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Policy matters

Access to Workplace Accommodations to Support Breastfeeding after Passage of the Affordable Care Act

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A B S T R A C T

Objectives: This study examines access to workplace accommodations for breastfeeding, as mandated by the Affordable Care Act, and its associations with breastfeeding initiation and duration. We hypothesize that women with access to reasonable break time and private space to express breast milk would be more likely to breastfeed exclusively at 6 months and to continue breastfeeding for a longer duration.
Methods: Data are from *Listening to Mothers III*, a national survey of women ages 18 to 45 who gave birth in 2011 and 2012. The study population included women who were employed full or part time at the time of survey. Using two-way tabulation, logistic regression, and survival analysis, we characterized women with access to breastfeeding accommodations and assessed the associations between these accommodations and breastfeeding outcomes.
Results: Only 40% of women had access to both break time and private space. Women with both adequate break time and private space were 2.3 times (95% CI, 1.03–4.95) as likely to be breastfeeding exclusively at 6 months and 1.5 times (95% CI, 1.08–2.06) as likely to continue breastfeeding exclusively with each passing month compared with women without access to these accommodations.
Conclusions: Employed women face unique barriers to breastfeeding and have lower rates of breastfeeding initiation and shorter durations, despite compelling evidence of associated health benefits. Expanded access to workplace accommodations for breastfeeding will likely entail collaborative efforts between public health agencies, employers, insurers, and clinicians to ensure effective workplace policies and improved breastfeeding outcomes.

The health benefits of breastfeeding for both infants and nursing mothers are well-documented. Infants who are breastfed have better health outcomes, including lower rates of respiratory and gastrointestinal tract infections, sudden infant death syndrome, allergic disease including asthma, obesity, and type 1 diabetes, among other conditions (Eidelman et al., 2012; Ip et al., 2007). Women who breastfeed have a lower risk of developing postpartum depression, type 2 diabetes, rheumatoid arthritis, and breast and ovarian cancers (Eidelman et al., 2012). Breastfeeding for longer periods and breastfeeding exclusively (breast milk only, without infant formula supplementation) are associated with greater health benefits (Eidelman et al., 2012).

Current public health and clinical guidelines recommend breastfeeding exclusively for 6 months, with continued breastfeeding for 1 year or longer (Eidelman et al., 2012; World Health Organization, 2001); however, many women fall short of meeting these guidelines. In the United States, breastfeeding initiation has increased in recent years, with rates reaching 79% in 2011 (compared with 75% in 2008; Centers for Disease Control

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and Prevention, 2012). Rates of breastfeeding exclusively through the first 6 months postpartum are also increasing, but reached only 18.8% of births in 2011 (Centers for Disease Control and Prevention, 2013). Although breastfeeding initiation rates have increased, some Healthy People targets remain unmet for vulnerable subgroups of women, as are Healthy People 2010 standards for breastfeeding exclusively (Centers for Disease Control and Prevention, 2012). In addition, many women do not meet their own personal goals for breastfeeding exclusively (Perrine, Scanlon, Li, Odom, & Grummer-Strawn, 2012). Subgroups of women facing barriers to breastfeeding include employed mothers, racial/ethnic minorities, and low-income women (Centers for Disease Control and Prevention, 2007).

In addition to health effects, breastfeeding may have significant financial benefits to society. One cost study showed that if 90% of U.S. women breastfed exclusively for 6 months, the nation would save $13 billion and prevent 911 deaths per year; most of these preventable deaths would occur among infants (Bartick & Reinhold, 2010). However, the economic effect of breastfeeding in the workplace is not generally captured in revenue flows, whereas the administrative and logistical challenges of providing workplace breastfeeding support are evident to employers and employees.

Over the past four decades, the labor force participation of U.S. childbearing women has increased substantially. Two-thirds of women giving birth for the first time between 2006 and 2008 reported working for an employer during their pregnancies. Nearly 60% of women employed during pregnancy had returned to work within 3 months, and 72% had returned to work 12 months postpartum (Laughlin, 2011). Prior research shows that prenatal employment has a negative effect on early exclusive breastfeeding (Attanasio, Kozhimannil, McGovern, Gjerdingen, & Johnson, 2013). Full-time maternal employment has been cited as a reason for early cessation of breastfeeding, and intention to return to work and full-time employment postpartum are associated with an increased risk of no breastfeeding (Fein & Roe, 1998; Hawkins, Griffiths, & Dezateux, 2007; Lindberg, 1996; Mandal, Roe, & Fein, 2010; Ogbuanu, Glover, Probst, Hussey, & Liu, 2011; Ryan, Zhou, & Arensberg, 2006). In addition, there are well-documented sociodemographic disparities in breastfeeding, regardless of employment status. Non-Hispanic Black women have lower breastfeeding rates than non-Hispanic White and Mexican-American women (Li, Darling, Maurice, Barker, & Grummer-Strawn, 2005). Rates of breastfeeding initiation are lower among low-income women, particularly those who are younger, unmarried, or have no college education (Ahluwalia, Morrow, & Hsia, 2005; Khoury, Moazzem, Jarjoura, Carothers, & Hinton, 2005). Low-income women may have a particularly difficult time managing both breastfeeding and employment because of their specific employment circumstances, such as hourly employment with limited break time, a lack of facilities for pumping and storing breast milk, service industry work requiring continuous customer contact, or limited support from employers or coworkers (Committee on Healthcare for Underserved Women, 2013; Kimbro, 2006).

The Affordable Care Act (ACA) of 2010 includes workplace-related provisions to address breastfeeding barriers among employed women (Patient Protection and Affordable Care Act, 2010). Section 4207 of the ACA amends the Fair Labor Standards Act and applies to all employees who are nonexempt from Section 7 of the Fair Labor Standards Act, including employees working for companies engaged in interstate commerce whose total annual sales exceed $500,000, health care facilities, schools, or public agencies. The amendment, which took effect when the ACA was signed on March 23, 2010, requires employers to provide reasonable break time and a private place, other than a bathroom, for breastfeeding mothers to use a breast pump to express their breast milk during the workday for at least 1 year postpartum ("Reasonable break time for working mothers," 2011). Employers with fewer than 50 employees can file for exemption if they prove that providing these accommodations poses undue hardship ("Reasonable break time for working mothers," 2011). The absence of such requirements has been noted previously as a substantial obstacle to breastfeeding (Shealy, Li, Benton-Davis, & Grummer-Strawn, 2005; United States Breastfeeding Committee, 2010). These provisions are expected to be particularly beneficial for women who have faced heightened barriers to breastfeeding (Drago, Hayes, & Yi, 2010). However, no studies of access to these supportive practices among employed women have been conducted since the ACA was passed.

The goal of this study is twofold: 1) to characterize the women who have access to breastfeeding accommodations in the workplace and 2) to examine the association between these accommodations and breastfeeding outcomes, including any breastfeeding and breastfeeding exclusively at 6 months postpartum and overall breastfeeding duration.

Materials and Methods

Data and Study Sample

We analyzed data from the Listening to Mothers III survey, commissioned by Childbirth Connection and conducted online by Harris Interactive. The core survey, administered between October and December 2012, contained responses from a national sample of 2,400 women who gave birth in U.S. hospitals between July 2011 and June 2012. A follow-up postpartum survey, conducted January through April 2013 among the same sample, had 1,072 respondents. Harris Interactive used a survey methodology in which eligible participants were recruited from a national panel. Harris Interactive also weighted the data (based on demographics and access to the Internet) to ensure that the group of respondents was nationally representative. Information about the Listening to Mothers III survey is available on the survey website (www.childbirthconnection.org/listeningtomothers/). In addition to data on women's pregnancy and intrapartum experiences, the survey captured several unique breastfeeding-related measures. The surveys contained information on workplace accommodations for nursing mothers and past breastfeeding experiences, as well as important sociodemographic factors such as marital status, education, insurance coverage, and family income. Researchers have used data from earlier Listening to Mothers surveys to successfully analyze various maternity-related issues, including breastfeeding, but this is the first examination of access to and effects of workplace-based breastfeeding support (Attanasio et al., 2013; Declercq, Labbok, Sakala, & O'Hara, 2009).

The sample for this analysis included respondents who affirmed employment at the time of the postpartum survey ($n = 550$). Further survey questions identified full- or part-time work, and whether self-employed or working for an employer. The survey did not collect information on firm size. This study was exempted from Institutional Review Board (IRB) review by the University of Minnesota IRB (study number 1011E92983).