Breastfeeding and Gender Inequality

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Abstract:

Many feminists have argued breastfeeding is a constraint that may prevent women from realizing nonmaternal opportunities. This article presents an alternative feminist perspective, arguing that the view of breastfeeding as a constraint glosses over the mediating role that gender inequality plays in the way breastfeeding impacts women's lives. Rather than focus on breastfeeding as a constraint, attention should be focused on the ways that socially created policies and practices, often based on a gender-similarity framework, sustain gender inequities. Policies and practices based on this framework negate the needs of the body, which exaggerates gender differences, redistributes gender inequities, and raise the costs of breastfeeding. In contrast, locating the constraint in the arena of gender inequality better explains how social decisions that differentially accommodate men's nonlactating bodies privilege men over women and help us recognize how passage of polices that accommodate lactating bodies represents progress toward equal opportunity.

Keywords: breastfeeding | women's status | gender equity | public policy

Article:

The changing roles women have experienced in the United States and in many countries around the world over the past half century have opened up new and exciting opportunities for more women in the paid labor force and in public life. Associations by many feminists that link lactation with exclusive maternity and formula with women's liberation (Badinter 2010; Ward 2000; Wolf 2007) might lead to the hypothesis that women's changing economic and political status is a key reason why only 36% of newborns globally are exclusively breastfeed for the first six months (Sguassero 2008). Certainly, changes in women's paid employment patterns have resulted in both new opportunities and resources for women, as well as new constraints and stressors, and many women struggle with work-family-life conflict (Oppong 1980; Waldfogel

and McLanahan 2011). Women's expanding role opportunities may lead us to wonder whether some women find breastfeeding serves as a constraint that prevents them from realizing nonmaternal opportunities and/or as a stressor that adds unnecessarily to their burdens. To the extent breastfeeding serves as a constraint that prevents mothers being able to realize other nonmaternal opportunities, this could reinforce gender inequality and/or continued low breastfeeding rates.

The view of breastfeeding as a constraint is relatively widespread in much feminist writing on the subject (Badinter 2010; Wolf 2007; 2011). French feminist Badinter (2010) writes that bottles

> give fathers the opportunity for additional contact with the baby and offers mothers some relief. This approval seems heretical to the ayatollahs of breast-feeding, even with their patina of modernity. … In the 1960s and 1970s, thanks to bottle-feeding, young couples experimented with sharing roles, which was much more conducive to the mother's freedom, allowing her to leave the house, sleep through the night, perhaps even go back to work without anxiety. … But the interchangeable roles were incompatible with the tenet of breastfeeding. (Badinter 2010, 98)

An alternative feminist perspective is that although breastfeeding may be perceived as constraining by many women who seek to breastfeed in public spaces (Campo 2010; Dowling, Naidoo, and Pontin 2012) or after returning to work (Hurst 2010; Lubold and Roth 2012), or by women with limited resources (Chin and Dozier 2012), the more appropriate location of the constraint is continued gender inequality (Hausman, Smith, and Labbok 2012; Smith 2012). What individual women, and many feminist writers, may view as a personal health behavior and infant-feeding choice is additionally a gendered social behavior and experience that is taking place in the context of continued gender inequities in labor, power, and social norms. These continued inequities, in combination with women's growing presence in the paid labor force, give rise to conflicting and contested ideas about maternity and breastfeeding, resulting in the constraining effects that breastfeeding has on some women's lives. My discussion first elaborates these two perspectives on constraint, particularly as they understand the role of women's bodies. However, I argue that seeing breastfeeding as a cause of these negative effects ignores the role of structural inequalities. Rather than focus on breastfeeding bodies as a constraint, research should instead focus on socially created norms and institutions, often constructed upon a framework of biological differences, which sustain gender inequities. Feminists from both perspectives would benefit from changing social policies and norms that fail to value women's unique abilities and create obstacles that constrain women's choices with their bodies and, in so doing, fail to provide the supports the female body needs to fully participate in the social world. Last, I discuss some of the ways in which US social policy has responded to embodied constraints.

THE LACTATING BODY AND BREASTFEEDING AS CONSTRAINT

Feminism has as its core purpose the elimination of gender inequality, and it has sought to overcome a legacy of “biology as destiny” or biological essentialism that threatens women's full and equal participation in society. Different overarching strategies emerged as feminist theorists and activists envisioned a variety of approaches to achieving gender equality. One vision focused on minimizing the differences between women and men, especially regarding reproduction, while another focused on whether to explicitly acknowledge reproductive differences and “incorporate women's reproductive requirements within a legal framework of equality” (Galtry 2000, 299). Williams (2000) refers to the two types of strategies as “maternalist” (seeking to empower women as mothers and within the private world of family) and “equal-parenting advocates” (seeking a new way of organizing work and family and hence empowering women in the public domain of work). Although different in many ways, both strategies were insistent on eliminating male privilege and masculinity as the norm (Williams 2000).

Feminists’ concern about biologically based sex discrimination was solidly grounded in real life and real politics. Gelb and Palley's (1996) analysis of the factors leading to the passage of the Pregnancy Discrimination Act in 1978 in the United States is illustrative. Prior to 1964, pregnant women were fired routinely; while liability concerns were often cited, Gelb and Palley (1996) note that “there were often aesthetic and moral reasons at the root of these practices—it was ‘not nice’ for pregnant women to work and it had a ‘bad effect on male workers’’’ (174). The passage in 1964 of Title VII of the Civil Rights Act resulted in a significant decrease in pregnancy-related employment discrimination. But three years later there was a serious setback when the Supreme Court ruled in *General Electric v. Gilbert* that denying women pregnancy-related disability was not discrimination based on sex, because the policy addressed pregnancy and not pregnant women. A coalition of more than 100 groups, including both women's rights and antiabortion groups, came together to pass the Pregnancy Discrimination Act to amend Title VII of the Civil Rights Act of 1964 to include pregnancy-related discrimination (Gelb and Palley 1996).

When possible, both maternalist and equal-parenting advocates preferred gender-neutral policy language so policies were able to benefit both men and women, thus emphasizing gender and biological similarity over difference. This was strategic; bills that are framed as gender-role *equity* are more likely to pass than are those framed as gender-role *change* (Gelb and Palley 1996). In the cases of pregnancy and childbirth, gender neutrality was not possible, so the typical strategy was to focus on child rearing as a gender-neutral activity. Galtry (2000) speculates this is probably why feminist visions of gender equality ignored breastfeeding: “Given that the process of lactation coincided with what had come to be reconceptualized as a strictly gender-neutral zone, it is likely that this unavoidably sex-specific practice posed tensions for feminist legal scholars” (301).

So while feminist activists and theorists sought to overcome the constraining effects of women's bodies and biology, breastfeeding advocates historically saw women's bodies quite differently. La Leche League conceptualized a strong link between biology, nurturing maternal behavior,

motherhood as the ideal role for women, and an improved society (Bobel 2001; Ward 2000; Weiner 1994). Weiner (1994) writes that the “La Leche League arose to defend traditional domesticity against the assaults of modern industrial life and to dignify the physical, biological side of motherhood in ways that have proved to have surprising appeal to many women” (363). They established a biological framework that strongly implied a biological inevitability. They did not see this inevitability as being constraining; rather, they saw it as being liberating and empowering.

This appeal to the power of women's biological differences clearly raises concerns by many feminists and fuels the viewpoint that breastfeeding is synonymous with traditional gender roles and that breastfeeding advocacy and promotion may further gender inequality. Badinter (2010) writes, “At the heart of the revolution in motherhood that we have seen unfold since the 1980s lies breastfeeding. Slowly but surely, nursing has won more and more supporters in the West. It has become a defining feature in a philosophy in which motherhood determines women's status and their role in society” (67). Many writers point to the “moralizing” of infant feeding that leads some women to feel pressured to breastfeed when they otherwise might not, and feelings of guilt when they do not meet their goals (Groleau and Sibeko 2012; Lee 2011; Taylor and Wallace 2012), an ideology which Joan Wolf (2011) terms “total motherhood.”

GENDER INEQUALITY AS CONSTRAINT

The view that breastfeeding itself is the location of the constraint glosses over the mediating role that gender inequality plays in the relationship between breastfeeding and its constraining effects. Connell (1987) outlines a theory of how gender operates through social structures that leads to an unequal allocation of opportunities, resources, and constraints on the basis of sex; these patterns lead to gender-based inequities in political, economic, and social status. The sexual division of labor reduces women's economic status by distributing wealth in ways that disadvantage caregiving relative to specific forms of productive work; the sexual division of power reduces women's political status by upholding the superiority of masculinity over femininity and the masculine body over the female body; and the sexual division of social relationships affects women's social status by establishing rewards and punishments for particular social relationships and emotions (Smith 2012). The costs of breastfeeding are raised by role differentiation that leads to unequal parental role expectations and economic opportunity; by social norms and policies that associate masculine bodies with authority and productivity; and by social norms that complicate women's search for social status by, on the one hand, equating breastfeeding with good motherhood and, on the other, sexualizing women's breasts as objects of male desire (Dowling, Naidoo, and Pontin 2012; Hurst 2012; Li, Fridinger, and Grummer-Strawn 2002; Rippeyoung and Noonan 2011, 2012; Stearns 2009; Taylor and Wallace 2012). For example, employed women may be “legitimately concerned about how breastfeeding or pumping may affect their relationships with their colleagues or superiors, or how breastfeeding might affect the admiration and respect others have for them” (Smith 2012, 33). This could place

women in the difficult situation of navigating a trade-off between social status at work, which supports their economic advancement, and social status as mothers.

Connell (1987) argues that a theory of gender is pointless if its basic determinants are biological, writing that “there is a strong relationship between social practice and biology; indeed gender would be inconceivable without it” (67). This perspective posits that although biology and the body, including women's biological ability to lactate and breastfeed, are not the basis for gender inequality, these sex-based differences can be used to further it. The policy challenge is to take seriously the constraints on breastfeeding and women's lives that are created by gender inequality and work to remove them in ways that do not simply re-create false, unattainable good-mother ideologies.

Although feminists’ and La Leche League's philosophical positions seem very different, they are actually flip sides of the same argument—women's bodies, including lactation, are used by individuals and society to establish a biological framework that, depending on your perspective, either constrains or empowers women. Those who see biology and the body as constraining seek to minimize its importance, whereas those who see the body and its functioning as liberating want to maximize and celebrate its importance and potential. Unfortunately, these differences create a public discourse that posits a false dichotomy between the body as opportunity and resource and the body as constraint and stressor.

Connell (1987) highlights two important things left out of the logic of the argument that the body is constraining. First, although there can be physical costs to breastfeeding (Kelleher 2006;Smith 2012), many people find body issues, including pleasure, suckling, or childbirth, to be important in their experience of sex and gender. These bodily experiences are real, and women should not have to sacrifice them. Second, and of critical importance: although there are biological differences between men and women, these differences are not responsible for the arrangement of social institutions that construct gender inequalities. Instead, culturally elaborated distinctions between men and women can form the basis of a socially constructed distribution of power that values masculinity over femininity. As Connell (1987) notes, “The gross exaggeration of gender is part of a continuing effort to sustain the social definition of gender that is necessary precisely *because the biological logic*, and the inert practice that it responds to, *cannot sustain the gender categories*” (81; emphasis in original). Ruth Hubbard (1990), for example, wrote 20 years ago that “biological differences between women and men are used to rationalize the stratification of the labor force by sex; they do not explain it. If society stratifies the work force into women's and men's jobs it does so for economic, social, and political reasons. Such stratification is not mandated by biology” (124).

The opposite of this position, however, is less articulated: Because the bodily and biological differences between men and women are not the true source of social gender inequities, the social and feminist decisions to ignore real differences in biological abilities or needs does not necessarily lead to gender equality. US employment practices that have largely ignored the needs

of mothers that extend from their unique biology—for example, failing to provide maternity leave to recover from childbirth, and workplace lactation support—have not led to equity in the workplace. Rather these policies feed into the prevailing ideology that holds to the superiority of masculinity. Indeed, negating—or working against—the needs of the body may serve to exaggerate the differences between men and women by making it *more* difficult for women to perform as "ideal workers" (Fletcher 2005; Williams 2000).

Social policies and norms that fail to value women's unique abilities work against the female body and its needs and, in so doing, fail to provide the supports the female body needs to fully participate in the social world. In essence, the body is important, and it becomes deterministic not only when its value, constraints, and/or needs are placed ahead of other characteristics or criteria (i.e., denying women employment opportunities because they are pregnant) but also when its value, constraints, and/or needs are ignored or minimized (i.e., denying women maternity leave). As such, negating the female body may transform the distribution of gender inequities in ways that lead to relatively greater equity for women who choose not to become mothers or not to breastfeed; the most inequity might be felt by mothers who cannot afford even to take the minimum six weeks of unpaid leave mandated by the Family and Medical Leave Act, those who do not qualify for it, those without private offices, or with only minimal control over their time. In effect, the failure to support women's bodies means that women who have less control over their time, their space, and their bodies bear the greatest burden. This redistribution may be partly responsible for the demographic patterns of breastfeeding in the United States and increasingly around the world, whereby women marginalized by education, race, income, and marital status are less likely to breastfeed (Lucas and McCarter-Spaulding 2012; Smith et al. 2012).

THE BODY AND SOCIAL POLICY

The body is mixed up in many social practices, not just gender. Bodies do many things and have many needs: they move, they breathe, they communicate, they carry babies and give birth, they lactate, they eat, they void, and they sleep. Sometimes the structures and policies of society work against the body, but at other times they do not. Society makes choices about when, where, and to what extent it will and will not value, recognize, and adjust to the needs of bodies. The dividing line may arise from benign neglect, from ignorance, or from an interest in creating or preserving particular power structures. We can observe when and where the structures and policies of society value, recognize, and adjust to the needs of the body, and which bodies are allowed to move, communicate, or void as needed. We can also observe how the structures of society have changed (or not) over time in response to the needs and demands of those who fall outside some prescribed dominant construction.

There are numerous non-breastfeeding-related examples of how social policy has and has not responded to the needs of the body that are illustrative. The Americans with Disabilities Act provided millions of disabled Americans with "reasonable" accommodations for equal

employment that are person specific; for instance, a deaf person may need a sign language interpreter, while a diabetic may need regular breaks to monitor blood sugar and insulin (US Equal Employment Opportunity Commission 2008). Alternatively, those who are fortunate to be able to void as needed while at work may not recognize the ability of the body to void (that is, "go to the bathroom") as a workplace accommodation to the needs of our bodies. However, those who cannot void as needed in the workplace well appreciate the toll this takes on their bodies and minds. Linder and Nygaard (1998) discuss the consequences for workers whose access to toilets is restricted, including a kindergarten teacher without aides who would have to line 20 children up outside the bathroom while using it (2). These authors note that not only is the right to void in the workplace a matter of pride and dignity it is also a health issue because restricted voiding leads to urinary tract, kidney, and bladder infections, causing damage and pain in both men and women. These two examples highlight how the policy decisions to accommodate bodies—and which bodies and under which circumstances—are a deliberate social choice, and how ignoring the needs of the body may, and does, lead to systematic inequality, while accommodating specific and unique bodily needs can create more opportunity.

BREASTFEEDING POLICY RESPONSES

Van Esterik (2012) reminds us that feminist theory "requires us to embrace both/and not either/or explanations." To move beyond the constraining "same or different" duality, we need to reframe the way we conceptualize the body's role in gender inequality and, as well, lactation as a source of constraint. Gender is about biology and about social practice; the body can be both constraining and liberating; breastfeeding is biological and social. Women's biological ability to lactate and the needs of breastfeeding mothers do not lead to an inevitable social role for women, and this biological sex difference is not responsible for the arrangement of socially determined economic, political, and social expectations, rewards, and opportunities that construct gender inequalities. Negating the lactating body does not eliminate gender inequality for most women. Instead, women whose bodily needs are not met must either seek special treatment or forgo opportunities to which they might otherwise have access or be entitled. As such, negating the body serves to exaggerate gender differences, redistribute gender inequities, and raise the costs of breastfeeding. These costs, in turn, may constrain women's lives and opportunities.

Williams (2000) refers to "an old gender war" that keeps us from designing and securing new public policies and systems that restructure work, family, power systems, and social constructions of sexuality to dismantle gender inequality. Locating the source of gender inequity in the woman's body is part of the old war that continues to undermine working parents, particularly mothers. Locating the constraints outside the body and in the arena of gender inequality helps us better recognize the existence of deliberate decisions about how women's and men's bodies and lives are differentially accommodated in our polices and the specific interests and privileges that are being served by these decisions. This location may also help us identify how arguments for the passage of social polices that accommodate women's lactating bodies and breastfeeding practices are part of a larger social response to accommodating different bodies

and lives as part of our progress toward equal opportunity. The costs of breastfeeding for many women, including unresolved physical problems (Smith 2012), feelings of shame, guilt, and embarrassment for not breastfeeding *and* for breastfeeding (too long or in the wrong space or place) (Kelleher 2006;Taylor and Wallace 2012), loss of income, low involvement of fathers in early child rearing (Rippeyoung and Noonan 2011; 2012), and the sexualization of breastfeeding (Li, Fridinger, and Grummer-Strawn 2002), are not caused by a sex-based ability to feed babies. Rather these costs are elevated by norms, policies, and practices that arise from and, in turn, sustain gender-based inequalities in labor, power, and social relationships. It is important not to ignore these costs to women who want to breastfeed; we can, however, address these without accenting formula use as the key solution (Rippeyoung and Noonan 2012; Lubold and Roth 2012; Taylor and Wallace 2012).

Bianchi (2011) writes that "the 'work and family' problem has no one solution because it is not one problem. Some workers need more work and more money. Some need to take time off around the birth of the child without permanently derailing a fulfilling career. Others need short-term support to attend to a family health crisis. How to best meet this multiplicity of needs is the challenge of the coming decade" (Bianchi 2011, 15). Add to that list the fact that some women want to breastfeed at work. Social and labor policy solutions that follow from the view that gender inequality is the location of breastfeeding constraints would seek to redress labor structures and policies that devalue motherhood and place primary responsibility for caregiving on women; power structures and norms that hold up the male body as authoritative while sexualizing the female body; and norms that construct breastfeeding alternatingly as moral when not chosen and sexual when practiced outside private spaces.

One set of policy and practice solutions are those that allow the costs of parenting, including breastfeeding, to be shared by fathers, communities, businesses, and governments. One example is the new provision of the US Patient Protection and Affordable Care Act of 2010 requiring employers with 50 or more employees to provide hourly workers with the time and space to pump. An additional solution, also courtesy of health care reform, is that new health insurance plans must cover, with no cost sharing, comprehensive lactation support and counseling and breastfeeding equipment rentals (US Department of Health and Human Services, Health Resources and Services 2012). Other potential solutions include increasing workplace flexibility; increasing the availability of child care at or near work; strengthening health care and community systems that help women acquire good knowledge and skills about breastfeeding; and developing public health and educational campaigns that acknowledge the important roles families and communities can play in making breastfeeding easier (see US Department of Health and Human Services 2011 for a comprehensive array of solutions).

However, research indicates that policies also need to be accompanied by changes in social norms if they are to be effective. Research from the National Study of the Changing Workforce found that even when employees had access to workplace flexibility many were worried about using it (Galinsky, Sakai, and Wigton 2011). Other studies have found that women who did take

advantage of employer-sanctioned flexibility suffered negative consequences, such as smaller salary increases, missed promotions, and more negative performance evaluations (Glass 2004; Judiesch and Lyess,1999). My research found that supervisors were more supportive of women pumping at work than they were breastfeeding at work; the difference stemmed largely from concerns related to public exposure of the woman's breast and the perceived need to place limits on where and how women breastfed (Smith 2011). Similarly, breastfeeding women have themselves expressed concerns about breastfeeding or pumping at work even when there are no policy obstacles, as in this example from Smith (2009): “My colleague [who is breastfeeding] washes her pump in the bathroom, which I never felt comfortable doing because I didn't feel comfortable letting my students know … that I was still pumping, that I was nursing. I felt it was personal [and might] potentially undermine my authority.” Passage of breastfeeding and family-friendly policies must, therefore, be accompanied by concurrent efforts to normalize breastfeeding and by ongoing vigilance and assessment to ensure that women's economic, political, and social status is not compromised.

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