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Lactating in St. Louis: Attachments, Technologies, and Disparities

Sarah Sobonya

Washington University in St. Louis

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WASHINGTON UNIVERSITY IN ST. LOUIS

Department of Anthropology

Dissertation Examination Committee:

Shanti Parikh, Chair

Barbara Baumgartner

Aunchalee Palmquist

Elizabeth Quinn

Bradley Stoner

Vetta Sanders Thompson

Lactating in St. Louis: Attachments, Technologies, and Disparities

by

Sarah Sobonya

A dissertation presented to the
Graduate School of Arts & Sciences
of Washington University in
partial fulfillment of the
requirements for the degree
of Doctor of Philosophy

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List of Abbreviations

AAP	American Academy of Pediatrics
CLC	Certified Lactation Counselor
FQHC	Federally Qualified Health Center
IBCLC	International Board Certified Lactation Consultant
IFBAN	International Baby Food Action Network
MICA	Missouri Information for Community Assessment
NACCHO	National Association of County and City Health Officials
PCOS	Polycystic Ovarian Syndrome
SIDS	Sudden Infant Death Syndrome
WIC	Special Supplemental Nutrition Program for Women, Infants, and Children

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Chapter 1

Lactating in St. Louis: Situating the Dissertation

1.1 Introduction

When I gave birth to my own daughter, I was lucky. Not in all respects: I was young and single and living on welfare and food stamps, with a GED and no job. With breastfeeding, though, I was lucky. Right after giving birth I opened my hospital gown and held my newborn daughter against my breast, and she expertly attached herself and began to suckle. After a period of uncomfortable engorgement, it was smooth sailing, and in defiance of the expectations for women in my situation I continued to breastfeed to the one-year mark and beyond.

In fact, those expectations were a significant reason that I did continue to breastfeed. The Clinton regime's increasingly draconian welfare "reforms" and my perception that there was broad public support for these policies left me feeling stigmatized as a bad mother who was unable to financially support her child. Health care providers invariably assumed I was formula feeding, and I latched on to breastfeeding as evidence of my maternal competence, proof that I could give my baby the best form of nourishment even if I could not give her the benefits of a two-parent family or a middle-class life. For me, then, breastfeeding was a way to separate myself from the stereotype of the uncaring welfare mother and instead attach myself to a more middle and upper class maternal community, even if only in my own mind. This attachment was shaped by both my own personal situation, as a young, white, and poor single mother, and by the political and social climate in Arizona, where I lived during the 1990s, which maligned recipients of government benefits and promised redemption through the adoption of white middle class values, like breastfeeding.

I use this idea of maternal attachments to frame my dissertation. My dissertation looks at the effects of different attachments on breastfeeding beliefs and practice in the St. Louis, Missouri, region between 2013 and 2015. The reasons for women's choices to breastfeed or not to breastfeed are complex, and structural barriers are often intertwined with values and beliefs about breastfeeding. Much of the research on breastfeeding that comes from the public health perspective looks at specific factors, such as a mother's level of education or where she gives birth, and attempts to quantify their influence on breastfeeding initiation and duration. This is a functional approach that, while useful in ascertaining the effectiveness of a particular intervention, necessarily loses much of the nuance and interplay that shape decision-making. Although my project began as an investigation of breastfeeding's direct monetary costs for women, I quickly found this line of inquiry to be frustratingly inadequate to explain the patterns of purchasing that I was seeing. Thus, I shifted my focus so that I could better understand the complexity of women's attitudes and responses.

To do this, it was helpful for me to think of each woman as part of an invisible web of connections, which I refer to as attachments. Women navigate breastfeeding while simultaneously managing their attachments at three different levels: intrapersonal attachments to beliefs and conceptions about themselves; attachments to the values and priorities of their social groups; and attachments shaped in response to larger structural and ideological forces in society. Other medical anthropologists have theorized similar levels of analysis: Nancy Scheper-Hughes and Margaret Lock described the individual body-self, the social body, and the body politic in their discussion of the mindful body, while Merrill Singer and Hans Baer posited four levels of analysis: macro-social, intermediate social, micro-social, and individual (Scheper-Hughes and Lock 1987; Singer and Baer 1995). While it can be useful theoretically to examine these levels

separately, in reality the separation is an illusion. For example, my (intrapersonal) attachment to feeling like a good mother led to my (social) need for approval from other mothers in my community, as a response to the (societal) vilification of welfare mothers through political and structural changes.

I argue that the notion of attachment is at the center of the act of breastfeeding, just as infant's attachment to his mother's breast is the first necessary step to nursing. This primary act of attachment may be repeated hundreds or thousands of times over the course of a breastfeeding relationship, and while at first many mothers struggle to achieve the correct position and the perfect "latch," if all goes well it soon becomes something many breastfeeding mothers can literally do in their sleep. In the same way, mothers hold attachments to various beliefs, values, social groups, ideologies, and structural realities, and these too may be removed from conscious awareness. For example, a woman who believes that fathers and mothers should contribute equally to parenting might view exclusive breastfeeding as a contradiction of that ideology, or a woman who must return to work a few days after her baby is born might not consider breastfeeding in light of this necessary early separation. In St. Louis, as well as in many American cities, race and socioeconomic status strongly influence how women understand, form, and enact these attachments. While this dissertation is about the ways women's attachments influence their beliefs about and practice of breastfeeding, it is also necessarily about the ways racial and socioeconomic disparities are manifested through breastfeeding beliefs and practices, so that breastfeeding serves as a lens through which these oppressions and disparities can be more fully viewed.

In my examination of shifting and competing attachments around lactation, I am particularly interested in three broad questions. First, I examine how constructions of good

motherhood, as deployed by women themselves and by different breastfeeding professionals, interact with women's breastfeeding practices and state policies concerning breastfeeding, as well as with wider processes of institutional racism, capitalism, and the consumer marketplace of breastfeeding. I also look at the idea of breastfeeding as natural and the ways this conceptualization has been promulgated by breastfeeding experts and public health agencies, as well as the ways this is reinterpreted and complicated at the local level. Finally, I examine the impacts of new technologies such as breast pumps that shift the focus from breastfeeding as an intimate process to breastmilk as a measurable product. By studying the interplay between these areas of inquiry and the pervasive structural inequalities in my research setting, I hope to gain a clearer picture of the local breastfeeding landscape.

In the remainder of this chapter, I situate my research historically, theoretically, and methodologically. I begin with an extended vignette that illustrates the racism and racialization in St. Louis breastfeeding support and advocacy. I then chronicle the history of the region, with a focus on practices and policies that led to racial and socioeconomic segregation in the region today. I follow this with a discussion of the bodies of literature relevant to my project and an explanation of my research methods. Finally, I conclude this chapter with an outline of the remainder of the dissertation.

1.2 “Disparities Pimping”: Breastfeeding in a Divided City

I began my research in 2013 expecting race to be a salient theme, and I quickly found that it was. In St. Louis, a racially segregated city with a history of institutional and structural racism (described later in this chapter), race is nearly always relevant. It is often difficult to disentangle the effects of race and racism from the effects of poverty, although as poverty itself can be effect

of racism the question becomes tautological. Most of my research took place before an unarmed African American teenager named Michael Brown was killed by a Ferguson police officer in 2014, an incident that catapulted the region's pervasive and systemic racism onto the national stage, but these racial divisions and inequalities were always here, even when publicly unacknowledged.

As part of my research, I spoke with both white and African American lactation professionals and breastfeeding advocates working in different settings. Both groups were aware that breastfeeding rates were lower among African American women than white women, increasing health-related risks to both African American women and their children (Hauck et al. 2011; Victora et al. 2016; Bartick 2013, and many others). However, the question of how to increase these rates highlighted some key conflicts between white and African American advocates. A number of white breastfeeding advocates, most of whom were older women with certifications and degrees, believed that their formal education and years of experience as lactation professionals qualified them as experts in all aspects of breastfeeding support, and they did not acknowledge that African American mothers needed or wanted anything substantively different from what they were already providing. Many African American breastfeeding advocates believed that the white advocates had already failed to provide culturally appropriate breastfeeding support to African American women in St. Louis, and thus were frustrated by the white women's refusal to acknowledge their culpability. The white advocates' access to institutional and economic power further exacerbated the separation, as their voices were repeatedly privileged. In this section, I highlight some of the specific ways I saw both white and African American women attempt to increase breastfeeding rates among African American women, including a detailed account of the grant-funded initiative I call Breast Friends Rising,

and I point out some of the ways structural inequalities and implicit racial biases influenced the progression of these efforts.

At the time I began my research, some African American breastfeeding advocates were already working within their communities to support breastfeeding mothers. The Breastfeeding Café I attended at a north St. Louis WIC (the Special Supplemental Nutrition Program for Women, Infants, and Children, described in more detail later in this dissertation) clinic in late 2013 is an example of this. The cafe was organized by two WIC employees, a breastfeeding peer counselor and a board-certified lactation consultant. All of the attendees were African American, as were the two WIC employees, who had used their own money to purchase juice and pastries for the Café. The materials they presented included a guide created specifically for African American women by the United States Office on Women's Health (2013) and a short film about breastfeeding that depicted African American, Latina, and white women breastfeeding. When I spoke with the peer counselor after the Café, she thought that it had gone relatively well but she was feeling discouraged by the how difficult it was to increase breastfeeding rates among the women in this community. Shortly after this, she took a medical leave from her job, which was part-time and paid only slightly more than minimum wage, and then she left WIC altogether. This story illustrates both the efforts of African American breastfeeding advocates and the lack of institutional commitment for their efforts, leaving them financially and emotionally sapped.

In 2013, when I joined the organization I call the St. Louis Alliance for Breastfeeding, there were no African American women attending the meetings. This non-profit advocacy group, which focuses on promoting breastfeeding and protecting the rights of breastfeeding mothers, rather than on providing direct breastfeeding support, was and is comprised of breastfeeding advocates and professionals working in both the public and private sector. Many of the members

worked with lower income women in varying capacities related to breastfeeding, and although race was not often explicitly mentioned during the meetings I attended in 2013 and early 2014, the demography of St. Louis and the geography of social services made it clear that many or most of these clients were African American.

The first Alliance meetings I attended included both formal and informal discussion about the group members' lower income clients. Sometimes the discussion was about ways to support these mothers, such as which medical billing code should be used to ensure that a mother on Medicaid will be eligible for a free breast pump. However, some white and middle income lactation professionals expressed frustration with their African American and poorer clients. For example, at my first meeting a member alluded to the previous meeting, when a guest had discussed the CDC guidelines for infant formula preparation in light of recent cases of Cronobacter bacterial contamination in Missouri and other states (Centers for Disease Control and Prevention 2012). According to the member, these guidelines included heating water to be mixed with powdered formula to 170 degrees (the CDC actually says 158 degrees) and then letting it cool to body temperature before feeding it to an infant who is less than three months old. "But of course none of *them* do that!" said the member with an eye roll, and others agreed that this practice was not something they had seen among their own clients. No one brought up the constraints that might impact a mother's ability to carry out these guidelines, such as access to a way to heat water for every feeding or having the time to do so.

By the middle of 2014, white breastfeeding supporters in the greater St. Louis area were beginning to focus more explicitly on breastfeeding's racial disparities, possibly in response to an increased emphasis on the issue by national La Leche League management. Many Alliance members were also involved in La Leche League, an international breastfeeding support

organization that I describe more fully in Chapter 3. For example, during this period Gina¹, a white Le Leche League leader and social justice activist, began bringing Annie, an African American breastfeeding advocate who did not own a car, to Alliance meetings. Over the next few months, Gina was active in promoting events such as a celebration of Black Breastfeeding Week, but I noticed that she was generally careful to amplify the voices of African American women rather than to speak for them. On one occasion, I observed Annie calling Gina out for overstepping, and Gina responded by apologizing and modifying her tactics. The two of them eventually developed a strong and mutually respectful relationship, which was apparent when they co-presented at the powerful breastfeeding class described in Chapter 5.

In contrast, other efforts to reduce this disparity were controlled entirely by white women. A white lactation professional and activist, Nancy, planned and funded what she called a “Multicultural Breastfeeding Photo Project” titled “Breastfeeding: The Universal Language of Mothers and Babies.” She recruited mothers from WIC, La Leche League meetings, and other connections, and gathered fourteen nursing mothers for a group photo shoot as well individual photos of each mother nursing her child (or children, in the case of the mother of twins). Three of the women in the photograph identified themselves as black and two as biracial (black and white). One of the black women was an immigrant from Africa and wore a dress from her country of origin, and one of the women was Latina and an immigrant from South America. Although the project was done under the auspices of the St. Louis Alliance for Breastfeeding, Nancy conceptualized, funded, and implemented the project.

¹ All names in this dissertation, except those of public figures, are pseudonyms.

In the almost two years since the photos were taken, Nancy has attempted to get prints of the photos made to either sell or give to local pediatricians and clinics, using money that she donated to the Alliance for this purpose, but as of June 2016 nothing had come to fruition. Although Nancy used the word “multicultural,” her focus was primarily on recruiting African American women. In contrast to Gina, who prioritized the voices of African American women and ensured that they were involved in decision-making, Nancy did not solicit input from women of color, or really from anyone, before embarking on her project. She provided lunch and a free 8 x 10 portrait to each mother, and my impression was that these portraits were the main reason women participated, and not a belief in the importance of this project as a way to combat racial disparities in breastfeeding.

Not all efforts were benign. In spring of 2014, I had a disturbing conversation with a white WIC employee about her efforts to increase breastfeeding rates among her African American clients. She was aware that there were places where women could sell breastmilk online, such as Craigslist and the website Only the Breast (www.onlythebreast.com), and she told me that she sometimes shared this information with her clients, particularly very low income clients, believing that they would be more likely to breastfeed if they realized they could make money by selling their milk². When I asked her what they would then feed to their own babies, she suggested that mothers would only be selling their excess pumped milk, but then added that even if their babies only got some breastmilk it would still be better than none at all.

This assertion that receiving payments for selling breast milk would lead to more women breastfeeding their own infants was eerily similar to that of executives from the bioscience

² This is probably a violation of WIC rules, and I have no reason to suspect that other WIC staff members knew about or condoned her actions

company Medolac, which helped to establish the benignly-named Mothers Milk Cooperative in Detroit during this same time period (Allers 2014). Medolac, a for-profit corporation, targeted African American women in Detroit in an attempt to convince them to sell their breastmilk for \$1 an ounce, which it then converts into a shelf stable product sold to hospitals for \$6 an ounce. Like the WIC employee with whom I spoke, Medolac's founder Elena Medo argued in an interview that these payments would make women more likely to breastfeed their own babies and to breastfeed them for longer periods, but offered no evidence to back up this claim. After African American breastfeeding activists vociferously protested Medolac's campaign the company pulled out of Detroit, while still arguing that their only intention had been to help mothers stay home with their babies for a longer period (Buia 2015).

Questions of propriety and profits are salient not only to the commodity of breast milk but also to the commodity of breastfeeding support. In fall of 2014, shortly after the death of Michael Brown, the National Association of County and City Health Officials (NACCHO) issued a request for applications for projects aimed at reducing breastfeeding disparities through peer and professional support. Gina shared the announcement via email with a number of local breastfeeding advocates, including a few African American women, and all were enthusiastic. A group coalesced to write the grant, which was due less than a month later. From the beginning, the issue of who would take ownership of the project was an issue. Gina argued that the Alliance should not take the lead on the grant, but should instead work to assist existing organizations from the community to be served. Others argued that there were no organizations supporting breastfeeding in this community, or at least none capable of writing a fundable grant in three weeks, and because of this the Alliance was eventually designated as the organization applying for the grant.

The role that La Leche League was to play was in this project was a contentious issue. At this time, there were no African American La Leche League leaders in the greater St. Louis area. Some members of the grant-writing group envisioned using the grant funds to expand La Leche League, specifically planning to hold meetings in the primarily African American north St. Louis county cities of Ferguson and Jennings; to recruit and train African American women from the community to be La Leche League leaders; and to hire a (white) consultant to write a “cultural competency” curriculum to be used by that and other La Leche League groups. I found all of these ideas extremely problematic. At one grant writing meeting, I pointed out that a La Leche League meeting had been held near Ferguson for many years but it been disbanded after many consecutive months when no one attended other than the leader who was running it. I suggested that this might indicate that the La Leche League model did not meet the needs of this community. A white longtime La Leche League leader dismissed my concern, suggesting it was more likely that the day of the week was a problem because many people were busy on Monday nights. This statement exemplifies how strongly many of the white women writing the grant defended La Leche League as a model and actively resisted the idea that this program did not meet the needs of many African American women. Rejecting La Leche League was tantamount to rejecting the superiority of white knowledge and white practice, an idea these white women found intolerable.

In the other camp, Gina, Annie, and others, including myself, proposed that the grant include funds to investigate existing interventions being used in the United States to successfully increase rates of breastfeeding among African American women and determine which would best fit in our region, giving African American breastfeeding advocates the autonomy to determine for themselves what the program would look like. The final grant was a combination

of the two approaches, with a significant role for La Leche League as well as funding for the cultural competency curriculum, but also a provision for hiring “Breastfeeding Champions” from the local community and funding for them to visit other programs. The grant also left open the possibility for these Champions to choose other pathways to become lactation professionals besides becoming La Leche League leaders.

Sherry Payne, an African American breastfeeding advocate in eastern Missouri, was unhappy that the Alliance had applied for the grant at all, believing that the organization’s lack of ties to the St. Louis area African American community should have dissuaded it from applying. Payne, an RN (Registered Nurse) and IBCLC (International Board Certified Lactation Consultant) who directs a non-profit organization aimed at improving maternal and infant health in African American communities called Uzazi Village, wrote a blog post in which she obliquely described the Alliance and castigated its members for applying for the grant, calling the move “disparities pimping” and “colonialist” (Payne 2014). While her statement that there was “no representation” from the local community in the writing of the grant was a small overstatement, the input from the few community members who were part of the process was indeed slight and their voices were not privileged.

In November 2014, NACCHO notified the Coalition that their project had been funded and would be receiving almost \$50,000 over the next 18 months. A white Coalition member with an MPH degree, Olivia, was designated the program director and four African American women, including Annie, were hired as Breastfeeding Champions. The women quickly renamed themselves Breast Friends. The original grant called for two administrators and three Champions, but the Champions advocated for a restructuring. They also disagreed with the initial salary structure, in which the program director was paid a higher hourly wage, and this too was

changed, although none of the Champions realized that Olivia was receiving additional funds from the grant to offset the costs of her “home office.” None of the positions were close to fulltime, although the number of hours fluctuated over the course of the grant.

By January, it was clear that at least some of the Breast Friends wanted greater ownership of the project and resented what they viewed as Olivia’s attempts to control the project. That month, many of the Alliance members who had worked on the grant met with the Breast Friends at a North County library to discuss the way the grant would be implemented. The Breast Friends arrived late and sat together, two of them caring for their children during the meeting. Although Olivia was clearly working hard to bridge the gap, the mood was tense. Alliance members talked about starting a La Leche League meeting in the area as soon as possible and had already created flyers, but the Breast Friends were resistant to the idea and were focusing on visits to other African American-focused breastfeeding organizations.

Halfway through the meeting, after an Alliance member described the usefulness of the La Leche League training, one of the Breast Friends spoke sharply, stating that the Breast Friends had already said that they were not going to use the La Leche League model. “You aren’t going to do mother to mother support?” responded another Alliance member disingenuously, implying that the La Leche model was the only way to provide mother to mother breastfeeding support. These continual references to La Leche League even after the Breast Friends has very clearly and repeatedly said that they were not interested in this model were an example of the central conflict that was evident from the early stages of this project: which group would be acknowledged as experts in supporting African American women who want to breastfeed?

I include this section in order to highlight some of the specific ways race and racism affects breastfeeding support and advocacy in this region. While all of the women I write about

in this section are passionate about increasing the number of African American women who breastfeed, many of the white women involved act in ways that preserve racist structures and undermine this effort. Framing breastmilk production as a way to earn some extra money, rather than as a way to nurture and protect one's own child, assumes that the former is more motivating for the mother, perpetuating stereotypes that paint poor African American women as bad mothers who do not care about their children. When white women repeatedly contradict African American women who are speaking about the breastfeeding support needs of their own communities, they are denying the validity of these voices and privileging their own, reinforcing the idea that only white people can be experts.³ This dissertation unpacks some of the effects of this pervasive racism.

1.3 St. Louis: History and Demography

St. Louis's racially segregated history and demography strongly influence the region's breastfeeding patterns. As of the 2010 United States Census the city of St. Louis had a population of 319,294 people and the population of the entire St. Louis metropolitan area was almost 2.8 million (United States Census Bureau 2015). Although the United States as a whole has become more racially diverse and integrated during the past decades, in a number of cities, mainly in the "Rust Belt" region in the Midwest and Northeastern United States, black-white segregation has been significant and persistent (Logan and Stults 2011). The Index of Dissimilarity for Black-White segregation in the St. Louis region in 2010 was 70.6, the ninth-highest in the country and a drop of only 11 percentage points in 30 years. Demographers

³ For more on this idea, I recommend: Tochluk, Shelly. *Witnessing whiteness: The need to talk about race and how to do it*. R&L Education, 2010.

consider an index of 60 or above to be very high. St. Louis is also a region with significant socioeconomic diversity and segregation, and it is unusual in that one city block can sometimes be all that separates million dollar homes from impoverished urban neighborhoods (Strasser 2012). Delmar Boulevard in St. Louis city is commonly called the "Delmar Divide" because it separates the northern section of the city, where residents are more likely to be African American and low income, from the southern section, where the residents are mostly white and more economically privileged. This divide has deep historical and political roots.

As in many United States cities, efforts to forbid African Americans from residing in certain areas of the city began in St. Louis in the early twentieth century (Gordon 2014). In 1910, only 6.4% of St. Louis's population was African American, but as that proportion grew during the next decade with the Great Migration north, white St. Louis residents formed a group called the United Welfare Association and began to agitate for legally mandated segregation (Primm 1998). Although the majority of the city's aldermen were against the initiative, the Association gathered enough signatures to force an election. In February of 1916, St. Louis passed the country's first segregation law legislated by initiative petition by a vote of 52,220 to 17,977. Under this law, no one was permitted to move to a block on which more than 75% of the residents were of a different race than he was.

The NAACP quickly filed a court injunction preventing the implementation of the initiative, and a 1918 Supreme Court ruling made the injunction permanent (Primm 1998). However, white people in favor of residential segregation found other methods of enforcing it. Many created neighborhood associations which then attached restrictive housing covenants to all residential properties within their boundaries. For example, the Marcus Avenue Improvement Association's housing covenant prohibited the owner from selling to anyone who was not white

for a period of fifty years (Smith 1995). In 1923 the St. Louis Real Estate Exchange created three zones within which residential properties could be sold or rented to African American clients; any real estate agent selling or renting a property in another area of the city to an African American client could lose his license (Gordon 2014). Governmental actions that supported racial segregation included enforcement of housing covenants, as well as the provision of subsidies for suburban development projects if they guaranteed the exclusion of African American residents and tax laws favoring private institutions that practiced segregation (Rothstein 2014). In addition, beginning in the 1930s, newly-created federal mortgage insurance programs routinely gave African American neighborhoods significantly lower ratings than white neighborhoods, making people buying houses in these areas ineligible for the lower interest rates and reduced down payments that these programs provided, in a process referred to as redlining (Covert 2014).

Segregation was the norm in public housing projects during this era. The most famous public housing project in St. Louis, Pruitt-Igoe, was initially segregated, with the Pruitt building reserved for African American tenants while the Igoe building housed only white tenants (Cendón 2012). By the time Pruitt-Igoe opened, in 1954, more groups were effectively challenging legally sanctioned segregation. Racially discriminatory housing covenants were banned in 1950, and the Supreme Court's handed down its landmark decision in *Brown v. Board of Education* in 1954 (Trifun 2009). White Pruitt-Igoe residents, concerned that they might soon be expected to live next door to African American residents, moved out of the project and often out of the city altogether, and this drop in rental income created a lack of funds that continued to grow over the life of Pruitt-Igoe (Cendón 2012). Although the federal government had funded

the project's construction, federal law required the local housing authority to pay for upkeep and maintenance with rental income, which rapidly became inadequate (Freidrichs 2011).

By the 1960s, crime was rampant in the area and the inhabitants of Pruitt-Igoe were increasingly blamed, although the vast majority of the residents were not criminals but rather poor African American families trying to survive in increasingly inadequate housing (Freidrichs 2011). With occupancy rates falling, the housing authority raised rental rates for the remaining tenants, charging some families more than their entire monthly income for rent. In 1969, Jean King led tenants in a rent strike that lasted almost a year, resulting in an agreement that limited rent to 25% of a household's income and required more tenant involvement in the management of the community (Barnes 2012)⁴. While the agreement signaled a sea change that would eventually spread through the country, it was not enough to save Pruitt-Igoe. The buildings were demolished between 1972 and 1977, and today the 33 acres of the original 57-acre site, which was once home to 15,000 people (Allen and Wendl 2013), is now an overgrown tangle of weeds and trees behind a leaning chain link fence.

The story of Pruitt-Igoe reflects many of the larger trends occurring in St. Louis during the latter half of the twentieth century. Between 1950 and 2000, the city of St. Louis lost an average of about 10,000 people per year (Gordon 2014), most of them white residents who moved first to inner-ring suburbs and then continued to migrate west to more distant suburbs. Between 1950 and 1990 half a million white people left the city, while the African American population in the city increased by about 35,000, shifting the demographic balance from 82%

⁴ According to Barnes (2012), the first meeting to organize the strike took place at the nearby Blumeyer housing project, which became Renaissance Place, the HUD HOPE VI community where I lived during the first year of my research.

white to just over 50% white (Gibson and Jung 2005). This “white flight” had clear financial implications for the city, as those with the resources to move to the suburbs were wealthier than those who stayed behind, creating and perpetuating a cycle that left poor black residents in a city with progressively declining resources (Gordon 2014). The racial and economic conditions in St. Louis today stem directly from these events that occurred during the past century, during which white residents first attempted to prevent African Americans from living in certain parts of the city through legal means and then, when that proved insufficient, leveraged economic privilege to create and maintain well-off and primarily white suburban regions and impoverished and primarily African American urban ones.

Currently, African Americans comprise 48% of the city’s population and whites 45%, with 7% identifying as “Other” (United States Census Bureau 2014). In St. Louis County, 70% of residents are white and 23% African American. Those overall percentages, however, mask the significant segregation in both city and county, as demonstrated by the St. Louis region section of a dot map created by the Welden Cooper Center for Public Service at the University of Virginia (Figure 1.1). The lines separating white neighborhoods from African American neighborhoods are distinct, with only a few small areas showing significant racial diversity. Although Delmar Boulevard is unmarked, one can easily trace it by following the line separating the green dots in the north from the blue ones to the south. Likewise, Interstate 170, which runs from north to south beginning near Berkeley, effectively separates the St. Louis region’s primarily white western suburbs from the mostly African American neighborhoods to the east.

This segregation and the resulting inequality are demonstrated in numerous ways, many of which were investigated by the For the Sake of All research team from Washington University in St. Louis and St. Louis University and described in their 2014 brief *A Report on the Health*

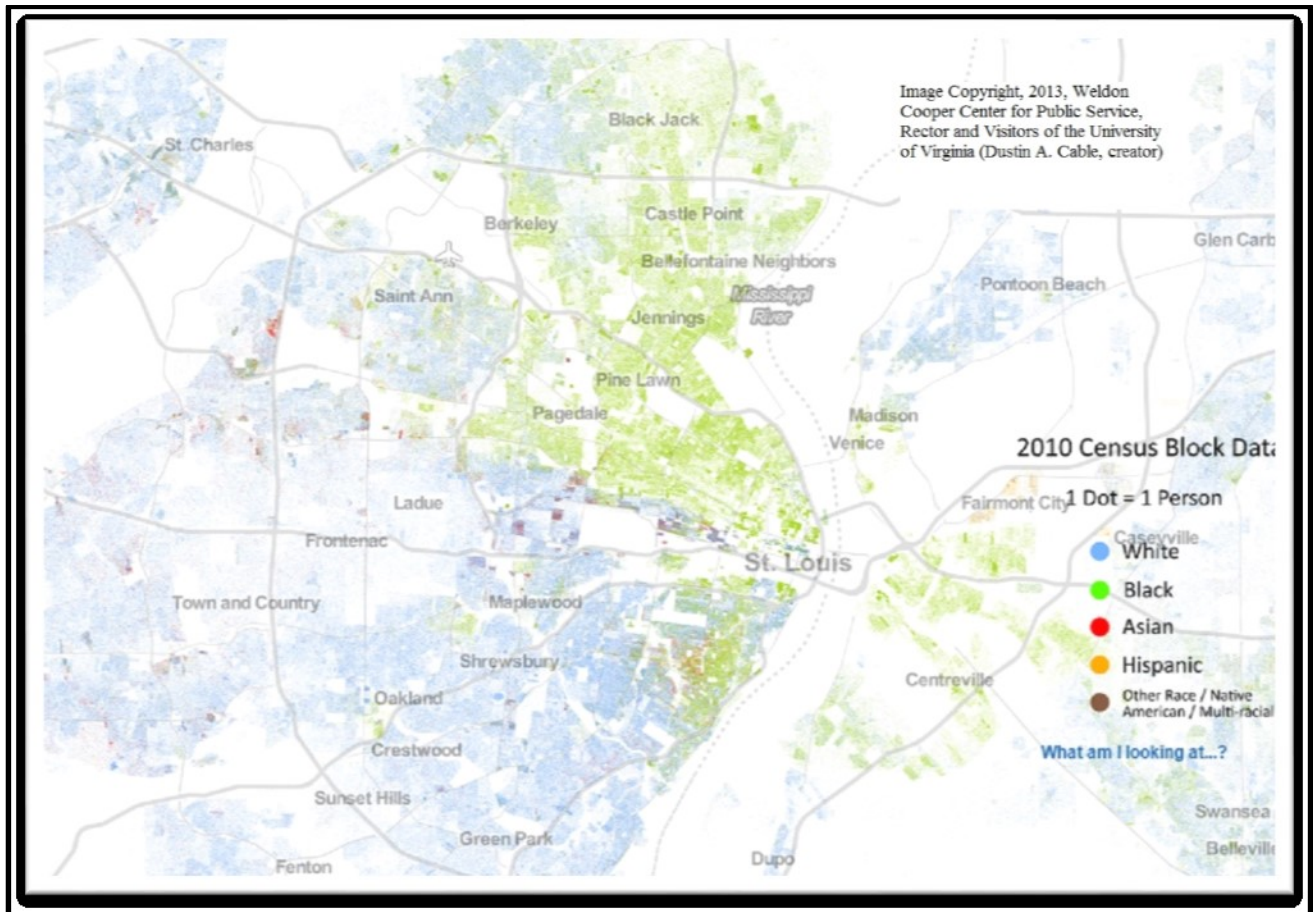


Figure 1.1 Dot map showing the distribution of St. Louis area residents by race, created by Dustin Cable. Source: <http://demographics.coopercenter.org/DotMap/index.html>

and Well-Being of African Americans in St. Louis—and Why It Matters for Everyone. The report meticulously documents significant disparities between white and African American residents in life expectancy, unemployment rates, poverty rates, educational attainment, and home ownership. The disparity is particularly pronounced for pregnant mothers and infants: in 2011, 27% of African American mothers living in St. Louis County and 38% in St. Louis City did not receive adequate prenatal care, compared to 5% and 8% of white mothers, and the infant

mortality rate in the region is three times higher for African American infants than white infants (Missouri Dept. of Health and Human Services 2015).

This pattern of inequality also holds true with breastfeeding. While overall breastfeeding rates for white and African American infants in the St. Louis region are not available, the Missouri Department of Health does track breastfeeding initiation for WIC recipients. In 2012, 72% of white mothers receiving WIC in St. Louis city breastfed at least once, compared to 50% of African American mothers (Missouri Dept. of Health and Human Services 2015). In the county, these rates were 68% and 58% respectively. Like prenatal care, breastfeeding is an important preventative public health intervention, and in this dissertation I show how the disparity in breastfeeding rates is a legacy of this region's history.

In this section I have explored how, over the past hundred years, the St. Louis region became the segregated and unequal place it is today. By situating my research setting in this historical context, I set the stage for later discussions of differences in breastfeeding beliefs and behaviors among women from different racial and socioeconomic categories, which often result from differences in resources and opportunities.

1.4 Review of the Literature

1.4.1 Grounding the Discussion: Introduction and History

My perspective in this dissertation is that of a critical medical anthropologist, and as such I am particularly interested in health equity and the political economy of health. Following medical anthropologists Merrill Singer and Hans Weir's theoretical model of critical medical anthropology, I am explicitly concerned with the social origins of breastfeeding praxis and the social relations that continue to shape it, as well as the issues of state power that underlie these,

(Singer and Baer 1995). In addition, I integrate medical anthropologists Nancy Scheper-Hughes and Margaret Lock's admonition that critical medical anthropology's focus on political economy must not ignore individual perspectives and embodied experiences (Scheper-Hughes and Lock 1986).

I use three key bodies of literature to situate my analysis. First, I draw on existing studies of breastfeeding in medical anthropology that address the two topics introduced above, political economy and embodied experiences. Many of the themes I found in my own research reflect but also complicate concepts explored in these earlier breastfeeding studies, reshaped by the conditions specific to my research site and time. Second, I discuss two areas of breastfeeding research in biological anthropology that provide important context to my work: evolutionary perspectives on weaning and biological perspectives on bedsharing and breastfeeding. Third, I take up critical race theory, looking particularly at intersectionality and applications to health equity. This section begins with a brief history of anthropological interest in breastfeeding and then delves into these three specific areas.

Female anthropologists have been the primary powerhouses behind anthropological studies of breastfeeding, and some of the earliest anthropological work to focus on breastfeeding came out of the feminist focus on women's health during the 1960s and 1970s. Breastfeeding as a distinct field of anthropological study emerged in the 1980s, but the subject was mentioned in a number of earlier ethnographic works, particularly those written by female ethnographers (Richards 1956; Gideon 1962; Kaberry 1952, among many others). Dana Raphael, a student of Margaret Mead, was the first sociocultural anthropologist to devote most of her career to breastfeeding issues. Based on her research on breastfeeding in other societies, in 1969 Raphael introduced the idea of the *doula*, meaning a person who will care for the mother's non-medical

needs during the perinatal period, and she viewed doulas as essential to breastfeeding success (Roberts 2016). After publishing her seminal book, *The Tender Gift: Breastfeeding*, in 1973, she went on to coordinate a team of anthropologists in conducting a worldwide study on breastfeeding for the US Agency for International Development (USAID) in the 1970s (Anthropology News 2016). Her later work included confronting infant formula manufacturers about their contributions to infant mortality and researching the effects of sexual abuse on breastfeeding. Raphael passed away on February 2, 2016.

Anthropologists have long framed breastfeeding as a biocultural process, perhaps best exemplified by biological anthropologist Katherine Dettwyler's co-edited collection titled *Breastfeeding: Biocultural Perspectives* (Dettwyler and Stuart-Macadam 1995). Although few book-length ethnographies have solely focused on breastfeeding (Cecilia Tomori's 2014 *Nighttime Breastfeeding: An American Cultural Dilemma* and Fiona Dykes' 2006 *Breastfeeding in Hospital: Mothers, Midwives and the Production Line* are two rare examples), a number of edited volumes and hundreds of published articles have been published. Anthropological work on breastfeeding is often interdisciplinary, drawing from the fields of nutrition, medicine, public health, sociology, women's studies, and more. An example of this is the recent edited volume *Giving Breast Milk: Body Ethics and Contemporary Breastfeeding Practice*, edited by sociologist Rhonda Shaw and feminist theorist Alison Bartlett (Shaw and Bartlett 2010).

1.4.2 Medical Anthropology: Political Economy and Embodiment

The political economy of breastfeeding encompasses a wide range of topics, from the detrimental influences of multinational infant food corporations on breastfeeding praxis to the ways breastfeeding is shaped by governmental policies on topics such as paid maternity leave

and the acceptability of public nursing. Noted anthropologist Margaret Mead understood these concerns, as she once told her students to "find a way that we can go from the peasant and working class breastfeeder to the elite, well-educated breastfeeder without a generation of bottles in between" (Raphael and Davis 1985:146). Mead's student Dana Raphael, described earlier in this section, was one of the first to directly address infant formula companies about their role in undermining breastfeeding in the Global South (Anthropology News 2016).

Anthropologist Penny van Esterik has written widely on this topic for 35 years, from her piece with Ted Greiner and Michael Latham on the actual prevalence of "insufficient milk syndrome" and the ways that formula companies can "undermine a mother's quantity in the quality or quantity of her own milk (1981:241) to her groundbreaking book *Beyond the Breast-Bottle Controversy* (Van Esterik 1989), a critical feminist analysis that examines the ways of health care systems have become enmeshed with the formula industry, to the detriment of breastfeeding. Her work has been instrumental in revealing the machinations behind infant formula marketing both in the United States and other countries of the Global North, as well as in the developing world. Much of the anthropological work on this topic addresses the interplay between development and modernity in a society (e.g. Obermeyer and Castle 1996; Schepers-Hughes 1993), looking at the structures of power that affect such disparate elements as aid programs, women's work schedules, and beliefs about how to feed infants. More recent research that draws heavily on the political economy perspective tackles topics such as the relationship between structural disparities and informal milk sharing in the United States (Palmquist and Doehler 2014) and the politics of safe infant feeding in a country struggling with AIDS (Kroeker and Beckwith 2011).

Phenomenological research on embodied experience of breastfeeding is another area of focus in the anthropology of lactation. Breastfeeding bodies are, with rare exceptions, female bodies. Even among non-Western societies numerous cultures connect breasts or breastfeeding with sexual intercourse. Van Esterik (2002) noted that prohibitions against intercourse while breastfeeding are common in many cultures and cites the Chagga in Tanzania and villagers in rural Zimbabwe as examples. Anthropologist Carla Makhlouf Obermeyer and researcher Sarah Castle (1996) explained that many cultures believe menstrual blood, if not shed through menstruation, can be transformed into either a fetus or breastmilk. According to them, the prohibition against intercourse during lactation is a method of preventing situations in which the breastfeeding infant and the fetus would be in competition for nourishment from the woman's blood. More recently, medical anthropologist Suzanne Gottschang (2007) found a similar explanation in Chinese traditional medicine for avoiding sexual intercourse directly prior to breastfeeding: according to her informants, because the fetus and infant are in the *yang* state, the pregnant or nursing woman must stay in a *yin* state, so that her yin blood may be transmitted to her child (either in utero or through breastmilk). Receiving her yin blood keeps her vulnerable young offspring balanced, which is essential for good health. Sexual intercourse, as well as certain foods, can make the mother's blood too yang and cause illness for her child.

In the Global North, the association between sexuality and breastfeeding, while it exists, has played out somewhat differently. Elizabeth Murphy, a medical sociologist who carried out longitudinal research with British new mothers, found that breastfeeding mothers were very aware of the societal association between sexuality and breasts and were quick to characterize themselves as modest and discreet, distancing themselves from brazen exhibitionists who nursed their babies by “flashing your flesh” and “flicking it out” (1999:203). American medical

sociologist Cindy Stearns (1999) delved more deeply into the concomitance of the maternal and the sexual within the same body part and the ways breastfeeding women experienced and negotiated this contradiction. Exceptionally aware of the potential stigma against breastfeeding, most of Stearns' subjects emphasized breastfeeding discreetly when around other people, to avoid making anyone feel uncomfortable. They were especially diligent around men, believing that some men became sexually aroused when observing nursing women.

Breastfeeding researcher Virginia Schmied and sociologist Deborah Lupton (2001) studied first-time mothers in Sydney, Australia, and found that most of the women fell into one of two groups: a minority, who considered breastfeeding a form of "intimate connection", in which they could "become one" and connect bodily with their babies (239), or the majority, who experienced their infants as an always-needy Other and found themselves losing agency over their own messy, leaky, transgressive, and uncontained female bodies. More recently, medical sociologist Orit Avishai (2007) found that before their infants' births, many U.S. mothers envisioned breastfeeding as a romantic or spiritual experience and believed that their breasts would naturally and automatically function to nurture their babies with breastmilk. These romanticized ideas about breastfeeding bodies conflicted with the reality they experienced. The messiness and unpredictability inherent to breastfeeding infants was especially challenging to their need for a more controlled lactation experience.

1.4.3 Biological Anthropology and Breastfeeding: Weaning and Bedsharing

Although my own work is explicitly focused on the sociocultural aspects of breastfeeding, breastfeeding is also a biological process, and the social life of breastfeeding is necessarily influenced by biological realities. Weaning, including both the cessation of

breastfeeding and the introduction of complementary and supplementary foods, has inspired an abundance of research by physical anthropologists. Biological anthropologist Katherine Dettwyler attempted to determine the age at which human infants would stop breastfeeding based on physiology, which she referred to as “the natural age of weaning for humans” (1995:44). She did this by comparing the typical weaning ages of a number of non-human primates with indicators such as tooth eruption and the length of the gestation period, arriving at 2.5 to 7 years as the age range for “natural” human weaning. One flaw in this analysis is its sole focus of the physiological needs of the individual nursing child, ignoring the potential costs to the maternal body as well as to the survival of the species, as longer lactation periods would necessarily lead to fewer offspring. Physical anthropologist Gail Kennedy (2005) has argued that this methodology itself is flawed, as humans are qualitatively different from other primates because of their larger brains, which require the early consumption of protein and calorie dense foods such as meat and organ tissue in order to develop to their full capacity. A third critique is that the nature of humans includes human culture, and therefore positing a weaning age independent of culture is an impossibility. Still, understandings of breastfeeding practices as natural hold great sway among some breastfeeding mothers today, which I discuss further in Chapter 5.

More recently, physical anthropologist Daniel Sellen (2007) challenged Dettwyler’s assertion that there is a natural age of for human weaning, arguing that unlike non-human primates, humans have evolved a flexible strategy for infant feeding and weaning, which has allowed humans to thrive in many different environments. His analysis specifically includes the maternal costs of breastfeeding, which are a factor in the variability of weaning age. Rather than relying on comparisons to non-human primates, Sellen looked at epidemiological and clinical

evidence to determine the feeding practices associated with optimal growth and development in human children, which include exclusive breastfeeding for about six months and some breastfeeding until at least age two. In many modern societies, however, including our own, most children are not breastfed for even the minimum period that is evolutionarily optimal for our species.

Finally, physical anthropologist James McKenna and a number of collaborators have amassed a significant body of research about adult and infant bedsharing, including a great deal of information about the relationship between bedsharing and breastfeeding. Bedsharing, a term that refers to an infant or older child sleeping with at least another person, most often his mother and possibly his father, has been condemned by most health authorities since the 1990s, including the American Academy of Pediatrics (Task Force on Sudden Infant Death Syndrome 2011), because it was believed to increase the risk of Sudden Infant Death Syndrome, or SIDS. The websites of most SIDS organizations, including that of SIDS Resources in St. Louis as of April 19, 2016, assert that bedsharing increases the risk of SIDS. Based on research in his sleep laboratory, however, McKenna has written and co-authored a number of articles that challenge this view. In an early article, he asserted that for breastfed infants in non-smoking homes, bedsharing protected infants from SIDS by promoting breastfeeding, which was known to be protective against SIDS, as well as by increasing the amount of time an infant spent in lighter stages of sleep, which is protective because it is more difficult for an infant who has stopped breathing to restart when he is in a deeper stage of sleep (McKenna 1996).

More recently, McKenna (2015) and others (Bartick and Smith 2014; Bartick et al. 2014) have agitated for changes to the AAP guidelines, arguing that blanket recommendations can do more harm than good. While formula-fed infants may indeed be safer in cribs, breastfed infants

may not be, for the reasons explained previously. In addition, breastfeeding mothers (including a number of mothers I met during my research) may fall asleep while nursing their infants on an easy chair or sofa, especially during the night, and this is a far riskier sleep situation. At the 2014 meeting of the American Anthropological Association, McKenna and physical anthropologist Lee Gettler proposed the term “breastsleeping” to describe process of bedsharing while breastfeeding, explaining in a later paper that they saw breastfeeding and bedsharing mother-infant dyads as behaviorally and physiologically different from other mothers and infants, and that this represented the evolutionarily normal sleep arrangement for humans and any research on infant sleep should reflect this (McKenna and Gettler 2016).

1.4.4 Critical Race Theory: Intersectionality and Health Equity

Although critical race theory encompasses many different areas of focus and methodologies, two key elements are central: first, “to understand how a regime of white supremacy and its subordination of people of color has been created and maintained in America,” seemingly in opposition to the country’s self-proclaimed values of equal rights and liberty for all; and second, to work towards changing this regime (Crenshaw et al. 1995:xii). Most relevant to my research is the work of black feminist theorists, who have used the idea of intersectionality to explicitly draw attention to the experiences of black women. One early example is Audre Lorde’s appeal to women to “root out internalized patterns of oppression within ourselves” and move from acknowledging only the difference between men and women to recognizing racial and other differences (Lorde 1984:122). The same year, bell hooks made a similar critique of mainstream (white) feminism, arguing that all women do not share a collective

oppression and that race and class significantly influence women's lived experiences (hooks 1984).

Lawyer and critical race scholar Kimberlé Crenshaw coined the term intersectionality to explain the ways women of color often exist at the intersections of multiple forms of oppression, which can compound each other and create the necessity for new and novel interventions (Crenshaw 1991). Sociologist Patricia Hill Collins applied the idea of intersectionality more specifically to analyses of women of color and work, both paid labor outside the home and domestic labor within it (Collins 2000). Collins also wrote explicitly about the ways feminist theorizing about motherhood had been decontextualized, ignoring the influences that race and class had on contemporary motherhood (Collins 1994). Most feminist investigations of motherhood have privileged analyses of mothers' efforts to escape domination by their husbands, marginalizing the experiences of mothers of color whose experiences centered on resisting racialized oppression and ensuring their children's survival.

Other work has explicitly tied intersectionality to issues of health and health equity. In her research on infant mortality with African American women in Harlem, anthropologist Leith Mullings found that the intersections of race, class, and gender had multiple and overlapping effects on participants' abilities to acquire and maintain safe housing and steady employment (Mullings 2005). Kin work, or the practices through which women build and maintain social networks, proved to be especially stressful for women who had achieved middle class status. Mullings hypothesized a model she called the Sojourner Syndrome, named for the 19th century abolitionist and women's rights advocate Sojourner Truth, to explain the particular stressors experienced by these middle class women. Because they were often the only people in their families to have risen out of poverty, their relatives counted on them more heavily for financial

and other support, but as African American women they still faced greater discrimination in the workplace and beyond, leaving them in a perilous position. This stress may explain some of the disparity in infant mortality between white and African American women from similar social classes, as stress causes the release of hormones that can increase susceptibility to infections or cause labor to begin prematurely.

Penny Van Esterik wrote, “In the study of breastfeeding, there is a convergence of different ways of knowing – a convergence of scientific knowledge, experimental knowledge, and experiential knowledge of generations of women, with moral and emotional values that all support action to support, protect, and promote breastfeeding” (1995:152). It is this convergence of knowledges that explains breastfeeding’s relevance to so many discussions within the field of anthropology. Breastfeeding is a deeply personal bodily act yet it is necessarily relational, as at least two people are always in some way involved. Breastfeeding is a biological function steeped in cultural meanings and shaped by the forces of politics, and the interplay between these materializes in a thousand different ways. While researchers can learn about breastfeeding in labs, we can also learn from the lived experiences of mothers, and from the stories they tell of their own mothers, and their mothers’ mothers. In this I dissertation strive to integrate these ways of knowing in order to analyze and illuminate the attachments held by breastfeeding mothers in St. Louis.

1.5 Research Methods

1.5.1 Overview

My project aims to discover how the various and multi-leveled attachments women form shape breastfeeding practice and beliefs, the ways that race and socioeconomic status affect how

women develop, understand, and apply these attachments, and how different ideologies influence breastfeeding narratives. My approach to analysis was primarily inductive, and I used grounded theory to derive relevant categories of inquiry from my data. I employed both feminist and critical race methodologies, as well as anthropological ones, in an effort to gain a holistic understanding that explicitly engaged with gendered and racialized structures of power. My focus on understanding a wide range of experiences required that I gain entry into multiple groups that were often very separate from each other, both geographically and in terms of lived experiences. My methods were specifically chosen to maximize both the diversity of perspectives I was able to access and the diversity of ways in which I interacted with the people I learned from.

1.5.2 Interviews

Interviews were an important component of my research. In 2013 and 2014, I conducted 52 semi-structured interviews with 44 women in the greater St. Louis area who had breastfed, were currently breastfeeding, or were pregnant and planning to breastfeed. I attempted to re-interview pregnant women at least once after their babies were born, although I was not always successful, particularly with insecurely housed low-income women who frequently changed residences and phone numbers. A number of the women were also professionals in lactation and related fields, and I interviewed these women about their professional experiences with breastfeeding as well as their personal ones. These included three perinatal doulas, two WIC breastfeeding peer counselors, a neonatal nurse, and a La Leche League leader. Interviews typically lasted for about an hour, although some lasted up to three hours. I used snowball

INTERVIEWEE CHARACTERISTICS (n=44)	
RACE	
Black/African American	12
White (non-Latina)	23
Biracial (Black/white)	4
Biracial (Asian/white)	2
Latina	3
HOUSEHOLD INCOME (median = \$56,000)	
< \$25,000	11
\$25,001 - \$49,999	5
\$50,000 - \$99,999	16
\$100,000 - \$150,000	10
> \$150,000	2
AGE (Median = 30.5 years)	
18-25	7
26-30	14
31-35	13
36-40	6
41+	4

Figure 1.2 Demographic characteristics of women interviewed

sampling to find a sample that was racially and ethnically diverse as well as socioeconomically diverse, with an emphasis on including both white and African American women from a range of social classes. Although my specific focus was the experiences of white and African American women, reflecting Philippe Bourgois' still-valid argument that in St. Louis "if you're not black you're white" (1989:106), my interviewees included three Latina women and two Asian women.

For each interview subject, I collected age, household size, household income, number of children and whether each had been breastfed, and racial category. All of these were based on self-report. In my recording of this data I classified "black" and "African American" as equivalent and "white" and "Caucasian" as equivalent. The median household income of my interviewees was \$56,000, just slightly above the 2013 median household income for all U.S. families of \$54,462 (DeNavas-Walt and Proctor 2015). In my dissertation, I use the terms "wealthier," "richer," and "poorer" to compare women at different points on this spectrum. When specifically describing women who have household incomes that place them below the Federal Poverty Level, I reference this designation.

All of my interviews were recorded, and I also took handwritten notes during each interview. Topics covered during interviews included reasons for breastfeeding, biggest breastfeeding challenges or concerns, breastfeeding-related expenses, use of breast pumps, and sources of breastfeeding information and support. Interviews were conducted in locations chosen by the interview subject, which included their homes, local restaurants or coffee shops, and public parks.

1.5.3 Participant Observation

Participant observation took many forms in this project. Because some women were reluctant to be formally interviewed for various reasons ranging from time constraints to concerns about my own trustworthiness, it was important for me to provide other opportunities for women to share their thoughts and experiences more informally, such as support groups (both in person and online) and community events. I also engaged in participant observation in both my area of residence and my workplace. I spent time with governmental and non-profit organizations to better understand their breastfeeding messaging and beliefs, which included both participation in trainings and work in public health and advocacy.

From August 2013 through July 2014, I lived in a HUD VI Housing Project in St. Louis. Although it was a mixed income community, the majority of the units were subsidized by HUD and thus most residents were low income. Women living in poverty in the United States often have long-standing patterns of hiding details of their lives from outsiders, particularly if they have been involved with government or social welfare programs that may penalize them for failing to follow rules or procedures (Dodson and Schmalzbauer 2005). Living here gave me more opportunities to build trust and rapport with low-income women through everyday interactions ranging from jump-starting a car to looking for wandering children. I talked informally with a number of women with babies or pregnant about infant feeding, and observed babies and their mothers or other caregivers during community meetings and classes. I also spoke with the older women who ran the community association about changes in breastfeeding practices in their community they had witnessed.

From March through October of 2014, I worked 6 hours a week at the breastfeeding support and resource center and children's resale shop I call Sweet Acacia, earning \$9 an hour.

As part of this job I sold nursing bras and other breastfeeding-related supplies, fitted women for nursing bras, rented hospital-grade breast pumps, and scheduled appointments with the store owner, who had a CLC credential and provided lactation help in a back office. I also visited four other stores that sold breastfeeding supplies (two national chains and two independent stores) and talked to employees about the items they recommended to breastfeeding mothers. This gave me insight into the perspectives of people who earned money by providing breastfeeding supplies or services, allowing me to compare their viewpoints with those of breastfeeding mothers.

I attended over 70 breastfeeding support groups in 2013 and 2014, with permission from the group facilitators, as well as a number of breastfeeding-relevant events. I specifically observed breastfeeding practices and how breastfeeding assistance was given, when applicable, and I listened to conversations and noted key themes as well quotes or specific stories that seemed relevant to my research questions. At the beginning of each group I identified myself as a researcher collecting information on breastfeeding. The group I attended most often was the private support group at the breastfeeding support center I call Sweet Acacia, which I attended almost every week for over a year. I also attended La Leche League meetings in four different locations. I was part of a number of Facebook breastfeeding support groups as well, including one run by La Leche League in St. Louis and two started by members of the Sweet Acacia support group. Through these support groups and other connections, I was invited to visit new moms and their newborns at two local hospitals, attend breastfeeding mom group play dates at various coffee shops, and attend two baby showers at private homes.

In addition, I attended a number of breastfeeding-related events run by different organizations. These included private events such as a WIC Breastfeeding Café, a baby shower

at a Federally Qualified Health Center (FQHC), a Black Breastfeeding Week celebration, and a breastfeeding education workshop run by the non-profit group I refer to as For Babies in this dissertation. I was invited to these by the organizers and identified myself as a researcher. I also observed the Great Latch On public breastfeeding event in August 2013, although at this event I did not identify myself.

I began working with two non-profit organizations in 2013 and remain involved with both at the time of this writing. The first, which I refer to as For Babies, is a collaborative initiative to reduce infant mortality in a local ward with one of the highest rates in the state. Collaborative members include employees of city and county health departments, FQHCs, and non-profits working with pregnant women and infants in this area, as well as community members and other interested parties. I have attended monthly meetings of the collaborative since 2013, giving me the opportunity to learn about the ways these professionals and others talk about breastfeeding and locate it within public health narratives. I also became a member of the organization I refer to as the St. Louis Alliance for Breastfeeding in 2013, which meets four times a year to address issues related to breastfeeding policy and advocacy. Members of this group include WIC employees, county health department employees, and lactation professionals in private practice, as well as others. Attending these meetings has allowed me to learn about the ways these professionals and advocates view the local breastfeeding landscape and the breastfeeding mothers they assist.

I attended two multi-day trainings as part of my research to learn more about the education breastfeeding professionals and paraprofessionals received, which complemented data from interviews and support groups about how women themselves interpreted and internalized the messages they received from professionals. I completed a 16-hour WIC Breastfeeding Peer

Counselor training course in 2013 and a 40-hour Certified Lactation Counselor (CLC) course in 2014. The latter course culminated in an exam, which I passed, allowing me to practice as a Certified Lactation Counselor if I choose to do so.

1.5.4 Data Analysis

My data analysis was an iterative process, reflecting H. Bernard Russell's discussion of grounded theory (Russell 2006:492). I wrote jottings daily, which I then wrote up as full field notes as soon as possible. A few months after beginning my research I began constructing a "map" of each interview, a technique I found very valuable. To construct an interview map, I first used my handwritten notes to create a rough chronological outline of interview themes. I then listened to each interview at regular speed and filled in time points at which different topics were discussed, as well as adding more details and transcribing short passages that were especially meaningful. As I continued to analyze my data, when a topic emerged as salient I was able to quickly find relevant sections in each interview and re-listen or transcribe relevant parts. This allowed me to continue to fine-tune my research throughout my field work, asking new questions or seeking out different sources of information. Full transcription of interviews was also easier because some sections had already been transcribed. After leaving the field I carried out a more thorough analysis of my data, coding both interview maps and transcripts as well as field notes for themes.

1.6 Roadmap to the Dissertation

In the remainder of this dissertation, I more closely examine some of the different attachments related to breastfeeding that I found in my research and analyze them to address

larger structural questions about the influences of capitalism, racism, and technology on women in U.S. society today. Chapter 2 begins with the history of infant feeding in the United States, analyzing the ways that broader societal ideologies have influenced trends in infant feeding among women from different racial and socioeconomic groups and identifying themes that remain relevant to breastfeeding today. Chapter 3 looks at geographies of breastfeeding in St. Louis, examining the ways race and class shape a breastfeeding mother's access to support and resources and how authoritative knowledge is differently constructed for different groups of women. Chapter 4 analyzes the hegemonic idea of breastfeeding as natural and normal, which has been disseminated in order to reduce stigma around the practice. This chapter looks at the various ways this narrative is complicated and interpreted on the ground, particularly by women who experience breastfeeding difficulties.

In Chapter 5, I discuss the relationship between breastfeeding and conceptualizations of good motherhood. I look particularly at how race and class shape these ideas, including different narratives about protection and the various ways breastfeeding is commodified. Chapter 6 examines attachments to technology, particularly the breast pump, and relationship between this new "technocratic breastfeeding" and the needs of a capitalist society. Finally, I conclude with a chapter in which I summarize my findings and some key theoretical impacts, then suggest future steps for breastfeeding advocacy.

Chapter 2

Histories and Attachments: Infant Feeding in the United States

2.1 Introduction

Attachment provides a lens through which to examine the ways women think about breastfeeding. Developmental psychologist Mary Ainsworth's idea of attachment as an affectional tie that binds a mother and infant (Ainsworth 1979) provides a point of departure for looking at the affectional ties that breastfeeding mothers in St. Louis establish and maintain. As in the past, these ties to certain values and ideologies create systems and patterns that influence not only the initiation and duration of breastfeeding, but also the forms it takes - where can it happen, who can see it, and even what sorts of technologies facilitate it. However, these patterns did not emerge in a vacuum, and examining the historical contexts that created them adds depth and nuance to my analysis of present-day practice.

Attachments, in the form of deep commitments to ideas of rightness, have long been part of American breastfeeding practices. During the colonial era, attachments to religious morality played a key role in the decision to breastfeed, and also in the choice of a wet nurse, whose moral values were viewed as potentially transmissible to the infant she nursed. As society increasing came to value motherhood during the nineteenth century, breastfeeding became part of the idea of a good and virtuous mother. Good mothers during the early twentieth century were those who kept abreast of the scientific literature and fed their infants the formulas and mixtures advocated by doctors, a moral imperative to modernity that left breastfeeding mothers behind as too uncaring or unintelligent to properly care for their infants. Finally, as scientific knowledge shifted during the latter part of the twentieth century and breastfeeding rates increased, moral

motherhood required not only that women breastfeed but that they do it for longer than ever before.

Science and technology and their ties to breastfeeding have also shifted over time. Technologies for removing milk from the breast have changed, as have those for feeding breast milk or other foods to infants. Scientific knowledge has been invoked throughout most of history to correctly endorse breastfeeding over other forms of infant feeding, although the science of the early twentieth century failed in this regard. Similarly, scientific ideas about the dangers of colostrum and the factors that make one a good wet nurse have been disproven over time, although they once influenced decision-making in significant ways. Scientific analyses of the composition of breast milk have been helpful in creating better substitutes, but attachments to these scientifically formulated breast milk substitutes led to difficulties in acknowledging their limitations. In contrast to this has been the theme of the natural, tied in during colonial times with the idea of God-given womanhood, during the “cult of true womanhood” era with essential womanhood, and in more recent times with a return to the practices of our earlier ancestors.

In this chapter, I chronicle and analyze the history of infant feeding in the United States from colonial times to the present. I am attentive to differences in infant feeding practices among women from different racial and socioeconomic groups, as well as to the larger political and ideological forces that influence them. I argue that present day breastfeeding practices and disparities, as well as the attachments that shape them, are grounded in this history.

2.2 Infant Feeding: Understanding the Options

The original and predominant method of feeding human infants has been breastfeeding by the biological mother via direct contact between the child and mother. However, substitutes

for a mother's breast milk have existed for thousands of years. Throughout most of human history, the preferred substitute was the milk of another lactating woman (Stevens, Patrick, and Pickler 2009). This may have been provided through an informal arrangement with another woman, perhaps after the death or illness of the mother, or women of higher status might employ a wet nurse or compel an enslaved woman to act as a wet nurse because she believed she was physically unsuited for the task. Archaeological evidence conforms the practice of wet nursing in ancient Babylon (Palmer 2009), Rome, Greece, and Egypt, dating back as far as 2000 B.C. (Stevens, Patrick, and Pickler 2009). The popularity of wet nursing waxed and waned throughout the following centuries, especially in Western countries, and after peaking during the seventeenth century (Weinberg 1993) it declined precipitously (but did not disappear altogether) during the nineteenth and twentieth centuries (Palmer 2009).

In addition to milk from an infant's own mother and milk from another woman, a third option for infant feeding is breast milk substitutes. Archaeological evidence of this option includes feeding vessels found in infant graves dating back to 4000 B.C. (Thulier 2009). These clay objects were originally thought to be oil lamps but chemical analysis found remnants of animal milks, which have historically been the preferred substances for feeding infants, either alone or mixed with water or other ingredients (Stevens, Patrick, and Pickler 2009). Other foods used historically included various combinations of flour or other grains, sugar, water, and tea (Golden 1996; Blum 2000). However, the mortality rate for infants being fed these substitutes instead of breast milk was much higher than that of babies who were breastfed, most commonly believed to be from diarrhea, dehydration, or illnesses contracted through tainted animal milks (Fentiman 2009). Early feeding devices were also difficult to clean well, creating a haven for bacteria, and babies typically accessed the milk by sucking on a small piece of cloth or sponge

that could also transmit disease, although the invention of the India rubber nipple in 1845 greatly reduced this problem (Weinberg 1993).

In the remainder of this chapter, I explain how these three options were understood and employed in the United States, starting from the period of intense European colonization at the end of the sixteenth century and ending with the present day. However, I do so while fully recognizing that American Indian mothers and infants in lived this country prior to European colonization, and that their history is also meaningful and important. To the best of my knowledge none of the women I met during my fieldwork were American Indian, so for the purpose of contextualizing my own research the European colonization is an appropriate time period to begin. Still, the topic of breastfeeding among American Indian women is a critical one, as health disparities between this group and white American are grave and persistent (Jones 2006) and National Immunization Survey (NIS) analyzed by the Centers for Disease Control and Prevention (CDC) documents lower rates of breastfeeding initiation and duration among American Indians and Pacific Islanders than among white Americans (Centers for Disease Control and Prevention 2010). Although a few ethnographic studies have been done (such as Dodgson et al. 2002), more work in this area is desperately needed.

2.3 “Suck the Breast While it is Open”: Infant Feeding in Colonial America

In colonial America, breastfeeding was a moral and religious issue as well as a practical one. The well-known Puritan preacher Cotton Mather addressed the moral duty of breastfeeding explicitly in many of his writings, opining in 1710 that women who choose not to breastfeed are “dead while they live” and excoriating them for failing to meet their maternal obligations (Golden 1996:11). Mather criticized wealthy mothers who chose to employ wet nurses rather

than curtail their active social lives, but he was more understanding of women who were unable to produce enough milk to feed their infants, prescribing special foods and medicines he believed were galactagogues (substances that increase milk production) and condoning the use of wet nurses by virtuous women whose milk supplies remained inadequate. Other Puritan reformers highlighted the importance of the maternal, milk-providing breast as a foil for the erogenous and sensual breast, viewing the failure to breastfeed as a sign of vanity and sinfulness (Thulier 2009). Breastfeeding metaphors were also used by clergymen of the time to emphasize their own importance as sustainers of spiritual life, including referring to themselves as “breasts of God” and inviting parishioners to “suck the breast while it is open” (Vandenberg-Daves 2014:14). This intense focus on lactating breasts makes sense in light of the high infant mortality rates during this time, as access to breastfeeding was truly a matter of life or death for many babies.

The typical breastfeeding duration during the colonial era is difficult to determine with certainty, but most infants probably nursed for one to two years before weaning (Brodie 1997). Factors related to weaning included the presence of teeth as well as the time of year, as mothers tried to avoid weaning during the frigid winter months as well as during the hot summer months when some diseases were more prevalent (Treckel 1989). Child care manuals from this era advised women to stop breastfeeding once they began menstruating again, because the authors believed the milk of a menstruating woman might harm or even kill an infant.⁵ Again, the health of the infant was paramount.

⁵ Nearly all mothers experience a cessation of menstruation for at least part of the time they spend breastfeeding, a phenomenon called lactational amenorrhea. This can last for up to two years or beyond, especially with frequent nursing and minimal mother-child separation.

For colonial-era women who did not breastfeed, wet nurses were considered the best alternative, allowing a woman to preserve both her own morality and the health of her baby. The popularity of wet nurses among upper class women of that time period in England influenced some elite white women in the United States to voluntarily hire a wet nurse, as colonial women tended to look to England for models of proper bourgeois behavior (Thulier 2009). Medical practitioners considered sexual intercourse while lactating potentially dangerous to the infant, creating another reason to hire a wet nurse, and for this reason wealthy husbands were often the deciding voice in the decision to hire one (Treckel 1989). Yet another reason to secure a wet nurse, especially during the early seventeenth century, was the belief that colostrum—the first fluid a woman’s breasts make after the birth of her baby—was toxic and potentially fatal if eaten by the infant. To safeguard the health of their babies, some prosperous mothers hired wet nurses to breastfeed their babies during the first days after birth, before their own milk had come in.

Criteria for choosing a wet nurse could be quite detailed. In eighteenth century Europe, where many believed that babies could absorb traits as diverse as bad teeth and personal beliefs through breast milk, characteristics such as hair color, height, and complexion were thought relevant to a woman’s aptitude as a wet nurse, as were her disposition and her intellect (Thulier 2009). However, while English legal and religious authorities were actively involved in regulating wet nursing, a well-established vocation in that country, no such infrastructure existed in the United States. This lack of a formal regulatory system, coupled with the comparatively small number of wet nurses available, resulted in most colonists holding somewhat less exacting requirements for a wet nurse, although they still considered her health and morality to be important factors (Golden 1996). Women living outside of the cities were considered healthier because of disease and contagion associated with urban spaces, and babies were often sent to live

with these rural wet nurses throughout the duration of breastfeeding, although some mothers visited their children frequently. The milk produced by mothers of male infants was thought constitutionally different from that produced by mothers of female infants, and hiring a wet nurse whose infant was the same sex as one's own was thus considered preferable, to avoid the possibility that the infant would develop the character traits of the opposite gender (Treckel 1989).

If mothers were too ill to breastfeed, abandoned their babies, or died during childbirth, events that were not uncommon, finding a wet nurse could be difficult, particularly for poorer women. Sometimes a neighbor who was breastfeeding her own child would offer to take in and breastfeed the infant in this situation, especially for a short period (Thulier 2009). Other infants were placed in public foundling homes, created in imitation of European institutions that cared for abandoned or orphaned infants, which often hired wet nurses to care for their charges (Golden 1996). Their salaries were lower than those of privately hired wet nurses, but still enough to make a significant contribution to the household. Women from higher social classes were more likely to work as private wet nurses, while those who were older or who were perceived of as morally corrupt (as demonstrated by practices such as having illegitimate children or engaging in drinking or other forms of debauchery) might be hired for less in the public sector. The wet nurses' own babies were often already weaned when they took on another, although some weaned their babies prematurely or attempted to nurse both, and some were mothers whose own infants had died. In addition to social class, remuneration of wet nurses was tied to the different political economies of rural and urban spaces. In rural areas, these wet nurses were sometimes paid in commodities such as tobacco, while urban wet nurses were paid in cash.

Although it is clear that interracial wet nursing occurred in colonial America, historians have not reached a consensus on the prevalence of this practice. In the northern United States, it seems clear that black women were hired only to breastfeed black or biracial infants, most often working as public sector wet nurses feeding orphaned or abandoned babies, while white infants were fed by white wet nurses (Golden 1996). In our present-day society, there is a presumption that enslaved black women in the American south were frequently compelled to breastfeed the children of their white owners, and documentation of this practice does exist (McMillen 1985). However, some historians believe it was relatively uncommon, and there is evidence that some white southern women instead hired white wet nurses to breastfeed their babies (McMillen 1985; Golden 1996). Surprisingly, there is also evidence of white women breastfeeding the infants of their black slaves, suggesting that the goal of preserving infant lives (whether for their economic or emotional value), may have been paramount in an era when no safe substitutes for breastmilk existed (McMillen 1985).

Regardless of the actual prevalence of white southerners forcing enslaved black women to act as wet nurses, it is clear that there are great differences between the experience of working as a paid wet nurse and that of being forced to provide such services as part of a woman's enslavement. A number of African American women today, knowing of this history of forced wet nursing, have discussed breastfeeding's symbolic value as a powerful reminder of slavery (see Chapter 4 in this dissertation). This picture (Figure 2.1) was posted on numerous blogs that were shared in many of the Facebook groups I followed during my research period. The bottom section, which gives the photo's origin, was always chopped off, and comments or captions accompanying the picture explained that the woman was a slave living in the United States prior to the Civil War, being forced to nurse her master's child.



Figure 2.1 “Type de Negresse d'ADANA’ (Mizrahi n.d.)

Many women reacted strongly to the image, decrying the use of the nursing women’s body in this way against her will and expressing concern for the well-being of her own infant. None were aware of the photograph’s true provenance: it is a postcard taken by a French photographer, probably in the early part of the twentieth century, in the city of Adana in what is

now Turkey (Mizrahi n.d.). The woman in the photograph is probably not a slave at all, and the child she is nursing may well be her own. Still, the woman's true identity may be less important than her potency as a symbol of oppression through lactation.

The third infant feeding option available to colonial era women was a breast milk substitute, a practice known as “dry-feeding” or “dry-nursing” (Thulier 2009) or “hand-feeding” (Golden 1996), and would now be called bottle feeding or formula feeding, although these early foods were not the proprietary infant formulas we are familiar with today. *Pap*, a mixture of flour or breadcrumbs cooked in an animal milk or water, was one common substitute (Thulier 2009). Another was *panada*, created of bread cooked in broth or milk, perhaps with the addition of an egg. Because of the scarcity of wet nurses, infants whose own mothers weren't available to breastfeed them were most likely to be fed one of these mixtures, although medical authorities of this time correctly believed that they resulted in a higher level of infant mortality (Treckel 1989).

Bottles used to feed infants were made from a variety of materials, from more common materials such as bone, wood, or metal (McMillen 1985) to the more expensive pewter, silver, or ivory bottles found in the homes of upper class women (Treckel 1989). *Pap boats*, oblong objects with spouts that resemble a gravy boat or a small teapot, were also used, although it is probable that some of these were used to provide supplementary foods during weaning rather than as a substitute for breastfeeding (Figure 2.2). It is also possible that some infants were induced to suckle directly from an animal, a practice documented in other places but not in colonial United States (Thulier 2009). In addition to health risks due to the nutritional deficiencies of these substitutes, improper sanitation also caused illness and death for infants, as bacteria lurked in improperly-cleaned feeding devices and the milks often spoiled due to heat (McMillen 1985).



Figure 2.2 Eighteenth century pap boats and ceramic feeders (Weinberg 1993:2017)

In summary, most women in colonial America breastfed their infants, and as in much of contemporary U.S. culture, breastfeeding was associated with motherly virtue. Wet nursing was more prevalent than in modern times, probably because of the poor quality of breast milk substitutes, and the practice of wet nursing was influenced by prevailing beliefs about race, social class, and morality. Breast milk substitutes, although a dangerous choice, were often the only option available, contributing to high rates of infant mortality.

2.4 Infant feeding from 1783-1920: From the Cult of Domesticity to Scientific Motherhood

2.4.1 For Richer...

Although much in the United States changed rapidly during the American Revolution, infant feeding practices changed more slowly. Immediately after American independence, most babies were still breastfed by their mothers, and of those who were not, the luckier were fed by wet nurses and the unlucky received animal milk, pap, or panada (Apple 1987). However, the societal view of mothers was shifting during this time. In middle and upper class white society, the ideology that historians now refer to as *republican motherhood* saw women as playing an essential role in maintaining the virtue of the new nation, although it still limited their influence to the home and family (Vandenberg-Daves 2014). By 1800, ideas of moral motherhood came to the fore among this group with what became known as the “cult of true womanhood” or “cult of domesticity”, a belief system that framed the mother as the moral and practical center of the family and ascribed great value to her role in raising her children (Apple 1987). Importantly, for these mothers not breastfeeding was seen as not only immoral but also against nature, foreshadowing the emphasis placed on natural parenting practices by more modern mothers (Levenstein 1983).

Breastfeeding was viewed as one of the greatest sources of pleasure and happiness for a mother and many wrote in rhapsodic tones about the sentimental joy of nursing an infant, such as this example in an 1830 book titled *Letters to Mothers*:

Were I to define the climax of happiness which a mother enjoys with her infant, I should by no means limit it to the first three months. The whole season while it is deriving nutriment from her, is one of peculiar, inexpressible felicity. Dear friends, be not anxious

to abridge this halcyon period. Do not willingly deprive yourselves of any portion of the highest pleasure of which woman's nature is capable. (Doyle 2011:962)

As society placed greater value on the domestic labors of mothers, physicians paid growing attention to the question of infant feeding, a vital maternal task. Although physicians generally agreed that breast milk was the optimal food for babies, they also questioned the wholesomeness of many individual women's breast milks, prescribing special diets or exercises as well as exhorting women to remain peaceful and composed in order to avoid harming their milk (Apple 1987). Physicians viewed breastmilk as a delicate substance, easily spoiled by illness, fatigue, or emotional upset.

As physicians became convinced of breastmilk's susceptibility to maternal influences, wet nursing fell into disfavor due to concern about the potential detrimental medical and moral effects of a wet nurse from a different social class (Golden 1996). Scientific experts of the day claimed to have proven that venereal diseases could be transmitted through breast milk, adding to existing fears about infants contracting diseases from a wet nurse (Levenstein 1983). Some physicians also expressed concern about the wet nurses' own children, who the cult of true womanhood decreed should also be receiving their mothers' milk (Golden 1996). Unless their own infants had died, the poor women who became wet nurses were thought to be lacking in the natural maternal instinct seen in their wealthier counterparts, a viewpoint that ignores the fact that women who became wet nurses often did so out of necessity in order to financially support their own children.

This anxiety about the breastmilk quality could not have happened without a concurrent increase in the availability of cow's milk, and the subsequent development of infant formulas, both of which greatly increased the chances of survival for an infant who was not breastfed. By

the first half of the nineteenth century cow's milk was generally available in the United States, and most artificially fed infants were given diluted cow's milk with a small amount of sugar added (Apple 1987). Canned condensed milk first became available in 1856 (Wolf 2001), and by the 1870s physicians were routinely recommending its use, diluted at a ratio of twelve parts water to one part milk (Levenstein 1983). However, physicians noted that infants fed either fresh or condensed milk had higher levels of mortality than breastfed infants, laying the groundwork for modern infant formulas as scientists began to turn their attention to breast milk substitutes. In 1855, Dr. Arthur V. Meigs was the first to accurately quantify the protein and carbohydrate content of human breastmilk through chemical analysis, knowledge he used in the recipe for the breastmilk substitute he named Meigs' Mixture (Wolf 2001). Meigs viewed the milk of a healthy and conscientious mother to be the best food for her infant, but he saw his scientifically advanced formulation as a potentially life-saving milk substitute for infants in institutions.

During this period, the commercial production of infant formula also emerged. Based on both chemical and physiological studies, German chemist Justus von Liebig constructed and sold the first commercially available infant formula in 1865, a mixture of cow's milk, malt flour, wheat flour, and bicarbonate of potash (Apple 1987; Stevens, Patrick, and Pickler 2009). It became available in the United States in 1869, followed quickly by Nestlé's Milk Food (which was available as a dry powder), Mellin's food (which required the addition of both milk and water) and many more (Apple 1987).

Boston pediatrician Thomas Morgan Rotch took infant formulas a step further. In 1891, he established the Walker-Gordon laboratories in Boston to fill prescriptions from pediatricians for custom-made infant formulas with varying amounts of fat, starch, protein, and other components (Levenstein 1983). By 1901, infant formula laboratories existed in eighteen North

American cities. The finely calibrated formulas they produced allowed doctors to choose any of the available theories on infant nutrition to construct their own recipes for the optimal nourishment of any particular baby, termed "percentage feeding", which could be altered by the tiniest degree each week in order to have exact empirical data on the infant's responses to each element. Dr. L. Emmett Holt, a prominent New York City pediatrician who wrote one of the most famous twentieth century texts on pediatrics, described percentage feeding as the "American or scientific method" shortly after the turn of the century, conflating modern science with patriotism and giving American mothers another reason to choose this new technology (Levenstein 1983:83).

These custom-made infant formulas created an important role for these newly minted pediatricians (at that time a brand new medical specialty in the United States), as middle and particularly upper class women now required their constant advice and supervision in order to correctly feed their infants. Indeed, physicians publicly expressed concern about the dangers of infant formulas marketed directly to the public, asserting that without medical oversight their use could lead to death (Apple 1987). Hence, as commercial production of infant formula increased, so did the demand for professional supervision of mothers by pediatricians and other medical professionals.

Although Rotch and other physicians of this era avowed that human milk was the standard for infant nutrition, they simultaneously undermined breastfeeding in various ways. First, they continued to express concerns about the potential missteps a nursing mother might make that would make her milk unsuitable for her infant, warning that emotional upset or an improper diet could endanger a breastfed infant (Apple 1987). Even if the mother's diet was considered healthful, doctors recommended that breastfed infants receive orange or tomato juice

to prevent scurvy and cod liver oil to ward off rickets, sending a pointed message that breastfeeding was insufficient to preserve good health (Apple 1995). Second, as ideas about germ theory took hold during this era, doctors became concerned that mothers' nipples might act as repositories for harmful bacteria, although there was no evidence to support this belief (Palmer 2009). Physicians began instructing women to wash their nipples rigorously before and after nursing, which often led to cracked and painful nipples and a cessation of breastfeeding.

A third way physicians of this era undermined breastfeeding was by characterizing human bodies, particularly lactating women's bodies, as unreliable and unscientific. This was a particularly damaging criticism in this era of rapidly advancing technology and industrialization at the end of the nineteenth century. Repeated analyses of breastmilk demonstrated the variability of its composition, and physicians expressed concern that this inconsistency meant that a woman's breastmilk might be unsuitable for her infant at certain times (Apple 1987). We now know that a woman's breastmilk's composition changes *in response to* the needs of her infant, but physicians of the time did not consider this possibility. They believed that breastmilk could never reach the same level of technical achievement as carefully measured and methodically produced artificial baby formulas, because a woman's body was flawed and unreliable. Women were increasingly viewed as potentially dangerous to their infants, requiring careful supervision and surveillance by male physicians to prevent them from inadvertently doing harm.

It is clear that the medical community played an important role in the shift from breastfeeding to the feeding of artificial baby milks, as physicians became increasingly involved in issues related to the care and feeding of infants. While they were motivated in part by concern and compassion, this does not preclude the influence of factors such as increased profit for individual physicians, nearly all of whom were men, and greater status for the field of pediatrics.

This medicalization of infant feeding was tied to larger societal beliefs about the importance of science and rationality in motherhood more generally, an ideology referred to as the *scientific motherhood*. Historian Rima Apple defines this scientific motherhood as "the insistence that women require expert scientific and medical advice to raise their children healthfully," and it created an imperative that mothers become knowledgeable about the current research in infant and child health and development, professionalizing their trade while concurrently asserting that their personal experiences and intuition were irrelevant to it, as correct mothering was necessarily performed according to science (Apple 1995:161). In an early example from the 1840s, Catharine Beecher published her *Treatise on Domestic Economy*, a guidebook for all domestic tasks that included specific scientific rationales for her advice (Apple 1995). During the following years, new ideas about science and modernity continued to influence ideas about good mothering and infant feeding.

Many of the themes from this section continue to resonate today. Mothers are still given scientific rationales for infant feeding practices, as well as other parenting practices, even when the scientific data is unclear or conflicting. Correct infant feeding is still something many women view as practically and technically difficult, and as in the past they seek expert advice, although for many higher income women the nature of these experts has shifted from male medical professionals to more nurturing female lactation specialists. Technological advances are still relevant to infant feeding: new ingredients are frequently added to infant formulas as they are identified by new analyses of breastmilk, and breastfeeding itself has become a technological process, as described specifically in Chapter 6.

2.4.2 ... And for Poorer

While women from higher socio-economic classes were struggling to fulfill the requirements placed upon them by the new regime of scientific motherhood, including professionally calibrated infant formulas, less affluent women were dealing with different issues. Infant mortality rates were extremely high during this period, particularly in urban areas. In 1897, the infant mortality rate in Chicago was roughly 180 per 1000 births, with a disproportionate number of deaths occurring in impoverished areas of the city (Wolf 2003). In 1900 the infant mortality rate in New York City was 198.4 deaths per 1,000 births (Levenstein 1983) and nationally the infant mortality rate in 1911 was 135, placing the United States 18th out of 30 countries surveyed (Thulier 2009). Diarrheal illnesses were the main cause of death of the majority of infants, often due to bacterial contamination in the milk they were drinking (Wolf 2003; Thulier 2009). Public health reformers were actively working on campaigns to improve infant health in urban areas by the beginning of the twentieth century, focusing their efforts on two fronts: increasing breastfeeding rates and improving access to clean and sanitary fresh milk-based foods (Levenstein 1983).

Data on the prevalence of breastfeeding among poorer urban U.S. women around the turn of the twentieth century is scant, and it is difficult to discern clear patterns. This may point to differences among different subgroups: impoverished urban women included recent immigrants from a number of countries, as well as poor white and African American women who were born here. Indeed, in 1908 public health officials in Chicago alleged that immigrants' failure to acculturate to the United States was the primary reason for infant mortality and targeted immigrant neighborhoods for visits from nurses who provided education on breastfeeding, ignoring both white and African American mothers born in this country (Wolf 2003), despite the

high mortality rates of African American infants (Wolf 2001). Four years later, these officials found only 39% of the women visited by public health nurses were exclusively breastfeeding their newborns. In contrast, a 1908 study of 1,000 Boston women found that 90% of the 500 women described as poor breastfed for at least nine months, while only 17% of the 500 identified as wealthy did so (Golden 1996). A 1919 public health campaign in Minneapolis, which offered unlimited home visits with a nurse trained in lactation support to every mother, regardless of income, increased breastfeeding rates to 72% at nine months after the first year (Wolf 2003). These varied rates may point to the popularity of mixed feeding, as many women began supplementing with cows' milk shortly after birth and the importance of exclusive breastfeeding was less well-known. In addition to cows' milk, many poor women offered their infants other foods during the newborn period, including items such as sausage or watermelon (Wolf 2001).

After conducting studies in a number of cities between 1910 and 1915, the newly-formed Children's Bureau, a federal agency concerned with the welfare of children, determined that breastfeeding rates increased as income decreased and the differences were significant (Levenstein 1983). However, mortality rates among artificially fed infants from poorer families were much higher than those of artificially fed infants from wealthier families: then, as now, wealth had a protective effect. Public health campaigns intended to promote breastfeeding among urban mothers were blunt, exhorting women to breastfeed with messages such as "Don't Kill Your Baby" (Figure 2.3). This 1910 placard, which was translated into nine languages, was printed by the Civic Federation of Chicago and posted in public locations throughout the city (Wolf 2001). The infant on the left, who is chubby and light-skinned, represents a baby who was breastfed for the recommended nine months and then given only clear milk and boiled water. The inset shows him being breastfed by his mother, who is also light-skinned. The skeletal infant

on the left has a darker complexion and is motherless, and is eating meat and bread and drinking beer and coffee. Thus, although richer white women like the one depicted in the placard were actually less likely to breastfeed than poorer women, these richer women were still held up as representations of this practice.



Figure 2.3 Placard by the Civic Foundation of Chicago, 1910. (Wolf 2001:125)

One of the key determinants of breastfeeding for lower and working class women was employment outside of the home. Statistics from late nineteenth century Baltimore show that the mortality rate of babies whose mothers worked outside the home was 59% above average, while the rate for mothers working in the home (such as women who took in laundry) was 5% below (Wolf 2003). The infants whose mothers worked away from home were most likely receiving cow's milk while those who worked out of their homes were more liable to be fed at the breast, at

least for a time. However, most working class women of this period labored at jobs in mills and factories away from their homes, making exclusive breastfeeding impossible (Schwab 1996). Ironically, some residents of homes for unmarried mothers left their own nursing infants in order to work for others as wet nurses, although the home might then try to hire a wet nurse to feed these infants (Golden 1996). By this period, however wet nurses were rare, and their services were typically sought only as a last resort for an ailing infant.

At the same time that public health departments were working to increase breastfeeding rates among the poor, other reformers were striving to increase the availability of clean cow's milk for bottle-feeding infants, to meet the needs of the working mothers referenced above as well as others who did not breastfeed. One of the leaders in this movement was a pediatrician named Henry L. Coit, whose infant son passed away in 1887 as a result of drinking contaminated milk (Waserman 1972). Governmental organizations at that time were reluctant to become involved in the provision of clean cow's milk to poorer families, believing it was prohibitively expensive and choosing instead to focus their efforts on the promotion of breastfeeding, so private citizens and charitable organizations took the lead.

One of the most significant innovations of the time period was the milk depot, also referred to as a milk station, an entity that supplied safe cow's milk to mothers. The first of these urban milk distribution centers was established in 1889 in New York City (Apple 1995). Originally milk depots provided raw milk certified as safe by the Medical Milk Commission, a private entity founded by Coit, but the high cost of producing milk according to the Commission's standards made this milk unaffordable to all except the very wealthy (Waserman 1972). The widespread adoption of pasteurization in the first decade of the twentieth century, as described below, allowed milk depots to become accessible to poorer mothers.

Philanthropist Nathan Strauss was the driving force behind the creation of many pasteurized milk depots, including sites in New York City, Philadelphia, and Chicago, and he personally subsidized the cost of providing milk to infants (Levenstein 1983). The New York Association for Improving the Condition of the Poor, a charitable organization, created a Milk Action Committee in 1908 and had opened 31 depots by 1911. By 1912, milk depots existed in at least thirty U.S. cities. While the poorest of the poor received the milk for free, most were required to pay something, usually the same cost that they would have paid for regular milk. Mothers were sometimes interrogated about their failure to breastfeed as a condition of receiving subsidized milk, and only mothers who claimed to be physically unable to produce sufficient breastmilk were deemed worthy to receive it. Infant mortality did decline among users of these depots, but they were only able to provide milk for a fraction of the infants who needed them (Lee 2007).

Pasteurization eventually came to revolutionize food safety, but it took decades for this discovery to take hold (Thulier 2009). Early attempts to sterilize milk by boiling it were viewed with suspicion, as many suspected (correctly) that the process would decrease the milk's nutritional value (Apple 1987). Pasteurization, which requires lower temperatures but still kills most bacteria, was widely recommended by physicians at the turn of the twentieth century. In 1893 large-scale milk pasteurization was begun in New York City, and by 1902 about 5% of the milk there was pasteurized (Tauxe and Esteban 2007). During this same year, the New York City Health Department discovered heavy bacterial contamination in its regular milk supply, impelling it to take a more active role in maintaining the safety of milk through educational programming for farmers and the enforcement of refrigeration during milk transport (Schwab 1996). Many mothers did not support these efforts, seeing them as a way to drive up the price of

milk beyond their means to pay (Wolf 2001). However, in 1908 Chicago passed a law requiring the pasteurization of milk, and New York and Philadelphia did the same in 1912, followed shortly by other major cities (Lee 2007).

While feeding their infants was not easy for poorer and working class white women, many African American women from the same social classes faced even more difficulty. Because ninety percent of African American women lived in the south, many in rural communities, they were out of reach of the public health campaigns that were common in cities – according to the United States Census Bureau, in 1900 only two of the 40 largest cities in the United States were in the south - and, as described above, African American women were sometimes specifically left out of the public health campaigns in urban settings (Blum 2000; United States Census Bureau 1998). Although some middle class African American activists worked tirelessly to reduce infant mortality in the black community, creating clinics and milk depots, their efforts were generally not supported by government agencies, thus limiting their effectiveness.

Although there is no direct data comparing the breastfeeding rates of white and African American women during the first half of the twentieth century, indirect data suggests that African American mothers were more likely to breastfeed their babies than white mothers during this period (Blum 2000). Some of the evidence supporting this contention comes from studies comparing breastfeeding rates in different regions of the United States, which found that rates were highest in the southeastern part of the country, where the highest percentage of African American mothers lived (Apple 1987). In addition to this, survey data from the 1950s onward shows higher breastfeeding rates for African American mothers until sometime in the late fifties or early sixties, which suggests that rates prior to this would have also been higher (Hendershot

1984). However, while increased breastfeeding may have somewhat ameliorated the effects of race and racism on infant mortality, they did not erase it altogether. Infant mortality rates for African American infants fell from 181 per 1,000 in 1915 to 100 per 1,000 in 1930, but rates for white infants during the same period fell from 99 to 60 per 1,000 (Ladd-Taylor 1995).

As in the past, poorer women and richer women today often rely on different sources of knowledge and support for infant feeding, and the messages they receive are likewise different. Wealthier mothers living a hundred years ago were encouraged to sleep well and avoid emotional upset in order to produce the healthiest milk for their children, positioning them as fragile and in need of protection, while poorer women were told that if they did not breastfeed they were killing their babies, implying that they were generally unconcerned about their children and needed strong reminders in order to do the correct thing. Presumably the quality of their breastmilk was not an issue, as poorer infants, like their mothers, were seen as being constitutionally stronger and thus better suited for hard labor. While richer infants were often given formulas custom-made for their unique needs, poorer infants in this era were lucky if they received milk free from bacterial contamination. As is true today, African American mothers received less help and support than white mothers, although it is likely that more of them breastfed.

2.5 “Nestle Kills Babies”: Infant Feeding from the 1920s to the Present

2.5.1 The Formula Shift

As large-scale pasteurization became the norm and pasteurized milk was readily available, milk depots faded from the scene, and by 1920 few remained (Schwab 1996). At the same time, manufacturers of commercial infant formulas began to enter into symbiotic

relationships with pediatricians, emphasizing the importance of medical supervision in infant feeding in return for physicians' endorsement of their products (Levenstein 1983). Indeed, many milk depots began to sell infant formulas as well as fresh milk. By the 1930s, many doctors were ambivalent about the breast milk / formula question, believing that factors such as the good character of the mother and the appropriate medical supervision were far more important (Apple 1994). With little breastfeeding assistance available and an emerging cast of experts assuring mothers that breastfeeding really made no difference, it is not surprising that mothers breastfed less and less.

Prior to the 1920s, evaporated milk was believed to contribute to scurvy so it was not commonly used to feed infants (Fomon 2001), but by the 1920s and 1930s, studies showed that infants fed homemade formulas based on evaporated milk grew as well as breastfed babies, and infant growth was considered the key marker of a healthy baby (Schuman 2003). From the 1920s through the 1950s, the primary food for most infants in the U.S. was a formula based on canned evaporated milk, to which mothers added a set recipe of ingredients that usually included sugar or corn syrup, cow's milk or water, and perhaps vitamins (Fomon 2001). In the 1950s, the first concentrated liquid commercially prepared formulas appeared, and by the 1960s these largely replaced powdered formulas. Iron supplemented commercial formulas first appeared in 1959 and were heavily marketed to parents. By the early 1960s, more babies were receiving commercially prepared formulas than evaporated milk formulas, a trend that persists to today (although some poorer African American St. Louis mothers still feed their infants evaporated milk-based formulas). During this forty-year period, infant formulas became normalized, as not only wealthy mothers but also poorer and middle class mothers relied on these carefully calibrated mixtures to feed their infants.

Breastfeeding rates fell sharply during the middle of the twentieth century. Whereas nearly 70% of women initiated breastfeeding between 1911 and 1915 and nearly 50% did so between 1926 and 1930, by 1946-1950 only 25% of women were even attempting to breastfeed (Hirschman and Butler 1981). Maternal concerns about not making enough milk had been part of breastfeeding discourse for centuries, but they reached a critical point during this era as medical knowledge about breastfeeding declined. Hospitals (where most women now gave birth) and physicians knew little about lactation, and routine hospital practices such as early supplementation, long separations between mother and infant, and washing nipples with alcohol after each feeding undermined breastfeeding success (Apple 1995; Apple 1987). Problems such as colic in breastfeeding babies were thought to be caused by maternal “nervousness” and weaning the baby to formula was typically prescribed as the cure (Blum 2000). Pediatricians believed that a sizable number of women were simply unable to breastfeed, perhaps because of these women’s delicate constitutions. By the mid-twentieth century, many women came to believe they were incapable of successfully breastfeeding before they had even been discharged from the hospital after giving birth (Apple 1987). This ideation reflected and extended the ideas held by physicians in the previous century about women’s deficient and inadequate bodies, reinforcing the belief that infant feeding required the expertise of male physicians.

The commercial marketing of first evaporated milk and later commercially produced infant formulas also played an important role in the shift from breastfeeding to infant formulas. A successful promotion strategy employed by two different evaporated milk companies was featuring infants of high order multiple births in their advertising. The Dionne Quintuplets, white sisters who were born in 1934, were used in enormously successful campaigns for Carnation Evaporated Milk starting in 1935 even though they refused to actually drink the product (Nathoo

and Ostry 2011). Ironically, breastmilk most likely played a major role in the quintuplets' survival, and they were fed donated breastmilk until they were five months old.



Figure 2.4 1935 Carnation Evaporated Milk ad with the Dionne Quintuplets (Nathoo and Ostry 2011:86)

In the 1940s, Pet Milk became the first national company in the United States to develop an advertising campaign that specifically targeted African American consumers, recognizing the rapidly rising purchasing power of the growing African American middle class (Mangun and Parcell 2014). The African American Fultz Quadruplets were targeted by Pet Milk shortly after they were born in 1948 to a 37-year-old deaf North Carolina mother, Annie Fultz, and her 59-year-old husband James, a sharecropper (Sanders 1968). Pet provided a small stipend and a live-

in African American nurse, who, with her husband later adopted the quadruplets. While Pet claimed to have treated the family well, buying them a farm and continuing to provide a stipend to the girls until they were in their teens, the quadruplets later spoke bitterly about the arrangement, noting that no funds were put aside for their future expenses.



Figure 2.5 1950s Pet Milk advertisement featuring the Fultz Quadruplets. Source: Facebook page run by the family: <https://www.facebook.com/TFQds/photos>

Commercial infant formula companies were successfully inserting themselves into hospitals by the 1940s and 1950s (Apple 1987). Some arranged to have their products mentioned by name in hospital orientation classes, or provided name cards for infant cribs featuring their own insignia, but perhaps the most valuable marketing strategy was to ensure that the baby's first bottle was a branded formula. During this era, formula manufacturers provided free or low-cost ready to use infant formula to hospitals, which was then fed to newborns (Schuman 2003). This allowed hospitals to stop preparing infant formulas themselves, saving them both time and

money. Mothers assumed that the formula they were given in the hospital was the best for their child, relying on their respect for the institution, and were likely to continue feeding the same brand at home.

2.5.2 Breastfeeding Returns

As the country shifted from the post-World War II economic boom to the political activism emblematic of the sixties, breastfeeding became the focus of renewed attention. In 1956, La Leche League, a mother-to-mother support group intended to support and encourage breastfeeding mothers, was founded by seven middle class, white women in Chicago (Van Esterik 1995). Although from its inception La Leche League has officially refused to involve itself in matters of politics, the act of sharing views and information in opposition to the generally accepted parenting practices of the time can be seen as a political act (I talk more about La Leche League in Chapter 3). Shortly afterwards, a number of related movements emerged: the combination of the feminist health movement and the back-to-nature “hippie” movement with new ideas about corporate responsibility and global activism created an environment exceptionally well-suited to the reappearance of nursing mothers (Blum 2000). Since 1972, the year that marks a low point in U.S. breastfeeding initiation (only 22% of mothers attempted to breastfeed that year), rates have more than tripled (Centers for Disease Control and Prevention 2014).

Although these new ideas about the value of maternal instincts might be framed by some as a rejection of scientific and medical knowledge, that would be an oversimplification. One of the two original founders of La Leche League, Mary White, was in fact married to a physician, and his research and support were instrumental in her ability to successfully breastfeed (Apple

2006). In fact, La Leche League has played a crucial role in increasing acceptance of breastfeeding within biomedicine (Weiner 1994). Hospital birth practices also began to shift during the 1960s as unmedicated births or epidural births replaced births with systemic anesthesia, allowing mothers to hold and breast feed their babies shortly after birth (Wright and Schanler 2001). Rooming in (newborn infants spending most of their time in the same room as their mothers, rather than in a separate nursery) became more common, and more women attended birth preparation classes that included specific information about breastfeeding. Hence, rather than being a rejection of scientific knowledge, the upsurge in breastfeeding can be seen as evidence of women's growing empowerment in the realm of the maternal, a shift that was especially evident for white and wealthier women.

The federal government intensified its focus on infant nutrition in 1974, when it established the WIC program in an effort to decrease infant and child morbidity and mortality due to nutrition-related causes (Baumslag and Michels 1995). The program provides supplemental foods, including infant formula, to lower-income pregnant and breastfeeding mothers, infants, and young children through a voucher system. During its first year WIC served 88,000 participants, a number that grew to 6.5 million by 1994, when it provided free formula to 37% of all United States infants. By 2010 that number was closer to half of all infants (Jensen and Lobbok 2010), and 54% of all formula purchases in the United States were made with WIC vouchers. Eligibility for WIC is limited to families earning up to 185% of the Federal Poverty Level (United States Dept. of Agriculture 2016).

WIC currently requires that formula companies bid for contracts with each state WIC program, offering the state rebates for formula purchased by WIC participants of up to 98% of the wholesale value of the product (Palmer 2009). This results in an increase in the retail

(unsubsidized) cost of infant formula, which may motivate mothers not eligible for WIC to breastfeed instead, thus increasing the disparity in breastfeeding rates between WIC enrollees and non-enrollees (Jensen and Labbok 2010). Indeed, mothers who receive WIC benefits are significantly less likely to breastfeed than mothers with the same demographic profile who do not participate in WIC programs. In 2009, WIC changed the composition of its food packages to increase the value of the package offered to breastfeeding mothers (Jensen and Labbok 2010). Still, the market value of the formula package is still significantly greater, and my ethnographic research uncovered numerous examples of breastfeeding mothers who either didn't use all of their WIC vouchers or left the program altogether because the foods offered were not what they and their families preferred to eat. I describe the breastfeeding support offered by WIC more thoroughly in Chapter 3.

During the late sixties and early seventies, infant formula companies began aggressively marketing their products in the Global South, resulting in soaring rates of infant malnutrition and mortality (Baumslag and Michels 1995). One of the most ethically disturbing practices was the formula companies' employment of "baby nurses" to visit new mothers and sell infant formula. These women dressed in nurses' uniforms and were sometimes actual nurses, and according to one study in Nigeria, most mothers believed these baby nurses were hospital employees recommending infant formula as the medically preferred feeding option. Doctors were also given free formula samples to distribute to their patients, and they received valuable gifts from the formula manufacturers in return.

During this period, Nestlé, based in Switzerland, was the largest manufacturer of infant formula (Baumslag and Michels 1995). In 1974, the Third World Action Group addressed Nestlé's practices specifically by publishing a pamphlet titled *Nestlé Kills Babies* in Germany

(Van Esterik 1995). Nestlé responded by filing a libel suit in a Swiss court, and while the highly-publicized trial resulted in a token victory for Nestlé, the negative publicity the company received proved highly damaging. A number of advocacy groups were founded in the wake of the Nestlé trial, among them the Infant Formula Action Coalition (INFACT) in Canada and the United States, the Baby Milk Action group in Britain, and the International Baby Food Action Network (IFBAN) (Palmer 2009). In 1977, one of the most influential consumer boycotts ever, against Nestlé products, was begun in order to bring attention to Nestlé's unethical promotion of its baby formulas in developing countries. Although the boycott was briefly lifted during the eighties, it was subsequently restarted and continues today.

In 1981, the World Health Assembly approved the WHO/UNICEF Code for the Marketing of Breastmilk Substitutes (often referred to as the "WHO Code" or simply "the Code" by breastfeeding activists and scholars), a set of provisions intended to eliminate marketing techniques that reduce breastfeeding rates worldwide (World Health Organization 1981). Among other requirements, the Code area bans the advertising of breast milk substitutes (such as infant formulas); the provision of free samples of breast milk substitutes to mothers, and the promotion of breast milk substitutes by health care providers. The delegate from United States was the only assemblyperson to vote against its adoption, as the result of a direct order from the pro-business Reagan White House (Van Esterik 1995). The Code was finally endorsed by the United States in 1994 under President Bill Clinton (Palmer 2009). Although the Code has been distributed to all corporations that produced baby formula, because it is not legally binding the implementation of its provisions has been largely dependent on the whims of the formula companies themselves, and thus far the companies have had little reason to follow the Code (Palmer 2009).

Breastfeeding initiation and duration rates dipped during the late 1980s but then recovered in 1990 and continued to rise (U.S. Department of Health and Human Services 2011). In 1997, the Work Group on Breastfeeding of the American Academy of Pediatrics (AAP) released a statement in which they noted many of the health benefits associated with breastfeeding and recommended exclusive breastfeeding for all infants for the first six months and breastfeeding combined with supplemental foods until one year (AAP Work Group on Breastfeeding 1997). In 2005, the group released an updated position statement that strengthened its recommendation by adding information about specific health benefits of breastfeeding that occur later in life (such as decreased incidence of obesity and asthma) as well as health benefits to the breastfeeding mother. This statement also endorsed breastfeeding past twelve months by stating: "Breastfeeding should be continued for at least the first year of life and beyond for as long as mutually desired by mother and child ... There is no upper limit to the duration of breastfeeding and no evidence of psychologic [sic] or developmental harm from breastfeeding into the third year of life or longer" (AAP Section on Breastfeeding 2005:499–500). The most recent AAP position statement, released in 2012, includes the strongest endorsement of breastfeeding yet, declaring that "infant feeding should not be considered as a lifestyle choice but rather as a basic health issue" (AAP Section on Breastfeeding 2012:e837).

According to the most recent CDC National Immunization Surveys, 80% of U.S. babies born in 2012 were breastfed at least once, 51.4% were breastfeeding at six months, and 29.2% were still breastfeeding at a year (Centers for Disease Control and Prevention 2016). Although breastfeeding rates have continued to increase for both white and African American mothers, this survey makes it clear that significant racial disparities still exist. In 2012, 83% of non-Hispanic white mothers began breastfeeding, 55.8% were still breastfeeding at 6 months, and 32.8% were

breastfeeding at a year, meeting the AAP's recommended duration. In contrast, 66.4% of non-Hispanic black mothers initiated breastfeeding, 35.3% were still breastfeeding at six months, and 16.9% were still breastfeeding at one year.

During the last sixty years, breastfeeding has been rediscovered by both medical professionals and women's groups, although each group had somewhat different concerns. While pediatricians have been involved in the management of formula feeding since the end of the nineteenth century, more recently pediatricians have re-involved themselves in the medical management of breastfeeding, as demonstrated by the progression of AAP position papers over the past 19 years. Breastfeeding in this context has been primarily framed in terms of health, with an emphasis on practices most likely to result in optimal health outcomes. However, my research suggests that although pediatricians are generally aware of the AAP recommendations for breastfeeding, many have little practical knowledge about lactation, and like their predecessors many inadvertently sabotage breastfeeding. Medical management of poorer women's breastfeeding has also become a concern of the state through the WIC program, leading to new forms of state surveillance of these women's bodies.

Beginning in the 1960s, some women began to develop more politicized understandings of breastfeeding. Awareness of the ways that infant formula companies exploit women in order to sell their products led them to see breastfeeding as an act of empowerment, and their attachment to environmental concerns led them to support breastfeeding as a more natural option. These women, who were generally white and middle- or upper-class, developed systems of breastfeeding education, advocacy, and support outside of the biomedical system, such as La Leche League and Baby Milk Action. In Chapter 3, I describe these two different systems in more detail and explore the ways they perpetuate racial and socioeconomic inequality.

2.6 Attachments and Breastfeeding

In this chapter I have explored and analyzed the history of infant feeding in the United States, examining cultural shifts that influenced the options available to mothers and the perceived acceptability of these options. I paid particular attention to how experiences are shaped by race, class, and other social categories, factors which have historically and still continue to influence infant feeding practices, significance, and meanings. I conclude by highlighting two key attachments from this history that influenced infant feeding practices and beliefs historically, which I argue persist in altered forms to the present day.

The conceptualization of breastfeeding as natural has been influential at various points in history. It was important to elite white women after the American Revolution, and then again in the 1960s as the nation developed an awareness of environmental causes. Many mothers today, both white and African American, find that this trope resonates with their own breastfeeding practice, and I describe some specific findings from my own research in Chapter 4. In fact, when a recent article in the journal *Pediatrics* problematized this conceptualization, the response from many breastfeeding mothers was swift and negative, indicating the importance and power this idea carries today (Martucci and Barnhill 2016).

A second theme is an attachment to technology and scientific information. Throughout most of the history in this chapter, this knowledge has been mediated by male physicians, who were responsible for interpreting and disseminating it to their female patients, reinforcing gendered power disparities. Some examples of this are the pseudo-scientific beliefs about the influences of diet, rest, and emotional upset on breastmilk, which late nineteenth century physicians used to monitor and control the bodies of their breastfeeding patients; and the later

valuation of technologically formulated infant formulas over breastmilk created by weak female bodies. While technological knowledge is still valued in the production of infant formulas, the electric breast pump is a technological advance of great importance to breastfeeding mothers today, as described in Chapter 6.

Chapter 3

Breastfeeding Landscapes: Geographies of Resources and Support

3.1 Mapping Breastfeeding

In 2014, the St. Louis Alliance for Breastfeeding added a map of all the breastfeeding resources available in the greater St. Louis area to its webpage. By clicking on different menus, viewers can alter the map to display different types of breastfeeding resources available in St. Louis city and St. Louis county. Figure 3.1, a map based on information from this resource, shows the locations of private (non-governmental) breastfeeding support groups in blue and WIC clinics in yellow.

In Chapter 1, I more thoroughly described the significance of the Delmar Divide in demarcating racial and socioeconomic segregation in the St. Louis region, while in this chapter I invoke the Delmar Divide in order to illustrate the racialized geography of breastfeeding resources. This street separates the predominantly lower income and African American northern region of the city from the whiter and more economically privileged southern region. Residential segregation also occurs along an east-west axis: residents of the western St. Louis county suburbs are predominantly white and wealthier, while those living in the more urban eastern area are more likely to be lower income and African American. For example, according to the United States Census Bureau, residents of the western St. Louis County city of Chesterfield had a median household income of \$94,263 in 2014, while the median household income that same year in Jennings, a city about ten miles northeast of Chesterfield, was only \$27,785 (United States Census Bureau 2015). Only 2.6% of Chesterfield residents were African American, compared to almost 90% of Jennings residents, as racial and socio-economic segregation in the

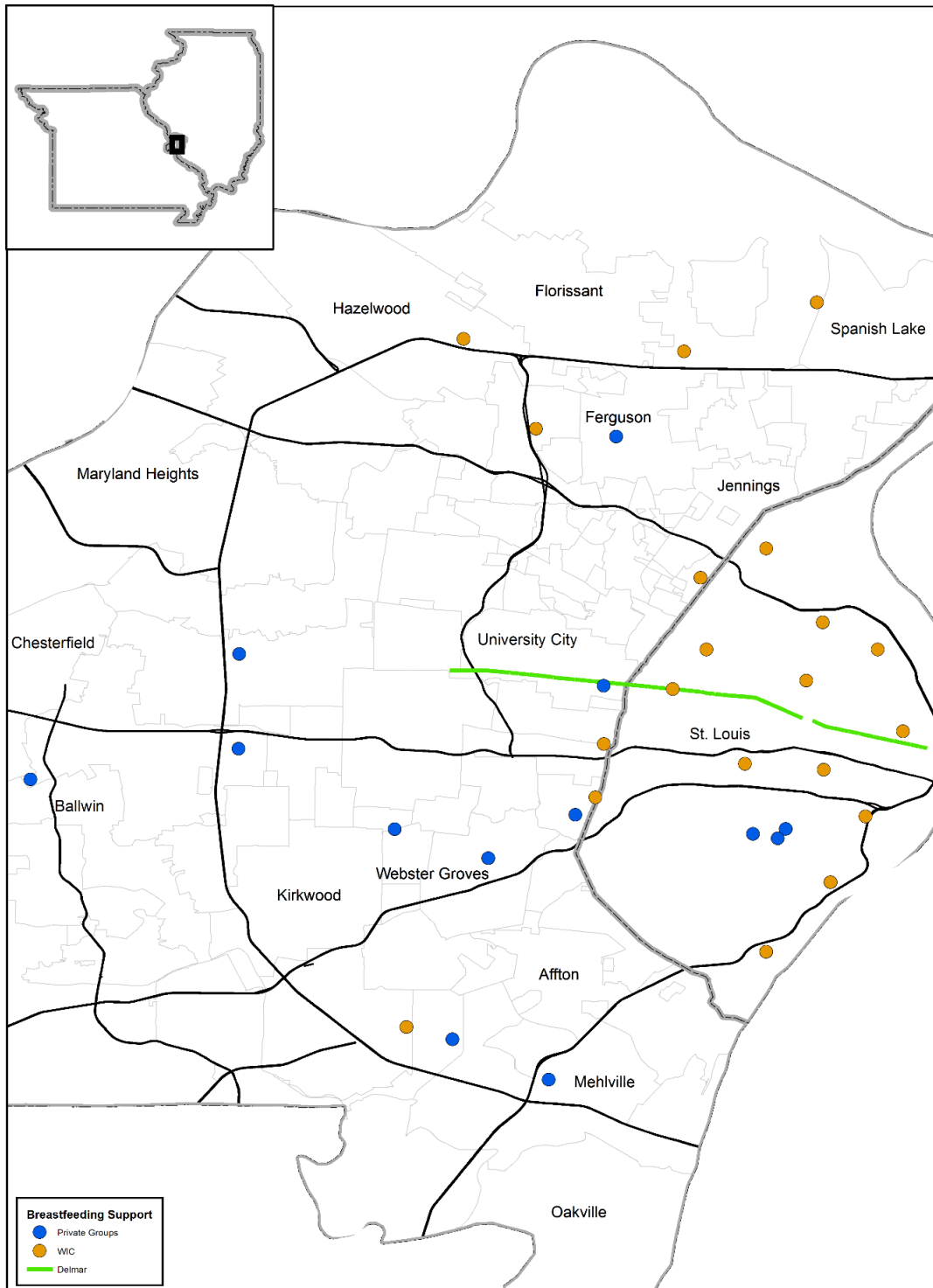


Figure 3.1 Breastfeeding support in St. Louis city and county. Map created by

William Winston and Sarah Sobonya.

region map closely onto each other, as they do in many American cities.

As Figure 3.1 shows, there is one non-WIC breastfeeding support group in the area north of Delmar Blvd and east of I-170. This is the new Breast Friends Rising group, I describe in Chapter 1, which was created in early 2015. The other twelve groups are all located south of Delmar Boulevard, providing a visual depiction of the disparity in non-governmental breastfeeding support. The distribution of WIC clinics, however, looks very different. WIC clinics, which serve lower income women, are spread fairly evenly within the more densely populated city of St. Louis, but they are non-existent in the western suburbs of St. Louis County.

This map demonstrates one way that the breastfeeding resources available to St. Louis women vary according to where in this region women live. Because residence patterns in this area are shaped by racial and socioeconomic segregation, the resources available to wealthier mothers, most of whom are white, are qualitatively different from those available to poorer mothers, more of whom are African American. Wealthier mothers can more easily access private support groups, which often offer peer-to-peer support, while low-income women may only have access to more medicalized help from government-run WIC clinics, which is often hierarchical and views breastfeeding through the lens of medicalization.

This chapter describes the racialized and classed landscapes of breastfeeding resources in this region, as well as the attachments different women form as they navigate these landscapes. I argue that poorer and African American mothers who want to breastfeed are disadvantaged in three ways: first, as described above, it is more difficult for these mothers to access affirming and helpful breastfeeding support services; second, economic barriers, including limited access to private health insurance, prevent purchases might increase breastfeeding success; and third, persistent segregation means that poorer women and African American women often come from

families and communities where for decades fewer women have breastfed, limiting contact with models for successful breastfeeding. I begin this chapter with a history of La Leche League and WIC, two of the oldest and largest organizations providing breastfeeding support in St. Louis. Using two composite women's stories, I then explore the ways women access services and navigate the structures that can promote or prevent breastfeeding success. Finally, I analyze these narratives as I argue that structural racism continues to influence the distribution of breastfeeding resources in St. Louis, in ways that harm poorer and African American women.

3.2 La Leche League: The Womanly Art of Breastfeeding

La Leche League was founded in a suburb of Chicago in 1956 by seven white, married, middle-class, and Catholic mothers (Blum 2000). According to La Leche League lore, all had breastfed their own children, unusual for that era, and most had breastfed at least one child without using any bottles (La Leche League 1963). Le Leche League grew out of the founders' experiences meeting other women who had tried to breastfeed but had been unsuccessful. All the founders were active in their local branch of Christian Family Movement, a Roman Catholic organization devoted to social action and the betterment of families, and felt that using their breastfeeding knowledge to help others was in tune with this group's philosophy (Weiner 1994). Indeed, the founders modeled the structure of La Leche League meetings on Christian Family Movement meetings.

As part of their work, the founders created and assembled a collection of materials on breastfeeding that eventually became their manual, *The Womanly Art of Breastfeeding*, which was first published in 1958 and is currently in its eighth edition. This manual facilitated the creation of affiliate groups by women in other areas who had successfully breastfed their own

children, and in 1964 the organization was incorporated as La Leche League International. Today La Leche League International reports over 3000 groups in 68 countries (Wiessinger, West, and Pitman 2010).

La Leche League's formation reflects a societal shift in ideas about child-rearing. As family sizes increased during the post-World War II Baby Boom, women began to question the ideology of scientific mothering (described in Chapter 2), which had encouraged mothers to rely on the expertise of physicians in all matters related to parenting. In contrast to this philosophy, La Leche League emphasized the wisdom of mothers. According to League doctrine, breastfeeding is a "womanly art" rather than a medical concern, and because of this La Leche League considered the knowledge of other women superior to that of physicians of the time, the vast majority of whom were men (Weiner 1994). The group promoted the model of "mother-to-mother support," and meetings were generally small gatherings of women held in a living room, a welcome break from the isolation many mothers experienced and evocative of feminist consciousness raising groups of this era. One early 1970s mother explained why she relied on La Leche League for breastfeeding assistance by saying, "My [male] doctor has never had a baby. My doctor has never nursed a baby... Sally Jones... has nursed three babies. Darlene Smith had nursed four...so this is why I called them instead of my doctor" (Lowman 1978:24–25).

From its inception, La Leche League was a strongly maternalist organization, in that it placed a high value on the domestic labor of mothers and believed this labor should be valued by society as a whole. The League saw breastfeeding as the quintessential representation of this labor. The founders wrote in *The Womanly Art of Breastfeeding* that breastfeeding was "an integral part of good mothering" (La Leche League 1963:10) because mothering should be based on "wise Nature's plan" (11), an allusion to the biological capacity for breastfeeding that most

women possess. The founders believed breastfeeding and motherhood enhanced a mother's status as a woman, as evidenced by the book's opening lines: "You are a woman who seeks to learn the ways of motherhood. You have never been more aware of your womanliness" (1). As was common during this era, they favored a clear separation of gender roles, noting, "We are all in favor of manly men. And La Leche League was formed for no other purpose than to help women be more womanly.... As long as women continue to bear babies and to nurse them, there is not much danger that the roles of mothers and fathers will become badly confused" (115). The League urged women to embrace motherhood fully, eschewing substitute caregivers and contraptions that served as mother substitutes such as pacifiers and bottles, or even playpens and strollers (Weiner 1994).

During the next fifty years, La Leche League's ideology adjusted to accommodate women's greater participation in the workforce, while still maintaining that little to no separation between mothers and their infants was the ideal. As second wave feminism gained traction during the sixties and seventies, La Leche League's leaders attempted to situate the organization within the feminist liberation ideology, arguing that women should be free to feed and nurture their babies in the ways they chose and that motherhood should be respected as a vocation in the same way a paying job was (Weiner 1994). Leaders during this time period found that the League's philosophy resonated with cultural feminists, who viewed breastfeeding as a uniquely female ability that as such was undervalued, as well as with women who supported the anti-consumerist back-to-nature ideals of the era, but that it was less popular with liberal feminists and others who sought workplace equality and employment outside of the home.

During the eighties and nineties, individual La Leche League groups varied in their support of working mothers: some offered useful assistance, while others believed that

separating infants from their mothers was intrinsically harmful and should be avoided if at all possible. After my own daughter was born in January of 1993, I attended two different groups in the Phoenix, Arizona, area and was struck by their different views on the subject of working mothers. The morning group affirmed the critical importance of minimizing mother-infant separation during the early years, while the evening group focused on ways to maintain the breastfeeding relationship and maternal bond when mothers worked during the day. Two of my friends who worked outside the home tried to become La Leche League leaders during that decade, but they were told that leadership required minimal separation between mother and infant during the first year, effectively eliminating mothers who had worked when their children were young. This position also effectively prohibited most poorer women and single mothers from becoming leaders, as they were unlikely to be able to afford to stay home with their children, reinforcing the organization's position as a resource for the middle and upper class.

The current La Leche League viewpoint is more accepting of mothers who work outside the home, although it strongly implies that this is not an optimal situation. The La Leche League Philosophy statement (2009), quoted on the La Leche League website updated 1/12/2015, states: "Mother and baby need to be together early and often to establish a satisfying relationship and an adequate milk supply" and "In the early years, the baby has an intense need to be with his mother which is as basic as his need for food." This attitude is also reflected in the most recent edition of *The Womanly Art of Breastfeeding* (Wiessinger, West, and Pitman 2010). Although the book discusses issues such as pumping, bottles, and child care in the chapter titled "When You Can't Be with Your Baby," this section also includes suggestions for mothers such as reducing work hours, asking to work from home, or changing careers to something that can be done with a baby in tow. According to La Leche League, "The research-based reality is that neither of you is

built, physiologically or emotionally, for long and regular separations" during about the first three years of a child's life (280).

While invoking science with a reference to research, this section is really focused on the primary importance of the domestic sphere: mothers and infants are biologically programmed – “built” – to spend the early years together, and separation is emotionally damaging. La Leche League has succeeded in removing breastfeeding from the exclusive purview of physicians and situating it as a “womanly art,” emphasizing the importance of mothering to families and to society and celebrating the maternal.⁶ As I saw during my research, mothers involved in La Leche League groups receive breastfeeding support that highlights their value as mothers and the importance of womanly knowledge, in a group setting that affirms the value of community but remains most accessible and relevant to white and wealthier women.

According to one longtime leader, La Leche League has been meeting continuously in St. Louis since February of 1960. Many local leaders have been part of the organization for decades. I received permission to conduct research at St. Louis area La League meetings from the Gateway La Leche League Research Review Committee in July of 2013. Between August of 2013 and August of 2014, I regularly attended the two monthly meetings, one in the morning and the other in the evening, and I occasionally attended other meetings (there were about fifteen regular monthly meetings in the St. Louis region during this period, although the exact number changed as meetings were started or stopped). A different longtime leader claimed that the morning group I attended had been gathering in the same location, a room in a church that is

⁶ La Leche League did recently change their rules to allow transgender men who had breastfed to become leaders, opening the door to new ideas about mothering vs. fathering. For more information, see Tapper 2014.

used for childcare during services, for more than 35 years. The church where the evening group met is in the same neighborhood, Tower Grove South, a gentrifying area near the center of the city.

In 2010, the racial composition of the city of St. Louis was 44% white and 49% African American, and the population of Tower Grove South was 55% white and 30% African American, with Asian residents making up most of the remainder for both (City of St. Louis 2011). The women who attended these groups, however, were mostly white, with only an occasional African American or Asian woman joining. I met four leaders and one leader in training at the St. Louis city meetings, all of whom appeared white, and the leaders I met while visiting other meetings were also white. This illustrates the disproportionate whiteness of these meetings, as compared to the population of both the city and the immediate neighborhood.

Although I did not ask the leaders I met about their household incomes, this role would be difficult for someone without some degree of economic privilege to hold. La Leche League leaders go through a comprehensive training program that typically lasts about a year; they are required to pay both an application and an accreditation fee; and practicing leaders are also required to pay annual leader dues (La Leche League International 2011). Some of the leaders I met also held additional credentials in lactation, although most did not. Leaders are not paid for their work.

The content of the La Leche League meetings I attended emphasized breastfeeding as an integral piece of attentive mothering. Meeting began with introductions, during which I briefly described my research and shared my status as a mother who had breastfed, and then moved to discussion on one of four rotating topics: the advantages of breastfeeding, getting off to a good start; avoiding and overcoming difficulties; and nutrition and weaning. Leaders explicitly invited

other group members to share their own wisdom, invoking an egalitarian ethos by making statements such as “We’re all moms.” Although the leaders were open to learning about scientific research regarding the health benefits of breastfeeding, discussions were more often focused on the ways breastfeeding strengthened the bond between mother and infant and led to happier and better-adjusted children. One La Leche League leader suggested on at least two occasions that the five surviving founders of the organization should be awarded the Nobel Peace Prize, because she believed that breastfed children grew up to be more peaceful adults. She was corresponding with a Chicago university near the organization’s birthplace in order to convince them to submit the nomination, and she felt that time was of the essence because two of the founders had already passed away.

In summary, La Leche League provides breastfeeding support as part of civil society. It is predominantly run by higher income and white women, and it emphasizes peer support in carrying out its mission. The organization views breastfeeding as part of the kind of mothering that women and infants were “built” for, and adherents emphasize breastfeeding’s importance in facilitating outcomes such as emotional well-being and more peaceful children, in addition to better health. In the following section I discuss the breastfeeding support provided through WIC, which provides a contrast to La Leche League’s philosophy and structure.

3.3 WIC: “I Try to Cover All of the Material the State Gave Me”

In 1974, the United States Department of Agriculture established WIC (Baumslag and Michels 1995). The program’s goal is the reduction of infant and child mortality and morbidity caused by nutritional deficiencies. WIC is best known for its voucher-based supplemental food allocation system, described more fully in Chapter 2, which provides infant formula to about half

of all infants born in the United States (Jensen and Labbok 2010). However, breastfeeding mothers have been eligible for WIC vouchers since the program's inception, and efforts to support them have increased as knowledge of the health risks associated with not breastfeeding has grown. In 1989, the federal government mandated that all state WIC programs spend a minimum of \$8 million on activities specifically aimed at breastfeeding promotion and support, and this was followed by a 1992 law requiring the establishment of a national breastfeeding promotion program, which has continued to grow and evolve (United States Department of Agriculture 2013). The specific focus of this section is WIC Breastfeeding Peer Counselors and the classes and groups that they and other WIC staff members facilitate.

Like La Leche League leaders, WIC Breastfeeding Peer Counselors are mothers who have breastfed a child (United States Department of Agriculture 2015). Ideally, they are women living in the same communities they serve, although in my research I found that this wasn't always the case. As well as leading groups or classes and seeing clients at WIC locations, peer counselors may be expected to be accessible to mothers by phone outside of business hours to provide additional support.

In November 2013, I attended the two day required training for WIC Breastfeeding Peer Counselors. Some of the topics addressed during the training were: how to act professionally; charting and record-keeping; when to refer a client to a nutritionist or an RN/IBCLC (the latter is the highest available credential in lactation); the health benefits of breastfeeding; and challenges a breastfeeding mother might face. While active listening and compassionate support were emphasized, so was the importance of keeping to the appropriate scope of practice, meaning that peer counselors must refer more technical questions to someone with more advanced credentials. This was frustrating for peer counselors who did have expertise in lactation support. During my

research, I met an African American woman who became an IBCLC while working as a peer counselor for WIC, who was still only permitted to operate within the peer counselor scope of practice because she was not also an RN or certified nutritionist. Unsurprisingly, she left her job at WIC, and in 2015 she joined the Breast Friends Rising group.

Missouri was one of the first states to use the Breastfeeding Peer Counselor model in its WIC programs. The Missouri Department of Health and Senior Services established the Missouri Breastfeeding Peer Counseling program in 1994, and subsequently began providing peer counselors to a limited number of WIC clinics (National WIC Association 2006). By 2006, 45 of Missouri's 118 WIC clinics had at least one peer counselor on staff, and by 2015 that number had risen to 73 (DHSS 2015). I formally interviewed two WIC Breastfeeding Peer Counselors during my research, a white single mother of four working in the city of St. Louis and a white single mother of one working in a small community east of St. Louis city, on the Illinois side of the river. At the time that I interviewed them in 2014, both worked part time and earned between \$9 and \$12 an hour, neither received benefits such as health care or vacation days, and both were still poor enough to qualify for WIC services themselves. I met four African American women who worked as WIC Peer Counselors during the course of my research, one of whom I describe in Chapter 1, although by the time I completed my research only one of the four was still working at this job. All the WIC Breastfeeding Peer Counselors I met during my research shared a deep commitment to helping women breastfeed, and many had sought additional training or purchased items with their own money to better help their clients.

Unlike La Leche League, which values peer to peer sharing of knowledge and emphasizes that its leaders are also moms, WIC is explicitly hierarchical, and peer counselors are at the bottom. The peer counselors I met were poorly paid and often frustrated by the lack of

resources at their disposal, complaining of lost or broken breast pumps and wishing they could provide cold drinks for their pregnant clients on hot days. They were constrained in the help they could give, and they were often required to refer clients to someone else even when they knew how to solve the client's problem themselves. While peer counselors generally had some freedom in how they ran their breastfeeding groups, they were also required to include specific information, as determined by state and federal governments. One peer counselor told me, "I try to cover all the material the state gave me," but admitted that it wasn't always the material she thought most relevant to her clients.

As a governmental agency, WIC clients are subjected to state surveillance. To receive WIC services, a woman must first apply, which requires her to disclose details about her medical history, financial situation, and personal habits (such as smoking or drug use). Peer counselors and other WIC employees document interactions with each client electronically, noting how and what the infant is being fed. Infants and pregnant mothers are weighed and measured, and at intervals they are subjected to blood tests. Participation in WIC programming, such as groups, classes, and appointments with staff members, may be required of clients in order to receive food vouchers.

WIC clients are demographically different from women who attend La Leche League meetings. All WIC clients have a household income at or below 185% of the Federal Poverty Level, while most La Leche League attendees are wealthier than this. According to the most recent available data from the Missouri Information for Community Assessment database (MICA), nearly 68% of the WIC clients in St. Louis City and St. Louis County who gave birth in 2008 were African American, 30% were white, and most of the remaining 2% identified as Asian, Native Hawaiian, or Pacific Islander (Missouri Dept. of Health and Human Services

2010). In summary, then, lower income and African American breastfeeding mothers are likely to receive breastfeeding help from a hierarchical, state-run program that requires them to share personal information and attend appointments and classes, and the information they receive is often medicalized and focused on health.

3.4 Navigating Breastfeeding: Two Stories

3.4.1 Orientation

In this section, I explore St. Louis's breastfeeding landscape through the stories of two women in order to show how the city's persistent racial and economic disparities and segregation affect first, the type of breastfeeding support and knowledge available to mothers; second, their access to items and services that facilitate breastfeeding; and third, the possibility of breastfeeding role models in their communities. Each woman is a composite of two or three women I met during my research, which helps protect the identities of the women who shared their stories with me, but each of the elements in these narratives happened to a woman in the St. Louis region between 2013 and 2015. By bringing these narratives together, I hope to provide a richer and clearer picture of the ways geography influences breastfeeding practice and possibilities, and to emphasize the role of place in lived experience.

While La Leche League meetings and WIC clinics are the most numerous providers of breastfeeding support in this region, other support groups do exist. Many hospitals offer breastfeeding support groups and classes for patients both before and after they give birth. To the best of my knowledge, five other breastfeeding support groups were meeting regularly as of 2015. One of these, the twice-weekly group at the Sweet Acacia retail store, is described in more detail in Chapter 5. Two other groups also meet at retail stores that sell items relevant to children

and parenting. A third independent group focuses on breastfeeding support as a Christian ministry and is held monthly at a church, and a fourth meets monthly at a feminist sex toy shop. All except the last are facilitated by CLCs. The facilitator of the last group became an IBCLC in 2015.

3.4.2 Amy's Story: Navigating in Abundance

“I’m a planner,” Amy told me, laughing. When she found out that she was pregnant, she was 36 and had been married to Steve, an attorney, for almost five years. Both white, they had professional careers and a combined income of over \$175,000, and they owned a house in the western St. Louis suburbs. Amy took on “Project Baby” (as she called it) with the same focus and attention to detail that had brought her success in her engineering career. After selecting a highly recommended obstetrician, she began investigating the birth options available to her at local hospitals, finally settling on a large facility not far from her house known for its gourmet meal options and sumptuous birth suites with whirlpool tubs. With Steve, she attended a series of birth classes at the hospital, at a cost of \$180 for the series, and began interviewing doulas (people, usually women, who are trained to provide support and information to mothers before, during, and after birth), finally settling on a woman with over ten years’ experience who exuded calmness and warmth. Her services were not inexpensive, but they could afford to pay over the \$1000 cost of her deluxe package of services, and many of their friends with babies had told them that having a doula was worth any price. Doula support has been shown to have numerous positive effects, including increasing breastfeeding rates (Kennell 2004), but the cost of their services is prohibitive for lower income women.

Amy had always planned to breastfeed. She had been breastfed herself, although only for six months, and all of her birth research had reinforced the idea that breastfeeding was the right choice. However, until the doula came to Amy's home to help her prepare a welcoming space for the baby and write her birth plan, Amy hadn't given much thought to breastfeeding; her focus was on having the best possible birth. The birth plan form provided by the hospital asked specific questions about feeding: did she plan to feed her baby at the breast, feed pumped milk from a bottle, or feed formula from a bottle? The doula encouraged feeding at the breast, on demand, and explained that this would encourage Amy's milk to come in faster. She also recommended that Amy check the "no pacifiers" box and the "rooming in" box, explaining that both of these choices would support breastfeeding.

The doula's comments made Amy think more about breastfeeding. Most of what she had heard in her classes and read about on the birth-related internet sites she frequented emphasized that breastfeeding was normal and natural (see Chapter 4 for more discussion of this trope), and her doula had reinforced this idea, but their discussion about the birth plan left Amy feeling concerned about her lack of specific breastfeeding knowledge. She searched for breastfeeding support groups on the internet and found the Sweet Acacia group nearby, as well as a number of La Leche League groups that weren't far from her home. La Leche League had a somewhat negative reputation among Amy's friends who had breastfed ("I thought they were all a bunch of hippies," she explained), a viewpoint shared by other mothers in the St. Louis area (Munz 2010). The Sweet Acacia group's Saturday morning time slot was also an advantage, because Amy was still working during the week. Her company was giving her almost four months of maternity leave, mostly paid, but she wanted to save it for after her baby was born.

Amy wasn't sure if she would be permitted to attend the breastfeeding support group at Sweet Acacia before she was breastfeeding, so she called the store to ask. The store employee who answered the phone told her that pregnant women were encouraged to come to group. "You can avoid so many problems if you're educated about breastfeeding before you have your baby!" the employee said enthusiastically. Amy and Steve went together, purchasing two small outfits and a package of blankets before making their way to the back of the store where the group was being held. As soon as she sat down, Amy felt relaxed and welcome. The other mothers were white, and many appeared to share Amy and Steve's socioeconomic class, evidenced by their expensive but casual clothing and their late-model cars in the store parking lot. The group members greeted Amy warmly and peppered her with questions about when she was due and where she planned to give birth. In moments, they were advising her about the best items on the hospital menu and telling her where her husband could go to get her a good cup of coffee. One mother held out the very large reusable plastic cup that she had received at the hospital, explaining that all breastfeeding mothers were given one and warning Amy that the nurses wanted women to drink the entire cup full of water. The group members' acceptance and advice conveyed an ethos of mutuality and community.

Amy was 39 weeks and 2 days pregnant when she went into labor. She had an uncomplicated vaginal delivery, and as soon as baby Calvin was born, the doctor gently placed him on her chest and tucked a blanket around them both. The infant began bobbing his head and trying to find the nipple, and when he found it he latched on and began to suck eagerly. "I thought, this is a piece of cake," said Amy about this period.

Amy and Calvin were discharged the second day after Calvin was born. Amy's milk came in on the fourth day, and she hoped now that Calvin was actually getting more to drink he

would not need to suck as hard, because her nipples were becoming red and painful. She tried using the nipple shields she had been given at the hospital, but Calvin seemed to fuss more with them on and pull his head away, so she put them aside. At her postpartum visit, the doula told Amy not to use the shields and suggested “laid back nursing”, or breastfeeding while semi-reclining (in a recliner chair or with the help of pillows), with Calvin face-down on her chest. When Calvin was a week old, the entire family returned to the Sweet Acacia group. Amy wanted to ask about nipple pain, but after another woman showed the group the red, open sore on her own nipple, Amy decided that her own pain was not that serious, and instead she purchased a soothing nipple salve.

Amy continued to find breastfeeding difficult. Although Calvin seemed to want to nurse frequently, he spit up often and struggled at the breast, wrenching himself off Amy’s nipples and screaming with frustration. Amy could see the milk spraying out whenever he unlatched during a feed, so she believed that she was making enough milk, but she didn’t know what else could be wrong. She called her own mother for help, but Amy’s mother remembered breastfeeding as “a beautiful experience” and couldn’t recall that she’d had any problems at all, so while she was sympathetic she had no practical advice.

Although Amy continued to attend the Sweet Acacia group once or twice a week, she was reluctant to bring the issue up there because so many of the mothers seemed to struggle with low milk supply. She was concerned that talking about her over-abundant supply would be viewed as a “brag-complain,” or that mothers with low supply problems might feel bad. Although ostensibly about breastfeeding support, the group had also become an important social outlet for Amy, and it was important that she present herself as caring and kind community

member. Instead, she asked for advice from a friend who had breastfed her own children, and her friend recommended an IBCLC who made house calls.

Amy called the lactation consultant, and the consultant arranged to be at Amy's house later the same afternoon, a visit that was eventually covered by Amy's insurance company. She diagnosed Amy with an oversupply and suggested block feeding, or feeding Calvin on only one breast for a period of 3-4 hours and then switching and feeding him only on the opposite breast for a similar time period. She also suggested that Calvin's frequent spitting up was actually reflux and recommended that his pediatrician assess him. Her pediatrician prescribed Zantac for Calvin and told Amy to burp him frequently and keep him upright for 20-30 minutes after feedings. Amy tried to do this but found it difficult, because Calvin often fell asleep after eating. She was still nursing at least every 2-3 hours around the clock and sleep was a precious commodity.

The lactation consultant suggested attending La Leche League meetings for additional help, so Amy looked online and found a number of nearby meetings, which she added to her schedule. At one meeting, a mother with a chubby older baby attached to her breast and a three-year-old hanging on her chair volunteered that craniosacral therapy had been "a lifesaver" for her older child, who had also struggled with reflux and poor sleep. This other mother described craniosacral therapy as a technique that allows the practitioner (often a chiropractor or osteopath) to detect a blockage of the flow of cerebrospinal fluid in the brain and spine, stop the flow so the blockage can be cleared, and then restart the flow. This description matches fairly well with the descriptions given by craniosacral practitioners, although they do not necessarily claim to stop the flow of fluid (Ernst 2012).

Amy brought Calvin to the craniosacral therapy practitioner recommended by the mother at the meeting, and immediately after the treatment, which cost \$35 and was not billable to insurance, Calvin appeared noticeably more relaxed and remained calm while nursing. However, after looking in Calvin's mouth, the chiropractor asked whether Amy was still feeling pain when nursing, and when Amy answered affirmatively the chiropractor suggested that Calvin should be assessed for a lip and tongue tie by a specialist. Amy's own pediatrician had already checked Calvin for a tie and determined that he did not have either, but when Amy asked the women in the Sweet Acacia Facebook group for advice, many of them replied that the specialist had found ties their own pediatricians had missed.

Amy brought Calvin to see the specialist, who determined that Calvin did have lip and tongue ties that were affecting his latch. The specialist cut ("released") the ties with a laser, a procedure called a frenectomy, and Amy immediately found nursing more comfortable. Amy's insurance provider covered most of the cost for this visit, but without insurance the charges would have been over \$800. To Amy, this was the turning point in her breastfeeding journey, although she is not sure if the lip and tongue ties were really the primary problem, or if they were simply the last ones to be fixed.

Calvin was three months old when his lip and tongue ties were released, and within a week he started sleeping for longer stretches and spitting up less often. After this, Amy found that breastfeeding was less of an ordeal, and that it more closely resembled the lovely bonding experience that her friends from group and her own mother had described. She continued to occasionally attend support groups even after returning to work, and she became close friends with some of the mothers. Using the breast pump she received through her insurance company, Amy pumped milk for Calvin while she was at work until he turned one, and three months later

he was completely weaned. She occasionally missed the special closeness breastfeeding had brought them, but she felt proud that she had succeeded in nursing him for a year.

3.4.3 Tasha's Story: Navigating in Scarcity

Tasha had always wanted to be a mother, and when she found out that she was pregnant she was determined to be the best mother she could be. An African American woman who had earned less than \$10,000 the previous year, Tasha was 21 years old and worked part time at a large home improvement store. She lived in a house in north St. Louis city with her boyfriend, Mark, who worked at a gas station in a western suburb of St. Louis, and a male roommate. Although Tasha had grown up in the area, her immediate family now lived in Florida, but she was particularly close to an aunt who still lived nearby. After Mark, Tasha's aunt Delores was the first person she turned to with the news, because she knew Delores, who had no children of her own, would be as overjoyed as she was.

Tasha had no health insurance through her employer, as is typical for jobs like hers. Although the individual mandate section of the Affordable Card Act had yet to take effect, it would not have helped Tasha. Her income was below the Federal Poverty Level, making her ineligible for the health insurance subsidies authorized by the Affordable Care Act, but because Missouri lawmakers did not expand Medicaid as was intended by the Act, she would have also remained ineligible for Medicaid (Bouscaren 2014). Once she became pregnant, however, Tasha became eligible for a Medicaid program specifically for pregnant women. She arranged to take a day off work, and she and Delores went to the Federally Qualified Health Center (FQHC) closest to her home to see a doctor, because she had heard from many people that prenatal care was essential to having a healthy baby.

At the FQHC, which Tasha referred to as “the clinic,” Delores paid the \$20 co-pay and Tasha was able to see a doctor, who verified her pregnancy and gave her a prescription for prenatal vitamins and handouts on healthy eating during pregnancy. A clinic staff member helped Tasha apply for Medicaid and acquire a temporary Medicaid card, which was valid until the last day of the following month. According to Medicaid regulations, her application should have processed within 15 days, but by the end of the next month she had heard nothing. Tasha was not alone in her predicament. During 2013 and 2014, Medicaid applications for pregnant women routinely took months to process, and some women actually gave birth before receiving their determination of eligibility (Kulash 2014).

In 2014, members of For Babies, a collaborative working to reduce infant mortality in St. Louis (see chapter 1 for more information about this group and my involvement), reported that some lower income women were aware of this long delay in processing these Medicaid applications, and they were therefore strategically waiting until the ends of their pregnancies to apply for Medicaid. This ensured that their births would occur while they were covered under the initial temporary eligibility period, something they viewed as important because without Medicaid coverage they were sometimes turned away by the hospitals where they wanted to give birth. However, this strategy also resulted in the women receiving no prenatal care prior to the final weeks of their pregnancies.

Tasha applied for Medicaid when she was about 11 weeks pregnant, and she was 24 weeks pregnant when she finally received her card. Therefore, she had no health insurance during most of the first two trimesters of her pregnancy. During the weeks while she was waiting for her application to be processed, she tried calling the Medicaid number numerous times, but most of the time she was either connected to an answering machine or heard a busy signal. She

was able to speak to someone once, and the person who answered the phone asked for her name and contact information and told that someone would return her call, but no one did. She continued to take her prenatal vitamins, and she told me how thankful she was that the doctor had included enough refills to get her through her entire pregnancy, and that a local supermarket filled prescriptions for prenatal vitamins for free.

With her new Medicaid card in hand, Tasha returned to the FQHC for another prenatal check-up. At this visit, she was referred to a series of prenatal education classes that met bi-monthly at the center, which she enthusiastically joined but then found disappointing. The classes were boring, she said, and the nurse who taught them had a strong accent and was difficult to understand. Tasha earned tokens for each class she attended, and the final class was a “baby shower” at which all of the women enrolled in the class used the tokens to “shop” for baby items like blankets and bottle warmers.

One of the classes included information on breastfeeding. Tasha listened closely and took the instructor’s statements about how healthy breastfeeding was for babies to heart. Breastfeeding was foreign to Tasha: she did not know anyone personally who had breastfed, and she could not even remember ever seeing someone breastfeeding on TV or hearing about any celebrities breastfeeding. However, she wanted her baby to be as healthy as possible, so she decided that she was going to give breastfeeding a try.

When Tasha was 34 weeks pregnant, she saw a flyer at the clinic for an upcoming Breastfeeding Café at the clinic's WIC office. Breastfeeding seemed mysterious to her, so she went to the event hoping to learn more. The Breastfeeding Café was facilitated by two African American women, a breastfeeding peer counselor and a registered nurse who was also an IBCLC. Together, they served juice and cookies to the half dozen women in attendance. Four of

the women were pregnant, including Tasha, and two had newborn babies in strollers. Two of the pregnant women had come with male partners, who smiled sheepishly as they loaded their plates with cookies.

To begin the program, the facilitators wheeled a TV and VCR on a cart into the room and showed an educational film on breastfeeding, which stressed that breastfeeding was natural, free, and healthier for babies and mothers. After the film, they explained a handout with information about proper nutrition during pregnancy and breastfeeding, including detailed information on how many servings to eat from each food group. When the peer counselor began to speak about getting a good breastfeeding start in the hospital, one of the women who had already given birth raised her hand and said that while her baby had nursed well in the hospital, now breastfeeding hurt all the time. She wanted to keep breastfeeding, but did not think she could continue because of the pain. The two facilitators exchanged a glance, and the lactation consultant moved to sit next to the woman. The two of them talked in low voices while the peer counselor continued to lead the discussion. After a few minutes, the lactation consultant softly invited the new mother to come into her private office, where the lactation consultant could watch while she nursed and discover what was causing her pain.

Tasha enjoyed the Café. She especially liked the peer counselor, who gave Tasha her phone number and said she was available to talk if Tasha had breastfeeding questions after her baby was born. Tasha liked that the WIC group was in a medical clinic and the facilitator was a nurse, because she felt that this meant the information she was getting was reliable. She knew that doctors and nurses spend many years in school learning their professions, giving them access to knowledge that she knew nothing about. Tasha enrolled in WIC feeling more confident in her ability to breastfeed her baby than ever before.

Tasha went into labor when she was 36 weeks and 4 days pregnant. After the doctors detected signs of fetal distress, she had a caesarian section (often referred to as a C-section). In 2013, 35.8% of U.S. babies born to African American mothers were born via caesarian section, as compared to 32.7% of U.S. babies overall (Martin et al. 2015). Because baby Mark was born at less than 37 weeks, he was considered preterm, as were 16.9% of Missouri babies born to African American mothers but only 10.23% of Missouri babies born to white mothers (national data is similar at 16.27% and 10.17% respectively) (Martin et al. 2015). Both prematurity and caesarian sections are associated with poorer breastfeeding outcomes (Thulier and Mercer 2009).

Little Mark, as his family called him, was small but healthy. When the nurses brought him to Tasha, she tried to put him to her breast but he was sleepy and did not latch on well. Tasha was in a lot of pain from her caesarian section, and it was difficult for her to hold Little Mark to breastfeed him because of the pressure his body placed on her incision. By the third day, the “lactation nurses”⁷ were concerned that Little Mark wasn’t getting enough milk, so they showed Tasha how to feed him her pumped milk with a syringe. One floor nurse reassured her that she could still breastfeed after she healed a bit and her milk came in, and encouraged her to give Little Mark some bottles so that she could rest and heal. “They already look at me like I don’t ‘pose to be breastfeeding, though,” she said about some of the nurses, but she continued to pump.

After five days, Tasha and Little Mark were discharged and went home. Tasha tried to get Little Mark back to the breast, but she wasn’t sure if he was latching on correctly, because her nipples were very sore and red and Little Mark didn’t seem to be getting much milk. She

⁷ This was Tasha’s term for the women who helped to breastfeed. It was unclear how much specialized training these nurses had in lactation management, if any.

decided that exclusive pumping might be a better way to go for the time being, until she healed more, but she had only the manual pump she had been given at the hospital and it did not seem to her to be very effective (see Chapter 6 for more about the types of breast pumps and their properties). Delores went to Target to look for a better breast pump, because Tasha was not eligible for one through her Medicaid plan. As of January 1, 2013, the Affordable Care Act requires private insurance plans to pay for breast pumps and lactation support services, but Medicaid is exempt from these requirements and states determine if their Medicaid programs will provide these benefits (Assistant Secretary for Public Affairs 2014). Most of the pumps Delores found at Target were far out of their budget, costing \$200 or more, but she purchased a manual hand pump that promised more comfort for about \$35.

Tasha tried to pump frequently, but she was discouraged by how little milk she produced. Her nipples still hurt, and she was only trying to put Little Mark on the breast once or twice a day so that they would have a chance to heal, but sometimes the pump hurt her nipples even more. Delores returned to Target and bought a single electric pump for \$50, but Tasha did not notice much improvement. Tasha tried to call the breastfeeding peer counselor from the Breastfeeding Café, but the counselor's voicemail message said she was on leave from the position. When Tasha called the WIC clinic directly, the receptionist told her she would need to come in for an appointment, which she still felt too weak to do.

Ten days after giving birth, Tasha was readmitted to the hospital because the incision from her surgery was infected. Little Mark stayed with her. Tasha's doctor told her that one of the medications he had prescribed could be dangerous to Little Mark, and he instructed her to avoid pumping or breastfeeding for a certain number of hours after taking it. At this point, Tasha started giving Little Mark formula for some of his feeds, although she also pumped when she

could. Tasha was discharged after three days in the hospital. She continued to pump occasionally at home, but she found that she was able to extract less and less milk, and by the time Little Mark was four weeks old he was only drinking formula.

Tasha felt some disappointment about not breastfeeding longer, because she still believed that breastfeeding was healthier than formula, but Little Mark was gaining weight and meeting all of his developmental milestones, and this reassured her. She brought Little Mark to the same pediatrician she saw as a baby, who helped her select the right formula. Tasha also returned to the WIC clinic, where she was given vouchers that paid for all of the formula Little Mark drank.

When I asked Tasha what might have enabled her to continue breastfeeding, she was pensive. Her stressful birth and caesarian section were the first things to come to her mind, as well as her later hospitalization, although she admitted that by the time she was readmitted, breastfeeding was already going poorly. The thing that would have really helped, she said, would have been “a little more help and coaching,” and perhaps someone who could have come to her house and helped with breastfeeding.

Amy’s and Tasha’s stories illustrate the contrasting breastfeeding resources available to wealthier white mothers and poorer African American mothers. While both wanted to breastfeed and both faced challenges in doing so, only Amy was ultimately successful. In the following section, I analyze these vignettes and draw out some of the differences between them, looking specifically at the types of support each could access, the effects of economic barriers and financial privilege, and the influence of social networks.

3.5 Landscape Analysis

3.5.1 Breastfeeding Support: Medicalization and Authoritative Knowledge

Both Amy and Tasha sought and received help from people they viewed as breastfeeding experts. Tasha learned about breastfeeding from biomedical practitioners: the nurse who facilitated her prenatal class, the WIC peer counselor and lactation consultant, and the “lactation nurses” at the hospital. Not surprisingly, the information she received focused on the health benefits of breastfeeding, and the assistance she received when she struggled was primarily technical, such as the hospital nurse’s suggestion that Tasha pump and use a syringe to feed her son. In contrast, Amy learned about breastfeeding from a number of sources. Some were clearly biomedical, such as her prenatal education classes, but much of her information came from experts from the periphery of or even outside of the biomedical system, such as doulas, lactation counselors (as opposed to board certified lactation consultants), and La Leche League leaders. In addition, the wisdom of other breastfeeding mothers was an important source of knowledge for Amy.

Medical anthropologist Brigitte Jordan’s idea of authoritative knowledge is a useful concept for understanding one way these two systems of support differed. Authoritative knowledge is the knowledge that “counts” in a particular situation, or the knowledge that seems natural and reasonable to the people involved (Jordan 1997:58). At private support groups, knowledge that counted often came from other group members. Although group facilitators all had some sort of training in lactation, they usually did not monopolize the discussion (there were exceptions), and typically many group members would offer suggestions and advice. When a mother shared a specific concern, a group member would often point out someone else in the group who had experienced a similar problem and encourage that person to contribute, saying

something such as, “Darla, that sounds like the same thing you talked about last month.” Darla’s personal success in increasing her milk supply or correcting a poor latch gave her authoritative knowledge on that topic.

Amy was able to sustain attachments to more than one systems of authoritative knowledge. She learned about the health benefits of breastfeeding, but she also learned about breastfeeding as “a beautiful experience.” Jordan (1997) notes that in less hierarchical settings, there are multiple systems of authoritative knowledge available, and women can choose among them. Amy did this by consulting both biomedical and alternative practitioners, as well as the mothers in her support groups, and using the information she found useful from each. These support groups also viewed breastfeeding mothers holistically, so that while nursing was their *raison d’être*, the groups also functioned as social outlets, as well as sources of information on other topics, such as where to find good coffee near a hospital obstetric unit.

In contrast, authoritative knowledge at the places Tasha went for breastfeeding information came only from the medical practitioners designated to provide it, and some of these practitioners were limited in what information they were permitted to give. For example, at the WIC Breastfeeding Peer Counselor training, I was repeatedly told that I could not suggest that an infant share a bed with his mother, even though research suggests that this practice, when done according to safety guidelines, may improve breastfeeding rates and thus decrease the incidence of SIDS (Bartick and Smith 2014). Another example: although both WIC employees at the Breastfeeding Café had successfully breastfed many children, they did not share any information about their own breastfeeding experiences, unlike the leaders of private groups.

The breastfeeding knowledge that Tasha accessed came from a medicalized understanding of breastfeeding. In an oft-quoted definition, medical sociologist Irving Zola

explained medicalization as the “process whereby more and more of everyday life has come under medical dominion, influence and supervision” (Zola 1983:295). In some settings, breastfeeding has become a process to be managed by biomedical professionals, who are viewed as having the scientific knowledge required to do so. In the past, Tasha had suffered when she was sick and had no health insurance, so she particularly valued her access to biomedical expertise. Her attachment to biomedicine made her more accepting of medicalized breastfeeding help. Because breastfeeding had never been part of her social *milieu*, it was something she heard about almost exclusively in a medical setting, and in this setting she trusted that the nurses and other professionals were experts. In contrast, Amy did not view the act of breastfeeding as falling primarily into the medical domain, although she did tend to view breastfeeding *problems* as medical issues.

In the United States, biomedicine is the system of knowledge sanctioned by the State, so it is not surprising that governmental facilities for low income people, like WIC clinics and FQHCs, propagate this medicalized understanding of breastfeeding. Cultural anthropologist Susan Brin Hyatt argued that medicalization provides a way for the State to manage poorer women’s bodies by reducing them to a set of signs and symptoms that can then be medically managed (Hyatt 1999). Once these bodies have become knowable and known, they can be controlled, so their poverty and sickness no longer represent threats to society. This medicalization of poor women’s bodies also allows the State to ignore the poverty itself, as the causes of distress are now viewed as purely medical issues. Tasha never suggested to me that her poverty influenced her breastfeeding experience. Her problems, as she saw them, were medical issues: her sore nipples and low supply, and Little Mark’s poor latch.

While private support groups are not generally located in the areas where most poorer African American women live, all of the groups I am familiar with are free and open to anyone who wants breastfeeding help or support (La Leche League does offer membership for a fee, but non-members are welcome at group meetings). While it might not be easy or convenient, poorer African American women could attend the same support groups Amy joined. And yet, very few did. While doing participant observation at over 70 private support group meetings, I saw very few African American women. I attended the Sweet Acacia group 55 times over the course of about a year, and during that period one biracial (white and African American) and one African American mother attended regularly, which I define as attending at least eight group meetings. I know from personal interactions with each that both had household incomes above the poverty line. Four other African American women attended this group between one and seven times, and of these, based on observations and conversations, I believe that only one had a household income at or near the poverty line. This one poorer, African American mother attended the group only once.

I spoke with this woman later about why she never returned to group, and she was quick to tell me that everyone had been very nice to her. She did disclose, however, that she was uncomfortable seeing women breastfeeding so openly, in the back of a retail store where men sometimes shopped. Other African American women shared their reasons for not attending private support groups in the St. Louis area in a local Facebook group. One explained her dislike of La Leche League meetings by saying, “I hate being the only black person [...] we as black women feel like we have to put on a mask around white women.” Another African American mother described how she and her baby were stared at while attending a private support group, stating that she thought people were trying to figure out why her baby’s skin was light. In

interviews, two wealthier African American mothers told me that they had attended some private support groups, because they really did need the breastfeeding help the groups offered, but they also felt uncomfortable as the only women of color in attendance. They also both complained about the confessional style of the groups, which one described as “too much crying and complaining about things that don’t actually matter.”

So, while segregated patterns of residence partially explain the differential access to support groups, this does not give the entire story. Many African American mothers do not attend private breastfeeding support groups because these groups don’t meet their needs as women of color, often because of covert racism. If an African American woman sees her baby’s skin color being inspected, or feels that she has to “wear a mask,” she will not feel safe and supported in that group. Groups like Breast Friends Rising, as well as similar groups in other cities, fill an important gap, providing more holistic and empowering support to African American mothers.

3.5.2 The Variable Costs of Breastfeeding

During the course of my research, I heard repeatedly that breastfeeding was free, or at least much cheaper than formula. For example, the film that Tasha saw at the breastfeeding Café specifically stated that breastfeeding was free. My data, however, shows a wide range of costs associated with breastfeeding, which I further discuss in Chapter 5. Tasha’s and Amy’s economic situations were very different, and this strongly influenced their access to certain breastfeeding resources. While of course not all white women in the St. Louis region are wealthy, and not all African American women are poor, in St. Louis City and County combined the median household income for African American families is \$28,951, while that of white

families is \$62,010, or more than double (For the Sake of All Project 2014:18). White women, then, are more likely to have an income sufficient to cover costly breastfeeding goods and services.

Amy spent well over a thousand dollars on items and services intended to facilitate breastfeeding. Out of pocket, Amy purchased doula services, prenatal education classes, home visits from a lactation consultant, and craniosacral therapy. She also paid the insurance deductibles and co-pays for Calvin's tongue and lip tie revisions, and she purchased many smaller items that made breastfeeding easier, such as nipple salve and nursing bras. Tasha purchased a few breastfeeding-related items, such as a nursing bra, but most of Amy's purchases were far too costly for her to afford. Some of these purchases might have aided Tasha in breastfeeding. While a recent meta-analysis found that craniosacral therapy has no therapeutic effects, making it unlikely that this service had any influence on Amy's breastfeeding success, doulas do have a significant positive effect on breastfeeding rates (Ernst 2012; Kennell 2004). Tasha specifically mentioned home visits by someone who could help with breastfeeding difficulties as something that might have allowed her to continue breastfeeding, but her Medicaid coverage would not pay for this service and she could not afford to pay for it herself.

Because the Affordable Care Act took effect before Calvin was born, Amy was able to get a high-quality, double electric pump from her insurance company, delivered to her doorstep at no cost to her. In contrast, Tasha had to pay out of pocket for all of her pumps, except for her first manual hand pump (I discuss the types of breast pumps in Chapter 6). Consequently, all of Tasha's pumps were relatively ineffective, and more appropriate for occasional use by a mother with a well-established milk supply than for someone like Tasha. Except when she was in the hospital, Tasha had no access to the type of pump that might have allowed her to maintain her

milk supply, which in turn might have enabled her to continue breastfeeding. While WIC does give double electric pumps to some women, Missouri WIC offices will generally provide them only when a mother is working at least 32 hours a week away from her baby.

These examples show some of the ways poverty leads to poorer breastfeeding outcomes, both directly, as poorer women cannot purchase items to help them breastfeed, and also indirectly, as Medicaid is not required to pay for the same breastfeeding services and support items as private insurance plans. Medical anthropologist Paul Farmer, who has devoted much of his career to documenting and healing the suffering of people living in poverty, advocates incorporating key ideas from liberation theology into secular health praxis, including the premise of the “preferential option for the poor” (Farmer 2014; Griffin and Block 2013). This refers to the belief that poor people should not receive the same health care as wealthier people, but that they should instead receive better care. Farmer argues that poor people are already marginalized, and therefore preferential care is their only hope of reaching equity – a sort of affirmative action in health care. So, while the Affordable Care Act currently mandates that private insurance pay for breast pumps and lactation consultants Medicaid plans are not required to cover either, achieving health equity might involve requiring Medicaid plans to provide not only breast pumps and lactation consultants, but also doula services.

3.5.3 Family and Community Support for Breastfeeding

Finally, the existing disparity in breastfeeding rates between lower-income African American women like Tasha and higher-income white women like Amy serves to perpetuate this same disparity. While Tasha had no friends or family members who had breastfed, Amy was able to call on her own mother for support and advice. Many of Amy’s friends had breastfed

their own children, and they were able to give her useful advice. The loss of these potential avenues of support can be critical for mothers. While Delores was a strong maternal figure for Tasha, and she was clearly devoted to both Tasha and Little Mark, she had no experience with breastfeeding and no knowledge of where to find help.

As demographic factors, being African American and being poor both decrease rates of breastfeeding initiation and duration, and each has an independent effect (Centers for Disease Control and Prevention 2006). I hypothesize that this disparity influences the probability that African American mothers in St. Louis will find breastfeeding role models through their social connections in three ways. First, African American mothers at any income level are less likely than white mothers to find breastfeeding role models in their own families, as the racial disparity in breastfeeding rates means that fewer of their mothers, aunts, or sisters will have breastfed their own children. Second, St. Louis's high level of segregation means that African American mothers are more likely than white mothers to live in primarily African American neighborhoods. In 2010, the average African American resident of the St. Louis metro area lived in a neighborhood that was 62% African American (Logan and Stults 2011). Because white mothers are more likely to breastfeed than African American mothers, an African American mother is statistically less likely than a white mother to find breastfeeding role models among her neighbors.

Third, African American mothers are less likely to be exposed to breastfeeding in the communities where they live because African American women are more likely than white mothers to live in high-poverty neighborhoods, defined as a neighborhood where at least 40% of the residents have an income below the Federal Poverty Level (Jargowsky 2015), and poorer women are less likely to breastfeed than wealthier women (Centers for Disease Control and

Prevention 2006). In 2013, 25.2% of poor African Americans and 9% of non-poor African Americans resided in high-poverty neighborhoods, but only 7.5% of poor white people and 1.2% of non-poor white people did (Jargowsky 2015). High-poverty neighborhoods are often under-resourced, and none of the private breastfeeding support groups in the St. Louis region are located in a high-poverty neighborhood.

In St. Louis, race influences where women live and, therefore, the availability of different breastfeeding resources. More white women than African American women have access to nurturing support groups, higher household incomes, and family and community members with breastfeeding experience. Women like Tasha fail to achieve their breastfeeding goals because they lack access to the resources they need for success, a manifestation of the structural and systemic racism operating in St. Louis and in the country as a whole. In this analysis, lack of breastfeeding support emerges as yet another assault on African American women and their bodies, particularly poor African American women, as a constellation of disparities coalesce to make breastfeeding difficult or impossible. This has both long- and short-term consequences for individual maternal and child health, but it also perpetuates the shortage of breastfeeding-knowledgeable family and friends to support other mothers in the community who want to breastfeed their own children.

Chapter 4

Breastfeeding and the Natural Body

4.1 Unnatural Consequences: “Let’s Fail at this Again”



Figure 4.1 Bravado bra windows advertisement. Photo by the author.

It was a warm fall day at Sweet Acacia, the children's resale store and breastfeeding support center mentioned earlier in this dissertation. The polished wood floors shone in the afternoon sunlight under circular racks of clothing arranged by color, creating rainbows of small shirts and dresses with just enough space between them for a stroller to pass. In the large picture window at the front of the store hung a three-foot-wide pink cardboard nursing bra with one flap open to expose an expense of white cardboard with a circular Bravado company logo where a nipple would be, emphasizing the shop's support of normalized and open breastfeeding. In this

chapter, I discuss the evolution of the present-day U.S. conceptualization of breastfeeding as natural and normal and the ways this trope plays out in the lived experiences of mothers. This opening vignette about a mother who attended Sweet Acacia's breastfeeding support groups illustrates how the natural breastfeeding construct influenced her self-concept as she struggled with breastfeeding, eventually coming to view both herself and her infant son as failing and defective.

Sweet Acacia's groups always met in the back of the store, next to racks of nursing bras and shelves of herbal galactagogues. On this day, employees had moved chairs and benches to form a large circle anchored by a row of couches, and then spread four well-worn quilts in the center. The store's breastfeeding support group had a stated starting time of 12:30 p.m., and women started to trickle in by 12:20 p.m., some pushing strollers or lugging infant seats and others "wearing" their babies on their chests in colorful cloth slings. Many of the women knew each other, waving as they settled into chairs and arranged their diaper bags and baby seats around them. Mothers of older babies lowered themselves to the floor and set their babies down on the quilts, where the infants stared wide-eyed at the assembled group. Most of the women arrived after 12:30, and it wasn't until 12:45 that the group leader, Jackie, came out of a back office and settled herself cross-legged onto a bench, smiling at babies and greeting many of the women by name. I was already sitting on the floor, catching up with some of the regular group members and smiling at newcomers.

Most women began attending the group when their babies were between one and six weeks old, and Ada, a white woman in her early thirties, was no exception. Her son Joey was eleven days old, with dark hair and a scrunched up little face. He rarely opened his eyes, and his body naturally curled into the position he had taken during the past nine months, arms and legs

held close. Ada's face was creased and her body was hunched over in her chair, and she looked both exhausted and sad. Group members glanced at her sympathetically but didn't speak to her. She appeared close to tears, and I at least was reluctant to say anything for fear of triggering actual crying.

Group started with introductions, as usual. When it was Ada's turn she gave her name and Joey's, and then, perhaps emboldened by the warm smiles or perhaps just desperate for help, she began to pour out her story. Joey was sleepy and wouldn't really latch on to her nipple, although she tried diligently. Her milk hadn't come in before she left the hospital, typical for first-time mothers in the area who are often released the day after their babies are born. The hospital nurses sent her home with formula and a list of breastfeeding support groups, and her pediatrician told her to be patient and keep trying, giving her some small bottles of ready-to-feed formula to use while she continued to "work on" breastfeeding.

Ada told us that she was putting Joey to the breast at least every three hours, stroking his cheek and then carefully inserting her large nipples into his tiny mouth, and hoping each time that he would finally latch on and suck deeply. Each time he fussed and wiggled and then full-out cried, until she gave up and pulled out the tiny formula bottle, and he would then settle down and drink. Sometimes, she said, she cried while giving him the bottle, her tears dripping into his hair. She didn't know what she was doing wrong, and why her son wouldn't nurse. She wondered why her breasts weren't making milk, or if they were just too big for him. She felt like a failure, she said. And then she wept, silent tears running down her cheeks as she looked at the floor.

Jackie was at her side in a flash, wrapping a supportive arm around Ada's shoulders and telling her it would be okay, that they could figure out what was going on with breastfeeding and fix it together. Let me know when you're going to nurse him and I'll come watch, she said. A

Certified Lactation Counselor (CLC), Jackie usually visited with mothers individually during the latter half of group, advising and adjusting in order to resolve minor breastfeeding issues. Jackie was always positive and encouraging, reflecting her belief that breastfeeding was natural and nearly all women could breastfeed successfully.

When Ada decided it was time to nurse Joey, Jackie was at her side. She began by reassuring Ada that everything would be okay, and then she asked Ada to put Joey to her breast. Almost immediately, Jackie identified a significant problem: Ada was leaning down to Joey, rather than bringing him up to her breast and positioning him horizontally across her chest. Jackie encouraged Joey to open his mouth in a wide gape, and then urged Ada to pull him towards her breast, which Ada did awkwardly. After a couple of tries, he seemed to be correctly latched, but the mismatch in size between his mouth and his mother's breasts made it difficult for me to ascertain whether he truly had enough tissue in his mouth.

Joey continued to fuss at the breast and after a short time Ada began to cry again and pulled him off. Jackie and the other group members lauded her efforts and told her to keep trying, that he would catch on. Before she left, she pulled out a small formula bottle and fed her son, then packed up and left without talking to anyone. Ada clearly found formula feeding much easier than breastfeeding, but her inability to breastfeed made her question whether she or her son was defective in some way. Jackie and the other group members appeared confident that Ada could breastfeed Joey, once she learned how, and in the 55 times I observed this group, the idea that every woman could breastfeed was universally accepted.⁸

⁸ This was somewhat nuanced, as group members acknowledged that a woman might not be able to produce enough milk to fully feed her infant; that some women *should not* breastfeed because of medication or illness; and that some infants might need treatment, such as revising a tongue tie, in order to breastfeed. At one meeting, I was concerned

I was not sure we would see Ada in group again, but she and Joey were there a week later, although she arrived very late and sat outside of the circle. Another woman and I offered to move over and make room for her, but she shook her head. There were deep gray shadows under her dark eyes and she again sat with her shoulders slumped. The group was starting to break up as the group members nursed and chatted among themselves when I scooted across the floor to sit near Ada, concerned that she was alone in her misery and wanting to offer support. Another mother with a young baby joined us, also inviting Ada to move forward into the circle. Ada declined, citing concern that she might need to feed Joey a bottle of formula, and the other mother reassured her that no one would look down on her for that. I remembered that Ada had fed Joey a bottle of formula the previous week before slipping out quietly, and I wondered if she had felt judged for it.

"Let's fail at this again," Ada said, as she lifted Joey to her breast. Although she was attempting to use the techniques Jackie had showed her, Ada appeared frustrated with the process. Her body was tense and her face was stern, her lips in a straight, thin line as she looked down and didn't make eye contact with anyone. Joey fussed and squirmed and then began to cry, and Ada's tears soon followed. She pulled a small bottle of formula from her bag and began to feed it to Joey, who quickly quieted and began to suck eagerly.

Just being in Ada's presence was difficult for me, because her misery felt almost palpable. I wanted to tell her to give up on breastfeeding, and to reassure her that it was not so important. I wanted to tell her to enjoy her baby, rather than tainting his early days with this

to hear mothers stating that they would breastfeed even if they were HIV positive. The WHO recommends exclusive breastfeeding for HIV positive mothers who cannot reliably access safe alternatives, although in practice this often proves challenging to mothers (Moland and Blystad 2009). However, for mothers in St. Louis, infant formula is unquestionably the less risky option.

frustration and misery about breastfeeding, but I felt unsure about potentially undermining her breastfeeding efforts and mindful of my role in the group. Although in over a year of attending the group almost weekly I never heard Jackie try to talk a woman who wanted to quit breastfeeding into continuing, I also never heard her encourage a woman to quit. Jackie told me that she saw her job as helping each woman achieve her own breastfeeding goal, and Ada had been clear that her goal was to exclusively breastfeed, even though she was failing to achieve it. I worried that to bring up the idea of stopping in this breastfeeding-positive space would be viewed as undermining this objective, so I stayed silent.

The next week, Ada looked much better. Her hair was neatly brushed and smoothed back into a ponytail, and her eyes looked brighter and more alert. The image cracked, however, when she went to nurse Joey. Lifting him out of his infant seat and opening her shirt, Ada put him to her breast. Her body was tense, and her movements were firm and no-nonsense as she pushed his head towards her nipple. Joey squirmed, and Ada shifted and tried again, prodding him to open his mouth. Joey arched his back and began to cry, and for a moment I thought Ada would cry as well. Instead, she brought Joey down to eye level and looked at him firmly, chiding him for "embarrassing me in front of the nursing mothers" by not breastfeeding. "You have one job," she told him, "And this is it." Indeed, Ada appeared shamed by Joey's failure to breastfeed, and her rebuke reminded me of how a mother might address an older child who was displaying bad manners but was clearly capable of doing better. Breastfeeding, according to this group, was normal and natural, and in order for Ada to believe that Joey was also normal, she needed to believe he was capable of nursing, if only he would properly do his "job".

Ada returned to group one more time, looking happier and more rested. I didn't see her put Joey to her breast at all this time, and she didn't bring up the topic of breastfeeding except

during introductions, when she told the group that breastfeeding didn't work out for her. Jackie frowned but said nothing – in fact, no one in the group questioned Ada's decision. Perhaps everyone was thinking of the contrast between her appearance and affect four weeks ago and today. Group members had discussed their concerns about Ada's sadness previously, both with her and after she had left, wondering about the possibility of post-partum depression and wondering what further steps might be warranted, but as her mood began to lift concerns abated.

Ada's breastfeeding experience is one of numerous stories I witnessed about breastfeeding "failure" – and failure is the word the women themselves use most often. Many women perceived their failure to breastfeed as a failure to adequately care for their children. Ada's question "What's wrong with me?" is borne of her frustration when her body fails to perform its maternity through breastfeeding competence. This defective mother narrative stands in contrast to the dominant public health and breastfeeding advocacy position, also embraced by Sweet Acacia, that argues for breastfeeding as the natural and normal option, a position that obscures the complexities of women's own breastfeeding experiences. In this chapter, I examine the current public discourse surrounding breastfeeding and argue that this trope is complicated in actual practice by breastfeeding women. I look specifically at five local narratives that demonstrate this: breastfeeding as the only possibility; breastfeeding as a reclamation of the past; integrating the sexual and the breastfeeding bodies; breastfeeding as an accomplishment; and breastfeeding failure as evidence of defective and incompetent bodies.

4.2 "It's Only Natural": Normalizing Breastfeeding

The Western idea that mothering is “natural” (at least for middle and upper class women) has been described at length by both social scientists and feminist scholars (Moore 1988; Blum

2000; Bobel 2010; among many others), and breastfeeding has increasingly been viewed as an essential piece of the natural mothering toolkit. Breastfeeding researcher Virginia Schmied and sociologist Deborah Lupton, writing about their social science research with Australian mothers, summed up this belief well when they stated, “All of the women in our study believed that breastfeeding was ‘natural’, and therefore desirable, crucial to their relationship with their baby and best for their baby’s health” (Schmied and Lupton 2001:238). This section describes how the trope of breastfeeding as natural has become predominant in the United States as a political strategy intended to increase breastfeeding rates, associating breastfeeding with maternal proficiency.

As described more thoroughly in Chapter 2, the low point for breastfeeding rates in the United States was in 1972, when only 22% of women initiated breastfeeding (Eckhardt and Hendershot 1984). Since then rates have climbed steadily for all demographic groups, although disparities among these persist (Centers for Disease Control and Prevention 2016). Organizations such as the American Academy of Pediatrics (AAP), the Office of the Surgeon General, and the American Public Health Association (APHA) have released position statements endorsing breastfeeding as the healthiest infant feeding option and calling for increased support for practices and programs that promote breastfeeding. For example, the APHA policy statement on breastfeeding states that "maintaining breastfeeding as the norm is seen as an important preventative health measure" (American Public Health Association 2007:para. 1). The Patient Protection and Affordable Care Act of 2010 includes a number of provisions intended to reduce barriers to breastfeeding, including Section 4207, which requires employers to provide reasonable break time and a private space with a locking door that is not a bathroom to breastfeeding mothers who are pumping at work; and Section 2713, which mandates that

insurance companies pay for lactation support and the purchase or rental of a breast pump.

Although these requirements do include numerous exceptions, they demonstrate a commitment by the federal government to increasing breastfeeding rates.

An important aspect of the breastfeeding promotion narrative is the focus on de-stigmatizing breastfeeding. In a 2011 call to action, the Surgeon General of the United States issued a report referring to breastfeeding as "natural" but noting that maternal embarrassment remains a powerful barrier to breastfeeding both in public and in private social situations (U.S. Department of Health and Human Services 2011). The report detailed specific incidents of harassment experienced by breastfeeding mothers, and also cited store owners and restaurant managers who said they had asked breastfeeding mothers to move to a more secluded area or leave their establishment. Normalizing public breastfeeding is thus viewed as critical to removing stigma.

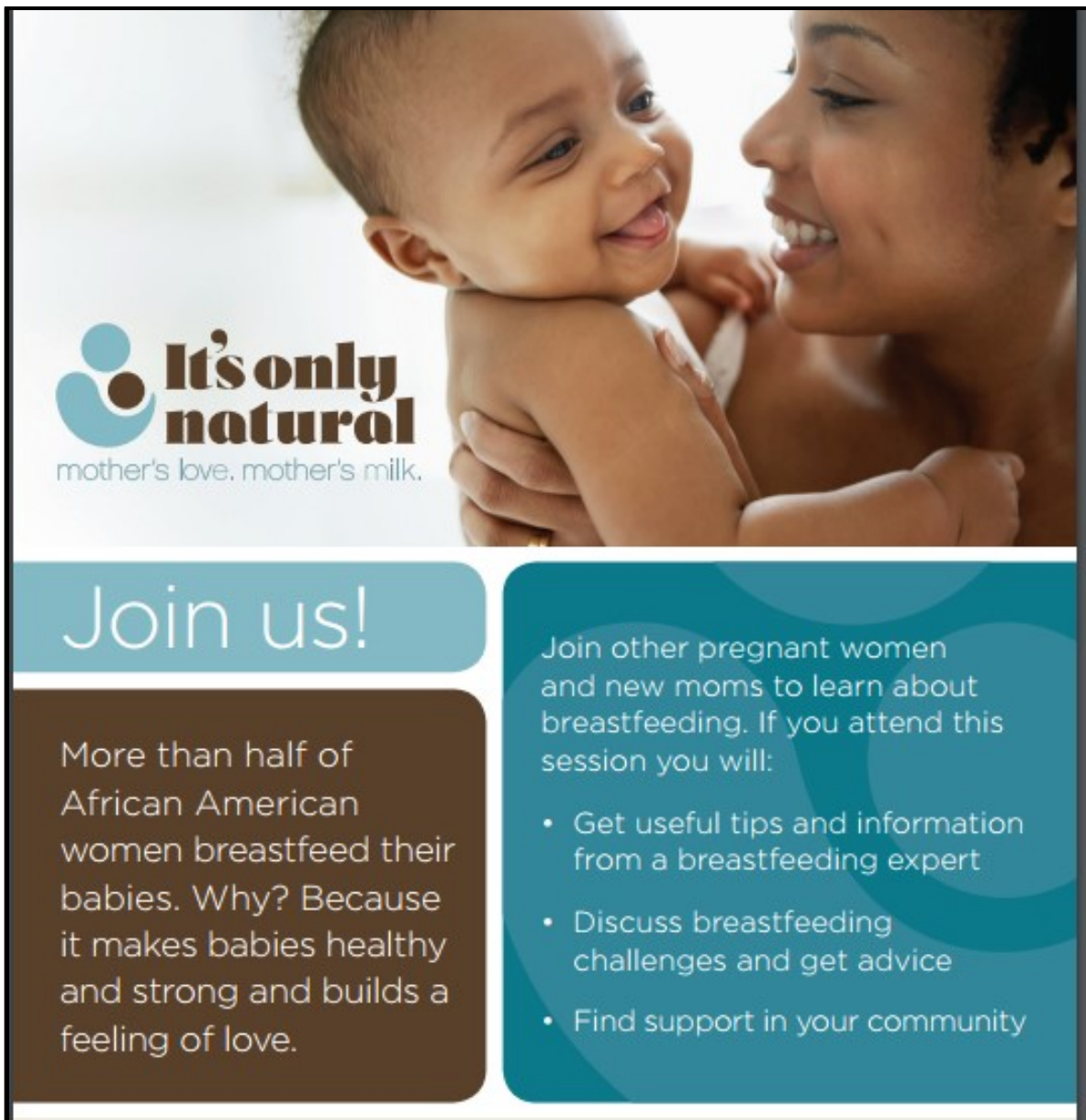
One key way breastfeeding advocates have attempted to do this is through the passage of legislation specifically aimed at protecting a mother's right to breastfeed in front of others. No states currently have laws forbidding public breastfeeding, and 49 states, the District of Columbia, and the Virgin Islands have passed laws specifically protecting a woman's right to breastfeed in public and private spaces where she is otherwise entitled to be (National Conference of State Legislatures 2015). Missouri Revised Statute 191.918, which was last revised in 2014, specifies that breastfeeding should not "be considered an act of public indecency, indecent exposure, sexual conduct, lewd touching, or obscenity," although it also specifies that a mother must breastfeed "with discretion". State breastfeeding advocates opposed the "discretion" portion of the Bill, but more conservative lawmakers preferred the previous wording, "with as much discretion as possible," so the phrasing was viewed as a compromise by

the advocates I spoke with. The need for an explicit statement that breastfeeding is not indecent, sexual, or obscene highlights the fact that some people do indeed see breastfeeding in these ways.

Breastfeeding advocates have used other platforms to promulgate the model of breastfeeding as the normal and natural way of feeding infants. The website Normalize Breastfeeding (www.normalizebreastfeeding.org) was launched in June of 2014 by Vanessa Simmons, a Ghanaian-American photographer and mother of three, who envisioned the project as a public media campaign intended to reduce stigma around breastfeeding and support diversity in breastfeeding. The hashtag she created, #NormalizeBreastfeeding, resonated strongly with breastfeeding supporters. A year later, searching Facebook, Twitter, and Instagram for #NormalizeBreastfeeding yielded hundreds of thousands of hits. Many women had attached the hashtag to a “selfie” showing breastfeeding in a public setting, while other women had attached the hashtag to stories about women being harassed for breastfeeding. In the public and private Facebook groups I belong to, women would often employ the hashtag when posting about their first forays into public breastfeeding, using it as a statement of their competence and achievement: by breastfeeding publicly they had proven themselves normal.

Since about 1960, rates of breastfeeding initiation and duration for African American mothers have lagged behind those of the U.S. population as a whole, resulting in breastfeeding promotions deployed specifically at this group (Centers for Disease Control and Prevention 2016; Hendershot 1984). In April of 2013, the U.S. Department of Health and Human Services Office of Women’s Health launched a website intended to “raise awareness among African American women of the importance of and benefits associated with breastfeeding and provide helpful tips” (U.S. Department of Health and Human Services 2013). Titled *It’s Only Natural:*

Mother's Love, Mother's Milk, the website includes videos depicting African American mothers



It's only natural
mother's love. mother's milk.

Join us!

More than half of African American women breastfeed their babies. Why? Because it makes babies healthy and strong and builds a feeling of love.

Join other pregnant women and new moms to learn about breastfeeding. If you attend this session you will:

- Get useful tips and information from a breastfeeding expert
- Discuss breastfeeding challenges and get advice
- Find support in your community

Figure 4.2 It's Only Natural campaign poster. Source: http://womenshealth.gov/itsonlynatural/pdfs/hhs_bfa_itsonlynatural_commposter_f_508%20copy.pdf

talking about breastfeeding, fact sheets about holding and latching techniques, articles on integrating breastfeeding into a variety of life circumstances, and a Leader's Guide intended to equip an organization to promote and lead an informational session about breastfeeding for African American women (Office on Women's Health 2013).

These materials (Figure 4.2) reinforce the idea that breastfeeding is normal and natural for African American women, employing statements such as "More than half of all African American women breastfeed their babies," which is true if breastfeeding is defined as initiating breastfeeding, but suggests that breastfeeding is more common among African American women than the statistics actually show. Of African American babies born in 2012, only about a third were exclusively breastfed at 3 months and 17% were still breastfeeding at one year, statistics that point to the relative rarity of breastfeeding among African American mothers in actual practice (Centers for Disease Control and Prevention 2016).

In the remainder of this chapter, I analyze some key assumptions in the hegemonic narrative of natural breastfeeding in order to demonstrate some of the ways this narrative is complicated at the local level. The natural trope postulates breastfeeding as timeless, positioning it as an unchanging biological reality. It stands in opposition to other cultural conceptualizations of women's breasts and bodies, such as the idea of the breast as a sexual entity. Similarly, it views breastfeeding as the baseline or standard, rather than as an exceptional achievement. Finally, this narrative suggests that to breastfeed is to be normal, and that a competent mother is one who breastfeeds, preferably without giving consideration to any other options, leaving no room for women like Ada and their incompetent maternity. Although these complicating discourses are presented individually, they are not mutually exclusive and many mothers

employed more than one, either simultaneously or at different times.

4.3 "Just Something That You Do": When Breastfeeding is Not a Choice

In my research, I found some mothers who appeared to have internalized the natural and normal narrative to the point that breastfeeding was not viewed as a choice at all: they simply knew that they would breastfeed their babies. These mothers were most often white women with higher levels of formal education and professional careers, but some women of color and lower income women also expressed this viewpoint. A 34-year-old white mother exemplified this perspective when she said, "I didn't really think about it. I just always knew that I would." A 37-year-old white mother of a breastfeeding toddler told me that she saw breastfeeding as a "no-brainer," adding, "Why in the world would anyone choose not to breastfeed?" This version of natural intentionally omits outside influences from the equation, as women resist describing breastfeeding as better or healthier or more virtuous. Instead, they frame breastfeeding as a natural and biological model that they have chosen not to resist. They view breastfeeding as effortless, as long as nothing is interfering with nature, while formula feeding represents an active disruption of this harmony. The question of why a woman would choose "not to breastfeed" is significant in its assumption that breastfeeding is the norm, and anything else represents a deviation.

Sociologist Chris Bobel's research on women she describes as "natural mothers" reflects a similar understanding of "the indisputable logic of nature that compels them to live out their lives" (2010:97). Like Bobel's "natural mothers," this group of women told me that they saw breastfeeding as simply the way things were done, and they appeared to take for granted that their bodies would be able to do so. At times, however, I wondered if there was a performative

aspect to these statements. Viewing breastfeeding as not a choice marks a woman as being completely in tune to the “logic of nature,” as Bobel describes it, so that she does not require any outside influences in order to do the correct and most natural thing. Some women seemed to have internalized a certain image of motherhood that they yearned to fulfill, such as the 29-year-old white mother of one who, while reflecting on her thoughts about breastfeeding when she was pregnant, told me, “I had an idea in my head of - I mean, the kind of mom I was going to be, was going to be the kind of mom who breastfed.” This no-choice position also elevates a woman’s status, marking her as someone who intuitively follows the right path, and also opening the door for judgment or exclusion of women who are less certain.

Thus, when a woman told me she never considered not breastfeeding, I am unsure if she truly did not see this as a decision to be made, or if she wanted me to view her as the consummate natural mother and her statement was a performance of this role. Some of these mothers made other statements that highlighted their prowess as natural mothers, such as telling me about their natural births or use of essential oils, but they did not use the same rhetoric to frame any of these choices as a “non-choice.” Significantly, these statements were almost always made directly to me, either in interviews or occasionally during support groups, suggesting that I as the researcher was specifically targeted for this message. Whether women have truly internalized this belief to this degree or whether they simply want me to think that they had, the idea that breastfeeding is so natural that it is not a choice clearly represents the power the breastfeeding as natural trope has achieved among some women in St. Louis.

4.4 Reclaiming Our (Invented) Past

4.4.1 African American Mothers and African Cultural Heritage

My research uncovered two complementary discourses around breastfeeding as reclamation of heritage, one exclusive to African American and biracial mothers who had an African American parent, and the other more common among white mothers. The first draws on Afrocentrism and African cultural heritage, referencing ideals of community and mutual support in a setting without the intrusion of white people. Women in this category tended to use the word “natural” spontaneously in conversation when they spoke about breastfeeding. Annie, the African American WIC breastfeeding peer counselor and breastfeeding advocate I describe in Chapters 1 and 5, exemplified this. In the workshop she facilitated for African American women, which I discuss more fully in Chapter 5, Annie used the word natural repeatedly and described breastfeeding support as a matter of "sisterhood", drawing on the idea of a community of African American women. On her Facebook page she wrote:

“Attachment Parenting” is a Western title for an age old way of life. I live as my African people do- so yes I believe in "Attachment Parenting". Since [Son] was born I research[ed] African traditional child rearing practices. My son is awesome and African culture is rich and powerful. ... [Son] is a little African boy... I wore [Son] for 3 yrs and breastfed for 3 1/2. We are unit and mom's word is law- not because I beat him, but because I put him first. African parenting practices came before "Attachment Parenting". Your truth lives in you[r] blood line.

A 21-year-old African American mother of one told me, “It’s just like, I want to breastfeed my baby. It’s something that comes from me.... It’s something I want to do naturally.” She thought of Africa as a place where people lived more closely to nature, eating foods that they farmed themselves and avoiding the chemicals she believed were common in foods eaten in this country. She expressed concern about the harmful effects chemicals might

have on her baby, and she avoided personal and infant care products she believed had been contaminated by them, saying, “I’m trying to be natural, period My hair is natural, no more chemicals.” She assumed that her African ancestors had breastfed their babies, before they were forcibly taken to this country as slaves.

A 41-year-old mother of one who identified as biracial specifically referenced the legacy of slavery in an interview when she wondered, “Are rates lower in the AA community because it’s associated on some level with black women being used as wet nurses? Are women rejecting that because it harkens back to a history of slavery? . . . It’s almost a way of saying ‘I reject that past.’” This explanation, like that of the mother in the previous paragraph, identifies slavery as the cause for breastfeeding’s disruption among African American women. In her breastfeeding guidebook for African American mothers, Katherine Barber, the founder of the African American Breastfeeding Alliance, devotes a chapter to the breastfeeding heritage of black mothers and connects coerced wet nursing during and after slavery to some of the current negative attitudes about breastfeeding (Barber 2005). However, she contrasts this narrative with descriptions of breastfeeding’s long history in Africa, sustained even in the face of European invasions and the slave trade, and she encourages mothers to reclaim this legacy. This reinforces the idea that breastfeeding is an African tradition that was disrupted by slavery.

Kiddada Green, founder of the Detroit –based Black Mothers’ Breastfeeding Association (BMBFA) explicitly states, “I am on a mission to reduce this disparity gap by reclaiming an African tradition of breastfeeding” (Green 2012). This authentic African-ness is associated by some with other Afrocentric markers such as the wearing of natural (unstraightened) hairstyles. Lauren Powers, a program coordinator at BMBFA, stated, “Seeing the Erykah Badu types, that is what people associate with breastfeeding. I think a lot of women think that. They think you have

to have the natural hair, things like that to be a person who breastfeeds” (Starr 2014: para. 9). In this discourse, African women breastfeed because they are touch with their natural, authentic selves and have not been polluted by white people’s ideas and oppressions. African American women trying to reclaim this authentic African-ness may do so through reclaiming African practices, such as wearing natural hair styles and breastfeeding their children.

4.4.2 “Crunchy” Mothers and the Collective Human Past

In contrast, white mothers who viewed breastfeeding as a reclamation of tradition did not reference Africa. Instead, they used words like "hippie" or "crunchy" to describe themselves (or to explain the ways that their parenting practices had been described by others), and referenced a more universal human past, when humans lived more harmoniously with the land. For this group, breastfeeding was part of a traditional way of parenting that had been standard for thousands of years but had subsequently been forgotten until more recent times. According to the mothers I spoke with, many of whom attended the Sweet Acacia breastfeeding support group, other elements often viewed as part of this parenting style included: using cloth diapers, co-sleeping (mothers sleeping with babies), "wearing" babies (using cloth baby carriers), making homemade baby food, and having a "natural" childbirth (the exact meaning of this term varied, but at minimum it implied an absence of anesthesia or pain medications).

Like the African American mothers, these women also viewed the “chemicals” found in modern society as dangerous, and they tried to limit their and their children's exposure to chemicals by eating organic foods and purchasing personal hygiene items labeled as natural for themselves and their infants. They believed that natural products and practices were healthier for them and their children. Some mothers told me that the hippies of the sixties were the first to

rediscover these practices, and one specifically referenced Ina May Gaskin's Midwifery Center on The Farm⁹. The term "crunchy" was thought to have originated from the "crunch" of granola, a food item often associated with hippies. Many of these mothers specifically connected the idea of natural with being crunchy or a hippie: for example, one white mother wrote on Facebook that being crunchy meant "doing things a more 'natural' way" and doing "what nature intended."

These mothers tended to specifically define themselves in opposition to what they termed "mainstream" parenting, the style they believed was predominant in society today, which was characterized by an emphasis on modernity and a lack of concern about chemicals and processed products. Mainstream parenting practices included: feeding baby formula, using jarred baby foods, using disposable diapers, putting babies to sleep in a crib, and putting babies in infant seats or bouncers rather than "wearing" them. Using Western medicine or biomedicine was considered mainstream as well, and the "crunchiest" mothers used essential oils to treat their children's ailments and did not vaccinate, although some mothers in this category noted that they were only "semi-crunchy" because they did use Western medicine and vaccinate. Among women in this group, breastfeeding was viewed as natural but not normal, and some explicitly equated mainstream practices with "things that 'normal' moms do". Although these mothers believed strongly that breastfeeding should be normalized, they did not see this as the reality. Available data, however, contradicts this perception: in 2012, 83% of all white mothers initiated breastfeeding and over half were still breastfeeding six months later (Centers for Disease Control and Prevention 2016).

⁹ The Farm Midwifery Center, founded in 1971 by Ina May Gaskin and still operating today, is widely considered the wellspring of the return to midwifery and less medicalized birth. See Gaskin (1996) for more.

In summary, the women who employ the two versions of this narrative embrace the idea of breastfeeding as natural, but they reject the idea that breastfeeding is normal in the United States today. Instead, they position themselves as atypical and anachronistic, believing that unlike "mainstream" mothers, they are reclaiming superior but forgotten practices from the past. Their actual knowledge of the places and times referenced tended to be quite limited – none of the African American women who referenced Africa had ever actually visited the continent, for example – and shaped by popular culture, resulting in descriptions of pasts when people lived peacefully together in natural settings where all of their basic needs were fulfilled and breastfeeding was simple and effortless. Thus, both of these discourses challenge the timelessness and universality of the natural narrative by associating natural breastfeeding with specific historical trajectories or particular places, the descriptions of which are often partially or entirely invented.

4.5 The Sexual Breastfeeding Body

The natural breastfeeding narrative constructs breasts as not sexual but as maternal, and therefore views breastfeeding as a non-sexual act. Many state laws regarding breastfeeding, including the previously mentioned Missouri Revised Statute 191.918, explicitly address this by stating that breastfeeding is not sexual conduct or sexual contact. I was told repeatedly in support groups that breastfeeding was not sexual, although group leaders sometimes added that women might experience erotic feelings while breastfeeding, but that these were normal and did not actually mean the woman was aroused. While a few white women mentioned "tingly" or "weird" feelings while breastfeeding, I never heard anyone describe being sexually aroused by breastfeeding.

Breasts, however, are considered sexual objects in U.S. culture, as well as in many places around the world, and I described some of the existing social science research on breastfeeding and sexuality in Chapter 1. In my own research, I found that richer, white women were vocal in their rejection of the idea that a breastfeeding breast could be sexually alluring or sexually responsive. At the Sweet Acacia support group and the La Leche League groups, both of which were rarely attended by African American women, most mothers nursed openly, seemingly unperturbed about showing their breasts to the group. On at least two occasions, a mother mentioned that her husband did not want her to breastfeed in front of others, and both times the group members were unanimous in their dismissal of the husband's concern, repeating the "breastfeeding isn't sexual" mantra loudly and vehemently. At another meeting, a white woman mentioned that her husband wanted to touch her breasts sexually but said she did not enjoy this. Other group members responded that they had also found their lactating breasts to be sexually unresponsive, and some reported that having their lactating breasts touched sexually was unpleasant. A woman whose children were weaned reassured this mother that her sexual desire and responsiveness would return after breastfeeding was finished, reinforcing both the idea that breasts can be sexual and the temporal separation of this sexual breast from the maternal, lactating one.

The complex history of the symbolic meanings ascribed to African American women's bodies in the United States creates difficulties specific to African American breastfeeding mothers. Sociologist Linda Blum pointed out that the racist trope depicting black women as more sexual and more physical has long been used against them, and she documented the ways her African American informants struggled to reconcile these ideas with the reality of breastfeeding bodies (Blum 2000). This made some of the black women she interviewed reluctant to breastfeed

because they were afraid of that others would see their lactating bodies as inappropriately sexual, to the point that some worried about child protective services removing their children because of breastfeeding. Unlike many of the white mothers Blum interviewed, African American mothers were reluctant to talk openly to her about the intersections of breastfeeding and sexuality or sensuality, and she found few references to this issue in popular media articles about breastfeeding directed specifically at African American women. More recently, anthropologist Nancy Chin and professor of nursing Ann Dozier documented a lower-income African American woman's breastfeeding experiences, which include being stared at, called "obscene" names, leered at, and told what she is doing is "disgusting" (Chin and Dozier 2012:67). Much of this harassment was clearly sexual in nature, reinforcing the idea that a woman's breast is a sexual object rather than a maternal one.

My own research uncovered examples of African American women trying to integrate the idea of the sexual breast with the natural breastfeeding narrative. At an educational workshop on breastfeeding for low-income African American women that I attended (described more fully in Chapter 5), one pregnant participant stated that she has been reluctant to breastfeed her first child because she had been concerned that putting her breast in her child's mouth would ruin his innocence, reflecting her view of breasts as primarily sexual objects that had the potential to corrupt. She said that she used to think of breastfeeding as "nasty" and "disgusting," an understandable description of an action she perceived as sexual being performed with a child. Although she was firm in her intent to breastfeed her new baby, she was also clearly struggling to re-imagine her breasts in a new way. A number of other attendees nodded and chimed in after she spoke, naming people in their lives who thought of breastfeeding in these same ways and then reassuring each other that breastfeeding was not nasty after all – it was natural.

Another African American woman was able to view their lactating breasts as sexual during the times when she was not actually nursing. This 23-year-old mother of three children, all of whom had been breastfed, told me that her breasts looked good and she considered them one of her best features, so when she got dressed up to go out she liked to show them off. I dropped by her house one evening when she was wearing a short, low-cut, tight orange dress with high heels, her hair straightened, eyelids glittery, and lips shiny. I knew she was breastfeeding her youngest at the time, but her outfit clearly emphasized her breasts as sexual rather than functional. One clue to her ability to successfully negotiate these two ways of thinking about her breasts may have been her insistence that when she was lactating, her breasts were forbidden to her romantic partners, something she made very clear in front of a group that included both me and her current boyfriend. While she was comfortable with the sexualized appearance of her lactating breasts, she would not accept them being touched sexually, allowing her to conform to both cultural ideals of beauty and maintain her status as a good breastfeeding mother.

However, women cannot control how others view their lactating breasts, and women with less agency may be forced to accept others' sexualization of breastfeeding. I conducted three interviews with a 24-year-old African American mother of three, who had no income of her own and lived in first a small apartment and later a motel room with her mother, stepfather, and children. When she was pregnant with her third child, she told me that she wanted to breastfeed but could not breastfeed in front of her stepfather because he might see her breast, so she planned to pump and bottle feed the pumped milk. When the family moved to a hotel room with no privacy, even pumping was not possible. Breastfeeding in front of others, especially men, was a

concern for many mothers, but lower-income mothers sharing living quarters with others have little power to resist and insist even in their own homes.

The natural breastfeeding narrative clearly separates breasts as pleasure from breasts as sustenance, but in practice many women struggle to reconcile these. Race and socio-economic status can shape the strategies mothers use as well as the strategies available to them, and women who have less autonomy and power can be constrained in their ability to resist others' sexualization of the women's breastfeeding practice.

4.6 “Breastfeeding is Darn Hard”: When Natural is Not Enough

For some women, framing breastfeeding as natural implied a commonness that they didn't feel adequately described the amazing and unique ability of a woman's body to produce breastmilk. Said a 30-year-old mother of one who identified as biracial, “It feels like it's a sort of discounting it, like, it's natural, you'll figure it out. It doesn't acknowledge how great it is – it's like, chewing gum, or waking up in the morning... It's something kind of ordinary.... It's sort of neutral.” She preferred to use terms like extraordinary or amazing to describe breastfeeding, and she stressed the many health benefits breastfeeding provides. Women at both La Leche League meetings and the Sweet Acacia support groups commonly referred to breast milk as "gold" or "liquid gold," emphasizing its value.

Some women also felt that the term natural implied that breastfeeding was effortless. A biracial mother of one stated: “It's probably what I thought before I had a baby, and then my experience with it was that it took a lot of work. It was something I thought was natural, and would come naturally, but then it didn't come naturally.” A white mother of one with a self-described "high pain tolerance" described breastfeeding as "the hardest thing I've ever done in

my life," as she chronicled the months of pain she had endured while nursing her son. At a playgroup, a third white mother summed up this point of view succinctly when she said, "It's not natural. It's darn hard."

Lauren, a 29-year-old white mother of two who struggled with low milk supply, gave this description of the grueling first weeks of her second child's life: "I would feed her and then supplement her, and then pump, and then feed her, supplement her, and then pump. Every hour and a half, two hours. It was pretty much my life." Feeding, in this narrative, refers to nursing at the breast, while supplementing means bottle-feeding milk she had pumped. During this period, she was doing everything she could to increase her supply, including eating items believed by many women to be galactagogues such as oatmeal, brewer's yeast, and flaxseed, and also using a prescription galactagogue (Reglan) for ten days, which had no effect. She continued this exhausting schedule for three weeks, saying, "I needed to do that for myself, I needed to try as hard as I could, but then there was a point in time where I was like, I can't do it anymore." At this point she stopped pumping but continued to feed her child at the breast as well as to supplement, initially with formula and later with donated breast milk, and at 18 months she was still nursing.

To Kristy, a 30-year-old biracial mother of two who had difficulty breastfeeding both of her children, the idea of breastfeeding as natural was discomfiting. "I think natural seems like easy. I mean like, dogs do this. Cats do this. Horses do this," she said emphatically. We were speaking in her living room while her baby sat on her lap and her preschool-age son played in the next room, but her raised voice brought him running into the room to see what had upset his mother. She lifted him onto the sofa near to her and snuggled him close as she tried to explain her thoughts and experiences. "Natural makes it sound easy but it's not," she said, "I don't think anyone is an expert breaster at first latch." Kristy had struggled to breastfeed her first child

and had stopped after only a few weeks, so when she was pregnant with her second child, she sought out expert help in order to be better prepared for breastfeeding. Unfortunately, her second child developed health issues shortly after birth that eventually necessitated a week-long NICU stay, during which he received both pumped breast milk and formula via bottle. The nursing staff measured his intake but only counted what he drank from the bottle, and the hospital personnel told Kristy that he needed to be consuming a certain amount in order to be discharged. "I just really wanted him home," Kristy said tearfully. She knew she was making poor breastfeeding choices, but her focus was on getting her son discharged as soon as possible.

Kristy had assumed that once they were home she would be able to discontinue supplementing with formula, but this had not happened. At time of this interview, her baby was four months old, and was being fed at the breast as well as receiving about 8-10 ounces of supplemental formula a day via bottle. Kristy was proud she was still breastfeeding and felt at peace with her need to supplement with formula, although she acknowledged that it had taken her a lot of time and emotional energy to achieve this acceptance. She contrasted this with her feelings of guilt and grief after her older son weaned from the breast when he was a few weeks old, which she described as "just awful." During her second pregnancy Kristy had conscientiously educated herself about breastfeeding, explaining, "I was going to do everything that I could, and that way I could forgive myself if it didn't work." Her comfort with her current mixed feeding regime stemmed in part from her knowledge that she had indeed sought expert assistance and had worked very hard to be able to breastfeed, and she chose to view some breastfeeding as success.

To Kristy, the idea that breastfeeding is natural was "a little bit insulting," since to her it implied that breastfeeding should come easily. Refuting the idea that breastfeeding was more

natural than formula, she asserted, "If I just wanted to give him natural I could give him organic formula... you know, it's naturally from a cow." Kristy also believed that the idea of breastfeeding as the natural way to feed babies implied that other ways were going against nature and were therefore wrong, or at least morally suspect. "So was my baby not supposed to make it then?" she asked, "If we lived in a society without formula are my kids supposed to be the ones that Darwin deemed not good enough to survive because I don't make enough milk for them to eat exclusively off my breast milk?" Reaching down to soothe the toddler curled at her side, she said emphatically, "Natural is a baby who's hungry being fed, however they're being fed."

The dominant natural breastfeeding narrative presumes that all women and infants can and should breastfeed, insinuating that those who cannot do so are incompetent and insufficient. By challenging this idea, Kristy created a space for herself and her children to be seen as competent, even though she did not fully breastfeed. Her sarcastic comment about her children being "not good enough to survive" was an attempt to rebut the implication that her children are defective and therefore unworthy even to live.

Kristy was more ambivalent about her own body's breastfeeding difficulties. At times she blamed herself, explaining, "I feel like congenitally or genetically or whatever it is I don't have an oversupply... I didn't have an abundant supply," and describing her guilt and grief over her first child's short breastfeeding duration. When she talked about breastfeeding her second child, however, she was more positive, explaining that breastfeeding "adds good stuff to my life instead of taking it away like it did for so long." Kristy accepted her limited milk supply and viewed breastfeeding as working. She viewed her body as competent for what it could do, rather than seeing it as incompetent because of her failure to conform to the natural breastfeeding paradigm.

This group of mothers rejects the characterization of breastfeeding as natural because they believe it implies that breastfeeding is simple and commonplace, a description not supported by their experiences. Some women prefer to use words like extraordinary, because they see breastfeeding as an amazing ability and view breastmilk as “liquid gold.” Other women object because for them, breastfeeding was very difficult, and to them, natural implies that a process will happen easily. Mothers who use infant formula in addition to breastfeeding may also reject the natural breastfeeding trope for its implication that infant formula is *unnatural*, and therefore bad or wrong. Rejecting the natural narrative in this way allows women like Kristy to view their own breastfeeding experience as a success, even though it did not conform to the dominant narrative. In the following section, I discuss women who see themselves as failing at breastfeed, and the ways they understand and interpret normal and natural breastfeeding.

4.7 (In)competent Bodies

4.7.1 Defining Breastfeeding Success

The medical discourse around breastfeeding sets out clear standards for breastfeeding success. The American Academy of Pediatrics (2012) prescribes six months of exclusive breastfeeding and at least 12 months of breastfeeding combined with the addition of complementary foods, while the World Health Organization (2015a:para. 3) recommends the same period of exclusive breastfeeding and some breastfeeding for “up to two years of age or beyond,” a somewhat confusing grammatical construction that manages to introduce the idea of two years of breastfeeding while simultaneously endorsing both longer and shorter durations. While lactation professions all told me that they tried to help mothers reach their own goals for breastfeeding, the mothers I met at Sweet Acacia and La Leche League meetings most

commonly understood successful breastfeeding as maintaining some amount of breastfeeding for at least 12 months, reflecting the AAP standard. The WHO standard, which primarily targets the Global South, was invoked more often in support of mothers who opted to nurse their children past 12 months, although the AAP guidelines do support breastfeeding for longer than a year if both mother and child wish to continue.



Figure 4.3 Breastfeeding badges from the La Leche League Facebook page

Source: <https://www.facebook.com/LaLecheLeagueUSA> (Photos)

Posters on the Sweet Acacia and other breastfeeding support Facebook groups who breastfed for a year often marked the occasion with a celebratory post, usually a baby photo with a caption such as, “Mamas I could cry!! We actually made it to one year!!” or “Happy 1 Year

Nurseiversary to us!!” followed by a chronicling of past breastfeeding struggles and statements of gratitude for help received. La Leche League USA has created a collection of breastfeeding badge pictures available on their Facebook page (Figure 4.3), including a gold medal with the words “I breastfed my baby 1 year,” and mothers sometimes included this as part of these posts. While some mothers posted to celebrate other milestones or “nursiversaries,” such as three months, six months, or two years, making it to the one-year mark was an especially meaningful maternal accomplishment.

Breastfeeding success was also marked by breastfeeding exclusivity, although the Sweet Acacia mothers tended to be less concerned with this than some other groups. Although health professionals generally follow the World Health Organization (2015b) definition of exclusive breastfeeding, meaning that a baby had received no solids or liquids other than breast milk, with the exception of vitamins, minerals, and medicines (including oral rehydration solutions), breastfeeding mothers often had a different definition. Many mothers in the Breastfeed, Chicago! Facebook group used exclusive breastfeeding to simply mean no formula, and one year nurseiversary posts sometimes included the statement that the baby was exclusively breastfed or “EBF,” even though it would be very unusual (and unhealthy) for a baby that age to not have started eating complementary foods. The term was less common in the in-person support groups I attended, although mothers who had supplemented with formula but then transitioned to feeding only breast milk would use “exclusive breastfeeding” to describe their current practice.

Poorer women in my study were generally less concerned with both breastfeeding duration and exclusivity. A poorer African American mother of three who was considered a breastfeeding success story by her friends and family (“That’s her thing!” her sister told me excitedly when I was introduced as a breastfeeding researcher) weaned all of her children

between three to six months, and supplemented each with formula within the first month. This mother told me she had to use formula bottles after she returned to her part-time job as a beautician. I asked her about pumping, but she told me that she really didn't have time for that at work, and she didn't even have a pump. She appeared untroubled about her babies drinking infant formula, telling me that they were very healthy because they were also breastfed, and noting, "They were greedy - they liked both!" She then corrected her statement to say that she thought they liked breast milk better, perhaps remembering that breastfeeding was the topic of my research.

Thus, the definition of breastfeeding success varies from woman to woman. Much of this is shaped by social class: wealthier women are more likely to define success as breastfeeding for a longer time period, often a year, and as not using any formula. Wealthier women who were exceptions to this, such as Kristy (whose annual household income was over \$100,000), had often faced significant breastfeeding difficulties. Many of the women who were exceptions also reported that coming to view their breastfeeding experiences as successful had been an emotionally arduous process, as they consciously resisted the dominant idea of success in their social *milieu*.

Although some lower income women did breastfeed for a year or longer, lower income women were less likely to consider a shorter term of breastfeeding to be a failure, and they were more likely to situate breastfeeding within the constellation of life responsibilities, rather than viewing it as a medal-worthy accomplishment. While richer mothers gained social status through breastfeeding, and particularly through enduring adversity and persevering, poorer mothers did not, and most did not feel compelled to continue when breastfeeding became too difficult or impractical.

4.7.2 “You Just Have to Hang On:” Failing at Breastfeeding

The theme of breastfeeding failure was most salient to richer mothers. A richer mother was more likely to see breastfeeding as vitally important, so her inability to breastfeed the way she wanted became a source of shame, as Ada chiding Joey for embarrassing her in front of her peers demonstrates. Joey, Ada said, had "one job:" to breastfeed, and his failure to do that implied that either he was incompetent or that she was. For if breastfeeding is normal and natural, a mother-infant dyad that cannot breastfeed successfully must be abnormal, so breastfeeding failure means that one or both parties is defective.

Defective mothers might be uncaring or uneducated, or they might be physiologically unable to breastfeed. Of the three, being uneducated carried the least stigma. I met a number of women who were breastfeeding a second child after failing (their term) with the first, and they almost always pointed at a lack of breastfeeding knowledge as a reason they had failed, then noted that they had “educated” themselves before having their second baby. Being “educated” about breastfeeding was a phrase I heard often in my research, and it referenced having a general understanding of how breastfeeding worked and what was biologically normal while breastfeeding, such as knowing how often a breastfed baby should be fed and understanding that lactating breasts create milk in response to demand. Lack of education as a reason for breastfeeding failure functioned as a mild indictment of the natural trope, because if breastfeeding were indeed natural then breastfeeding education should be unnecessary, as it was for other mammals. Others objected to this argument, framing the need for education as proof that U.S. society had strayed too far from nature: in societies where breastfeeding occurred frequently and publicly then no education would be required, but in the modern America it was.

The most common physiological explanation women gave for their breastfeeding failure was an insufficient milk supply. This concept was defined as *insufficient milk syndrome* in 1980 by Judith Gussler, a research scientist for Ross Laboratories, and Linda Briesemeister, an anthropologist. They promoted a biocultural explanatory model, hypothesizing that in more industrialized societies, mothers and infants no longer spent most of their time in close proximity to each other, which led mothers to nurse less frequently (Gussler and Briesemeister 1980). Because breast milk is produced based on demand, less breast stimulation results in decreased production.

In a commentary on this piece, medical anthropologists Ted Greiner, Penny Van Esterik, and Michael C. Latham suggested that less frequent feeding was actually an effect of women's beliefs that their supplies were insufficient, rather than the initial cause (Greiner, Van Esterik, and Latham 1981). These authors believed that messaging from infant formula companies and some medical professionals led women to believe that milk insufficiency was common and that infant formula was a benign solution. This, in turn, led women to diagnose themselves as having insufficient milk when their infants cried or fussed, even though sometimes they actually were producing quantities of breast milk that were clearly adequate. They then supplemented with formula and nursed less frequently, causing their supplies to fall. Researchers in a variety of disciplines have continued to address the question of insufficient milk syndrome, including asking whether or not the issue being described was actually a syndrome at all. More recent research (Johnie Mozingo et al. 2000; Otsuka et al. 2008; Marshall and McFadden 2014) has referred specifically to the *perception* of low milk supply, clarifying that oftentimes the women were actually producing enough milk for their infants.

Some of the mothers I met who had struggled with low milk supply were subsequently diagnosed by a physician with a condition known to lead to this problem, such as Polycystic Ovarian Syndrome (PCOS) or Insufficient Glandular Tissue. Although women were often grief-stricken by these diagnoses, they were also comforted, because the diagnosis shifted the responsibility for breastfeeding failure away from the sphere of things a woman could actively control, relieving her of personal responsibility. Although her body was now officially designated incompetent and abnormal, she herself could no longer be blamed for being uncaring or uneducated.

Mothers who failed because they were uncaring were the most stigmatized of the three groups, and they were also the most likely to not be physically present: no mother defined herself as failing at breastfeeding because she did not care enough. Private support group members sometimes described other women's failures to breastfeed harshly. One white mother spoke at length in a support group about her "selfish" sister, who left her three-month-old-baby for ten days to go on a cruise. Although her sister did bring a pump, the sister did not use it often enough, and her supply dried up by the time she returned home. Group members generally agreed that this had been a poor breastfeeding decision, and when one mother asked if perhaps the sister just had not been "educated" about breastfeeding and so had not known the risks, the original speaker dismissed this possibility, explaining that she had told her sister about the risks but only cared about having fun. A third group member sighed and said that she could not imagine even wanting to leave a young infant for so long, saying, "I'm sure I wouldn't enjoy myself at all, I'd be so worried." Some mothers, then, failed at breastfeeding not because their breasts were defective, but because their mothering instincts were. The sister demonstrated her flawed maternity when she was unwilling to sacrifice fun in order to continue breastfeeding,

and she did not experience the distress that the group believed should have been natural when separated from her infant.

Ada's grief over breastfeeding demonstrated that she did care, positioning her as a concerned mother who was struggling to succeed. Her own belief was that there was something wrong with her body, although as far as I know, she never received a medical diagnosis relevant to breastfeeding problems. However, her decision to stop trying left her in a categorical limbo. In the weeks following her departure, remarks from some group members made it clear that they believed Ada had given up too soon. One mother, for example, said, "I had a really rough time too in the early weeks, but you just have to hang on." To some, Ada's unwillingness to "hang on" marked her as insufficiently maternal, although other mothers in the group viewed her obvious suffering as sufficient proof of her mothering instincts.

Women who try and fail at breastfeeding complicate the normal and natural breastfeeding narrative in different ways. Women who fail because they are not educated challenge the narrative by asserting that maternal instinct is insufficient, claiming instead that a specific body of knowledge is necessary for breastfeeding success. Women who fail for physiological reasons define their own bodies as abnormal, so that their failure does not conflict with the dominant narrative. Finally, women who fail for other reasons are deemed unnatural as mothers, as demonstrated by their unwillingness to continue breastfeeding.

4.8 Conclusion

The dominant narrative that frames breastfeeding as normal and natural has been an important public health tool for increasing breastfeeding rates in the United States. However, local discourses demonstrate that this narrative is complicated on the ground as women work to

integrate it with their experiences, situations, and beliefs about mothering and their bodies. Some women have internalized the idea that breastfeeding is normal and natural to the extent that they dismiss the idea of breastfeeding as a choice, viewing it instead as simply the way infants are fed. Other women ground this narrative in an imagined past or a faraway place, viewing breastfeeding as part of a more natural tradition of practice. The sexualization of breasts in the United States is difficult for some women to reconcile with the conceptualization of breasts and breastfeeding as natural. Some women find the idea of natural breastfeeding insufficient, instead viewing breastfeeding as an extraordinary achievement. Finally, for women who fail at breastfeeding, the natural breastfeeding trope creates a conundrum, and they attempt to integrate it with beliefs about their own bodies and mothering that allow them to view themselves as caring and competent mothers.

Race can influence the ways women reinterpret the natural narrative. White women may form an attachment to the “crunchy” ideals that reference an idealized human past and situate breastfeeding as a part of the traditional human repertoire of practices, while African American mothers may instead develop an attachment to Africa as an unpolluted place where community and sisterhood support and affirm breastfeeding mothers. White mothers are more likely to reject the sexuality of their lactating breasts altogether, while African American women may be more conflicted, and they may find ways for the sexual breast to co-exist with the maternal one.

Social class can also shape women’s understandings of breastfeeding as natural. Wealthier women may be more attached to the idea of breastfeeding as naturally tied to maternal instincts, believing that ideally a mother should not even consider any other ways of feeding her infant. They may view mothers who do not breastfeed as unnatural, because either their bodies or their maternal instincts are defective. In contrast, poorer mothers are generally less concerned

about breastfeeding as evidence of maternal prowess, and they are less likely to judge mothers who do not breastfeed as unnatural.

Chapter 5

Breastfeeding and Good Mothering

5.1 “This Child is a Breastfed Child”

As I drove through north St. Louis to the Light of God Missionary Baptist Church, passing the small businesses with weathered signs and barred windows that then transitioned to a more residential neighborhood with stop signs at every cross street, I noticed that nearly every house had the same sign in front. "We Must Stop Killing Each Other" they read in stark black letters, with a simple rendering of the St. Louis arch as a background. I had seen many such signs since Michael Brown's 2014 death, but never this many in a row, one or more in every single yard. Some of the houses were boarded up and it was clear that no one lived there, at least not officially, but the signs were in front nonetheless. This plea for an end to violence was repeated for over a mile, the visual equivalent of an old 33 record that skipped on the same words until someone finally nudged it past that groove.

For me, the stuttering ended at the church, where I entered the church's clean, modern conference center and followed the voices I heard down the carpeted hallway. In the room at the end of the hall I found what I had come for: a perinatal education workshop run by For Babies, a small non-profit working to reduce infant mortality in this area of St. Louis. For Babies was founded when the alderman of this ward learned that infant mortality rates here were the higher than in any of the other 27 wards in the city, and this series of workshops was an attempt to reduce these rates through education. The topic for this day's workshop was breastfeeding.



Figure 5.1 St. Louis children holding “We Must Stop Killing Each Other” signs.

Photograph: James Clark (Kendzior 2015)

When I arrived, eight women who lived in or near this ward were already sitting around three round tables, some with infant seats beside them and others with their chairs pushed back to accommodate their growing bellies. All were African American, reflecting this ward’s 97% African American population (City of St. Louis Planning and Urban Design Agency 2011), and all had been poor enough to qualify for Medicaid during their pregnancies. Many already had children, and I could hear muffled voices from the room next door where childcare was provided. The mothers were tuned to their own children’s voices, and when they heard a particular cry or whine they would turn to the workshop organizers and ask if they might go and check on their children, then awkwardly rise to their feet, and shuffle out the door.

The topic of previous month’s workshop had been SIDS. That workshop’s presenter had been a professionally-dressed white woman with handouts and a slick PowerPoint presentation, which she projected onto the screen at the front of the room. It was clear that she had given the

same presentation many times before, and in fact, I had seen it months earlier at a training I attended with two For Babies employees. In contrast, today's two presenters dressed casually and had no PowerPoint. One was Gina, a white La Leche League leader, and the other was Annie, an African American WIC breastfeeding peer counselor, both of whom I introduced in Chapter 1. Gina and Annie had spoken to me previously about their passion for reducing the racial disparity in breastfeeding in St. Louis, and both had already committed time and energy to this mission.

The presenters opened the workshop simply, first introducing themselves and then asking the women to share their thoughts about breastfeeding. After a brief silence, one woman hesitantly raised her hand, launching an enthusiastic conversation that continued unabated until the group ran out of time and the taxis started arriving to take the women home. The first woman to speak was heavily pregnant and the mother of one, and she began by stating emphatically that she used to think breastfeeding was "disgusting" and "nasty." She had struggled with the idea of putting her breast into a baby's mouth because a baby was "innocent," alluding to the breast's sexual symbolic meaning. Now, however, she thought differently, and she planned to breastfeed her new baby for his "health." Other group members nodded in agreement.

For these women, the idea that breastfeeding was healthy for babies was pervasive and powerful. Nearly all of the women repeated it at some point during the workshop, like a talisman to protect their children and prevent illness. Annie, whose three-year-old son was playing in the childcare room next door, lamented that her son had been ill the previous week and said that she wished he was still nursing, implying that breastfeeding might have prevented or mitigated his illness. She said that she missed breastfeeding because it had provided a way to connect with her son and keep him near. "It's natural for mothers and babies to be close," she told the group,

explaining that the closeness babies experience in utero is what feels right to them after birth, and that breastfeeding facilitates that closeness and bonding.

One of the workshop attendees nodded vigorously and spoke up, mentioning that her toddler son still slept on her chest a lot of the time, and that she thought that was all right. I cringed, remembering the SIDS speaker's insistence that babies never sleep with an adult, but the For Babies staff members did not interfere. "I want my son right with me. I get nervous when he's not," another mother said of her preschool-age child. A different woman agreed with her, stating that a mother cannot know what will happen to her children in her absence. "I'm afraid for him every time he goes out the door," she said of her 9-year-old son. I thought about the signs on the way in, and about Michael Brown, gunned down the previous August less than three miles from where we were sitting.

The group bubbled with conversation, women talking over each other and sharing their fears for their children. "I don't like to leave him with nobody except my mother," said the mother of a 4-year-old, explaining that some of her friends called this spoiled but she didn't think she could trust anyone else to watch him closely enough. Some of the other women had also been accused of this sort of spoiling but they strongly refuted the accusation, citing the importance of keeping their children safe and protecting them. Gina agreed, pointing out that human infants and children were meant to be close to their mothers, skin touching skin, and that this was a norm for our species. Annie told the women that the reason they felt so strongly about keeping their babies and children close was that this was natural, and that breastfeeding was an extension of that natural closeness and protection. She described taking her son to childcare and telling his caregivers, "This child is a breastfed child, he's precious and you need to treat him right."

In this chapter, I analyze two contrasting narratives about being a good mother and argue that breastfeeding has been integrated into each in different ways. In the first, exemplified in the vignette above and more prevalent among African American mothers, a good mother is one who protects her child from harm. In this narrative, breastfeeding is viewed primarily as a way to prevent harm through illness, but also as a way to promote bonding, thus keeping children closer to their guarding mothers. In the second narrative, more common among white and wealthier mothers, a good mother is one who sacrifices for her child, investing time and money to ensure that her child has the best possible start in life. In this narrative, breastfeeding is less about protecting an infant from illness and more about creating a smarter, healthier, and happier child.

I begin this chapter with a discussion of historical conceptualizations of motherhood in the U.S., in which I emphasize the different experiences of white and African American mothers and how these came to influence beliefs about good mothering. I then delve more deeply into my two good mother narratives, using ethnographic data to explore the ways they are enacted on the ground. I conclude by discussing the implications of each narrative on breastfeeding praxis.

5.2 Being a Good Mother: A Brief History of the Cult of Motherhood

The idea of motherhood has had powerful symbolic value in many societies. Psychiatrist Carl Jung (and others) theorized the archetype of the Great Mother, a figure that resides in humanity's collective unconscious, influencing our emotions and images in ways that are usually outside of our awareness (Neumann 2015). Many of the world's major religions emphasize the importance of mothers, from the prominence of the Madonna figure in Catholic and Orthodox artwork to the Muslim *hadith* stating that Paradise is at feet of mothers. Still, being a good mother has not always involved the guidance and nurturing we associate with mothers today. In

the United States, prior to the eighteenth century, fathers were responsible for ensuring that their children remained safe and grew to be good and moral citizens, while (male) authority figures deemed women inadequate to this responsibility (Hays 1996). The primary responsibilities of motherhood were to conceive and give birth to children, and then to keep them alive during infancy (Vandenberg-Daves 2014). The principal marker of a good mother was her fertility, although breastfeeding was also valued because it was widely understood to increase infant survival rates.

In colonial America, neither white nor African American women were considered to have ownership of their own bodies, much less their children, and both were expected to bear children for the white man who possessed them (Hill 2008). As was true for white women of the time, bearing children could also enhance the status of enslaved African American mothers. Of course, the situation for enslaved African American women was far more extreme: they could be tortured or killed without penalty, and their infants could and often were sold and sent to live far away. As Frederick Douglass said, "The domestic hearth, with its holy lessons and precious endearments, is abolished in the case of a slave mother and her children" (Vandenberg-Daves 2014:33). African American women, however, did their best to protect their children from the effects of slavery whenever they could, sometimes suffering whippings or imprisonment as a result. Douglas' own mother traveled twelve miles at night to see him when he was an infant, often after working a full day in the field (Hill 2008).

Although white society of the time valued enslaved African American women's production of their own children rather than their mothering of these children, African American women were valued for the mothering work they did for elite *white* children (Hill 2008). In the cultural imagination of the time, a "mammy" was an African American woman who was devoted

to caring for children of white slave owners, sacrificing her own welfare out of love for these children (Roberts 1993). A powerful and knowledgeable figure in the domestic realm, the good mammy also viewed herself as unmistakably inferior to white people and did not attempt to influence the moral development of her charges, a task she was considered constitutionally unable to perform (Roberts 1993; Hill 2008). Thus, to white society, being a good mother as an enslaved African American woman required two things: giving birth to a large number of biological children and being a devoted caregiver to a white woman's children.

To these African American women, however, protecting their own children from harm was paramount, as demonstrated by the nocturnal journeys made by Frederick Douglass's mother. Similarly, Sojourner Truth referenced her maternal anguish at losing her children in her famous 1851 speech, saying, "I have borne thirteen children, and seen them most all sold off to slavery, and when I cried out with my mother's grief, none but Jesus heard me! And ain't I a woman?" (Truth 1851). These historical precedents foreshadow current narratives about good mothering: wealthier white mothers prioritized devotion and sacrifice on behalf of their children (in the past this came primarily from enslaved African American caregivers rather than their actual mothers), while African American mothers prioritized protection for their children.

During the late eighteenth and early nineteenth century, concerns about moral deterioration in the wake of an increasing shift toward capitalism and urbanization led to the re-imagining of women as keepers of morality and virtue (Vandenberg-Daves 2014). This cult of true womanhood, which I also discussed in Chapter 2, exalted women for their roles as mothers, while simultaneously judging them for any failure to live up to the part (Apple 1987; Welter 1966). As fathers' employment shifted from the farm to the office, the home was re-imagined as a refuge from the outside world, and mothers became responsible for carefully guiding their

children towards a productive adulthood while safeguarding their innocence (Hays 1996). Families invested more time and money into their children, sending them to school and purchasing toys and books intended to ensure proper development.

In practice, these ideas were primarily applied to a select subset of women, mainly those who were white and middle or upper class. Poorer women did not have the option to withdraw into their homes and the domestic realm; they and their children worked both in and outside of the home just to survive (Hays 1996). While some reformers of the time attempted to instill middle class values such as purity and piety into poorer women and their children, including at times plucking the children from the street and sending them out West to be adopted by more morally acceptable farming families, most of these efforts had little effect. Indeed, even elite white women did not often fully actualize this true womanhood: while the ideology asserted that mothers were uniquely suited to caring for their children, in practice children in most middle and upper class white families were cared for by slaves or by hired domestic servants, typically immigrant or free African American women with children of their own (Vandenberg-Daves 2014).

The end the nineteenth century marked the emergence of scientific motherhood, an ideology characterized by the belief that medical and scientific knowledge is necessary in order to raise children well, and that mothers therefore must depend on medical experts to successfully complete this responsibility (Apple 2006). I described this philosophy's effects on infant feeding in Chapter 2. By the early twentieth century, these ideas predominated among native-born white mothers, but many immigrant and African American mothers had limited access to this new information (Vandenberg-Daves 2014). Although informational newspapers and mothers' groups specifically for the African American community existed, they were primarily accessible to the

small percentage of African American mothers who had achieved middle class status. Like middle class white mothers, these women tended to carefully follow advice from physicians and scientific experts of the day (Apple 2006). However, poorer African American mothers, especially those residing in the less-urbanized South, often had little access to physicians or other sources of new scientific knowledge, and as a result they relied more heavily on existing kin networks for information. African American mothers were also more likely to be working outside the home (often as domestic servants for white women), making them unable to perform the exacting mothering duties prescribed by the scientific experts of the day, even if they had wanted to do so. Still, many in the white majority condemned African American mothers who failed to conform to this image of the good mother, labeling them morally suspect and irresponsible and advocating eugenics as a potential solution (Hill 2008).

In contrast to this perception of African American mothers as bad mothers, the mammy figure was romanticized by white people in the early twentieth century (Vandenberg-Daves 2014). This imagery served a number of functions for the white majority group: it eased feelings of guilt about slavery by focusing on the idea of African American women's devotion to white children, implying that enslavement had benefitted African American women by giving them the experience of maternal fulfillment through caring for white children; it erased African American children; and it justified the continued employment of African American women as domestic servants by highlighting their supposed devotion to white babies. Thus, African American mothers were simultaneously criticized as bad mothers to their own children and lauded as good mothers to white children.



Figure 5.2 Cartoon protesting the proposed “Black Mammy” monument, from the March 2, 1923 Baltimore Afro-American. Source: <http://southernspaces.org/2009/southern-memory-southern-monuments-and-subversive-black-mammy>

During the 1920s, the U.S. Congress introduced legislation to fund the construction of a historical monument to the "Black Mammy", which became a flashpoint for African American activists (Vandenberg-Daves 2014). Through speeches and political cartoons, such as the one shown in Figure 5.2, they suggested that Congress's efforts should be spent on addressing racial injustices such as the murders of thousands of black men by lynch mobs instead of reinforcing self-serving stereotypes of black mothers. Many of these activists were mothers themselves, and their advocacy is another example of their efforts to protect their sons. Ultimately, plans to create a mammy monument were scrapped.

By the 1940s and 1950s, scientific motherhood had expanded to include a strong emphasis on children's psychological development, adding another realm of knowledge for mothers to master in order to ensure that their children became healthy and productive adults (Apple 2006). Unsurprisingly, this call for maternal attention to the psychological needs of children led to the censure or blaming of mothers whose children displayed developmental or psychological problems (Vandenberg-Daves 2014). Autism, for example, was believed to be a response to "refrigerator mothers" who were insufficiently loving to their children, while schizophrenia was thought to be caused by "schizophrenogenic mothers." Juvenile delinquency, alcoholism, immaturity, and homosexuality were all thought to be related to maternal inadequacy in some form. Although many of these specific causal beliefs have fallen out of favor, researchers in child development continue to blame inadequate maternal sensitivity for problems such as academic difficulties or failed romantic relationships (Raby et al. 2015).

Today, the conviction that mothers have a special role to play in the lives of their children suffuses ideas about good mothering in the U.S., but the specific beliefs about that role vary, particularly among women from different races and socioeconomic classes. While beliefs about

what comprises good mothering are both complex and nuanced, in the remainder of this chapter I focus on two particular narratives from the entirety: good mothering as protection, which I argue is more common among African American and poorer mothers; and good mothering as investment and sacrifice; which I contend is more prevalent among wealthier mothers. My specific focus is how breastfeeding is incorporated into each of these narratives.

5.3 Protection as Good Mothering: “She Never Been Sick”

In anthropology, there is often tension between the universal and the particular. I decided to do my research in St. Louis because it was representative of many cities in the rust belt of the United States, places that were once thriving industrial centers but are now struggling with decreasing populations, high crimes rates, racial segregation, poverty, and an overall lack of hope. St. Louis could have been Detroit, or Cleveland. Then, on August 9, 2014, an unarmed 18-year-old African American man was shot and killed by a police officer on a quiet street in the middle of the afternoon, and Ferguson, Missouri, a first-tier St. Louis suburb once best known for its train station, became the epicenter of a national movement focusing attention on the lack of value accorded to Black lives in the United States. “Black Lives Matter” was and is both a rallying cry and a correction of the status quo, a clear and emphatic assertion that Michael Brown’s life had value, as did the lives of Eric Garner, Trayvon Martin, Freddie Gray, Rekia Boyd, Sandra Bland, and many others. Although the setting for my fieldwork did not change, public discourse about race grew and shifted after Brown’s death, highlighting existing tensions and emphasizing the effects of racism on everything from law enforcement to health care.

As they grieve for their son, Brown’s parents also grapple with the parental imperative of protection and their inability to keep their son from harm. “I should have been there to protect

him,” said his father, Michael Brown, Sr., a thought that haunts him (Richardson 2015). Brown’s mother, Lezley McSpadden, explained her understanding of protection an essential duty of motherhood: “You see, because as a mother, when your child is hurt, scared or in danger, you hurt, you want to comfort them, and you will protect them from harm, even if it means laying your own life down” (McSpadden 2016:9).

Brown’s parents were fighting an uphill battle. African American boys between the ages of 15 and 19, Brown’s age when he was killed, are about 40% more likely to die than white adolescents the same age (Heron 2016). The number one cause of death for African American boys in this age group is homicide, accounting for nearly half of all deaths, and the homicide rate for African American boys in this age range is nearly ten times that of white boys the same age. As Black feminist scholars Claudette Lee and Ethel Hill Williams wrote, “The major challenge... to a black mother raising sons today remains the same as that of yesterday – survival. Racism, discrimination, and oppression define the childhood of an African American male. Mothering for an African American woman is defined by fear for her male child” (Lee and Williams 2002:56). For African American mothers, protection is more critical because survival is less certain.

The mortality disparity between African American and white children in the United States does not begin when they reach adolescence. In fact, the disparity is even greater at the beginning of childhood than at the end: when compared to white infants, African American infants are more than twice as likely to die before their first birthdays (Heron 2016). The situation is even more dismal in St. Louis city and St. Louis County, where African American infants are about three times more likely to die than white infants (Missouri Dept. of Health and Human Services 2015). From the very beginning, then, African American children are more at

risk, their lives more fragile and tenuous, and African American mothers must from beginning navigate how to best protect their children with a special urgency.

Nationally, just over half of this infant mortality disparity is due to causes related to preterm birth, which occurs significantly more often among African American women than white women (MacDorman and Mathews 2011). Sudden Infant Death Syndrome (SIDS), accounts for another 6% of the difference, with all other factors explaining smaller percentages of the disparity. Extensive research supports the assertions that breastfeeding is protective against SIDS and that it reduces the incidence and severity of diarrheal and respiratory infections in infants and young children (Hauck et al. 2011; Victora et al. 2016). Breastmilk is also strongly protective against necrotizing enterocolitis (NEC), an illness with a mortality rate of 30% or more most commonly seen in preterm infants (Gephart et al. 2012). Thus, breastfeeding is a potent weapon against some of the illnesses that particularly affect African American babies.

Breastfeeding is incorporated into good mothering as providing protection trope first and foremost through breastfeeding's role in protecting infants from sickness. At the workshop I described at the beginning of this chapter, health was a particular concern for the participants. Although Gina mentioned a few specific health benefits that breastfeeding provided, such as a reduction in allergies and asthma, most often general statements about illness and health were sufficient to convey the message: breastfeeding was important because it prevented babies from getting sick. The health benefits of breastfeeding also provided a rationale for breastfeeding in specific situations when it might meet with disapproval: one woman at the workshop shared hesitantly that her 18 month old still nursed sometimes, then quickly added out, "But she never been sick, never!" By invoking her daughter's good health, this mother grounded the practice of breastfeeding her toddler in the domain of protection.

While this workshop was one of the few places I heard women explicitly connect breastfeeding to the broader theme of protection, African American women alluded to this idea in interviews when they talked about breastfeeding as a way to prevent illness. Examples include saying that breastfeeding would “keep them [babies] from getting sick,” and telling me that their children had never been sick until they stopped breastfeeding. While both white women and African American women talked about the health benefits of breastfeeding in interviews, African American women did so more often than white women. When I asked the women I interviewed to tell me why they decided to breastfeed, all of the African American women mentioned health reasons, while about a third of the white women did not. White women who did mention the health benefits of breastfeeding were often less definite, such as the richer mother of a seven-month-old who said, “I haven’t really seen them [health benefits] yet, but I know that it’s supposed to help her in general be healthier.”

Socioeconomic status also appeared to influence responses to this question. Preventing sickness was less of a concern to wealthier women: all but one of the women who did not mention health benefits had a household income over \$50,000 a year. As preterm birth and infant mortality rates in the U.S. are negatively correlated with household income (Olson et al. 2010), it is unsurprising that safeguarding infant health would be more relevant to poorer women. Most women with household incomes above the poverty line who did mention health benefits gave a minimum of three different reasons for breastfeeding, such as: “Number one is more money [because she does not need to spend money purchasing infant formula], but also because I know it is most beneficial for her health-wise, and the bond it creates between mother and child I think is like, life everlasting.” While health did influence this mother’s decision to breastfeed, it was not the only reason or the first reason she mentioned. In contrast, almost all women of any race

who had household incomes below \$15,000 gave no more than two reasons for their decision to breastfeed, always including breastfeeding. Some examples from women in this socioeconomic category are: "It's healthier," "Getting sick less," and stating that breastmilk is "healthier than the can milk."

A second way that women incorporated breastfeeding into the narrative of protection was through the closeness and bonding they believed were facilitated by breastfeeding. Both white and African American mothers mentioned bonding or closeness in about half of my interviews, but African American mothers were more likely to specifically talk about this close bond as something that persisted past infancy. One African American woman told me that her husband had been breastfed and that was the reason he and his mother were so emotionally close. As evidence of this closeness, she explained that he called his mother more often than any of his sisters, none of them had been breastfed. Historically, African American mothers have often been prevented from maintaining physical closeness to their children, first by slavery and later by the economic necessity of working long hours away outside the home, giving a particular urgency to forming a close emotional bond. The stronger this emotional bond, the more likely a child is to seek his mother's counsel or tell her about his life, giving her greater opportunity to protect him.

In summary, protecting children is a primary marker of good motherhood for some women. Overall, this is a more significant concern for African American women than for white women. Socioeconomic class also determines the relative importance of protection for a woman, as poorer women find this issue more salient than richer women. In my research, I found that breastfeeding was incorporated into the narrative of protection on two ways: primarily, women viewed breastfeeding as protecting infants by preventing sickness, but women also saw

breastfeeding as protective because it facilitated the formation of a closer bond between them and their children.

5.4 Sacrifice as Good Mothering: “A Lot of Pain, a Lot of Pain”

5.4.1 Intensive Mothering in the 21st Century

The cult of true womanhood ideology that was ascendant two hundred years ago continues to resonate in the ideas about good mothers that some women hold today. In 1996, sociologist Sharon Hays coined the term “intensive mothering” to describe the style of mothering she viewed as the “dominant ideology of socially appropriate child rearing in the contemporary United States” (Hays 1996:9). In an echo of the cult of true womanhood, intensive mothering presumes that a mother receives joy and fulfillment from the process of mothering, and that this is the most meaningful part of her life. In the same vein, mothers are viewed as uniquely qualified as caregivers, because no one else can love a child in the same way. Most importantly, intensive motherhood is an exacting and demanding undertaking, and good mothers must be willing to sacrifice on behalf of their children. Hays writes:

[Intensive mothering] includes lavishing copious amounts of time, energy, and material resources on the child. A mother must put her child’s needs above her own. A mother must recognize and conscientiously respond to all the child’s needs and desires, and to every stage of the child’s emotional and intellectual development. This means that a mother must acquire detailed knowledge of what the experts consider proper child development, and then spend a great deal of time and money attempting to foster it.... this is an emotionally taxing job as well, since the essential foundation for proper child development is love and affective. In sum, the methods of appropriate child rearing are construed as *child-centered, expert-guided, emotionally absorbing, labor intensive, and financially expensive*. (8, italics in the original)

In the twenty years since the publication of Hays’ book, intensive mothering has remained a relevant idea for social scientists, feminist scholars, and others interested in

parenting. Which Hays believed that all U.S. mothers are influenced by this prescriptive ideology, she and others also note that its relevance is shaped by factors such as race and class. In general, mothering practices of white and wealthier mothers are more strongly influenced by the ideas of intensive motherhood, while poorer and African American mothers are more likely to actively resist this ideology or find it too difficult to implement (O'Reilly 2004; Elliott, Powell, and Brenton 2015). Indeed, it is clear from the description above that intensive mothering requires a good amount of social and economic privilege to practice, as did the cult of true womanhood in previous centuries.

The popular parenting style referred to as attachment parenting or "AP" typically requires intensive mothering. The term attachment parenting was coined by pediatrician William Sears more than thirty years ago (Green and Groves 2008). Sears and his wife, Martha, developed a list of tools they believed were useful in creating a strong attachment with a new baby, which they viewed as critically important to a child's future happiness and success. These tools, which they referred to as "The 7 Baby B's," included: birth bonding, breastfeeding, baby wearing, bed-sharing (mother and infant sharing a bed), belief in baby's cries, balance and boundaries, and beware of baby trainers (Sears and Sears 2001). A number of the mothers I met during my research (primarily but not solely white mothers) self-identified as attachment parents.

Many of the Baby B's are necessarily time- and labor-intensive, but one could easily argue that caring for a young infant appropriately is necessarily time- and labor-intensive. Adherents of attachment parenting, however, tend to retain these more intense methods well past the newborn stage. In their study of self-identified attachment parents, education professors Katherine Green and Melissa Graves found that 30.2% of mothers had never left their babies with another caregiver (even the infant's father) during the first 12 months; mothers who

breastfed their children did so for an average of 35.8 months; and of the mothers who currently had six-to eighteen-month-old babies, 75.6% reported sleeping with their babies (2008). Study respondents were overwhelmingly white and married, and over half had at least a bachelor's degree.

As described in detail in Chapter 2, the correct infant feeding decisions have long been associated with good motherhood, although ideas about just what that decision should be have varied. Starting in the late 1960s and early 1970s, discourses about breastfeeding's superiority in promoting infant health spread rapidly in both the medical literature and popular culture (Wolf 2010). By the 1980s and 1990s, the idea that "breast is best" had firmly taken hold. Today, these discourses position breastfeeding as superior to infant formula not only because it results in better infant health but also because it promotes bonding and attachment between mothers and babies; improves psychological well-being, increases IQ, and decreases obesity rates of previously breastfed children and adults; improves maternal health and self-esteem; demonstrates environmental responsibility and closeness to nature; and other benefits (Murphy 1999; Schmied and Lupton 2001; Wall 2001; Lee 2008; Victora et al. 2016).

Previous research has demonstrated that mothers who are most influenced by the intensive mothering ideology, including many attachment parents, view breastfeeding as necessary to being a good mother (Lee 2008; Murphy 2000; Knaak 2010; Faircloth 2010). Medical and parenting experts state that breastfeeding is the infant feeding method most closely associated with the production of smart, happy, and healthy offspring, the ultimate goal of intensive mothering. In the next sections, I look at how mothers sacrifice economically and physically in order to breastfeed.

5.4.2 The Costs of Breastfeeding: “I Would Have Paid Anything”

“Breastfeeding saves dollars and makes sense” states the United States Breastfeeding Committee’s website (<http://www.usbreastfeeding.org/dollars-sense>). The page supports this claim in part by referencing physician Melissa Bartick and independent researcher Arnold Reinhold’s claim that “If 90% of US families could comply with medical recommendations to breastfeed exclusively for 6 months, the United States would save \$13 billion per year,” based on the indirect and direct costs of illness and premature death for ten diseases for which risk reduction had been previously demonstrated through exclusive breastfeeding (Bartick and Reinhold 2010:1048). However, this framing does not consider the costs of breastfeeding to individual women, and contrary to the assertion that “breastfeeding is free” that I discussed in Chapter 3, every woman I met during my research who breastfed for more than a day incurred some related costs.

While some researchers have examined the effects of time spent breastfeeding or pumping on maternal income potential (Smith and Forrester 2013; Rippeyoung and Noonan 2012), little systematic research has investigated the average out of pocket costs paid by U.S. mothers to facilitate breastfeeding. However, some data supports the idea that breastfeeding can be costly. In her study of 25 class-privileged and primarily white breastfeeding mothers in California, anthropologist Orit Avishai found that they commonly spent hundreds of dollars on items and services intended to ensure breastfeeding success (Avishai 2007). In a blog post on the online website Babble, parenting journalist Kate Tuttle asked “If breastfeeding’s so cheap, why do so many women spend so much money doing it?” (Tuttle 2008). According to her estimates, breastfeeding for a year costs between \$0 and \$2,411.40, while formula costs between \$1,167.77

and \$3,035.60. Avishai and Tuttle reference a similar assortment of breastfeeding-related items and services, which correspond with the purchases made by women in my own research.

While I was not able to document the total dollar amount spent on breastfeeding by the women I interviewed, as at the time of the interview most were still breastfeeding and thus still potentially purchasing, I did collect data on breastfeeding expenses incurred prior to the interview. The amount of money that women reported spending ranged from less than \$20 to over \$2,000. While the total financial investment in breastfeeding was highly variable, some patterns did emerge. Unsurprisingly, poorer women tended to spend less overall. While the majority of my interview subjects spent between \$150 and \$400, most women living below the poverty line spent less than \$50. White and African American mothers from the same socioeconomic class spent similar amounts. Mothers who did not receive a free double electric pump spent more (at the time of my interviews, some insurance plans had been grandfathered in and did not have to provide pumps under the Affordable Care Act, and other plans were providing only manual hand pumps), as did mothers who experienced significant breastfeeding difficulties.

Richer mothers were more likely to invest significant time and effort in determining what purchases were necessary for breastfeeding success, reflecting the practices of intensive mothering. Many books, websites, and baby supply stores have created lists of items that breastfeeding mothers should purchase. The Parents magazine website, for example, features a relatively short list of must-have items: nursing pads, a daytime nursing bra, a nighttime nursing bra, and a nursing pillow (Hartshorn 2016). More items are included on a separate list of things a breastfeeding mother might want, including lanolin cream, a breastfeeding guidebook, and a comfortable chair, while pumping is given its own list. The Buy Buy Baby store's Baby Book

BREAST PUMP & ACCESSORIES

THE BENEFITS OF BREASTFEEDING

Breastfeeding offers important benefits to both you and your baby. Breast milk is easy for your baby to digest and contains antibodies that protect him from infection. Studies suggest that breastfeeding lowers your risk of getting certain cancers, and it also helps you get back to your pre-baby shape faster. Plus, it's a unique bonding experience. If you can't or don't want to nurse, infant formulas provide the same nutrition. Talk to your pediatrician about which formula is right for your baby.


 CHECKLIST
breastfeeding
toolkit

- BREAST PUMP
- STORAGE BAGS
Specially made for freezing breast milk
- FEEDING SET
Includes extra bottles, caps and nipples.
- MICROWAVE STERILIZER BAGS
Kills germs on bottles, nipples, pacifiers and pump accessories
- CLEANING WIPES
Lets you clean your pump and accessories anytime, anywhere
- CAR-LIGHTER ADAPTOR
Enables you to pump when you're on the go
- REUSABLE ICE PACK
Keeps breast milk cold in a cooler
- BREAST OINTMENTS AND GEL PADS
Soothe cracked and sore nipples
- BREAST PADS
Slip right into your bra to protect against leaks
- NURSING BRAS
Provide extra support and easy access
- NURSING COVER
Keeps things under wraps when you nurse in public
- NURSING PILLOW
Positions your baby while you breastfeed
- NURSING STOOL
Helps you maintain a comfortable position while breastfeeding

Figure 5.3 Buy Buy Baby Breastfeeding Toolkit (Buy Buy Baby 2012:35)

includes a list of 13 items that comprise a “Breastfeeding Toolkit” (Figure 5.2), including a breast pump, microwave sterilizer bags, and a nursing cover (Buy Buy Baby 2012:35). While none of the mothers I interviewed said they had made all of their initial purchases based on this type of list, several reported consulting one or more such lists to determine what to buy.

Nursing bras and nursing tanks were the most frequently purchased items. The prices of these items vary widely: a nursing bra from Walmart, for example, costs about \$10, while a nursing bra from a designer line like Cake or Bravado can cost \$60 or more. Most women also bought a nursing pillow (or received one as a gift) and nursing pads (these are tucked into a bra to absorb milk that may leak between nursing sessions). While all except one of the richer women I interviewed owned at least one breast pump, the majority had received their pumps through their insurance companies at no cost. Women who pumped frequently had additional expenses related to pumping, such as milk storage bags and pumping bras. I talk more about breast pumps in Chapter 6.

The mothers in my study who spent the most money on breastfeeding-related purchases were those who were both richer and had significant difficulty breastfeeding. Amy, whom I described in Chapter 3, was one such mother. Many of the purchases made by mothers who struggled to breastfeed were both qualitatively different from and more expensive than most other breastfeeding-related purchases. Struggling mothers were more likely to spend money on services, such as craniosacral therapy, chiropractic care, and private lactation support. They also purchased foods and supplements intended to remediate breastfeeding problems, such as flaxseed or fenugreek to increase milk supply or lecithin to prevent plugged milk ducts. Two of the mothers I interviewed used prescription galactagogues; one used Reglan and the other

Domperidone (which is not approved for sale in the U.S. and was consequently both difficult and expensive to procure).

Spending more money can allow mothers to defend their claim to good motherhood. The intensive mothering ideology requires that a mother do what is best for her child at each stage of development at any cost, which means she must breastfeed during infancy. Mothers who are not succeeding at breastfeeding are in danger of being viewed as bad mothers, and focusing attention on their financial sacrifices deflects attention from this deficit. Both in interviews and at support groups, mothers sometimes detailed the numerous purchases they had made in the quest to breastfeed, which served to underscore the mother's level of commitment.

When a mother commented at a Sweet Acacia support group meeting that she had saved a lot of money by breastfeeding, another group member responded by listing everything she had spent money on thus far in order to continue breastfeeding: herbal and prescription galactagogues, rentals costs for a hospital-grade breast pump, a Supplemental Nursing System, craniosacral therapy, lactation consultant services, a number of co-pays for physician visits, and more. This second group member, who was wealthier and white, added the costs of these items as she spoke and concluded with a number in excess of \$1,500. She pointed out that this did not include the amount paid by her insurance company, which she estimated would at least double the total. Then she looked down at her son, a chubby-cheeked and cheerful baby who was propped on her lap and chewing on a giraffe teething toy, and told the assembled group, "I would have paid anything, though. Giving him the best start in life is worth any price." This willingness to sacrifice financially and pay any amount demonstrated the depth and intensity of her commitment to breastfeeding, and by extension her commitment to being a good mother.

5.4.3 Suffering to Breastfeed: “Everything that’s Worth Doing Usually Comes with Pain”

A second way that breastfeeding mothers sacrifice in order to be good mothers is by enduring physical pain and discomfort. Although every lactation professional I met told me that breastfeeding is not supposed to hurt, emphasizing that pain is a sign of a problem, when I asked a subset of the mothers I interviewed to rate the worst pain they had experienced while breastfeeding on a scale of 1 (no pain) to 10 (the worst pain I’ve ever felt in my life), the majority of women rated their pain at least 5, and one woman told me her pain was a 13. White women and richer women were more likely to report significant pain than African American and poorer women, in both interviews and other settings. This should not be taken to mean that women in these groups experienced less pain, as self-report is subjective.

Pain was also a topic that wealthier white women talked about frequently, in both groups and interviews. A 36-year-old white mother of one with an annual household income over \$100,000 told me in an interview that she considered herself someone with a high pain tolerance, explaining that she was active in sports and had broken bones in the past but found that breastfeeding was far more painful. When I asked her to tell me about the pain she had experienced while breastfeeding, she said, “I’ve had mastitis a lot and that was painful, and milk blisters are really painful. A lot of pain, a lot of pain, more pain than I would have ever - more pain than I thought the birth was. I never thought I would have so much pain throughout. I just didn’t think about how painful it could be.” Breastfeeding, she said, is “the hardest thing I’ve ever done in my life.”

However, while this mother had not expected such a high degree of pain, she also appeared to find the pain appropriate when she considered the high value of breastfeeding. “[E]verything that’s worth doing usually comes with pain,” she explained. Being a good mother,

according to the principles of intensive mothering, requires a mother to invest and sacrifice, and suffering physical pain is proof that a mother has done this. Mothers also talked about pain in support group meetings, and while sometimes it was clear that they were seeking solutions, other times mothers appeared to be looking only for acknowledgement and sympathy, rejecting offers of help. For example, one mother rebuffed offers of help by telling the group that she was already being treated by a healthcare practitioner, and another stated that her fair complexion and tendency to sunburn easily made her nipples more sensitive to pain (a breastfeeding-related version of the racist belief that people with darker skin are less sensitive to pain).

While African American women did sometimes talk about breastfeeding pain, in both interviews and group settings, they were less likely to describe pain as an indicator that breastfeeding was “worth doing” and to view suffering pain a sign of good motherhood¹⁰. Instead of talking in detail about their pain, African American women more often mentioned pain as an indicator of a problem, and then moved on. For example, a 30-year-old mother of one who identified as biracial (white and African American) began to explain why she used nipple shields for a short period by saying, “I was having some chapping issues and stuff.” When I probed and asked if she felt that the shields had been necessary at the time to remediate the chapping, she answered, “Definitely in the moment I was in so much pain, and yeah, so I felt it was helpful, and it was – it ended up being a bridge to a very successful nursing relationship.” In this response, she noted that the “chapping issues and stuff” were causing significant pain, something she had not found necessary to say in the beginning. After mentioning this pain once, she shifted the conversation back to the question of nipples shields, and her narrative continued

¹⁰ Indeed, some African American mothers were frustrated by white mothers’ tendency to talk at length about their pain and suffering at these meetings, as I described in Chapter 3.

without any further mention of pain. This was typical of the more matter of fact way most African American mothers talked about pain.

Like mothers who report spending more money than most on breastfeeding-related purchases, mothers who report experiencing more pain than most are often women who are struggling with breastfeeding. Just as financial sacrifices enabled mothers in the former group to claim the mantle of good motherhood, bodily sacrifices function in the same way for the latter group. Indeed, mothers who found breastfeeding difficult often fit into both categories, reporting both high expenditures and high pain.

5.5 Conclusion: Two Narratives of Good Mothering

More than twenty years ago, sociologist and Black feminist theorist Patricia Hill Collins explained the substratum beneath different ways of mothering: “Physical survival is assumed for children who are white and middle-class. The choice to thus examine their psychic and emotional well-being and that of their mothers appears rational. The children of women of color, many of whom are ‘physically starving,’ have no such choices however. Racial ethnic children’s lives have long been held in low regard” (Collins 1994:49). Most white, middle-class mothers, then, have the privilege of assuming that their children will live to adulthood. For them, protecting children’s physical selves is an afterthought, something that may become momentarily important when a baby spikes a high fever or a teenager stays out too late but otherwise remains in the background. These mothers worry instead that their children will be bullied at school, or that they will fall in love with the wrong person, or never fall in love at all.

And of course, most mothers are concerned about these things, African American or white, richer or poorer. Mothers want their children to find happiness. But while richer white

mothers are able to assume that their children will be physically safe and devote their resources instead to their children's emotional fulfillment, academic success, and future productivity, African American mothers, as well as poorer mothers and other mothers of color, must first ensure that their children survive. For African American children, this survival is much less certain. Protecting their children's physical well-being is thus a primary concern for their mothers, while other concerns are less important.

For African American mothers, then, protecting children from physical harm is construed as good mothering. Most mothers who integrate breastfeeding into this narrative of protection do so by referencing the breastfeeding's health benefits, which reduce the probability that an infant will succumb to disease. Some also value breastfeeding as a way to facilitate closeness and bonding, which allow mothers to more easily protect their children.

A second construction of good mothering, which is more relevant to richer white mothers, although it is not exclusive to this group, assumes that survival is a given and encourages mothers to invest fully in the intellectual and emotional development of their children. Breastfeeding, because medical experts have deemed it optimal for child development, becomes a necessary piece of good motherhood. To demonstrate sufficient commitment to the important work of mothering, mothers must "give until it hurts," as the saying goes, and sacrifice for their children. Two ways that mothers demonstrate sacrifice while breastfeeding are first, by spending significant amounts of money on breastfeeding-related purchases; and second, by enduring physical pain related to breastfeeding.

Chapter 6

Technology, the Pump, and the Body

6.1 “These Frickin’ Pumps!”

“These frickin’ pumps! I just want to throw them out of the window most of the time!”

The woman speaking to me over coffee was a doula who had worked with new mothers in the St. Louis area for over a decade, and she believed that in most situations, breast pumps were detrimental to establishing a breastfeeding relationship. Other breastfeeding professionals I spoke with shared this opinion, and at both of the lactation education trainings I attended (leading to certifications as a Certified Lactation Counselor and a WIC Breastfeeding Peer Counselor), facilitators expressed concern about the current emphasis on breast pumps in breastfeeding discourse. These trainers believed that early pump use can lead to breastfeeding failure, a contention supported by recent research (such as Forster et al. 2015)

However, most breastfeeding mothers today do use breast pumps, and they use them early. The Infant Feeding Practices Study II, a longitudinal study of U.S. women who were pregnant between May and December of 2005 and gave birth to a single term or near-term infant weighing at least five pounds, included a number of questions about milk expression (which in this study referred solely to hand or manual milk expression, or the extraction of breast milk by manipulating the breasts with one’s hands) and breast pump use. According to this study, 86% of mothers who were breastfeeding when their infants were 0-2 months old had pumped breast milk or attempted to do so (Centers for Disease Control and Prevention 2015:fig. 3.50). Half of these mothers began pumping when their infants were a week old or younger, presumably well before most would need to leave their infants to return to work (fig. 3.51). Hand expression was

comparatively rare: only 15% of these mothers had also expressed milk by hand (fig. 3.52). Premature infants were excluded from the study, eliminating the largest category of infants who would be medically unable to nurse directly at the breast. A more recent study of 40 breastfeeding mothers in Cincinnati found that 100% of the mothers expressed milk (Geraghty, Sucharew, and Rasmussen 2013). Likewise, all of the breastfeeding mothers I formally interviewed pumped milk at some point, although one mother reported that she only did so only for the first of her three children.

Because pumping is so ubiquitous, one might assume that the process is pleasant for women, but this is not the case. None of the women I met during my research enjoyed pumping. At best, a woman might tell me that she “didn’t mind it,” especially after she had been doing it for a while. More often, though, women said they “hated” to pump, or described pumping in terms like “such a pain!” or “just awful.” Many women in my study found pumping uncomfortable or painful, and some reported physical injuries to their breasts as a result of pumping. This is not uncommon: according to the Infant Feeding Practices Study II, almost 14% of pump-using mothers with infants aged 0-2 months old reported being hurt by their pump (Centers for Disease Control and Prevention 2015:fig. 3.59). Sore nipples were the most common injury, but almost 22% reported bruising and almost 2 % experienced infections (fig. 3.61). More than 11% of the mothers reporting an injury caused by a breast pump consulted a health care professional for treatment (fig. 3.62).

Why, then, do breastfeeding mothers pump their milk? The generally accepted answer, that women pump in order to ensure a supply of breastmilk to their infants when they are physically separated from these infants, is clearly true but also clearly insufficient. In fact, more than a third of mothers of seven month olds who pumped did not cite “To get milk for someone

else to feed to my baby” as one of their reasons for pumping (Centers for Disease Control and Prevention 2015:fig. 3.72). What else, then, is compelling women to pump?

I argue that lactation-related technologies, primarily breast pumps, have produced a new understanding of breastfeeding as a bio-technological process with the goal of maximizing milk production, one that requires the use of such technologies to be successful. Thus, my analysis adds a new dimension to medical anthropologist Robbie Davis-Floyd’s concept of “technocratic birth” by theorizing a “technocratic breastfeeding” (Davis-Floyd 1994). In this chapter, I detail four ways this Brave New Breastfeeding influences breastfeeding praxis. First, it suggests that mothers’ bodies are inherently untrustworthy, positioning milk extraction and storage as a way to guard against bodily malfunction and coercing increased attachment to pumps and other machinery. Second, it facilitates and de-stigmatizes milk sharing, disconnecting a woman’s milk from her body and creating an alternative to the defective technology of infant formula. Third, it privileges quantification, encouraging mothers to measure not only the growth of their babies but also the volume of milk they produce, tasks that require the use of technology. Finally, it allows mothers who find the physical act of breastfeeding intimidating or uncomfortable to breastfeed (or is it breastfeeding?) from a distance.

6.2 Meet the Pump

6.2.1 Today’s Breast Pumps

Breast pumps today are ubiquitous in American culture. They add humor to prime time television shows, such as when Rachel on *Friends* received a pump as baby shower gift and mistook it for a beer bong (Foss 2013). They humanize political candidates, exemplified by vice presidential candidate Sarah Palin’s description of juggling work and motherhood when she had

to “put down the BlackBerries and pick up the breast pump” in the middle of the night (Westfall 2008). Yet prior to the 1980s and 1990s, many breastfeeding mothers did not own or use a breast pump. My own daughter was born in January of 1993, and when she was young I was active in both real life and cyberspace breastfeeding communities such as La Leche League, the usenet group misc.kids.breastfeeding and the parent-1 email list, an international group with thousands of members. I never owned a pump, although I sometimes hand expressed small amounts of milk, and this was not uncommon among the breastfeeding mothers I knew who did not work full-time outside the home when their babies were young. Breastfeeding mothers who did work outside the home sometimes used piston-style manual pumps, which were ineffective and painful, or battery-operated single pumps, which were only marginally better.

Today breastfeeding mothers have more options. Most current breast pumps fit into one of three general categories: manual pumps, personal electric pumps, and hospital-grade electric pumps. The least expensive of these are manual breast pumps, which most often cost between \$20 and \$50 and can be used to pump from only one breast at a time. Manual pumps are generally very simple, typically consisting of some sort of flange that fits onto the breast and connects to a bottle and a simple air pump that is powered by squeezing the mechanism with one hand. Most women find that while manual pumps can be valuable for occasional use, they are tiring and time-consuming, and they are generally not as effective at extracting milk as electric pumps.

In my research, I found that electric pumps made for personal use were the most commonly used type of breast pump. Although both single and double electric pumps exist, the double pumps were much more popular among the women in my study. These pumps, which generally cost between \$150 and \$400, are larger than manual pumps. Some manufacturers

package them in a discreet reusable tote bag or small backpack. The more expensive versions of these pumps come with rechargeable batteries, so they can be used in places where women do not have access to electrical outlets. These pumps are easier to use and more efficient than manual pumps, and the lactation specialists I know recommend them to women who need to pump regularly and have a well-established milk supply.

The third type, hospital-grade electric pumps, are intended for use by multiple women at different times. All are closed system pumps, which means that the tubing and the parts of the pump that come into contact with a woman or her milk never touch the pump itself. This enables many women to use the same pump without risk of contamination, as each brings her own “kit” consisting of flanges, tubing, and connectors. While some personal use electric pumps are also closed system pumps, they are specifically marketed as single-user pumps.

Hospital pumps typically cost between \$1,000 and \$2,500, making them unrealistic purchases for most women. Instead, most mothers who use these pumps at home rent them. In 2014, monthly rental rates in the St. Louis area were between \$40 and \$80, depending on the pump style, plus an additional one-time cost of about \$50 for the kit. Often, women who rented hospital grade pumps had used the same brand of pump in the hospital after giving birth, and they had received a kit there. Hospital grade pumps are the most effective at extracting milk, and lactation specialists recommend them for women with supply issues and women who are exclusively or almost exclusively pumping (women who rarely or never feed their babies at the breast). However, these pumps are significantly larger and heavier than electric pumps made for home use, making them more difficult to transport, and the overall cost of renting a hospital grade pump will usually be that of purchasing a personal use pump if a mother breastfeeds for more than a few months.

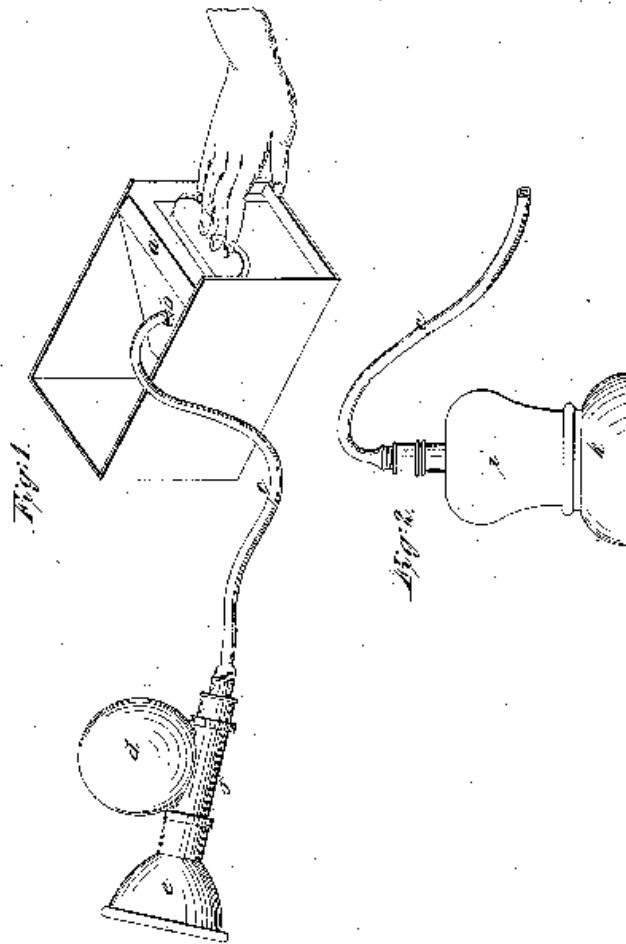
6.2.2 Pump History

The date of the first breast pump is unclear. Some scholars believe that *guttus* type ceramic vessels dating to the 6th to 5th century BCE were used not only as infant feeding implements but also as tools for extracting milk from a woman's breast (Obladen 2012). These vessels had two holes, and modern-day experiments demonstrated that a lactating woman could insert her nipples into one hole and then fill the vessel with water and stop it up with a finger. Intermittently allowing water to flow out created a suction that drew out the milk, which then collected in the vessel. During the Middle Ages, European women used a number of different pumps, including the *tiralatte*, which consisted of a glass with a large opening that was placed over the nipple and an attached rubber tube that the mother herself would suck. The *tiralatte* was considered a treatment for engorgement (a sometimes painful condition that occurs when breasts are overly full of milk), so the milk pumped thusly was not fed to an infant.

The first mechanical breast pumps were patented in the mid-nineteenth century and were, perhaps unsurprisingly, based on the design of milking machines for dairy cows (Garber 2013). Figure 6.1 depicts one of the earliest examples, invented by Orwell H. Needham and patented in 1854, which combined a manually operated air pump, flexible tubing, and an India rubber cup that fit over a woman's nipple (Needham 1854). Although Needham claimed that "the effect and sensation produced upon the nipple and breast are exactly similar to those produced by a sucking child," no documentation from a woman who used the pump exists to attest to this claim.

In 1923, Edward Lasker, an engineer who worked for a cow milking machine manufacturer, and Isaac Abt, a Chicago pediatrician who was concerned about the premature infants in his hospital who were too weak to feed at the breast, filed a patent for an early electric breast pump (Martucci 2013). Within a few years, their pump was considered essential for every

O. H. Needham.
Breast Pump.
No. 11,135. *Patented June 20, 1854.*



U.S. PATENT OFFICE: WASHINGTON: 1854.

Figure 6.1 Diagram from an early breast pump patent application (Needham 1854)

hospital, both to feed premature infants and to treat cases of mastitis and engorgement in nursing mothers. The ideology of scientific motherhood was still prevalent during this period, with its insistence on medical management of even routine infant and child care (see Chapter 2 for more on this history). Therefore, it seemed natural that these technologically sophisticated breast pumps must remain in hospitals, where they could be used under medical supervision, rather than sending them home with mothers.

In the 1940s, Swedish engineer Einar Egnell invented a double electric pump that more closely mimicked the sucking actions of an infant, with suction that stopped and started rather than being continuous (Martucci 2013). After years of testing prototypes in Stockholm's Södersjukhuset hospital, in 1961 Egnell founded Medela, today the world's most successful manufacturer of breast pumps (Martucci 2013; Pendleton 2015). In 1965, an American maternal health researcher approached La Leche League with promotional materials for Egnell's pump, which was then being marketed for home use through a rental program. (Martucci 2013) Although La Leche League showed some interest in this new pump, League newsletters from the seventies make it clear that the organization viewed pumps as medical devices and not something that should be adopted for general use.

With the continued increase in both breastfeeding rates and the rate at which mothers of infants worked outside the home, however, pumps grew in popularity throughout the 1980s and 1990s. In the United States, Medela's 1991 introduction of first vacuum-powered electric pumps marketed for home use revolutionized the industry (Lepore 2009). Compared with previous pumps, this one was both more efficient and more accessible to breastfeeding mothers. Five years later, Medela unveiled the more sophisticated Pump in Style pump model, marketed to professional women and the most popular pump among women I met during my research.

Overall, Medela's pump sales quadrupled between 1996 and 2009, while breastfeeding initiation rates increased by less than 15% during that same time period (Lepore 2009; U.S. Department of Health and Human Services 2011). Thus, while breastfeeding mothers have utilized pumping technologies for centuries, pump use has dramatically increased during the past 25 years, a shift that suggests fundamentally different breastfeeding praxis.

6.2.3 Accessing Breast Pumps

Although electric breast pumps had become common among breastfeeding mothers by the early twenty-first century, especially mothers who worked outside the home, the Affordable Care Act of 2010 increased the availability of pumps to many U.S. mothers. As of January 1, 2013, most insurance plans were required to pay for breast pumps for nursing mothers (Kliff 2013). The Act did not specifically define this requirement, however, and initially insurance companies interpreted its vague mandate in different ways. Blue Shield of California, for example, would only pay for the rental of a hospital grade pump, while United Healthcare gave women the option of either renting a hospital grade pump or owning an electric pump made for home use.

When I began my research in August of 2013, many of the women I met did not know that their insurance companies were required to provide them with free pumps, and therefore had purchased pumps themselves. Of those who did request the pumps, some women complained that their insurance companies required them to wait until after their babies were born to order a pump, and others were unhappy with the limited options they were offered. Most insurance companies required mothers to order their pumps from specific websites, and often the pumps they made available were stripped-down versions of commercially available pumps, which had

initially been produced for distribution through WIC clinics (Pendleton 2015). Three different lactation professionals told me about clients whose insurance companies would not pay for electric pumps at all, providing only manual or battery powered pumps. Still, the Affordable Care Act provision has clearly had increased rates of pump ownership among U.S. women. Medela, the best-selling brand of breast pumps in the United States, saw its sales increase by 34% in the first two years following the implementation of the pump provision (Pendleton 2015).

Although 31 states require Medicaid to cover breast pumps, Missouri is not one of them, and the Affordable Care Act does not apply to Medicaid recipients (Kliff 2013). During a meeting of the St. Louis Alliance for Breastfeeding in September of 2013, members who were familiar with Medicaid agreed that only one St. Louis Area Medicaid plan, Home State, would pay for breast pumps. Home State's 2013 Member Handbook states that it will pay for "[m]anual and/or electric breast pump for new mothers over 20 years old"¹¹ (Home State Health Plan 2013:31).

Most Medicaid recipients are also eligible for WIC benefits (see Chapter 3 for more about the WIC program), and WIC does provide breast pumps to many breastfeeding mothers. According to the Missouri WIC website, manual pumps are offered to any breastfeeding mother who may be occasionally separated from her infant; personal-use double electric pumps are offered to women who are exclusively breastfeeding at 4 weeks and are separated from their babies for at least 32 hours a week because of work or school; and hospital-grade electric pumps are offered to mothers who have premature or hospitalized infants, have given birth to multiples, or who are having breastfeeding problems and must return to work (DHSS 2016). This conforms

¹¹I was not able to find out why mothers who were less than 20 year olds were excluded, as this requirement appears to unfairly discriminate against a class of mothers who are already disadvantaged.

to the information I was given by Missouri DHSS Breastfeeding Coordinator Kathy Mertzlufft, at the WIC Breastfeeding Peer Counselor training in November of 2013. However, Mertzlufft also encouraged applying the guidelines flexibly whenever possible. For example, when a WIC employee at the training asked if she could offer an electric pump to a breastfeeding mother who was only working 25 hours a week Mertzlufft was quick to approve, provided that the employee's WIC office had enough pumps available.

Indeed, according to WIC employees I spoke with, the availability of pumps was an important determinant of who received a pump. Many WIC offices had difficulty maintaining their inventory of hospital grade pumps. A WIC peer counselor told me: "In our whole book, we have like 75 different pumps. At the office, the most we ever have is eleven. Most of them are lost, fell off the face of the planet, people moved to Colorado and are homeless now, people got evicted and lost all their stuff, like, I mean, they just disappear." At the WIC training I attended, I heard about a moth infestation rendering one office's hospital grade pumps unusable.

As described above, the breast pumps available to WIC clients are generally not the popular commercially available pumps, but are instead bare-bones versions made specifically for this market. Some lactation professionals have found that these stripped-down pumps are less effective at extracting milk (Pendleton 2015). WIC employees reported to me that these pumps seem poorly made and break easily. The same WIC peer counselor quoted above described the frequent problems her clients had with their personal-use pumps (this office distributed Hygeia pumps): "The Hygeia, the moms like, we end up loaning them pumps because their Hygeia quit working. If they're working full time, they're pumping three times a day, then the motor's gone bad." While these lower quality breast pumps may increase profits for companies, they perpetuate the disparity in health care between wealthier and poorer mothers, as mothers who

cannot pump the milk their infants need may simply stop breastfeeding. I also found that wealthier women sometimes purchased a commercially available pump when the insurance-provided pump was ineffective, again increasing pump company profits.

6.3 The “Stash”: Freezers Full of Breast Milk

“Building a stash” was a frequent topic of discussion at the Sweet Acacia breastfeeding support group. By “stash”, the women were referring to a stockpile of frozen breast milk stored in either a home freezer or, preferably, a deep freezer (chest freezer) because they were aware that milk stored in a deep freezer lasted longer before it “expired”. The milk was typically stored in some sort of small plastic bag, either bags made specifically for this purpose by companies like Medela or sometimes simply in sandwich bags, which were considered cheaper but more likely to leak or allow freezer burn. Pictures of large stashes were sometimes posted on the group’s Facebook page, similar to the one in Figure 6.2, and they received numerous “Likes” and positive comments.

Women usually started building their stashes within the first month after their babies were born, and some started as soon as their milk came in, a few days after giving birth. Many women expressed frustration with their lack of pumping success during the early weeks, although this is not surprising as newborns generally nurse very frequently (as often as hourly) and ingest very small amounts of milk at a time (Bergman 2013). On the group’s Facebook page, women would sometimes post pictures of how much they pumped during a particular pumping “session” along with the number of ounces, either to celebrate a particularly good output or to express frustration about a number they perceived as too low.



Figure 6.2 Freezer stash of breastmilk. Source: <http://happeningsoftheharperhousehold.net/2012/07/friendly-debates-with-the-danielles-donated-breast-milk/>

At support group meetings, mothers often asked for help in increasing their milk output. One frequent suggestion was to wake up earlier in the morning for an additional pumping session, because milk supply is usually highest then, even though lack of sleep was also a frequent complaint. Many women recommended foods or herbal supplements intended to increase supply, sometimes sharing recipes for “lactation cookies.” These recipes varied but frequently included oatmeal, brewer’s yeast, flax seed, and chocolate (although some women clarified that the chocolate was more for taste than as a galactagogue). Although sometimes group members proposed solutions related to the pump, such as purchasing or renting a more

effective pump, checking or replacing the pump membranes or tubing, or having the pump motor tested at Sweet Acacia (a service the business provided free of charge) to make sure it was still working well, more often the body itself was targeted for interventions. This reflects the idea of a woman's body as a machine that requires repair in order to produce properly, as described by Emily Martin and then applied to breastfeeding by Fiona Dykes, although here fixing the breasts is more removed from the medical realm (Martin 2001; Dykes 2005).

The biggest driver behind creating a stash was the fear of running out of breast milk. Mothers feared that they wouldn't be able to produce enough milk for their babies at some point and would be forced to supplement with formula, so they wanted to create a reserve¹². For some mothers, this was directly connected with having to leave their babies and return to work: they feared that their bodies would not respond as well to the pump as to their babies, so they would not be able to pump as much milk as their babies needed. Other mothers were concerned that their bodies would produce less when they started regularly leaving their babies for an entire workday, and at that point they would no longer be supplying a sufficient quantity of milk.

Mothers who did not return to work also worried about running out of milk. Some were concerned about occasional "low supply days" when their bodies might fail to produce enough milk, while others were concerned about their milk supply in general, worrying that their bodies would mysteriously produce less and less milk as time went on. Finally, some just wanted to be able to be prepared if they were unable to breastfeed for a short time, such as leaving their babies

¹² In Chapter 4, I discussed some of the literature on the perception of insufficient milk supply, which is relevant to this chapter as well

with another caregiver for a short time or drinking enough alcohol that they felt unsafe to breastfeed.¹³

In short, breastfeeding mothers worry that their bodies will fail, and technology allays this fear. “What if I wake up one morning and no milk comes out?” asked the nursing mother of a two month old at a support group. Although the other members and facilitator were quick to assure her that “breastfeeding doesn’t work that way,” one woman piped up to contradict them, saying that she knew a woman who experienced exactly that. The academic literature on breastfeeding does not include any similar cases, at least none that I was able to find, but whether this story was an actual occurrence, an urban legend, or a blend of the two, it clearly resonated with some mothers. Because they could not consciously control their breastmilk production, could not will the milk to appear, there was always a fear that their bodies would suddenly run dry and there would be no more milk. Most realistically, mothers worried that their milk production would dwindle slowly, until they could no longer satisfy their babies. In either scenario, bodies were the potential problem and technology was the solution. Pumping and storing milk is a safeguard against the possibility that a woman’s body will prove to be deficient.

Having milk stashed in the freezer is protection against future insufficiency, and the more milk the better. Both supply and demand may fluctuate over time. Because demand is outside of their control –the mothers I met during my research generally agreed that babies had “growth spurts” (an idea validated by Lampl, Veldhuis, and Johnson 1992) during which they would

¹³ The question of how much alcohol one could drink and still safely breastfeed was highly contested among the women I met during my research. Although research demonstrates convincingly that the breastmilk of even an extremely intoxicated mother would not contain enough alcohol to affect her baby (Haastrup, Pottegård, and Damkier 2014), many mothers would not breastfeed for eight hours or more after only one or two alcoholic drinks, a position reinforced by commercial products such as breastmilk alcohol level test strips.

suddenly require much more milk than before – the best way to guard against running out of milk is to focus on supply. While mothers do what they can to increase their milk supplies, eating foods or taking herbal supplements they believe will increase milk production as well as nursing frequently and making sure they have sufficient “skin to skin” time with their babies, none of these practices comes with any guarantee. The best way to ensure that they will have enough milk to meet their infants’ future needs is to pump it and store it away (and even that can fail, if a freezer breaks or the electricity goes out, both of which happened to more than one woman during my research).

Breastfeeding mothers, then, are mitigating potential bodily insufficiency through the use of technologies such as breast pumps (as well as accompanying items such as deep freezers), in order to avoid the use of infant formula, an older technology created for the same purpose. As discussed more fully in Chapter 2, the initial ascendance of infant formulas was correlated with the rise of scientific motherhood, an ideology that saw the scientific assembly of ideal infant foods by medical experts as necessarily superior to the seemingly haphazard production of breast milk by bodies of overly emotional and excitable women. We now know that breast milk is actually very finely attuned to the requirements of each individual baby, and that its composition is almost constantly adjusting to current circumstances (Ballard and Morrow 2013). As it has become more evident that technology cannot create a better product, technological efforts have shifted from product to production, and while some women do express concern that their milk is not “rich enough” or “healthy enough” for their babies, they were far more concerned about the quantity than the quality.

This attachment to milk stockpiles was far more prevalent among middle or upper class mothers, and income was a more important determinant than race. This is perhaps unsurprising

given the difficulty some lower income women have acquiring pumps and other breastfeeding technologies. While economically privileged women generally revealed any formula use early on, it was common for low income breastfeeding mothers to simply not mention that their infants were also getting some formula until it came up peripherally in conversation. I never felt that this was being consciously hidden from me, but rather that they defined any breastfeeding as breastfeeding and did not consider some formula use especially relevant. While these mothers agreed that breastmilk was better than formula, they believed that the breastfeeding they did provided their babies with the important benefits and formula was simply a neutral substance that could be given when breastfeeding was not practical or convenient, rather than a polluting substance. Few pumped regularly, and the focus on large milk stashes was largely absent.

6.4 Milk Sharing as an Alternative to “All the Crap that’s in Formula”

Many richer breastfeeding mothers in my study considered formula very risky: it was “made in a factory” with lots of people and therefore possibly contaminated; it had “all those chemicals” in it; and it was bad for an infant’s gut flora. Although some lower income women believed that as long as their babies were receiving some breastmilk, their babies would receive all of the benefits of breastfeeding, richer women saw infant formulas as necessarily polluting, even if babies were also receiving breastmilk. News stories about contaminated formula and formula recalls only added to this fear, even when the stories came from as far away as China (Huang 2014). “If I gave my baby formula and something happened to her, I could never forgive myself,” said a mother at the Sweet Acacia support group during an informal discussion of one such news story, and while not all of the other group members shared her sentiment, many nodded in agreement. This conceptualization of infant formula as risky and dangerous conforms

to previous social science research with breastfeeding mothers (Murphy 2000; Lee 2008; Knaak 2010).

All of the mothers in this group viewed their own pumped milk as safer than formula, and many agreed that in general, another breastfeeding mother's milk was also safer. Although milk banks, which primarily provide milk to premature and medically fragile infants, pasteurize and carefully test all donated milk before distribution (Human Milk Banking Association of North America 2016), none of the 15-20 mothers I met who participated in informal milk sharing did any sort of formal testing or processing, although they did ask the donor about medications and about how the milk had been collected and stored if she was not someone in the recipient's immediate social circle. One mother who received milk from at least three different donors asserted, "Moms don't do things to their babies that hurt them," which she saw as especially true of breastfeeding mothers who were willing to share their milk. The sharing aspect was important to them, as most agreed said that they would never buy breastmilk – in general, they viewed women who would sell their milk as morally suspect and as exploiting mothers who were struggling to produce enough milk. The idea that trust and altruism are central to the practice of contemporary milk sharing (as opposed to milk selling) is also supported by more comprehensive recent research (Palmquist 2015; Gribble 2014).

Lauren, a 29-year-old white mother of two, was an emphatic supporter of milk sharing. She struggled with a low milk supply from birth with both of her children, a problem she believed was a result of her polycystic ovary syndrome, hypothyroid, and insufficient glandular tissue. She felt that she had no choice but to wean her older child to formula early on, because her son was not gaining weight and breastfeeding was extremely painful. When her second child was born, she felt more prepared, and with the help of a birth doula she was able to breastfeed

this baby within an hour of giving birth. At first it seemed that everything was going well, but her daughter also failed to gain weight and needed supplementary feeding. Lauren initially supplemented with her own pumped breastmilk, which meant a grueling schedule of nursing and pumping, but this exhausting regimen eventually proved to be too much for her.

Before telling me about the first time she fed her second child a bottle of formula, Lauren warned me that she would probably cry, and while there were no actual tears it was clear that this was a difficult thing for her to recall. “It’s not that formula’s awful,” she said, “It’s just not what I wanted.” She was concerned about “all the crap that’s in formula” and continued to put her daughter to the breast every time she fed her, but she was also supplementing with a couple of ounces of formula at each feed. She “didn’t feel good” about giving her daughter formula, and when she first saw donor milk being exchanged at a Sweet Acacia group she was intrigued and looked online for more information. Lauren found a post from a woman who had a stash of frozen milk that she was trying to give away on a Facebook group set up to facilitate informal milk exchanges and began corresponding with her. Lauren told me that she asked the donating mother “if she was on medication, or you know, like if she drank or she smoked” but added that she probably would have accepted the milk even if the other mother drank alcohol, because Lauren also enjoyed a beer now and then. When she went to pick up the milk for the first time (a hundred ounces), Lauren admitted that she was nervous, but added, “The thing that helped make it okay in my head was like, this woman is feeding her own child this milk.”

To Lauren, the risk that another mother would intentionally or even thoughtlessly harm her baby was not a significant concern, and she went on to accept donor milk from other donors, two of whom were able to make regular donations. By the time she was four months old, Lauren’s baby was drinking only breast milk. “It’s spectacular. I love it!” Lauren said of donor

milk. On one occasion, she was given another woman's stash of hundreds of ounces of donor milk and wrote ecstatically about it on Facebook, posting a picture showing a freezer filled with tiny bottles full of milk. Lauren continued to combine nursing with bottles of donor milk until her baby was over a year old, and she recently shared that her 22-month old daughter was still breastfed.

While milk recipients like Lauren sometimes screened their donors to ensure that the milk was safe, especially mothers they did not personally know, donor mothers sometimes screened recipients for moral worthiness. Echoing the previous chapter's good mother narratives, a 29-year-old mother of one told me that a milk recipient should be putting significant effort into increasing her own milk production, usually through frequent pumping. At the time of our interview, she had given stashes of over 100 ounces each to three different women. She described her rationale for deciding who to give her milk to by saying, "I'm kind of picky about who I give my milk to. I don't want you just to be, like, not working that hard, or not pumping, like, you want to sleep six hours and you don't want to get up and pump, and I'm like, 'Dude, you do your hard work and then I'll give you some extra milk too.'" She admitted that this sounded "sort of judgmental," but she justified her viewpoint by explaining that many mothers were looking for breastmilk, so she believed it was important to reward those who were most invested in their children's wellbeing.

While two of the mothers I interviewed had directly breastfed other children, many more had participated in informal milk sharing arrangements. Indeed, for some mothers breastfeeding another woman's child was taboo, and in one support group where it was discussed, fewer than half of the mothers who were present were even hypothetically willing to do it. Lauren regularly fed her daughter bottles of breastmilk during the Sweet Acacia support group, even when women

who had given her pumped milk were at group as well and could presumably have breastfed her baby directly, or at least attempted to do so. While pumping and freezing milk is logistically easier than setting up a wet nursing arrangement, these technologies also create a separation between the lactating mother and the infant. The more intimate act of breastfeeding is replaced by the more mechanical act of pumping, which in turn replaces the defective technology of infant formula.

6.5 Quantification and Breastfeeding: Measuring Motherhood

In this new bio-technological world, breastfeeding is eminently measured and measureable. Various technologies are used to quantify breast milk production. The methods recommended to most mothers by medical professionals such as maternity nurses or pediatricians, as well as by lactation specialists, involve tracking the baby's output (counting both wet and soiled diapers), the number of times the baby is put to the breast, and the interval between feedings. If these numbers match the expected minimums for a baby of a certain age, breastmilk production and intake are deemed adequate. Most mothers are given a form for tracking some or all of these indicators in the hospital, a very low-tech method, although now many apps make this task easier (Figure 6.3). This is a relatively crude and indirect measurement of milk production, however, and this information is often not enough to reassure a mother that she is making enough milk.

Weighing a breastfed baby gives a somewhat more precise measurement of a mother's milk output: if a baby is only ingesting breast milk, it stands to reason that the more milk he drinks, the more weight he will gain. Especially for newborns, household scales meant to weigh

adults are notoriously inaccurate, so special baby scales are preferable. The most sensitive baby scales are accurate to a tenth of an ounce. These are usually only found in hospitals and doctors' offices, or baby supply stores may make them available for rental (Sweet Acacia had one such rental scale, as well as scale in the store that was free to use).

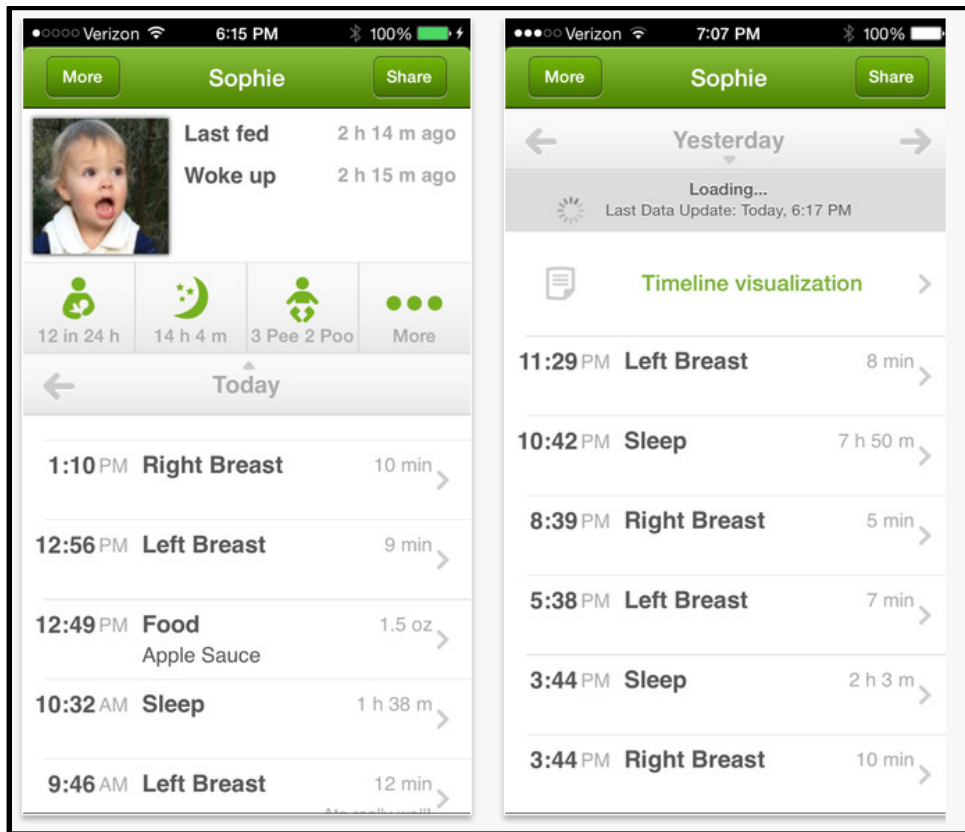


Figure 6.3 Baby by Smallnest iTunes App. Source: <https://itunes.apple.com/us/app/baby-by-smallnest-track-breastfeeding/id491236385?mt=8>

Mothers can also use these extremely precise scales for a procedure that breastfeeding mothers called a “weigh-nurse-weigh,”¹⁴ which measures a baby’s intake at one specific feed. To

¹⁴ This is derived from the protocol for test weighing (Scanlon et al. 2002)

do this, a mother will undress her infant to his diaper and weigh him, and then note the exact weight. Immediately afterwards she will breastfeed her baby, and then she will return him the scale wearing the same diaper, which she will take care not to change until after weighing. By subtracting the original weight from the new weight, she has a reasonably accurate measurement of the weight of the milk transferred during that particular feed. This method was very popular among the Sweet Acacia mothers, but because it gave only a snapshot and did not necessarily represent an average feed, it did not give a full picture of milk production. A company called MilkSense claims on its website (<http://milksense.com>) that its Breastfeeding Monitor can accurately measure the amount of milk in a mother's breast both before and after breastfeeding, but evidence of accuracy is lacking.

In short, then, measuring breastmilk that is transferred directly to the baby at the breast is difficult. In contrast, quantification of breast milk extracted by a pump very simple. Milk is typically pumped directly into a receptacle that is clearly marked with lines for ounces and half-ounces (Figure 6.4), and sometimes for milliliters as well. It is not only easy to measure pumped breastmilk; it is also nearly impossible to avoid measuring it. These ubiquitous measurement marks quite clearly reinforce the message that it is important for a woman to know how exactly much milk she has pumped, that precise quantification matters, and matters a lot. In support groups, some women reported that seeing how many ounces of milk they were accumulating (or not accumulating) while pumping was so stressful that they would cover their milk receptacles with a blanket or sweater until they were finished, because only then could they relax enough for their milk to let down. Still, at some point every woman sees what she has produced, and for most the result had a direct emotional impact: a large quantity of milk led to feelings such as pride, happiness, and relief, while a particularly lackluster session brought anxiety, frustration,

and feeling “like a failure”. Accumulating milk, then, is an important way in which to quantify breastfeeding success.



Figure 6.4 Ameda Purely Yours breast pump.

Source: <https://www.amedadirect.com/ameda-purely-yours-breast-pump.html>

After pumping milk, most mothers initially stored it in a refrigerator or cooler, then transferred it to a freezer at the end of the day. Milk was usually frozen in bags, as noted earlier. Most mothers tried to store a standard amount of milk in each bag, typically either two or four ounces, so that they could quickly see exactly how much milk they were pulling out for a feed.

Frozen milk bags were usually dated, to make it easier to see which were oldest and to check for expired milk (among the breastfeeding mothers I met, the generally accepted recommendations for the maximum length of time that milk could safely be stored were up to 6 days in the refrigerator, 6 months in a regular freezer, and up to a year in a deep freezer, which roughly matches the guidelines put forth by governmental agencies and medical experts).

Most women kept careful track of their milk stashes. Some knew exactly how many ounces they had frozen and would report these numbers in support groups, adding their concerns about whether or not this was enough. Stashes of 300 ounces or more, which not necessarily typical, were not rare. The Sweet Acacia group leader, Jackie, reassured mothers that they only needed to store enough milk for a day or two stashed, because when they were at work they would be pumping to replace the milk their babies ate while they were apart, so each day they would come home with milk for the next day. While a few mothers took her words to heart, most remained concerned, searching for the exact number of ounces that they needed to have in order to guarantee that it would be enough. Today, there are also apps that both track pumping and determine when a stash is sufficient, assuming that current rates of consumption and production continue (Figure 6.5).

Nancy Mohrbacher, an IBCLC, has developed a “teaching concept” she calls the “Magic Number” (2011). This number, which depends on both breast storage capacity and breast fullness, represents the total number of times a breastfeeding mother who is not exclusively feeding her infant at the breast should remove milk for her breasts in a 24-hour period (through either nursing or pumping) in order to ensure an adequate milk supply. For example, a mother with a magic number of seven could nurse her infant once before leaving for work, pump three times during the day, and then nurse three more times after returning home.



Figure 6.5 Pump Log app. Source: <https://itunes.apple.com/us/app/pump-log-track-breast-milk/id814112299?mt=8>

While some aspects of breastfeeding have long been quantifiable and quantified, this capability to quantify has increased dramatically since the pump-driven technological shift. However, while the pump made measurement easier, quantified breastfeeding is also intelligible as part of the growing trend of the “quantified self.” This term, created in 2007 by *Wired* magazine, refers to the use of technology to track and analyze one’s physical being, using tools such as fitness trackers and genetic testing (Lupton 2013). These ideas extend Foucault’s concept of technologies of the self, which referred to practices of self-monitoring and self-management

and asserted that in modern society, the directive to know oneself has superseded the charge to take care of oneself (Foucault 1988). Privileging information over subjectivity, however, privileges medicalized understandings of breastfeeding and thus frames the lactating body as chaotic and requiring discipline: breastfeeding or pumping must happen the correct (or “magic”) number of times each day, and women must produce the proper amount of milk.

6.6 Planning to Pump: “I Don’t Think I Could Nurse Direct”

Although the practices detailed in the three preceding sections were more common among white and richer women, I did find evidence of a fourth technologically-driven practice, planned exclusive pumping, that appeared more common among poorer women, primarily poorer African American women. My data is not robust: two interviews with mothers, one informal conversation, and one interview with a WIC peer counselor. However, I include this in my dissertation as a catalyst for theoretical discussion and potential future research.

While I did meet a number of richer white women who were feeding their infants only pumped milk and never feeding them at the breast, a practice they called exclusive pumping or EPing, none of them had planned to feed this way. Instead, they were EPing because they could not feed their babies at the breast for one reason or another, usually related to the infant’s inability to latch correctly. In contrast, two African American women with household incomes below the Federal Poverty Level told me when they were pregnant that they were considering only feeding pumped milk. One, who was 20 and pregnant with her first child, said, “Someone also told me that it’s easier if you pump instead of letting them latch on to the breast.” The second, who was 24 and had two older children, neither of whom she had breastfed, said, “It’s not as painful if you just pump it and give it to them, bottle feed it to them.” During a

conversation at a maternity home for mothers in crisis, a white woman who had breastfed her three children badgered a pregnant African American woman who did not plan to breastfeed until the pregnant woman finally said that she might pump for her baby, as long as he didn't actually have to suck on her breast.

These three statements suggest two concerns driving the desire to only pump: the perceived difficulty of breastfeeding and the perceived sexuality of breastfeeding. These are the same issues the white WIC peer counselor identified in mothers she counseled. On the perception that pumping is easier, she said, "We do have electric pumps that we loan out to moms, and I can't tell you how many moms I've seen where they come it really early postpartum saying I want to pump, because they think it's just going to be easier, just to pump and give a bottle, so we issue them a pump and lo and behold, before you know it they've weaned. Because the pump just is not easier. It's double the work." When she discussed sexuality, she said, "They're not comfortable – again, that's where sexuality plays in to all of this. I'll have moms where, you know, they'll say, 'Oh, it's just weird. I could maybe pump, but I don't think I could nurse direct, you know, baby on my boob.'" This peer counselor worked at a WIC clinic in an ethnically and racially diverse part of St. Louis city, but she told me that African American mothers were more likely to choose to exclusively pump.

These mothers attempted to use pump technology to mediate their infants' access to breastmilk. While they perceived breastfeeding itself as too difficult and intimate, they viewed technology positively and felt more competent to use a breast pump and bottle feed than to breastfeed. A study of low-income, pregnant, and primarily African American mothers in Cleveland provides some insight: the mothers who participated were knowledgeable about breastfeeding's health benefits, but they had very little understanding of the process of

breastfeeding (Alexander, Dowling, and Furman 2010). Like the two mothers I interviewed, they were afraid it would be painful or difficult. In this way, poorer mothers who did not have access to the same information resources and experiences as richer mothers attempted to compensate for this disparity through a technological fix.

6.7 Attaching to Technology: Two Implications and a Conclusion

6.7.1 All About That Milk

Technocratic breastfeeding has two important implications. First, the focus on accumulating milk with a pump and sharing it or storing it in a freezer privileges the idea of milk as a product over that of breastfeeding as a process. This is a reductionistic view, one that views the milk itself as the essence of breastfeeding. The more holistic perspective would consider everything that breastfeeding entails: the closeness and physical contact between mother and infant, the physiologically specific way the infant must use his mouth and jaw in order to extract milk, the shift in milk flow in response to the infant's sucking and the mother's responding let-down, the hormonal responses in the mother's body, and more. This is not to say that some of these cannot also be present when bottle feeding an infant, but they must be intentionally added, rather than existing as essential parts of the process. While research comparing the health outcomes for infants fed only at the breast to those fed pumped breastmilk is sparse, a few recent studies suggest that feeding pumped milk does indeed have potentially deleterious effects when compared to feeding at the breast. For example, coughing and wheezing may be correlated with feeding pumped milk (Soto-Ramírez et al. 2013), and infants fed expressed milk gain weight more rapidly than those fed only at the breast (Chapman 2012). I could find no studies that

specifically examined the effects of pumping on a mother's health, when compared to feeding her baby at the breast, another avenue for future research that should be explored.

Conceptualizing milk as a product then, does not serve mothers and babies particularly well. It does, however, serve the interests of our capitalist economic system in two ways. First, it allows mothers to work at jobs outside of the home while simultaneously providing their infants with breastmilk, pressuring them to become the character that sociologist Linda Blum called the "career-breastfeeding Supermom" (Blum 2000:59). While most countries provide all mothers with paid maternity leave (Kurtzleben 2015) and many provide them with guaranteed paid breastfeeding breaks at work (Heymann, Raub, and Earle 2013), the United States offers neither, although since 2010 a federal law in the United States has mandated that most women have the right to unpaid pumping breaks at work (Murtagh and Moulton 2011). Although this law is often framed as a victory for women, and indeed the women I met during my research generally viewed it as such, it also serves to support increased separation between mother and infant, in contrast to the laws in other countries that mandate that women can have her baby brought to her at work for breastfeeding. Mothers who pump essentially add an hour or more of unpaid labor to their work day, time spent pumping, setting up and putting away pumps, storing milk, and cleaning pump parts and milk containers.

Second, the conceptualization of milk as a product requires women to engage in the capitalist economic system by purchasing items perceived as necessary in order to successfully manage that product. Although some items are frequently purchased by most breastfeeding mothers, regardless of pumping practices (see Chapter 5 for more on items purchased for breastfeeding), others are only used when pumping. In addition to one or more pumps, mothers in my study bought breastmilk storage bags, "hands free" pumping bras, car adapters for pumps,

milk collection cups for collecting any milk that leaked between pumping sessions, deep freezers, travel coolers, and replacement parts for pumps. Breast pumps and accessories are a very lucrative business today. According to a recent article in Bloomberg Business, “Breast pumps and accessories such as bottles made up 90 percent of closely held Medela’s revenue of 577 million Swiss francs (\$630 million) in 2014” (Pendleton 2015). Medela is only one of the growing number of companies competing for these dollars, and its revenue has continued to climb.

6.7.2 Insufficient Bodies

A second implication of the attachment to technology is the assumption that bodies, and particularly women’s bodies, are insufficient. Lactating bodies required meticulous technological management to guard against failure, and without this they could not be trusted to continue to produce a sufficient amount of milk. Some women managed their recalcitrant breasts through smart phone apps that sounded alarms whenever it was time to pump or nurse, as well as tracking the feedings and pumping sessions, while others did the same with computer calendars or alarm clocks. Although scheduled feedings have long been a salient topic in infant care, previous discourse focused almost exclusively on the needs of the baby rather than the mother and her breasts. At least for young infants, scheduled feedings are no longer recommended and feeding “on-demand” is now the AAP and WHO recommendation (AAP Section on Breastfeeding 2012), but many women do not trust that the infant’s desired feeding schedule will be sufficient to build and maintain their milk supplies.

As medical anthropologist Robbie Davis-Floyd wrote in her discussions of the technocratic model of birth, “Because of their extreme deviation from the male prototype,

uniquely female anatomical features such as the uterus, ovaries, and breasts, and uniquely female biological processes such as menstruation, pregnancy, birth, and menopause are seen as inherently subject to malfunction” (1994:1126). Although breastfeeding was not included in her list of “uniquely female biological processes”, one could quite easily situate it there. Davis-Floyd found that the modern American obstetric practice was “technocratic” in that it privileged scientific knowledge and models, and that in contrast to the more predictable and dependable male body, the female body is “an abnormal, unpredictable, and inherently defective machine” (1994:1127).

Davis-Floyd described how medical technologies function as “prostheses” in the birthing process, performing tasks once done by bodies. By the same logic, breastfeeding has also become a technocratic process, and technologies such as breast pumps and breastmilk storage and feeding apparatus are the prostheses that are replacing some of the functions of the messy and unreliable female body. While Davis-Floyd and others (Dykes 2005; Martin 2001) have analyzed the female body as a “defective machine,” I suggest that women do not view their bodies as machines at all, and it is this that makes these bodies insufficient. Today, defective machines are knowable and repairable: I have replaced the hard drive in my computer twice while writing this dissertation, for example. Bodies refuse to be machines: they are messy and chaotic. Technological prostheses do not replace defective machines but instead discipline and quantify unpredictable bodies, creating not a better machine but a better body, or perhaps a cyborg (Haraway 1991)

6.7.3 Conclusion

In 1989, medical anthropologist Penny Van Esterik wrote about the unanticipated and unattended effects of the new technology of feeding bottles of formula in countries in the Global South (Van Esterik 1989). Drawing on engineer Mary Anderson's framework for understanding technology transfer, she described the ways feeding bottles influenced the "doer" (who fed infants), the location (where infants were fed), the timing (when and how frequently infants were fed), and the skills and knowledge (what information is necessary to feed infants in this way). Breast pumps also affect infant feeding in all four of these domains, and it does so doubly, influencing both the extraction of the milk and its later feeding. The pump becomes the doer, in reference to extraction, and most often another caregiver becomes the doer for feeding. Extraction and feeding take place in different locations, sometimes thousands of miles apart (Boyer 2010). Milk extraction is often scheduled based on the needs of the workplace, rather than in response to the mutually constituted dance of infant hunger and maternal breast fullness. While most caregivers feed pumped milk based on infant hunger cues, there is also pressure to time feedings to avoid running out, and particularly to avoid feeding pumped milk when the infant's mother will be returning shortly. Finally, as described in this chapter, pumping milk requires a great deal of knowledge: how to use the pump without causing injury, how to make one's milk "let down" (begin to flow) when pumping, how to store pumped milk, and so on. Feeding pumped milk also requires specialized knowledge: how to reheat stored milk, how to bottle feed without undermining breastfeeding (Kassing 2002), what bottles to use, and more.

While modern breast pumps have undoubtedly allowed many breastfeeding mothers to provide breastmilk to babies in situations where this would not have previously been possible, they have also changed and shaped breastfeeding in ways that were not anticipated, and they

have changed the very way we think about breastfeeding. As someone who breastfed in the era just before near-universal pumping and technocratic breastfeeding, I found myself well-positioned to appreciate the enormous impact of this transition. In 1993, the breastfeeding mothers I knew envisioned a future with paid maternity leave, on-site childcare centers, infant-friendly workplaces, and accessible and competent lactation support. While all of these do exist, they are rare, and we in many ways are compensating for this lack with breast pumps. Women and infants, I believe, deserve better.

Chapter 7

Conclusion: Contributions and Recommendations

7.1 Review of Key Arguments

I began this dissertation by talking about the idea of attachments, which I defined as the web of connections that situates each person in the world. I divided attachments into three overlapping levels: intrapersonal attachments to beliefs and ideas about oneself; social attachments to the morals and norms of one's family and community; and macro-level attachments shaped by large-scale structural and ideological forces. Using the data that I collected about these attachments, I analyzed breastfeeding praxis. In the greater St. Louis, Missouri, area, my research site, racial and socioeconomic disparities have a significant impact on lived experiences, including the experience of breastfeeding, and my dissertation spotlighted many of these effects.

In the first section of this chapter, I review the key points of my dissertation by briefly summarizing each chapter. The second section spotlights two key theoretical contributions of my dissertation: first, I augment current knowledge about the ways racism creates and perpetuates health disparities by identifying some ways that racism influences breastfeeding in St. Louis; and second, I extend ideas about the relationship between capitalism and breastfeeding by adding the direct costs of breastfeeding. In the final section, I translate these into policy recommendations that I believe will improve the subjective experience of breastfeeding for women, which will then result in increased breastfeeding rates.

The first two chapters of my dissertation situated my research geographically, theoretically, and historically. In Chapter 1, I introduced my project and then opened with an

ethnographic vignette highlighting the ways race and racial bias influenced local efforts to promote breastfeeding. I described my research setting and methods, and I reviewed the literature relevant to grounding my own project. In Chapter 2, I detailed and analyzed the history of infant feeding in the United States, pointing out key ideological themes that were relevant to some of the attachments I identified in my later analysis.

In my third chapter, I examined the racialized and classed landscape of breastfeeding resources in St. Louis city and county. I argued that poorer and African American breastfeeding women were disadvantaged by both the quantity and type of help available to them. Chapter 4 took up the dominant construction of breastfeeding as natural and analyzed the ways this was understood and interpreted by local women, drawing out patterns and examining both the causes and effects of these different local meanings.

My fifth chapter analyzed two constructions of good mothering and the role that breastfeeding plays in each. In the first, which defines good mothering first and foremost as protection, breastfeeding is viewed primarily as way to prevent sickness and secondarily as a means to facilitate closeness between mother and child. In the second, which is informed by the intensive mothering paradigm, good mothering is demonstrated through a mother's self-sacrifice in order to carry out practices such as breastfeeding believed to lead to optimal child development. The first is more prominent among African American mothers, whose children's survival is less certain, and the second among richer mothers.

In Chapter 6, I argued that breastfeeding in the United States has become technocratic, as breast pumps and other technologies have become mandatory for breastfeeding mothers. This informs an understanding of lactating women's bodies as defective and subject to malfunction, and thus requiring of mechanical prostheses such as pumps. While pumps and other technologies

are generally viewed as beneficial because they facilitate the provision of breastmilk to infants who otherwise would not have access to it, I contend that pumps are a flawed solution to larger structural problems.

7.2 Theoretical Contributions

Racism can be theorized as occurring at three levels: individual racism, perpetrated by a racist person or social group; institutional racism, perpetrated by a social or governmental institution; and structural racism, which is cumulative and caused by the interactions among various institutions (powell 2007). In their article about the effects of structural racism on health, Gilbert Gee and Chandra Ford define structural racism as: “The macrolevel systems, social forces, institutions, ideologies, and processes that interact with one another to generate and reinforce inequities among racial and ethnic groups” (Gee and Ford 2011:117). Although the authors postulate structural racism as the largest contributor to health inequities, they note that this mechanism is understudied. My work, then, adds the mechanisms through which structural racism acts on breastfeeding to this body of knowledge.

My dissertation theorizes a number of ways that structural racism operates to produce breastfeeding inequities. As I showed in Chapter 3, the persistent racial and socioeconomic segregation in St. Louis city and county has resulted in a dearth of breastfeeding resources in areas where residents are predominantly African American. Institutions such as La Leche League do not hold groups in these areas, and when African American women do attend La Leche League meetings, they may feel scrutinized and unwelcome. WIC, which in this region serves primarily African American women, requires that women share personal information, submit to

blood tests, and attend compulsory classes in order to receive services, and many WIC service providers are underpaid and under-resourced.

Additionally, lactation professionals may hold racial biases that influence the way they practice. The WIC staff member who told her patients that they could sell their breastmilk for money is an example of this, as she assumed that African American women would value money more highly than the health of their infants. Another example are the hospital nurses who offered Tasha formula bottles and looked at her like she shouldn't be breastfeeding. I interviewed a richer white woman who gave birth at the same hospital at around the same time and also had a complicated birth, and she reported to me that the nurses were very supportive of breastfeeding. A final example is the struggle for power over the Breast Friends Rising initiative, in which white lactation professionals repeatedly dismissed the opinions of the African American women who were involved.

My second theoretical contribution extends ideas about the relationship between capitalism and infant feeding by adding the costs of breastfeeding. Older scholarship on this subject focused on infant formula companies that profited by selling their product to women who might otherwise have breastfed (Palmer 2009; Van Esterik 1989). Most recent research has examined the effects of capitalist understandings of time (Tomori 2014; Dykes 2008) or of machine-like bodies (Blum 2000; Dykes 2005) on breastfeeding praxis. However, my own research found that while breastfeeding is often viewed as free or inexpensive, women often spend hundreds of dollars or more purchasing items or services intended to facilitate breastfeeding.

While some of these items are useful or necessary, such as nursing bras, breastfeeding mothers are also encouraged by manufacturers and retailers to purchase items that they may not

want or need, such as nursing covers or a nursing stool. Mothers who pump regularly often purchase additional items such as breastmilk storage bags or car adapters for breast pumps. Mothers who are struggling to breastfeed are especially vulnerable to marketing, as they may purchase items or services in an attempt to remediate breastfeeding problems. For some, these purchases may also serve as evidence of their investment in their infants, reinforcing their identity as good mothers. While breastfeeding may cost less than infant formula, then, breastfeeding mothers still participate in the capitalist economy through their purchases of breastfeeding-related products.

7.3 Recommendations

In this final section, I detail my recommendations for improving the experience of breastfeeding for women. I begin at the macro level with my suggestions for institutional policy shifts, looking particularly at federal laws and international institutions. I then shift to the local level and focus on promising developments in the St. Louis area, and the ways these can be supported.

First and foremost, we can support breastfeeding women best by mandating *paid maternity leave*. In the Global North, the United States is the only country that does not require companies to provide some amount of paid leave after the birth of an infant (Kurtzleben 2015). I recommend a minimum of six months' maternity leave, during which women are paid at least 75% of their usual wage. Babies typically begin eating complementary foods at around six months, making this a reasonable time for mothers to return to work.

Once mothers have returned to work, I would also recommend legislation guaranteeing women *paid pumping breaks* and *paid breastfeeding breaks*. While U.S. law does now require

that most employers allow women to pump at work (although not all employers comply with the law), these breaks are unpaid. The World Health Organization found significantly higher exclusive breastfeeding rates at six months in the 111 countries where paid breastfeeding breaks were a legal right (Heymann, Raub, and Earle 2013). This held true for low, middle, and high income countries. Laws typically required one hour breaks.

I would require *breastfeeding support parity* between Medicaid plans in every state and private plans covered under the Affordable Care Act. This would make all lower income mothers eligible for free breast pumps and lactation support, without having to enroll in WIC. I would also *expand coverage of lactation professionals* so that all mothers had the option to see the lactation professionals of their choice, even if that person were not part of a medical practice or was not an IBCLC.

I also recommend *changes to the International Board of Lactation Consultant Examiners requirements for certification* as an International Board Certified Lactation Consultant (IBCLC). The current requirements include 14 college classes in fields such as biology, anatomy, and anthropology; specific education in lactation; and hundreds of hours of clinical internship, followed by taking and passing a comprehensive (and expensive) exam. These requirements disenfranchise lower income women and women of color, who are less likely to have taken the relevant college courses and often do not have access to an internship, which most intern supervisors charge for. Women are able to use La Leche League leader experience to fulfill clinical hours, privileging women who are already predominantly white and middle or upper class.

In addition to these institutional shifts, I recommend increased community support for and investment in groups such as the one I call Breast Friends Rising in this dissertation. In order

to be effective, white breastfeeding advocates must become educated about the ways racism affects breastfeeding support, so that they can work as allies and supporters while recognizing their limitations. Besides this group, which hopes to become an independent non-profit now that the grant funding has ended, the new Community Birth and Wellness Center in Ferguson, Missouri, is promising a model for empowering and woman-centered breastfeeding and reproductive support for African American women. The center, which is currently located in a living room and open one afternoon a week, was founded by three African American doulas. It currently partners with another birth center, “borrowing” their (white) midwife once a week, but one of the doulas is attending midwifery school and hopes to eventually work at her own center. The group recently found and rented their own site, and move-in is schedule for the end of July.

In closing, then, this is the kind of change that matters most. The best way to increase breastfeeding rates among African American women - or any women - is to return ownership of breastfeeding to them, and then support them in creating breastfeeding relationships that work. When breastfeeding is a part of the communities that women are attached to, women breastfeed.

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