Lactation and the Working Woman: Understanding the Role of Organizational Factors, Lactation Support, and Legal Policy in Promoting Breastfeeding Success

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Abstract This chapter explores the organizational factors shown to impact a woman's ability to successfully combine breastfeeding and work. As such, we explore the role of support for breastfeeding at work, flexible work arrangements, organizational policies, and other work characteristics on women's work attitudes and well-being, as well as on, breastfeeding initiation and/or duration. The chapter discusses interventions to overcome organizational barriers, with a focus on employer education efforts and workplace lactation programs, both of which promote breastfeeding continuation upon return to work while resulting in numerous corporate benefits. Last, we conclude with a timely overview and interpretation of the complex legal landscape surrounding this critical topic in the United States, including a discussion of recent changes in legislation intended to afford the lactating working mother additional protection in the American workplace.

Keywords Workplace lactation · Breast milk pump · Breast milk expression · Nursing at work · Workplace breastfeeding · Breastfeeding support

New mothers are faced with a myriad of stressful and demanding challenges regarding childcare and return to work decisions. Among these is the critically important choice to initiate breastfeeding and to sustain it upon rejoining the workforce. Increased public health campaigns have attempted to raise awareness of the importance and benefits of choosing breast milk and of the common traps that women often face in successfully breastfeeding. While the "breast is best" message has had widespread promotion, only 18.8 % of the U.S. population meets the recommendation to breastfeed exclusively for the first six months of infant life (U.S. Centers for Disease Control and Prevention 2014). The issue is complex, as it

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spans beyond the boundaries of work and is affected by a variety of factors ranging from issues of public health relevance to legal rights and protections offered to women in our society.

Decade-long national goals promoted by the Healthy People 2020 initiative specifically highlight the need to both increase the proportion of mothers who breastfeed their babies and improve the duration and quality of breastfeeding. This goal places special emphasis on the influence of the social and physical environment, such as the workplace, on breastfeeding success (U.S. Department of Health and Human Services 2014). In recent years, the Surgeon General, the Centers for Disease Control and Prevention (CDC), and the Office on Women's Health (OWH) called specific attention to the promotion of breastfeeding and delineated the employment related restrictions that created barriers in supporting this initiative. While the 2014 CDC Breastfeeding Report Card indicates a general trend of rising breastfeeding rates, the data indicates a sharp decline between indicators of exclusive breastfeeding at three and six months.

A large body of research supports the medical, neurodevelopment, and psychological benefits of breastfeeding for infants and mothers (for a comprehensive summary see Ip et al. 2007). For example, studies have shown that breastfed infants have a reduced incidence and severity of several diseases, such as diarrhea, otitis media, respiratory tract infections, urinary tract infections, bacterial meningitis, bacteremia, necrotizing enterocolitis, insulin dependent diabetes, and lymphoma (Leon-Cava et al. 2002). Breastfeeding also reduces the chance for sudden infant death syndrome and improves chances for dental health (Palmer 1998). Indeed, the benefits of breastfeeding to the child may be said to be both nutritive and immunological. Maternal health benefits are also impressive, including lowered risk of ovarian cancer, reduced menstrual blood loss, weight loss, and enhanced self-esteem and confidence (Leon-Cava et al. 2002). Further, the incidence rate of breast cancer can be reduced in developed countries by increasing breastfeeding duration, although the exact mechanism by which it serves to protect maternal health is unknown (see Möller et al. 2002). Cost savings of $13 billion dollars per year have been estimated across as many as 10 pediatric illnesses if 90 % of U.S. families complied with the recommended six months of exclusive breastfeeding (Bartick and Reinhold 2010). This same study estimated as many as 911 preventable infant/child deaths per year associated with the increased risk for sudden infant death syndrome, necrotizing enterocolitis, and lower respiratory tract infection posed by suboptimal breastfeeding rates.

Given the many cited benefits of breast milk, what factors may be influencing the choice to initiate and maintain breastfeeding among working U.S. women? While a thorough answer to this question requires an ethnographic examination of cultural and societal influences on breastfeeding norms, focal to this chapter is the notion that employment outside of the home is a significant contributor to the low percentage of women following the recommendations of the American Academy of Pediatrics (AAP), the World Health Organization (WHO), and the CDC regarding breastfeeding milestones in the United States. This is a critically important factor given that over half of the women with infants less than 12 months of age are active

members of the labor force (U.S. Department of Labor, Bureau of Labor Statistics 2007).

While the decision to initiate breastfeeding may be less dependent on maternal employment and more so on the length of maternal leave before returning to work postpartum (Calnen 2007; Nobel & The ALSPAC Study Team 2001), studies have consistently shown a negative relationship between post-partum maternal employment and breastfeeding duration across various ethnic, education, and age groups (Johnston and Esposito 2007; Ong et al. 2005; Ryan et al. 2006), with lower rates for women working longer hours (Gielen et al. 1991). Indeed, mothers working full-time are 25 % less likely to breastfeed six months after birth than non-working mothers (Ryan et al. 2006). With limited protections under the Family Medical Leave Act, the majority of women are returning to employment after an average of 12 weeks of maternity leave, coinciding with the critical period of breastfeeding decline illustrated by the CDC Breastfeeding Report Card. Further, while almost every state now has legislature protecting a mother's right to breastfeed in public, less than half had laws regarding breastfeeding in the workplace prior to the signing of the Healthcare Reform Bill (National Conference of State Legislatures 2014). As a result, combining work and breastfeeding is a salient issue for organizations and the modern day working mother.

This chapter discusses the organizational factors that impact women attempting to successfully combine breastfeeding and work, as well as the theoretical backdrops against which these issues can be further examined. The chapter also addresses issues of workplace accommodations, with a special emphasis on workplace lactation programs and their many benefits to both organizations and lactating working women. Last, we conclude with a timely overview and interpretation of the legal landscape affecting this critical topic. In this chapter, the term *breastfeeding at work* refers broadly to the act of expressing or pumping breast milk at work to feed an infant at a later time, as well as to the actual act of feeding the infant directly from the breast during the workday. The vast majority of research cited, however, is primarily focused on pumping, given the low base rate of workplaces with babies at work policies (more on this in a later section).

The Lactating Woman and the Organization

The transition back to work after birth is often an emotionally taxing period for new mothers. Feelings of guilt, worry, and anxiety are commonly prompted by issues of childcare planning and separation from the infant. However, individual differences among women influence their ability to cope with this transition and its challenges. Indeed, DeMeis et al. (1986) concluded that a woman's preference for work was a more salient factor in influencing her feelings about the separation from her child than her actual employment status. Past experience with breastfeeding and the desire to do so are also critical (see Johnston and Esposito 2007) in aiding success. Nonetheless, the lactating woman determined to maintain the breastfeeding

relationship with her infant is faced with additional planning and, depending on her work, may encounter a variety of external obstacles to goal attainment.

Workplace support for breastfeeding has received growing attention as a means of ameliorating the already challenging task of balancing work with milk expression (Rojjanasrirat 2004). Greene and Olson (2008) developed a measure to assess perceptions of emotional and instrumental support by the organization and the people in it. In this regard, support for breastfeeding at work extends beyond having a physical space to express breast milk, which can be offered by means of compliance with company or legal mandates, but with little socio-emotional support behind it.

Manager and Coworker Support for Breastfeeding at Work

Current research has sought to explore the role that workplace support for breastfeeding by supervisors and/or coworkers could have on breastfeeding duration, the psychological well-being of the lactating woman, and outcomes of organizational relevance. In a two time wave study of over 300 working breastfeeding women in the U.S., support by supervisors/coworkers was significantly related to a variety of outcomes, including burnout, post natal depression, work-family conflict, self-rated performance, organizational commitment, and job satisfaction (Bruk-Lee and Buxo 2013). Evidence from this research also suggests that support for breastfeeding by others at work can have a unique effect on women's levels of burnout and post natal depression that cannot be accounted for by post partum material and emotional support provided by others in the household. Similarly, Miller et al. (1996) found that the support of the attending physician was a major factor contributing to residents' breastfeeding success.

However, a large percentage of companies continue to lack a formal breastfeeding policy and data suggests that a majority of managers showed mixed feelings about the need for one in the workplace (Chow et al. 2011). Employers who knew of other organizations that supported breastfeeding were more likely to report positive attitudes towards it, although only 20 % believed that human milk provided health benefits that formula could not (Bridges et al. 1997). Overall, women have consistently reported that their managers serve as organizational constraints in their ability to pump breast milk at work (see Thompson and Bell 1997; Witters-Green 2003) and evidence points to a relationship with breastfeeding duration (Tsai 2013). Data from the national Infant Feeding Practice Study II also indicated that a lack of supervisory support for breastfeeding at work significantly raised the likelihood of weaning from exclusive breastfeeding during the first six months of the infant's life. Consistent with these findings, Bruk-Lee and Buxo (2013) reported that of the women who reported weaning, only 6 % of women indicated that their healthcare provider influenced them in some way to stop expressing milk, while 30 % pointed to their employer or supervisor as the reason for doing so.

Findings also suggest that childless women perceive lactation friendly policies less fairly than do other working groups (Seijts 2004), which could further alienate the breastfeeding mother and reduce the buffering effects of a supportive work environment. While breastfeeding accommodations are reasonable in cost, Zinn (2000) stated that "coworkers may be as difficult as the employer to convince about the importance of breastfeeding and the need to support the mother" (p. 218). The increased pressure from coworkers for the returning mother to carry her weight combined with her desire to pass "unnoticed" after having taken maternity leave benefits makes the new mother particularly vulnerable to skipping pumping breaks, which are so essential in maintaining milk supply. However, women who have combined work and breastfeeding are essential in supporting new mothers to find ways in which they can cope with organizational barriers, balance their work/life demands, and promote acceptance for workplace lactation. Findings suggest that coworkers' attitudes towards breastfeeding are typically more favorable for those who have been exposed to a breastfeeding or pumping mother at work (Suyes et al. 2008).

Issues of Maternity Leave, Work, and Space

Compelling research indicates that flexible or part-time work and longer maternity leave support better breastfeeding rates for working mothers. Hence, organizational policies and benefits can play a significant role in workplace lactation and serve as either facilitators or hindrances. Haider et al. (2003) found that work requirements greater than or equal to 32 h per week reduced breastfeeding by 3.1 % compared to nonworking mothers. Among female physicians, shorter maternity leave and full time employment were associated with decreased breastfeeding duration (Authur et al. 2003). Similar conclusions were reached from a nationwide study of 2431 mothers pointing to the higher risk of breastfeeding cessation for women returning to work at 12 weeks or earlier and for those working full-time (Lindberg 1996). Moreover, each week of additional maternity leave has been found to increase breastfeeding duration by almost half a week, with the lowest breastfeeding duration found among women returning to work in the first 10 weeks after delivery (Roe et al. 1999). More recent research on the reconciliation of work and breastfeeding points to parental leave that exceeds six weeks as a significant contributor to breastfeeding continuation (Guendelman et al. 2009). This is a particularly concerning fact for working women in the U.S., which is cited to be the only industrialized nation without a national policy for paid maternity leave (Heymann et al. 2007). Due to recent economic pressures, women have returned to work sooner, putting low income women at an even higher risk for early weaning. In a recent opinion essay regarding the role of paid maternity leave and breastfeeding, Calnen (2007) stated that "the toll that families will have to pay for [the separation of mother and child during first several months after delivery] in the years to come has yet to be calculated" (p. 42).

Factors regarding the characteristics of work can also affect a mother's ability to express breast milk (Jacknowitz 2008). Alternative work arrangements, including part-time work and flextime, reduce the amount of time that the mother/infant pair is separated and support breastfeeding goals. For example, control over one's work schedule is advantageous in allowing women discretion over the time based demands of pumping. Indeed, flexible break options typically facilitate workplace lactation efforts which, on average, require approximately one hour total spread over several breast milk expression periods (Slusser et al. 2002). Recent findings showed that 37 % of women requested permission prior to pumping and that 13 % reported at least sometimes being denied a pumping break (Bruk-Lee and Buxo 2013). While women in the professional ranks are more likely to have access to greater privacy at work and autonomy, their increased work demands also pose unique challenges to this group (Brown et al. 2001). Nonetheless, salaried women are more likely to express breast milk at work than hourly paid mothers (Ortiz et al. 2004). For some occupations, such as school teachers, the nature of the work creates impediments that interfere with appropriate pumping breaks. Military women also cite temporary duty assignments, military obligations, and military rank as leading issues impacting breastfeeding success (Stevens and Janke 2003).

Additional physical constraints of work are commonly cited by lactating working women. Lacking a private suitable place to pump and store breast milk is commonly acknowledged. Thompson and Bell (1997) noted that low-income mothers who qualified for the special supplemental nutrition program for women, infants, and children (WIC) expressed concerns about their boss, time to pump, privacy, and ability to store their milk at the job. Too often, women are forced to use a bathroom, storage space, or their car in lieu of an adequate private space to breastfeed or pump. With recent changes to the Fair Labor Standards Act, qualifying employers are tasked with providing a dedicated private functional lactation space. However, data from focus groups reveal that some employers consider this type of requirement to be too taxing on their already limited space or simply consider the investment too costly (Brown et al. 2001). The need for a dedicated lactation space is not only an issue of privacy and comfort, but one of hygiene as well.

Work Family Balance and Stress Based Perspectives on Workplace Lactation

Research on workplace lactation has primarily focused on evaluating the effectiveness of programs on impacting outcomes of interest, with an emphasis, of course, on breastfeeding initiation and duration. Much of the research, however, has been atheoretical and driven by the need to isolate correlates, antecedents and consequences associated with breastfeeding at work. While this is a necessary start in exploring the relevance of breastfeeding in relation to the workplace, there are

various theoretical frameworks that can be used to further advance knowledge in a more nuanced way.

One such framework is based on the concept of work-family balance. Clearly, the demands placed on the new mother returning to work are many and span both the family and work spheres. Achieving a state of work-family balance upon transitioning back to work may seem like a daunting goal for many women and one that is constantly redefined based on the unique challenges of motherhood and employment at different stages. In fact, women often struggle with reconciling the idea of being a "good mother" with also being a "good employee" and are commonly left with the feeling that they cannot be both. In essence, then, what is work-family balance? The issue of balance can be traced to the principles of role theory (Katz and Kahn 1978), from which the concept of role conflict, defined as the conflicting demands and expectations placed on a person's work role, is expanded to spheres of work and family. Specifically, Greenhaus and Beutell (1985) referred to work-family conflict as "a form of interrole conflict in which the role pressures from the work and family domains are mutually incompatible in some respect" (p. 77). However, a more holistic look at work-family balance also considers the possibility for work-family positive facilitation in which the experiences and skills gained in one of the two domains aids functioning in the other (e.g., Grzywacz and Marks 2000). Early linking mechanisms have been proposed to help explain the relationships between various domains of work and family life (see Edwards and Rothbard 2000). Among these, for example, is the notion that spillover from one sphere to the other can happen for both the losses and gains associated with each role. In this regard, when considering the balancing act of the working lactating woman, both the stressors encountered in these roles and, perhaps, the "reaffirmation for the [lactating working] mother of the quality of her parenting" (Corbett-Dick and Bezek 1997, p. 13) can negatively or positively influence her sense of balance between work and family life.

Despite the many obvious avenues for research supported by using a work-family balance framework, few have drawn on existing related theories. Among these, Cardenas and Major (2005) expanded on the obstacles and organizational solutions available to address the needs of breastfeeding women at work by identifying time-based, strain-based, and behavior-based conflicts experienced by women attempting to continue breastfeeding upon their return to employment. In response, several workplace interventions were identified, which were aimed at addressing the various sources of work-family conflict, including lactation programs, support systems, flexible work arrangements, and onsite/subsidized child care options. More recent research also evaluated the role of workplace support for breastfeeding on breastfeeding goal intentions and duration using a work-family framework. In particular, the researchers reasoned that the time and behavior based demands of breastfeeding at work would compete with work-related demands and expectations; however, the availability of resources such as support and accepting workplace norms could promote balance between the roles (Spitzmueller et al. 2015).

A second and equally promising avenue for theory based research is tied more specifically to the notion of stress. Rojjanasrirat (2004) notes that workplace stress serves as a major obstacle to successful continued breastfeeding. In some cases, stress can interference with proper milk let-down, the process whereby oxytocin triggers the flow of breast milk, hindering the ability to pump at work. For these moms, it is widely recommended that they condition the let-down reflex by focusing on reminders of the baby, using visualization, and engaging in relaxation strategies. These recommendations can prove challenging for women pumping in inadequate spaces, at risk for interruptions, or under heavy workloads.

As cited earlier, issues of workplace support and organizational constraints can interfere with goal attainment for women hoping to reach recommended breastfeeding milestones. As such, these serve as conditions of the work environment that are commonly appraised by women as threats to their well-being, thus consistent with a transactional view of stress (e.g., Lazarus 1991). Under such a view, the breastfeeding mother judges her demands to exceed her available resources, highlighting an incompatibility between her work and breastfeeding that triggers and promotes the stress process. The strain reaction elicited by the experienced workplace stressor can be emotional (e.g., guilt), physical (e.g., engorgement due to skipped pumping sessions), or psychological (e.g., depression) in nature and can be immediate or experienced over a long term period.

The emotion-centered model of job stress (Spector 1998) presents an ideal framework from which to start theorizing about issues of workplace lactation. The model assumes a directional flow in which perceived stressors lead to emotional reactions that terminate in strains. Hence, the relationship between stressors and experienced strains is indirectly channeled through the experience of the emotional states induced. For women trying to pump during the workday, the experience can be highly emotional. For many, feelings of worry and anxiety are induced by a preoccupation with the amount of breast milk that her body is able to produce. Shame and embarrassment have also been cited with the experience (Bentovim 2002), particularly in unsupportive workplaces. Hence the centrality of emotions is relevant here.

The emotion-centered model of stress also accounts for individual differences and characteristics that may conditionally influence the stress process. While it has been applied in a variety of contexts (see Spector and Bruk-Lee 2008), an adapted model is recommended as a starting point from which we can begin to explore the complex processes by which work can impact a lactating woman's decision to continue breastfeeding, and her well-being, job attitudes and work behaviors (see Fig. 4.3.1).

As can be seen, the working breastfeeding woman may perceive elements of her work or the act of breastfeeding/pumping at work as stressful. These factors can include the workload, constraints of the work environment, and the demands of expressing breast-milk, among many others. These stressors bring about a variety of strains affecting the working woman (e.g., burnout, depression, work-family conflict, breastfeeding cessation, and engorgement) and the organization (e.g., commitment, performance, withdrawal, and job attitudes) which are, at least in part,

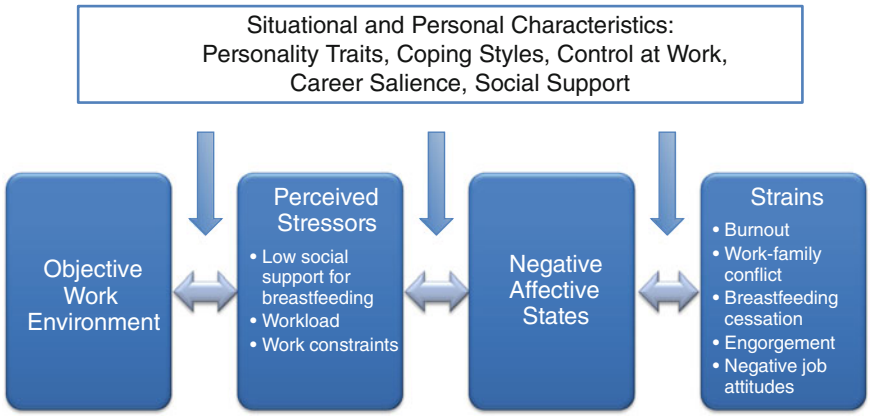

Fig. 4.3.1 Using an emotion-centered model of job stress in the study of workplace lactation

mediated through negative emotional states. However, these relationships can also be affected by the woman's coping strategies, control at work, and personality characteristics such as trait anxiety and core self-evaluation. Broadly speaking, women using problem-focused coping strategies, having more control over the specific workplace stressor, displaying stronger core self-evaluations, or reporting lower levels of trait anxiety are expected to experience weaker resulting strains. A large body of literature supports the importance of these variables in the stress process (e.g., Kammeyer-Mueller et al. 2009; Karasek 1979; Lazarus and Folkman 1984; Spielberger 1979). Further, while workplace support has been widely treated as a buffer in the stress literature, such that, for example, it ameliorates the impact of job stressors on well-being (e.g., Frese 1999), it is also possible that the *lack* of support per se acts as the perceived stressor. Such a model also supports testing the differential impact and role of socio-emotional and instrumental workplace lactation support (e.g., lactation rooms and education) on the stress process experienced by breastfeeding women.

Interventions to Help Women Overcome Barriers

Due to the many economic pressures plaguing today's single-earning families, the rising number of dual earning households, and women out-earning their husbands, women at work are reluctant to ask for additional reasonable accommodations from their employers to support breastfeeding. This notion is further supported by prior research indicating that family-friendly policies may be underutilized due to employee concerns regarding status (Glass 2000). Recently, the Society for Human Resource Management (2009) determined that one in four companies provided accommodation for breastfeeding.

The term "corporate lactation" barely came to fruition in the 1980s and despite the growing number of women in the workforce today, corporate lactation programs remain largely uncharted territory. Yet, mass media campaigns and federal mandates and laws, as well as the 2011 Surgeon General's "Call to Action" (U.S. Department of Health and Human Services 2011) to support breastfeeding, have raised increased awareness of workplace lactation issues. Within the context of work, the Call to Action enlisted the following targeted goals:

- "Work toward establishing paid maternity leave for all employed mothers" (pg. 50).
- "Ensure that employers establish and maintain comprehensive, high-quality lactation support programs for their employees" (p. 51).
- "Expand the use of programs in the workplace that allow lactating mothers to have direct access to their babies" (p. 52).
- "Ensure that all child care providers accommodate the needs of breastfeeding mothers and infants" (p. 53).

These four action areas are intended to increase the quality of life for working mothers. Indeed, according to the International Labour Organization (2012), "One of the five essential elements of maternity protection is enabling mothers to continue breastfeeding upon returning to work" (p. 2). Clearly, a supportive work environment is a key to success for women trying to balance the transition to work, challenges of motherhood, and stress of maintaining an adequate milk supply. Although factors such as the employee's healthcare support, maternity care, and home and societal conditions are very important (Johnson and Esposito 2007), these are outside of the control of the workplace.

Educating Organizations on the Benefits of Workplace Lactation Programs

While it is true that many employers lack an understanding of the importance of supporting the lactating woman or the impact that workplace policies can have on the long term success of the breastfeeding relationship between mother and child, findings also suggest that employer/employee education regarding the benefits of breastfeeding at work can help to increase the promotion and support of workplace lactation programs (Seijts and Yip 2008).

In this vein, the Health Resources and Services Administration unleashed a comprehensive national project called *The Business Case for Breastfeeding* (U.S. Department of Health and Human Services 2008). The resource kit includes colored pamphlets featuring working women in a variety of job settings and was specifically developed with American businesses in mind. The compelling argument presented is one that organizations could identify with, emphasizing the business benefits and bottom line impact of supporting breastfeeding. Despite the fundamental premise

that breastfeeding is best, the education focuses on showing businesses that workplace lactation support is a win-win proposition. Previously, breastfeeding education focused completely on the health benefits to the child and mother, however, *The Business Case for Breastfeeding* presents evidence to show that workplace lactation support lowers healthcare costs (U.S. Department of Health and Human Services 2008; Cohen et al. 1995), reduces absenteeism (Cohen et al. 1995), retains valuable employees (Cohen et al. 1995; Ortiz et al. 2004), creates positive public relations and loyal employees (Cohen et al. 2002), and helps the company follow legislative mandates (Slavit 2009). Additionally, results from three large scale organizational case studies show that breastfeeding mothers and babies save $240,000 annually in healthcare expenses, which has a compelling organizational impact (Slavit 2009).

As part of *The Business Case for Breastfeeding* initiative, a national program was conducted to train more than 3000 educators and health providers on how to use the available resources with businesses in local communities. However, within a very short period of time, it became apparent that a top-down approach was also needed in order to secure commitment from top level management, who could in turn, help to shape a corporate climate in support for breastfeeding at work. Indeed the promotion and sustainability of family-friendly organizations starts with positive and supportive leadership (see Hammer et al. 2011). For example, the University of California system has a strong policy to support nursing women in all of their 10 college campuses, five medical centers, three national labs, and many other medical and educational locations (see exhibit 4.3.1). The system further provides a President's Award for Lactation Accommodation to the best program within the system. Having a policy at the system level has a strong impact as it assures employees that these programs will not fall apart with changes in personnel.

Workplace Lactation Programs: Breastfeeding Success and Key Components

Breastfeeding duration rates for mothers employed in organizations with formal lactation programs have been found to be equivalent to breastfeeding duration rates in non-working mothers (Cohen and Mrtek 1994). Similarly, attendance at breastfeeding support groups encourages goal-setting and longer breastfeeding duration (Chezen and Friezen 1999). Some lactation programs have also emphasized the critical role of the father in influencing feeding choices and encouraging the mother. Cohen et al. (2002) studied the effectiveness of a paternal lactation program, which provided lactation counseling for the father and partner, and breast pumps for the partner to use at home or work. Not only did the percentage of men choosing to participate in the program increased across the years, but their partners (most of whom were employed) continued to breastfeed at six months after birth and displayed similar breastfeeding rates to the organization's working mothers.

Lactation consultants, flexible lactation support policies and a collaborative support network help the award-winning Breastfeeding Support Program at the University of California, Davis to offer 48 pumping rooms across the university's central campus and a nearby Sacramento health campus that is home to UC Davis Medical Center.

Lactation consultants play a central role in supporting pump room users at both campuses. On the central campus in Davis, a staff lactation consultant leads classes, runs support groups and consults with mothers who have breastfeeding concerns. At the Sacramento campus, a team of consultants provides prenatal classes, a weekly breastfeeding support group and one-on-one consultations with employees to navigate pumping and feeding challenges.

An online registration process connects employees at both campuses to the consultants, a list of pumping locations and a roster of resources and benefits available through various university work-life balance programs.

A proactive, flexible support program helps make breastfeeding convenient and sustainable from a time and productivity standpoint. Pumping stations are incorporated into plans for new construction and the university allows office, closet and restroom space in existing buildings to be converted into exclusive pumping areas as well. An institutional policy aims to limit the walk between a mother's work station and a nearby pumping station to no more than five minutes.

The program employs a "takes a village" philosophy to cultivate support and resources from several arenas across the university. On the Davis campus a student housing office helps to provide furniture, a Women's Research Center hosts educational classes and members of a Venture Club purchase hospital-grade pumps. Lactation support on the Sacramento campus program combines efforts from several departments including human resources, environmental services, volunteer services and the lactation program for patients.

The UC Davis Breastfeeding Support Program will be featured in an upcoming "Business Case for Breastfeeding" special University and Schools publication through the U.S. Department of Health and Human Service's Office on Women's Health.

Exhibit 4.3.1 Making Breastfeeding Work at UC Davis

These findings suggest that workplace lactation programs span gender roles and with some modification can benefit all employees. The predictive success of a variety of lactation program components has also received attention. Specifically, Balkam et al. (2011) focused on the availability of prenatal breastfeeding classes, telephone support, return to work consultation, and access to lactation rooms. Both the number of services in which women participated and having a return to work consultation to discuss issues related to maintaining breastfeeding at work predicted breastfeeding duration at six months after birth.

While it is most common for women to express breast milk at work for later use, feeding the infant directly from the breast increases and reinforces bonding between the pair, supports neurological and psychological development of the baby, and supports duration of breastfeeding. Indeed, patterns of mother-child bonding may be influenced by physiological mechanisms triggered by the act of breastfeeding

(see Strathearn et al. 2009). Therefore, babies-at-work programs can be a beneficial in select work settings. For example, employees who work for daycare centers, small offices, and child friendly environments could potentially arrange this option. At this time, however, more research is needed on their effectiveness and strategies for proper implementation.

Characteristics of the Workplace Lactation Space

Basic lactation space requirements include a private non-bathroom room with a door that locks, a table, chair, and electrical outlet. However, employers can go beyond the basics and provide a sink, refrigerator, natural lighting, breast pump, and lactation consultant support. The physical location must be conveniently located to maximize its use, as remote lactation rooms would present additional time management challenges to planning break times. The UC Davis case study (see exhibit 4.3.1) describes a "5-minute rule" in which lactation spaces are strategically placed to not exceed a five minute walking distance from the employee's primary place of work. In this exemplary effort, every new building has a pump room included in its blueprint.

Although the actual breast pump is hardly addressed in worksite lactation programs, the functionality of the breast pump becomes a vital topic when a mother is absent from her baby for 20–50 h per week, as longer periods of separation can influence breastfeeding success. Most lactation consultants would agree that multi-user pumps, sometimes referred to as hospital grade pumps, are more effective than consumer pumps at emptying the breast (Meier et al. 2008). The Affordable Care Act (ACA) requires most health insurances to cover the expenses associated with the use of a breast pump, which brings the need for breast pump usage and accessibility to the forefront in the American health industry. However, this has also caused the insurance and Durable Medical Equipment (DME) industry to respond with poorer pump options. Indeed, a report from the National Women's Law Center (2015) concludes that adequate support and equipment are often inaccessible due to cumbersome administrative barriers posed by some insurance companies. Further, insurance coverage can be limited to the use of manual pumps, an often ineffective option for working mothers. The report delineates additional barriers to receiving the coverage intended by the ACA to provide comprehensive lactation support, including access to equipment.

The Legal Landscape of Workplace Lactation

The most accurate thing that can be said about the protected status of employees who wish to express breast milk in the workplace in 2014 is that it is very much in flux, though a longstanding tide against legal protection seems to be turning. With the passage of key laws and new interpretations of older laws on both the state and

federal levels, the idea that protection can exist is becoming more widely accepted. Challenges to plaintiffs, however, in the form of limitations of these laws' language and interpretations, persist.

Federal Laws and Claims

There are various federal laws that afford employees certain rights that may touch upon breastfeeding, but a close analysis of each statute as a vehicle for recourse and its interpretation by the courts reveals sharp limitations on the protections afforded. A brief listing of these follows:

1. *Title VII of the Civil Rights Act of* 1964 protects employees from workplace discrimination and harassment on the basis of sex. *The Pregnancy Discrimination Act of 1978* (PDA) amended Title VII to specify that the phrase "because of sex" "include[s]… because of… pregnancy, childbirth, or related medical conditions," and to ensure that "women affected by pregnancy, childbirth, or related medical conditions shall be treated the same [as all other employees] for all employment-related purposes". The PDA does not mandate reasonable accommodations for pregnancy or for lactation.

2. *The Americans with Disabilities Act of* 1990 (ADA) prohibits workplace discrimination against employees because of their status as "disabled" within the meaning of the Act and mandates the affording of reasonable accommodations to such employees.

3. *The Family Medical Leave Act* (FMLA) mandates that covered male and female workers receive up to twelve weeks of unpaid leave within one year after major life events such as the birth or adoption of a baby, serious health conditions which render an employee unable to work, and situations in which an employee needs to be a caretaker for a family member with a serious health condition (Family and Medical Leave Act, 29 U.S.C. § 2612 2013). While this law may be useful for breastfeeding mothers who are covered by the statute and are able to take unpaid leave, once they return to work, the FMLA offers them no protection with respect to any requests to express breast milk at the workplace.

4. *The Patient Protection and the Affordable Care Act* of 2010 (PPACA), which amends Sect. 7 of the Fair Labor Standards Act (FLSA), mandates that an employer provide (1) "a reasonable break time for an employee to express breast milk for her nursing child for 1 year after the child's birth each time such employee has need to express the milk"; and (2) "a place, other than a bathroom, that is shielded from view and free from intrusion from coworkers and the public, which may be used by an employee to express breast milk" (Patient Protection and Affordable Care Act, 29 U.S.C. § 207(r)(1)-(3) 2013). Although the space provided need not be dedicated exclusively for this purpose, it must be available upon demand. The Act explicitly states that employers are not required to compensate employees for the time they spend expressing breast milk, although to the extent that breaks are compensated for all employees, a lactating woman making use of one should be treated no

differently than anyone else (Patient Protection and Affordable Care Act, 29 U.S.C. § 207(r)(1)-(3) 2013).

However, the PPACA has somewhat limited applicability (Zech 2013). In order to invoke its protections, an employee must be a nonexempt employee under the FLSA (Fair Labor Standards Act, 29 U.S.C. §213 2004); Reasonable Break Time for Nursing Mothers 2010). If, for example, a woman works for an employer with fewer than fifty employees, the employer will be exempt from compliance to the extent that compliance would confer an undue hardship on it. Further, if a woman's job is considered managerial, executive, or professional in nature, among other categories, she may be an exempt employee not covered by the Act.

Until the PPACA was enacted, plaintiffs making claims predicated upon their inability to express breast milk in the workplace had been largely unsuccessful in their attempts to vindicate their rights under Title VII, the PDA, and the ADA. Many courts simply have not traditionally been amenable to the notion that expressing breast milk at work is tantamount to discrimination against women on the basis of pregnancy, a pregnancy-related condition, or sex. (Martinez v. N.B.C., Inc. 1999; Bond v. Sterling, Inc. 1998; Barrash v. Bowen 1988; Wallace v. Pyro Mining Co. 1991; Puente v. Ridge 2009; McNill v. New York City Dep't of Corr. 1996; Fejes v. Gilpin Ventures, Inc. 1997).

In 2012, a district court in Colorado explicitly held that Title VII did not "extend to breast-feeding as a child care concern" (Falk v. City of Glendale 2012, p. 3). The court elaborated, however, that "[a] plaintiff could potentially succeed on a claim if she alleged and was able to prove that lactation was a medical condition related to pregnancy, and that this condition, and not a desire to breastfeed, was the reason for the discriminatory action(s) that she suffered" (Falk v. City of Glendale 2012, p. 3). Moreover, the court noted that a sex discrimination case could lie where employees were generally permitted bathroom breaks, but a lactating employee was denied breaks because she would be expressing breast milk (Falk v. City of Glendale 2012, p. 3). That plaintiff nonetheless failed on her claims.

The tide may be turning, however. In 2013, the Fifth Circuit Court of Appeals reversed a district court's holding that being fired for expressing breast milk was not, as a matter of law, sex discrimination in violation of Title VII (E.E.O.C. v. Houston Funding II, Ltd. 2013). The Court of Appeals stated that "lactation is a related medical condition of pregnancy for purposes of the PDA. Lactation is the physiological process of secreting milk from mammary glands and is directly caused by hormonal changes associated with pregnancy and childbirth" (E.E.O.C. v. Houston Funding II, Ltd. 2013, p. 428). The court further observed that "the issue here is not whether [the plaintiff] was entitled to special accommodations. .. but, rather, whether [the defendant] took an adverse employment action against her, namely, discharging her, because she was lactating and expressing milk" (E.E.O.C. v. Houston Funding II, Ltd. 2013, p. 429). This is significant because it refocuses the query away from what some consider the specious issue of whether gender ought to be "accommodated" under Title VII, and onto the true issue of seeing discrimination in the face of a request to express breast milk at work as

discrimination because of a pregnancy-related condition, and thus, discrimination because of sex.

Further, some courts are open to the idea that the failure to accommodate a nursing mother may, in fact, constitute pregnancy-based discrimination (E.E.O.C. v. Houston Funding II, Ltd. 2013; Martin v. Canon Business Solutions 2013; Lara-Woodcock v. United Air Lines, Inc. 2013). In a recent Colorado district court opinion, the court noted that:

> "[b]ecause human physiology is such that one only lactates as a by-product of pregnancy . . . accommodation of the need to express breast milk readily fits into a reasonable definition of pregnancy, childbirth, or related medical conditions. As such, Plaintiff's access to facilities to express breast milk is relevant to whether Defendant discriminated against her based on her pregnancy" (Martin v. Canon Business Solutions 2013, p. 8).

The PPACA, as mentioned, contains the most explicit mandate protective of lactating mothers in the workplace. However, its construction by courts looks to have limited its effectiveness. In 2012, a federal district court in Iowa decided that the PPACA did not create a private right of action against an employer that violates its requirements (Salz v. Casey's Mktg. Co. 2012). The court held that while an employee alleging violations of the Act may file a complaint with the Department of Labor, who could subsequently pursue injunctive relief in federal court, she may not initiate her own suit in court (Salz v. Casey's Mktg. Co. 2012). This is significant as the reality underlying how relief must be sought means that, as a practical matter, the timing of this process may impede a victim from retaining her employment or successfully meeting her breastfeeding goals. Further, victims are not seen to have any damages for lost wages or to compensate her for harm to her health or child.

State Laws and Breastfeeding at Work

There are currently twenty-seven states in addition to Puerto Rico and the District of Columbia with laws pertaining to the expression of breast milk in the workplace (National Conference of State Legislatures 2014). Most of these entail requirements that employers furnish employees with both adequate time to express breast milk and a private, secure room in which this may be done (e.g., Ark. Code Ann. § 11-5-116 2009; Cal. Lab. Code §§ 1030-1033 2002; Conn. Gen. Stat. § 31-40w 2001; Me. Rev. Stat. tit. 26, § 604 2009; Minn. Stat. § 181.939 1998; Mont. Code Ann. § 39-2-215, 39-2-216, 39-2-217 2007). It is explicitly stated in many of these laws that a bathroom or a toilet stall is inadequate space and some states, like Indiana, also require the expenditure of "reasonable efforts" to procure a refrigerator in which employees can store expressed breast milk (IND. CODE §§ 5-10-6-2, 22-2-14-2 2008). The vast majority of states are explicit about not requiring that the mandated breaks be paid, although the type of employer to which the statutes apply (public or private) and threshold number of employees they must have do vary.

Some jurisdictions, like the District of Columbia and New York, explicitly include breastfeeding as part of its definition of discrimination on the basis of sex (D.C. Code § 2-1402.82 2007; N.Y. Lab. Law § 206-c 2007). Others, like Washington and Texas, stop short of legislating the allocation of break time and space, and instead create "mother-friendly" or "infant-friendly" designations for employers who promulgate policies that support workplace breastfeeding (TEX. HEALTH & SAFETY CODE ANN. § 165.003 1995; WASH. REV. CODE § 43.70.640 2001). In some instances, statutes contain directives for state agencies, like Oklahoma's and Rhode Island's mandate that the Department of Health "issue periodic reports on breastfeeding rates, complaints received and benefits reported by both working breastfeeding mothers and employers" (OKLA. STAT. tit. 40, § 435 2006); R.I. GEN. LAWS § 23-13.2-1 2003).

It is important to note that while some state statutes address themselves to both breastfeeding and pumping breast milk, most only address themselves to pumping, which has led some researchers to posit that the statutes' "relative effectiveness" may vary (Murtagh and Moulton 2011, p. 217). Scholars have also noted that since less than half of the state laws in place have enforcement mechanisms and so many contain "provisions that likely dilute their effectiveness," the impact of these laws remains to be seen (Murtagh and Moulton 2011, p. 217).

Failed Proposed Law and Current Reform Efforts

The Breastfeeding Promotion Act has been introduced and reintroduced since the 105th Congress (1997–1998) until the 112th Congress (2011–2012). It would have amended Title VII to include lactation and the expression of breast milk as protected conduct under the PDA and expanded the PPACA (Breastfeeding Promotion Act of 2011, 2011). Thus, there would be more protection for lactating women at the federal level. The bill, however, never made it out of committee, and despite the fact that it has been introduced and reintroduced over again, it has never been passed.

Many individuals and breastfeeding advocacy groups, like the National Breastfeeding Center, have taken issue with the limitations and drawbacks of the PPACA's ambit of protection (Wittmeyer 2014; Hollander 2014; Saint Louis 2013). For example, the provision contains no penalty for employers who fail to comply, so many worry about its effectiveness and deem enforcement mechanisms illusory (Zech 2013, p. 17). Cries for reform continue, with many saying that only time will tell what, if any, legislative reform or judicial interpretation will provide truly comprehensive protection to all female employees who wish to express or pump breast milk in the workplace.

Concluding Remarks and Future Research Directions

The current mass media messages and public health campaigns urging women to choose breastfeeding, coupled with restrictive maternity leave options in the U.S. and inconsistent workplace lactation policies, can make the transition back to work a very stressful event for new mothers. On the bright side, a growing number of companies are valuing the benefits of healthy work and experiencing firsthand the return on investment from creating and sustaining work cultures that value health promotion and wellness (Bennett et al. 2003). Indeed, estimates suggest that organizations can get up to threefold their investment in workplace lactation programs (Tuttle and Slavit 2009), which perhaps makes this an ideal time to pursue answers to the many questions still left unanswered.

Much work is still needed to comprehend the processes underlying the influence of workplace factors on breastfeeding duration and the well-being of lactating working women. For example, the role of employment related maternal separation anxiety (Hock et al. 1989) may have important implications for balancing breastfeeding and work. That is, women may respond differently to the stressors associated with breastfeeding at work if they feel more guilt and worry from having to leave their children in non-maternal care while they work. Further, what role does career salience, or the importance of work in one's life, play in breastfeeding initiation and duration among working women in various occupations? The effectiveness of various coping strategies in buffering the strains associated with a non-supportive breastfeeding work environment has been large unexplored. Further, while breastfeeding duration is a critically important outcome, more focus is needed on the woman's strain experience. How does combining work and breastfeeding impact job attitudes and behaviors? Does breastfeeding support at work help offset the occurrence of post natal depression in working women? Indeed, the cross over effects between home and work for breastfeeding mothers are obvious and the impact of organizational policies on breastfeeding decisions has long term public health implications for future generations. Studies investigating the impact of workplace stress on the breastfeeding mother-child relationship are needed. Does the time away at work serve to enrich the time spent with the child when reunited or does the stress accumulated during work spillover onto the parenting techniques used at home? Similarly, does the physical separation from the infant caused by returning to work place any limitations on the health and psychological benefits derived from breast milk for the mother or child? These and other questions require an interdisciplinary approach to research that can more fully consider the many factors influenced by combining work and breastfeeding demands.

Which workplace lactation component is most useful to parents? Previously cited preliminary research suggests some variation among the wide range of options available, but published empirical evidence on babies-at-work programs is scarce at best. To advance this question, psychometrically sound measures of employee lactation program satisfaction and effectiveness are needed. While quite a bit of

research has focused on socio-economic status differences in breastfeeding initiation and duration, its impact on workplace lactation outcomes by means of access to better childcare or quality breast pumps has not been sufficiently explored. Further, what impact will the ACA have on the use of high quality breast pumps by working women, as insurance companies may seek ways to minimize costs associated with their requirement to make pumps available?

This chapter is largely shaped by the current conditions surrounding the breastfeeding working woman in the U.S. and recognizes that societal and cultural norms for breastfeeding play a significant influence on workplace acceptance. We have seen a strong national commitment towards breastfeeding promotion, highlighted by the rising numbers of Baby-Friendly Hospitals. We are hopeful that the emergent focus on physical and psychological wellness by organizations will be a lasting one and that, with the growing number of breastfeeding mothers rejoining the workforce, systematic efforts to educate employers, lactation accommodations, and support will be readily available.

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