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Introduction: *Maintaining lactation after returning to work is imperative for overall breastfeeding success, yet mothers who return to full-time employment outside the home are unlikely to meet their breastfeeding goals. Breastfeeding-friendly worksites are one potential solution.*

Method: *Using semi-structured interviews with employees in one rural New England town (N = 18), we aimed to better understand the barriers and supports to continued lactation at "breastfeeding-friendly" worksites.*

Results: *Five key themes emerged from participants' narratives; two built environment-focused themes are discussed here.*

Discussion: *Findings expose the disproportionate burden placed on women when care- and wage-work are combined, even in worksites at least theoretically committed to supporting lactation following a return to work.*

Keywords: lactation; employment; occupational stress; qualitative research

Despite decades of research indicating that breastfeeding benefits both the health of mother and child, the U.S. still falls far short of national goals for both initiation and maintenance of breastfeeding at the population-level (U.S. Department of Health and Human Services, 2013). One issue preventing the U.S. from reaching these goals is the lack of paid maternity leave, a feature peculiar to the U.S. relative to other high-resource nations (Aitken et al., 2015; Guendelman et al., 2009; Huang & Yang, 2015). Because we do not have universal paid leave for postpartum women, many are forced to return to work within weeks of birth, meaning that people who are breastfeeding must find a way to combine working with pumping—a difficult task which, in turn, leads to earlier weaning (Huang & Yang, 2015). There are federal regulations, such as the *Break Time for Nursing Mothers Law*, covered by the *Affordable Care Act* update to the *Fair Labor Standards Act*, designed to help women combine work with lactation. These regulations include reasonable time allotted for pumping breaks (federal law does not require this time to be paid) and private space, other than a bathroom, for expressing breast milk (though the space does not have to be permanent or a dedicated lactation space; Fair Labor Standards Act of 1938).

Furthermore, the Centers for Disease Control and Prevention (CDC), as part of their Workplace Health ScoreCard (HSC) initiative, developed a 122-question worksite assessment tool for quality improvement that includes lactation-specific questions allowing employers to be designated as "breastfeeding-friendly" if they met certain standards (see left column of Table 1). Our overall objective, for this article and the companion piece (Cheyney et al., 2019), was to describe women's experiences of continuing lactation while returning to a worksite that has been designated as "breastfeeding-friendly." In this article, we describe experiences related to the physical spaces.

Method

Detailed methods are described in the companion article (Cheyney et al., 2019). Briefly, we recruited 21 women who, in the last 5 years, had attempted to continue lactating after returning to employment at

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Table 1. CDC Worksite HSC Lactation-Support Questions and Revisions

Questions[a]	Suggested Revisions[b]
During the past 12 months, did your worksite:	During the past 12 months, did your worksite:
1. Have a written policy on breastfeeding for employees? *Answer, "yes" if the policy is included as a component of other employee policies or as a separate policy related to breastfeeding.*	1. Have a clearly written policy on breastfeeding for employees that is accessible and involves a plan for implementing, evaluating, and modifying the policy as needed? *Answer, "yes" if the policy is included as a component of other employee policies or as a separate policy related to breastfeeding.*
2. Provide a private space (other than a restroom) that may be used by an employee to express breast milk?	2. Provide a private, dedicated, single-use, lockable space (other than a restroom) with outlets, comfortable chair/s, a sink, a table or shelf, and a refrigerator to store breast milk that may be used by an employee to express breast milk?
3. Provide access to a breast pump at the worksite?	3. Provide stigma-free, easy access for purchasing and/or using an available breast pump at the worksite?
4. Provide flexible paid or unpaid break time to allow mothers to pump milk?	4. Provide multiple, flexible, paid or unpaid daily break times to allow mothers to pump milk as needed, for the entire duration of breastfeeding?
5. Provide free or subsidized breastfeeding support groups or educational classes? *Answer, "yes" if these sessions address breastfeeding as a single health topic or if breastfeeding is included with other topics. These sessions can be provided in-person or online, onsite or offsite, in-group or individual settings, through vendors, on-site staff, health insurance plans, programs, community groups, or other practitioners.*	5. Provide access to free or subsidized breastfeeding support groups and educational classes for all employees and employers, as part of creating and maintaining a supportive work environment where all employees can be valued for their productive and reproductive labors? *Answer, "yes" if these sessions address breastfeeding as a single health topic or if breastfeeding is included with other topics. These sessions can be provided in-person or online, onsite or offsite, in-group or individual settings, through vendors, onsite staff, health insurance plans, programs, community groups, or other practitioners.*
6. Offer paid maternity leave, separate from any accrued sick leave, annual leave, or vacation time?	6. No change suggested for criterion #6. More research is needed.

Note. CDC = Centers for Disease Control and Prevention; HSC = Health ScoreCard. A comparison of the CDC HSC lactation-support questions (questions 42 to 47 on the HSC) compared to suggested revisions that emerged from in-depth, semi-structured interviews with breastfeeding mothers ($N = 21$) who shared their experiences of returning to work with the intention of continuing to breastfeed at a worksite that was self-evaluated as "breastfeeding-friendly."

[a]The CDC's original lactation-support questions from the HSC, developed in 2013.

[b]Our suggested revisions, developed in 2017.

a worksite that had been evaluated as "breastfeeding-friendly" using the CDC HSC. We conducted semi-structured interviews that were patterned after the HSC criteria, combined with open-ended, follow-up questions to elicit a more thorough description of women's experiences, unconstrained by *a priori* categories. This approach allowed us to saturate themes (Fusch & Ness, 2015) associated with the HSC, while also allowing subthemes to emerge organically. Audio-recorded interviews were transcribed verbatim, and then independently coded for themes by four of the authors; disagreements were resolved through discussion and revisiting of transcripts until consensus could be achieved (Sweeney, Greenwood, Williams, Wykes, & Rose, 2013). The Institutional Review Board at Oregon State University approved the study protocol, and all participants provided verbal informed consent.

Results

Demographic characteristics of the sample are summarized in Table 1 of the companion article (Cheyney et al., 2019). As expected, given the HSC-based structure of the interview prompts, issues raised by participants clustered around the six HSC lactation-support criteria (see Table 1). The following five key themes, which mirror the first five HSC lactation items, emerged from participants' narratives: (a) "Closing the gap": written policies are not enough; (b) A "private space" for milk expression: barriers and supports in the built environment; (c) Breast pump accessibility: exploring what "access" means in this context; (d) Flexibility: rights versus favors; and (e) "We need a cultural shift!": moving beyond support groups and breastfeeding education. We identified but did not achieve concept saturation for the theme related to the sixth criterion (paid maternity leave, discussed further in the companion piece, Cheyney et al., 2019).

Below we describe themes two and three, which are focused on the built environment of the workplace, using participants' narratives to illustrate their experiences of attempting to continue breastfeeding in a workplace that had been officially deemed "breastfeeding-friendly."

Theme 2. A "Private Space" for Milk Expression: Barriers and Supports in the Built Environment

This theme relates to the second HSC lactation-support criterion, which requires that employers provide a private, non-restroom space for breast milk expression. Some aspects of the built environment at participants' worksites were experienced as obstacles, others as supports. The most significant barrier to breast milk expression occurred when the designated "private space for milk expression" functioned, in practice, as a shared, multi-purpose space. Participants discussed having to "compete for space" or "struggling to fit milk expression in" quickly and under pressure because someone else needed the room. One participant explained:

> *I think if you have your own office, you're fine, but if you don't, finding a place to pump that is truly private where no one else is trying to get in to use the room for something is a big problem.*

When the "private space" for milk expression was, in practice, a multi-purpose space, returning to work while breastfeeding was described as stressful, even "destined to fail," because of the necessity of having to negotiate for time and space with co-workers and management. One participant said:

> *I wasn't sure whether people were in there at certain times of the day, and it was nerve-racking. I had to knock and tell my male colleague [who was also her supervisor] that I needed the space. He said he thought I would only need it once a day, and I was totally stressed out having to describe to him how pumping for a newborn works.*

This participant felt that having to negotiate for more time in a shared, multi-purpose space, or even having to talk about breastfeeding with her male boss was "mortifying." She described that conversation as having "undermined" her professionalism "in some intangible way." Ultimately, this participant believed that as a result of these stressors she was not able to breastfeed for as long as she had planned.

Another participant described her "choice" of early cessation of breastfeeding after returning to her breastfeeding-friendly workplace as a direct result of the designated lactation room functioning as a multi-purpose space:

> *Our designated space was a room that also had the only shower in it. So, my co-workers would work out during lunch, and then want to get in there to take a shower. It was awful. I would be in there trying to pump, and they were outside beating on the door wanting to get in for a shower.*

She described being angry as she looked back on that time. However, in the moment, she "just felt humiliated having to walk out of there holding my pump and my milk."

In addition to the need for a single-use, private space, the contents of that space are also critical. One participant reported having to breast pump in a room that had no furniture:

> *You could pump in there, but you would have to drag a chair in because there was no place to sit . . . the door does lock, but it was a little weird because there was no table, so everything had to go on the floor.*

Another participant, in discussing the need for a place to store breast milk said, with reference to some co-workers:

> *We had someone here that did not like having breast milk in the fridge near her food . . . so the mom who was breastfeeding had to have someone pick up her milk after she breast pumped. The only way that worked was that I think her mother lived in the area and was retired.*

In contrast, two participants had very positive experiences with the built environment of their worksite. Both attributed their success to the fact that they had access to a private, dedicated, single-use, lockable space with the following amenities: electrical outlets, a comfortable chair, a sign-up sheet outside the door, a sink, and space to store milk. Both stressed that they did not feel pressured by other demands for the space and that they realized from talking to breastfeeding mothers from other worksites that this was essential.

The HSC follows the minimum federal guidelines that require a space other than a bathroom. However, participants' experiences of the "private, non-bathroom spaces" provided by some worksites suggests that this criterion is inadequate. If a breastfeeding employee has to negotiate for space with co-workers, or if the room is inadequately equipped, the benefits of having a space cannot be fully realized.

Theme 3. Breast Pump Accessibility: Exploring What "Access" Means in This Context

The HSC credits worksites for providing access to breast pumps because this form of support has been shown to increase breastfeeding duration after returning to work (Tsai, 2013). "Access to breast pumps" is not clearly defined in the HSC. One state-level coalition defined access as either physical access to a breast pump at a mother's worksite that the employer can purchase or rent or help employees purchase and receive a breast pump through their worksite (Beth, Branch, Holloway, & Sullivan, 2013). Participants' narratives concur: this is a critical aspect of supporting employed, breastfeeding mothers. However, few of the worksites represented in this study provided access to breast pumps in a way that met the needs of returning employees**.** One participant described her experience of trying to acquire a breast pump before giving birth:

> *The HR [human resources] women asked why I needed to pump, [because] I had not even had the baby yet . . . So, they just don't get it. It took me four weeks to get one, and that is precisely why I started in the prenatal period. I know how these things work. It was really frustrating.*

She went on to question:

> *So if we are a "family-friendly" workplace, why is this so hard? What if I had not pushed so hard? HR even commented on how persistent I was. Do they want people to give up, I wonder?*

Barriers to accessing breast pumps were experienced at multiple levels, from employees who struggled with human resource staff to struggles with insurance companies moving slowly or requesting multiple rounds of documentation to approve or reimburse breast pump purchases. Some participants ultimately obtained breast pumps through their worksites, but not always in time to return to work as planned. Many purchased breast pumps out-of-pocket and took them to and from work until access at work could be guaranteed, though in some cases, this effectively never occurred.

Three participants described feeling like breast pumps *were* accessible, and they noted some specifics: helpful assistance acquiring a breast pump; space for washing and maintaining breast pump components; and a place to store breast milk. One participant summarized her experience:

> *Having access to a pump means something to me that is more than just hey, there is a pump in the building. It means that the worksite helps rather than hinders the process of getting one, then when you get one, there is a space to use it, clean it, and store what comes out of it. Otherwise what good is it? Just having a pump I mean.*

Such experiences caused participants to question what "access" means in this context: just having a breast pump at the work site did not ensure useful access.

Discussion

Participants' narratives indicate that adherence, on paper, to the HSC lactation-support criteria does not, by itself, necessarily result in a worksite that is experienced by women as breastfeeding-friendly. Specifically, participants described a disconnect between written policies and implementation (theme 1); a need for improved access to single-use, adequately equipped private spaces for breast milk expression (theme 2); and readily available worksite breast pumps (theme 3). Participants also indicated a need for substantial outreach and education efforts for co-workers and supervisors that might enable flexible, stigma-free breaks for breast milk expression (theme 4), as well as an overall cultural shift in the workplace (theme 5) toward genuinely valuing and supporting breastfeeding employees, given that breastfeeding is associated with so many individual-, corporate-, and societal-level benefits (Bai & Wunderlich, 2013; Boyer, 2014; CDC, 2011; Frank, 1997; Hausman, 2013; ICAN: Infant, Child, & Adolescent Nutrition, 2012; Murtagh & Moulton, 2011; National Business Group on Health, 2010; Smith & Forrester, 2013; Spitzmueller et al., 2015; Stuebe, 2014).

The HSC lactation support items are a critical starting point for evaluating workplace climate and built environment needs of breastfeeding employees. However, we posit that, as currently written, the first five HSC lactation-support items are insufficient, allowing worksites to be described as "breastfeeding-friendly" when in practice, from the perspective of breastfeeding employees, they may not be. As such, we have proposed specific wording revisions to the HSC lactation-support items (see Table 1 for a comparison of current and revised HSC language).

Current breastfeeding-friendly criteria allow for high variability in workplace climates and implementation that may leave some employees questioning the practical value of "breastfeeding-friendly worksites." Based on our findings, we recommended adding more detailed language to the HSC lactation-support criterion to potentially reduce the gaps between written criteria and lived experiences as informed by participants' narratives about returning to work while breastfeeding. For example, above we describe the inadequacies of the second HSC lactation-support item, which currently reads: "Provide a private space (other than a restroom) that may be used by an employee to express breast milk." The improved specificity gained by adding the following qualifiers: "dedicated, single-use, lockable space with outlets, comfortable chair/s, a sink, a table or shelf, and a refrigerator to store breast milk," more clearly captures the precise needs described by participants who wished to continue to lactate after returning to work. Participants were careful to emphasize that these are essential components, not "appreciated amenities" (Office on Women's Health, 2018).

In addition, as we reflected on our experiences of talking with participants, we were all struck by the call for greater support from supervisors and employers. Participants saw those in positions of authority as most in need of education, largely because they are perceived as having the greatest power to shift the culture of the workplace. Hence, we have suggested a shift in the language of the fifth HSC lactation-support criterion (in bold) from: "Provide free or subsidized breastfeeding support groups or educational classes," to "Provide **access to** free or subsidized breastfeeding support groups **and** educational classes **for all employees and employers, as part of creating and maintaining a supportive work environment where all employees can be valued for their productive and reproductive labors.**"

Similarly, the fourth HSC lactation-support criterion currently reads: "Provide flexible paid or unpaid break time to allow mothers to pump milk." This could be more effective if employers assumed the responsibility of modeling a stigma-free climate wherein workplaces: "Provide **multiple**, flexible, paid or unpaid **daily** break time**s** to allow mothers to pump milk **as needed, for the entire duration of breastfeeding.**" Participants' narratives make clear: sociocultural change must begin at the top of workplace hierarchies.

To our knowledge, this study is the first qualitative evaluation of the lactation-support questions on the CDC's HSC. Given the gap between the HSC lactation items and the lived experience of returning to work while breastfeeding identified in this work, one can easily appreciate the importance of evaluation (Turnock, 2012). We found that current HSC-based practices are insufficient to ensure what they intend: that returning employees are able to access the supports that will enable them to continue breastfeeding.

In a feminist critique of the cultural politics of combining lactation with wage-work, Boyer (2014) interrogates the impact of the *2011 Reasonable Break Time for Nursing Mothers* provision of the Patient Protection and

Affordable Care Act, asking: "What kind of normative conceptions of working motherhood does this legislation enable?" Instead of seeing *Reasonable Break Time* as a means of promoting infant and maternal health and wellbeing, Boyer argues that this legislation, in as far as it seeks to harmonize the demands of wage-work and care-work, is highly extractive and exploitative of women. In "codifying this one solution to workplace lactation in the absence of expanded paid maternity leave or workplace breastfeeding, *Reasonable Break Time* fails to deliver policy support for the range of embodied maternal practices" (Boyer, 2014). That is, the exclusive focus on workplace pumping constrains the "politics of the possible" (Mouffe, 2005; Ranciere, 2010), preventing the exploration of alternative ways of combining lactation with wage-work, such as creating spaces for infants at worksites and offering longer paid maternity leave to all new mothers. We recognize that the modifications to the HSC we propose here are, at best, a short-term, stop-gap solution to a policy that requires much deeper and more comprehensive reform if we truly aim to reduce costly morbidities associated with the early cessation of breastfeeding.

Limitations

We appreciate that our data come from a homogeneous sample of primarily white, college-educated, full-time, and salaried employees living in one rural area in New England, and thus likely do not reflect the broader array of experiences of breastfeeding employees across the U.S. This is a function of the research question, the types of employers who aimed to be breastfeeding-friendly, and of the recruitment strategy wherein we did not explicitly recruit a cross-section of all people in the research community who returned to work with the intention to continue breastfeeding.

Hourly-wage laborers, for example, are conspicuous in their absence. However, if White, college-educated, salaried, middle-class employees at breastfeeding-friendly worksites struggle to combine care- and wage-work, how much more challenging might continued lactation be for minimum-wage, single- parent workers of color (California WIC Association, 2009)? Our findings thus likely underestimate the barriers to continued breastfeeding after returning to work for the majority of U.S. women.

Rather than aiming to represent all women, the purpose of this project, as with all qualitative research, was to gain a deeper understanding of a specific phenomenon from the perspective of the participants. The rewording of the HSC lactation-support criteria we propose is an important starting place. Increasing the precision of the language raises the bar for workplaces and may help to reduce the gap between theory and practice elucidated by participants' narratives. In addition, because we did not achieve concept saturation on the sixth HSC lactation-support criterion ("Offer paid maternity leave, separate from any accrued sick leave, annual leave, or vacation time"), we were unable to fully assess how this final lactation-related item was experienced by breastfeeding individuals as they returned to work. Our findings suggest some new directions for the implementation and evaluation of evidence-informed workplace breastfeeding policies.

Conclusion

Dinour and Szaro (2017), in their recent systematic review of the research on employer-based programs to support breastfeeding individuals, argued that "maintaining breastfeeding while working is not only possible but also more likely when employers provide the supports that women need to do so." The five key themes identified in this study provide a qualitative assessment of what those supports might look like. Analysis of participant's breastfeeding experiences after returning to work indicate several specific suggestions that worksite wellness programs and current assessment tools can incorporate to more effectively support successful breastfeeding even within worksites already designated as "breastfeeding-friendly."

In addition, breastfeeding advocates could engage in some specific actions aimed at reducing barriers for women who wish to continue lactating following a return to work. Specifically, lactation consultants and breastfeeding coalition members could create materials for human resource departments that educate about the importance of creating occupational and workplace cultures that are expressly supportive of breastfeeding and breastfeeding employees. Such supports could go a long way toward initiating the cultural shifts participants claimed were essential to maintaining truly breastfeeding-friendly workspaces. Readers and advocates could also reach out to local Chambers of Commerce to help educate businesses or contact unions to inform them about the importance of negotiating for lactation supports at worksites.

Our team shared these findings with the State Department of Health and Human Services, the local community Health Department, and the CDC, and testing of the revised criteria proposed here is currently

underway in one state. They also highlight the need for larger-scale reform including greater access to paid leave. In the words of one participant: "If workplaces want women to continue to breastfeed after returning to work because of all the benefits to society and so on, then they must be committed to doing more than checking boxes on a scorecard."

References

Aitken, Z., Garrett, C. C., Hewitt, B., Keogh, L., Hocking, J. S., & Kavanagh, A. M. (2015). The maternal health outcomes of paid maternity leave: A systematic review. *Social Science & Medicine*, *130*, 32–41. doi:10.1016/j.socscimed.2015.02.001

Bai, Y., & Wunderlich, S. M. (2013). Lactation accommodation in the workplace and duration of exclusive breastfeeding. *Journal of Midwifery & Women's Health*, *58*(6), 690–696. doi:10.1111/jmwh.12072

Beth, D., Branch, H., Holloway, B., & Sullivan, C. (2013). *Eat smart North Carolina: Businesses leading the way in support of breastfeeding* [PDF]. Retrieved from http://www.eatsmartmovemorenc.com/Breastfeeding/Texts/ESMM_BreastfeedingGuide-PrintRes.pdf

Boyer, K. (2014). "Neoliberal motherhood": Workplace lactation and changing conceptions of working motherhood in the contemporary U.S. Feminist Theory. *15*(3), 269–288. doi:10.1177%2F1464700114545321

California WIC Association. (2009). *Increasing breastfeeding in the low-wage worksite* [PDF]. Retreived from http://www.calwic.org/storage/documents/wellness/bf_worksite.pdf

Centers for Disease Control and Prevention. (2011). *The surgeon general's call to action to support breastfeeding*. Retrieved from https://www.cdc.gov/breastfeeding/promotion/calltoaction.htm

Cheyney, M., Henning, M., Horan, H. L., Bovbjerg, M., & Ferguson, M. (2019). From policy to practice: Women's experiences of breastfeeding-friendly worksites, part 1. *Clinical Lactation, 10*(3), XX-XX.

Dinour, L. M., & Szaro, J. M. (2017). Employer-based programs to support breastfeeding among working mothers: A systematic review. *Breastfeeding Medicine*, *12*(3), 131–141. doi:10.1089/bfm.2016.0182

Fair Labor Standards Act of 1938, 29 USC § 7.

Frank, E. (1997). Breastfeeding and maternal employment: Two rights don't make a wrong. *The Lancet*, *352*(9134), 1083–1084. doi:10.1016/S0140-6736(05)79752-X

Fusch, P. I., & Ness, L. R. (2015). Are we there yet? Data saturation in qualitative research. *The Qualitative Report*, *20*(9), 1408–1416.

Guendelman, S., Kosa, J. L., Pearl, M., Graham, S., Goodman, J., & Kharrazi, M. (2009). Juggling work and breastfeeding: Effects of maternity leave and occupational characteristics. *Pediatrics*, *123*(1), e38–e46. doi:10.1542/peds.2008-2244

Hausman, B.L. (2013). Breastfeeding, rhetoric, and the politics of feminism. *Journal of Women, Politics & Policy*, *34*(4), 330–334. doi:10.1080/1554477X.2013.835673

Huang, R., & Yang, M. (2015). Paid maternity leave and breastfeeding practice before and after California's implementation of the nation's first paid family leave program. *Economics & Human Biology*, *16*, 45–59. doi:10.1016/j.ehb.2013.12.009

ICAN: Infant, Child, & Adolescent Nutrition. (2012). *Breastfeeding disparities: Challenges and solutions*. Retrieved from http://journals.sagepub.com/doi/pdf/10.1177/1941406412453564

Mouffe, C. (2005). *On the political*. London, England: Routledge.

Murtagh, L., & Moulton, A. (2011). Working mothers, breastfeeding, and the law. *American Journal of Public Health*, *101*(2), 217–223. doi:0.2105/AJPH.2009.185280

National Business Group on Health. (2010). *Investing in workplace breastfeeding programs and policies*. Retrieved from https://www.businessgrouphealth.org/pub/?id=f2ffe4f0-2354-d714-5136-79a21e9327ed

Office on Women's Health. (2018). *Supporting nursing moms at work: What employers need to know*. Retrieved from the Office on Women's Health website: https://www.womenshealth.gov/supporting-nursing-moms-work/what-law-says-about-breastfeeding-and-work/what-employers-need-know

Ranciere, J. (2010). *Dissensus: On politics and aesthetics*. London, England: Continuum.

Smith, J. P., & Forrester, R. (2013). Who pays for the health benefits of exclusive breastfeeding? An analysis of maternal time costs. *Journal of Human Lactation*, *29*(4), 547–555. doi:10.1177/0890334413495450

Spitzmueller, C., Wang, Z., Zhang, J., Thomas, C.L., Fisher, G.G., Matthews, R.A., & Strathearn, L. (2015). Got milk? Workplace factors related to breastfeeding among working mothers. *Journal of Organizational Behavior*, *37*(5), 692–718. doi:10.1002/job.2061

Stuebe, A. M., & Schwarz, E. B. (2010). The risks and benefits of infant feeding practices for women and their children. *Journal of Perinatolology*, *30*(3), 155–162. doi:10.1038/jp.2009.107

Sweeney, A., Greenwood, K. E., Williams, S., Wykes, T., & Rose, D. S. (2013). Hearing the voices of service user researchers in collaborative qualitative data analysis: The case for multiple coding. *Health Expectations*, *16*(4), e89–e99. doi:10.1111/j.1369-7625.2012.00810.x

Tsai, S. Y. (2013). Impact of a breastfeeding-friendly workplace on an employed mother's intention to continue breastfeeding after returning to work. *Breastfeeding Medicine*, *8*, 210–206. doi:10.1089/bfm.2012.0119

Turnock, B.J. (2012). *Public Health: What it is and how it works* (5th ed.). Burlington, MA: Jones and Bartlett Learning.

U.S. Department of Health and Human Services. (2013). *Healthy people 2020*. Retrieved from https://www.healthypeople.gov/

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