

Feeding the State

Breastfeeding and Women's Well-Being in Context

Breastfeeding is increasingly argued to be universally beneficial to babies, mothers, families, and society at large and is promoted as a costless solution to many individual and societal problems such as the obesity epidemic, asthma, and inequalities in intelligence. In this paper, I argue that we have cause to view state sponsored breastfeeding promotion with some suspicion because the arguments used by advocates became a convenient tool used by states to avoid responsibility for taking on more costly solutions to children's and women's health, such as tackling the lack of affordable and safe housing, gendered labour market inequities, or disparities in early childhood education.

Since the 1990s, the overarching discourse among physicians, nurses, child development and parenting experts, is that breastfeeding is the best form of infant nutrition (Law, 2000; Wall, 2001; Wolf, 2007). Many feminists have taken on breastfeeding as a feminist cause (Galtry, 2003; Hausman, 2003; Smith, 2004; Wolf, 2006) arguing that breastfeeding is a part of women's natural reproductive capacities and that efforts by doctors between the 1950s-1970s to discourage women from breastfeeding were evidence of a patriarchal medical model that aimed to take control of women's bodies (Apple, 1987; Hausman, 2003). Breastfeeding is increasingly argued to be universally beneficial to babies, mothers, families, and society at large and is promoted as a costless solution to many individual and societal problems such as the obesity epidemic, asthma, and inequalities in intelligence (Baumslag and Michels, 1995; US DHHS, 2000).

Although feminists have cause to question the medicalization of women's bodies, in this paper, I argue that feminists also have cause to view state sponsored breastfeeding promotion with some suspicion. I begin by outlining the context

of breastfeeding promotion that emerged with the promotion of breastfeeding by women as part of both the feminist women's health movement and a more pronatalist women's movement, in order to advocate for the health of women and babies. However, I posit that the arguments used by advocates became a convenient tool used by states to avoid responsibility for taking on more costly solutions to children's and women's health, such as tackling the lack of affordable and safe housing, gendered labour market inequities, or disparities in early childhood education. Thus, in this paper, I aim to capture a standpoint of breastfeeding that differs from dominant discourses to show how governments have used breastfeeding advocacy to reduce their responsibility for social welfare and that in the process, women's actual health and well-being has been lost in a sea of normative prescriptions about motherhood.

The rise of breastfeeding advocacy

By the early 1950s, with the rise of obstetrics and gynecology as a medical specialty, the control of women's reproductive health shifted from midwives "caring" for women in their homes to male doctors "treating" women in hospitals. Science became the way of managing many aspects of women's daily life: childbirth was medicalized and doctors aggressively promoted infant formula as the ideal means of feeding babies. Doctors argued that women often did not produce sufficient milk and as there was no way to measure milk output from breastfeeding, formula would be safer for infants (Apple, 1987). This line of reasoning backfired, however, when, in the 1960s, poor water quality, lack of maternal education, and poverty led to large-scale infant death, as women used unsanitary water or diluted their formula to make it last longer, leading to dysentery and malnourishment (Baumslag and Michels, 1995). After this, and because of the broader women's health movement pushing for women to challenge the medicalization of their bodies, many feminists joined the more pronatalist organizations, such as La Leche League (LLL), in arguing that women needed to take back control of their bodies and be supported in doing what is purported to come naturally to them (Blum, 1999).

As breastfeeding became increasingly normalized, advocates argued that women were being systematically discriminated against by their employers when denied opportunities to breastfeed their babies or to pump their milk at work, by restaurant owners when asked to nurse in bathrooms, or by hospital personnel who are inadequately preparing women to breastfeed successfully, particularly poor women and women of colour (Gatrell, 2007; Hausman, 2003). These feminists argue that hospitals are ill equipped to support women through the difficulties of breastfeeding and are too quick to provide free handouts of formula when mothers experience inevitable bumps in the road to exclusive breastfeeding success (Baumslag and Michels, 1995; Hausman, 2003). They also promote provisions such as maternity leaves, legal protections for breastfeeding, and employer provided lactation equipment (Baumslag and Michels, 1995; Galtry, 2003; Hausman, 2003).

Critiques of the critics

Although feminist and non-feminist breastfeeding advocates are highly critical of the medical establishment in their failure to adequately support breastfeeding, they are largely uncritical and unquestioning of research demonstrating the benefits of breastfeeding, overlooking evidence that does not support their view (Hausman, 2003; Wolf, 2007). For instance, Julie Smith (2004) lists the benefits of breastfeeding based on the American Academy of Pediatrics recommendations including a statement that there “is also increasing evidence to support breastfeeding in terms of normal bonding and attachment [and] brain development and IQ” (371). She goes on to say:

However, much cultural knowledge of the health risks of artificial feeding, and the proper skills for breastfeeding are based on inaccurate and, in some cases, biased information from two or three decades ago. All health professionals working with mothers have a professional responsibility to keep up to date on breastfeeding and breastfeeding management from sources without a commercial vested interest, so they can enable the patient to make an informed choice. But even health practitioners are not necessarily well informed and are susceptible to commercial pressures affecting the infant feeding decisions of their clients. (371-372)

Yet, Smith too fails to provide an unbiased and complete review. For instance, research has also shown that although breastfed babies *may* show earlier and stronger mother-child attachment, formula fed babies' levels of attachment are within a normal range (Else-Quest, Hyde, and Clark, 2003). Additionally, much of the research on attachment theory which stresses the importance of bonding, has not been supported by evidence, but by the opinions of parenting “experts” in parenting manuals published in the popular press (Eyer, 1993). Further, much of the research correlating breastfeeding with IQ fails to take into account important confounding factors. While earlier studies controlled for income and education and continued to find a significant effect of breastfeeding on IQ, more recent studies that control for more direct measures of heritability and environment, such as mother's IQ and interaction with her child, have generally found the correlation between breastfeeding and IQ to be nonsignificant (Jacobson and Jacobson, 2006).

Research that does not find support for breastfeeding is often presented (as Smith [2004] does in the above quote) as being carried out solely by formula manufacturers, calling its objectivity into question. There are a number of problems with this way of critiquing the literature. First, there are profit seeking capitalists other than formula manufacturers who have a financial interest in infant feeding. For instance, breast pump manufacturers have an important stake in seeing women couple employment with breastfeeding. Notably, a frequently cited article used by the United States Department of Health and

Human Services Blueprint on Breastfeeding (2000) to demonstrate the ability of women to incorporate nursing into their work lives was carried out by Marsha B. Mrtek, the researcher consultant of Medela, Inc. a world leader in breast pump manufacturing (Cohen, Mrtek, and Mrtek 1995).

The accusation of bias also overlooks non-profit-seeking motives for advocating one's position. Jacqueline H. Wolf (2006) writes, "[g]iven their lack of education, physicians tend to give such inappropriate advice to women about breastfeeding that a favourite activity of international board-certified lactation consultants is exchanging stories about doctors' ignorance" (399). As Max Weber (2001 [1947]) posited, those within certain social statuses will often engage in means of social closure in order to garner greater rewards. For instance, lawyers will create bar exams as a way to limit access to those who can become lawyers and as a result, lawyers can demand higher wages. Similar processes are possible among the lactation experts themselves; by disparaging the capacity of doctors and nurses to provide adequate supports for new mothers, a niche for lactation specialists is developed. Although, it may be true that lactation specialists are best prepared to help mothers establish successful breastfeeding, there is no clear evidence that they are wholly devoid of self-interest in the research that they produce.

As Sandra Harding (2004) cogently argues in her critique of science and in defence of standpoint theories:

Conventional conceptions of scientific method enable scientists to be relatively good at eliminating those social interests and values from the results of research that differ *within* the scientific community.... but scientific method provides no rules, procedures, or techniques for even identifying, let alone eliminating, social concerns and interests that are shared by all (or virtually all) of the observers, nor does it encourage seeking out observers whose social beliefs vary in order to increase the effectiveness of the scientific method. (45-6)

Many advocates of breastfeeding have been, themselves, successful breast feeders and have, as evidenced by this success, lived within circumstances that facilitated this. Because of the presence of an "interest that [is] shared by all," there is a general consensus among advocates that breast feeding is achievable in all but a few rare instances. This then makes it unsurprising that I have found no studies that detail the experiences of women who have been less successful at breastfeeding or that critically examine the benefits of breastfeeding for society relative to other potential social structural changes, such as the elimination of poverty, inadequate housing, or racism, to name a few examples.

The neoliberal context

Breastfeeding advocates worked throughout the 1970s not only to promote the benefits of breastfeeding but also to draw attention to the problems associ-

ated with formula promotion, most notably the babies who were dying due to poorly prepared formula. After massive amounts of activism, including a boycott of the formula maker Nestlé and major lobbying of the World Health Organization (WHO) and the United Nations International Children's Education Fund (UNICEF), in 1981 advocates found success when the WHO and UNICEF adopted the International Code of Marketing of Breastmilk Substitutes, which set international standards for marketing formula. The U.S., however, refused to sign on, as then President Reagan argued it was too much governmental involvement in business. However, thirteen years later, in 1994, President Bill Clinton signed on to the code, which to advocates signaled progress in the battle to increase breastfeeding (Baumslag and Michels, 1995).

Because breastfeeding advocates have sought international support from governmental and/or not-for-profit organizations such as the WHO, the UN, and the United States Agency for International Development (USAID), many view their recommendations as unbiased and without any significant conflicts of interest (see, e.g., Baumslag and Michels, 1995; Hausman, 2003; Wolf, 2006). Thus, many researchers begin their articles noting these international policies and codes. Although these agencies are not directly profiting from the promotion of breastfeeding, it is naïve to believe that they are disinterested parties focused on uncovering the relative scientific pros and cons of breast milk. Rather, the WHO, along with the rest of the UN and its affiliates, has been shifting its focus toward increasing privatization and partnerships with corporate interests, rather than by supporting states to provide for their citizen's health care needs directly (Buse and Waxman, 2001).

This shift to increasing private, corporate provisions for social reproduction (e.g. health care, welfare spending, and so on) from state provided provisions developed over the course of the twentieth century. Although the post-depression era was characterized by Keynesian economic policies that saw the state as responsible for providing for the social welfare of its citizenry, in the 1960s, states began to see an increasing dependence on the state by the poor. Welfare programs were seen to create economic dependency and not encourage the poor to become self-sufficient. Rather than provide for the needs of the poor, governments of the west, particularly in the liberal capitalist economies such as the UK, Canada, the U.S., and Australia, shifted toward neoliberalism, restructuring welfare programs to make eligibility more difficult, cutting taxes and eliminating many corporate regulations. The stated goal was to increase the self-sufficiency of individuals and the flexibility of businesses to be more innovative and productive (Cameron, 2006; Rinehart, 2006).

With the deregulation of industry and newly developing technologies beginning in the 1970s, many businesses moved production overseas to the global south where wages and regulations were laxer than in the industrialized north. As such, labour unions needed to focus on protecting jobs for domestic workers, which weakened their power to bargain for wages. Thus, well-paying jobs available to those without a university degree were increasingly replaced

with low-paying jobs in the service sector that provide few benefits (Rinehart, 2006). As a result, families were decreasingly able to survive on one income and, along with a push from the women's movement of the 1970s, women began entering the labour force in record numbers (Padavic and Reskin, 2002).

Because of this rise in women's labour force participation the basic needs for social reproduction increased, since women no longer stayed home to look after their children and breadwinner spouses. I argue that this raises a difficulty for neoliberal policy makers who aim to minimize state involvement in domestic activities while ensuring that the needs of social reproduction are met. However, with the rise of women pushing for increasing control of their bodies, we can see the state is provided with an easy way to (not) address the needs of infants by promoting a form of childcare that cannot be provided by the state (or by men)—breastfeeding. Although, as Naomi Baumslag and Dia L. Michels (1995) point out, there are many aspects of parenting that men could do (and that in some cultures men have been known to breastfeed), within our culture, breastfeeding places a unique form of responsibility on the nursing mother, by making her tied to the baby for feeding, and even should she pump her milk, she needs to do so every few hours. This also sets in motion patterns of parenting where the mother is seen as the primary care provider for the child. Within couples, the father is encouraged to serve as a mother's assistant by changing diapers, cooking meals, and taking care of other secondary needs. Within single-parent families, these mothers must do the work by themselves or if they are fortunate, they can seek the help of other family members, such as parents or grandparents.

One way to encourage breastfeeding has been to focus on the benefits of breastfeeding not only for the children but also for women, families, and communities (Wall, 2001). However, we can see an underlying interest in abdicating responsibility for social reproduction by the U.S. government. For example, the U.S. Department of Health and Human Services Blueprint for Infant Feeding argues that breastfeeding saves money for families. However, the research cited as evidence for this is actually research demonstrating the cost savings that would be accrued to *Medicaid*, should WIC¹ recipients breastfeed instead of receiving supplemental payments for formula. The savings potentially accrued to WIC through breastfeeding is also a central argument of Baumslag and Michels (1995) in their call for greater breastfeeding support. This is notable, particularly considering that according to Baumslag's biography in their book, she "has served as an advisor to USAID, UNICEF, WHO, the Georgia Department of Human Resources, PAHO, and the governments of many developing countries" (back flap).

Although the US DHHS, (2000) may advocate breastfeeding, the introduction of stingier welfare programs in the United States in the 1990s have been estimated to have had a negative impact on breastfeeding rates. Steven J. Haider, Alison Jacknowitz, and Robert F. Schoeni (2003) found that the overall breastfeeding rate in the U.S. would have been 5.5 percent higher in

2000, had states not enacted strict welfare-to-work policies, which included new mothers. Thus, there is a climate, particularly in the United States, of encouraging breastfeeding while restructuring the government to actually make breastfeeding more difficult, at least for women on welfare.

Canada has done much more than the U.S. in supporting breastfeeding by its introduction of paid parental leave, which has the potential to facilitate breastfeeding by providing women with the time needed to establish breastfeeding. However, as Michael Baker and Kevin S. Milligan (2007) have found, while time spent breastfeeding has increased by one month on average, child and maternal health has not changed appreciably since before the maternity leaves were enacted. Thus, the state sponsored programs supporting breastfeeding have been more successful at keeping women out of the labour force than at improving child welfare. Taking women out of the labour force could have potentially serious implications for women's well being for a number of reasons. For one, when women are out of the labour market they may lose opportunities to network, gain promotions or raises, and their wages can depreciate if they leave long enough to become deskilled. This also makes women increasingly vulnerable to poverty following divorce or the death of a spouse and their retirement pensions can be affected by time out of the labour force (Holden and Smock, 1991).

Additionally, the overarching discourse by state-produced materials in Canada and the U.S. is that breastfeeding is simply a choice and that those who are unable or unwilling to breastfeed just need a lesson on how to parent their children best. Or occasionally more strongly, some advocates, such as Baumslag and Michels (1995), argue that formula feeding should not be presented as a choice and more needs to be done to keep formula from being distributed to women discharged from the hospital after birth or to poor women who receive WIC payments.

Further, although, the US DHHS (2000) argues that “[a]chieving an increase in the promotion of breastfeeding will require the collaboration of Federal agencies, State and local governments, communities, health professional organizations, advocacy groups, multidisciplinary scientists, industry, health insurers, and the American people” (19), the only concrete objectives they outline are related to changes in the privately funded health care system, the workplace, and family and community. This ignores the structural and material constraints on breastfeeding that women may experience (Kukla, 2006; Wolf, 2007). For instance, those who work in the service sector do not have office doors that they can close to discretely pump their breast milk. Women who have been assaulted may experience post-traumatic stress when nursing their babies (Kukla, 2006). Those who live with many relatives or roommates may not have the privacy that is desired for the early, often difficult, days of establishing nursing. Instead of adequately addressing these issues (among potentially many others) by paying for or requiring employers to provide paid lactation breaks with private lactation stations, creating a climate in which sexual assault

does not happen, or ensuring adequate affordable housing, in 2004, the U.S. introduced a new promotional ad campaign stressing the dangers of formula usage (Kukla, 2006; Wolf, 2007).

My story

My view of breastfeeding is also not unbiased, emerging from my experience of marginal success at breastfeeding. I had an exceedingly large first baby when I was a 25-year-old graduate student at the University of Iowa, and gave birth to my son before any of my highly educated, primarily white middle class friends had kids. I thought breastfeeding would be easy and I planned to do it for at least a year based on the benefits I read about in the books and magazines I scoured while pregnant. After a long labour that ended in a c-section delivery of an over eleven-and-a-half pound baby, I had difficulty establishing breastfeeding. Despite help from nurses in the hospital, he had a poor latch so my nipples became cracked and bled, we got thrush (my nipples, his mouth), and then, the worst, he did not have a bowel movement for five days. I was exhausted and depressed and was worried that he was starving. My reading of the parenting magazines at the time told me that women always produce enough milk but I struggled to believe that when my baby was born the size of a typical six-week-old. So, with the support of family and friends I quit nursing when he was ten days old. I felt so guilty that I tried to create a breastfeeding environment for my now bottle-fed son. I held him almost constantly, brought him to school with me, held the bottle near my breast, and never, ever propped up a bottle for him. I was devastated when I read a newspaper report of a study showing a seven-point difference in IQs between breastfed and formula fed babies.

When my second son was born two years later, I was determined to make breastfeeding successful. This time I worked hard to avoid another c-section and was lucky that he was only nine pounds and eleven ounces. I read more about breastfeeding before he was born, sought out the advice of every nurse and the lactation consultant in the hospital to help me, had a home health nurse come to my house after the baby was born, and this time my sister could help me since she had had a baby in the interim who she successfully breastfed for over a year. I still struggled to make enough milk for him to have the adequate number of wet diapers per day and ended up alternating pumping my milk and nursing him every hour. I supplemented out of a cup or a syringe with as little formula as possible and took fenugreek pills to boost my milk. By the time he was six weeks old I was able to nurse him exclusively with no formula supplements. I was very proud.

And then, a week later, when he turned seven weeks old, I had to start teaching a summer school class. He and his older brother were in daycare in the mornings when I would teach and then I would come home and nurse him immediately. After the class ended at the end of July, I was to present my very first paper at a professional conference. At the conference, while trying

to network and meet people, I would go back to my hotel room and pump my milk, wincing as I poured it down the sink since I could not refrigerate the milk and bring it back home. At the end of August, I went back to school full time, leading four hours per week of discussion sections while teaching two classes at a community college, 30 minutes from my house. My Mondays and Wednesdays involved me being in a car or in front of a class for about eight hours straight per day. I could pump neither while driving nor while teaching and, thus, by mid-September, when my baby was around four months old my milk finally dried up.

The differences in my breastfeeding of my first and second sons is the story told by many advocates to suggest that women need to be better educated about how to breastfeed properly and they need lactation consultants to help them (Baumslag and Michels, 1995). In my case, the greater supports did lead to a longer duration of breastfeeding with my second son, but I still found myself unable to meet the recommendations for a full year or even reach six months of breastfeeding with no supplementation. What else could explain my falling short of breastfeeding ideals?

Although a problem for other mothers (Hausman, 2007), I had no objection to nursing in public. I was quite comfortable and proud to show the world what a good mother I was by doing what I was doing. I figured if anyone was uncomfortable seeing an occasional flash of breast; that was their problem to deal with, not mine. And the animalistic, drippiness was, though occasionally inconvenient, not an affront to my sensibilities, as Fiona Giles (2004) suggests in critiquing our contemporary “idealized, deodorized, and denatured” (37) images of breasts. My ending of breastfeeding had more to do with my material and career needs. With a husband who worked in social services his monthly take-home pay was under \$2000 which barely covered our \$700-plus-utilities rent for a trailer-parkesque modular home rental and his \$850 per month student loan repayments. Working was essential to our survival and the costs of not working exceeded the costs of formula.

When I unexpectedly got pregnant at the end of my first year of graduate school, faculty were supportive of my family demands. However, this often meant not being included in research projects because they did not want to put undue pressure on me and because I was afraid to seek out opportunities for fear of not being able to pull my weight on the projects after my child was born. Thus, presenting my own research at a conference allowed me to begin the process of academic publishing. Had I not left my child with his father to attend that conference (all of us going together was financially out of the question), I would have had no publications to go on the job market with later on, which would have likely meant the end of a never fully begun career. Thus, my ability or inability to breastfeed was not simply constrained by a lack of knowledge about breastfeeding or by a lack of enough lactation consultants to help me. Although those things mattered, there was the rest of my life that mattered too.

Dilemmas for advocates

For many women, breastfeeding is a powerful experience where one can feel uniquely able to provide another life with its most basic needs. This provides women with some power and freedom from male authority and capitalist producers of formula. Additionally, others have noted that breastfeeding shifts the focus of breasts as sexual objects for men to food sources for infants. Thus, calls for women to breastfeed challenges patriarchal notions of women's bodies as male sex objects (Hausman, 2003). Breastfeeding, seen in this light, makes sense to become a feminist cause to rally around because it is a source of control for women over their own lives.

However, this control over the feeding of their infants can often conflict with finding control in other aspects of their lives. Breastfeeding can mean a loss of income, a change of career, or a return home. For many women who have been successful in the labour market, this is a difficult pill to swallow. For most women these "choices" are a practical impossibility. Thus, within our current socio-political and economic system breastfeeding has the potential to have a negative impact on women's overall economic well being.

Advocates, such as Bernice L. Hausman (2003), who draws on the work of Penny Van Esterik, are increasingly looking not at how to create more breast feeders but how to create an environment in which all women could choose to breastfeed. To do so would require radical change in how work is organized and in increasing provisions for lactating mothers, such as by providing lactation stations and extended and well paid maternity leaves. It would also require that mothers would not be penalized when taking the leaves, not just by eliminating blatant discrimination, but also by compensating foregone wage appreciation and/or wage depreciation. Thus, real change would require changes at the level of the nation-state, not just a series of private solutions.

Some of these things are possible in an alternative economic system. For instance, when looking at the industrialized west, Sweden has managed to facilitate both high rates of breastfeeding and high rates of labour force participation, compared to the U.S. and Ireland (Galtry, 2003). However, according to Nabanita Datta Gupta, Nina Smith, and Mette Verner (2008), in the Nordic countries men take few parental leaves, occupational sex segregation is the norm with women disproportionately located in the public sector, and a wage gap, though smaller than in the U.S. and Canada, remains stagnant. More still needs to be imagined and done.

Infants need to be fed and women have been endowed with a unique capacity to provide nourishment for them. There is cause to celebrate this ability and to fight to ensure that women continue to be able to do so. However, this unique capacity also has the potential to be exploited as a means for men, the state and society at large to relinquish responsibility for the difficult task of rearing children. Although breastfeeding advocates are increasingly calling for major social changes that would facilitate more women choosing to breastfeed, we continue to see a disproportionate burden placed on moth-

ers. As Michelle J. Budig and Paula England (2001) argue, there is a social value in rearing children and mothers pay a disproportionate wage penalty for this unpaid work. I argue that pressures to breastfeed increase the potential penalty because breastfeeding is carried out only by women and encourage family dynamics in which women are the primary parents and men are called on as helpers. Thus, whatever benefits accrue to the breastfed babies, without state policies that address the economic disadvantages breastfeeding women confront both in their private and public lives, women and children at large will see few improvements in their overall well-being and the rest of society will continue to free-ride off the breasts of mothers.

¹Women, Infants, and Children (WIC) is a federal program to provide supplemental money for food for low-income mothers and their children.

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