This publication was supported by Cooperative Agreement Number 6NU38OT000161-05-03, funded by the Centers for Disease Control and Prevention. Its contents are solely the responsibility of the authors and do not necessarily represent the official views of the Centers for Disease Control and Prevention or the U.S. Department of Health and Human Services.
Background: The Importance of Supporting and Promoting Breastfeeding

For most infants and mothers, breastfeeding provides an array of benefits and protective factors. Maternal and child health experts recommend breastfeeding infants immediately following birth for at least one year, and exclusively breastfeeding through six months of age. Overall, while about 81 percent of mothers in the U.S. initiate breastfeeding following birth, only one-third of babies are still breastfed at 12 months.

Women across the economic spectrum, from recipients of assistance under the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) to higher-income women, experience common barriers to breastfeeding, including:

- Policies and practices that do not actively support—and sometimes discourage—women from breastfeeding in hospitals or at work.
- A community’s or family’s beliefs that make it less acceptable for women to breastfeed.
- Individual breastfeeding challenges that could potentially be overcome or addressed with sufficient support from peers or professionals.

Experts recommend developing comprehensive, integrated strategies to address these barriers and creating policies and practices to more effectively support mothers.

Establishing a Breastfeeding State Learning Community

CDC’s Division of Nutrition, Physical Activity, Overweight, and Obesity initiated a unique project to help states improve their breastfeeding rates. Using a learning community model, ASTHO funded eighteen states and the District of Columbia (DC) to reduce breastfeeding barriers by:

1. Increasing practices supportive of breastfeeding in birthing facilities.
2. Improving access to professional and peer support for breastfeeding.
3. Ensuring workplace compliance with the federal lactation accommodation law.

For the first three years of the learning collaborative, ASTHO provided $15,000 to each participating state to pilot or enhance system-level breastfeeding promotion strategies that were likely to be sustained and spread across the state. Some states received “enhanced” funding—$30,000 in years one and two, and $25,000 in year three—to work more collaboratively with their state coalitions. The lead agency in most states was the state health agency, and several state health agencies worked closely with their state breastfeeding coalitions or task forces. Table 1 lists each state and its main area of focus for each year of the learning community.
Table 1: ASTHO Breastfeeding Learning Community State Goals

<table>
<thead>
<tr>
<th>State</th>
<th>Learning Community Focus</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Increasing supportive practices in birthing facilities</td>
</tr>
<tr>
<td>Alabama+</td>
<td>1, 2</td>
</tr>
<tr>
<td>Alaska</td>
<td>1, 2</td>
</tr>
<tr>
<td>Arkansas</td>
<td>1</td>
</tr>
<tr>
<td>Delaware+</td>
<td>2, 3</td>
</tr>
<tr>
<td>District of Columbia+</td>
<td>1, 2</td>
</tr>
<tr>
<td>Georgia</td>
<td>1, 2, 3</td>
</tr>
<tr>
<td>Hawaii</td>
<td>1, 2, 3</td>
</tr>
<tr>
<td>Illinois</td>
<td>1, 2, 3</td>
</tr>
<tr>
<td>Louisiana+</td>
<td>1, 2, 3</td>
</tr>
<tr>
<td>Nevada</td>
<td>1, 2, 3</td>
</tr>
<tr>
<td>New Hampshire</td>
<td>1, 2</td>
</tr>
<tr>
<td>New Mexico</td>
<td></td>
</tr>
<tr>
<td>North Dakota</td>
<td>1, 2, 3</td>
</tr>
<tr>
<td>Ohio</td>
<td>1, 2, 3</td>
</tr>
<tr>
<td>Oklahoma+</td>
<td></td>
</tr>
<tr>
<td>South Dakota</td>
<td>1, 2, 3</td>
</tr>
<tr>
<td>Texas</td>
<td>1, 2, 3</td>
</tr>
<tr>
<td>Vermont</td>
<td></td>
</tr>
<tr>
<td>West Virginia</td>
<td>1, 2, 3</td>
</tr>
<tr>
<td>Wyoming</td>
<td>2, 3</td>
</tr>
</tbody>
</table>

+ Indicates states receiving enhanced funding.
1 Indicates focus area in year one.
2 Indicates focus area in year two.
3 Indicates focus area in year three.

Members of the ASTHO Breastfeeding Learning Community convened virtually four times per project year. The meetings focused on general topics of interest to participating states and provided time for teams to exchange updates and resources. These virtual meetings have featured presentations from a variety of states and national experts on a range of topics, including state milk-banking efforts, creating worksite accommodations, building a patient-centered approach to breastfeeding, and updating the group on state and national breastfeeding policy. (Descriptions of and links to archived learning community virtual session presentations can be found in Appendix A.)
This project summary will:

- Describe ASTHO’s work with states and how states implemented strategies to improve breastfeeding rates through the learning community.
- Summarize project themes and notable outcomes from states.
- Identify opportunity for state health agencies to support breastfeeding.

States’ Lessons Learned

Over the course of the learning community project period, ASTHO asked the 18 states and DC to reflect on their experiences and synthesize their lessons learned for three critical systems-level components: policy, data, and partnership and stakeholders. These systems components cut across strategic focus areas, and their inclusion enhances the likelihood that efforts will be sustained and replicated or scaled across the state.

Some state teams focused on broad systems-level interventions at birthing facilities or businesses, while others focused on specific populations with lower rates of breastfeeding initiation or duration secondary to lack of access to peer or professional support. Some states piloted their efforts in communities wanting to promote breastfeeding, while others took a more regional approach to encourage professional support and “healthy competition”—or positive peer pressure—between hospitals or employers.

ASTHO reviewed the learning community participating states’ 2017 final reports, analyzing themes across states and, where possible, synthesizing outcomes from the projects within the three systems components. Additionally, ASTHO used state-submitted project evaluation data to inform its analysis and aggregation of specific outcomes. Each year of the learning community, ASTHO asked states to provide evaluation data on outputs and short- and medium-term outcomes specific to each strategy, which came from a variety of resources such as Medicaid, WIC, or surveys such as mPINC or state-level National Immunization Survey results. ASTHO also inquired about common long-term outcome measures, including the numbers of infants who were (1) ever breastfed, (2) breastfed at 6 months, (3) exclusively breastfed at 6 months, and the proportion of children who were overweight or obese.

Policy

Notable Project Outcomes:

- Participating states trained 874 healthcare peers and professionals to understand breastfeeding and strategies and techniques to support breastfeeding women.
- During the project period, the number of hospitals designated as breastfeeding-friendly increased from 23 to 73.
- During the project period, the number of hospital professionals trained increased from 13 to 4,859.
Within each strategic focus area (increasing supportive practices in birthing facilities, improving peer and professional support, or ensuring worksite compliance with the federal lactation accommodation law), state teams worked on formal and informal policy development and adoption to increase breastfeeding rates (see Appendix B):

- States working to *increase supportive practices in birthing facilities* sought to increase the number of hospitals in their states that were designated as “baby friendly,” based on the Baby-Friendly USA *Ten Steps to Successful Breastfeeding*. States created unique hospital designation programs, addressing different steps on the continuum to become baby friendly or breastfeeding-friendly, based on criteria in state-specific recognition programs. Other policies include reducing or eliminating free gifts or services, such as samples, marketing materials, or equipment from infant formula manufacturers or distributors. The Ohio learning community team also focused on helping hospitals adopt the American Academy of Pediatrics’ Safe Sleep recommendations.

- States increasing *peer and professional support* worked on policies related to professional development and training, such as requirements for new staff and additional professional development and training for clinical and hospital-based staff to learn more about breastfeeding and strategies and techniques to better support breastfeeding women and their families.

- States seeking to increase *worksite support for breastfeeding* helped businesses create policies governing lactation support and accommodation. In particular, South Dakota’s learning community team sought to enroll worksites in a breastfeeding-friendly business initiative. States also helped businesses create policies for training staff on the requirements of federal and state accommodation laws, as well as the business case for breastfeeding and ways to support breastfeeding employees.

States shared the following lessons learned from their policy-related breastfeeding promotion activities:

- It’s helpful to have toolkits, templates, or sample policies available when trying to promote policy creation and adoption.
- States can increase their levels of collaboration and maximize ongoing efforts to promote breastfeeding by building on existing efforts, such as those relating to chronic disease prevention. For example, New Hampshire’s Division of Children, Youth, and Families workgroup on safe infant care includes breastfeeding.
- Leveraging existing relationships with partners, particularly state hospital associations, can be key to moving breastfeeding promotion efforts forward.
- States can consider incremental steps, such as creating a draft policy and getting feedback, before finalizing a policy and getting approval in order to avoid resistance and increase stakeholder buy-in.
- Using the word “policy” might have unintended implications. Consider tailoring your terminology based on audience and avoiding terms that may be foreign or irrelevant to that audience.
- Consider that the term “baby-friendly” might have negative connotations for some audiences. (For example, some stakeholders in Wyoming perceived this to mean that other hospitals were *unfriendly* to babies.)
- Note that informal policies, such as pledges, can also be persuasive, especially when formal policy development is difficult to navigate or requires formal adoption by governing bodies.
• Keep in mind that change is hard. Attitudes, biases, and personal beliefs can lead to a lack of support or fear that patients or clients would go elsewhere, but patience and compassion can help develop creative solutions to perceived barriers.
• A multidisciplinary task force can help engage a range of stakeholders and move the work forward. Short-term changes using quality improvement methods can also help make the changes more incremental, tailored, and accepted.

New states can consider undertaking the following steps to inform their breastfeeding promotion efforts:

• Begin by establishing breastfeeding policies within their own organizations and affiliates to lead by example and ensure leadership buy-in.
• Research the target communities and conduct extensive needs assessments to identify community barriers and assets before beginning to understand the community context influencing behaviors.
• Consider using a “step approach” with opportunities to recognize small steps toward a larger goal, such as to identify worksites or hospitals that meet one or two steps at a time.
• Use quality improvement methods or collaborative learning sessions to increase peer-to-peer learning and engagement.

Data

State teams relied on a range of data sources to inform their breastfeeding promotion work. Health agencies rarely “own” their data, and some have data sharing agreements with hospitals to allow access to data. Several states find that they could use both enhanced population-level data, particularly more real-time data, as well as more detailed qualitative or individual-level information about women’s thoughts, attitudes, and intentions, and insights from evaluation of policy and practice more directly aligned with interventions.

States commonly used the following data sources for information related to breastfeeding practices and outcomes:

• CDC’s Maternity Practices in Infant Nutrition and Care (mPINC) survey
• CDC’s Pregnancy Risk Assessment Monitoring System
• CDC’s National Immunization Survey
• CDC’s Youth Risk Behavior Surveillance System
• Vital statistics
• Newborn screening data
• WIC data or USDA Food and Nutrition Service Breastfeeding Data Local Agency Report
• Medicaid and other payer data
• Health agencies’ certified lactation consultant data
• Centralized state data repository
• State breastfeeding report cards or scorecards
• State surveys
• Needs assessments
• Labor department data or Occupational Health and Surveillance Program data
States shared the following lessons learned from their data-related breastfeeding promotion activities:

- Data are often out of date, so it may be difficult to plan to address trends in close to real time. (For example, data from CDC’s National Immunization Survey data is three years out of date.) Practitioners would value data that are more specific to localities or hospitals to allow for more specific interventions, identify hot spots, or address barriers.
- Data on mothers, outside of CDC’s Pregnancy Risk Assessment Monitoring System sample, is sometimes difficult to obtain. More data would be helpful to show a more complete picture of breastfeeding challenges in the state.
- States would also benefit from more specific qualitative or survey data on a range of issues, such as women’s prenatal intention to breastfeed and readiness, reasons for breastfeeding cessation, the needs of specific populations (such as rural women), or barriers to worksite pumping policy implementation, to allow for more targeted education outreach and support efforts.
- States found that tracking short- and medium indicators through program evaluation to be helpful in tracking and understanding the effects of policy changes on processes and behaviors, since longer-term outcomes related to breastfeeding initiation and duration are often a result of larger data systems, which lag in reporting by at least one to two years.
- Data dashboards provide potential opportunities to highlight breastfeeding, particularly in relation to other critical health measures.
- Meaningful improvements in trend data, such as mPINC scores, motivate hospitals, providers, and other stakeholders to engage in breastfeeding promotion improvement.

New states can consider undertaking the following steps to inform their breastfeeding promotion efforts:

- Use available data, including mPINC scores, to guide and track actions, particularly with the assistance of an epidemiologist.
- Work collaboratively with partners, including colleges and universities, to identify additional existing sources of data or to develop new data capacity, particularly focused on real time data and data that reflect individual level knowledge, attitudes, and behaviors.

**Partnerships and Stakeholders**

Throughout the project, state teams worked closely with partners and stakeholders to amplify and complement one another’s efforts. In several states, this project prompted stakeholders to more comprehensively analyze existing efforts and practices and promote breastfeeding more strategically. For example, Ohio’s learning community team reviewed their grant and sub-awardee grant announcements and requirements and modified the language to clarify requirements of these entities to ensure that their policies and practices support breastfeeding in their activities. Learning community teams from New Mexico and Georgia reviewed their own state health agency policies for supporting breastfeeding mothers on staff and promoted these policies within their own departments and affiliates.

Many states have a long history of collaboration to promote breastfeeding, particularly among state breastfeeding coalitions or task forces, and this learning community provided enhanced support for their
work together. In other states, this learning community helped establish new partnerships, such as with chambers of commerce, human resources associations, or state departments of labor. In Ohio and Georgia, state hospital associations provided access to hospitals and providers, allowing increased visibility and credibility for the states’ breastfeeding promotion efforts.

Learning community states’ partners included:

- State breastfeeding coalitions or task forces or state maternal and child health coalitions.
- Local breastfeeding support groups, such as Healthy Start New Orleans, Black Mothers’ Breastfeeding Club of Shreveport/Bossier, and Thrive Mama Collective of Oklahoma City.
- Health promotion groups, such as Oklahoma City Healthy Start Initiative, New Hampshire’s Foundation for Healthy Communities, the New Hampshire Commission for Human Rights, and RiseVT.
- State perinatal quality initiatives.
- Medical group state chapters or affiliates, such as American Academy of Pediatrics or medical society chapters.
- State hospital associations.
- WIC.
- Head Start, Early Head Start, and home visiting programs.
- State Medicaid or other insurers.
- Health systems.
- State health agency divisions or staff, including chronic disease and maternal and child health/Title V staff, and school health staff.
- Colleges and universities.
- Lactation consultant or midwifery organizations.
- Mothers’ Milk Banks.
- Worksite or employer associations, human resources groups, or occupational health organizations.
- Individual worksites.
- Other organizations, such as the Baby First Network, the Healthy Fathering Collaborative, the Oklahoma City-County Health Department, the Oklahoma Health Authority, the Oklahoma Family Network, the Oklahoma Healthy Birth Alliance, a local Catholic church in Lawton, OK, Healthy Childcare Alabama, tribal organizations, MomsRising, and local YMCA chapters.

States shared the following lessons learned from their partnership-related breastfeeding promotion activities:

- Partners can facilitate new relationships between health departments and entities such as hospitals, providing introductions and lending credibility to breastfeeding efforts.
- Staff turnover within partner groups can present a challenge to continuity.
- Competing priorities will always present challenges, as partners are always busy and working toward their own goals and objectives. Breastfeeding advocates can consider coordinating goals, objectives, and measures with partners to better align efforts and resources.
• States should continue to engage partners through their resources and infrastructure developed through this project.

New states can consider undertaking the following steps to inform their breastfeeding promotion efforts:

• Identify and collaborate with key partners and stakeholders to amplify and enhance efforts.
• Leverage existing and ongoing efforts to align with breastfeeding goals and objectives, particularly with states’ perinatal quality initiatives, hospitals, and WIC agencies.
• Identify or create an advisory group or leaders to coordinate and streamline breastfeeding efforts and potentially work together to identify funding opportunities.
• Identify relevant breastfeeding champions in communities, healthcare systems, and other settings.

Conclusion: Opportunities for State Health Departments to Support Breastfeeding

Since ASTHO’s Breastfeeding State Learning Community began in 2014, participating states have developed and enhanced efforts to support breastfeeding women and their families through systems-level interventions, such as creating and implementing policies in healthcare settings and worksites and increasing the availability of peer and professional lactation support. Over the project period, states increased the number of designated baby-friendly hospitals, trained healthcare and hospital staff to better provide more responsive support to breastfeeding mothers, supported community breastfeeding efforts, and enhanced worksite breastfeeding support. These system interventions provide crucial infrastructure that enhance both the sustainability of breastfeeding efforts and models for scaling up efforts statewide. Through this work, states identified lessons learned, described above, which help other states begin to consider and address systems-level changes toward the goals of improving breastfeeding rates.

Appendix A: List of 2014-2017 ASTHO Breastfeeding Virtual Learning Sessions

Year One Virtual Learning Sessions

- **Learning Session 1 (Dec. 1, 2014)** features three states’ approaches to increasing the number of breastfeeding-friendly hospitals in Iowa, expanding breastfeeding support among low-income women of color in New York, and developing an infant-friendly worksite designation program in North Dakota. The United States Breastfeeding Committee also discusses how a state breastfeeding coalition can effectively partner with its state health agency to improve breastfeeding rates.
- **Learning Session 2 (Feb. 11, 2015)** features a presentation from Connecticut’s learning community team describing its comprehensive, cost-effective approach to support breastfeeding and sharing resources and tips for supporting work across the three learning community topic areas. Participating states were also able to separate into smaller groups to discuss the topics of hospital maternity practices and peer and professional/workplace support.
- **Learning Community Technical Assistance Call: Supporting Breastfeeding in the Workplace (Feb. 20, 2015)** features a presentation from CDC about the requirements and application of the federal lactation accommodation law and its enforcement, as well as an overview of CDC’s recommended strategies to support breastfeeding in the workplace. Learning community teams from New Mexico and Vermont also provide an overview of their project aims and strategies to improve workplace support in the states.
- **Learning Session 3 (March 31, 2015)** features a presentation from NACCHO about how it is reaching out to local communities to increase breastfeeding among minorities and underserved populations. Texas’ learning community team also provides an overview of its initiative to increase workplace breastfeeding support through policy implementation and a comprehensive employer resource guide.
- **Learning Session 4 (May 19, 2015)** features a presentation from Delaware Division of Public Health Director Karyl Rattay, the past chair of the state breastfeeding coalition, and state health department staff. The presentation discusses breastfeeding support across the agency and key breastfeeding support partnerships, including lessons learned from working with the coalition. Several learning community teams (Alabama, Washington, D.C., Illinois, Louisiana, North Dakota, and Vermont) also presented the successes they have achieved through this project that they aim to sustain and spread moving forward.

Year Two Virtual Learning Sessions

- **Learning Session 1 (Sept. 10, 2015)** features a presentation on state successes, experiences, challenges, outcomes, and lessons learned from year 1 of the learning community, as well as a kick off of the second year of the learning community. CDC also provides an update on strategies for increasing breastfeeding, and the United States Breastfeeding Committee presents on health equity in breastfeeding promotion and support.
- **Learning Session 2 (Dec. 1, 2015)** features a presentation from the Oklahoma and Louisiana learning community teams on breastfeeding coalition partnerships, as well as a presentation from the Ohio learning community team on engaging hospital associations in breastfeeding initiatives. Breastfeeding learning community state teams also presented updates on key action steps taken since the September learning session.
• **Learning Session 3 (March 1, 2016)** features a presentation from the New Mexico learning community team on breastfeeding workplace support and a presentation from the District of Columbia team on peer and professional support. In addition, breastfeeding learning community state teams present updates on key action steps taken since the December learning session.

• **Learning Session 4 (May 3, 2016)** features a presentation from Attya Chaudhry and Megan Phillippi from the Association of Maternal and Child Health Programs on the Affordable Care Act and Medicaid breastfeeding support. States also presented their successes to round out the second year of the breastfeeding learning community.

**Year Three Virtual Learning Sessions**

• **Learning Session 1 (Oct. 4, 2016)** features a presentation from the United Health Foundation on the America’s Health Rankings Health of Women and Children Report. The presentation highlights findings from the reports and examines breastfeeding-specific measures.

• **Learning Session 2 (Dec. 6, 2016)** features a presentation from Dr. Marion Rice from the Center for Social Inclusion National First Food Equity Cohort and Dr. Naomi Bar-Yam at Human Milk Banking Association of North America (HMBANA) on the future of milk banking in the United States. The presentation highlights the history of milk banking, HMBANA’s role in providing safe human milk, and existing and emerging public policy related to banked human milk.

• **Learning Session 3 (March 2, 2017)** features a presentation from Dr. Naomi K. Tepper from the CDC and Dr. Alison Stuebe and Dr. Amy Bryant from the University of North Carolina’s Department of Obstetrics and Gynecology on the Safety of long-acting reversible contraception among breastfeeding women. The presentation highlights the importance of breastfeeding and immediate postpartum contraception. It also provides recommendations for different types of contraception methods and related complications. Dr. Stuebe and Dr. Bryant discuss the ethical considerations of advocacy and clinical care including shared decision making and decision support.

• **Learning Session 4 (May 16, 2017)** features a presentation from Lindsey Dermid-Gray from the Nevada WIC Program on tele-lactation successes and lessons learned in Nevada. The presentation describes the features of the PACIFY Smartphone App that was utilized in WIC clinics in Nevada.
**Appendix B: List of Breastfeeding Policies and Practices Adopted in Hospitals in Learning Community States**

**Policies Adopted: Hospital Policies and Practices**

<table>
<thead>
<tr>
<th>Policy</th>
<th>State Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>Baby-Friendly designation (includes policy requirements)</td>
<td>• Six hospitals in Alabama have been designated baby-friendly by the Baby-Friendly Hospital Initiative (BFHI) since 2011.</td>
</tr>
<tr>
<td>State breastfeeding-friendly recognition</td>
<td>• In Alabama, 28 delivering hospitals reviewed, updated, or established hospital policies that align with the 10 Steps to Successful Breastfeeding.</td>
</tr>
<tr>
<td></td>
<td>• Ohio increased the number of maternity hospitals with model lactation policies from 49 to 70. The state also increased the number of hospitals recognized for Step 1 in Ohio’s recognition program from 24 to 46.</td>
</tr>
<tr>
<td></td>
<td>• North Dakota assisted one hospital in becoming North Dakota Breastfeeding Friendly.</td>
</tr>
<tr>
<td></td>
<td>• Nevada worked with nine facilities to implement 5 key practices into formal policy.</td>
</tr>
<tr>
<td></td>
<td>• Wyoming created the Wyoming 5-Steps to Breastfeeding Success mini-grant program during the project period and four hospitals had or planned to change hospital policies related to the steps in the grant.</td>
</tr>
<tr>
<td>Training (mandatory or voluntary)</td>
<td>• In Alabama, education for staff qualified for 16 training hours required by BFHI.</td>
</tr>
<tr>
<td></td>
<td>• North Dakota birthing facilities require mandatory staff training, including one hour of breastfeeding policy and practice changes. New staff are trained by the lactation coordinator for one day of orientation and online modules related to breastfeeding policies and practices.</td>
</tr>
<tr>
<td></td>
<td>• Nevada delivered a four-hour training to non-baby-friendly Nevada maternity centers on five key breastfeeding promotion practices.</td>
</tr>
</tbody>
</table>
### Other policies, such as to reduce formula use, promote Safe Sleep, or recommend supervisor-employee meetings

- Georgia convened three train-the-trainer workshops for the Georgia 5-STAR Hospital Initiative.
- Alabama opened a Mother’s Milk Bank and established 10 milk deposits. It now provides pasteurized breast milk to eight delivering hospitals.
- Ohio Department of Health (ODH) language now includes American Academy of Pediatrics safe sleep recommendations, the importance of skin-to-skin care, and the role of fathers and partners in promoting breastfeeding.
- One North Dakota hospital has updated and approved a human milk and supplementation policy.

### State-level action, including a legislative, state agency, or all-state policy focus

- Alabama hosted a breastfeeding summit to address disparities in breastfeeding rates.
- Ohio Department of Health (ODH) revised its infant feeding/breastfeeding policy for ODH programs and sub-grantee agencies to include language supported and followed by breastfeeding-friendly hospitals. This policy now prohibits ODH from accepting or providing free gifts of services, including samples, marketing materials, or equipment from infant formula manufacturers or distributors, as well as from co-sponsoring events with formula manufacturers.

---

### Policies Adopted: Peer and Professional Support

<table>
<thead>
<tr>
<th>Policy</th>
<th>State Examples</th>
</tr>
</thead>
</table>
| Training (mandatory or voluntary) |  - Alabama awarded scholarships for 30 hospital staff to become certified lactation counselors.  
  - Oklahoma trained women of color to provide peer support and breastfeeding counseling.  
  - Using the EPIC BEST program, Delaware trained 213 professionals on breastfeeding practices in year three of the project, and 712 over the course of their project.  
  - Louisiana trained 322 professionals through Gift Community Breastfeeding trainings during the project period, including 137 in year three. |
## Policies Adopted: Workplace Accommodation

<table>
<thead>
<tr>
<th>Policy</th>
<th>State Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>Baby-Friendly designation (includes policy requirements)</td>
<td>• Vermont established 15 new or edited written breastfeeding policies, which covers worksites and is written into employee handbooks in participating K-12 public schools.</td>
</tr>
<tr>
<td></td>
<td>• Alaska developed and implemented breastfeeding worksite policies in eight communities across Alaska and at 10 different businesses (including the University of Alaska Anchorage and a high school that serves pregnant and parenting teens). Four of these sites were hospitals/clinics. All sites placed the policies in their employee handbooks, which are given to all new hires. Supervisors also received the policies to share with existing employees.</td>
</tr>
<tr>
<td>State breastfeeding-friendly recognition</td>
<td>• During year three, South Dakota increased the number of businesses designated through the Breastfeeding-Friendly Business Initiative from 101 to 352.</td>
</tr>
<tr>
<td></td>
<td>• Vermont increased the number of worksites recognized as breastfeeding friendly from 43 in 2013-2014 to a total of 166 by July 2017.</td>
</tr>
<tr>
<td>Training (mandatory or voluntary)</td>
<td>• New Hampshire created a free online training module and toolkit for establishing breastfeeding-friendly policies.</td>
</tr>
<tr>
<td>Increased awareness of policies</td>
<td>• In Alaska, the breastfeeding team assisted worksites in sharing breastfeeding-friendly policies with supervisors and suggested an email that employers could share with current employees.</td>
</tr>
<tr>
<td>State-level action, including legislative, state agency, or all-state policy focus</td>
<td>• The New Hampshire Lactation Advisory Council was created in 2018 through legislation and renewed in 2018 to consider issues such as the availability of accommodations and support for breastfeeding mothers, whether New Hampshire needs to revise the law to protect breastfeeding mothers, and other issues.</td>
</tr>
</tbody>
</table>