More than Feeding: Lived Experiences of Low-Income Women Receiving Lactation Support

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More than Feeding:
Lived Experiences of Low-Income Women Receiving Lactation Support

by

Emily A. Dunn

A thesis submitted in partial fulfillment of the requirements for the degree of
Master of Arts
Department of Anthropology
College of Arts and Sciences

and

Master of Public Health
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Date of Approval:
March 26, 2013

Keywords: breastfeeding, evaluation, maternal and child health, feminism, applied anthropology

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ACKNOWLEDGMENTS

This work would not have been possible without the assistance and encouragement of my mentor, Alex Boyer. I sincerely appreciate the support and guidance of my committee, Nancy Romero-Daza, Ellen Daley, and Daniel Lende. I want to thank Amy Hammant for her time and counsel. Most importantly, I am grateful to the mothers who allowed me into their homes. Thank you for sharing the details of your lives.
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ABSTRACT

Increasing breastfeeding duration, especially among low-income women, has become a national public health priority. These mothers and their babies have less equitable access to support, resources, and the health benefits of breastfeeding. This thesis examines breastfeeding from a biocultural perspective with a focus on political economy, embodiment, and human rights. This research explores the lived experiences of new mothers who receive services from a community non-profit lactation support program which is aimed at providing in-home postpartum breastfeeding support to low-income/at-risk mothers. Evaluation of program services and analysis of women’s narratives will provide insight into improvement of lactation services for all women.
CHAPTER ONE: INTRODUCTION

The public health significance of breastfeeding is well known, with breast milk providing a multitude of protective health benefits for both mother and child (American Academy of Pediatrics 2012). Research has found that longer durations of breastfeeding are associated with greater protective effects and health outcomes for mothers and babies (U.S. Department of Health and Human Services 2011). It is known that women who intend to breastfeeding understand the health benefits for the baby, but knowledge alone is not enough to overcome significant breastfeeding barriers (Mitra et al 2004). Three-fourths of women in the U.S. initiate breastfeeding, but fewer than half are still breastfeeding at six months (Centers for Disease Control and Prevention 2010). Large health disparities exist by government-defined racial/ethnic\(^1\) categories and income levels, with black infants and low-income income infants breastfeeding at the lowest rates (CDC 2010, Ryan, Wenjun and Acosta 2002).

Factors that have been found to have a large influence on breastfeeding success include interpersonal support levels, education, employment, and wealth or income level, issues which are related to the socioeconomic context (Rudzik 2012:108). Other factors that influence the breastfeeding experience include structural barriers such as limited

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\(^1\) “Race” in anthropology is conceptualized as a social construction without biological basis in which humans are classified into groups based on heritable characteristics, common geography and shared customs. In this thesis, the culturally and government defined racial and ethnic classifications will be used.
maternity leave, lack of work support for breastfeeding, and cultural mores that promote formula feeding and discourage nursing in public. This study explores these and other factors in order to better understand the lived experiences of low-income women from an anthropological perspective.

Anthropologists are well positioned to examine the broad context in which breastfeeding is situated. The consideration of biological, historical, political, economic, and socio-cultural dimensions is a unique contribution of anthropology to the topic of breastfeeding. As Rudzik (2012) writes, “Breast-feeding is a quintessential anthropological subject, being rooted in our evolved biology and profoundly influenced by our cultural beliefs and practices. While the ability to breast-feed is virtually universal among women, the experience of breast-feeding is particular to each woman” (108). Anthropologists have played an integral role in illuminating the evolutionary and biological significance of lactation in human history, as well as the cultural and societal forces that affect the practice of breastfeeding worldwide (Trevathan 2003; Dettwyler 1995; Van Esterik 1995; Avishai 2011; Tomori 2011).

Breastfeeding cannot be understood without considering all levels from the individual to community to world capitalism. Penny Van Esterik writes “As much a part of the self and identity as political economy… breastfeeding research requires synthesis of multiple methods and theoretical approaches,” thus making it an ideal topic of inquiry for anthropology (1995:163). As “anthropology is at the nexus of the biological and social,” a biocultural approach is a useful theoretical framework for the examination of lactation (Levins and Lewontin 1998:xi). Furthermore, feminist inquiry into lactation encompasses an examination of power, class, race, and economics as well as advocacy
for the rights of breastfeeding women. Bernice Hausman (2003) writes, “approaching breastfeeding as an issue or health activism for women and children is really about approaching breastfeeding as an aspect of women’s rights” (196). The topic is particularly suited for both applied anthropology and public health, with their emphasis on addressing contemporary problems among vulnerable populations, promotion of community advocacy, and social justice.

**Research Setting**

This research took place in Hillsborough County, Florida at a small community non-profit health program called the Baby Café. The program is part of the abcProgram (A Better Childbirth Program) run by Champions for Children and funded by the Hillsborough County Healthy Start Coalition and The Children’s Board of Hillsborough County. Hillsborough County’s Baby Café provides drop-in nursing assistance at a peer support group once a week and has expanded to include home visitation, phone consultation, and breast pump rental services provided by Certified Lactation Counselors (CLC’s) or International Board Certified Lactation Consultants (IBCLC’s). Drop-in sites are located in Tampa, and home visits are provided to mothers all over Hillsborough County.

The Baby Café home visitation program provides services for women who may not otherwise be able to access or afford visits from a lactation consultant or a breast pump rental, such as low-income and/or at-risk women enrolled in WIC (Women, Infants and Children) or Healthy Start, or women with infants in the Neonatal Intensive Care Unit (NICU). Healthy Start considers mothers and babies to be “at-risk” if there are any
indications that the child is in jeopardy of poor health and developmental outcomes, as Healthy Start’s main goal is to reduce infant mortality. Not all women who are referred to Baby Café fit these criteria, but no woman is turned away.

The Hillsborough County Baby Café drop-in sites and postpartum groups were created out of a recognized need for postpartum lactation assistance. The program director and the educators discovered that the women who attended breastfeeding education classes did not seem to be breastfeeding “very long” (A. Boyer, Personal Communication 2013). Informal phone calls with past participants revealed that though most women said they tried breastfeeding, they would stop within the first two weeks for reasons such as insufficient milk or discomfort. When the staff suggested to mothers that they visit the Baby Café for assistance, the mothers said they could not come and preferred a home visit. Thus, the target population identified the need for home visitation services. It was clear that there was a lack of healthcare providers providing pump rentals and in-home lactation consultations, especially for the low-income/at-risk population.

Staff from the Baby Café began conducting home visits in 2006. Presently, the main focus of the program is to provide breastfeeding support through hospital or home visitation to women experiencing breastfeeding problems in the early postpartum period. This program emphasizes home visits by an international board certified lactation consultant (IBCLC). The aim of these visits is provide immediate support to solve a specific breastfeeding issue, in addition to delivery of a hospital grade breast pump, if requested. The program is needs based; the IBCLC only goes to a client’s home upon
request for help with a specific issue. As a result, the Baby Café clientele are all women who intend to breastfeed.

Baby Café receives an average of seven new referrals for home visits and pump rentals per week, with the majority of referrals coming from hospitals in Hillsborough county, and the rest from pediatricians, Healthy Start, WIC, affiliated parenting groups, other community partners, and self referrals. Calls from hospitals are typically from the Neonatal Intensive Care Unit, but may also originate from the regular postpartum unit or the lactation nurses. Currently, the responsibility for follow-up remains with the client. Because the purpose of the program is to resolve a specific issue, services are only continued beyond the first contact at the client’s request.

**Study Overview**

This research sought to examine the unique perceptions of low-income women with their breastfeeding experiences and the lactation support that they have received. It utilized an ethnographic research method approach to understand the lived experiences of this population of mothers and the services they receive from the Baby Café’s home visitation lactation support services. The study involved the use of participant observation and semi-structured interviews with recent and current clientele of the Baby Café home visitation program. This research was done at the request of the Baby Café program director, who identified a need for an evaluation of the program. The study drew on biocultural and feminist theory, with an emphasis on political economy and human rights perspectives.
Despite research which shows low breastfeeding rates and shorter duration among women from lower socioeconomic backgrounds (Ryan, Wenjun & Acosta 2002; CDC 2010), and the effect that support in the first weeks postpartum can have on improving breastfeeding duration (McKeever et al. 2002; Mannan et al. 2008), there is insufficient program evaluation research as well as a dearth of qualitative research on what programs best help improve rates and duration of breastfeeding in this population. Furthermore, there is a lack of qualitative literature that contributes to understanding the lived experiences of low-income breastfeeding women.

This research has direct implications for the Baby Café home visitation program. By understanding women’s breastfeeding experiences, including their support needs, it can be determined whether Baby Café is meeting them and where the program can improve. Qualitative research will help evaluate the services that Baby Café provides and offer a critique of present efforts and suggestions for improvement. These results will inform future lactation interventions among low-income women. Results will not only improve this local lactation support program, but also have the potential to improve future breastfeeding support for all women. A greater understanding of low-income women’s breastfeeding experiences can contribute to understanding the socio-cultural context of breastfeeding. This project builds on literature that seeks to better comprehend the myriad influences on breastfeeding duration and rates.

**Research Aims**

This study focuses on the lived experiences of low-income/at-risk breastfeeding women and the context in which these experiences take place. Additionally, it seeks to
evaluate the services these women receive from the Baby Café home visitation program.

This research aims to:

1. Explore low-income women’s lived experiences with breastfeeding,
2. Evaluate whether Baby Café’s current program processes meet these women’s needs in order for them to successfully breastfeed, and
3. Investigate the socio-cultural context of breastfeeding in the U.S. and its impact on these women’s experiences with breastfeeding and lactation support services.

Defining “Breastfeeding”

There is a lack of uniformity in terminology used to describe breastfeeding behaviors, and few papers published in peer-reviewed journals include any definition of breastfeeding. Labbok and colleagues (1997) have called for greater consistency in defining breastfeeding. Earlier research used the term “exclusive breastfeeding” to refer to the feeding pattern of any baby that was not given formula, whether the infant was also fed other foods and liquids (Labbok, Belsey and Coffin 1997). Much of the research to date still refers to an infant as “breastfed” even if they were only ever breastfed once. Additionally, many breastfeeding definitions focus on the amount of breast milk received in relation to other liquids and foods. For example, the Interagency Group for Action on Breastfeeding defines breastfeeding as exclusive, almost exclusive (water and juice in addition to breast milk), and partial (high, medium, or low, depending on the ratio of breast milk to other forms of infant food) (Labbok and Krasovec 1990). As a result of these varying and unclear definitions, much research is not comparable.
Moreover, when an infant is called “breastfed” or a mother “breastfeeding” it is unclear whether the child is fed directly at the breast or is receiving breast milk by another delivery method (e.g., bottle, cup, spoon, syringe). The World Health Organization (2012) currently defines exclusive breastfeeding as receiving only breast milk and no other food or drink. This does not take into account how the baby is fed, only what he/she is fed, thus excluding the impact of certain aspects of the breastfeeding process and relationship. Noel-Weiss, Boersma, and Kujawa-Myles (2012) call for researchers to develop new definitions of breastfeeding, taking into account not just intensity but also feeding method. They put forth that feeding at the breast has a different effect on a woman’s self-efficacy than pumping and feeding bottled milk, and that the physical contact with a mother’s breast may impact the well being of the infant. Additionally, research shows that feeding directly at the breast results in a “distinctly different infant growth pattern compared to providing human milk by bottle, and that bottle-feeding (regardless of contents) may be a risk factor for more rapid infant weight gain” (Chapman 2012:456). Focusing on the milk and not on the different feeding processes, which are physiologically different, leads to the view of mothers as disembodied breasts as opposed to whole women. The method of infant feeding is significant, as it encompasses the health consequences of bottle-feeding and the experience of mothers who express their milk instead of feeding the baby directly at the breast. Therefore, research studies should carefully describe both the source of the nutrition and its delivery method.

For the purposes of this thesis, the term “breastfeeding” will be used to refer to the receipt of breast milk, either from the breast or by any other means. In an effort to
provide an accurate depiction of the breastfeeding experience, results will refer specifically to the feeding method provided by participants. Issues related to feeding method will be discussed in the concluding chapter.

**Thesis Outline**

The following chapter will present the background and significance of breastfeeding with an emphasis on the U.S. context. This review of the literature will include an examination of breastfeeding from public health and anthropology perspectives. It will situate the study in both biocultural and feminist theoretical frameworks.

Chapter Three will present the overall research design and methods used in this project, including a description of data collection and analysis. This chapter also includes an exploration of the positionality of the researcher as a social scientist in training and birth/breastfeeding professional.

Chapter Four is the results chapter, which will present all the findings from the data analysis. Demographic information on the participants is provided, followed by the results divided into six major themes that emerged from analysis of the participant interviews.

The final chapter will proffer a discussion of the study findings within the context of the literature. Recommendations will be made for the Baby Café home visitation program. In addition, limitations of the research, contributions this study makes to both public health and anthropology, and future research directions will be provided. This final chapter will explore themes that emerged from the analysis and consider broader impacts.
of these findings, as well as offer general societal recommendations and directions for breastfeeding advocacy.
CHAPTER TWO: BACKGROUND AND SIGNIFICANCE

This chapter outlines the public health significance of breastfeeding and explores breastfeeding from an anthropological perspective. This chapter considers the biological, evolutionary, political, historical, economic, social, and cultural contexts of lactation. I specifically consider factors that are relevant to the experiences of the low-income population of breastfeeding mothers. The theoretical framework used for this thesis is biocultural medical anthropology, which for the purposes of my examination specifically encompasses a discussion of political economy, and embodiment. The framework also incorporates feminist theory, including a human rights-based and advocacy approach.

Breastfeeding and Public Health

Benefits of Breastfeeding

A new baby benefits from breast milk in a myriad of ways. Both short-term and lifelong advantages to a breastfed child’s health have been documented by research. In the first months of an infant’s life and beyond, breast milk provides nutrition and immune protection that breast milk substitutes cannot emulate. A live substance, breast milk is constantly changing to protect an infant against illness (Newman and Pitman 2009). According to the American Academy of Pediatrics, breastfeeding decreases “the incidence and/or severity of a wide range of infectious diseases including bacterial
meningitis, bacteremia, diarrhea, respiratory tract infection, necrotizing enterocolitis, otitis media, urinary tract infection, and late-onset sepsis in preterm infants” (2005). Research shows that in the U.S., breastfeeding reduces infant mortality by 21 percent, with the potential to save or delay 720 post-neonatal deaths each year (Chen & Rogan 2004; Jones et al. 2003).

Additionally, studies show a decreased risk of sudden infant death syndrome (SIDS) in a child’s first year of life, as well as decreases in rates of “type 1 diabetes, type 2 diabetes, diabetes mellitus, lymphoma, leukemia, Hodgkin disease, overweight and obesity, hypercholesterolemia, and asthma in older children and adults who were breastfed, compared with individuals who were not breastfed” (American Academy of Pediatrics 2005). Moreover, infants fed formula at a young age may be exposed to health risks specifically associated with the formula. Infants fed formula have a different pH and gut flora than breastfed infants. Formula-fed infants are colonized with more pathogenic bacteria and less of the healthy bifidobacteria (Penders et al. 2006). Infant formula in powder form is not a sterile substance and has been associated with deaths due to Enterobacter sakazakii and Salmonella enterica (World Health Organization 2007). Furthermore, exposure to infant formula, not merely the lack of protection afforded by breast milk, can increase risk of illness such as allergies and diabetes (Walker n.d.).

The health risks posed by infant formula are most extensive in settings where there is a lack of water quality and families may not have access to sterile resources (Gribble et al 2011). Diarrhea, one of the main killers of children in less developed countries, can be minimized by breastfeeding. Breastfeeding does not require the purchase or sterilization of infant formula or bottles, and access to a reliably secure and
safe food and water supply. Risk of infant diarrhea and death is high in countries where children miss out on immune protection from breastfeeding, families are forced to dilute the infant’s formula, or formula is mixed with unclean water (Newman and Pitman 2009, Gribble et al 2011).

While most discussions on the benefits of breastfeeding focus on the health of the baby, there are also several health benefits for the mother. For instance, in the short term, breastfeeding has been known to decrease the risk of postpartum hemorrhage, increase pregnancy spacing as a result of lactational amenorrhea, and aid in post-pregnancy weight loss (Philipp & Jean-Marie 2007). There is also a decreased risk of pre-menopausal breast cancer and ovarian cancer in women who breastfeed (American Academy of Pediatrics 2005). Breastfeeding also decreases the risk of type two diabetes and uterine cancer (Stuebe et al 2005; Rosenblatt & Thomas 1995).

These health benefits translate into economic benefits. Formula fed infants cost the healthcare system $331 to $475 more each in the first year of life than breastfed babies (Ball & Wright 1999; U.S. Department of Health and Human Services 2010). A review and analysis of the economic benefits of breastfeeding conducted in 2001 found that if breastfeeding rates met the Healthy People 2010 goals of 50 percent of women breastfeeding at six months, $3.6 billion annually would have been saved (U.S. DHHS 2010; Weimer 2001). A study conducted in 2007 found that “If 90 percent of US families could comply with medical recommendations to breastfeed exclusively for 6 months, the United States would save $13 billion per year and prevent an excess 911 deaths, nearly all of which would be in infants” (Bartick & Reinhold 2010). The full cost of breast milk
substitutes feeding is a shared cost, as the social cost of infant formula use is higher than the private cost (Smith 2004:374).

Employers and employees profit from the positive health effects of breastfeeding. Fewer illnesses among children and mothers mean that employees take less time off to care for sick children or tend to the mother’s health, leading to higher productivity and fewer health insurance claims, which greatly benefit employers (U.S. DHHS 2011). The government and non-profit agencies also save money when more women breastfeed, because less money is spent to provide infant formula to low income mothers through programs like the Supplemental Nutrition Program for Women, Infants and Children (WIC) (American Academy of Pediatrics 2005). In 2007, the annual cost to “provide formula to mother’s enrolled in” WIC was $2,665,715 (Trevathan 2010).

In addition to those mentioned above, breastfeeding has even more benefits for mother, child, and society. The act of breastfeeding increases the desire to and quality of bonding between mother and child, leading to better adjusted new mothers and babies (Bai et al 2009; Guttman & Zimmerman 2000). Breastfeeding also leads to more sleep for both parents, which has a large effect on mental health and productivity (Doan, Gardiner, Gay & Lee 2007). The rate of postpartum mood disorders, such as postpartum depression (PPD), is lower among breastfeeding mothers (Mancini, Carlson & Albers, 2007; U.S. Department of Human Health Services, 2011). Moreover, breastfeeding is also associated with higher developmental scores and improved cognitive development (Oddy et al 2011; Quigley et al 2012). A further point to note is that breast milk is a natural, renewable resource, and so there are ecological benefits to breastfeeding as well.
Breastfeeding leads to a reduced carbon footprint, due to a lack of associated transportation costs or packaging waste (U.S. DHHS 2011).

**Breastfeeding Rates**

The World Health Organization recommends exclusive breastfeeding up to six months of age with continued breastfeeding up to two years or beyond (WHO 2012). The American Academy of Pediatrics also recommends exclusive breast milk for the first six months with “continuation of breastfeeding for 1 year or longer as mutually desired by mother and infant” (AAP 2012). Unfortunately, though 80 percent of mothers in the U.S. intend to breastfeed, many mothers stop breastfeeding within the first few weeks (Declerq et al 2009). More than 85 percent of women intend to breastfeed exclusively for three months or more, two-thirds are not meeting their intended duration (Perrine et al 2012).

The Healthy People Goals outlined by the U.S. Department of Health and Human Services in 2000 for breastfeeding were to increase mothers who “ever breastfed” (initiated breastfeeding in the early postpartum period) to 75 percent, those who breastfed at six months to 50 percent, and at 12 months to 25 percent (U.S. DHHS 2000). The 1999 baseline numbers for these goals were 64 percent, 29 percent and 16 percent, respectively. According to a survey conducted by the Centers for Disease Control and Prevention, in 2007 the U.S. had met the Healthy People 2010 goals for infants who were ever breastfed (CDC 2010). Unfortunately, despite these rising initiation rates, duration of breastfeeding at six and twelve months remains low, with 43 percent of women breastfeeding at six months, and only 22 percent breastfeeding at 12 months (U.S. DHHS 2011). While this shows a positive trend in breastfeeding in the U.S., the goals for
duration have not been met. The fact that the numbers drop off after this period demonstrates that although mothers want to breastfeed, they are being met with obstacles that impede their success.

Furthermore, despite overall improvements and upward trends in breastfeeding in the United States, disparities still exist by race/ethnicity, income and education level, and geography. Women with less than a high school education are less likely to breastfeed than those with higher levels of education, and breastfeeding rates among African American women are much lower than those among white women (CDC 2010). Low-income women are less likely to breastfeed than middle or high-income women (Ryan, Wenjun & Acosta 2002). Thirty four percent of women receiving the Special Supplemental Nutrition Program for Women, Infants and Children (WIC), which uses income to determine eligibility, are breastfeeding at six months, compared to 54 percent of women who are ineligible for WIC due to middle/high income (CDC 2010).

The result of these disparities is that lower SES women and their children, who tend to already have disadvantaged social, economic and health status, are further disadvantaged by not receiving the benefits of breastfeeding. Moreover, these mothers with the fewest resources have the least ability to overcome breastfeeding barriers (Gross et al 2011). Increasing breastfeeding rates and duration, especially among low-income and minority groups, has become a national public health priority.

**Breastfeeding Interventions**

The most vulnerable time for breastfeeding success is the first few days postpartum; during this time the breastfeeding rate plunges. The most critical time for breastfeeding assistance is in the first two to three weeks (Gross et al. 2011). The
Surgeon General’s recent Call to Action to Support Breastfeeding (U.S. DHHS 2011) cites as an example of a breastfeeding barrier the “inadequate assurance of post discharge follow-up for lactation support.” The report states “upon discharge from the hospital, mothers may have no means of identifying or obtaining the skilled support needed to address their concerns about lactation and breastfeeding; further, there may be barriers to reimbursement for needed lactation care and services” (U.S. DHHS 2011:25). Early problems that are not resolved are the cause of discontinuation of breastfeeding in the first weeks postpartum. These problems can include problems with infant latch, infant weight and growth concerns, pain, perceived lack of milk supply, problems with pumping, feeling overwhelmed, and psychological distress (Li et al. 2008, Gross et al. 2011).

Research supports the effectiveness of interventions in the first few days and weeks postpartum. Such research has examined the effects of home visits by Lactation Consultants, telephone contact, peer-to-peer support groups or professionally led breastfeeding drop-in centers. Postpartum interventions that began in the hospital and continued with home visits and or telephone support increased breastfeeding (Hannula et al 2008). In-home lactation support from a certified lactation consultant, telephone support, and combined professional and peer support all positively affect breastfeeding outcomes (Hannula et al 2008; McKeever et al 2002; Mannan et al. 2008). The Surgeon General’s report states:

“In various communities, the health care system has successfully coordinated with community networks to provide breastfeeding support to ensure that mothers have access to breastfeeding assistance after they return home. An important part of this assistance is having access to trained individuals who have established relationships with members of the health care community, are flexible enough to
meet mothers’ needs outside of traditional work hours and locations, and provide consistent information.” [U.S. DHHS 2011:24-25]

A qualitative synthesis of breastfeeding research found that mothers felt that they did not receive the breastfeeding support they needed or wanted from health professionals, and at times received conflicting advice (McInnes and Chambers 2008). As a result, social support was valued more highly than medical support.

Research on breastfeeding among low-income populations also shows the effectiveness of home and hospital visitation for improvement in duration of breastfeeding and reduction in breastfeeding challenges (Pugh et al. 2002; Raisler 2000; Gill, Reifsnider & Lucke 2007). A recent study of nursing mothers at two community health clinics who were predominantly Hispanic and/or black women receiving Medicaid, found that at two weeks post-partum, nearly 90 percent of the group receiving assistance from a lactation consultant was breastfeeding compared with 65 percent of the control group (Bonuck et al. 2005).

*Women, Infants and Children (WIC) Program*

The United States Special Supplemental Nutrition Program for Women, Infants and Children (WIC) is intended to serve low-income pregnant, postpartum, and breastfeeding women, infants and children up to age five who are nutritionally at risk. The Food and Nutrition Service (FNS) of the U.S. Department of Agriculture administers the WIC program, which provides nutritious foods to supplement diets, information on healthy eating, breastfeeding promotion and support, and referrals to health care. FNS writes that WIC serves “53 percent of all infants born in the U.S.” (FNS, n.d.). Women, infants and children must meet income guidelines, a state residency requirement, and be determined to be at “nutritional risk” by a health professional. In order to qualify for
WIC, the applicant must already be enrolled in other programs such as Medicaid, or her gross income must fall at or below 185 percent of the U.S. Poverty Income Guidelines.

Mothers who receive WIC who choose to breastfeed are provided counseling and educational materials, follow-up support through peer counselors, an enhanced food package, and are eligible to receive breast pumps or breast shields\(^2\). They are also eligible to participate in WIC longer than non-breastfeeding mothers (up to one year compared to six months) (FNS n.d.). According to the FNS website, “routine issuance of infant formula for partially breastfed infants less than one month of age is not authorized.” Each WIC state agency is responsible for implementing the program, and may vary in staff and food packages (Colman et al 2012).

The National WIC Association’s *Guidelines for WIC Agencies Providing Breast Pumps* states that WIC is authorized to use funds to purchase breast pumps. Some reasons listed for which breast pumps may be provided include:

1. When infants are premature and unable to suck; 2. When infants have severe feeding problems (e.g., cleft lip or palate) or unable to suck; 3. When mothers have difficulty establishing or maintaining an adequate milk supply due to maternal/infant illness; 4. When mothers and infants are separated (such as hospitalization or returning to work or school); 5. When mothers have temporary breastfeeding problems, such as engorgement; and 6. When mothers have twins or triplets. [n.d.:1]

The Guidelines note “Providing breast pumps to all breastfeeding women regardless of need may have the unintended consequence of reinforcing a lack of confidence to breastfeed” (3). WIC encourages local programs to assist mothers in establishing and

\(^2\) Made of thin silicone, a nipple shield is worn over the nipple and areola while the baby nurses. It may be helpful for some mothers who have flat or inverted nipples, to protect sore nipples, when a baby refuses the breast but will take a bottle, or for premature infants. Its use is intended to be only temporarily.
maintaining lactation without the use of a breast pump, and that pump support should be accompanied by lactation counseling.

Research specifically on breastfeeding mothers who are low-income has found that women who receive help from trained peer counselors have greater initiation, exclusivity, and duration of breastfeeding (Kistin, Abramson and Dublin 1994; Arlotti et al 1998; Anderson et al 2005; Pugh et al 2002). A randomized control trial among low-income inner-city Latina women found that the rate of not exclusively breastfeeding at one, two, and three months was significantly lower in the peer counselor group compared to the control group (Anderson et al. 2005).

Qualitative analyses on breastfeeding among low-income women have focused on WIC participants (Raisler 2000; Stolzer 2010). These mothers felt that getting back into their life routine at home, work, or school was an important issue. Valued traits in their peer counselors included the ability to respond promptly to distress calls, making home visits, providing hands-on assistance, and being caring and knowledgeable (Raisler 2000). Most of the time, low-income women understand the benefits of breastfeeding but encounter constraints such as work, social restrictions, lack of social support, and limited access to professional assistance (Stolzer 2010). Research on breastfeeding rates among WIC participants compared to WIC-eligible families and non-eligible families suggests lower breastfeeding rates among participants (Colman et al 2012, U.S. DHHS 2011). Some scholars suggest that the WIC program deters low-income women from breastfeeding through the free formula distribution (Stolzer 2010). Holmes et al. (2009) found that WIC participants see a contradiction in WIC as both a formula provider and
promoter of breastfeeding. As it currently functions, WIC may not be the most ideal model of a breastfeeding intervention for low-income women.

Theoretical Framework

A Biocultural Perspective

Lactation is inherently biocultural; it is an evolved human biological process and a behavior that is culturally determined and shaped. Nowhere in the world is breastfeeding merely physiological. Indeed, “Breastfeeding is the ultimate biocultural phenomenon; in humans breastfeeding is not only a biological process but also a culturally determined behavior” (Stuart-Macadam 1995:7). The study of breastfeeding necessarily entails an understanding of the human body’s relation to societal forces, which is the strength of a biocultural medical anthropology perspective. This perspective takes into account the evolutionary, biological, social, cross-cultural, political, historical, and ecological aspects of health issues. It considers that “human bodies do not exist in isolation from their ecological and sociocultural milieu, which in turn has been shaped by various historical processes” (Wiley and Allen 2009:6). With the use of a biocultural perspective, we can understand breastfeeding within these multiple contexts. These contexts interact to create particular breastfeeding experiences.

Evolution has changed the way women breastfeed, and a study of human origins history and physiology can help us understand the biological aspects of lactation. Biocultural theory retains an evolutionary viewpoint for the contribution of prehistoric perspectives and adaptation (Walker 1998). Patricia Stuart-Macadam writes, “For more than 99 percent of our existence all human infants have obtained their main nutrition through breastfeeding and as mammals we have an evolutionary
history of lactation that is even more ancient... Alterations of this age-old pattern can have profound implications for the physiology, growth and development and health of human infants and children as well as for the physiology and health of women.” [1995:7]

Recent changes have occurred as a result of a loss of community networks and breastfeeding role models and a greater reliance on the medical profession and hospitals to receive advice and make health decisions (Newton 1995:x). While in the past, women would turn to family members and community networks for help with breastfeeding, authoritative knowledge now rests in the hands of medical professionals and hospitals. This medicalization of breastfeeding is discussed in greater detail below.

In general, breastfeeding literature has not approached lactation from a holistic biocultural perspective, with much of the literature focusing on either cultural aspects or biological aspects (Stuart-Macadam 1995). Cultural perspectives that focus solely on beliefs and behavior ignore the manner in which mothers and their infants are biologically linked. However, the view that breastfeeding is solely biological, as clinical biomedicine understands it, “privileges the body as the only relevant environment,” and “individuals are perceived as uniquely responsible for their health” (Wiley and Allen 2009:7). The biocultural perspective challenges this biological reductionist point of view and examines the medicalization of breastfeeding and the sociocultural factors that affect health.

In breastfeeding, biology and social context are “inextricably related, and an alteration in behavior can have a reciprocal effect on biology” (Stuart-Macadam 1995:7). Behavior affects biology when, for instance, the society shifts to perceiving breasts as sexual objects and babies are bottle-fed instead of fed at the breast. Or when “babies in some societies are denied colostrum, with all its beneficial properties,” being high in
antibodies and protein, because it is believed to be dirty or poisonous (Stuart-Macadam 1995:9).

Further, breastfeeding is a complex process that interacts not only with biology and culture, but that is also affected by environmental and political conditions (Van Esterik 2002). As Rudzik (2012) writes, “A woman’s biological systems provide the capacity for lactation, her structural and cultural milieux often define the parameters for decisions about infant feeding, and her individual experience shapes her own breastfeeding practice” (108). The decisions that she makes are intertwined with structural factors such as poverty and inequality. The biocultural perspective in medical anthropology increasingly incorporates the concept of political economy, which examines power and socioeconomic status and their impact on health (see full discussion under History, Policy, and Economy section). Furthermore, a biocultural approach addresses the concept of embodiment: the idea that the body is both physical and social, and the social impacts the physical body. This concept can help us overcome the dominant biomedical view that the lactating body is separate from its social, historical, political and environmental context. Thus, it is useful to use a biocultural framework to examine lactation. These themes will be explored in greater detail in the sections below.

**Feminism and Breastfeeding**

Historically, feminists were not concerned with constraints on breastfeeding, as the pregnant body took precedence as the subject of feminist analysis of reproductive issues (Hausman 2003). Indeed, some feminists today are actually anti-breastfeeding, as they perceive that lactation suggests essentialism and biological determinism (Hausman 2003). The major issue of this group of feminists is perception that the pressure on
women from society to breastfeed is “a way of entrapping them in the maternal role” (Smith, Hausman, and Labbok 2012:xii). Present-day public health campaigns that focus on health messages and individual behavior change only reproduce the dominant ideology of the “good mother.” A feminist analysis of breastfeeding, as Smith, Hausman, and Labbok (2012) explain, must go beyond, through an examination of the reality of women’s lives. Penny van Esterik, a feminist anthropologist who writes on breastfeeding, says she takes from feminism the argument that “the personal is political,” namely that the theoretical cannot be separated from the practical (Van Esterik 2012). A feminist approach focuses on the social constraints of breastfeeding, such as gendered social structures, economic status, and division of power, and a rights framework. Feminists examine the structural inequalities that affect the lives of women, including class, race, and gender.

Because women’s bodies are attributed with different social identities, and people experience the world through their bodies, situatedness is an important concept for valuing women’s perspectives and experiences (Harding 1993; Haraway 1988). Women’s lower status in society contributes to their subordination, and consequently, lack of support for the issues that affect them. Additionally, an intersectional approach takes into account the fact that all patterns of oppression in society, such as gender, race, class, sexual orientation, etc., mutually influence one another (Crenshaw 1995; Dodgson 2012). Because breastfeeding rates and experiences vary by race and class, it is important to understand the relation of these to each other and to social inequality. It is essential to understand that “women’s experiences are always constructed in the complex intersections of these societal forces” (Smith, Hausman, and Labbok 2012:6).
A feminist approach calls for the focus to be removed from individual maternal failings, subsequent guilt, and anger at public health campaigns that ignore reality. Sociocultural and economic issues constrain women’s behaviors and are obstacles to a woman’s right to breastfeed. Instead, the focus must be on the structural constraints that impact breastfeeding success, such as “workplace rules and support, the constraints of women’s social roles, the changing context of public policy and law, the influence of race and racism, the importance of social class, the effects of medicalization… and the meaning of women’s exposed bodies in public” (Smith, Hausman, and Labbok 2012:4). Rather than focusing only on health and choice, which only inhibit women from realizing their rights, there is a need to focus on the cultural, political, historical, economic and social. A feminist perspective will greatly inform this examination of women’s breastfeeding experiences.

**The Biology of Lactation**

Humans have been providing nutrition to our offspring by breastfeeding for the majority of human history. Biology provides the capacity for human bodies to lactate and provide for our young in this manner; indeed, our breasts are what make us mammals. Wenda Trevathan has focused on the hormone interplay during pregnancy, birth, and breastfeeding and the way in which milk production and letdown occur (Trevathan 2003, 2010). Breast milk production is based on supply and demand; the more an infant suckles, the more the hormones prolactin and oxytocin are released, which leads to increased milk production and letdown (milk ejection). When the frequency of suckling is decreased, possibly because the infant is separated from the mother (after birth or when
the mother returns to work) or is supplemented with something other than breast milk, less milk is produced.

Breastfeeding is an evolved and adaptive behavior. Biological anthropology research emphasizes the composition of breast milk and the health benefits of breastfeeding, as well as the high rates of illness among children who are formula fed (Trevathan 2003; Fildes 1995; Stuart-Macadam 1995; Cunningham 1995). The composition of breast milk “has evolved with and is tailored to the physiological and growth needs of each species,” including humans (Trevathan 2003). Human milk is low in fat and protein and high in carbohydrates, which matches development requirements, and also matches the frequent nursing pattern seen in humans compared to other species. Additionally, milk composition changes during a feed, throughout the day, and as the infant grows, matching his or her nutritional and immunological requirements.

The evolution of lactation has implications for infant and maternal health. For instance, suckling immediately after birth helps stimulate contraction of the uterus, which reduces maternal mortality from postpartum hemorrhage. Furthermore, the composition of human milk necessitates frequent feeding, which requires close contact. Evolutionary and biocultural research has found that co-sleeping likely evolved because of human infant vulnerability and the low fat composition of breast milk that necessitates frequent feeding (Gettler & McKenna 2011). The energetic needs of lactating women are generally higher than those of non-lactating women, but comparatively the energetic cost of lactation is relatively low in humans (Fouts et al 2012). Moreover, the volume of breast milk produced is associated with infant feeding rather than with the mother’s nutritional status.
James McKenna and colleagues have found that “from an evolutionary viewpoint, so entwined are the biology of infant sleep” that breastfeeding frequency is determined by where infants sleep, and that co-sleeping supports breastfeeding (McKenna and Bernshaw 1995:265). Additionally, sleep lab studies have found that co-sleeping and breastfeeding may help prevent Sudden Infant Death Syndrome (SIDS), and that current cultural norms and pediatric recommendations against co-sleeping need to be redefined (McKenna, Ball & Gettler 2007). Further anthropological research on breastfeeding and sleep has emerged, particularly with a focus on embodied practices, moral dilemmas, and cultural construction of sleep arrangements of the breastfeeding dyad (Tomori 2011).

Moreover, frequent breastfeeding plays a role in suppressing ovulation in the mother (lactational amenorrhea), which leads to reduced fecundity, which can act as a natural birth spacer (Ellison 1995, Van Esterik 2002). The more frequently a mother nurses the infant the more resumption of ovulation is suppressed, which tends to be rare in societies where scheduled feedings are encouraged (Wiley and Allen 2009). Research shows that longer birth intervals improve maternal and child health and reduce infant mortality (Trevathan 2003).

Evolutionary anthropologists have found that many of our modern breastfeeding behaviors create a mismatch between our evolved biology and societal norms (Trevathan 2010, McKenna and Gettler 2011). Cultural factors dictate whether a mother will breastfeeding or formula feed her child, how soon an infant will nurse after birth, whether or not the mother and infant co-sleep, how frequently breastfeeding occurs, and when the infant will be weaned. These influence the effectiveness, or lack thereof, of the protective

Examples of practices that delay initial nursing and interrupt milk production include the practice of routinely separating mothers from their infants immediately after birth and discarding colostrum (the first milk, which is high in antibodies) and waiting to feed the infant the true milk (Trevathan 2003, 2010). Putting baby on a schedule rather than allowing for baby-led, spontaneous feeding, which is common in developed nations, can also reduce milk production (Woolridge 1995, Trevathan 2003). Also, cultural practices often dictate “variation in beliefs about the timing and method of weaning” (Trevathan 2003:233). Supplementation is frequently encouraged at around six months of age. Katherine Dettwyler’s (1995) research comparing primate gestation length, birth weight, adult weight, timing of the first molar, and other measures has determined that the “natural” age of weaning for humans should be between two and a half and six years. However, it is rare in developed nations for women to breastfeed for longer than six months.

Despite its biological origins, breastfeeding is not always practical or optimal for all women. Society assumes that mothers instantly and intrinsically bond with their offspring and naturally breastfeed, but feminist anthropologists have refuted the arguments for maternal instinct as part of our human evolutionary legacy. Nancy Scheper-Hughes (1985) argued that maternal bonding is socially produced, culturally and historically bound, and not at all an innate and universal concept. Sarah Blaffer Hrdy (1999) explores this concept as well, explaining that the idea of the self-sacrificing mother is a product of human cultural ideas, not the dominant reality, and is based on
ideas of morality. In our culture, we believe that it is immoral and unnatural for a mother not to bond with her baby, not to want to breastfeed, and not to enjoy breastfeeding. Hrdy’s research (1999) finds that not all mothers instantly bond with their children, but that mothers constantly weigh their needs with the needs of their offspring in a cost-benefit analysis. Hausman (2003) calls for a feminist evolutionism, in which attention is paid to the ways that mothers assess their options in constrained social circumstances (153). The following sections explore the social, political, historical, and cultural context of breastfeeding.

**History, Policy, and Economy**

While breastfeeding has a biological origin, politics, power, and economic forces also affect its practice. Merrill Singer explains that human biology has been deeply influenced by “the changing political economy of human society” (1996:497). A political economic perspective comes out of critical medical anthropology, which focuses on “imbalances in power relations and differential access to health,” particularly how capitalism and neoliberal economics relate to health (Walker 1998:78). This perspective aims to understand health by examining macro-level influences on human biologies. Health varies by context and is “affected by and reciprocally influence[s] such factors as the control, production, and the distribution or material resources, ideology, and power” (Goodman and Leatherman 1998:19).

As Wiley and Allen (2010) write, “one of the most obvious sources of variation in health across the globe is economic status…those with fewer resources are doubly at risk of poor health” (26). Research on inequality and health shows that there is a strong
relationship between socioeconomic inequality and health outcomes. This correlation tends to do more with relative poverty. An individual’s health in a less egalitarian society will be worse than the health of an individual in a more egalitarian society (Guyen and Peschard 2003:449). According to the political economy perspective, changing the economic, social, and political structures that lead to differential access to resources is the solution to health disparities. Women who are socially vulnerable and marginalized, particularly low-income and minority mothers are less likely to have access to adequate health care, safe domestic spaces, and social support (Kukla 2006).

Research has shown that breastfeeding disparities exist between racial/ethnic groups and classes. In the U.S., institutional limitations associated with racism and poverty create structural violence. The medical anthropology concept of structural violence, popularized by Paul Farmer, is “violence exerted systematically – that is, indirectly – by everyone who belongs to a certain social order” or the social structures such as poverty and racism that perpetuate diseases (Farmer 2004:307). Race and class affect the lived realities of women’s breastfeeding experiences, limiting the possibilities open to them, and leaving them disadvantaged and at risk for harm (Hausman, Smith, Labbok 2012). Chin and Dozier (2012) argue that structural violence negates the concept of choice, because it decreases available options, denies “access to resources,” and inflicts “emotional and physical suffering on individual people” (65). They argue that for low-income women who struggle with transportation, safety, food, healthcare, housing, and so on, agency is essentially thwarted. As Dodgson (2012) writes, “Viewing SES through compartmentalized categorically based epidemiology does not reflect the complexity of embedded power and privilege within social situated behaviors” (79).
In addition to the disadvantages resulting from structural violence, racism also has a profound effect on the lives of mothers. Access to services and type of services received differ depending on the socially and governmentally defined concept of race/ethnicity. Hausman explains, “as long as breastfeeding is medicalized, the differential access to medical care in the United States significantly impacts the actual practice and experience of breastfeeding mothers and infants across the socioeconomic spectrum” (2003:26).

Furthermore, healthcare providers have been shown to provide different information and advice to African-American women and Hispanics based on pre-conceived expectations (Dodgson 2012). Research has also found that patients who were women of color received less assistance from predominantly white nurses who perceived that minority patients would require too much of their time (Spitzer 2004). Racial disparities have also been recorded in education, employment, and how much leave time workers take (Lucas and McCarter-Spaulding 2012).

While breastfeeding intention and duration are often framed as individual choice, the circumstances in which these choices are made are closely tied to structural indications such as socioeconomic status and poverty. Most interventions are designed to increase breastfeeding by focusing on the individual and not addressing underlying conditions such as income level, education, and employment, which constrain infant feeding (Rudzik 2012; Tomori 2011; Scheper-Hughes 1992). As Blum argues, “the material circumstances of white middle- and upper- class women’s lives mean that they are more likely to experience such advice as appropriate and achievable” (Hausman 2003:219). Feminist anthropology discourse incorporates the point that research and interventions should not be focused solely on the individual but also on larger economic
and policy factors, such as capitalism and corporations, globalization, poverty, and socioeconomic status. Some ethnography explores how breastfeeding is embedded in systems of production and consumption in a globalized economy (Van Esterik 2002).

**Medicalization**

Out of the Enlightenment era came the idea of dualism – that the mind and the body are separate. This concept, and the idea that the body can be broken down into parts, led to the view of the body as a machine (Davis-Floyd 2004; Martin 1987). Doctors became mechanics who actively manage and “fix” broken aspects of the body. The male body became the norm and female bodies were considered deviant from this norm. Thus, the female body is considered a defective machine, and all its processes inherently “anomalous and dangerous” and more “subject to the vagaries of nature” (Davis-Floyd 2004:52). Emily Martin (1987) explains that much of the language used to describe female reproductive processes is negative, while those used to describe those of males are more positive. These views changed the way women’s bodies were conceptualized, particularly reproductive processes, both by biomedicine and women themselves.

Mechanization of the human body, the idea that women’s bodies are defective, and the separation of mind and body led to the view that parturition is pathological and must be controlled with technology (Davis-Floyd 2001). Industrialization brought with it a new attitude towards medicine and bodies. Childbirth began to be treated as an assembly line production process where female bodies should be managed and controlled in a factory-like hospital in order to create the product – the baby (Dykes 2005). This mechanical model of female bodies and how they fit in with capitalist production methods extend to breastfeeding. Fiona Dykes (2005) writes,
If the breasts (machines) are in ‘good-working order’ then they will ‘produce’ the right amount and quality of the ‘product’, breast milk. If the labourer uses them effectively, then they will deliver the ‘product’ efficiently and effectively and in the correct amount to the ‘consumer’, the baby. (2005:2291)

Just as childbirth has become medicalized and technologized, so has infant feeding.

At the turn of the 20th century, infant feeding reflected the “mechanistic, dualistic and reductionist assumptions of the Enlightenment,” presenting breast milk as a product (Dykes 2005:2285). As Tomori (2011) writes, “Formula offered a modern, scientific and rational method of feeding babies” (2011:64). The increasing involvement of physicians in birth and breastfeeding “led to increased management of infant feeding” where a scientific approach of strict feeding schedules and precise measurements took over (Tomori 2011:63). Breastfeeding, long a normal part of life for women who become mothers, has become medicalized: treated as a medical condition with problems that need to be diagnosed and treated. Authoritative knowledge of lactation is now within the realm of biomedicine.

The increase in the profession of lactation consultants is a demonstration of the increasing medicalization of breastfeeding, as their chief goal is to identify and treat patients’ breastfeeding issues. As anthropologist Aimee Eden (2012) explains, lactation consultants work within the biomedical system, but also embrace a woman-centered philosophy. The lactation consultant is able to fill in a gap in care, as pregnancy/birth care providers and pediatricians have minimal training in lactation. While it is important to appreciate and honor the fact that lactation is a normal aspect of physiology and the life cycle, it is also worth the attention of professionals who can help when nursing experiences differentiate from the norm. Sometimes stuck in between respect for
embodied knowledge and biomedical knowledge, lactation consultants “simultaneously empower women and contribute to the medicalization of breastfeeding” (Eden 2012:99).

**History**

Historical archives provide an important context for framing the culture of breastfeeding in the United States. In cultures throughout history, infant feeding choices were influenced by state and religious texts and policies, as in the case of wet-nursing (Van Esterik 1995). Higher-class families were able to hire wet-nurses to feed their children, while working-class mothers frequently relied on alternative feeding methods. Artificial feeding (generally with animal milk) of infants often resulted in morbidity or mortality.

Changing economics and the ability to purchase breast milk substitutes in conjunction with the active promotion of breast milk substitutes by formula companies led to a dramatic increase in formula feeding and a drop in breastfeeding (Trevathan 2003). By World War II, the majority of women in the U.S. bottle-fed their babies; only one in five women began breastfeeding in hospitals through the middle of the 20th century (Trevathan 2003, Tomori 2011). Breastfeeding, especially on-demand, was depicted as outmoded and unsophisticated, whereas bottle-feeding was something done by the affluent citizens of Western nations (Dykes 2002). Additionally, messages about insufficiencies of breast milk compared to infant formula were widespread. This active promotion of infant formula was a major factor in decreasing breastfeeding rates.

As birth rates began to fall in developed nations in the 1960’s, the formula industry began to market to developing nations (Van Esterik 1995, Trevathan 2003). Marketing of baby formula to women in developing countries who could not afford to
pay for it, did not have access to clean water, or who did not understand that using formula would interfere with going back to breastfeeding led to malnutrition and death for infants who missed out on immune protection from breastfeeding. Outrage for unethical marketing practices gave rise to consumer boycotts of infant formula manufacturers, particularly the Nestlé Corporation (Van Esterik 1995, Trevathan 2003).

This boycott resulted in the creation of the World Health Organization/UNICEF International Code of Marketing of Breast Milk Substitutes (WHO 1981). The code was developed with “the cooperation and consent of the infant formula industry,” and was adopted by the World Health Assembly vote (Van Esterik 1995). Fundamentally, the code states that marketing of substitutes can not directly or indirectly target the consumer (no free samples given to pregnant women or parents at all), but advertising about formula can be given to health care providers; the government and not formula companies, may provide literature on infant feeding; and all donations of money or equipment by formula companies to health care providers must be done openly and without special benefits.

This code, however, is not law. Infant formula companies who promote and distribute free and low cost breast milk substitutes to physicians and health care facilities, and advertise and provide free samples to mothers, frequently disregard it. Violation of the code led a renewed boycott of Nestlé. In the second half of the 20th century, there was a shift to return to notions of the “natural” way – in childbirth, breastfeeding, and mothering. Grassroots movements, such as the La Leche League peer support group for breastfeeding mothers, led to an increase in breastfeeding rates and the development of the lactation consultant (Trevathan 2003; Tomori 2011; Eden 2012).
In 1990, the WHO/UNICEF Innocenti Declaration on the Protection, Promotion and Support of Breastfeeding was created, along with the World Alliance for Breastfeeding Action (WABA) (Van Esterik 1995). WABA is a global network of non-governmental organizations and individuals who act on the Innocenti Declaration. WABA’s first campaign was the Baby Friendly Hospital Initiative, which, in conjunction with UNICEF and the WHO, aims to protect, promote and support breastfeeding in hospitals. Presently, there are only 150 hospitals in 34 states designated Baby Friendly in the U.S., and six percent of babies in the U.S. are born in Baby Friendly facilities (Baby Friendly USA Inc. 2012).

The 1990’s saw major efforts to increase breastfeeding rates in the U.S. This included the Healthy People goals, the establishment of the United States Breastfeeding Committee, blueprints for action from the Department of Health and Human Services, and American Academy of Pediatrics policy statement promoting breastfeeding. In 1998 the first breastfeeding legislation, aimed at the rights of working women to express milk during their infants’ first year, was introduced in Congress. It was not enacted, but in the same year state WIC agencies were authorized to use food funds to purchase or rent breast pumps (Food and Nutrition Service). The 2010 Patient Protection and Affordable Care Act was the first U.S. law passed promoting breastfeeding-friendly workplaces. Most recently, the U.S. Surgeon General Regina Benjamin issued the “Call to Action to Support Breastfeeding,” aimed at describing the steps that can be taken toward a society-wide approach to remove breastfeeding obstacles. Benjamin writes, “This approach will increase the public health impact of everyone’s efforts, reduce inequities in the quality of health care that mothers and babies receive, and improve the support that families receive.
in employment and community settings” (U.S. DHHS 2011:iii).

**Current Policies**

Breastfeeding legislation and policy are huge contributors to breastfeeding disparities (CDC 2008). Research on state breastfeeding trends has found that children in states with no breastfeeding legislation were less likely to have been breastfed (Kogan et al, 2008). Only 44 states specifically allow women to nurse in any public or private location, only 28 states exempt nursing from public indecency laws, and only 24 states have laws related to breastfeeding in the workplace (National Conference of State Legislatures, 2010). Additionally, there is little to no health insurance coverage for lactation counseling and other services and products related to breastfeeding, despite the fact that the health benefits of breastfeeding would save insurance companies money. Furthermore, there is no protection from discrimination or being fired for being a nursing mother (Forbes and Rigg, 2009).

Employment policy is important to the discussion of breastfeeding, as 53 percent of mothers with children under the age of one are in the workforce (Calnen, 2007:34). Rippeyoung and Noonan (2012), in their study of the income consequences of breastfeeding, point out that since breastfeeding is less compatible with paid work, breastfeeding mothers are more likely to reduce their work hours. As a result, mothers may be negatively affected in the long-term; for example, losing out on promotions or experiencing prolonged earnings losses. Only 32 percent of nursing mothers concurrently maintain employment (Calnen, 2007). Working mothers breastfeed for a shorter amount of time than non-working mothers, especially if they work full-time (Mills, 2009; Johnston and Esposito, 2007, Calnen, 2007).
Workers who are paid an hourly wage have less control and are less able to take paid breaks to nurse or express breast milk (Kimbro 2006; Brown, Poag and Kaspryzseki 2001). Many work environments prohibit mothers from bringing their infants to work and/or lack on-site childcare or a lactation room to nurse or pump in privacy. Fortunately, in 2010 the Patient Protection and Affordable Care Act amended the Fair Labor Standards Act with the section “Reasonable Break Time for Nursing Mothers.” This act requires that an employer provide break time and a private, non-bathroom location to nursing mothers for one year after a child’s birth (United States Breastfeeding Committee 2012). The act does not require that the break time be compensated, and employers with fewer than 50 employees are not subject to these requirements.

The time of return to work is the most powerful predictor of breastfeeding duration (Calnen 2007). The United States is among the worst countries in the world for paid parental leave. It is one of the only nations in the world that offers zero weeks of paid maternity leave benefits, and mothers in the U.S. have shorter periods of job protected leave (Berger, Hill and Waldfogel 2005; Ogbuanu et al 2012). A report by Lovell, O’Neill and Olsen, found that nearly a quarter of the best employers for working mothers provide four or fewer weeks of paid maternity leave, and half provide six weeks or less (2007). Currently the only federal law related to parental leave in the U.S. is the Family and Medical Leave Act, which provides for 12 weeks of unpaid leave under certain conditions. Low-income women tend to be the least able to take leave from work due in part to the type of employment they hold. Lack of paid maternity leave causes the greatest breastfeeding complications for those who hold “nonmanagerial positions, lack job flexibility, or experience psychosocial distress” (Guendelman et al. 2009:e45).
Many anthropologists and sociologists from the feminist school of thought focus on lack of parental leave and laws protecting breastfeeding at work as major contributing factors to the practice of breastfeeding (Tomori 2011; Hausman 2003; Labbok, Smith and Taylor 2008, Rippeyoung and Noonan 2012). Breastfeeding “can be understood only within the context of wealth and poverty, female labor, the exploitation of women in the service of men, and the social systems that reinforce male power” (Kitzinger 1995:386). Paid parental leave and on-site daycare, so that the mother can nurse her child without the use of a breast pump, would allow long term breastfeeding to occur without class-based considerations. Unfortunately, as Cecilia Tomori notes, “The U.S. stands out among wealthy industrial nations for its resistance to implementing structural changes that enable and support breastfeeding, such as access to health care, paid parental leave, subsidized and on-site childcare, and tighter regulation of the infant formula industry” (2011:3). These policies would protect all mothers more broadly and work against the reproduction of class, gender, and racial inequalities.

**The Socio-Cultural Context**

Breastfeeding is influenced by social and cultural factors, and much research has focused on variation in feeding practices. Cultural studies and cross-cultural comparisons have focused on who feeds the child, where breastfeeding occurs, how often it occurs, duration of infant feeding, how breastfeeding is learned, and how it is experienced, in addition to the level of support in society, how society views breasts, and postpartum taboos (Hadley, Patil & Gulas 2010; Gottschang 2007; Dettwyler 1995; Stuart-Macadam 1995; Avishai 2011). As Van Esterik (1996:n.p) writes, “Breastfeeding as a process is
culturally constructed: that is, in spite of its physiological base, the process itself, its meaning, and the way it is integrated into cultural systems varies globally.” It is also an embodied practice that incorporates and reflects the social context.

Variation in beliefs and practices regarding breastfeeding is frequently determined by social customs and norms that are culturally specific. As Orit Avishai (2011) elucidates:

Conditions, norms and customs govern infant feeding decisions – breast milk or breast milk alternatives; who may feed the child at the breast – the mother, a paid wet nurse, other mothers in a network of childcare; where breastfeeding is to occur – in public, at the workplace, in the presence of family members, or only in the privacy of one’s home; how often breastfeeding should occur – according to a fixed schedule or ‘on demand’, in response to infant cues; how long breastfeeding should last – through early infancy or well into toddlerhood; how breastfeeding is to be learned – within the mother’s informal kin and social networks or through specialized professionals; and how breastfeeding is experienced – as pleasurable and empowering or as a burden. [34-35]

In some cultures, lifestyle determines whether infants are fed on demand no matter when or where they need to be fed, and in others breastfeeding is private and scheduled (Trevathan 2003). Moreover, beliefs about avoiding certain food or activities while breastfeeding dictate a woman’s nursing experience and determine when to wean. A baby may be weaned if the mother becomes pregnant again or wants to become pregnant. Additionally, in some cultures maternal depression and sexual intercourse are thought to contaminate the mother’s milk, or tradition dictates that the colostrum is dirty and should be discarded (Fouts 2012; Trevathan 2003; Dettwyler 1995).

In the U.S., beliefs and misconceptions about the quality of breast milk have an effect on breastfeeding initiation, duration, and exclusivity (Dykes and Williams 1999). Marketing of formula as “fortified” leads to the belief that it is just as good or possibly even better than breast milk. Campaigns to increase vitamin and mineral supplementation
while breastfeeding can lead to ideas that breast milk alone is not adequate. Especially since many physicians endorse infant formula (a violation of the WHO Code), many women believe that infant formula is better for their infants than breast milk alone (Dettwyler 1995; Trevathan 2003).

Indeed, health care providers play a huge role in determining breastfeeding success. Obstetricians, gynecologists, and pediatricians have little to no training and knowledge of human lactation, so patients lack both prenatal and postpartum education and guidance with breastfeeding. A 2006 study found that “clinicians report feeling that they have insufficient knowledge about breastfeeding and that they have low levels of confidence and clinical competence in this area” (U.S. DHHS 2011:15). As a result, they rarely speak with their patients about breastfeeding. They are unable to educate their patients about nursing “techniques, current health recommendations on breastfeeding, and strategies to combine breastfeeding and work” (U.S. DHHS 2011:15).

Physicians also have their own personal beliefs or cultural biases, or may be influenced by propaganda or gifts from formula marketing companies. Indeed, “a recent survey of pediatricians showed that many believe the benefits of breastfeeding do not outweigh the challenges that may be associated with it,” and so they often recommend that women do not breastfeed (U.S. DHHS 2011:15). Clinicians may make recommendations based on their own personal experiences with breastfeeding, even if these are not evidence-based and go against the recommendations of the American Academy of Pediatrics (Szucs, Miracle & Rosenman 2009). Occasionally, physicians do not emphasize breastfeeding with their patients because they do not want to make women feel guilty (Dettwyler 1995).
Hospital procedures have a large effect on the initiation of breastfeeding. Increasing medicalization and high use of technological intervention during childbirth can negatively impact breastfeeding success. Certain medical interventions during birth make breastfeeding more challenging, including instrumental delivery with forceps or vacuum, pain medication and anesthetics, intravenous fluids, and cesarean section (Smith 2007). Also detrimental to breastfeeding success is the routine practice of separating mothers from newborns, not encouraging skin-to-skin contact immediately after birth, not practicing rooming-in, and not showing mothers how to maintain lactation if the newborn must be separated from the mother for a period of time (Forbes & Rigg 2009, U.S. DHHS 2011). A Centers for Disease Control and Prevention (2008) study found that birth facility practices related to lactation are frequently not evidence-based and interfere with breastfeeding. The 2012 CDC Breastfeeding Report Card reports that 24 percent of birth facilities supplement healthy, full-term newborns with non-breast milk. Research also shows that supplementation with non-breast milk and use of pacifiers and artificial nipples, which many hospitals do even against the mother’s express wishes, can have a negative effect on breastfeeding success (Dewey et al 2003; Perrine et al 2012). Moreover, hospital discharge “goody bags” containing formula samples and coupons are an institutional breastfeeding pitfall (Rosenberg et al 2008; Howard et al. 2000).

Social support, both skilled and informal, has been shown to be associated with breastfeeding success (McInnes & Chambers 2008, Schmied et al 2011). Research has also found that poor support can contribute to early cessation of breastfeeding (Schmied et al 2011). There is a lack of International Board Certified Lactation Consultants on staff in health facilities; in some hospitals it is as low as one IBCLC for every 1,000 births.
(CDC 2012). Family pressures from the baby’s father, grandmother, or other relatives can sabotage breastfeeding, especially if they provide misinformation or are unsupportive (Dettwyler 1995; U.S. DHHS 2011). Partners who feel left out if they cannot help feed the baby, or grandmothers who did not breastfeed themselves, may pressure a mother to bottle-feed. Moreover, peer-to-peer support is an important component of social support for breastfeeding mothers, but there is fewer than one La Leche League leader per 1,000 live births in the U.S. (CDC 2012). WIC peer counselors and other government workers whose recommendations affect breastfeeding success are not adequately trained in breastfeeding (Beal et al 2003).

Government initiatives have a large effect on the socio-cultural climate of breastfeeding, especially in the form of public health breastfeeding campaigns. These campaigns focus on educating individual mothers and influencing their decision to breastfeed. They are frequently based on risk and assume that the reason the mother is not breastfeeding is a result of lack of knowledge or a moral failing in not making the right choice (Hausman 2003; Kukla 2006). Feminist scholars focus on how despite the relative failure of these campaigns they tend to be the repeated tactic for increasing breastfeeding rates. Kukla (2006) questions the ethics of breastfeeding promotion approaches such as the National Breastfeeding Advocacy Campaigns of “Breast is Best” and “Babies Were Born to be Breastfed.” She writes that these advocacy campaigns assume rational behavior of individual mothers and fail to take societal and political barriers into account. Framing breastfeeding as a choice obscures the cultural and institutional realities of the practice in our society, and assumes that women are free to make unconstrained decisions about infant feeding (Dettwyler 1995; Avishai 2011). Such an approach ignores larger
structures, such as poverty and racism, and social circumstances that restrict some women from freely choosing breastfeeding. This perspective does not take into account the fact that responses to breastfeeding are not always rational. Reactions to the bodily experience of breastfeeding frequently have little to do with rationality and a great deal to do with emotional responses.

**Embodiment**

The study of breastfeeding necessarily entails an appreciation of women in relation to their own bodies. Public health breastfeeding campaigns traditionally focus on the biomedical, the individual, and cultural beliefs. They rarely take women’s lived experiences of their own bodies into account. As feminist scholar Bernice Hausman (2003) notes, lactation is an embodied maternal practice, one that “establishes a specific kind of relation between the mother and the infant through the mother’s body, thus demonstrating a radical embodiment in which two individuals share a physiological relation” (192). The embodiment approach takes into account social and cultural meaning, does not distinguish between the mind and the body, and views the body as both physical and symbolic. The body is more than a biological object; it is meaningful and relational and exists within a particular societal and historical context (Lende & Lachiondo 2009). This approach is relevant to understanding women’s experiences of breastfeeding. “Breastfeeding heightens awareness of body as self and body boundaries; but meanings assigned to bodies and boundaries are neither universally shared nor unchanging,” Van Esterik explains (2002:263). As it is a biosocial process that is both naturally and culturally shaped, a look at breastfeeding requires an understanding of the
human body’s relation to societal forces.

Breastfeeding experiences are very complex and subjective, wherein actions and decisions are structured by society, culture, economics, and politics. Women utilize embodied knowledge that is developed from their own social and personal experiences to make breastfeeding decisions. Women may rationally understand and believe in the positive health benefits of breastfeeding, but this may be understood separately from their personal experience, which may be positive or negative. Breastfeeding is frequently portrayed by health campaigns as a pleasurable, intimate connection between mother and child; however, this fails to take into account women’s embodied experiences. As Blum asserts, “no bodily practices carries inherent, invariable meaning” and so the positive aspects of breastfeeding may not be universal or guaranteed (Kelleher 2006:2728). Many women find breastfeeding to be quite the opposite, and on occasion, even damaging to their self-image and autonomy.

A woman’s decision not to breastfeed may not be adequately explained by a failure to weigh the costs and benefits, the hindrance by poverty, or a cultural belief regarding breastfeeding practice (Schmied and Lupton 2001). While some women find the breastfeeding experience pleasurable and intimate, others find it to be unpleasant and inconvenient with too much self-sacrifice (Schmied and Lupton 2001). Some women may not breastfeed because they feel physically uncomfortable with the practice, experience resentment toward their child, or feel a sense of lost sexuality or control.

There is a growing body of literature focusing on the embodied experience of breastfeeding. Several studies suggest “while women often expect their embodied experiences to mimic the idealized maternal sentiments depicted in breastfeeding
promotional materials, many mothers experience ambivalence, negative, painful, revulsive and mechanized/disembodied sensations that often lead to cessation of breastfeeding” (Tomori 2011:30). And as Avishai argues, women may “encounter several different, often contradictory experiences at the same time and over the course of the breastfeeding process” (Tomori 2011:31). Women frequently make decisions about their bodies in ways that are more complex than just abstract thought and rational understandings, and this includes embodied ways.

Phenomenological studies of lactation seek to describe an experience from the point of view of the women themselves (Rudzik 2012). This type of research explores the lived experience from the perspectives of the participants (Trado and Hughes 1996). Phenomenology, like embodiment, enables us to realize that the mind and body are inseparably intertwined, not separate, and breastfeeding takes place within a specific context (Ryan, Todres and Alexander 2011). In their phenomenological study of perceived breast-milk inadequacy, Dykes and Williams (1999) found that perceived inadequacy of milk led to a decrease in the mother’s self-confidence. Some mothers perceived a lack of control while breastfeeding as opposed to formula feeding. Many mothers reported a feeling of isolation and lack of adequate social support. The authors report that perceived milk inadequacy could stem from feeding practices or from culturally induced lack of confidence in a woman’s ability to nourish her baby. A woman’s perception of her breasts may affect her breastfeeding experience, as well as going back to work, being “tied down,” coping with physical issues, and experiencing a change in lifestyle (Trado and Hughes 1996).
Research has shown that women expect a certain breastfeeding experience, and when they do not know how to overcome problems, they stop breastfeeding in the first couple weeks postpartum (U.S. DHHS 2011). One of the most common reasons cited for cessation of breastfeeding is “not enough milk” or insufficient milk syndrome. While there are instances in which a woman cannot physiologically produce enough milk for her child, this is a rare occurrence (Trevathan 2003). This syndrome is related to rigid or infrequent feeding patterns in Western societies and marketing of formula and health care practices that result in high rates of supplementation of the breastfed baby which disrupt the “supply and demand” of milk production (Dykes 2002). Some mothers may have concerns about the quantity or quality of their milk because breast milk is not viewed holistically, but rather as only important for its nutritional components (Dettwyler 1995; Dykes and Williams 1999). In studies of breast milk production there is increased investigation of women’s experiences expressing their milk with breast pumps (Tomori 2011). These studies suggest that most women did not enjoy pumping, resent the time spent pumping, and focus a great deal on the quantity that they are able to produce with the pump (Avishai 2011, Tomori 2011).

Breastfeeding is an “immensely complex subjective-corporeal activity,” explains Bartlett, and one in which lived experiences are fundamental (Kelleher 2006:2728). It is a biocultural practice that “acknowledges the inter-related influences of the social and physiological” (Kelleher 2006:2728). Increasing medicalization of breastfeeding, with a transfer of authoritative knowledge from the embodied experience of women to the teaching of the medical professional, results in “headwork that not only reinstalls the mind–body dichotomy of the Cartesian subject, but disempowers women as mothers”
(Bartlett 2002:376). Because the body can incorporate the social and political, it can also display indications of social inequality and marginalization. An exploration of the embodied realities of breastfeeding reveals the relationship between the social reality and the lactating body.

*Sexualization of Nursing*

A woman may enjoy breastfeeding because of the experience of intimacy she enjoys. Many women do report experiencing sexual pleasure or sensuality during breastfeeding (Tomori 2011). In fact, finding nursing pleasurable is not surprising given the high amount of oxytocin present and required for lactation as well as love-making, and may be an evolutionary adaptation (Hrdy 1999; Dettwyler 1995). Any sexual qualities of breastfeeding are seen as improper owing to the fact that modern society has come to view the female breast as an erotic sexual object. Dettwyler (1995) outlines four fundamental assumptions that underlie the cultural context of breastfeeding in the U.S.: 1. The primary purpose of breasts is for sex, 2. Breastfeeding only services a nutritional function, 3. Breastfeeding should be limited to very young infants, and 4. Breastfeeding is only appropriate when done in private (174). As a result of these assumptions, a woman nursing an older toddler is seen as sexually perverse, as is any woman who finds breastfeeding pleasurable (Kukla 2006; Dettwyler 1995).

Because the female breast is sexualized in our culture, there is increased sexual vulnerability in public spaces (Kukla 2006:163). Because of the role of the breast in sexual arousal, nursing, especially in public, is frequently considered to be improper and immodest. Breastfeeding in public has become a controversial issue in modern American culture, wherein “breastfeeding mothers are asked to negotiate an exceptionally
complicated set of codes of privacy and publicity” (Kukla 2006:163). Many women experience fear and embarrassment regarding breastfeeding, either in public or even among friends, and “embarrassment remains a formidable barrier to breastfeeding in the United States and is closely related to disapproval of breastfeeding in public” (U.S. DHHS 2011:13). In the U.S., breastfeeding legislation varies by state. Forty-five states have laws specifically allowing women to breastfeed in any location, and 28 states exempt breastfeeding from public indecency laws (National Conference of State Legislatures 2011). In Florida, Statute 383.015 states that “A mother may breastfeed her baby in any location, public or private, where the mother is otherwise authorized to be, irrespective of whether the nipple of the mother’s breast is uncovered during or incidental to the breastfeeding” (2012). Additionally, Florida Statute 827.071 states, “A mother’s breastfeeding of her baby does not under any circumstance constitute ‘sexual conduct’” (2012). Despite this legislation, it is commonplace for women to be asked or forced to leave restaurants and airplanes for breastfeeding. Breastfeeding mothers are frequently told that they are violating public decency laws when they nurse in public.

As breastfeeding and formula promotional materials convey, breastfeeding is an activity that white, heterosexual, married women do within the home. Nursing in public is particularly disruptive when a mother’s body challenges normative conceptions of femininity or if the child is “too old” to breastfeed (Kukla 2006). As there is little enforcement of existing laws protecting a mother’s right to breastfeed anywhere she has the right to be, nurse-ins have grown in recent years. These grass-roots activist protests target locations where nursing women have been harassed or removed. They have been held in public spaces such as restaurants, stores, coffee shops, schools, and even at the
Facebook headquarters. Nurse-ins can be generally credited with promoting positive breastfeeding policies (Boyer 2011).

**Human Rights and Advocacy**

Penny Van Esterik calls for anthropologists to include advocacy because “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” (1995:162). She argues that because anthropology is becoming increasingly reflexive, with a focus on the positionality of the researcher, and because of the discipline's long history of applied work and greater focus on human rights, professional anthropologists must embrace advocacy discourse.

Many who study breastfeeding have proposed that breastfeeding is a human rights issue (Rippeyoung and Noonan 2012; Van Esterik 1995; Gribble et al 2011; Labbok et al 2008; Hausman 2003). The Conventions on the Rights of the Child outlines, in Article 24, the right of the child to enjoy the highest attainable standard of health and for parents to be fully supported in the use of knowledge of the advantages of breastfeeding (United Nations 1990). Unfortunately, the U.S. “has tended to ignore international agreements concerning breastfeeding in favor of business-oriented policies” (Hausman 2012:19).

Many feminist advocates argue for the need to re-conceptualize breastfeeding as a health issue and a reproductive issue that constitutes a right to health for both mother and child (Gribble et al 2011; Hausman 2003). Because education without social change will
not make a difference, breastfeeding advocacy must pay attention to the structural impediments to breastfeeding; for example, “economic barriers, lack of support from medical personnel, and work/family patterns – that mothers face” (Hausman 2003:227).

Van Esterik explains (Hausman 2003) that the goal is to create conditions so that breastfeeding is possible and valued in society, not so that every woman must breastfeed her infant, but that every woman could. Much second wave feminism has presented breastfeeding as a choice similar to formula feeding, but it is not a realistic choice if it is not supported by policies and programs that provide all women with opportunity, education, health care, sociopolitical support, and control over their bodies and lives (Labbok et al 2008).

Moreover, feminist activism seeks to improve the condition and position of women, confirm a woman’s power to control her own body, and challenge the view of the breast as a sex object (Van Esterik 1994). By advocating for breastfeeding, Jacqueline Wolf explains, feminists also advocate for employment practices and parental leave, and against pervasive sexualization and objectification of women (Tomori 2011:86). Because patriarchy, capitalism, and technology play a role in the construction of power inequalities, the reduction of socioeconomic, gender, racial, and ethnic inequalities is necessary to breastfeeding advocacy (Tomori 2011). The low rates of breastfeeding among minority and poor women fit with their lack of real choice, as they lack flexibility in their careers and private lives, and experience health care discrimination in the U.S. (Hausman 2003). Activists must work towards increased maternity leave and policies that provide specific benefits for mothers. This movement could improve the embodied consequences of inequalities and lead toward greater social justice (Tomori 2011:92).
A mother without social support and financial resources will be unable to overcome structural constraints that influence the practice of breastfeeding. Breastfeeding cannot be a choice if a mother who chooses to breastfeed is incapable of actually breastfeeding due to policies and practices that impede her choice. Focusing on a woman’s right to breastfeed removes the demand from the woman’s person and places it on social and political context, “focusing attention on her ability to realize her rights” (Hausman 2012:19). A human rights advocacy approach to breastfeeding protects the right of the mother/baby dyad to breastfeed by providing an environment that makes breastfeeding possible (though not obligated). In order to create this environment, states must adhere to the International Code of Marketing of Breast Milk Substitutes, promote the Baby Friendly Hospital Initiative, implement maternity benefits, and protect breastfeeding in public. All impediments to the right to breastfeed must be removed in order for these human rights to be universally applied.

Taking into account the frameworks presented in this chapter, the following chapter outlines the methods of this study.
CHAPTER THREE: METHODS

Current research on the breastfeeding experiences of low-income women is primarily quantitative in nature or focuses on only one aspect of the breastfeeding experience. Ethnographic methods of medical anthropology are useful to uncover the lived experiences of breastfeeding mothers, especially when focusing on a population from a specific geographical location. Through in-depth interviews and participant observation, the operation of the Baby Café home visitation program and the experiences of its breastfeeding clientele are illuminated.

When evaluating a health program, “seeing the program from the participants’ perspectives and understanding the meaning they attribute to the program” allows an insider’s view as to why the program has specific effects and identifies any unanticipated outcomes of the program (Steckler et al. 1992:4). Anthropology, feminism, and public health seek to improve the health of communities, and many feminist perspectives such as positionality and “the value of women’s stories as experiential embedded narratives” are compatible with social science research (Van Esterik 2012). Because ethnography is concerned with descriptions of the human condition, it can aid in expanding understanding of complex phenomena.

This research project utilizes a qualitative approach in order to understand the experiences of new mothers in the postpartum period and the services they receive from
the Baby Café’s home visitation lactation support services. The program director of the Baby Café identified a need for an evaluation of the home visitation portion of the program. She identified a desire to understand the Baby Café clientele and gather information on their births, breastfeeding initiation, common barriers to successful breastfeeding, intensity of lactation service utilized, and breastfeeding outcomes. This study also assessed satisfaction with services.

The study consisted of participant observation of Baby Café program processes and semi-structured interviews with recent and current clientele of the Baby Café lactation support home visitation program. Both of these ethnographic tools were useful because “examining an issue under multiple lenses can deepen both inquiry and understanding” (LeCompte and Schensul 2010:180). Qualitative research helps evaluate the services that Baby Café provides and offers a critique of present efforts and suggestions for improvement.

**Participant Observation**

**Data Collection**

Phase I of this research, participant observation, occurred in the Spring and Summer of 2012. Participant observation, the foundation of cultural anthropology, involves observing people and their activities, and also engaging in the activity (Bernard 2011).

Observations were made inside participants’ homes while the Baby Café’s IBCLC conducted her lactation support visit. The purpose of these visits is to provide a breast pump and/or provide a lactation consultation in response to the need of the client.
Mothers are screened ahead of time so the IBCLC knows what kind of support the client is in need of before she visits the mother’s home. The main purpose of the visit is to troubleshoot for the mother, but also provide informational, emotional and physical lactation support to a woman and her family. Mothers generally only receive one home visit, though they are encouraged to follow-up if they need assistance in the future.

I kept field notes on the home visits. Participant observations at representative in-home lactation consultations contributed to a deeper understanding of the breastfeeding and support service experience. Observations of the home visitation program led to greater understanding of the overall service that the program provides to women. Moreover, the observations provided a knowledge base of positivistic data with which to evaluate the actual services rendered. These visits and observations provided a knowledge base of the program operations and clientele, and helped in creating an appropriate interview guide. The program director and the IBCLC of Baby Café helped arrange my participation in five lactation consultations with current clientele.

**Semi-Structured Interviews**

**Recruitment**

Purposive sampling within the Baby Café program was used to recruit interview participants, via Baby Café client encounter forms provided by the program director. Encounter forms contain all the client and referral information that the lactation consultants use to contact the client and do the consultation. The program also sends these to the health department for reporting purposes. Participants were called and invited to participate if they met the following inclusion criteria: 1. The mother had received a
home visit (with or without receipt of a breast pump), 2. The mother had been seen by the lactation consultant in the previous six months, and 3. The mother was most likely WIC or Healthy Start eligible (she had been referred to Baby Café from WIC/Healthy Start, or Baby Café had referred them to WIC/Healthy Start). Because women are referred to the program if they need help with breastfeeding postpartum, all of the women who receive services from the Baby Café, and all of the women in this sample, intended to breastfeed and initiated nursing or expressing breast milk immediately after the baby’s birth. A $25 incentive was provided for participation.

Recruitment for interviews proved somewhat challenging. The Baby Café encounter forms, which are the only records kept with information on the client, are not entirely dependable; for instance, several forms were lacking one of the following: mother’s birth date listed, baby’s birth date, date of service, an explanation of what service was provided, and who provided the service. As a result, I ended up recruiting one mom who though she had received assistance in the previous six months, had actually had her baby nine months prior to our interview.

An additional challenge was the use of phone calls to recruit. Unfortunately, many of the families were no longer at the phone number provided, phone numbers were disconnected, and on occasion there was no voicemail or answering machine at which to leave a message, as might be expected when working with a population in which telephones or residences may not be constant. The response rate was about 43 percent, or 15 participants recruited out of 35 attempts.
Data Collection

Phase II of this research consisted of in-depth, semi-structured interviews conducted with 15 participants. The ethnographic interview provided for in-depth information on certain topics, and allowed me to gather personal histories and descriptions of practices and to assess knowledge and beliefs from representative individuals (LeCompte & Schensul 2010). Interviews were open-ended with frequent probing. Participants were encouraged to provide as much or as little information as they felt comfortable sharing, as this was an attempt at collecting their narrative in their words. Interviews were conducted in a location of the participant’s choice. Most of the interviews took place in the participant’s home, but two took place at public restaurants and one occurred in a children’s playroom room at an apartment complex clubhouse. Several interviews occurred while other family was present in the home; some were conducted without the presence of any of the mother’s children.

The purpose of these interviews was to gather narratives on the lived experiences of the women related to breastfeeding. By understanding what these women’s breastfeeding experiences, including what their support needs are, it can be determined whether or not Baby Café is meeting those needs, and where Baby Café can improve.

Interviews covered the following topics: mother’s knowledge of and attitudes towards breastfeeding prior to pregnancy, mother’s birth experience, mother’s experience with breastfeeding since the baby’s birth, any barriers to successful breastfeeding, physical and emotional perceptions of breastfeeding, factors influencing decisions and actions, comparison of nursing experience with prior children (if applicable), nursing in public, types of support received, breastfeeding duration and intent, mother’s perceptions
of the support received by Baby Café, satisfaction with Baby Café, and any recommendations for program improvement. The semi-structured interview guide is provided in Appendix A.

Data Analysis

Interviews were digitally recorded and transcribed verbatim. Field notes and transcriptions were read closely, coded, and analyzed for recurrent themes. Analysis, the “search for patterns in data and for ideas that help explain why those patterns are there,” for this research was informed by Bernard (2011) and Spradley’s (1979) domain analysis techniques. Additionally, narrative analysis was utilized to search for regularities in how the women told their stories, the meaning that they give to their experiences, and how they interpret their reality (Bernard 2011). A set of codes based on the interview guide was developed for deductive analysis. This was combined with a grounded analysis of themes that emerged from the transcripts.

Ethical Considerations

This project received approval from the University of South Florida Institutional Review Board. This research is considered low risk to participants. All clientele had the right to refuse to participate in this research. The decision to participate did not and will not affect the services the women receive.

All attempts were made to minimize risk. Visits for participant observation were only made if the lactation consultant felt it would be appropriate for me to attend, and my presence was explained to and approved by the client. During recruitment for interviews,
the purpose and nature of the research was explained to the potential participant. Prior to beginning any interview, participants received an oral explanation of the informed consent form. Interview participants received a paper copy to read, sign and return. This was the only document collected with any personal information. Interviews took place in a location of the participant’s choosing, and all data (hard copy and digital) was kept anonymous and confidential. For the purpose of this thesis, the names of the participants have been changed to pseudonyms.

**Positionality**

As an anthropologist, a woman, and a maternity care professional, it is important for me to contend with my own situatedness and be reflexive. Positionality is the presentation of my awareness and assessment of myself regarding my influence or contribution on research. Shannon Speed writes, “Feminists made patently clear that our representations of others were products of our own social positioning, our own ‘situatedness’ in relation to those people and cultural dynamics we chose to represent” (2008:3). Sarah Harding argued that “all knowledge attempts are socially situated” and that “knowledge has a particular historical subject” (1993:56,63). I agree with Sarah Harding and Donna Haraway’s calls for understanding situated knowledge and standpoint in social science research (Harding 1993; Haraway 1988).

Explaining my positionality, or delineating my position in relation to the study, allows the reader to understand the viewpoint from which the research was conducted. Reflexivity is the emphasis on the recognition of the role that researchers play in shaping the objects of research. Not all perspectives are equal; every researcher will see and
understand a situation differently than another based on their context. It is important to state where I am coming from to create better ethnography. My positionality in this research involves the fact that I am not just an ethnographer; I am also a maternity care professional. As a birth doula and a certified lactation counselor I provide breastfeeding care and counsel for women. This means that I enter this research with training and appreciation beyond a true outsider or a layperson. I am a lactation counselor studying the act of lactation consulting and the breastfeeding experience.

Though I’ve never breastfed a child, I have extensive personal interest and knowledge of the societal, cultural, organizational, community, interpersonal, and individual influences on the breastfeeding experience. Working with mothers and babies means that I am aware of existing laws and programs that are intended to protect, promote, and support breastfeeding, and how they play out in reality for mothers. Moreover, I understand the physiology of lactation and have been trained to physically and emotionally assist with breastfeeding. This involves recognition of the many facets of a mother’s potential challenge and successes with breastfeeding. Because I have been there, helping with breastfeeding for a number of women in my capacity as a doula, I know exactly what it is like in the hospitals immediately postpartum. Listening to women’s breastfeeding experiences, and observing a woman receive lactation consultation, I can place myself in the consultant’s shoes.

I was aware of my position as an “expert,” but made attempts to position myself as an observer more interested in the mothers’ experiences than in what I knew or did not know. I demonstrated my comfort with their breastfeeding and I listened without judgment. I could not share with the participants the embodied experience of having
breastfed my own children, but I am fully aware of advantages and obstacles to breastfeeding. I consider myself an activist for breastfeeding, also known as a “lactivist,” or lactation activist. As it is often the poorest women who have the least access to resources that protect, promote, and support breastfeeding, in this research I consider myself an advocate as well as an academic. Anthropologists “are able to participate in constructive ways because of our critical awareness of an accountability in local social relations and politics (Enslin: 1994:557). I am hoping that this research will make useful contributions to the community.

The next chapter explores the results of the data collection and analysis.
CHAPTER FOUR: RESULTS

This research project comprehensively explores the way low-income and at-risk women physically, emotionally, economically, and socially experience nursing and lactation assistance. This chapter will present the findings of this study. First, the participant demographics are presented. The chapter is divided according to six themes that emerged from the analysis: knowledge and intentions, the Baby Café program processes, other support, economic matters, perceptions and embodiment, and nursing in public.

Participant Demographics

A total of 15 individuals participated in this research; all were women who had received Baby Café lactation support services for their infant within the previous six months. Participants ranged in age from 16 years to 42 years, with a mean age of 31 years. One-third of the women were unmarried or single, which included women who were co-habitating. Sixty percent of the women had one child only, one mother had twins, and 10 were first time mothers. The age of the baby from the mother’s most recent birth, for which she received Baby Café services, ranged from one month to six months, with one outlier at nine months of age. The reported method of delivery revealed a 40 percent Cesarean section rate, which is higher than the national average (32.8), the state
average (38.1), and Hillsborough county average (36.8) (Hamilton et al 2012; Florida Department of Health 2011).

All of the women either received WIC service or were WIC-eligible but had not received the program’s services. More than half of the mothers reported receiving Healthy Start services. At the time of the interview, five women were working, two reported being on maternity leave, five women reported not working, one was in high school, and three reported going back to college. Several participants were foreign-born, including women from African and Latin American countries.

The majority of the women received all of the program’s direct lactation support services: a home visit, receipt of a breast pump, and phone support. Four of the women received a breast pump (either a rental or one to keep) only, and two of the women received a home visit only. Several of the women received more than one home visit and/or multiple phone consultations. Referral sources reported by the participants included word of mouth, maternity hospital nurses, Healthy Start, their pediatrician, La Leche League, and their hospital in general. The reported referral differed from the referral source noted on the Baby Café encounter forms in two instances – both listed a hospital, while the mother reported a personal contact had led her to the Baby Café. It is unclear why this discrepancy exists, but may indicate either an inaccurate memory on the part of the client or errors in the records.

All the mothers intended to breastfeed and initiated nursing or expressing breast milk immediately after the baby’s birth. This is consistent with the clientele of the Baby Café, as the program is need-based; mothers only receive assistance from the program if they request or are referred for help with breastfeeding. Reported intention varied for
length and exclusivity of breastfeeding. Some mothers simply noted a distinct length of
time (e.g. six months, one year, two years) or a vague goal (two to four months or as long
as possible), while others stated that they specifically wished to breastfeed exclusively for
six months and continue up to a year. At the time of the interview, only one mother had
met her intended breastfeeding duration with her baby. Some mothers were still
breastfeeding babies and had not yet reached their intended duration, though several had
already supplemented with infant formula. Nine of the fifteen mothers did not achieve
their breastfeeding intention.

Table 1: Participants’ Intended Breastfeeding Duration

<table>
<thead>
<tr>
<th>Participant</th>
<th>Baby’s Age</th>
<th>Intended Goal</th>
<th>Actual Duration</th>
<th>Intention Met?</th>
<th>Baby in NICU</th>
</tr>
</thead>
<tbody>
<tr>
<td>Brandy</td>
<td>4 mo</td>
<td>2-4 months</td>
<td>1 week</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Gabriela</td>
<td>1 mo</td>
<td>6 months</td>
<td>2.5 weeks</td>
<td>No</td>
<td>N</td>
</tr>
<tr>
<td>Taylor</td>
<td>2 mo</td>
<td>6 months</td>
<td>3 weeks</td>
<td>No</td>
<td>N</td>
</tr>
<tr>
<td>Jasmine</td>
<td>5 mo</td>
<td>1 year</td>
<td>4 months</td>
<td>No</td>
<td>N</td>
</tr>
<tr>
<td>Christy</td>
<td>5 mo</td>
<td>1 year</td>
<td>4.5 months</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Shauna</td>
<td>4 mo</td>
<td>6 months</td>
<td>6 weeks</td>
<td>No</td>
<td>N</td>
</tr>
<tr>
<td>Grace</td>
<td>3 mo</td>
<td>1 year</td>
<td>6.5 weeks</td>
<td>No</td>
<td>N</td>
</tr>
<tr>
<td>Latoya</td>
<td>9 mo</td>
<td>2 years</td>
<td>7 months</td>
<td>No</td>
<td>N</td>
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<tr>
<td>Jessica</td>
<td>1 mo</td>
<td>3 months</td>
<td>8 weeks</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Monica</td>
<td>6 mo</td>
<td>6 months</td>
<td>Still breastfeeding</td>
<td>Yes</td>
<td>N</td>
</tr>
<tr>
<td>Uma</td>
<td>4 mo</td>
<td>1 year</td>
<td>Still breastfeeding</td>
<td>-</td>
<td>N</td>
</tr>
<tr>
<td>Jennifer</td>
<td>6 mo</td>
<td>1 year</td>
<td>Still breastfeeding</td>
<td>-</td>
<td>N</td>
</tr>
<tr>
<td>Maria</td>
<td>2 mo</td>
<td>As long as possible</td>
<td>Still breastfeeding</td>
<td>-</td>
<td>Yes</td>
</tr>
<tr>
<td>Quinn</td>
<td>4 mo</td>
<td>6 months</td>
<td>Still breastfeeding</td>
<td>-</td>
<td>N</td>
</tr>
<tr>
<td>Bella</td>
<td>1 mo</td>
<td>1 year</td>
<td>Still breastfeeding</td>
<td>-</td>
<td>N</td>
</tr>
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</table>
It is significant that the nine mothers who had stopped breastfeeding at the time of the interview intended more than they achieved. This is consistent with research that shows that 60 percent of women who start breastfeeding stop earlier than desired, due to difficulties with lactation, infant weight concerns, illness or the need to take medication, or the effort associated with pumping milk (Odom et al 2013). In my sample, reasons for switching to formula feeding included those mentioned above, in addition to difficulties pumping breast milk while working or attending school, financial impediments, baby’s refusal to nurse, or baby’s health complication. These are discussed in detail in the sections below.

It is important to note that breastfeeding outcomes among Baby Café clientele are impacted by the nature of the program. Because the program focuses on mothers who receive Healthy Start (determined to be high-risk) or were referred to the program by hospital staff because of a particular high-risk situation, some of the infants had special circumstances that may have made breastfeeding especially difficult; for example, four participants reported that their baby had been in the Neonatal Intensive Care Unit (NICU) for complications resulting from premature birth, a neural tube defect, a cleft lip, and Down syndrome.

**Antepartum Knowledge and Intentions**

The women in this study had varying levels of breastfeeding education and exposure to breastfeeding prior to their pregnancies and their birth. Though all initiated breastfeeding, not every mother felt the same way about breastfeeding prior to the birth
of their baby. Participants’ knowledge and intentions are presented in order to frame their breastfeeding experiences.

**General Feelings Prior to Birth**

Prior to having their first babies, nearly all of the mothers knew that breastfeeding was healthy for the baby, especially the baby’s immune system. “*Everybody just always said it’s what’s healthy, it’s what’s good for the kids*” proclaimed a mother when asked about what she knew about breastfeeding before having her four children. Grace, a 27-year-old mother of three-month old, said that before getting pregnant,

> I knew breastfeeding existed, but I never even paid attention to it. I never gave it thought, I guess cause I wasn’t pregnant. So I never actually gave attention to it. I never thought about it. I never, never researched it or anything until I got pregnant. And then everybody started giving me information about it. And they started telling me you know it’s very healthy for the baby, it helps him build his immune system. And I was like ‘oh you know that sounds really good.’ You want the best for your child.

Before having her baby, Monica, a 31-year-old mother of six-month-old said that she was excited about breastfeeding “*It’s going to be cheaper, less expensive and it’s better for her… I wanted to do it. I was excited to do it, mainly because it’s healthier for them.*” She explained, “*All I knew was what I had been told or what I had been reading. That’s all I knew.*”

Taylor, a 22-year-old mother of a two-month-old described herself as “*very judgmental. And I was very stuck on the babies have been eating for 18 hundreds of years before and he’ll breastfeed if he’s hungry enough and all that.*” She stated that she “*was looking forward to it the entire time I was pregnant that’s like all I would talk about – that I was going to breastfeed.*” A mother who had moved here from Africa before having her children articulated a similar sentiment:
I’ve always wanted to breastfeed all my life. Even before having kids I’m like oh I’m going to breastfeed! Because back home we breastfeed exclusively for the first six months and, without water, and start giving water at seven months and you know start giving some other things. Well most times women at home try to breastfeed up to one year. Sometimes more than one, but usually one. So I had that mentality, I was like oh when I get here I’m going to breastfeed. Even though I’m not working right now, I was like oh I’m going to, since I’m at home I’m going to breastfeed exclusively.

Uma, a 26-year-old mother of two children who moved to Florida from Africa stated that what she knew about breastfeeding was that for “Africans, no formula, or nothing.

Breastfeeding, breastfeeding, breastfeeding. So I knew breastfeeding was good. And it was good for me too, just to lose my baby weight and all that. And I knew it was the best formula for the baby. Breastfeeding, yeah.” She recalled that she initially told her mother she was not going to breastfeed and “She was like, what? What are you saying? Yeah, she said if I did that to you, you wouldn’t be here right now. That was what she told me, so I was like, I’m scared, I’m gonna breastfeed.”

More than one mother described viewing breastfeeding prior to their birth as natural and idealized. “I see women breastfeeding their babies. That’s as much as I need. And I know it’s a natural process and everything” voiced Quinn, a 36-year-old mother of twins. She explained what she knew:

I knew it was going to be beneficial to them. You know. Make antibodies. Get antibodies from me to fight infections and everything. That infant formula would not do that. I knew it was going to be nutrional [sic]. Breast milk is always better. It’s just a natural thing. Imagine… it’s just natural. You see all these animals and everything. The animals that have breasts and breastfeed. Do you see anyone giving them formula? No. You know they breastfeed their young ones until they are able to fend for themselves. It’s just the natural thing. And you see the animals live and survive so. It’s a natural thing, that’s why I really wanted to breastfeed!

Jennifer, a 30-year-old mother of a six-month-old, described that she had known that she was breastfed, as well as her sisters, and that she thought of breastfeeding as idyllic. She said “I don’t know, I just always… it seemed so idyllic. That was my perception of it. It’s
"just such a close, natural, happy thing," and during her pregnancy she thought “it’s a natural process, it’s been happening for thousands and thousands of years, and it’s just gonna work for me.” She described what she knew before she had the baby:

I had read some books. I knew it wasn’t going to be easy or pain free or any of those things. I knew that it was definitely the best nutrition for my baby. I knew it would help me lose my baby weight a lot faster. And most of it was just like what I read about and I was really focusing on was like absence of chemicals, absence of artificial everything. And then it was easy. I mean, easy not easy, but once it’s established then it would be… you don’t have to pack up a whole bunch of equipment to go out and do stuff, you just stick the baby on there. And that I think I got a little bit caught up in that. That I had seen friends and family members that had babies. It was like oh they just latch on, and that’s that.

Two mothers had a different attitude toward breastfeeding prior to their more recent pregnancies. Gabriela, a mother who had two much older children expressed that before having her third child at age 42, she felt that breastfeeding was “good, but, you know, I thought that now the formula and stuff was good enough for the baby” and that she only tried breastfeeding because her baby had Down syndrome and because the hospital staff encouraged it. Shauna, who had her first child at age 41, explained that despite having grown up seeing breastfeeding, she had not been pro-breastfeeding:

I never was pro breastfeeding. My family is from the islands and they’re like all into that natural breastfeeding stuff and vitamins and stuff like that. And they were like. They just do it. In my family, everybody just breastfeeds til the kids like, I don’t know, 6 months, a year maybe. So I already knew about breastfeeding. I grew up my whole life seeing. I have a huge family, seeing everybody do it. Then my mom, I’m the oldest of 6 so she had kids like later on in life, too, close together so it was like a huge age gap between us. Over like 10, 15 years between us, me and my younger brother and sister. So I was of age to know what was going on. And I just saw it, and I just didn’t like it. I saw my mom. My mom I think really traumatized me breastfeeding. Cause the way she’d just whip out her boob, and it’d be hanging out the same way, and I was just like… I didn’t like how it looked. She didn’t make it look glamorous. It wasn’t like other mothers on TV, how they do it and they’re like rocking the baby and such. She made it look like, I don’t know, like some African in Africa or something. How they walk around with their boobs hanging out. And I was like I didn’t like that, seeing that at home. I didn’t like that at all. That image just traumatized me. It
wasn’t glamorous to me. You see it on TV and you see, like now, all these women with the little wrap and they’re holding their little baby and they’re rocking him. And they make it look all glamorous and stuff. Not in my house. Not with my mom. My other aunts, they were like normal with it. My mom, she just, as I said, just had the boob hanging out. Whips it out. She just didn’t care. She was just like, very nonchalant with it and I was just like, ew, that is something I never want to do ever in life.

Despite the fact that breastfeeding was a normal part of life throughout her childhood she did not personally identify with it as something good. Seeing her family members breastfeed did not make her more comfortable with breastfeeding; quite the opposite effect occurred. The conception conflicted with the imagery she had seen in the media and she had an adverse reaction.

Shauna went on to explain that her feeling toward breastfeeding changed somewhat once she became pregnant and was going to have her own baby:

And like I said when I got pregnant and I had been, I guess I was older and I knew more about it, that it was better for the baby’s immune system and everything. And how they push it now, they really push it down your throat even if you don’t wanna breastfeed. They like force you to, you know, practically. So, I mean, I kind of agreed to it, because I just felt different when I was pregnant. It had changed. If I didn’t feel different when I was pregnant, there would be nobody. I’m very strong-minded. There would be nobody that coulda talked me into any kind of breastfeeding. But I felt different with my pregnancy. I felt like more connected to the baby so that’s why I wanted to do it. And then the father, like I said, he was like oh it’s better for the baby.

She indicates a dislike of how she feels society forced her to agree to breastfeeding, but also indicates that she feels she chose to nurse of her own accord. Both of these older mothers indicate that they initiated breastfeeding because of the support and encouragement they were given and the education they had received on breastfeeding benefits for the baby.
Education

Many women said they learned about breastfeeding by reading on their own, and a few said they had grown up seeing women breastfeed. Eight out of fifteen mothers had received some education on lactation prior to the birth of the baby, either through a parenting/newborn course, WIC/Healthy Start, or through their professional education. Three of the women had received medical/nursing education, which greatly influenced their knowledge and intention to breastfeed. Christy, a twenty-three year old mother of two relayed “I’m a nurse. I believe in how healthy it is and how healthy it is for me. Supposedly you lose an extra 500 calories a day, so it helps you lose that baby fat and all these things that are just good for breastfeeding.” Despite her knowledge and belief, she says, it still just did not work for her. Maria, a 35-year-old mother of a 2 month old, explained that she knew the importance of breastfeeding because she had been a doctor in Cuba and always explained the benefits to her patients, and that her knowledge made her especially motivated to provide breast milk to her premature infant.

Other mothers who received education from breastfeeding and newborn classes in the community learned the difference between breast milk and formula, how to hold the baby, how to help the baby latch on, bonding with the baby, and more. A teen mother who had taken a breastfeeding class focused mainly on what she had learned about the differences between formula and breast milk. She expounded what she learned:

It’s better for him and it will be better for you, you don’t have to worry about buying formula and what will be the right formula or be the wrong formula. You could breastfeed however long you want to, you breastfeed when you want to. And it was just information. Just like basically it’s just better for everybody. I mean, it’s like, it’s said that breastfeeding babies are very smart. And when they said that I was like, ‘I want my baby to be smart.’ Just like everybody else that wants their baby to be smart. So I was like, okay. Maybe he’ll be smart in class, because he was breastfed, so I was like, okay, I’ll just breastfeed. So like the
information I got was just breastfeeding because it’s like he getting a lot of nutrition that formula doesn’t give you. And he’s getting the most healthiest thing. And then they try to put it on the formula, like this is close to breast milk. But really nothing is close to breastfeeding, you’re getting it from your mom.

While one mother attributed her ease with breastfeeding to the information she had received from WIC and Healthy Start prior to the baby’s birth, nearly all of the mothers who took classes still needed help. One mother admitted that she “had even taken previous classes while I was pregnant, so that’s why I was so sure it was going to work.”

Though the mothers found their education useful, there was also a general sentiment that the education alone was not enough. Grace, a 27-year-old mother of a three-month-old elucidated that learning different positions in which to hold the baby using a fake baby was “weird at first, because it wasn’t a real baby.” Another mother confessed that though she took a couple classes, she did not feel she knew much about breastfeeding, and that she relied on the nurses at the hospital to show her what to do. This denotes that women need more than prenatal lactation education in order to successfully breastfeed.

Three of the mothers who did not take a class described a barrier to their access. Uma, a 26-year-old mother who was not working, with limited transportation, said she had intended to take a class at the end of pregnancy and then a health issue arose that required the baby to be born earlier than she had anticipated. Another mother said she got a job and no longer qualified for WIC, so she did not end up taking the WIC class that she had intended to take. Bella, a 27-year-old mother of a one-month-old, said she had not taken any prenatal classes, because “I knew right off the bat I was going to have a C-section. I was like, ‘I don’t have to go to classes.’ …My doctor never mentioned anything to me about classes, and I never even thought about them.”
Reasons for Breastfeeding Duration

As mentioned above, mothers reported varying lengths as their target breastfeeding duration and exclusivity goals. Six mothers specifically listed six months as their intended length, six stated one year, with the remainder intending to breastfeed “as long as possible.” Before both of her children presented with special needs, Christy, a 23-year-old mother, intended to breastfeed for “A year. Isn’t that everyone’s intention at the beginning? Oh, yeah, the initial year that they say that you should feed a baby by breast milk. I was “I’m so going to do it.” It didn’t happen.” Very few mothers discussed their goals for exclusive breastfeeding, but Taylor, a 22-year-old mother of a two-month-old did explain that she wanted to “do at least 6 months. Even if I had to add formula with it when I went back to work” because,

They say because of the nutrients the brain develops better with the baby. Plus you lose weight, too. And I had gained so much being pregnant so I was excited about that. Just the whole bonding thing, too. I think after 6 I think they get too old. I feel like that’s too much. Some people do it forever, but, I don’t know, I think 6 months is a good time frame.

Despite the fact that she was very pro-breastfeeding before she had her baby, she reveals an alignment with the prevailing societal attitude that a baby can be “too old” for breastfeeding. Taylor encountered complications with her health postpartum that led her to stop providing breast milk to her baby at around three weeks.

The prevailing reason behind each mothers’ chosen goal was the babies’ health. Said a mother of one, “I thought I was gonna do it for six months. ‘Cause like I said I was never pro breastfeeding like all these other mothers. I just was doing it just to do it ‘cause I heard it was good for the baby.” 42-year-old Gabriela explained that she wanted to breastfeed her third baby, after not breastfeeding her first two, because she learned,
“That it was good for the babies. That it helps them a lot and their immune system. That it’s the best milk they can drink in the first year of their life at least… And then him being with Down syndrome, his immune system is weaker, so I wanted to get that in, and I also wanted to try that bond you build with the baby. You know? Like I said, I wasn’t, like, expecting like, to go for the year, but at least six months.

She, too, only made it about two and a half weeks pumping and providing her baby with breast milk before she stopped. For Jessica, a 26-year-old mother of two, her intention to breastfeed was based on a moment’s decision when she was asked if she was going to breastfeed. She and several other mothers listed that their intended duration was a result of knowing that it helps build the baby’s immune system.

Intention was also influenced by what participants’ mothers and other family members had done; Bella, a 27-year-old mother of one described her decision making process:

I was like, okay, a year is good. My sister-in-law is still breastfeeding and her daughter is three. I knew that I didn’t want to go on for that long, but just from talking to my mom and talking to other moms that I know, they all say that usually a year is the cutoff point so I was like, okay a year. Now I know how beneficial it is for her so I would have kept on going as long as she needed it. She loves it.

She was providing as much breast milk as she could for her one-month-old daughter in addition to supplementing with formula, due to a lack of supply resulting from breast implants. She was not optimistic that she could continue to breastfeed for much longer.

Two mothers shared additional reasons for their intended breastfeeding goal. Christy, who was unable to use typical forms of contraception, said that she intended to breastfeed for a year “because it’s a natural way to help prevent other pregnancies and although it’s not guaranteed, it’s better than nothing.” Shauna, a 41-year-old single mother said that she chose six months as her goal because,
It just seemed like long enough. ‘Cause I figured he’ll be on solid foods by then, too. I guess that’s when they feed them solid foods or something I’d heard or read. He’ll probably have teeth, and I was like I don’t want anybody sucking on my breast that has teeth. I had heard about babies clamping down on nipples. And I was like nope, that’s not gonna happen. So I don’t know, I just said 6 months seemed like a good, good enough for his immune system, to me in my mind. I guess I just came up with my own little mathematical estimation.

These mothers, unlike most of the other mothers, included some personal benefits for themselves and their physicality in their reason for weaning at a certain time.

**Plans for Breastfeeding Next Baby**

With the exception of one mother, the women all said that they would breastfeed another child in the future. Among first time mothers, there was a sentiment of knowing what to expect the next time, now that they have experience with breastfeeding. Maria, a 35-year-old first time mother said that with her next baby she would “like to [breastfeed] for a year at least. Yeah, at least a year. I’m hoping by the next time you know that I would it would be in a different situation where I’m able to just have the time and the flexibility to just breastfeed more and of course pump as well.” Gabriela, a mother of three said that if she were to have another baby she would try breastfeeding again, even though she was not successful with her one-month-old, “To see if I got it that time... But, this other pregnancy’s been different, so like they say, you can never, you can plan it, but you don’t know until it happens.” 27-year-old Grace stated she would definitely breastfeed another child, stating, “I loved the experience. I like how they attach to you.”

The exception was a mother who pumped breast milk for her son, in addition to formula, for about six weeks. Shauna had not been a very excited about breastfeeding prior to having her baby, but gave it a try anyway. She was an older mother, having her first baby at age 41, and was not living with the baby’s father. She said she might consider having another child, but she does not plan on breastfeeding him or her. She
confessed, “No, I don’t think I would, no. It was just too much work… I don’t think I wanna try. I’ve been saying no, no, no, I’m never gonna do it again… If I have another baby I don’t think I want to.” She did not enjoy not having any family support, having to do everything on her own, the experience of pumping, and the way she perceived her post-breastfeeding body.

**Baby Café Program**

When a referral comes in, either from a hospital, community partner, or the mother, the program director fields the phone calls and screens the client. An encounter form is filled out and sent to the program’s International Board Certified Lactation Consultant, who uses the information to set up and conduct the consultation. Observations of lactation consultations in the home revealed the way the IBCLC conducted her visits. All visits included triage, asking about baby’s weight gain, baby’s waste, challenges experienced, and giving advice. She was very hands-on and focused on instruction and problem solving, physical problems, and showed use of the breast pump. She asked a lot of questions and managed the woman’s emotional and mental concerns. Also, the IBCLC gave everyone her personal contact number and encouraged women to call or text if they had any concerns.

Participant descriptions of the home visits that they received mostly corroborated what was seen through observations, and had very positive reports of the IBCLC. Taylor, a 22-year-old new mother of a two-month-old baby shared that the IBCLC also reassured her that she was doing well: “She was really good. She explained everything to me about how their stomach works. And she helped me calm down when I was really upset. About
**being patient, and different things to do... She was good. She was attentive. She made sure I knew everything.**” Jennifer, a 30-year-old first-time mother of a six-month-old described her visit with the IBCLC, explaining that she asked what her feeding routine is, observed the baby feeding, helped with latching, observed breast pump use, checked the baby’s mouth, provided some suggestions for new nursing positions, and lent her a breast pump. She said, “*[the IBCLC]* was so comfortable with it and I mean as soon as she walked in the house she seemed comfortable. So it just put us, I think both of us at ease.”

Quinn, a mother who just had her twins at 35 years explained that the IBCLC informed her about what a proper latch looks like, talked about her diet and nutrition, provided her with a nipple shield, observed the baby nursing, and weighed the babies before and after the feeding to assure her that the babies were getting milk. In describing the lactation consultant, Brandy, a 40-year-old mother of four said:

*She was awesome. She came, she sat down with me, she showed me how to work the pump, she talked to me constantly, if I ever had any questions she didn’t care what time of the night it was, just call her she was very, very awesome. She came, she helped me with the whole engorgement told me what to do with that, and walked me through it, and tried to help me even through…she didn't have to come and do it, she could have just walked me step by step what to do and she literally stopped what she was doing, and came here with her cabbage*³ *and helped me.*

The comprehensive nature of the lactation consultations and the IBCLC’s willingness to assist in any way are strengths of the home visitation program. The IBCLC was called “supportive” during a time of great stress by a majority of the women.

Women were pleased with the fact that they could contact the IBCLC at any time for reassurance and advice. “*She more like comforted me. And explained that I was doing the right things. She was very supportive. She made herself available. I could call her if I*

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³ Cabbage leaf compresses applied to the breasts are used to relieve painful engorgement.
needed her” explained a young mother. Monica, a 31-year-old mother of a six month-old said, “Any problems you have, anything you need, give me a call, I will answer. If I don’t answer, leave me a message, and I will call you back,” and that “She gave me her personal cell phone number and she said call anytime.” Jennifer said that the IBCLC called her to check on how things were going, and made every effort to put her in direct contact with someone from WIC. The mother also recounted the ease of the communication:

And that I could just text. I think that’s actually how I got ahold of [the consultant] the first time. Was I sent a text and then she said why don’t you call me. And then, it just made it, cause it’s kind of like an uncomfortable thing to have, well for me, to say I’m failing at something. I’m doing really bad. So it was kind of like, all right, I’ll send a text. And then we’ll see how that goes. And then maybe from there I’ll take the next step. It’s not like a, oh here we’ll make an appointment and you come in and you bring your baby. Like the home visit is really, it’s really helpful. Cause we couldn’t have gone anywhere.

Jessica, a 26-year-old mother of two who had seen the IBCLC twice for her second child who had a cleft lip recounted: “Any time I had a question, I could pick up the phone and just call her or text her. And I’m getting a response right away. You know, so, that was a really big help.” More than one mother indicated that the IBCLC had come over or responded to an inquiry even at late hours. Several Baby Café clients reported that the IBCLC was able to help them almost immediately after they requested it, sometimes visiting or dropping off a breast pump the very same day the mother was discharged from the hospital.

Data collected through participant observation suggest that even if a mother had only been referred for the use of a breast pump the lactation consultant would still sit down with her and discuss any concerns and answer questions. All of the client visits for which I was present included a conversation about the infant’s feeding patterns, use of a
breast pump, safe milk storage, and so forth. However, not all of the women sampled reported receiving a full home visit with receipt of their breast pump, or phone assistance in addition to other services. Four of the mothers explained that they received a breast pump without any time spent interacting with a lactation consultant at all. One mentioned that the IBCLC came with the breast pump, “said a little bit about how to use it” and then left. Another mother said that she was told where to go to pick up the pump herself. Quinn, mother of twins, said that the IBCLC, “didn’t even sit down, she just stood up, and then brought the breast pump, and then... it was the same thing, just stood outside, she called me, I came for it, and that was it.”

Despite this, every mother was unanimously in favor of the program. All participants reported being very satisfied with the service that they received from the Baby Café. “Very satisfied. I have no complaints at all. No complaints at all. Like everything was literally always there for when I needed it, how I needed it. Everything” said Grace who had received a pump only. Jessica, who had more than one home visit and phone support, shared this sentiment, saying that with Baby Café’s help she “lasted longer than I did the first time around.” Monica, who was very satisfied with the Baby Café, explained, “They were efficient and they were... they were concerned and they were great on the phone. Like I got off the phone and I was like wow. One, they were treating this like an emergency, and two, they were nice. And the lactation consultant was nice.”

Maria, whose baby was born premature, expressed that the program was “A tremendous help to me, tremendous help… to lend us that pump; that was a huge help to me. And in a desperate situation for me, because I wanted... and I could not alone. I had to have that support.” Indeed, about a third of the mothers explicitly stated that their
main reason for seeking help from the Baby Café was to obtain a breast pump, either to be able to go back to school or work, to feed a baby who was having trouble latching onto the breast, or to be able to provide breast milk for an infant who was not able to breast feed consistently as a result of hospitalization of the mother or the baby.

Other mothers noted that it was a desire to receive assistance from someone. Jessica said she sought help from the program “Cause he wouldn’t latch on. So I needed a second opinion. I needed to hear from somebody else. Oh ok I was putting him on, but I wasn’t sure he was latching on well. So I needed somebody to see and tell is he latching on well.” A mother who expressed great eagerness to nurse her child stated that her reason was “Cause I didn’t want to give up, so I wanted like a second - I wanted an extra input.”

Additionally, mothers explained that they lacked information, especially if this was their first baby, or if they had never been around a newborn or anyone who had breastfed. Mothers sought information and reassurance on whether they were nursing properly, on different ways to hold the baby and fix a latch, and on determining if the baby was eating enough and gaining the appropriate amount of weight. More often than not they were “100 million percent satisfied” with the services that they had received.

Most mothers had no recommendations for the program other than to keep doing what they are already doing. The clients felt they had received the help that they had needed, whether or not they were able to breastfeed for as long as they intended. One mother expressed that it was difficult to get to the Baby Café’s office when she returned her pump. Another mother expressed that she had a Baby Café rented breast pump in her possession much longer than the length of time she had been told she could keep it, and
well after she stopped needing it. Some mothers felt that they were unable to provide recommendations because they had not actually been able to meet with or speak to the lactation consultant at length, or because they were not told that the program had any services other than provision of breast pumps. Christy, a 23-year-old mother of two children with special needs stated, “I never knew that Baby Café did anything but give pumps. Nobody told me they did anything but give the pumps. I just received stuff. I guess my recommendation is make the services more known, advertise, better advertisement because I didn’t know.”

Uma, a mother who had received aid from Baby Café with both of her children had a specific recommendation:

They should keep doing what they’re doing. And maybe add more visits. And just to check up on. Cause somebody like me would not call again. So I’ll just deal with it. Because I’ll feel like oh I’m stressing the person and everything….So just to maybe call again to just… just check up on the patient. I know that they have more patients to take care of. But just to breeze in and check on the patient.

It seems that while the IBCLC encouraged mothers to contact her, she may not have uniformly followed up with every one, as many of the mothers reported not having received multiple phone calls or home visits. As in the case of this mother, many women may feel hesitant or embarrassed to make the call, but might still need assistance in order to continue breastfeeding.

**Other Support**

The women who received services from the Baby Café home visitation program were not without other forms of lactation support during pregnancy and postpartum. Many received support from WIC, Healthy Start, hospital staff, family members and
peers. The extent to which each woman received these forms of support varied, as did their impressions of the value of the support.

**Perceptions of Hospital Support**

The women had mixed reviews of the help that they received from the hospital staff immediately after giving birth. Some mothers found them incredibly helpful. Both a teen first-time mother and a 40-year-old mother of four agreed “*the hospital gives you a lot of support*” and the people are “*really helpful. They come, they help you, and they show you how to latch on.*” Monica, a 31-year-old mother of one, explained how the postpartum nurses helped her physically to breastfeed after the baby was born: “*The nurses showed me all the different positions to put her in... And they put her up to me and they would position her head and keep her head there long enough for her to latch. And then once she was latched, they’d show me where to put my arms.*” Maria, whose baby who had to be in the NICU, expressed that though the baby received a bottle for the first several days of her life, the nurses were supportive when the mother told them that she would like to breastfeed. She received assistance from Healthy Start, was referred to Baby Café, and received a breast pump.

In many of the cases, the women described the help from the nurses coming in the form of emotional support and encouragement. Gabriela, whose baby was born with Down Syndrome and had to stay in the NICU emphasized that the lactation nurse was always present, telling me “*every time I was going to feed the baby, we would call her, she would be right over.*” She also said that the nurses were highly instrumental in her success in the first few days, as the “*nurses in the hospital, they encouraged, and they would come, and say, ‘oh don’t give up’... That’s what helped, too. If not I would have*
given up.” The hospital staff was also very psychosocially supportive of Quinn: “when I was in the hospital they told me, ‘don’t give up, just try, and try, and try, don’t, don’t give up, do whatever you can do if you can, just try, keep moving, keep moving.’” Shauna, who had her first baby at age 41, said that she developed a rapport with one of the nurses, with whom she spoke every night. Taylor said she also had one very supportive nurse, who she described as “so persistent. She stayed up all night. Every time I had to feed him, she’d come in. She was the one that got him to latch the first day. For a couple seconds. And she was just very on-it.”

Unfortunately, not all of the mothers found the hospital staff to provide useful support with breastfeeding. Jessica said she received conflicting advice each time she spoke with her doctor about the best way to feed her baby that was born with a cleft lip. Her baby was in the NICU for two and a half weeks, and she said:

The nurses there were just like forcing him on. They weren’t really trying to help me get him to latch on. And just because he didn’t latch on they were like, ‘ok he’s not latching on so you’re going to have to tell WIC to give you the pump to help you breastfeed that way.’

22-year-old Taylor had mixed feelings about the postpartum nurses. She did receive assistance from the hospital lactation consultant, who showed her how to use a nipple shield, but she complained:

Maybe if the nurses hadn’t been so pushy when I got there. Like after I had the baby, the first day before I even got in the room, I hadn’t even sat down. The nurse walked in and said ‘oh you’re not going to be able to breastfeed, your nipples are flat.’ Just like that…. Didn’t even know me, just said that out of nowhere. And they were really pushy about the ‘he needs a bottle, he’s not getting enough.’ So I think that if we had not given him a bottle...

In both of these cases, instead of offering to help the mother physically and emotionally with breastfeeding, the nurses were quick to say that the baby needed a bottle. Overall,
the hospital postpartum staff was found to be supportive, especially when they referred the mother to the Baby Café or WIC for additional help or to receive a pump for free. In some instances, however, the referrals were incomplete; for instance, a referral to Baby Café but not WIC for a breast pump (though the mother qualified for WIC), a referral to Baby Café without provision of in-hospital lactation support, or lack of referrals to other community resources (e.g., peer-support groups).

**WIC and Healthy Start**

Nearly half of this Baby Café client sample had Healthy Start. Healthy Start provides low income and at-risk mothers and infants with home visits, care coordination, classes and information on family planning, childbirth, parenting, breastfeeding, proper nutrition, smoking cessation, and more. Mothers said that Healthy Start checked up on them regularly, either sending someone to the home to check on them or following up by phone each month. They described their Healthy Start caseworkers as very helpful, bringing videos and pamphlets on breastfeeding and information on Baby Café and WIC. A couple of the mothers found Healthy Start to be annoying or inconvenient, as they had trouble coordinating with their care coordinators, but this was no the dominant perspective. Grace, mother of a 3-month-old, explained that if Healthy Start and WIC had not explained breastfeeding to her she would have had no idea what she was doing. She attributed her early breastfeeding success to having received this information from the two agencies.

Many mothers received breastfeeding classes or information from WIC prenatally. Women explained that as soon as they contacted WIC or WIC contacted them, WIC informed the mothers about breastfeeding. Lactation counselors at WIC were
described as very supportive and helpful. WIC called mothers and made appointments for them to go to the WIC office to see a lactation counselor, ask them how things were going, and provide an opportunity to ask questions. Quinn, mother of twins, said, “they weigh the babies, like how big they are getting, from the first time I birthed them to now, so they were like’ Good job, you did good job, cause they gained weight.’”

One mother expressed that all she got from WIC was brochures, so she did not find them to be much help. Maria, 35, gave this account of her experience with WIC: “I went to WIC several times and first they kept giving me formula but that did not last even one or two times. And the third time... I said, ‘Look, do not give me the formula.’”

Christy stated with frustration that she had been placed on a waiting list for a breast pump from WIC, and they never called her. She fell through the cracks and never ended up hearing about her wait-list status, and she had no idea why. She reported that since she started bottle-feeding her baby, WIC has given her plenty of formula.

WIC provides mothers with breast pumps, but mothers encountered some issues with their system. Some mothers who had WIC were not told that they could receive a pump, others experienced obstacles obtaining one. Mothers were told that they had to “prove” a certain status in order to receive one: that they were breastfeeding, exclusively breastfeeding, had a special need, or were going back to work/school. “Their lactation nurse gave me a manual breast pump, because since I was doing both [formula and breast milk], and I wasn’t just breastfeeding” explained a mother. This mother, whose baby had a cleft lip, as well as another mother with a special needs baby, both encountered trouble receiving pumps from WIC.
More than mothers would comment: “WIC took a while to give me a pump” and stated they were grateful that they had been referred to the Baby Café to receive one. Baby Café seems to be picking up the slack for WIC, who does not have enough breast pumps, and possibly enough breastfeeding peer counselors, to accommodate all the qualifying women who need this support. Many mothers did end up receiving pumps from WIC, but this shortage indicates a hole that Baby Café has been able to fill.

The Most Helpful Support

When asked to identify the most helpful support that they received, a few of the mothers replied it was their referral to and support from the Baby Café, specifically the breast pump. A 23-year-old mother of two expressed that having a consistency of supplies, mainly the breast pump, from the hospital to Baby Café was the most helpful support that she received. A 27-year-old mother agreed, saying, “The most helpful thing was the breast pump. When the breast pump came into my life, period. I was like oh my god, this is so amazing.” For others, it was the home visit with the lactation consultant. A 26-year-old mother detailed her feelings:

[The IBCLC] when she came over and showed me. And was actually here helping me do it. I think I felt more comfortable. Because of the fact that she was helping… she was here, at my house, showing me. I mean at the hospital they can show you 2 or 3 times and stuff, but by the time you get home, you’re not going to really remember. And luckily she was here. And helped me do it. That was, it was pretty much [her].”

Having someone to speak with, in general, was cited as the most helpful aspect of support for a number of the women. “I think one of the things that helped was sitting down and talking to someone about my problem, the different ways to help increase my supply” explained a young mother of a baby who had been in the NICU. A first-time
mother who had received help both from the IBCLC and a WIC peer counselor shed light on this, explaining

I think just having like the breast feeding counselor, both [the IBCLC] and the girls at WIC, who were like, it’s normal. It’s normal. You’re going to be fine… Just like having people who knew what they were talking about. Talk me down. And like explain to me that they’ve seen it all before. They’ve seen worse. So, yeah. And I liked that they would call and check up on me. And not just you know say like, ok here’s the services. Call us when you need something… so that it’s not just that one time relationship of here’s the pump, here’s the book, have fun. It’s like reoccurring.

In these instances it was more professional breastfeeding help, but for some, just peer support helped the most. Latoya, a teen mother, conveyed “people talking to me and telling me I should keep breastfeeding, because it’s better for him, that was the most support that you know I gained.” She also stated that her mother helped her out a lot, and was “My biggest support, biggest, still is, she makes the doctors come in, she does this, she does that. Stuff I don’t even know about, it’s already done. Everything. She still does.” One mother was part of a Facebook group with her friends who were also mothers where they encouraged one another to breastfeed.

**Personal Support System**

Regrettably, most of these mothers lacked a personal support system locally. Again and again mothers reported they had no family in Tampa, in Florida, or in the U.S. Some had husbands-only; others did not even have that. A mother explained that with her first child she had stopped breastfeeding because she had no one close to her to support her, and “everything was just kind of overwhelming. So you just give up, you know.” A mother who greatly relied on her professional help from lactation counselors told me “I don’t really have like a resource of just a friend to talk to.” As a result of lack of family support, a single mother communicated, “It was just too much after having a C-section
without help. All that breast pumping stuff... When I started giving him formula, nobody was protesting at my door or anything.”

Moreover, un-supportive family members were listed as particularly discouraging. An unmarried black mother said it was the baby’s father and the family that she called on the phone who encouraged her to give in and bottle-feed the baby. An unmarried mother explained how her family was unhelpful, “My mom had stopped breastfeeding me after she was probably about two or three months so my mom already was like, ‘You’re probably going to have to go on formula.’ I didn’t have a lot of support from her or a lot of support from my cousin. My cousin was like, ‘I went from formula after a month.’” A mother told me that she might have stopped breastfeeding “if I couldn’t have gotten anybody to support me. Like if my mom had eventually said like all right honey just stop. You know? If that’s what I heard from everyone.”

Nearly all of the mothers had never been to a peer-support group for breastfeeding. With the research and anecdotal evidence suggest that peer support is exceedingly beneficial for breastfeeding success, this demonstrates a need in this community for increased access to peer support groups. Only one mother listed that she had spoken to a La Leche League leader, and attended a support group at the hospital where she gave birth. She described this group and how it is helpful: “The support group is basically, there is experienced moms and new moms there that all get together and talk about the breastfeeding experience. It’s just helpful to hear how everybody else is handling it.” Several mothers stated that they either did not know about any peer support groups, could not get to any, or simply did not attend. It is a shame that more mothers do not utilize this kind of personal support network, as breastfeeding is “so demanding on
you, that, you need to be encouraged. You know, have someone there, you know, pushing
you and just motivating you to keep going, you know, because you need that. You need to
have support. That’s key.”

Room for Improvement

When asked if they received any inadequate support, two mothers named specific
support that they found to be the least helpful. A 27-year-old mother said that her family
was incredibly unhelpful. Some support that she wished she had received was more
access to breastfeeding classes while she was pregnant. “My doctor never mentioned
anything to me about classes, and I never even thought about them,” she asserted. It
would be beneficial for maternity care providers to speak to their patients before they
have the baby about breastfeeding and community lactation resources.

A 30-year-old mother listed the hospital support to be the least helpful,
specifically her lactation nurse,

Who was like, he’s just got to figure it out, you guys will be fine. Was like, no,
that’s not helpful. I’m asking you to seriously make the baby nurse. How do you
do that? She was just like he’ll just figure it out. Like too laid back about it. When
I was clearly really upset about it.... It makes me think that this lady is not telling
me the truth. And that kind of compounds the problem, because then you get
nervous about what you’re doing. So I think that was the least, the least helpful.

This reflects the poor support that some mothers reported receiving from hospital staff,
and indicates that the hospital is definitely an area where lactation support can be
improved. But it is noteworthy that the majority of women said that they received no
poor support. A single mother who had received a pump from Baby Café and was on
Medicaid, WIC, and Healthy Start stated, “everyone that I went to for help gave me help,
you know. Everyone like family-wise, you know, services-wise, everyone helped me and
everything that I asked for was always there.” She was able to provide breast milk for her
baby with few issues until she decided to switch to formula for personal convenience. It is encouraging that this mother received exactly the support that was right for her.

**Economics**

Because the Baby Café program focuses on a particular population of women, the participants tend to be women with differing needs, perceptions, and access as a result of their income status. Participants expressed their impression of the cost of breastfeeding as compared to formula feeding, working and breastfeeding, how breast pumps were associated with their financial status, and other economic barriers.

**Breastfeeding as Less Expensive than Formula**

Several women related that they chose breastfeeding because they had heard, or considered it to be more economical than formula feeding. One woman explained, “I honestly wanted to breastfeed because I thought it was cheaper. I was like it’s a lot cheaper than formula so I’ll do it that way.” A mother of two explained, “if you have to bottle feed, then you have to buy the formula and it’s expensive. Really it’s way too expensive. A baby, it’s a lot, you’ll be spending a lot buying formula.” A 31-year-old divulged that when she reached two months breastfeeding her baby she was tired of it. She said, “I thought I was done with it. But then you know, we’re like most people in this economy: paycheck-to-paycheck. So we can’t afford formula.”

Teen mother of one, Latoya, declared “If I had to speak to anybody else, I would tell them to breastfeed. Saves you a lot of money. A lot.” However, she also recounted that when the baby was five months old, it became difficult for her to produce milk, she began drinking Mother’s Milk tea to increase her supply. She said that when she was drinking
the tea she was producing enough, “but the tea costs like 5 dollars for like 4 teas. So I was like oh no. And then we have food stamps, so I was like I’d rather him be on formula than me be paying out of my own pocket for some Mother’s tea.” For this mother it was a trade-off between a breastfeeding-related expense and free formula provided by WIC. Other mothers also had to weigh breastfeeding with money. A woman who was working and in school explained: “I wanted to breastfeed him for at least a year. But already like 4 weeks into it I already saw that I needed to get a job and he couldn’t be so dependent to me.” She received a breast pump from the Baby Café and was either nursing the baby or pumping breast milk during her work breaks. She related that she then realized “it’s not gonna work. I’m missing a half an hour of work, and then I started seeing my paycheck going low. And I was like no, I really need this money.” For her, lost wages that resulted from nursing breaks were an issue that outweighed her commitment to breastfeed.

Another mother shed light on the monetary advantages and disadvantages of breastfeeding, explaining,

Cheaper… that’s the conception that you’re given. …Though I don’t know about that now. They say it’s less expensive. But if you think about it, you have to buy a pump; you have to buy bottles to pump into. You have to buy storage bags, milk storage bags. After the refrigerator it needs to go to the freezer. And those bags, you go through like that. And you need enough bottles to keep stocked up.

As a result, provision of a free pump from a worksite, WIC, or the Baby Café has a huge impact on breastfeeding-related finances. As the expense is a determinant of infant feeding decisions for some women, these pump rental or donation programs play a role in reducing the potential financial burden of breastfeeding.

**Breast Pumps**

Provision of a breast pump resulted in a reduction in the economic burden for the low-income breastfeeding women. Many of these women were told in the hospital that
they needed a breast pump in order to keep up their supply and provide mother’s milk for a baby who could not feed from the breast. For the same reasons, a mother who needs to be able to return to work or school before the infant is six months old is especially in need of a breast pump. Regrettably, the inability to obtain a breast pump, especially a very expensive electric breast pump, can be a barrier to breastfeeding success.

A first-time mother shared how grateful she was to be referred to the Baby Café for the use of a breast pump, which she would not have been able to afford. Her nurse “had said ‘you know you can go downstairs and rent a pump and it’ll cost you this much, and these are the numbers to call.’ And I just I looked at her and she must have read my face and she’s like, ‘Or we have a free service that will help you.’ And I was like ‘yeah, cause I’m not working…’ So, whatever the cost of a pump was gonna be was not within my budget at all. So I think I called before I even was discharged from the hospital.”

For babies who need to stay in the NICU, keeping up a supply of milk with the use of a breast pump is especially important to ensure that the infant receives mother’s milk. Because the cost of a breast pump can be prohibitive, mothers who may need a pump immediately after the baby’s birth may be unable to obtain one.

Furthermore, a breast pump is especially useful for low-income/at-risk mothers who may need to return to work or school within the early postpartum period. During long periods away from the baby, mothers may need to express milk to both relieve physical discomfort and keep up their milk production. They also need to be able to express milk to save for the baby to receive while the mother is away from her infant’s side. Latoya was able to pump milk and feed her infant breast milk while she was attending high school until the baby was seven months old, thanks to the receipt of an electric breast pump. She shared,

I end up going to school… I had to go to the nurse and pump and store. I had to pump… as soon as I came home I had to pump. And throughout the day I had to
pump and do homework, pump, and save some for my mom. Cause she quit school to watch my baby. So like I had to pump, save some for him, go to school, come back. It was just, same routine. No formula for the whole 7 months.

With the help of her mother, and the assistance of the breast pump, this young mother was able to go to school full-time and still provide her baby with breast milk.

A mother of twins, Quinn, narrated how she is able to continue breastfeeding her five-month-old babies with the use of a rental pump. She said the “breast pump helped a lot. I still have a breast pump from WIC because I’m working. So, I pump before I go to work and when I come back home. I try to save as much as I can for them.” She also pumps during her breaks at work. Programs that provide mothers with the use of a pump aid in the reduction of the financial load and increase breastfeeding success.

**Worksites**

Work was indicated as an obstacle to breastfeeding, especially if the woman was unable to nurse or express milk during the workday. “Work is the only challenging thing,” said a Jasmine, 35-year-old first-time mother, “you know every six hours I’d pump.” She actually put herself on a pumping schedule before she went back to work so that she would have a supply in the freezer for when she was away from home.

Moreover, when asked what may have been the one thing that would make her unable or unwilling to continue breastfeeding, Bella, a 27-year-old mother of a one-month old, answered, “The only thing that I can think of is work. If I wasn’t able to pump then I wouldn’t be able to do it.” Fortunately, she had bought a pump attachment kit to use a hospital-grade electric pump at work, which was provided for the employees in a nursing mother’s room. Her employer also had a childcare center on the premises, which enables mothers to nurse their children during their work breaks. Only one other mother was able to nurse her child at her workplace; Monica, still nursing her six-month old, was home
nine weeks before her place of employment asked her back to work and she was able to place her son in the on-site daycare. She was pleased to be able to go back to making money and still be near her baby.

On-site assistance is a large help to nursing mothers, but, sadly, very few employers offer this type of service. One mother outlined this, stating that “unfortunately they don’t have like certain areas where you can go and pump. It’s not like they support that kind of stuff, you know.” Monica said that if she had been unable to take as much maternity leave as she did, she “would still have continued breastfeeding, but it would have been a lot harder. ‘Cause I would have had to pump constantly.” She said her work had told her “‘oh we’ll just pull a chair into the bathroom and you can pump in the bathroom.’ And I’m like no. Not gonna happen.” She let her employer know what the law requires, and stated that her worksite space for pumping “is fine. It makes due. It’s no big deal. But ideally, there should be a separate room. It could be near the bathrooms, but not in the bathroom.” As work support was not the norm, having to return to work early in the postpartum period proved a challenge for breastfeeding mothers.

**Work and Maternity Leave**

Many of the women indicated that going back to work was difficult to reconcile with breastfeeding. A mother of four said that she quit breastfeeding her first child when she went back to work, and that she intended to breastfeed her fourth child until she went back to work and school. One mother said she pumped at work, but her supply went down a lot and she had to start supplementing her daughter with formula.

A number of the mothers reported that they would have wanted more time off than they received. Most of the mothers indicated that they had taken fewer than 12
weeks of maternity leave, either because of their employment circumstances or their financial circumstances. A mother on WIC and Medicaid commented, “I wanted to do 12 weeks but I had recently started working... So, I didn’t. I couldn’t take enough time.” Other mothers took off four weeks, six weeks, and nine weeks. One mother was out for about 10 weeks, as she had used some saved-up vacation time and then worked part time from home. Jessica, 26-year-old mother of two said that with her first baby she “would have liked at least the full 3 months been able to breastfeed.” “I don’t even think I got the full 12 weeks off,” she bemoaned, “And then once I had him I had him and then had to turn back around and go back to work.” Bella, a 27-year-old mother of a one-month-old, disclosed, “I’m lucky enough that I’ve had all this time off from work... I’m not getting paid for like the last month, so I’ve been saving up this whole time just to make sure that I am able to spend as much time with her as I can.”

Not all women were back at work or planning for a return to work. Maria, had moved to Florida with her husband from Cuba explained that she was not currently working because she and her husband had ended their careers when they moved, and they do not yet have U.S. work permits. She expressed that she would like to work, but since she is not working, she can be home nursing her daughter. “I'm taking advantage and I'll do it,” she declared, but she recognized “if I give birth again and am already working here in the United States...” she would only receive a couple months of maternity leave.

Another woman who had also moved to Florida from abroad, Uma, related, “I am staying at home and I have the time. Not everybody gets that time. Some people have to work, work, work. But right now, I have to take care of her, And I have my husband supporting me. So while I still have the time, why not?” She was able to benefit from her
husband’s financial support. Similarly, Brandy, mother of four, who was eligible for WIC, Healthy Start, and Medicaid, had familial economic support. She explained that when she had her first baby “I was living with my mom, I was 19 years old. I didn’t have any bills or anything, so I didn’t have to worry about rushing back to work.”

**Other Economic Barriers**

Work was not the only challenge to the breastfeeding experience that these low-income women encountered. Coping with the uncertainty of economic stability affected Grace’s thoughts on how long she intended to breastfeed her next child. “Depending on how my living situation is and my economical stability and if I’m still going to school at that moment and stuff like that,” she explained. Additionally, dealing with organizations that are meant to help low-income and at-risk women and babies with breastfeeding was also a trial. For instance, several of the mothers indicated that WIC’s rules about pump rentals were a barrier. In the words of Christy, a 23-year-old mother of two,

> I had to fight for the WIC pump because normally they only give it to moms who are working or in school, and since my situation was different in that she’s special needs, can’t latch on. I wanted to breastfeed her for her surgery and everything. They finally consented to it, but it took me a while to talk to somebody.”

She had also been denied a pump with her first child, saying “I was a stay-at-home mom at the time so they were not going to give me any pumps or anything like that.” As she was not working in order to take care of her special needs children, she had a difficult time receiving a breast pump for as long as she needed one.

For Shauna, 41, being a single-mother created a struggle for her as she tried to care for herself and the baby alone and also breastfeed. “I just had a C-section, I’m trying to deal with the new baby. And I’m a single mother, no help at all. I’m trying to pump, get him dressed. Trying to go on appointments. And it was just taking so long” she
disclosed. Uma, 26-year-old mother of two children said she did not drive, which hindered her from attending breastfeeding classes while she was pregnant, as well as going anywhere for breastfeeding assistance. She imparted, “Anywhere I go my husband has to drop me because we don’t have two cars. So that’s why I couldn’t go myself. And for me to fit in a schedule, it’s kind of always hard.”

**Perceptions and Embodiment**

The physical and the emotional were intertwined for these mothers, who described how the corporeal act of breastfeeding made them feel both physically and emotionally. Breastfeeding necessitates being in close proximity to the child every few hours, which can challenge a mother’s self-perception and cause disruption to social practices. These mothers’ perceptions of their physical breastfeeding experience led to mixed emotional responses.

**Personal Privacy**

Women’s breastfeeding experiences begin straightaway after childbirth, during which they often relinquish their privacy, as they are physically and emotionally exposed and vulnerable. As Bella described just one month after her first birth, “After you give birth you’re used to everybody just poking and prodding you everywhere.” The breastfeeding assistance that they receive immediately in the hospital and at home in the early postpartum can often seem unnerving to women who are not used to such exposure and touch of their breasts. “It was weird at first,” said Monica, “Because I’m usually a very private person. So getting used to, especially in a hospital, having myself exposed and open like that, it was hard at first. At first I didn’t want to.” The women experienced
a lot of hands-on assistance, which, while generally welcome, was more intimate than many of the women had expected. “I had people grabbing my boobs and showing me how it’s done and how it’s not done,” explained Christy, a 23-year-old mother. Brandy, whose fourth child was four months old, also described how she was uncomfortable with how physical her helpers were with “that cramming the baby onto your breast thing that they do. And I really didn’t like them doing it.”

Monica gave an account of how she felt learning to breastfeed in the hospital, saying, “I’m not used to being wide open like that. And so for them to just come in and move my gown aside and you know put her up and act like its nothing. I was taken back by it a little bit. And then after a while I kind of got used to it.” This was perceived by the women as something else new that they would have to get used to quickly now that they had a baby. Bella, 27, stated that she was so stressed out and determined to breastfeed that she “would pop out my boob and I did not give a crap whoever was there, but it’s just, it’s difficult when she’s screaming and I’m frustrated because I don’t know what the hell I’m doing.” But the help received from the hospital lactation nurses made some women physically and psychologically uncomfortable. Shauna explained,

They’re like oh cram him on your boob. I’m like, this feels like really animalistic to me, I don’t like the feeling of this. The lactation lady and the nurses, they’re like push him on your boob. They’re like ‘I know it feels violent, but this is how you have to do it. You have to show him who is in charge, who’s the boss.’ I’m like lady you are crazy, sitting here cramming my boob into the kid’s mouth. That’s all they kept telling me to do.

Taylor, who had a two-month-old, described that she was more comfortable in the privacy of her own home when she was by herself because “When I was at home... it was a little bit easier to try. Because I was alone.”
Production and Pumping

Making milk was a frequent concern of the mothers during their breastfeeding experience. Starting immediately in the hospital, continuing at home, and even emerging after nursing for months, concern over milk supply was a pervasive worry. “If I couldn’t produce, then I can’t breastfeed,” summarized Monica, who cited lack of production as the only concern that would make her unable to breastfeed. Shauna even expressed worry over not leaking any milk during her pregnancy like she knew others did. Many mothers felt the way this woman felt about nursing one of her children: “My body just was never producing enough of what he wanted. He wanted and wanted. Literally, I was feeding him like every hour. I would get done and it would be time to put him right back on.”

“I can’t keep up with her,” expressed a 31-year-old mother, who continued, “I mean she would nurse me dry and still be hungry. They’re like ‘oh, you’re never dry.’ There’s nothing coming out, I’m dry. Not having a second letdown.” Quinn, 35-year-old mother of twins, explained that she was giving her babies the breast but “maybe I did not make sufficient amount of liquid or something to fill the breasts well… I sometimes thought it was not full or I did not have enough to fill it because it still seemed that I had not letdown enough.” Family and health counselors advised both mothers that the more they nurse the more they will make. Others turned to additional methods to increase their milk supply, such as certain foods, teas, or medications. Pumping and breastfeeding at the same time also helped one woman increase her production for a time; however, most mothers did not experience an increase in milk supply. Described 41-year-old mother of one, Shauna, “It [milk supply] like severely dropped off when I just was only doing that.”
Concern over production appeared to stem from the act of expressing breast milk with the use of a pump. Every single one of the women had used a breast pump at some point, and their experiences were mixed. Women were frustrated over how little milk their bodies appeared to be making, as measured by the output from pumping. “I was worried he wasn’t getting enough, because I wasn’t able to pump enough in time for him” expressed a first-time mother. Her sentiments were echoed by Gabriela, a third-time mother who said, “I would only pump two ounces and it would take me a whole hour. And then to reproduce more, and it was already two hours for him to eat again.” Staying ahead of the baby’s needs with a back-up breast milk supply in the fridge was a goal of many mothers.

The pump made production hard for 31-year-old Monica, who noticed that during the work week while she was away from her baby, she made less and less milk from pumping. “By Friday, I can notice, it’s getting low. And then Saturday and Sunday she nurses. And then Monday I’m back up to filling up two bottles in one pumping at work,” she explained. Pumping was how most of the participants perceived their milk supply, using exact ounce measurements to convey their impression. “It’s like I’ll pump and get an ounce. I’m so jealous of the people that are able to produce and produce and produce and get stuff, and I’m just fighting for an ounce,” declared Bella, 27-year-old mother of a one-month-old. Brandy, whose 4-month-old had been in the NICU, recounted, “I was getting like maybe two and a half ounces out of one side and this side… nothing, like, literally a few drops. So, it was very frustrating.”
“Frustrating” was a term I heard over and over when it came to the experience of expressing milk. Mothers became discouraged and annoyed at the process of pumping. Christy, 23-year-old mother of two related,

Of course, it makes me feel defeated when you try so hard and just nothing comes out. It’s like you can feel it in there and it will just not come out. You’ll sit there for two hours with the dang pump attached to your breast and nothing is coming out. It’s not doing anything.

Even with an abundant supply of milk, mothers did not enjoy the process of pumping.

“By the time that process of like pump, feed, pump, clean the pump, clean the breast shield, he was hungry again. And so I literally spent pretty much all day every day with my pump,” described Jennifer, a mother who had a good supply but struggled with getting her son to nurse from the breast. This view was shared by Shauna who said, “it just seemed like a lot of work to me. It seemed like it should have been more natural and it just seemed like a lot of work.”

**Breastfeeding vs. Bottle feeding**

Of course, relying on a breast pump to feed the baby means a switch from nursing the baby at the breast to feeding with a bottle. Mothers compared the two processes, explaining how they felt both mentally and bodily. Jennifer, mother of a six-month-old, was initially totally reliant on her breast pump, but then was successfully nursing at the breast. She stated that pumping “was such a process. And it was so... not special and cuddly. It was so much more clinical than it is now.” The general sentiment was that bottle-feeding takes more time and effort, either with expressed breast milk or with infant formula. “To me it is more comfortable for me than the bottle. Because the bottle must be heated. It is more work. In that aspect. Now, here is the food, and you put the baby on,
and... It's easy. For me, it's easier,” explained Quinn. Another woman who pumped milk for both of her children revealed,

It’s one thing when you feed solely on breast milk or to the breast directly because it takes about half the time. You just put the child to the breast. You push her on the other breast... you’re done. They ate, you’re good, you’re empty, you put them in the stroller and you go.”

Both a mother of four and a teen mother of her first child proclaimed breastfeeding made things easier at night. Brandy said that with all her children, “I put them in the bed with me and just, you know, latch 'em on, I don’t have to get up and worry about the bottles.”

Most mothers preferred breastfeeding to pumping and bottle-feeding, but there were some exceptions. Grace, a 27-year-old single mother who worked and went to college conveyed, “When I switched to the pump, it gave me a lot of relief. I had more independent movement for myself.” Though her breastfeeding experience went well, and she now had to pump, she was glad to have some autonomy and not have to have the baby physically near her all the time. Pumping can be more time-consuming than breastfeeding, but it can allow a mother to maintain her preferred lifestyle. Quinn described her experience with her twins:

I feed them from the bottle, both, both ways. Sometimes on the breast, sometimes on the bottle. Like, when it be easier, I just give them the bottle. Because the breast, it can take like, how long for them to be full. But the bottle, you just give it to them. They don’t care. So, anytime I have time I just give them the breast, for them to suck, for more to produce more, yeah.

For her, the bottle required less of her personal time to feed the babies. She did note, however, that she still needed to feed at the breast in order to keep up her milk supply.

Pain

Pumping was useful, but also tedious, frustrating, and time-consuming. Furthermore, for many women, it was actually painful. “The pump was like starting to
make my breasts hurt, too, ‘cause I guess it was like pumping so vigorously.” reported Shauna. Taylor, 22, explained, “Physically, [breastfeeding] didn’t hurt me... the pumping hurt a lot, because I was pumping all the time. So that I mean that kinda messed up, physically, my breasts a little bit. And scarred them up.” She and several mothers reported a substantial change as a result of using a pump. Another mother also reported that her baby feeding on her did not hurt, but the pump altered her breasts: “After a while, even the electric one, my nipples couldn’t handle it no more. They would like, they were like get so stretched out. That I never thought my nipples would stretch out like that.”

Many mothers pumped through the pain with the goal of increasing their production and/or continuing to provide mother’s milk for their baby in some form. “It hurt. And the more I pumped, the worse it got,” stated Brandy. She continued, “The pump was a good pump that they gave me, but it was very, very painful.” “Your nipple is getting huge and sore because of the constant sucking motion,” said one mother of using her breast pump. Jessica, 26-year-old mother of two, added, “The pain... I only felt pain with the pump. The first couple of times of breast pumping. But then afterwards, you know, I guess your body gets used to it.”

Most of the pain was attributed to the baby’s latch, which, when corrected, brought some women relief. “Everyone is afraid, oh I don’t wanna breastfeed cause it’s painful. If she’s latched right, it’s not painful,” elucidated Monica. Grace, 27, explained that at first, “the pain was really strong. It really hurt every time he latched on because the nipple was sore,” but the pain didn’t last. “After that,” she continues, “Everything was perfectly fine. After it got cured, I was like, oh it’s not so bad.” Quinn said, “if I still
didn’t get it right with them latching, I would have stopped, because that, it hurts so bad, yeah, I would have stopped.”

The release of milk was also cited as particularly painful for some mothers. “The pain is whenever I would be somewhere and he would get hungry and fussy. And it’s like... your body just knows its feeding time. Yeah, and I can feel it flowing,” described Jessica, mother of two. Monica, who was still breastfeeding her six month old explained that she only felt pain from her letdown:

“It’s not like painful cause she’s latched on, it’s just my milk production. I have a very strong letdown. So when I letdown... when it was first happening, I was grimacing every time. Because I can feel it. I can feel the milk flow. And even to this day, when she’s eating... when I have a letdown I can feel it. It’s not as painful as it was, but its still pretty strong.

These women were surprised to be able to feel their letdown so strongly and for it to be a painful experience. Jennifer, 30, who was also still breastfeeding her six month old explicated her experience with milk letdown:

The first time I felt my milk letdown... I thought I was having a panic attack. ‘Cause that was the only time I’d ever felt that tightness in my chest before. And I woke up and I was like what’s happening to me? And I started to kind of shake and I had the chills... It was like a really weird bodily sensation in the beginning. It still kind of tricks me into feeling a little bit nervous every time I get letdown.

It appears that most mothers were willing and able to tolerate the pain and continue breastfeeding and pumping.

Although a couple of the mothers described switching to infant formula because of the pain of breastfeeding and pumping, some actually stopped at a certain point because of a fear of future pain. Most notably, this centered on the baby’s teeth. “Teeth. Teeth is the only thing,” articulated Jessica, who reported that teeth would be the one thing that would have made her stop breastfeeding if she was able to do it that long.
Latoya, who had successfully breastfed until her baby was seven months old, commented,

> When I started to see those teeth come in, I was kind of scared then, yeah, so I’m like, no, okay, I’m going to stop…. Because he likes to, he likes to bite, he does, when his teeth came in I was like, oh, no, I really want to stop breast feeding. Cause that hurt.

Additionally, Brandy, 40-year-old mother of four said that she found it odd that women breastfeed their kids until they are two or three years old, because “it’s kind of weird, once they start getting teeth.”

Many mothers spoke of withstanding the pain and sacrificing themselves for the good of their baby. Bella, who was unable to produce very much milk due to breast implants she had received years earlier expressed, “The pain part, I was so focused on actually being able to successfully breastfeed that I didn’t even pay attention to it. I was just like I don’t care.” “I was ready to endure the pain,” explained Uma, a 26-year-old mother of two who was still breastfeeding her four month old. She called the cracked and bleeding nipples painful and aggravating, but noted, “I can endure it.” Jasmine, 35, asserted that she was willing to surrender to the pain:

> I mean it’s something that you just have to accept. You’re going to go through it, but it’s worth it. It’s like you go through the pain and the ugliness (‘cause it does not look cute at all you know bleeding ugh) but it is definitely worth it. ‘Cause you know she’s getting the optimum milk. So it was worth it. But it was a sacrifice. Definitely.

A couple women also mentioned bleeding and cracked nipples, but they generally put nipple cream on and eventually they healed. Bella explained that she was “so desperate to just get it right I didn’t, I just whatever, its part of it. I didn’t even think about it.”
Exhaustion

While many women were willing to endure pain, not everyone did well with the level of mental and physical exhaustion that they experienced. In the words of Jasmine, 35-year-old mother of one, “It was just very hard. It was exhausting.” “There was a point where I was tired of doing it. I was tired; I was just tired of doing it. I don’t wanna do this anymore. I don’t want to get up in the middle of the night and feed her, I don’t wanna,” expressed Monica who said she tried, but changed her mind about, switching to bottle-feeding only. “Between pumping and feeding and pumping and feeding, I had no sleep and no time and no other life... It was just very exhausting every two hours to try to keep that supply up, and I said I’m not this devoted,” explained Christy, who, in addition to caring for her older child, had her youngest baby in the NICU. Many of the women were surprised at how much time feeding the baby actually took.

Mothers expressed that having to care for both themselves and the baby immediately postpartum, especially in certain circumstances, was fatiguing. Some of the mothers did not have live-in partners, so the burden was great. Furthermore, some mothers were recovering from cesarean sections in addition to struggling with breastfeeding and caring for the baby. Taylor, who developed an infection after her cesarean surgery speculated that if she had not experienced that infection, she would have had more energy, tried to breastfeed longer, and “maybe woulda been successful.” Shauna, who gave up on breastfeeding, and confessed that she did not regret doing so, told her story:

I mean, to be honest. I feel like, I’m 41 and just having my first baby. I have a lot of other things going on, so it was like, to me, with him not cooperating, it was like getting to be an inconvenience. ‘Cause it’s taken a long time. ‘Cause normally you just breastfeed them and then you know put the boob away and just
go about your business. You don’t have to sit there pumping and trying to like not be leaking milk. And trying to run to the sink and pouring it in bottles. And doing all this other stuff. And boiling bottles and all this stuff. It was getting to be too much work… I don’t know, I was just tired. At that point I was kinda glad to be not breastfeeding anymore. I mean, unfortunately, I guess I shouldn’t be saying that, I guess I’m a bad mom. But it was just like, it was enough was enough already.

Sleep deprivation, coupled with pain, lack of support, and worry over the wellbeing of their newborn contributed to the negative embodied challenges of breastfeeding for these women.

**Other Sensations**

While pain and exhaustion were anticipated from what women had heard from their family and peers, whether or not they experienced it women described breastfeeding to feel different than they had thought it would. In the words of first-time mother Grace, 27, “*It was what I expected from what I learned, but the sensation wasn’t what I thought it would be,*” though she described it as a good sensation. “*It’s totally a different feeling,*” she continued, comparing it to her sexual experience, “*Like it’s different when you have your partner do things to you than when you feel your son or your child doing things. And you’re like wow it’s a different feeling.*” Jessica, mother of two, related how breastfeeding felt for her the first time,

*It was different. Just because you never like think of, ‘yeah I’m going to have a baby suck on my breast.’ Whatever, you know. And then when they do it’s like ‘oh I get to feed them.’ So it was awkward at first, but then as days go by you kind of get more and more used to it… Like in the beginning, it hurt. Because you know don’t ever have anybody in that vicinity area. And then as the days went by, it started I guess, hurting less and getting used to it… I guess, like, physically, it felt weird until I got used to it. Once I got used to it, I felt more comfortable. And now, of course, I don’t feel anything.*

Overall, women expressed that breastfeeding did not feel the way that they expected, mainly because they never could have imagined what it would be like to have a baby on
their breast round the clock. As Latoya, who said she loved breastfeeding illustrated, compared to what she thought

It was actually better. It wasn’t like people said it was going to be, it was kind of like, I guess different…. Kind of like, you have somebody sucking on your nipple, it’s like this is different, this is like intense, you know? It was kind of like, you had this every day, somebody doing this for a whole seven months. So it was very different, but at the same time, it was a better different. Yeah, I liked it.

Mothers described it as a “surreal” and “awesome experience.” They enjoyed having their children close to them, saying things like “it feels good to breastfeed.”

When they were able to successfully breastfeed, women conveyed that it made them feel like a mother, especially Latoya, a teen mom who said, “It made me feel more like a mother, you know? Because at a young age, it made me feel more like, responsible, with breastfeeding.” She also observed that it made her feel proud because, “You don’t see a lot of teenagers breastfeeding, because they just want to go straight to formula.” Jessica also mentioned, “When I was breastfeeding, it felt pretty good. It felt like this is natural. This is what I’m supposed to do. I felt a mom in a sense.” Uma, 26-year-old mother of two noted that breastfeeding made her “feel happy to know that I was capable of feeding him.” Similarly, Gabriela, a 42-year-old mother who did not have an easy time with breastfeeding stated, “it was a nice experience, to see him, eating from my breast, you know? It was something nice... It made me feel good that I was feeding my kid with my own milk.” The experience was very emotional for all of the mothers, especially because the baby depended on them. Mothers enjoyed that they were able to provide for their children with their own bodies. 22-year-old Taylor explained that it made her feel important, and that she felt it was “something that you can do for a baby that a man can’t.”

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Mothers described breastfeeding as the most meaningful way to bond. “That closeness, that intimacy. It’s just you and her. It was just a beautiful experience, really, really nice. Makes you feel connected, you know, and… feel warm inside,” described Jasmine, who breastfed for four months. She went on, “It’s just a good feeling it really is. Like, oh my gosh, you know, this is you know my creation. And you just feel that bond… just feeling her close and knowing that it was you feeding her.” Latoya, who was not breastfeeding anymore said, “I love breastfeeding. If I could still breastfeed, ‘cause breastfeeding is a bond. It is. So if I had a choice I would still breastfeed.” This teen mother explained that even if the baby did not need to be fed and was not hungry, she would be ready for him to be close to her, so she would allow her baby to nurse just so she could have that moment with him. “I loved the fact that he got very attached to me and when he saw me he would get excited and all that. That sensation is really good,” explained another mother. Uma expounded, “You bond with the baby more when you breastfeed than when you bottled feed. It’s just true. Even though some people argue it, it’s just true.”

As a result, it is understandable that mothers who were not capable of breastfeeding their children felt disappointed. Bella, who experienced physical challenges with milk production professed, “I thought I wasn’t bonding with her. I just felt like here’s this baby and what am I supposed to do with her, and I can’t breastfeed so now what? How are we going to bond? It was more emotional than it was physical for me.” These mothers felt like they were missing out on a key aspect of motherhood. Shauna, mother of a 4-month-old, explicated, “He wouldn’t latch on, so I didn’t really get the whole experience of rocking my baby to sleep and breastfeeding... so, it was like I kinda
got cheated out of that.” Christy, who was unable to feed her special needs babies for very long due to their health circumstances expounded on her feelings:

I guess it was defeating because I was I have all the people who … I guess that poor pitiful me attitude that anybody gets … I want it the most and everybody else gets it and they just take it for granted, and I don’t even get to experience what I want to, or do what I want to do.

Some mothers described that their baby would reject their mother’s breast, screaming and shoving away, making the women feel extremely distressed and saddened. Said Jennifer “he got to the point where when I would offer him the breast, he would clamp his mouth shut and turn his head away. And that was kind of hard to see. That he would rather have a bottle than nurse.”

Perception of Self and Baby

Many women expressed how they perceived themselves and their breastfeeding bodies. If they were nursing or pumping all the time, they felt, as one mother put it, “like a cow.” Breastfeeding resulted in bodily changes that many of the women noticed. More than one mother discussed their breasts becoming “saggy” or “falling” after breastfeeding. In the words of 41-year-old Shauna,

My breasts don’t feel the same ever since I had the breastfeeding incident of pumping. My breasts don’t feel the same and I’m not happy about that at all. They’re like soft now. And that made me not happy and if they get any softer if I’m gonna breastfeed again, no. I don’t wanna do it. Cause I don’t feel like the way they used to feel. So I’m not happy about that at all.

Though she specifically attributed the change to pumping, she declared that she would not breastfeed again for fear of changing her breasts even more as a result. Research shows, however, that although breasts lose elasticity from pregnancy, breastfeeding is not the culprit (Rinker et al 2008). Positive changes noted by the participants included weight loss, having more energy, and healing faster, and the temporary lack of menstruation.
More common, however, was the disappointment in their bodies. Some mothers attributed their lack of success to the shape of their nipples, (e.g., too flat, too large, or not large enough). Brandy, 40, asserted that her baby would suck and get nothing from one breast because “it was not communicating,” though her daughter would latch onto her other breast. Mothers held their bodies responsible for the failure to do what they wanted. “There is nothing that they could have done differently to make my experience different; it just, my body, there was something going on with my body” explained Brandy, who was only able to provide breast milk for her NICU baby for one week. Likewise, two mothers reported despondency at their milk drying up when the baby was one month old. “I don’t know, it just stopped cold turkey. I don’t know if it was just me doing something wrong, or if it was, you know, just that my body wasn’t used to producing,” said Jessica, who never wanted to stop breastfeeding. She remarked, “It really sucks that my body is the way it is. That it just decides to stop.” “I told her that I was drying up,” explained Bella, recounting her help from the IBCLC. “She… told me to follow-up with her, but I’m not going to waste her time if my body’s just not doing what it’s supposed to.”

Others held the baby responsible for the breastfeeding challenges that they experienced. Babies were described as unwilling to breastfeed because they “didn’t wanna latch,” were “pissed off,” and wanting more milk because they were “greedy.” One mother explained that at first her baby would only feed on one side and “That was the only boob he wanted.” Breastfeeding failure resulted from the baby “giving up on the breast,” because “he wasn’t never getting satisfied,” and bottles were easier, explained Brandy. Comparably, Uma, mother of two, said her son would start to latch really well,
but when she fed him from a bottle in public, it was a struggle again. “Anytime you give him bottle, he forgets how the breast nipple feels,” she stated.

Two older mothers who were breastfeeding for the first time both attributed much of their lack of success with breastfeeding to their child rather than themselves. One of them explained,

Other people, they just, their kid just latches on, I don’t know. My kid didn’t wanna latch on. He was not interested. And I would just keep trying to put the breast in his mouth and he would like take the nipple and like stick his tongue out and be like ‘eww!’ Like, ‘what’s that?’ I’m like, I’ve never seen a kid do this before.

Gabriela described her baby as preferring the bottle because he was lazy and desperate. Not for lack of trying, “He wouldn’t latch. …Because he was lazy… It wasn’t a problem with him eating, it was just he was really lazy,” she explained, but “the bottle, just suck on it, and there it is.” She repeatedly put the onus on the child, saying, “I tried, I did my part, but he couldn’t.” She specifically noted that it was not anything wrong with her, but the baby: “I’d spend nights there, trying, trying, and he would get desperate. And it was ‘cause of him, not because of, of my breasts, or anything, it was him.” These mothers perceived that their kids “had like a severe resistance to breastfeeding. He wanted breast milk in a bottle. And when I couldn’t pump it, that was it for him,” and so they stopped breastfeeding.

**Nursing in Public**

Feeling exposed and vulnerable is a common aspect of the breastfeeding experience with which many women were acquainted. Cultural disapproval and the social stigma associated with nursing in public locations can greatly discourage a mother from
breastfeeding in public. The way women outwardly felt generally about nursing in public ran counter to the way they felt inwardly about their own power to breastfeed publicly.

**Outward Attitudes**

These breastfeeding mothers elucidated how they felt about seeing other women breastfeed in public. Outside of their own experiences breastfeeding in public, attitudes toward others were generally positive. “I used to see women come in all the time and they would have themselves with a blanket over their shoulders covering up completely and breastfeeding their child,” explained Grace, who worked at a restaurant before she was pregnant, “I found it always cute, you know. Like I never thought of it wrong. You’re breastfeeding your child.” Taylor, 22, expressed that before she had her two-month-old baby, she “always thought it was weird, you know, to ordinary people that don’t have kids,” to see a woman nursing in public. Now, however, she says,

I don’t see anything wrong with breastfeeding in front of other people… I think if you’re like, modest with it, you know and you cover yourself, I don’t see a problem with it, in public or anything. You have to eat a hamburger at McDonalds or something. He’s gotta eat and that’s where he eats from.

Attitudes towards a baby and mother breastfeeding in public may have changed for many of the women, now that they are mothers who have themselves breastfed their children. They understand better the need to feed the child, and how difficult it can be to care for a baby and to breastfeed.

The sentiment that women should be modest emerged in many of the women’s standpoints on public breastfeeding, reflecting the overarching societal opinion towards the exposure of breasts in public. Several of the women referred to a woman’s “modesty” and “covering up.” Prior to having her four-month-old baby, Shauna said she did not approve of women nursing in front of her:
It wasn’t like I have a problem with nudity at all. But it was just like, I don’t know, it just seemed animalistic to me. Like some kind of animal just popping out your boob, feeding your kid, and then your boobs dangle all over the place. I don’t know. I just wasn’t a fan of it.

She admitted that after she had her baby, she felt differently, but she still expressed, “I think for modesty reasons you should probably cover it up, you know, but I mean, not just whip out your boob like I’ve seen some chicks do. But that’s how they roll.” Only one mother, Monica, 31-year-old mother of one, shared her knowledge of the policies that protect mothers who nurse in public, “It’s the law. The law says you can nurse wherever the heck you want. Wherever, however you want. Open, exposed, and covered. No one can say anything. You can be in the middle of a playground and do it and you won’t get nothing.”

Outward opinions on women nursing in public included the sentiment that breastfeeding is natural, and thusly so is doing it in public spaces. When asked how she felt about nursing in public, a mother conveyed, “I don’t care. I feel like it’s natural. That’s what women did before there was formula and before there was bottles. That’s what women did, and it’s natural.” Shauna also said she feels like it is natural, and then offered her perspective of societal attitudes toward breastfeeding in public:

I don’t think that it’s something that should be such a big deal in our society. I think in America we like stress about the wrong things, to me… I think America over sexualizes certain things for like stupid reasons. Because in Europe and other countries I don’t think that it’s the same way that it’s viewed. And I just don’t see what the problem is. And a lot of people are like freaked out about it and like protesting and I’m like are you serious? It’s just breastfeeding. To me, I think it’s a personal choice. If you wanna do that, with your breasts and your kid. That’s your business. If you don’t, you know, don’t… I mean that’s your breast. That’s men gonna be like perverts staring at your breast. If you don’t mind, and that’s fine by me. ‘Cause that has nothing to do with me. It’s not affecting me either way. If they wanna cover it, that’s fine. And if they don’t, that’s fine with me, too.

She continues,
People are making it into such a controversy nowadays. It’s like it’s ridiculous to me. In the olden days, that’s the only way that they had to feed their babies. And it was like not a big deal. I don’t know if men were looking at it as sexy back in the old days. I don’t think so. But nowadays everything is like so like twisted and perverted. They’re taking like feeding a baby as making it into sexual, which I don’t think it should be. That, to me, is gross. For men to be staring at a breastfeeding woman and thinking that that’s something sexy. That’s weird to me. But it’s our society.

Monica agreed, “The community needs to be more aware, more tolerant.” These beliefs demonstrate that while breastfeeding mothers have respect for other women nursing in public, they still struggle with what is societally proper.

Inward Attitudes

Participants acknowledged that their own attempts to breastfeed in public elicited unwanted attention. Jasmine, mother of a five-month-old, expressed that she did not nurse her daughter in public because,

I just didn’t want to get… gawked at. Because if people don’t really take too kind to see woman nurse, I don’t know why. It’s natural, I mean, you have women walking around here half naked anyways, and yet something as in feeding a baby is like ‘oh my gosh!’ And it’s looked down upon, you know. I guess because I just I didn’t want to have to deal with that look. At people gawking me. And I’ve even heard stories about people made comments, like, ‘oh, couldn’t you go somewhere else,’ ‘couldn’t you cover up’ or whatever. Even though the person would be covered up I guess it would not be enough.

It was unclear, however, whether any of the mothers had actually experienced any embarrassing situations in public, except for one 31-year-old mother, Monica, who was still nursing her six-month-old. “You get several stares. You’ll get a couple ‘ugh! Why are you doing that in the middle of…?’ you know. You’re exposing your… you know,” she explained. She added that some people expressed disbelief that she was nursing in public, but that also, “then you’ll get those silent people, giving you that silent nod of approval, like good for you. And then you say you’ll get nosey teenagers. Or nosey… or the nosey kids.”
Outward attitudes toward nursing in public differed, for the most part, from the way women felt inwardly about their own capacity to breastfeed in public. “I’m not going to have a problem with other people. I encouraged them to do it... It’s just me thinking, yeah, how am I going to do it? The baby, is he covered right?” put forward Gabriela, a mother of a one-month-old. Uma, a 26-year-old mother of two who was from Africa said, If I was back home I wouldn’t feel any way, but here. You don’t want to be nursing and somebody walks up to you, like what are you doing here, it’s indecent exposure, so I don’t want that. I don’t want that kind of confrontation. I’d rather avoid it than have to deal with it.

Quinn, another mother from Africa also stated she would not breastfeed in public “Because everybody will be looking at you, and I don’t like that. Like, if it’s a private place I’ll do it.” Grace, 26-year-old mother of a three-month-old, claimed she did not breastfeed in public because, I didn’t feel comfortable. I guess ‘cause it’s too of a private intimacy feeling that I have. Even though it shouldn’t be and you should be able to breastfeed your child anywhere you want. But I don’t know I just didn’t feel comfortable ‘cause some people would stare. Some people, like probably men, would try to get a look at something they’re not supposed to. So I just tried to like not. I actually tried not even to go to restaurants the first month or so until I got the breast pump.

Once she had the breast pump, she was able to express her milk and feed the baby with a bottle when she was in public.

Many women said that they simply avoided embarrassment and confrontation by bottle feeding, never nursing, in public. “I would just carry expressed milk with me,” expounded a 25-year-old mother. “I’m not the type to be in public, even though there’s places now you can do it,” explained Gabriela, mother of three, “But I was willing to even pump it, you know? And from hour to hour, because I’m not the type, no matter how much it covers, to be like, doing it in public.” But sometimes even the need to pump while outside of the home came up, so not feeding directly at the breast was still
physically and psychologically awkward. Christy, mother of two young children explained, “It was just an inconvenience because it’s like if you wanted to go to the store, you’d have to find the right time to go to the store, and pump.” She, like many other mothers, would retreat to her car to pump. “It was just embarrassing, sitting in my car pumping in the dead heat of the summer. I was, ‘I’m tired. I’m just done. I can’t do this anymore.’” And she would still experience discomfort from exposure, anyway, “Of course, you’d find one or two people who just sit there and stare at you while you’re pumping.” Uma relayed

I usually pump before going out. And then when I feel the baby is hungry and I’m really out and I don’t have enough in bottle, I’ll just go and stay in the car and nurse. But I really feel because of how corrupt the world is now, I can’t even try it. Just go out and openly start breastfeeding. Maybe if I had a covering, I can do it. But I don’t think I want to put my baby into all that stressful… covering him up just to feed him. I’d rather stay in the car with the tinted windows and just breastfeed him.

Maria, mother of a two-month-old, shared that she simply tried not to take the baby out “unnecessarily,” but if need be, she would find a private place or go to the car.

Nursing mothers went out of their way to avoid the public gaze. Jessica, who had breastfed two children, said, “I don’t have a problem with people who nurse in public, but I would rather go to the bathroom, and find an area, like, you know how some bathrooms have... the nursing stations. Like I would go and do that. But, if I’m out at a park, I don’t think I would be able to.” If they were at someone’s house, they would excuse themselves to another room. At restaurants they would excuse themselves from the table and nurse or pump in the car. Though the car was frequently cited, this setting was not always ideal. She made clear, “I wouldn’t pump in my car because it’s out in the open and there’s more businesses around us and it’s not like much privacy.” Furthermore, women lamented getting caught in the middle of the store and experiencing a letdown,
needing to pump, or being compelled to feed a hungry baby and having no place to go. Monica, who was comfortable nursing in private rooms, vocalized her concern, “But in the middle of a store? In the middle of Wal-Mart where would you go? Where would you go? You’re in the middle of Wal-Mart, there’s a lot of people. Or in the middle of a grocery store. I’ve yet to figure that one out. You’re in the grocery store, what are you gonna do?” Women were unanimous that the bathroom was an unacceptable place to nurse or pump, declaring bathrooms unsanitary. At shopping malls many women felt lucky that nursing mothers rooms were available so they could go somewhere private that was not a bathroom.

These actions reflect the isolation and inconvenience that many mothers experience simply for breastfeeding. Jasmine, 35-year-old mother of a five month old, explained that she would seek out a private place “even if it was a pain in the butt sometimes because it’s like... whatever I was doing or if I was in the middle of a conversation, you had to like, ‘excuse me for a couple of minutes, like 15 minutes,’ and ‘uh, I’ll be back,’ you know, so that’s the only I guess downfall about it.” Moreover, having to provide for the comfort of others meant creating difficulties for themselves. Brandy related that her husband “was kind of wigged out about it. Like, what are you doing you’re pulling boobs out in front of everybody but I was like it's a natural thing, its breastfeeding.” In an effort to protect her husband from embarrassment, she would try to nurse before she went out. Monica, mother of a six-month-old articulated,

I’m perfectly fine with it. I love it. I have no problem doing it… Husband’s not such a fan of it. He’s always like, ‘you know people can see you.’ I’m like, ‘yes they can. And that’s all right. ‘Cause there’s a baby there.’ And I usually, like if we’re out in public, I have a blanket over or something… But my six month old is way ahead of the curve developmentally and he figured out that he can just lift it
up. So I had to get these big swaddlers and I have to actually tuck it under his bum so he can’t lift it up while we’re nursing in public.

Planning was evidently a key factor in successfully breastfeeding in public.

Covering up appeared to be the solution for mothers to maintain their decorum, avoid shame, and shield others from discomfort. Concerned for the comfort of others in public, Bella, a mother of a one-month-old conjectured, “That’s not, I’m assuming, something that somebody wants to see, but I would be tactful and not do it in the middle of a Chic-Fil-A or whatever.” “I’m more respectful... just because I have an older daughter. Even at home I cover up. Even at home I cover up when she’s around. But I know others they don’t care. They’re not going to cover up. But, I try and be respectful,” said a Monica, 31. Shauna, who only breastfed in public twice during the six weeks she was able to maintain it, stated, “When I did try to do it I covered him up. It wasn’t like he was latching on in public anyway... So I just covered it up. Cause I don’t want any perverts looking at me and my kid, you know.” Latoya, teen mom of one, who initially said she breastfed in public and she did not care, clarified that it was a little awkward, and so she covered up and, “I wasn’t very out in the open... I would cover up with a blanket and, you know, hide my stuff.” She said her baby got hungry in the grocery store and she “would have to like, you know, cover my shirt, put a blanket over, walk down the aisle while breastfeeding. No one really noticed, they think he’s asleep.”

Privacy, modesty, and avoidance of embarrassment were key to a mother’s choice to avoid nursing in public. If a mother must remain bound to her home throughout her child’s nursing duration, be excluded from social gatherings in order to feed her child elsewhere, and/or scorned and humiliated for breastfeeding, than she will be less likely to nurse exclusively and nurse for very long.
The main findings of the results presented in this chapter include evidence that this population of mothers may not be receiving adequate support from health care providers, WIC, employers or family members, but that Baby Café is meeting their perceived needs for lactation support and breast pumps. The main reason these women wanted to breastfeed was for the health benefits for the baby. Additionally, while mothers express acceptance of others nursing in public, overall they find that doing so themselves is a challenge and therefore few do so. There was little consensus regarding whether lack of success in meeting their lactation goals was due to their personal failure or was the fault of the baby. One of the main findings was the pervasiveness and impact of the breast pump, which will be discussed in detail below. The following chapter will include a discussion of these findings, recommendations for the Baby Café program, and conclusions.
CHAPTER FIVE: DISCUSSION AND RECOMMENDATIONS

The results of this study substantiate previous studies on breastfeeding challenges for women and the effect that social support can have on the breastfeeding experience. This research also highlights new areas related to the breastfeeding experiences of this population, which deserve further discussion. This chapter will explore in-depth the findings of this study in the context of relevant literature, discuss implications and offer recommendations, discuss limitations of the study, and contributions of the investigation to anthropology, public health, and feminist research.

Discussion of Results

Knowledge and Intentions

Women’s self-reported knowledge of breastfeeding and intentions to breastfeed prior to having their baby corroborate what has been found in previous research (Nelson 2006). The women knew about the health benefits breastfeeding confers the baby. Even women who had not felt strongly about breastfeeding decided to try it at the outset because of the nutritional and immunological benefits for the baby. The mothers had idealized expectations about breastfeeding being natural and idyllic, and they mentioned bonding with the baby. Generally, participants intended to breastfeed for the length of
time recommended by health campaigns, with some hoping to nurse for as long as possible.

Attendance at breastfeeding education classes did not appear to affect duration or exclusivity of breastfeeding for these mothers. While breastfeeding education can help a mother feel confident with breastfeeding before having her baby, and potentially help a mother recognize lactation challenges, it is possible that taking a course may not be helpful. While some mothers said the education helped them with positioning and latch, several of the mothers reported that breastfeeding did not end up being how they expected from what they had learned and read. Furthermore, education alone may not be enough for a mother who is in pain and does not know how to deal with it, has a real medical problem, receives poor advice from a healthcare professional, or who lacks social support. Additionally, it cannot make up for the other barriers that women experience, such as lack of societal support for breastfeeding at work or in public.

Several of the mothers commented on the recommended length of lactation as seeming “too long” for them, either for their own personal comfort or because the child would be too old. It is interesting to note that the perceived length of breastfeeding duration varied depending on the woman (six months, one year, until the baby has teeth, when the baby starts solid food). Even though the women expressed an age at which one should stop, there was no single accepted time at which a length was considered too long.

It is encouraging to note that despite the challenges experienced by these women, every woman (with one exception) said that she would breastfeed her next baby. Even though most of the women did not achieve their intended duration, they did not lose the confidence and determination to try again. A focus on the medical benefits of
breastfeeding is useful in increasing breastfeeding rates as well as getting medical professionals on-board with protecting, promoting, and supporting breastfeeding, but it cannot be the only focus. There must also be an emphasis on breastfeeding as the biological and social norm for mothers and new babies.

**Economics**

The benefit of breastfeeding as being less expensive than formula feeding has particular significance for mothers who are low-income. Unfortunately, mothers who must turn to expressing breast milk rather than nursing at the breast are burdened by the cost of bottles, storage bags, and potentially a breast pump. Adequate assistance and support for breastfeeding is essential for these mothers to be able to successfully nurse at the breast in order to eliminate or delay the need to spend money on breast milk supplies. As low-income women are more likely to have to return to work, and therefore required to express milk, they also need to purchase these supplies and take unpaid pumping breaks while on the job. This can be a hidden economic burden of continuing to provide breast milk for the infant.

Moreover, for this group of mothers, the majority of whom were taking advantage of their WIC eligibility, breastfeeding may not be less expensive all the time. As one of the participants noted, breastfeeding became more expensive than receiving free formula from WIC once she had to pay for a tea to increase her milk supply. Some of these mothers may encounter the choice between paying for the equipment necessary to keep up their milk supply or losing money from taking pumping breaks at work, and receiving infant formula at no cost from WIC.
The furnishing of electric breast pumps by community groups reduces the economic strain on low-income and at-risk families. Electric breast pumps, which many women express are much more useful and effective, are also very expensive. Provision of free and low-cost pumps by the Baby Café, WIC, and similar organizations helps women who may be likely to terminate breastfeeding to continue to supply their infants with breast milk. In a population that could benefit most from the health advantages of breastfeeding, this is a tremendous service.

Knowing that she will have to go back to work can sometimes put excessive stress on a mother who worries about saving up a supply of milk ahead of time. The inability to take time off of work to be with and nurse the infant severely disrupts the breastfeeding experience. A mother who was new to her job was ineligible for a full 12 weeks of unpaid maternity leave. Employers are exempt from FMLA leave requirements if the time of employment is less than twelve months or if the company has fewer than 50 employees (unless state laws have more relaxed stipulations) (US Breastfeeding Committee 2012). Many of the mothers quit breastfeeding their children when they returned to work, or intend to stop breastfeeding when they return to work or school. If they had not, they expressed how difficult it was to constantly pump; finding time, finding a place, and keeping up a milk supply were all downsides of working and breastfeeding. In truth, “integrating waged employment with maternal nursing continues to be a major challenge to increasing the duration of breastfeeding, a stated U.S. public health goal” (Hausman 2003:185).

Furthermore, since breastfeeding mothers can actually be fired for breastfeeding or pumping at work, women are in even greater danger of losing money and jobs or
having to quit breastfeeding. Oddly, although the Patient Protection and Affordable Care Act (PPACA) provides the right to pump at work, discrimination acts that protect mothers from being discriminated against on the basis of pregnancy and childbirth do not protect breastfeeding mothers (U.S. Equal Employment Opportunity Commission n.d.). In addition, the majority of mothers’ worksites do not support mothers who need to nurse or express breast milk during work hours. Very few employers follow the steps recommended by the Business Case for Breastfeeding, or even the stipulations of the “Reasonable Break Time for Nursing Mothers” section of the PPACA.

In addition, many of the women of low socioeconomic status lacked reliable transportation. One woman had to wait for her husband in order to drive her anywhere, as he used the only car and she did not drive. Other women were living with relatives and friends, such as a Nigerian woman whose husband is still in Africa, and could not always depend on them to provide transportation at any time. Research has shown that lack of transportation is a barrier to receipt of prenatal care for socioeconomically disadvantaged women, and the same holds true for lactation services (Sword 2003; Meier et al 2006). Lack of transportation means that women are unable to attend breastfeeding peer support meetings, get to locations to pick up a pump, or meet with a lactation consultant outside of the home in a timely manner.

**Perceptions and Embodiment**

While mothers may know the benefits of breastfeeding, they did not seem to indicate any worry over dangers of formula feeding. The sentiment was that breastfeeding was “healthier,” “beneficial,” and “best,” but mothers were not overly concerned with adding formula to their feeding methods. Although it is not well known,
research shows that young infants fed formula are exposed to some health risks associated specifically with infant formula. Mothers who had to supplement with formula or cease breastfeeding were sad to not be able to have provided more or done it longer, but there was no sentiment that formula was hazardous in any form. Most likely this reflects not only the prevailing bottle culture, but also advertising by the formula industry, and the fact that nurses, doctors, and WIC peer counselors all recommend and supply formula.

Perception of insufficient milk was not always linked to a doctor telling the women their baby was not gaining enough weight or not seeing a large amount of milk after pumping. Occasionally it was based simply on self-doubt or a perception that the baby was “still hungry.” Sometimes it was not that the mother saw that she was not producing a lot of milk by measuring output from milk expression, but that she perceived from the baby’s actions that the infant simply was not getting enough or was not satisfied. Interestingly, many women placed the onus on the baby for breastfeeding challenges. They would say they did all they could, but the infant would be “greedy,” or forget how to latch on, or preferred the bottle. This could suggest that mothers need to be better educated on infant cues and how to respond to them, or that the infant is “an active participant in the outcome of breastfeeding” (Ertem 2001). A few of the mothers noted that every child is different, and it may be that the mother’s perception of the baby is truly separate, in her mind, of her own ability to nurse.

Women had important physical aspects of their breastfeeding experience. Many women described being poked and prodded, breasts grabbed and babies shoved, and “popping” or “whipping” out boobs. Their language indicates an uncomfortable and
sometimes violent experience with both breastfeeding and professional lactation support. They perceived their bodies as exposed, altered, in pain, and sometimes failing them. Some women described feeling somewhat upset, uncomfortable, or mildly appalled at the changes that breastfeeding did to their bodies. Surprising pain from pumping or from milk letdown had an effect on women’s breastfeeding experiences. Use of a breast pump has been associated with discomfort, tissue damage, and other adverse effects (Buckley 2009). Moreover, in agreement with the literature, many women expressed that they were concerned over insufficient milk supply. They regarded their bodies as not doing what they were supposed to do, or what the mothers wanted them to do, by not producing enough milk. Most of the women lacked trust in their bodies to lactate.

Some participants noted feeling exhausted or tired of nursing, of losing sleep, or of pumping. This was a result of a change in the way of life that they were accustomed to, but also to certain challenges. One of these challenges included caring for both an infant and oneself after a cesarean section, especially as a single mother. Healing from a surgery, and for one mother, an accompanying infection, make a struggle with breastfeeding an added burden. Additionally, studies have shown that cesarean sections are associated with negative effects on breastfeeding and mothers who have C-sections are more likely to breastfeed for shorter durations (Rowe-Murray and Fisher 2002; Zanardo et al 2010; Smith 2007). A reduction in non-medically indicated cesarean sections would greatly improve women’s breastfeeding experiences.

The choice to nurse at the breast or use bottles stemmed from a mother’s attitude about her lifestyle. One mother mentioned wanting “independent movement” and bodily freedom for herself. Several mothers noted that milk in a bottle allows others to
participate in feeding the baby, and makes it so the baby can continue to be fed breast milk even when the mother is away or if she does desire to physically nurse. Other mothers found that having to pump and feed with bottles did not give them independence and ease of movement. Women expressed that they felt like they were constantly getting up to get a bottle or clean bottles, or that they were tied to their pump. As a result, many of the women did not find breastfeeding to be enjoyable, natural, idyllic, or empowering. Some felt that nursing at the breast freed them from the pumping and bottles routine.

It appears that there is occasionally a tradeoff between freedom/autonomy of self and self-sacrifice. Breastfeeding can be a sacrifice of a mother’s conception of her body, her time, and her lifestyle. This corresponds with Schmied and Barclay’s (1999) research, which found that breastfeeding sometimes made demands on the “rational, autonomous and independent self of the woman” (330). The transition to motherhood and learning to breastfeed were exhausting for mothers, and persistence and effort on the part of these mothers was evident. It is unmistakable that “each mother must find it ‘workable’ from her own personal perspective” (Nelson 2006:e15). Additionally, not all mothers felt guilt or expressed self-doubt when they were unable to meet their intended duration or exclusivity. A few women felt that they had done all they could, did not enjoy the experience, or were satisfied with how long they had gone. Though very little research discusses it, this study shows that some mothers resist the imperative to breastfeed (Schmied and Barclay 1999).

None of the mothers explicitly stated that they were breastfeeding for themselves, though they listed some immediate physical benefits of nursing including weight loss and reduced fertility. In addition, one mother did express pride in choosing a “better route”
for herself and her child, and in her ability to breastfeed when her own mother could not. No one explained that their reason for breastfeeding was that they had learned that it would also reduce their chances of developing cancer or diabetes, some of the benefits for women who breastfeed (AAP 2012).

Though the experience was different from what they had expected, mothers felt that breastfeeding made them feel good physically and emotionally. While they had to get used to the idea of someone other than their sexual partner on their breast, they came to enjoy it in a different way than sexual breast stimulation. They found it intimate and it made them feel more like mothers. Studies have shown, regardless of duration, mothers who feel they’ve had a successful breastfeeding experience report pride and confidence in their capacity to mother (Nelson 2006). Breastfeeding also made the women satisfied and proud that they were able to feed and nurture their children from their body and watch the baby grow. Mothers who were able to enjoy the physical closeness as a result of successfully nursing at the breast relished in the bond they felt as a result. But while some mothers felt connected, the lack of that physical and emotional bond among mothers who had breastfeeding challenges had consequences for mothers’ emotional and mental health. The emotional significance that breastfeeding has for women has been well documented in the literature (Schmied and Barclay 1999; Nelson 2006).

Nursing in Public

The women who participated in this study expressed acceptance of others breastfeeding their children in public. A few of the women said that they felt differently about breastfeeding and women who nurse in public now that they are mothers themselves. Because mothers believed breastfeeding to be natural and something that
mothers must do to feed their children, they accepted others’ choice to nurse in public. They did admit, however, that because people are going to be around, a woman should be modest and cover up. This came across as the most acceptable form of public breastfeeding – the good and proper mother. Interestingly, a participant who repeatedly referred to breastfeeding as sometimes seeming “animalistic” also adamantly expressed that breastfeeding should not be seen as sexual.

When breastfeeding in public was occurring outside of their own nursing experience, women were positive about it. This was not the case, however, when mothers discussed their personal ability and desire to nurse in public. Even though breastfeeding is natural, and the baby needs to be fed, or milk needs to be expressed, the prospect of breastfeeding in public was daunting for most mothers. As infants need to feed as frequently as every two hours, and public nursing with discretion is a skill that does not always come easy to mothers, women who were unwilling or unable to simply sequester themselves in their home encountered the need to nurse in public. They recognized that they needed to be discreet in order to protect their own comfort and that of others. The women would take responsibility by preparing bottles to bring ahead of time, covering themselves and the baby up, or leaving wherever they were to nurse in a car or other private location. They recognized it both as a personal issue (embarrassment) and societal problem (disapproval) that must be dealt with at the individual level. Increased isolation and effort on the part of the mother to hide herself from societal disapproval of breastfeeding in front of others only further discourages mothers who want to breastfeed.

The general attitude was that society could be more supportive of nursing in public, but fortunately there is increased access to nursing mothers’ rooms. None of the
mothers found the bathroom an acceptable place to nurse or pump milk. Trouble with the breast in public seems to emerge from the expectation that sexual aspects of a woman should remain separate from her maternal aspects. Thus, a “good maternal body” is one that is not sexual, but also one that breastfeeds (Stearns 1999). Discretion while nursing in public avoided transgressing the boundaries between maternal and sexual. Almost none of the mothers actually reported receiving negative feedback from someone while they were in public, simply an impression of stares and comments from their husbands. While some mothers did not even try nursing in public because they were “not the type,” a few mothers were assertive in their right and their ability to nurse in public. Even the mothers who did nurse in public however, would be sure to cover up. Similar to Cindy Stearns’ (1999) findings, “women proceeded with their breastfeeding as though it were deviant behavior, occurring within a potentially hostile environment” (312).

**Social Support**

Reports on the support received at the hospital were both positive and negative. In the opinions of some of the women, support from hospital staff with breastfeeding was very helpful, both with physical assistance and emotional encouragement. Mothers recognized when a nurse went out of her way to provide support. When nurses and doctors were not persistent in helping the mothers achieve their goals, the woman noticed. Mothers reported that some of the nurses seemed quick to suggest supplementing with formula or expressing milk with a pump instead of working harder to get the baby to latch onto the breast. Conflicting advice from healthcare specialists or poor provider attitudes were experienced by some participants. When the medical professionals are the first people that women go to, the best possible support needs to start with the providers.
When referred to the community for additional resources, mothers were pleased. The majority of the mothers did not describe receiving poor support, but those that did listed certain aspects of hospital support, lack of family support, or trouble obtaining a breast pump from WIC. Though Healthy Start and WIC services were generally helpful in terms of breastfeeding information, advice, and support, the support received by enrolled mothers varied. Some reported receiving several services, while others reported receiving very few. Wait lists, lack of equipment, falling through the cracks, or not finding the services convenient led many women to never receive the support from these agencies.

Personal support networks were also noted as extremely helpful for breastfeeding success, and mothers who were supported by their partners or families were at an advantage. As one-third of the mothers were unmarried, and at least one woman’s husband was living abroad, not everyone had financial and practical support from a legal partner. A young woman who was still in high school was fully provided for by her mother who dropped out of school to help raise her grandchild. Two women were raising their babies without much involvement from the baby’s father. Having someone to talk to, provide practical assistance, or give psychosocial support was very important to new mothers. Unsupportive family members could discourage a mother in her breastfeeding endeavor, and were listed by women as an obstacle.

Lack of peer support groups for breastfeeding mothers was an issue for these mothers. Peer support from mothers who have experience breastfeeding has been shown in numerous research studies to improve breastfeeding success (U.S. DHHS 2011). While mothers explained that encouragement and support were essential, unfortunately most
were unable to attend support group meetings due to lack of knowledge, lack of access, or lack of interest. Those who were able to attend a group or see a WIC breastfeeding peer counselor had positive things to say. This indicates that the community could do more to promote mother-to-mother support groups and peer counseling.

The Baby Café

Among the most helpful support received was referral to the Baby Café, receipt of a breast pump from the Baby Café, and having physical and emotional in-home and phone support from the IBCLC. Mothers explained that when they were unable to receive a breast pump from WIC or elsewhere, they were grateful to accept one from the Baby Café. Having the IBCLC come to their home, where they felt more comfortable than at an office or hospital, was highly beneficial. That the IBCLC was able to offer not only hands-on in-person support, but also emotional and psychosocial support either in the home or by phone at any time was a bonus of the program.

The ability to contact the IBCLC any time of day or night, by phone or by text, made mothers very comfortable with asking for help when it was needed. They felt reassured that the IBCLC offered for them to contact her, and several reported that she referred them to and helped them communicate with other community agencies. Receipt of prompt assistance, either by phone or in-person, was a big plus for the participants. This is an indication that the program is meeting the types of support that new mothers need: ease of contact to seek help with difficult personal issues whenever it is needed. Additionally, visits in the home remove the barrier of a new mother who feels she has trouble getting her baby out, cannot wait to get help, or finds the most worthwhile assistance to be in comfort of her own home.
Clients who received in-home lactation consultations reported that they were all-inclusive. The IBCLC listened, offered advice, and answered questions. She helped mothers with latching, positioning, and use of a breast pump. While the specified aim of the program is to solve immediate breastfeeding issues, the IBCLC also sometimes took the time to provide a comprehensive assessment. Mothers appreciated this, and when the IBCLC took her time with them and made sure they knew and understood everything. The Baby Café clientele provided positive feedback on the IBCLC, her accessibility, her demeanor, and her methods. Some mothers reported receiving help several times from the IBCLC either by phone or in their home, but the majority received only one home visit.

Unfortunately, not every study participant received a comprehensive in-home lactation consultation. As all participants were selected for recruitment if their encounter forms listed that they had received a home visit with the IBCLC, it was somewhat of a surprise to find that some of the women reported that they received a breast pump drop-off and/or pick-up only, with or without a short discussion about how to use the pump. These mothers felt satisfied with the services they received, however, as they had sought out the Baby Café with the purpose of obtaining a breast pump. Half of the mothers who received only a pump sought one so that they could return to work or school, so may not have required any additional consultation. The other half of the mothers who reported borrowing a pump but receiving no additional services had infants with particular cases, e.g., special needs or multiples. These mothers may have benefitted from further assistance from an IBCLC.

The women expressed that they had received satisfactory support from the Baby Café. No one felt like they had received poor services; all felt like they received what
they needed. Regrettably, very few knew that Baby Café had more to offer than breast pumps and/or home consultations. None had been informed about the Baby Café’s drop-in site for peer counseling. This is an important social element, where women are able to meet breastfeeding mothers, speak with them, and feel encouraged by them. Moreover, not every mother followed-up with the IBCLC after the initial contact, although they felt they could have benefitted from additional assistance. For mothers who feel hesitant to reach out on their own, it would be beneficial for the program staff to check-in. A consistent time and number of follow-ups for every client could greatly improve the program’s processes in order to meet the needs of the mothers.

This study cannot evaluate program outcomes as the sample size is small and several of the women were still breastfeeding. It is interesting to note that at the time of the interviews, only one mother had met her breastfeeding duration goal. As noted above, sixty percent of the participants did not achieve their breastfeeding intention. Twenty seven percent of mothers who received Baby Café services provided breast milk to their baby for at least six months.

**Pumping**

Women are seen by a healthcare provider regularly during pregnancy to receive support, but this level of support is not always continued in the postpartum period, especially for breastfeeding. Continuity of lactation support for new mothers needs to be established in a manner that does not contribute to an increased medicalization of breastfeeding. The medicalization of breastfeeding, in which breast milk is seen as a product, and the mother and baby are viewed and treated separately instead of as a dyad,
ignores the social and psychological aspects of breastfeeding. This has resulted in an increased reliance on technology and a culture of fear of doubt among mothers. Additionally, it has led to the advent of the breast pump as a solution for “insufficient milk” syndrome, as lactation consultants recommend the use of a breast pump in order to increase a mother’s milk supply. The breast pump gave rise to a larger focus on the product more than on the process. Inadvertently, doctors, nurses and lactation consultants who prescribe the breast pump perpetuate the notion that a mother’s body may be inadequate (Torres 2009).

The breast pump contributes to the perception that breast milk is viewed as a product, especially since it is used to measure milk output. Van Esterik (1996) writes, “breast pumps contribute to the medicalization of breastfeeding and emphasize breast milk as a product rather than breastfeeding as a process” (273). The main goal becomes ensuring the baby receives the nutrition and protective health benefits it affords. Emphasis is placed on getting the product to the baby, and not on any other aspects of breastfeeding. Furthermore, as this ethnography points to, seeing the quantity of milk they produced affected the way many women viewed their supply and breastfeeding overall. The medical model separates the mother and baby, and the pump contributes to the perpetuation of this concept.

Research on lactation consultants’ opinions on breast pumps found that some LC’s are quick to suggest a pump instead of working on getting the baby to nurse (Buckley 2009). Also, many mothers have come to view a breast pump as a necessity rather than a luxury, assuming that they will bottle-feed at some point. The breast pump goes along with increasing technological intervention into what was once a normal, non-
medical part of life. It perpetuates the mistrust that many women have in their breastfeeding bodies; if the body is a “faulty machine,” replace it with a working one (Buckley 2009). Like increased technologization of childbirth, increased technology is likely to foster the need for even more technology. It also creates the idea that providing breast milk is similar to providing infant formula.

The breast pump is considered useful in many instances, including for provision of breast milk for premature infants who are unable to feed at the breast but greatly benefit from mother’s milk. As noted above, pumps also allow women to continue producing milk even when they are away from the baby or unable to nurse for a period of time. Moreover, pumps are not only used to feed the baby expressed milk, but frequently to increase or maintain supply so that mothers may continue breastfeeding. Research has found that expressing breast milk (manually or with a pump) is associated with increased likelihood of breastfeeding to six months (Win et al 2006). The U.S. Department of Agriculture reports that usage of a breast pump supports women in continuing breastfeeding, especially when they return to work or school (National WIC Association n.d.).

But the pump may not always be a beneficial, helpful solution. In fact, while the breast pump may improve breastfeeding for some, it can also harm breastfeeding success. Studies have found that the breast pump is useful in some cases, but a 2002 study found that the use of a breast pump in the first three weeks postpartum puts women at a higher risk for cessation of breastfeeding (Schwartz et al). Additionally, the pump cannot adequately replicate natural infant suckling, as the pump does not stimulate letdown in quite the same way. Research reveals differences in hormone levels in mothers who
pump compared to mothers whose baby nursed at the breast (Hill et al 2009; Zinaman et al 1992). Furthermore, Breast pumps are not a necessity; in fact, manual expression has been shown to produce more colostrum in the first 48 hours than the breast pump (Ohyama et al 2002). Research also shows that hand expression improves breastfeeding rates compared to breast pumping, especially for infants labeled poor feeders (Flaherman et al 2012).

As the mothers in this study would attest to, breast pumps have recently become viewed as a necessity. Some of the participants noted that the pump provided them greater independence and flexibility. So is the breast pump a feminist technology that creates “temporal and spatial freedom” for mothers, or a technologized solution to the issue of dealing with the natural function of women’s breasts? (Boyer and Boswell-Penc 2010:119). With the recent Patient Protection and Affordable Care Act, breastfeeding support, supplies and counseling are covered by insurance with no cost sharing. It may be a medical necessity for mothers who have premature infants, essential for working mothers, and it can also help women increase confidence and perception of control over milk production. But increased access to a pump and protected pumping breaks at work might reduce the need to provide adequate maternity leave; leave that would allow mothers to actually nurse their children. Due to the nature of society today, the breast pump may “remove the incentive for employers to come up with more—and perhaps better—alternatives for women trying to combine work and nursing (Boyer and Boswell-Penc 2010:130).
Recommendations to the Baby Café

As a result of examination of the Baby Café’s program processes and exploring women’s experiences with the program’s services, I offer several recommendations. Recommendations are based on this qualitative process evaluation, which examined the programs implementation and operations as well as clientele satisfaction. This assessment did not attempt to determine the impact of the program on client outcomes.

As 100 percent of the participants were grateful for the help that they received, the Baby Café should continue to provide its immediately available phone and home consultations and breast pump delivery. These services provide a solution to the physical and emotional challenges in early postpartum, and remove the barrier of the exhausted mother who feels she has trouble getting her baby out or cannot wait to get help. Furthermore, services are free, which removes the financial barrier for women who would not otherwise obtain lactation assistance due to cost. Women who are disadvantaged economically cannot access the costly services of an on-call lactation consultant; this option is generally available to higher income groups with greater support networks. The women were near unanimous in their complete satisfaction with the services received from the program, and absolutely pleased with the caring and diligent support from the program’s IBCLC. The IBCLC should continue to make herself available for women to call anytime, as this was highly appreciated.

Based on feedback received from the mothers themselves, it is clear that the program has some areas that could be improved. First, the program should integrate better follow-up with clients. Some of the women who had later breastfeeding challenges or stopped breastfeeding altogether would have benefitted from additional support from
the program, but did not receive it. This could be due, in part, to not all women being comfortable with the idea of reaching out again on their own. Checking up on the client via phone and potentially performing an additional home visit could prolong a mother’s breastfeeding experience.

Secondly, delivery of rental or donation breast pumps, and retrieval of the loaner pumps, could be improved upon. At the moment, some pumps are dropped off without providing a full lactation consultation. As about half of the mothers who received pumps were having some trouble with latching and maintenance of milk supply, they would have benefitted from receipt of a consultation in conjunction with receipt of the pump. Perhaps the Baby Café program can work out a way to provide a comprehensive home visit with each breast pump delivery. Moreover, the process of pick-up could be streamlined as well, to prevent mothers from having a Baby Café rental pump in their possession even after they receive a pump from WIC or discontinue breastfeeding. When picking up a pump, the IBCLC could speak with the mother about why she no longer needs the pump (in case the mother is deciding whether or not to quit, and might benefit from speaking with someone). In cases where the mother calls to request that the pump be retrieved from her home, the lactation counselor staff could discuss this with her. This way, the IBCLC may not even need to be the one who retrieves the pump, if it is determined that the mother does not require any further lactation assistance. A more streamlined system of pump retrieval would improve the experience for mothers, as well as make sure all the breast pumps are retrieved in a timely manner.

Thirdly, the Baby Café should improve its communication of the program’s activities. Comments from study participants indicated that several were unaware that
Baby Café offered more than one of its services. For instance, mothers who only received a breast pump were unaware a home lactation consultation was a service, and none of the mothers knew that Baby Café had a drop-in location for peer counseling. Based on the literature, this population of women would greatly benefit from participation in a mother-to-mother peer support group. By not referring mothers to the peer support group that Baby Café provides, the program is not meeting all of these women’s needs. It might be appropriate for the Baby Café staff and their community partners who refer to them to inform mothers of additional services, such as phone consultations and the drop-in peer support meetings.

In addition, it is recommended that the Baby Café refine its record keeping. The written reported service or referral source sometimes differed from what the clients verbally reported. It is unclear why these discrepancies exist; they could be errors in either the record-keeping or inaccurate memory on the part of the client. Moreover, while reviewing the encounter forms, it was clear that some forms were incomplete, with some lacking data such as mother’s age, baby’s age, date of service, and so forth. A more efficient database and service tracking method would allow consultants to accurately record the services provided and other details. The program would greatly benefit from improving their client report database and other records, as this data will be useful for future progress reports, evaluations, or grant applications.

Overall, the Baby Café program provides effective continuity of care between the health care and community support systems. The program responds to the Surgeon General’s Call to Action to Support Breastfeeding note that an important part of lactation assistance includes “having access to trained individuals who have established
relationships with members of the health care community” and “are flexible enough to meet mothers’ needs outside of traditional work hours and locations” (U.S. DHHS 2011:25). The Baby Café home visitation successfully provides this type of care coordination in Hillsborough County, FL.

Limitations

Due to the nature of ethnographic research, the findings of this research project are not representative of all low-income mothers, and results may not be generalizable to other populations or communities. Time and monetary constraints limited the number of consultations observed and women interviewed. It would have been beneficial to be able to increase the sample size and complete follow-up interviews during or after data analysis. Furthermore, time was unavailable to complete a client survey, so this research does not evaluate the outcomes of the program.

To add, there exists the possibility of recall or response bias when interviewing mothers about their breastfeeding actions, which can be a very personal and political topic. This could have been further exacerbated if women gave more positive answers about their own behaviors or the Baby Café program because the researcher was connected to the program. Though the researcher’s position was explained to participants, there is always the possibility of misunderstanding and/or a desire to say what they believe the interviewer wanted to hear. Furthermore, during a program evaluation there is always the possibility of the aversion to being assessed. As the program staff was aware of the nature of the research and the IBCLC chose which home visits would be observed,
there could have been an observational bias. This may have resulted in my seeing the “best” cases or altered behavior on the part of the consultant or the client.

**Contributions to Anthropology and Public Health**

Previous research has found that low income women list among their reasons to bottle feed instead of breastfeed pain associated with breastfeeding, lack of a supportive social network, a concern for modesty when nursing in public, the perception that breastfeeding is restrictive and inconvenient, and the need to return to work or school (Raisler 2000). This study confirms that these are important issues, and delves deeper into an exploration of the context of these women’s lives. The study contributes to a better understanding of women’s lived experiences breastfeeding their children and their reflections on the different kinds of support they received. Not only does it present the unique challenges that these women experience, but it also explores the context in which these challenges occur, both from their perspective and from an anthropological perspective.

Moreover, this thesis contributes to anthropological research on certain issues related to breastfeeding that are lacking in the literature. For instance, very little research has been done on nursing in public or on how breast pumps are changing the way women breastfeed. In addition, this thesis discusses the narratives of low-income breastfeeding women in a feminist context, an area of interest that is growing in the advocacy literature. It adds to a discussion of breastfeeding as a human right and improved breastfeeding experiences as a path to social justice. Moreover, this study contributes to the understanding of embodiment of the breastfeeding experience.
This research illuminates the way low-income women navigate their motherhood in light of the distinctive aspects of their experience, from a lack of resources to a lack of power. Furthermore, it presents their perspective on the type of lactation support that they are able to access. The study contributes to the growing understanding of how to improve breastfeeding for a priority population. It results in public health recommendations for community groups that work with low-income and at-risk mothers, which can be used to improve lactation support programs for all disadvantaged women. Public health practitioners can use these research findings as starting points or for improvements for their own community lactation support programs. This research will contribute to increased quality of life for low-income, at-risk mothers.

Additionally, this research contributes to anthropological advocacy work, applied anthropology, and the growing field of anthropology in program evaluation. Little research has been conducted on ethnography’s role in process evaluations of intervention programs (Hong et al 2005). As ethnographic research of a community-based health promotion program, it provides greater depth of examination of program processes than simply questionnaires and quantitative data. Public health research would benefit from more research that examines not just outcome data, but also the lived experiences of the communities that are the target of health interventions.

**Future Research**

Future research is needed to expand this program evaluation and exploration of women’s breastfeeding experiences. Locally, quantitative data collection and analysis would enhance evaluation of the program. A quantitative research study could enhance
this evaluation, allowing for a larger sample size, and greater generalizability. Future research should focus on an outcome evaluation to discover whether the program has an effect on breastfeeding duration and/or exclusivity among this population. I have already assisted the Baby Café in developing a survey so that program staff may collect data on their past clientele and compare breastfeeding duration among their clientele with state and national data. Once collected, survey data will be used to evaluate whether the program is meeting its intended outcome: to increase breastfeeding duration for low-income and at-risk women and babies. Additionally, his survey could aid in program improvement. Outcome data from a larger sample could be used to explore whether or not there is an association between duration of breastfeeding and which services (breast pump, phone consultation, home visit) a woman received.

While not a specific focus of this study, several participants alluded to nursing at night and possibly bed sharing. Biological anthropologists have focused on co-sleeping and breastfeeding and found that when done safely, they can actually be protective (McKenna and Gettler 2011). It would be useful to further study this topic from a socio-cultural perspective, especially in light of the dominant public health campaigns in the U.S. against co-sleeping (Gettler and McKenna 2010). Despite these messages, research has shown that many parents choose to sleep with their infants, and a blanket statement against co-sleeping ignores the context and realities of their lives (Tomori 2011). Future anthropological research on this topic may even encourage a move toward public health campaigns that promote safe co-sleeping environments rather than discouraging the practice altogether.
Very little anthropological and public health research has been conducted on the topic of extended nursing. Katherine Dettwyler, who has explored the biological aspects and cultural context of extended nursing for decades, recently conducted survey research of U.S. mothers who nursed for a minimum of three years (2004). Her research found that extended breastfeeding is most common among European-American middle and upper class women who are highly educated. As this topic has received limited attention in the U.S., further research should be done on perspectives of extended breastfeeding. It would be interesting to explore the low-income women who breastfeed past two years: the outliers. This topic would benefit from a feminist analysis. Moreover, there is a dearth of ethnographic literature on nursing in public, which has a large impact on the breastfeeding experience. Much of the current research provides quantitative data but very little rich context to the experience from both the perspectives of nursing mothers and of others.

Furthermore, anthropological literature is deficient on the topic of breast pumps, an important theme that emerged from this analysis. There has been some feminist discussion of the manner in which the breast pump may actually undermine efforts to protect, promote, and support breastfeeding (Boyer and Boswell-Penc 2010). Additional qualitative research on the use of breast pumps, breastfeeding outcomes by pumping mothers, health care providers’ perceptions of breast pumps, and so forth is needed. To add, a more in-depth look at the issue of maternity and paternity leave from disciplines other than feminist and women’s studies would be a boon to the breastfeeding literature.
Directions for Advocacy

While most public health initiatives that focus on improving breastfeeding rates focus on individual and interpersonal level solutions, such as increased education, I believe that improvement in breastfeeding experiences for mothers will only occur through a focus on upstream determinants. Persuading women to breastfeed for health reasons in order to be a “good mother” ignores the realities of their lives and creates a “moral minefield” (Smith, Hausman and Labbok 2012). Low-income women in particular may experience educational efforts as exhortations to breastfeed, “since the information can be presented without any practical method of following through to achievement” (Hausman 2003:87). As I have explored in this thesis, the lives and experiences of mothers who choose to breastfeed are constrained by cultural and political economic forces.

Changes can start in the hospital, where the majority of births in the U.S. take place. No matter how much education a woman and her family receive, poor treatment or breastfeeding advice in the hospital can sabotage breastfeeding. Changes must transpire in childbirth practices and routine interventions that are known to affect breastfeeding, such as increased use of IV fluids and epidural anesthesia. Every birth location should implement the Ten Steps of the Mother Friendly Childbirth Initiative (Coalition for Improving Maternity Services 2013). These ten steps are intended to encourage the practice of a “woman-centered, non-interventionist approach” that emphasizes informed decision-making and evidence-based care (Davies n.d.). Additionally, every hospital should work towards Baby Friendly designation. In addition to improving breastfeed rates, research has found that racial and income disparities in breastfeeding virtually
disappear in hospitals that have implemented the Baby Friendly Hospital Initiative’s Ten Steps (Merewood et al. 2007; California WIC Association and the UC Davis Human Lactation Center 2008).

At the community level, continuity of skilled lactation support between the birth location and the home/community settings is essential. As this research demonstrates, this type of support is what meets mothers’ needs in the early postpartum. Programs that provide lactation support and supply breast pumps for low-income mothers, as well as increased training of patient- and family-centered healthcare providers and lactation counselors, are necessary. The Surgeon General has listed adequate education and training of clinicians as one of the proposed actions to support breastfeeding, stating, “Clinicians are consistently identified by patients as preferred sources of information and guidance on breastfeeding. Therefore, clinicians need to demonstrate competency in supporting lactation and breastfeeding” (U.S. DHHS 2011:46).

Lack of paid maternity leave restricts women’s breastfeeding actions and is a policy “designed for the typical (masculine) worker” (Lucas and McCarter-Spaulding 2012:148). Privileged women who are not socioeconomically disadvantaged are better situated to be able to take extended unpaid maternity leave, and therefore are able to “choose” to breastfeed. Legislation that increases access to paid maternity leave would help eliminate disparities in breastfeeding, as breastfeeding disparities are associated with the work environment (Lubold and Roth 2012). Moreover, policies that create supportive environments for breastfeeding outside of the home, either in public or at work, need intensification. Worksites should not only allow for pumping breaks, but also permit a mother to have access to her breastfeeding infant. Steps must be made towards changing
attitudes toward nursing in public, and also enforcement of laws that protect a mother’s right to breastfeed in public spaces.

At a societal level, it is essential that women’s unpaid domestic and/or reproductive work and family work be recognized as labor, as it is important to economic success. The redefinition of work would help influence current gender hierarchies. Breastfeeding practices are adversely affected by women’s lower status compared to men. “The low status of women is reinforced by the pervasiveness of gender-based personal and structural violence, the sexualization of women’s bodies and their breasts as objects of male desire, and by continued gender inequities in labor, power, and social relationships” assert Smith, Hausman and Labbok (2012:283). Increased gender equity, and recognition of breastfeeding as a human right, must occur in order for women to realize their full potential and truly make free choices regarding infant feeding, employment, and their lives. As Alison Stuebe writes, “a choice that is not also a right is not really a choice – it is a privilege” (2010).

Women who wish to breastfeed but cannot, due to the structural issues that constrain their lives, are denied the human right to breastfeed. It is the responsibility of nations to protect the right to breastfeed so that all mothers and babies may benefit. Protection of this right necessitates full implementation and enforcement of the International Code of Marketing of Breastmilk Substitutes (World Health Organization 1981). Reframing breastfeeding as a right will aid in moving toward provision of an environment that is truly supportive of a woman’s ability to breastfeed.
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APPENDIX A

Semi-Structured Interview Guide
These interviews are semi-structured ethnographic interviews in which clusters of topics are addressed as follows. All responses are open-ended and conversations may emerge from a participant’s response and interviewer’s follow-up questions.

1. Do you have more than one child?
2. For each child:
   • Tell me a little bit about your pregnancy and birth with your (first, second) child.
   • Tell me about your breastfeeding experience with your (first, second) child. What has breastfeeding been like?
   • What was your knowledge of breastfeeding prior to the birth? How did you feel about breastfeeding? How long did you intend to breastfeed? How did you make this decision?
   • Did you experience any challenges? Can you tell me about them? What would have made you unwilling or unable to continue to breastfeed?
   • What types of support did you have? What do you think helped or would have helped the most?
   • How long did you breastfeed your (first, second) child?
3. (if applicable) How did your breastfeeding experience differ between your first and second child?
4. Tell me about your experience with Baby Café.
   • How did you find out about it? What was your main reason for seeking support from the program?
   • What services did you receive, and what were they like? Please describe them for me.
   • How satisfied are you with the services you received from Baby Café?
   • Do you have any recommendations to improve the program?
5. Demographics: How old are you? Are you married? What is your current work? Do you receive Healthy Start, or Medicaid, or WIC?
APPENDIX B

IRB Approval Letter

May 25, 2012

Emily Dunn
Community and Family Health
13201 Bruce B. Downs Blvd.
MDC 56

RE: Expedited Approval for Initial Review
IRB#: Pro00008217
Title: Women's Experiences with Breastfeeding and Support Services: A Program Evaluation of Baby Café

Dear Emily Dunn:

On 5/25/2012 the Institutional Review Board (IRB) reviewed and APPROVED the above referenced protocol. Please note that your approval for this study will expire on 5/23/2013.

Approved Items:
Protocol Document(s):

Internship Proposal IRB Protocol Baby Café 5/7/2012 6:04 PM 0.02

Consent/Assent Documents:

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Please note, the informed consent/assent documents are valid during the period indicated by the official, IRB-Approval stamp located on the form - which can be found under the Attachment Tab. Valid consent must be documented on a copy of the most recently IRB-approved consent form.
It was the determination of the IRB that your study qualified for expedited review which includes activities that (1) present no more than minimal risk to human subjects, and (2) involve only procedures listed in one or more of the categories outlined below. The IRB may review research through the expedited review procedure authorized by 45CFR46.110 and 21 CFR 56.110. The research proposed in this study is categorized under the following expedited review category:

(6) Collection of data from voice, video, digital, or image recordings made for research purposes.

(7) Research on individual or group characteristics or behavior (including, but not limited to, research on perception, cognition, motivation, identity, language, communication, cultural beliefs or practices, and social behavior) or research employing survey, interview, oral history, focus group, program evaluation, human factors evaluation, or quality assurance methodologies.

As the principal investigator of this study, it is your responsibility to conduct this study in accordance with IRB policies and procedures and as approved by the IRB. Any changes to the approved research must be submitted to the IRB for review and approval by an amendment.

We appreciate your dedication to the ethical conduct of human subject research at the University of South Florida and your continued commitment to human research protections. If you have any questions regarding this matter, please call 813-974-5638.

Sincerely,

[Signature]

John Schinka, PhD, Chairperson
USF Institutional Review Board

Cc: Various Menzel, CCRP
USF IRB Professional Staff