Response to DACOWITS RFI W6:

Health and Welfare of Pregnant and Postpartum Women

Prepared for the DACOWITS Business Meeting: September 2015

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The Committee is interested in reviewing medical research and laws that support the health and welfare of pregnant and postpartum women.

The Committee requests a literature review in the form of a written response from Insight on medical studies and research related to pregnancy, postpartum and breastfeeding policies and/or regulations, and federal and/or state laws which delineate the rights of pregnant and postpartum mothers. Examples may include:

- Pregnancy, postpartum, and breastfeeding policies in the civilian sector;
- Current Federal Government policy on pregnancy, postpartum, and breastfeeding for federal workers;
- Laws that protect the rights of nursing mothers in the workplace, time provided, and outline the type of space which must be provided;
- Standard or average length of civilian sector pregnancy/maternity leave policies (e.g., Family and Medical Leave Act);
- Medical correlations between postpartum depression and military deployments; and
- Medical reasoning in regards to the health of the mother and the infant, which supports the need for postpartum operational deferment.

Introduction

The Defense Advisory Committee on Women in the Services (DACOWITS) has a longstanding interest in issues affecting pregnant and postpartum Service members, including the rules and regulations that govern their daily experiences on the job. Most recently, at the June 2014 quarterly meeting, representatives from each Service briefed the Committee on their respective branches' pregnancy, breastfeeding, postpartum fitness testing, and operational deferment policies. To develop a fuller understanding of the context and rationale for these policies, the Committee requested a literature review outlining the laws that support pregnant and postpartum women as well as the medical research justifying these protections. This document begins with an overview of the nationwide laws that protect pregnant, postpartum, and breastfeeding workers, followed by a description of the policies that apply to Federal workers and private-sector workers. The next section focuses on the medical literature that underpins some of these policies, and the document concludes with a discussion of postpartum depression as it relates to the general population and Service members.

Nationwide Laws Protecting the Rights of Pregnant, Postpartum, and Breastfeeding Workers

Table 1 outlines the key legislation that protects the rights of pregnant, postpartum, and breastfeeding workers in the United States. It is divided into three sections; the first includes foundational legislation applicable to the majority of workers, the second highlights legislation specific to pregnancy and nursing, and the third outlines State-specific legislations and protections.

Currently, among 173 countries, the United States is one of only four without a national policy requiring paid maternity leave (the others are Swaziland, Liberia, and Papua New Guinea).[1]

Table 1. Nationwide Laws Protecting the Rights of Pregnant, Postpartum, and Breastfeeding Workers

Law	Summary	Who is covered?
FOUNDATIONAL LEGISLATION *These laws apply to workers with a broad range of family, medical, or disability-related needs. The diverse population that they protect may include pregnant, postpartum, and breastfeeding workers; workers who have adopted a child; and/or workers who are experiencing temporary pregnancy-related impairments. They apply to workers across a range of sectors, including those employed by certain government and private employers.*		
Family Medical Leave Act (FMLA) *Effective August 5, 1993, for most employers and employees* *Effective February 25, 2015, updated definition of spouse to include same-sex spouses*	The FMLA requires covered employers to provide eligible employees with 12 weeks of unpaid, job-protected leave for certain family and medical reasons. This includes the following pregnancy and parenting-related reasons: • The birth of a child • The care of a newborn within one year of birth • The care of an adopted or foster child within one year of placement • The care of a child with a serious health condition • A serious health condition (including pregnancy) that makes an employee unable to perform the essential functions of his or her job. The law requires the continuation of health insurance coverage on the same terms as before the leave. Covered employers are prohibited from discriminating against employees who take FMLA leave, and must treat FMLA leave the same as other comparable types of leave for purposes of accruing seniority and benefits. After the leave is over, employees have the right to reinstatement to the same job they had prior to taking leave, or one of similar pay and level.	**COVERED EMPLOYERS:** • Public agencies, including State, local, and federal employers • Local education agencies (schools) • Private employers with 50 or more employees in 20 or more workweeks in current/ preceding calendar year **ELIGIBLE EMPLOYEES:** • Work for covered employer • Have worked for employer for at least 12 months • Have worked 1,250 hours during 12 months before leave • Work at a location where employer has at least 50 employees within 75 miles
Americans With Disabilities Act (ADA) *Signed into law July 26, 1990* *Amendment effective January 1, 2009; expanded*	The ADA makes it unlawful for an employer to discriminate against or harass a qualified employee because of his or her disability. The ADA also requires employers to provide reasonable accommodations to employees with disabilities, unless those accommodations would constitute an undue hardship for the employer. Although pregnancy alone is not considered a disability by the courts, the ADA provides protection for workers with pregnancy-related impairments, such as gestational diabetes or preeclampsia. Therefore, an employer may have to provide a reasonable accommodation—such as leave or modifications that enable an employee to perform her job—for a disability related to pregnancy, absent undue hardship such as significant difficulty or expense.	• Employers with 15 or more employees • Applies to private employers, State and local governments, employment agencies, and labor unions

Law	Summary	Who is covered?
protections for temporarily disabled workers		
LEGISLATION SPECIFIC TO PREGNANCY AND NURSING *The following laws were designed specifically to protect the rights of pregnant, postpartum and breastfeeding workers. As with the FMLA and ADA, they apply to workers across a range of sectors, including those employed by certain government and private employers.*		
Pregnancy Discrimination Act (PDA) of 1978 *Approved October 31, 1978* *U.S. Equal Employment Opportunity Commission updated enforcement guidance on June 25, 2015*	The PDA made clear that Title VII of the Civil Rights Act, which prohibits discrimination on the basis of sex, also prohibits discrimination on the basis of pregnancy. The law requires that women affected by pregnancy, childbirth, or related medical conditions be treated the same for all employment-related purposes, including job benefits, as other workers who are similar in their ability or inability to work. The PDA applies to hiring, promotion, benefits, firing, and all other terms and conditions of employment. The PDA's pregnancy-related protections are as follows: • Freedom from discrimination or harassment on the basis of pregnancy or related condition (including miscarriage, pregnancy termination, recovery from childbirth, lactation) • Freedom from discrimination motivated—even just in part—by pregnancy condition, such as being fired for being pregnant and unmarried • Same access to job modifications—such as light duty—as other temporarily disabled employees have • Freedom from being "pushed out" of the workplace or required to take early leave because of pregnancy, childbirth or lactation • Health insurance coverage for pregnancy-related conditions, as long as the employer provides coverage for other medical conditions • The right to the same treatment as other employees, including temporarily disabled employees, including accrual and crediting of seniority, vacation calculation, pay increases, and temporary disability benefits	• Employers with 15 or more employees • Includes federal, State, and local governments as well as employment agencies and labor organizations
Nursing Mother Provision of the Fair Labor Standards Act (FLSA) *Provision effective March 23, 2010*	The Patient Protection and Affordable Care Act (ACA) modified the Fair Labor Standards Act (which established basic job protections like minimum wage and overtime pay), by adding the Nursing Mothers Provision to require that covered employers provide eligible employees with the right to pump breast milk on the job. Covered employers must grant eligible employees the following: 1. Reasonable break time to express milk for a nursing child for one year after the child's birth 2. A place, other than the bathroom, that is shielded from view and free from intrusion from coworkers and the public, which may be used to express breast milk The law also protects workers from retaliation (like reassignment to a less desirable job, taking away job duties or benefits, or firing) for	**COVERED EMPLOYERS:** • Involved in interstate commerce with gross revenue of at least $500,000 per year • Employers with fewer than 50 employees may seek exemption if compliance would impose an undue hardship

Law	Summary	Who is covered?
	asserting their rights or filing a complaint about these issues, if they seek to assert these rights on the job.	**ELIGIBLE EMPLOYEES:** • Only nonexempt employees are officially covered (generally, hourly employees are exempt) • Employers may choose to honor the provision for exempt employees as well; the Federal Government, for example, applies the same procedures to executive branch civilian employees.

STATE-SPECIFIC LEGISLATION AND PROTECTIONS

Some States have enacted additional legislation to protect and support the rights of pregnant, postpartum, and breastfeeding workers. Specific laws vary from one State to the next. Summaries of the different State laws and protections can be found in several locations online, including those listed below.

State-specific **breastfeeding** laws:

- 49 States, the District of Columbia, and the Virgin Islands have laws that specifically allow women to breastfeed in any public or private location; 27 States, the District of Columbia, and Puerto Rico have laws protecting breastfeeding in the workplace.
- The National Conference of State Legislatures summarizes unique State-specific laws related to breastfeeding at http://www.ncsl.org/research/health/breastfeeding-State-laws.aspx

State-specific protections for women who are **pregnant or nursing**:

- The U.S. Department of Labor provides interactive maps showing State-by-State employment protections, protections against pregnancy discrimination, provisions for pregnancy accommodation, and workplace breastfeeding rights at http://www.dol.gov/wb/maps/

State-specific **family leave:**

- Some States have enacted family leave insurance programs to provide wage replacement for workers who take leave to bond with a new child or care for a seriously ill family member:
  - California's Paid Family Leave program (established in 2002) and New Jersey's Family Leave Insurance (established in 2009) offer partial wage replacement of up to six weeks for eligible workers.
  - In 2013, Rhode Island enacted a law (effective in 2014) to cover up to four weeks of wage replacement.
- Additional States have passed family leave laws that apply to firms smaller than those that are covered by the federal FMLA guidelines, or that extend the duration of job-protected leave.[2]

Current Pregnancy, Postpartum and Breastfeeding Policies for Federal Workers

The debate surrounding federal parental leave policies has gained traction in recent years. President Obama and Congress recently launched efforts to change federal parental leave policies. In January 2015, following a proposal from the President, members of Congress introduced legislation that would grant Federal employees 6 weeks of paid parental leave if passed.

Currently, federal workers do not get paid maternity leave. They can take 12 weeks of unpaid leave under FMLA and/or use a combination of other paid leave options. Federal workers are protected by the same pregnancy-, postpartum-, and breastfeeding-related laws that apply to other workers, including the right under FMLA to take 12 weeks of unpaid parental leave (see section 2 of Table 2, which describes such nationwide laws). However, there are some potential differences in the pregnancy and postpartum benefits Federal workers receive. While some employers outside of the federal sector provide employees with paid parental leave, federal employers generally do not. Instead, federal workers typically use a combination of other resources to address their pregnancy and postpartum needs. This may include paid sick leave, paid annual leave, donated leave from other employees, and/or alternate work arrangements.

The Office of Personnel Management (OPM) manages the relevant pregnancy, postpartum, and breastfeeding policies that guide all federal agencies. OPM is responsible for the policies that govern federal workers' leave and workplace flexibilities. Though individual agencies may vary in their administration of these benefits, or the exact flexibilities they offer, they must adhere to OPM's Federal Government-wide rules and regulations. Figure 1 illustrates the roles and responsibilities of OPM, federal agencies, and federal employees.

Figure 1.Roles in Implementing Pregnancy and Postpartum Policies for Federal Workers

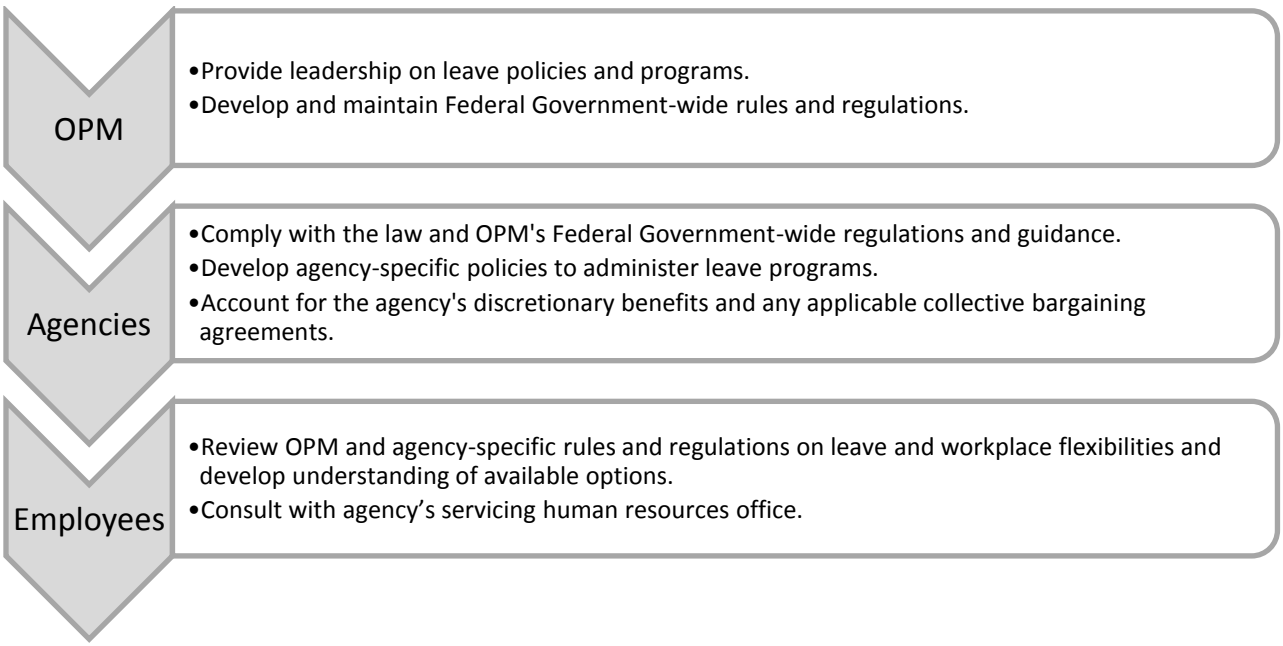


Table 2 summarizes the leave policies and flexibilities available to federal employees. These are outlined in further detail in OPM's Guide for Establishing a Federal Nursing Mother's Program[3] and its Handbook on Leave and Workplace Flexibilities for Childbirth, Adoption, and Foster Care.[4]

Table 2. Leave and Workplace Options for Federal Workers

Leave/Option Type	Description
Breastfeeding Policies *This section summarizes key points from OPM's Guide for Establishing a Federal Nursing Mother's Program.*	
Breastfeeding Guidance	OPM provides federal agencies with resources, guidance, and best practices for establishing supportive breastfeeding policies in the workplace. Their guidelines are based on the Nursing Mother Provision amendment to Fair Labor Standards Act (see Table 1). The provision technically applies only to nonexempt employees, but the Federal Government's policy (under OPM's authority) is to apply the same procedures to exempt Executive Branch civilian employees. Based on this policy, agencies are expected to provide the following (at a minimum) in their nursing mother programs: • A clean, private space (which can be temporary depending on the agency's circumstances and employee demographics) created for the use of nursing mothers, which includes a place to sit and a flat surface other than the floor for nursing mothers to place their breast pumps and other supplies • Reasonable break time that supports an employee's need to express breast milk—both in frequency and duration OPM's research highlights several Federal agencies with exemplary worksite breastfeeding programs such as the National Security Agency, the National Institutes of Health, the U.S. Department of Energy, and Congress. Benefits offered at these sites include breast pump availability on site, overview sessions, and education classes for breastfeeding mothers, onsite lactation consultants, and televisions, refrigerators, and/or microwaves in each nursing mother's room.
Pregnancy and Postpartum Leave Options *This section summarizes key points from OPM's Handbook on Leave and Workplace Flexibilities for Childbirth, Adoption, and Foster Care, which outlines the various leave options workers may use to accommodate their pregnancy and postpartum needs.*	
Sick Leave	An employee is entitled to use sick leave for personal medical needs while pregnant or recovering from childbirth; to care for a family member who is pregnant or recovering from childbirth; to care for a family member, including a newborn, with a serious health condition; or for general family care purposes, such as well-baby doctor visits or illnesses. Sick leave also can be used for purposes related to the employee's adoption of a child, such as appointments with adoption agencies or required travel. An agency may request administratively acceptable evidence to back up sick leave requests, such as a document indicating the duration of the employee's or family member's recovery from childbirth. **OPM Example:** Demont's wife is hospitalized because she is experiencing an extremely high-risk pregnancy. Demont wants to use some of his 600 hours of sick leave to be with her in the hospital. His supervisor initially wants to deny this request; since Demont's wife will be in the hospital, the supervisor thinks Demont will not be "caring for her" and is not

Leave/Option Type	Description
	entitled to sick leave for that period. However, OPM's sick leave regulations allow sick leave to be used if the family member of the employee requires psychological comfort and would benefit from the employee's care or presence; therefore, Demont's sick leave request cannot be denied. However, the agency could request certification from the health care provider concerning the family member's need for psychological comfort and that the family member would benefit from the employee's care or presence.
Advanced Sick Leave	Upon an employee's request, an employee must be granted advanced sick leave to the maximum extent practicable, in accordance with sick leave laws and regulations and consistent with mission needs. Employees are eligible for a maximum of 240 hours (30 days) of advanced sick leave for purposes of a serious health condition or for purposes of adopting a child or caring for an adoptive child with a serious health problem, and a maximum of 104 hours (13 days) for general family care purposes, including routine doctor's visits for adoptive children. An agency may grant advanced sick leave for the same reason it grants sick leave as specified in law and regulation, including for the purposes related to childbirth, adoption, and caring for family members as outlined above, irrespective of the employee's existing annual leave balance. Except in very limited circumstances (such as disability retirement or death), an employee is required to repay advanced sick leave. Because advanced sick leave must be repaid, an agency should not advance sick leave when it is known (or reasonably expected) that the employee will not return to duty. Advance leave may be beneficial to new employees who have little or no sick leave accumulated.
Annual Leave	Annual leave, which is essentially "vacation time" for federal workers, may be used for any purpose, subject to the right of the supervisor to approve a time when the annual leave may be taken. Annual leave may be used for pregnancy, childbirth and recovery from childbirth, adopting or fostering a child, bonding with or caring for a baby, or for other childcare responsibilities, including taking a child to medical appointments or well-baby doctor visits, or any other purpose.
Advanced Annual Leave	Advanced annual leave may be granted to the maximum extent practicable, in accordance with annual leave laws and regulations and consistent with mission needs. An agency may advance the amount of annual leave an employee would accrue during the remainder of the leave year. Note that this means that the later in the leave year the employee requests advanced annual leave, the smaller the amount that may be advanced. Agencies are advised to advance annual leave to the maximum extent practicable for purposes related to pregnancy, childbirth, adoption, or foster care. An agency may grant advanced annual leave for the same reasons it grants annual leave as specified in law and regulation and as described above, irrespective of the employee's existing annual leave balance. New employees are eligible to receive advanced annual leave. As with advanced sick leave, employees are generally required to repay advanced annual leave. Advanced annual leave may be beneficial to new employees who have little or no annual leave accumulated.

Leave/Option Type	Description
Family and Medical Leave	Under the FMLA, Federal employees are entitled to a total of up to 12 workweeks of unpaid leave during any 12-month period for one or more purpose related to childbirth or adoption/foster care once they have been with an agency for 12 months (though agencies may choose to offer newer employees an FMLA-like benefit). For more information, see Table 1. The FMLA can be invoked for the employee's own care for a serious health condition, which includes incapacity to work related to pregnancy and childbirth, even if no medical treatment is actively sought during that time and even if the period of incapacity does not last longer than three consecutive days; to care for a birth mother, including a wife, daughter (within certain restrictions—typically younger than age 18), or mother for reasons related to pregnancy and childbirth; or for parents to care for a newborn. An employee is entitled to take FMLA leave on an intermittent basis or on a reduced leave schedule for absences in connection with a serious health condition such as conditions related to childbirth. A reduced leave schedule is a special kind of intermittent leave that amounts to a change in an employee's usual number of working hours in a workweek or workday, in many cases reducing an employee's full-time schedule to a part-time schedule for the period of FMLA leave. **OPM Example:** Ralph is a Federal employee working for the U.S. Department of Veterans Affairs. He and his wife are adopting a baby from Kazakhstan. Ralph plans to use sick leave for "activities necessary for the adoption to proceed," including travel to and from Kazakhstan and time spent there. When he returns home, he plans to invoke his entitlement to unpaid leave under the FMLA and spend 12 weeks with his new daughter. His supervisor maintains it is critical that Ralph return to work as soon as possible, and counts the time spent in Kazakhstan towards Ralph's 12-week entitlement. However, Ralph is entitled to use his sick leave, independent of his FMLA entitlement, for his time in Kazakhstan. Congress was very specific that, for Federal employees, FMLA leave is in addition to any other paid or unpaid leave granted by the agency. Therefore, Ralph is entitled to use his sick leave for adoption-related activities and then to invoke his entitlement to unpaid leave under FMLA for an additional 12 weeks.
Leave Sharing Programs	An employee may be eligible to apply for and receive donated annual leave under an agency's leave sharing programs if the employee or the employee's family member (including an adoptive or foster child) is experiencing a medical emergency and if the employee will exhaust his or her own annual and sick leave ("available paid leave"). Donated annual leave may be provided to the birth mother or a family member caring for the birth mother during her period of incapacitation. There are two leave sharing programs that can be used during a birth mother's period of incapacitation or to care for a child with a medical emergency—the Voluntary Leave Transfer Program (VLTP) and Voluntary Leave Bank Program (VLBP). Additionally: • Donated annual leave may be used only for a medical emergency—e.g., any period of incapacitation of the mother or illness of the baby that will last at least 24 work hours— and may not be used to care for a healthy child.

Leave/Option Type	Description
	• There is no limit on the amount of donated annual leave a leave recipient may receive. However, any unused donated annual leave must be returned to the leave donor(s)/bank when the medical emergency ends. • Donated annual leave may not be used to bond with or care for a healthy newborn; to care for a child with a routine illness; or to take the child to medical, dental, or optical appointments or well-baby doctor visits. • An employee who returns to work part-time and who uses donated leave part-time to care for a family member recovering from childbirth accrues leave in his or her regular annual and sick leave accounts for the time spent in work status and in his or her set-aside annual and sick leave accounts when using donated leave. • Donated leave may be substituted retroactively (1) for any period of leave without pay used because of a medical emergency, or (2) to liquidate indebtedness from advanced annual or sick leave due to a medical emergency.
Leave Without Pay	An employee may request leave without pay (LWOP) to be absent from work for purposes related to pregnancy and childbirth, or adopting/fostering a child. An employee may request LWOP without invoking FMLA, even if he or she has available paid leave. Supervisors should refer to agency internal policy and collective bargaining and/or union agreements prior to granting approval. However, agencies are encouraged to offer leave without pay for a longer period than what is provided under the FMLA, to the maximum extent practicable for pregnancy and childbirth. LWOP can be used in addition to the flexibilities already available, subject to agency policy and any applicable collective bargaining agreement. This may be offered to new employees with less than one year of employment who are not yet eligible for FMLA.
Compensatory Time Off	Three types of compensatory time off may be earned and used for reasons related to pregnancy, childbirth, adoption, or foster care. 1. Compensatory time off in lieu of overtime pay 2. Compensatory time off for travel 3. Religious compensatory time off **OPM Example (compensatory time off for travel):** Noor is facilitating agency efforts to recruit science, math, engineering, and technology (known as STEM) students to come work at the National Aeronautics and Space Administration. It is January, and she is in her first trimester of pregnancy. She is traveling frequently to campus recruiting fairs and earning quite a bit of compensatory time for travel. She and her supervisor have discussed how she can use this time once she gives birth because she will not have enough sick leave to cover her full period of recovery from childbirth.
Alternative Work Schedules	Alternative Work Schedules (AWS) permit an employee to complete an 80-hour bi-weekly pay period in less than 10 days. Employees have a right to request an alternative work schedule without fear of retaliation in accordance with agency policy and any collective bargaining agreements. These schedules enable managers and supervisors to meet their program goals and at the same time help employees to better balance work, personal, and family responsibilities. There are two categories of AWS: compressed work schedules and flexible work schedules.

Leave/Option Type	Description
	Compressed Work Schedules. These are fixed work schedules that enable full-time employees to complete the basic 80-hour biweekly work requirement in less than 10 workdays. **Flexible Work Schedules.** These are flexible work schedules that enable employees to select and alter their work schedules to better fit their personal needs and help balance work, personal, and family responsibilities.
Telework	Telework provides employees the flexibility to better manage their work, family, and personal responsibilities. Under an agency's telework policy, an employee may be permitted to work at home or other worksites geographically convenient to the employee's residence. Telework is a valuable tool that can be used when an employee transitions back to work after the birth or adoption/foster care assignment of a child. Telework is often used in conjunction with paid leave during the transition period between childbirth or adoption/foster care assignment and the return to full-time official duties. Telework must be approved by the employee's supervisor based on the agency telework policy and the ability of the employee to accomplish his or her work. Employees cannot telework while actively caring for a newborn. **OPM Example:** Mark and his wife adopted a new baby, Doris, several months ago. They have a live-in au pair caring for Doris at home each day. Mark discussed with his supervisor the fact that he has a home office on the third floor, and that the au pair cares for Doris on the first and second floors. His supervisor has approved Mark to telework on Wednesdays. As a new parent adjusting to life with an infant and the demands of parenthood, Mark appreciates the extra sleep he can get on Wednesdays when he is not commuting, and also enjoys the extra time he has to prepare a nice dinner for the family on Wednesday evenings.
Part-time Employment and Job Sharing Arrangements	Agencies are encouraged to offer part-time schedules to employees who are pregnant or have given birth, are adopting or fostering a child, or who are caring for a newborn, to the maximum extent practicable. Agencies are also encouraged to develop job-sharing programs in partnership with their unions and other stakeholders. Furthermore, when job-sharing programs are planned for organizations where employees are represented by a labor organization with exclusive recognition, by law, agencies must notify the union and bargain in good faith on any negotiable proposals the union submits. Part-time employees working between 16 and 32 hours a week remain eligible for all benefits available to full-time workers, on a prorated basis (retirement, leave, insurance coverage). **OPM Example (part-time employment):** Anna and her husband, Corey, have recently had their second child and now have an infant and a toddler. Anna started back to work full time, but her schedule is too stressful. Anna discusses her situation with her supervisor, and he provides approval for her to work a part-time schedule of 30 hours a week. The extra 10 hours are just what Anna needs to get both children to their respective daycares. The extra time also provides a cushion that allows Anna more time to breastfeed the baby.

A. Sample Scenario (From OPM Handbook)

Given the wide range of leave options that federal workers may use in various combinations to accommodate the birth or adoption of a child, OPM provides federal workers with several examples of how leave may be used. The example below describes a female worker who needs to take leave for the birth of her child and the leave options available to her; she is new at her job, and therefore is not eligible for FMLA and has not accrued much leave.

Jordan is a new Federal employee who has 6 months of service and, therefore, does not qualify for FMLA. She would like to stay home with her baby for 3 months before returning to work.

She has 40 hours of sick leave and 40 hours of annual leave. Jordan is put on medically prescribed bed rest for two weeks prior to the birth of her child. She uses 40 hours of sick leave for bed rest and prenatal appointments from March 9 through March 13. Jordan then requests and is granted 40 hours of annual leave, which she uses from March 16 through March 20.

On March 23, Jordan gives birth to her baby boy. Following the birth of her son, Jordan requests and is granted 240 hours of advanced sick leave to cover her period of recovery from childbirth from March 23 through May 1.

Tip: *As soon as Jordan can demonstrate that she will exhaust her available paid leave (sick and annual leave), she may apply to receive donated annual leave under the VLTP/VLBP for her period of her recovery from childbirth. She can use the donated annual leave to repay the advanced sick leave taken during her recovery from childbirth.*

Next, Jordan requests and is granted 64 hours of advanced annual leave (the amount of annual leave she would accrue through the remainder of the leave year) for bonding with her son between May 4 and May 13. Finally, Jordan requests and the agency approves Jordan's request for LWOP for bonding with her baby from May 14 through June 23. She is not in a pay status the workday before or after the Memorial Day holiday, so she will not be paid for the holiday.

In Summary:

- March 9–March 13: SICK LEAVE for bed rest/prenatal appointments (5 days)
- March 16–March 20: ANNUAL LEAVE for bed rest/prenatal appointments (5 days)
- March 23: BABY BORN
- March 23–May 1: ADVANCED SICK LEAVE for recovery from childbirth (30 days maximum)
- May 4–May 13: ADVANCED ANNUAL LEAVE for bonding with baby (8 days)
- May 14–June 23: LWOP for bonding with baby, if approved. Employee would not be in a pay status on the day before or after the Memorial Day holiday (May 25), so would not be paid for the holiday.

Current Policies for Private-Sector Workers

This section outlines the landscape of current policies related to pregnancy and postpartum leave for private-sector workers. The first section of this chapter addresses access to leave, and the second section explains leave usage.

A. Access to Leave

Like their federal counterparts, U.S. private-sector workers are protected by national and sometimes State-specific pregnancy, postpartum, and breastfeeding laws. For example, like federal workers, private workers have the option of taking 12 unpaid weeks of job-protected leave under the FMLA if they work for a covered employer. Survey findings from the U.S. Department of Labor's Family and Medical Leave Act in 2012 Survey indicated the FMLA has had a positive impact on the lives of workers without imposing an undue burden upon employers, and employers and employees alike found it relatively easy to comply with the law. Additionally, it found that 59 percent of employees worked at covered firms and met all eligibility requirements for FMLA benefits.[5]

Though pregnant and postpartum workers have access to certain protections, there is no universal paid-leave policy for new parents across private or public settings. The overall proportion of employees with paid family leave is relatively small. Estimates vary depending on the source, and whether that source separates paid disability-related leave from family leave. Estimates from DOL surveys indicate as few as 12 percent or as many as 35 percent of employees had access to paid "maternity" leave.[6]

More employers appear to provide their workers with paid sick leave, with approximately six out of 10 workers receiving access to paid sick time[7] that may be used for pregnancy and family-care reasons (in addition to other medical needs).

The availability of family leave and other related benefits can vary widely depending on interrelated factors like occupation, employer, and socioeconomic status. Proportionally few American workers overall have access to paid family leave, but it is even rarer among specific populations. Income level, industry, company size, and region can all affect a worker's access to paid leave, as shown in Table 3.

Table 3. Access to Paid Family Leave for Civilian Employees, 2010 and 2012

All Employees	2012	2010
Occupations		
Management, Professional, and Related	18%	17%
Sales and Office	13%	11%
Natural Resources, Construction, and Maintenance	9%	8%
Service	7%	8%
Production, Transportation, and Material Moving	6%	6%
Average Wage		
Lowest 25%	5%	5%
Highest 25%	19%	17%
Establishment Size		
1 to 99 Workers	8%	7%
100 Workers or More	15%	13%

All Employees	2012	2010
Region		
New England	11%	11%
Middle Atlantic	10%	9%
East North Central	13%	14%
West North Central	11%	10%
South Atlantic	14%	13%
East South Central	8%	7%
West South Central	12%	9%
Mountain	8%	9%
Pacific	13%	14%

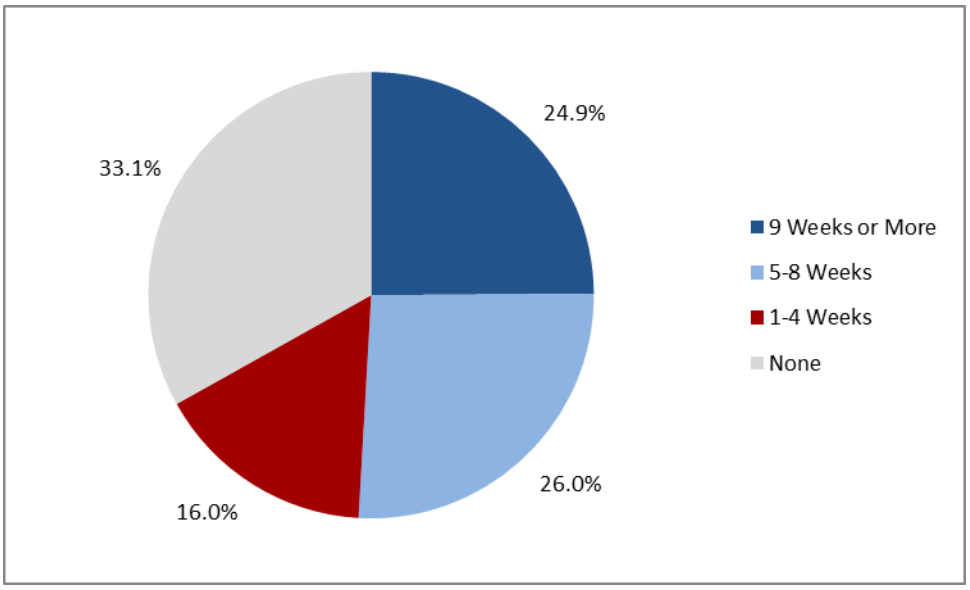
Notes: Paid family leave in the National Compensation Survey definition includes paid maternity, adoption and paternity leave, as well as leave to care for a sick child, or a sick adult relative; only paid leave in addition to short-term disability leave is counter. Data are unadjusted for tenure rates; typically, workers will not have access to leave in the first few months after joining a company.
Source: National Compensation Survey (U.S. Department of Labor, Bureau of Labor Statistics 2010 and 2012).[8]

B. Leave Usage

Like Federal workers, many women in the private sector cannot afford to take unpaid leave and usually use a combination of short-term disability, sick leave, vacation, and personal days to have some portion of their maternity leave paid. Given their limited access to paid family leave, it is not surprising that many Americans return to work relatively quickly following the birth or adoption of a child. According to the Health Resources and Services Administration's Maternal and Child Health Bureau,[9] nearly one-third of employed women in 2006–2008 (29.4 percent) did not report taking any maternity leave (paid or unpaid) during their last pregnancy.

Of the women who did take maternity leave during their last pregnancy, the average length of leave was 10.3 weeks. Among these women, 33.1 percent did not have any portion of their maternity leave paid. Only 24.9 percent of women reported paid maternity leave for more than two months (nine or more weeks). Figure 2 provides a fuller picture of paid maternity leave among women. We outline the benefits of paid leave further in the next chapter.

Figure 2. Weeks of Paid Maternity Leave Received Among Women Ages 18–44 Who Took Maternity Leave,* 2006–2008



**Respondents were asked to report based on their last pregnancy.*
Source: Centers for Disease Control and Prevention, National Center for Health Statistics. National Survey of Family Growth 2005–2008. Analysis conducted by the Maternal and Child Health Information Resource Center.[10]

The length of leave taken for parental reasons varies considerably between women and men, as well. DOL's Family and Medical Leave Act in 2012 Survey indicated that seven of 10 men in that year took leave of 10 days or less. It also showed that men were half as likely as women to receive paid leave for parental reasons. In addition, the Institute for Women's Policy Research found that access to leave impacts the amount of leave taken; for example, women are twice as likely as men to receive paid leave for parental reasons, and they are far more likely to take leave for six weeks or more (38 percent of women compared to 6 percent of men).[11]

Medical Rationale for DoD and the Services' Pregnancy, Postpartum, and Breastfeeding Policies

This chapter highlights the medical rationale behind DoD's and the Services' policies regarding pregnancy, postpartum operational deferment, postpartum fitness testing, and breastfeeding. It is organized into four sections covering the medical reasoning in support of each of these four topics.

At the June 2015 DACOWITS business meeting, each Service briefed DACOWITS on the rationale behind their pregnancy, postpartum, and breastfeeding policies. Each Service's reasoning, as covered in their briefings, is provided in Table 4.

Table 4. Services' Rationale for Pregnancy, Postpartum, and Breastfeeding Policies as Described During June 2015 DACOWITS Business Meeting

Service	Pregnancy Policy Rationale	Postpartum Operational Deferment Policy Rationale	Postpartum Fitness Testing Policy Rationale	Breastfeeding Policy Rationale
Army	DoD clinical practice guidelines Balance of operational requirements with health and well-being of mother and baby	DoD clinical practice guidelines Balance of operational requirements with health and well-being of mother and baby	DoD clinical practice guidelines	(not provided)
Air Force	Operational requirements Supported by evidence which is regularly reviewed- American Congress of Obstetricians and Gynecologists (ACOG), Occupational Safety and Health Administration Fetal Protection Program, and Equal Employment Opportunity Commission; also supported by Pregnancy Discrimination Act.	Driven by operational requirements and advised by a consensus of experts	ACOG committee opinion with consideration of current occupational health "return to work" guidelines	Consensus of medical experts, current literature, and breastfeeding advocates (American Academy of Pediatrics (AAP), American College of Nurse-Midwives, ACOG)
Coast Guard	DoD clinical practice guidelines	DoD clinical practice guidelines	N/A (Coast Guard does not have a fitness testing policy)	DoD clinical practice guidelines

Service	Pregnancy Policy Rationale	Postpartum Operational Deferment Policy Rationale	Postpartum Fitness Testing Policy Rationale	Breastfeeding Policy Rationale
		Aligned with Navy		
Marine Corps	Recommendations and input of Director, Health Services, Headquarters U.S. Marine Corps	Recommendations and input of Director, Health Services, Navy Medicine (BUMED), and ACOG	Recommendations and input of Director, Health Services, BUMED, and ACOG	Input of Director, Health Services
Navy	Civilian health care community practices Balancing sailors' health and career development with operational needs of ship during deployment	World Health Organization (WHO) and The Surgeon General's Call to Action to Support Breastfeeding	ACOG guidelines for reasonable time for weight loss and to obtain a satisfactory level of fitness	ACOG, AAP, WHO/United Nations Children's Fund Ten Steps to Successful Breastfeeding

A. Medical Rationale for Pregnancy Policies

In this section, we present research pertaining to protecting mothers and fetuses during pregnancy, specifically when the mother has a physically demanding or potentially hazardous job. For women who have jobs that include intense physical activity, the medical recommendations below can be applied.

In 2009, DoD and the U.S. Department of Veterans Affairs (VA) updated their Clinical Practice Guidelines[1] for the Management of Uncomplicated Pregnancy.[12] Only recently has a substantial amount of research been completed to support the ideas that **it is both safe and beneficial to exercise during pregnancy.** Currently, there is no evidence to suggest that regular maternal exercise is associated with fetal compromise or unexplained fetal death. In the 2009 guidelines, DoD/VA recommended:

1. That all healthy pregnant women perform regular mild to moderate exercise sessions, three or more times per week (strong recommendation)
2. The development of individualized exercise programs for all pregnant women based on their prepregnancy activity level (insufficient evidence)
3. Avoidance of high-altitude (>10,000 feet) activities, scuba diving, and contact sports during pregnancy (insufficient evidence)

The Agency for Healthcare Research and Quality, through its National Guideline Clearinghouse, published the Occupational Guidance for Physical and Shift Work of Pregnant Women in the United States[13] that can be applied to active duty servicewomen. This guidance relied on 31 peer-reviewed articles and encourages primary care providers to make the following recommendations to the pregnant woman's employer:

[1] VA and DoD define clinical practice guidelines as "recommendations for the performance or exclusion of specific procedures or services derived through a rigorous methodological approach that includes: 1) determination of appropriate criteria such as effectiveness, efficacy, population benefit, or patient satisfaction, and 2) literature review to determine the strength of the evidence in relation to these criteria."

- **Physical activity:** In an uncomplicated normal pregnancy, the following work schedule restrictions may be followed: sedentary activities until 40 weeks or beginning of labor; light activities until 38 weeks; moderate activities until 32 weeks; heavy activities until 26 weeks; very heavy activities until 20 weeks.
- **Manual lifting:** Maximum recommended weight for infrequent lifting during pregnancy ranges from 17 to 36 pounds for the first 20 weeks and from 17 to 26 pounds for greater than 26 weeks.
- **Long working hours:** Overall, long working hours are associated with a low to moderate risk for low birth weight, small-for-gestational-age baby, intrauterine growth restriction, and preterm birth. Long working hours are inconsistently associated with an increased risk of preeclampsia and pregnancy-induced hypertension.
- **Shift work:** Shift and night work is associated with a low to moderate risk for adverse pregnancy outcomes.
- **Prolonged standing:** In general, prolonged standing for greater than three hours per day results in no more than a low to moderate risk for adverse pregnancy outcomes.
- **Heavy physical activities and lifting/bending/climbing:** Overall, during the first 34 weeks of pregnancy, work activities to which the woman is accustomed prior to pregnancy offer a low to moderate risk of adverse pregnancy outcomes. Trunk bending for more than one hour a day after 34 weeks gestation offers a moderate risk for reduced fetal head circumference. There is limited evidence of risk for spontaneous abortion from heavy lifting.

The Military Services must also consider exposure to potentially harmful toxins in the workplace. **Preconception and prenatal exposure to toxic environmental agents can have a profound and lasting impact on reproductive health across the life course.** For example, prenatal exposure to certain chemicals has been documented to increase the risk of cancer in childhood.[14]

B. Medical Rationale for Postpartum Fitness Testing Policies

In this section, we present the medical reasoning guiding postpartum physical fitness testing policies. While medical recommendations regarding exercise during pregnancy are presented in the prior section, here we outline the American Congress of Obstetricians and Gynecologists (ACOG) guidance pertaining to resuming physical activity postpartum.

ACOG guidelines for exercise during the postpartum period[15] indicate that **rapid resumption of physical activity has no adverse effect, but gradual return to former activities is advised**. Many of the physiological and morphologic changes of pregnancy persist 4 to 6 weeks postpartum; this will vary from one individual to another, with some women able to resume an exercise routine within days of delivery. There are no published studies to indicate that, in the absence of medical complications, rapid resumption of activities will result in adverse effects. However, having undergone a reduction in activity level, returning to baseline level of activity should be gradual. No known maternal complications are associated with resumption of training. Moderate weight reduction while nursing is safe and does not compromise neonatal weight gain. Finally, a return to physical activity after pregnancy has been associated with decreased incidence of postpartum depression, but only if the exercise is stress relieving and not stress provoking.

C. Medical Rationale for Breastfeeding Policies

Many national and international bodies have published guidelines and recommendations on breastfeeding. Key publications (many cited by the Military Services as rationale for their policies) are summarized below.

There is a growing emphasis on breastfeeding nationwide. According to the 2014 Breastfeeding Report Card, breastfeeding rates continue to rise in the United States. These data show that 79.2 percent of newborns have ever breastfed; 49.4 percent were breastfeeding at 6 months, decreasing to 26.7 percent breastfeeding by 12 months.[16]

In 2012, the American Academy of Pediatrics (AAP) reaffirmed its breastfeeding guidelines.[17] Breastfeeding provides the healthiest start for an infant, and promotes a unique bond between mother and baby. **AAP, the American College of Nurse-Midwives (ACNM), ACOG, the World Health Organization, and the United Nations Children's Fund all recommend exclusive breastfeeding for approximately the first 6 months of a child's life, followed by breastfeeding and the introduction of complementary foods until at least 12 months of age**, [18] [19] [20] [21] and continuation of breastfeeding for as long as mutually desired by mother and baby. This recommendation is supported by infant health outcomes; breastfeeding protects against a number of infant health problems (respiratory illness, ear infections, etc.) and has even been shown to have an impact on adolescent and adult obesity. Choosing to breastfeed should be considered an investment in the short- and long-term health of the infant, rather than a lifestyle choice. Breastfeeding can provide emotional satisfaction for mothers and helps them to recover from childbirth more quickly and easily—hormones released during breastfeeding help return the uterus to its regular size more quickly, can reduce postpartum bleeding, and may reduce the risk of developing diseases like Type 2 diabetes, rheumatoid arthritis, and cardiovascular disease.

In his 2011 Call to Action to Support Breastfeeding, **the Surgeon General called breastfeeding "one of the most highly effective preventative measures a mother can take to protect the health of her infant and herself."**[22] This report detailed several obstacles postpartum women face in attempting to breastfeed as they return to work, including the following:

- Many women mistakenly think they cannot breastfeed if they plan to return to work after childbirth, and may not talk with their employers about their desire to breastfeed, or how breastfeeding might be supported in the workplace.
- Among employed mothers, studies have found lower initiation rates and shorter duration of breastfeeding. Rates of breastfeeding initiation and duration are higher in women who have longer maternity leave, work part time rather than full time, and have breastfeeding support programs in the workplace.
- Because most lactating mothers who are employed express milk at work for a childcare provider to bottle feed to the infant later, these providers are essential in helping employed mothers continue to breastfeed after returning to work. However, a mother feeding her infant directly from the breast during the workday is the most effective strategy of combining employment and breastfeeding because it promotes the duration and intensity of breastfeeding and strengthens the relationship between mother and infant in the critical first months of life. The skin-to-skin closeness that occurs during breastfeeding promotes bonding and attachment between mother and infant, increases the efficiency of breastfeeding, and enhances the neurological and psychosocial development of the infant.

D. Medical Rationale for Postpartum Operational Deferment Policies

The medical literature on pregnancy, postpartum physical fitness, and breastfeeding are all incorporated into the rationale behind postpartum operational deferment policies.

In 2009, DoD published a Report to the White House Council on Women and Girls that described, among other things, its rationale for the four-month minimum postpartum deferment period.[23] According to this report, **the four-month minimum deferment period was established "to provide for medical recovery from childbirth (normally 6 weeks) and to provide military mothers and their families with additional time to prepare family care plans and to establish a pattern of childcare.**" The report stated, "Our policies also acknowledge that too long a mandatory deferment postpartum may prove injurious to women's career aspirations." The authors further described how the Military Services' differing policies, as well as ongoing reviews and adjustments, reflect the discretion of the Secretaries of the Military Departments to balance force readiness, high operational demand, and deployable manpower requirements with the time needed for a new military mother to bond with her child and recover from childbirth.

Since there is no clear equivalent of operational deferment for most private sector workers, there is little research on the topic in the civilian literature. As an alternative, we have provided a review of the literature that supports paid leave for new parents. In March 2015, the Minnesota Department of Health, Center for Health Equity published its White Paper on Paid Leave and Health that outlined the social and medical benefits of paid leave policies for individuals and families.[24] Key findings from this report are outlined below.

Paid leave allows parents to spend time with new infants, resulting in better health for both infants and mothers. Many studies have shown experience and environment play critical roles in developing the capacity and functionality of the brain. The nature of parent-infant relationships is critical to the healthy development of young children.[25] Research into adverse childhood experiences, trauma, and toxic stress for infants and toddlers lacking these types of relationships also shows that adverse experiences can negatively influence the health, economic standing, and educational success of individuals and have an intergenerational impact.[26] Conditions resulting from overtime work, multiple jobs, or shift work can lead to high levels of stress in families' every day environments, which in turn can affect children's development.[27]

Maternity leave is associated with higher rates of breastfeeding and breastfeeding for longer periods of time. The benefits of breastfeeding to children's health have been widely researched and documented.[28] In one study, for instance, duration of breastfeeding increased by one-third of a month for every additional month not at work.[29]

Paid parental leave is associated with significantly better infant health, including fewer infant deaths.[30] The positive effects of parental leave on infant mortality were observed only when the leave was paid. There were "no significant effects with unpaid or non-job-protected leave."[31] Maternity leave is associated with higher rates of vaccinations, well child check-ups, and timely health care provider visits when infants become sick.[32]

Parental leave provides more time for maternal health recovery. More than six weeks are needed for women's reproductive organs to go back to their nonpregnant state,[2] and many medical disorders, fatigue, discomfort, and risk of infection last beyond three months.[33]

[2] According to DoD, six weeks is adequate.

Postpartum Depression Overview

This section presents a brief overview of postpartum depression, including incidence rates and indicators in both the general and military populations.

A. General Incidence and Indicators

Postpartum depression and other mood disorders are experienced by approximately 13 percent of new mothers and may develop as late as three to six months after birth. Research has indicated 13 predictors of postpartum depression: prenatal depression, self-esteem, childcare stress, prenatal anxiety, life stress, social support, marital relationship, history of previous depression, infant temperament, maternity blues, marital status, socioeconomic status, and unplanned/unwanted pregnancy. [34]

Although the research on the association between length of maternity leave and maternal depression is not conclusive, researchers have found that **longer leaves (up to six months) are associated with decreased symptoms of maternal depression.**[35] Maternal depression, if left unaddressed, can have serious negative impacts on children's physical and mental health and cognitive development.[36]

B. Military Incidence and Indicators

The Armed Service Health Surveillance Center estimated that almost 10 percent of active duty servicewomen and about 8 percent of military spouses experience postpartum depression.[37] However, another study found a rate of postpartum depression in an active duty military sample of nearly 20 percent, elevated in comparison with averages in the civilian population. [38]

Appolonio and Fingerhut's 2008 study found **a lack of association between postpartum depression and military-specific factors**. Women who were in a dual-military relationship were not at higher risk for postpartum depression. Additionally, women who were dealing with an impending deployment or whose spouses were deployed were not more likely to report depressive symptoms. An upcoming military move, rank, and base housing were also unrelated to symptoms of postpartum depression.[39] Not all studies revealed the same findings, however. Research in a 2013 study on the association between deployment and postpartum depression indicated that deployment before childbirth, regardless of combat experience, and deployment without combat experience after childbirth did not increase the risk of maternal depression. **Military women who deployed with combat-like experiences after childbirth were at increased risk for postdeployment maternal depression. The risk, however, appeared primarily related to combat rather than childbirth-related experiences.**[40]

Additional research indicated that maternal anxiety predicted fatigue at six weeks after delivery. More than half of the women in the study had not regained full functional status when they returned to work, and 40 percent still displayed symptoms of postpartum depression and anxiety.[41]

While not directly pertinent to DACOWITS' focus, research has shown that having a spouse who deployed during pregnancy is a risk factor for having a positive postpartum depression screen.[42]

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