stacks of formula, and nurses gave formula away to every mother after delivery. The Baby-Friendly Initiative encourages nurses to only give formula to mothers who ask, which dramatically decreases the demand for formula. Moreover, as knowledge and acceptance of breastfeeding improves over time, demand for formula should continue to decrease, which will result in diminishing incremental formula costs.[260]

South Carolina Analysis: Strengths and Challenges

South Carolina's success demonstrates the potential efficacy of using financial incentives to promote Baby-Friendly practices. However, the relatively small number of hospitals that were able to achieve Baby-Friendly certification within the short time period of the promotion raises some concern that the program may have been an effective incentive only for those hospitals already on track towards achieving Baby-Friendly status. This does not seem to concern South Carolina officials, who believe that the certification of high-achieving hospitals will increase competitive pressure for other hospitals, and that these private market incentives will encourage more hospitals to pursue Baby-Friendly certification.[261] Nevertheless, other states designing a financial incentive model and hoping to target a wider range of hospitals might consider allowing a longer time frame to achieve certification, or providing lower cash rewards for

[255] Telephone Interview with BZ Giese, *supra* note 247.
[256] *Id*.
[257] *Id*.
[258] *Id*.
[259] *Id*.
[260] *Id*.
[261] Seanna Adcox, *SC Medicaid Agency Awards Baby-Friendly Hospitals*, AUGUSTA CHRONICLE, Nov. 14, 2013, http://chronicle.augusta.com/news/metro/2013-11-14/sc-medicaid-agency-awards-baby-friendly-hospitals.

reaching certain benchmarks of success, rather than a large lump sum for achieving full Baby-Friendly status.

Implementing a program like South Carolina's also assumes that the state has substantial funding to dedicate to such an endeavor. South Carolina decided to devote Medicaid funding to the initiative on faith that improving health outcomes for infants through promoting healthy breastfeeding practices would ultimately reduce Medicaid expenditures.[262] Although numbers on the financial impact of the "Race to the Date" initiative on the state are not available, SCBOI's 2011 initiative to reduce the number of elective cesarean section births resulted in $6 million in savings in the first financial quarter of 2013.[263] This finding provides strong support for the proposition that investing scarce resources in prophylactic practices to improve infant health outcomes creates substantial savings in the long run.

D. Legislative Mandate

At least two states have utilized legislation to mandate or formally encourage hospitals to implement the Baby-Friendly Hospital Initiative.

1. California

California decided to use legislation as a means for implementing BFHI in its hospitals.[264] Law and policy makers recognized their responsibility to new mothers and their babies and have thus provided legislation to encourage breastfeeding and remove potential barriers.

In 2013, California's Legislature passed a law requiring that all hospitals adopt the Ten Steps of the Baby-Friendly Hospital Initiative by 2025.[265] The law (introduced as Senate Bill 402) states: "All general acute care hospitals and special hospitals…that have a perinatal unit shall, by January 1, 2025, adopt the "Ten Steps to Successful Breastfeeding," as adopted by Baby-Friendly USA, per the Baby-Friendly Hospital Initiative, or an alternate process adopted by a health care service plan that includes evidenced-based policies and practices and targeted outcomes, or the Model Hospital Policy Recommendations." [266] While the law does not require certification, it does require hospitals to adopt the 10 steps or an equivalent process to achieve the objectives of the BFHI.[267]

In order to assist hospitals in meeting this goal, the California Department of Public Health, collaborating with the California Breastfeeding Coalition and Inland

[262] *Id*.
[263] *Id*.
[264] *See* CAL. HEALTH & SAFETY CODE § 123367 (2013).
[265] *Id*.
[266] *Id*.
[267] *Id*.

Empire Breastfeeding Coalition, created model hospital policy that incorporated all of the steps of the Hospital Initiative.[268] The recommendations strengthen breastfeeding promotion and support and are based on the Ten Steps of the BFHI. The team developed these initiatives after extensive research, and all references are included in the extended policy.[269] The California Policy Initiatives are:

- "Policy #1: Hospitals should promote and support breastfeeding.
- Policy #2: Nurses, certified nurse midwives, physicians and other health professionals with expertise regarding the benefits and management of breastfeeding should educate pregnant and postpartum women when the opportunity for education exists, for example, during prenatal classes, in clinical settings, and at discharge teaching.
- Policy #3: The hospital will encourage medical staff to perform a breast exam on all pregnant women and provide anticipatory guidance for conditions that could affect breastfeeding. Breastfeeding mothers will have an assessment of the breast prior to discharge and will receive anticipatory guidance regarding conditions that might affect breastfeeding.
- Policy #4: Hospital perinatal staff should support the mother's choice to breastfeed and encourage exclusive breastfeeding for the first 6 months.
- Policy #5: Nurses, certified nurse midwives, and physicians should encourage new mothers to hold their newborns skin to skin during the first two hours following birth and as much as possible thereafter, unless contraindicated.
- Policy #6: Mothers and infants should be assessed for effective breastfeeding. Mothers should be offered instruction in breastfeeding as indicated.
- Policy #7: Artificial nipples and pacifiers should be discouraged for healthy, breastfeeding infants.
- Policy #8: Sterile water, glucose water, and artificial milk should not be given to a breastfeeding infant without the mother's informed consent and/or physician's specific order.
- Policy #9: Mothers and infants should be encouraged to remain together during the hospital stay.
- Policy #10: At discharge, mothers should be given information regarding community resources for breastfeeding support."[270]

[268] *Providing Breastfeeding Support: Model Hospital Policy Recommendations,* INLAND EMPIRE BREASTFEEDING COAL. AND INLAND COUNTIES REG'L PERINATAL PROGRAM (2005), *available at* http://www.cdph.ca.gov/programs/breastfeeding/Documents/MO-05ModelHospitalPolicyRecommend.pdf [hereinafter *Providing Breastfeeding Support*].
[269] *Id*. at 6.
[270] *Id*. at 8.

The policy recommendations are designed to give basic guidance to medical professionals in revising their infant feeding policies. The policy recommendations function to assist hospitals and health care providers in meeting the national and state public health breastfeeding goals, including those established by California law. The Department of Health found that working with hospitals to revise individual breastfeeding policies was more successful if they treated the policy recommendations listed above as a guide that should be adapted to fit an individual hospital's needs rather than strict requirements.[271]

While California does not provide funding for hospitals that achieve certification, the Department of Public Health provides online materials to assist hospitals in reaching their goals. Online materials include staff training programs[272] and model policy recommendations and toolkits for each policy step.[273]

Additionally, the Birth and Beyond California (BBC) Project, a collaboration among the California Department of Public Health, Maternal, Child and Adolescent Health Division and many local organizations and individuals, sought to enhance and improve breastfeeding procedures within the state, utilizing quality improvement methods designed to assist implementation of evidence-based policies as well as training to bolster the breastfeeding policies.[274] Directors in the targeted regions promoted the BBC project through "e-mail, postcards and fliers to inform hospital administrators, community partners, and breastfeeding coalitions about the project."[275] In regions where interest was initially low, they enlisted the support of Orange County's Maternal Child Health Director and targeted the four hospitals in the region with the lowest breastfeeding rates.[276] The BBC project held workshops, reviewed policies, and held monthly meetings or teleconferences for participating facilities.[277] Through this project, 23 hospitals participated, 685 staff members were trained, and hospitals made progress in implementing the California Model Breastfeeding Policies.[278]

---

[271] *Id*. at 7.
[272] *Increasing Exclusive Breastfeeding Rates in California Hospitals: A Workshop for Hospital Administrators and Key Decision Makers,* CAL. DEP'T OF PUB. HEALTH, http://www.cdph.ca.gov/HealthInfo/healthyliving/childfamily/Pages/IncreasingExclusiveBFRates.aspx (last modified Mar. 15, 2012).
[273] *Breastfeeding Model Hospital Policy Recommendations On-Line Toolkit,* CAL. DEP'T OF PUB. HEALTH, http://www.cdph.ca.gov/HealthInfo/healthyliving/childfamily/Pages/MainPageofBreastfeedingToolkit.aspx (last visited April 25, 2015).
[274] BIRTH AND BEYOND CALIFORNIA: HOSPITAL BREASTFEEDING QUALITY IMPROVEMENT AND STAFF TRAINING DEMONSTRATION PROJECT REPORT, CAL. DEP'T OF PUB. HEALTH (2012) *available at* http://www.cdph.ca.gov/HealthInfo/healthyliving/childfamily/Documents/BBCP_FinalReport2.17.2012.pdf [hereinafter BIRTH AND BEYOND CALIFORNIA].
[275] *Id*. at 8.
[276] *Id*.
[277] *Id*. at 9.
[278] *Id*. at vii.

The California Department of Health encourages creating an interdisciplinary team to review and strengthen breastfeeding policies within hospitals.[279] Members of that team should include individuals who support breastfeeding, understand the breastfeeding program, and represent the cultures of the community they serve.[280] Educating mothers on the rationale and benefits of breastfeeding at many points throughout their pregnancy and teaching breastfeeding support groups to continue encouraging mothers to breastfeed were found to increase breastfeeding rates.[281]

California Analysis: Strengths and Challenges

Regarding successful implementation, the final report of the BBC project suggests that hospital networks are critical in sharing strategies and approaches to overcome barriers to breastfeeding.[282] BBC project analysis also reveals that education on skin-to-skin practices and maternal-infant attachment is an essential component of hospital staff breastfeeding training.[283] Finally, the BBC project indicates that internal training in hospitals notably improved staff competency and provided ongoing breastfeeding education to new and current staff.[284]

Overall in California, a variety of agencies, including the Department of Health, local and state breastfeeding coalitions, and the surgeon general, supported increased hospital breastfeeding practices.[285] This encouragement from high-level agencies and officials, coupled with the 2013 legislative breastfeeding mandate, has helped increase breastfeeding rates in California. Increased rates of breastfeeding was scene in hospitals that instituted Baby-Friendly policies.[286] As of 2014, in-hospital exclusive breastfeeding has increased since 2010 from 56.6% to 64.6%. [287] Moreover, across California, exclusive breastfeeding has increased by 8% since 2010, with the highest

[279] *Id*. at 10.
[280] *Breastfeeding Hospital Policy Recommendation Policy #1*, CAL. DEP'T OF PUB. HEALTH, http://www.cdph.ca.gov/HealthInfo/healthyliving/childfamily/Pages/BFP-MdlHospToolkitPolicy1.aspx (last visited May 1, 2015).
[281] BIRTH AND BEYOND CALIFORNIA, *supra* note 274 at vii.
[282] *Id*.
[283] *Id*.
[284] *Lessons Learned from the Birth and Beyond California Project,* CAL. DEP'T OF PUB. HEALTH, http://www.cdph.ca.gov/HealthInfo/healthyliving/childfamily/Pages/BirthandBeyondCaliforniaDescription.aspx (last visited Apr. 6, 2015).
[285] *Breastfeeding Publications and Support,* CAL. DEP'T OF PUB. HEALTH, http://www.cdph.ca.gov/HealthInfo/healthyliving/childfamily/Pages/MO-BFP-BreastfeedingPublicationsAndReports.aspx (last visited Apr. 6, 2015).
[286] *Bringing Breastfeeding Home: Building Communities of Care,* CALIFORNIA WIC ASS'N AND THE UC DAVIS HUMAN LACTATION CTR., 1 (2013), *available at* http://www.calwic.org/storage/documents/FactSheets2014/statefactsheet2014FINAL.pdf
[287] *Id*. at 1.

increases among women of color. The number of baby-friendly hospitals has also increased from 12 in 2006 to 62 in 2014. [288]

2. Illinois

Illinois also opted to use a statutory requirement to increase breastfeeding rates, with the passing of the Hospital Infant Feeding Act in 2013.[289] Unlike California, which required wholesale BFHI adoption, Illinois opted for an interim step, requiring that: "(a) Every hospital that provides birthing services must adopt an infant feeding policy that promotes breastfeeding."[290] The Act also asks hospitals to consult the BFHI in its implementation, stating that "in developing the [infant feeding] policy, a hospital shall consider guidance provided by the Baby-Friendly Hospital Initiative."[291] Since the act only came into effect within the last year, it is too early to measure its overall effect but initial signs are positive. Exclusive breastfeeding at six months has risen from 11.1% in 2013[292] to 18.2% in 2014.[293] At least one additional hospital has become designated as a Baby-Friendly Hospital since its implementation.[294] Ultimately, more time and evaluation will be necessary to measure the complete effects of the Hospital Infant Feeding Act.

V. RECOMMENDATIONS FOR MISSISSIPPI

A. Collaboration

Collaboration with a range of stakeholders was stressed as a vital contingent of success for all of the states surveyed. Working with local organizations, other government departments, administrators and staff of hospitals, and facilitating hospital networks were all emphasized as necessary to encourage efficient implementation of breastfeeding policies and community support for those policies.

1. Local, Community Organizations

All states stressed working with established, local organizations to assist in encouraging hospitals and communities to support breastfeeding initiatives. Working with organizations that already have established ties with hospitals, and having those organizations present when engaging in staff training and discussions with administrators has aided in success in many states. For example, Arizona's partnership with the well-established Arizona Perinatal Trust bolstered buy-in for the five-step

---

[288] *Id*. at 5.
[289] 210 ILL. COMP. STAT. ANN. 81 (2013).
[290] *Id*.
[291] *Id*.
[292] BREASTFEEDING REPORT CARD U.S. 2013, CTRS. FOR DISEASE CONTROL AND PREVENTION 4 (2013), *available at http://www.cdc.gov/breastfeeding/pdf/2013breastfeedingreportcard.pdf*.
[293] BREASTFEEDING REPORT CARD 2014, *supra* note 38 at 4.
[294] *Designated Facilities By State*, BABY-FRIENDLY USA, https://www.babyfriendlyusa.org/find-facilities/designated-facilities--by-state (last visited Mar. 23, 2015).

program the Health Department implemented.[295] The California Breastfeeding Coalition and Inland Empire Breastfeeding Coalition provided expertise in creating California's breastfeeding policy initiatives.[296] States, such as Colorado, noted that their Department of Health was not an expert in the field of breastfeeding; collaborating with organizations that were experts established legitimacy in hospital trainings and alleviated some of the burdens associated with creating training and resource materials.[297] Further, the Colorado Breastfeeding Coalition assisted in giving presentations about the BFHI to local hospitals.[298]

It would also be helpful to partner with organizations with a significant presence in the community when attempting to educate mothers and establish peer support groups to help women continue breastfeeding upon leaving the hospital. A substantial obstacle noted by many states was the lack of education regarding breastfeeding that mothers received prior to, during, and after giving birth.[299] Working closely with community organizations and treating them as important stakeholders in the process to achieve breastfeeding goals can help women understand the importance of breastfeeding before giving birth, and can encourage them to continue breastfeeding when they return home.

In Mississippi, collaborating with organizations like the Mississippi Breastfeeding Coalition, the North Mississippi Breastfeeding Coalition, R.O.S.E., and local La Leche League International support groups could alleviate burdens on the State's Department of Health and contribute expertise and community presence.

2. Other Government Departments

Partnering with other government departments was also noted as particularly helpful in establishing a successful Baby-Friendly program. Connecticut particularly noted that working closely with the state's WIC was successful.[300] Collaborating with WIC helped bridge the gap between the Health Department and the community. Sharing information and ideas also ensured that the departments were not duplicating or undermining each other's efforts. Collaborating on major projects and initiatives relating to breastfeeding also allowed the departments to combine and utilize funds as effectively as possible when reaching to achieve similar goals.

Mississippi's WIC is an important point of contact with the community, as it provides breastfeeding support staff and peer support opportunities for mothers upon

[295] *Baby Steps to Breastfeeding Success*, *supra* note 141, at 1.
[296] *Providing Breastfeeding Support, supra* note 268.
[297] Telephone Interview with Jennifer Dellaport, *supra* note 95.
[298] *Initiative Raising Awareness*, *supra* note 111 at 2.
[299] See e.g., CONNECTICUT FINAL EVALUATION, *supra* note 170 at 43.
[300] Interview with Michele Griswold and Marilyn Lonczak, *supra* note 192.

leaving the hospital, as well as online breastfeeding resources and guides. Fostering a strong collaboration with the state WIC would allow the Health Department to gain access to the community, use funds efficiently, and share information and ideas.

3. Hospital Administrators and Staff

Treating hospitals as partners in the initiative to support breastfeeding was noted by most states as integral to success.[301] Working with hospital administrators was essential in achieving buy-in, and establishing meaningful relationships with key administrators was needed to assuage any safety or monetary concerns top-level employees may have. Working with those administrators and providing them with relevant data to combat some of those concerns can be crucial to achieving buy-in. For example, pushback from hospital Chief Financial Officers in South Carolina would have been more easily alleviated if the Health Department worked with all administrators in understanding the long-term costs of becoming Baby-Friendly.

Working with all members of hospital staff was also stressed. Providing extensive training to nurses is critical to ensuring that mothers are encouraged to breastfeed while in the hospital. For example, the rooming in requirement had significant pushback from mothers in Connecticut.[302] Providing nurses with training, as well as specific scripts to use with mothers, was noted as particularly helpful to convince mothers of the safety and benefits of rooming in.[303]

While most hospitals focused on training nurses in baby-friendly policies, many state departments realized that other health care staff members should also be trained and encouraged to speak to expecting mothers about the importance of breastfeeding. For example, Arizona noted that the lack of training extended to OB/GYNs and general physicians was a major shortcoming in encouraging breastfeeding at every level.[304] Because OB/GYNs and physicians constitute major points of contact between women and hospitals, ensuring encouragement at those stages can be critical to encourage continuation of breastfeeding practices upon leaving the hospital.

4. Facilitating Hospital Networks

California, Colorado, Connecticut, and Texas specifically noted that facilitating networks for hospitals to share information, best practices, questions, and concerns was helpful to increase buy-in.[305] For example, Colorado's Baby-Friendly Collaborative,

---

[301] See e.g., *Supra* note 272; Telephone Interview with Jennifer Dellaport, *supra* note 95.
[302] CONNECTICUT FINAL EVALUATION*, supra* note 170 at 26-27.
[303] *Id*.
[304] *Baby Steps to Breastfeeding Success*, *supra* note 141, at 3.
[305] Telephone Interview with Jennifer Dellaport, *supra* note 95; BIRTH AND BEYOND CALIFORNIA*, supra* note 274; Interview with Michele Griswold and Marilyn Lonczak, *supra* note 192; *Improving Statewide Breastfeeding Rates, supra* note 223.

consisting of hospitals working through the first stage of the Baby-Friendly Hospital Initiative, allowed hospitals to troubleshoot problems and progress together through each certification phase.[306] California's experience showed that hospital networks were critical to share strategies and educational resources for staff and the community.[307] The Mississippi Health Department could facilitate hospital networks by hosting webinars and creating online forums to hospitals looking to share information and troubleshoot problems.

B. Resources and Training

One of the most significant barriers noted most consistently by hospitals considering participation in the BFHI is funding.[308] Any way to alleviate monetary pressures on interested hospitals has been to be found incredibly helpful to increase hospital buy-in to BFHI. One cost-saving method consistently referred to by most states is providing free or subsidized trainings and resources to hospitals who agree to participate.

Most states surveyed here provided an initial meeting and training to hospitals, run by the State Health Department and collaborating expert organizations.[309] Having hospitals complete a pre-training survey to assess where they are in the implementation process and tailoring the trainings to best address the hospitals' current needs helped hospitals make the most out of the time spent in those trainings. For example, Arizona required pre-training assessments to determine what stage each hospital was at in the implementation process, and shaped trainings to support each hospital's particular needs.[310] After initial trainings, some states also offered assistance through free online training courses, follow up meetings with staff and administrators, and free access to breastfeeding consultants throughout the certification process.[311]

Additional resources for hospitals should also be provided. Hospitals from the states surveyed have noted that model policy guides, online training courses, model scripts for nurses, community resources, and self appraisal tools are all incredibly useful sources that State Health Departments should provide to help implement the BFHI without incurring exorbitant costs.

Many of the states surveyed did not directly encourage hospitals to become certified as Baby-Friendly, choosing instead to assist hospitals in achieving only some

[306] Telephone Interview with Jennifer Dellaport, *supra* note 95.
[307] BIRTH AND BEYOND CALIFORNIA, *supra* note 274 at 17.
[308] *See e.g.,* CONNECTICUT FINAL EVALUATION, *supra* note 170 at 43.
[309] *Supra* note 218; *Initiative Raising Awareness*, *supra* note *111* at 2., *Baby Steps to Breastfeeding Success*, *supra* note 141, at 1.
[310] *Baby Steps to Breastfeeding Success*, *supra* note 141, at 2.
[311] See e.g., CONNECTICUT FINAL EVALUATION, *supra* note 170 at 4; *Baby Steps to Breastfeeding Success*, *supra* note 141, at 3.

of the steps or encouraging a state certification. In Colorado, Arizona, and Connecticut, asking hospitals to only commit to five steps was a helpful way to get hospitals started without feeling overwhelmed by all of the BFHI costs and requirements.[312] It should be noted that if Mississippi chooses to encourage full-scale Baby-Friendly certifications for its hospitals, the BFHI provides resources to those hospitals that register in their certification program. Because there are fees associated with the official BFHI process, offering funds to hospitals to register and complete the process should be considered to offset those costs to hospitals.

Another source of funding problems hospitals ran into was the cost associated with increased staff and paying staff for time spent in training sessions. Many hospitals noted that, in order to provide enough time for nurses to spend with mothers in explaining and encouraging breastfeeding, hospitals incurred costs in requiring an increase of nursing staff.[313] Additionally, while training was provided for free, hospitals still had to pay health care staff for the time spent in training sessions. Some hospitals also recognized the need for expert lactation specialists and consultants to be on staff to assist nurses and mothers, requiring additional cost.[314] Funding to help alleviate some of these staff related costs would go a long way to help hospitals stay committed to encouraging breastfeeding.

C. Community Support

Community awareness of breastfeeding benefits and support for hospital initiatives was noted as particularly lacking in some states. Hospitals noted that community awareness could increase a mother's knowledge and support of breastfeeding before she enters a hospital to give birth, alleviating the costs associated with requiring a nurse to spend more time explaining the benefits of breastfeeding to new mothers.[315]

Partnering with community organizations and other state departments can be of crucial importance in informing families of the importance of breastfeeding, and what to expect when they enter a Baby-Friendly hospital. Texas created state media campaigns consisting of television ads, websites, and online videos extolling the benefits of breastfeeding.[316] Connecticut hospitals specified the need for more materials aimed specifically at educating mothers before and during their hospital stay.[317] Community connections and peer support are also important in encouraging women how continue

[312] *See supra* Section IV.A.
[313] Interview with Michele Griswold and Marilyn Lonczak, *supra* note 192; Telephone Interview with Veronica Hendrix, *supra* note 217.
[314] Telephone Interview with Veronica Hendrix, *supra* note 217; CONNECTICUT FINAL EVALUATION, *supra* note 170 at 43.
[315] Interview with Michele Griswold and Marilyn Lonczak, *supra* note 192.
[316] Telephone Interview with Veronica Hendrix, *supra* note 217.
[317] CONNECTICUT FINAL EVALUATION, *supra* note 170 at 44.

breastfeed. Generally, WIC Programs have the community connections and reach to provide peer support services. Mississippi's WIC Program currently provides access to peer counselors, lactation specialists, and lactation consultants.[318] Expanding these programs could be a beneficial way to provide support to Mississippi mothers. Community organizations can also provide the resources for effective peer support groups. For example, the La Leche League currently has seven groups supporting Mississippi.[319] La Leche League offers meetings, assistance by phone and in person, and breastfeeding workshops.[320]

VI. CONCLUSION

Mississippi is a state with some of the lowest health indicators in the country and it is undoubtedly true that the state's low breastfeeding rates contribute to these declining outcomes. Raising breastfeeding rates would be a highly effective first-step to lowering the rates of these chronic and crippling conditions, such as diabetes, childhood obesity, and cancer. The Baby-Friendly Initiative offers a cost-effective, impactful method for raising rates of breastfeeding.

There are a myriad of ways Mississippi can support hospitals in meeting the goals of the Baby-Friendly Hospital Initiative. While states have approached the task from different perspectives and have had varying obstacles to overcome, some general themes were consistent in the states surveyed. All emphasized the importance of community buy-in, organizational collaboration, and provision of trainings and resources in encouraging hospitals to implement their breastfeeding initiatives. Whether the Health Department chooses to encourage hospitals to fully implement the Baby-Friendly Hospital Initiative, or to create a separate initiative to support breastfeeding policies, each of these recommendations can assist in ensuring a successful campaign to increase breastfeeding rates in Mississippi.

[318] *Breastfeeding: The Best Start in Life*, MISS. STATE DEP'T OF HEALTH, WOMEN, INFANTS, AND CHILDREN PROGRAM, http://msdh.ms.gov/msdhsite/_static/41,0,144.html (last visited Apr. 6, 2015).
[319] LA LECHE LEAGUE OF ALABAMA, MISSISSIPPI, AND LOUISIANA, http://www.lllalmsla.org/ (last visited Apr. 6, 2015).
[320] *Id*.