

## Review

# Barriers to breastfeeding in male dominated society

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The U.S Department of Health and Human Services, the American Academy of Pediatrics, the World Health Organization and many others recommend breastfeeding for at least a year. Despite this recommendation, the Center for Disease Control (2011a) estimates that only 23.8% of infants are still breastfed until age 1 in the United States. The benefits of breastfeeding are well documented, yet, a December 7, 2011 headline reads, "Breast Milk or Formula: Why All the Drama?" Breastfeeding is a controversial issue, especially public breastfeeding. There have been several news stories over the last ten years about women asked to leave public places when breastfeeding. This review will address the attitudes and beliefs that create barriers to breastfeeding.

**Key words:** Breastfeeding, infant and maternal health, feminism.

## INTRODUCTION

A December 7, 2011 headline reads, "Breast Milk or Formula: Why All the Drama?" Breastfeeding has become a controversial issue as supporters feel very strongly that breast is best and may even judge mothers who choose not to breastfeed as the aforementioned news article suggests that "30% of breastfeeding moms think formula feeding moms are selfish and lazy" whereas, 83% of breastfeeding moms felt they were being criticized by formula feeding mom (Revelant, 2011). This controversy is interesting considering that 74% of babies born in 2008 were breastfed, however, the percentage of babies still breastfed at a year was only 23 (CDC, 2011b).

Data from the National Immunization Survey (2011) of babies born in 2007, found socio-demographic factors to be associated with increased initiation and continuation of breastfeeding. Race was a factor associated with different rates of breastfeeding with 86.4% of Asian babies born in 2007 ever breastfed, 80.6% of Hispanic babies, 77.7% of Caucasian babies, and 58.7% of African American babies were breastfed at some point. At a time, Asians had the highest breastfeeding rates, with only 34.8% of these babies breastfed and African Americans still had the lowest breastfeeding rate with only 12.5% of 12-month old babies still breastfed. 67.5% of babies born to women of babies born to women who do not qualify receiving WIC, supplemental food for low income women, infants, and children, initiated breastfeeding, while only 17.5% were still breastfeeding at a year, whereas, 84.6%

for WIC initiated and 27.6% were still breastfeeding at a year (CDC, 2011b). Maternal age was also associated with rates of breastfeeding with 59.7% of babies born to women under 20 ever being breastfed, 69.7% of babies born to women 20-29 years and 79.3% of babies born to women over 30 ever being breastfed. For those babies born to women who were not high school graduates, initiation of breastfeeding rate were 67%, while the breastfeeding rate for college graduates was 88.3%. Wolf (2006) cautions that initiation rates should not be celebrated since initiation can simply mean an infant was breastfed one single time before leaving the hospital.

There is a race gap in infant mortality rates; in 2001 for white babies the infant mortality rate was 5.7 out of 1,000 and for black babies it was 14 out of 1,000 (Wolf, 2006). "Epidemiologists have long theorized that the significantly higher death among black infants is due to black women's lack of access to prenatal care. Consequently, black women give birth to more low-birth-rate infants than white women. Some researchers now contend, however, that the fact that white women initiate breastfeeding at more than twice the rate of black women might account for the race gap in infant mortality at least as much as low birth weight" (Forste et al., 2001, cited in Wolf, 2006)". Slusser and Lange (2002) argue that living with the baby's father and having his support is the most important indicator for African American women to breastfeed (p. 185) and they also note that other research has found the balance between benefits to the

infant and inconvenience to themselves to be a factor for African American women (p. 184).

The US Department of Health and Human Services, the American Academy of Pediatrics, the World Health Organization and many others recommend breastfeeding for at least a year, although we can see from CDC (2011a) statistics that only 22% of infants are still breastfed at a year old in the United States. The benefits of breastfeeding are well documented. Formula companies continue to strive to create a formula that is as close to breast milk as possible, but there are nutrients in breast milk that cannot be replicated by man. Breastfed babies have higher immunity to ear infections and diarrheal illnesses. The Agency for Healthcare Research and Quality reports “that a history of breastfeeding was associated with a reduction in the risk of acute otitis media, non-specific gastroenteritis, severe lower respiratory tract infections, atopic dermatitis, asthma (young children), obesity, type 1 and 2 diabetes, childhood leukemia, sudden infant death syndrome (SIDS), and necrotizing enterocolitis” using sibling analysis to control for household and hereditary factors (Ip et al., 2007). A number of studies indicate that breastfeeding is associated with a reduced risk for metabolic syndrome and for diabetes for both mother and child and that duration matters (Gouveri et al., 2011; Stuebe et al., 2005, 2011; Ram et al., 2008; Villegas et al., 2008). The AHRQ report (2007) also concludes that breastfeeding reduces a woman’s risk of type 2 diabetes, as well as breast and ovarian cancer and possibly reduces the risk for postpartum depression.

While there is a push to encourage breastfeeding, mothers may face a challenge when it comes to feeding their babies in public. Blum (1993) acknowledges this stating that “breastfeeding may represent an especially late capitalist public/private contradiction” (p. 292). In 2006, a mother was kicked off a Delta flight for refusing to cover her breastfeeding child with a blanket. In 2007 complaints were issued when a mother at an Applebee’s in Kentucky was asked to cover her child while breastfeeding and a mother at a Hillstone Restaurant Group in Florida was asked to leave the restaurant because she was breastfeeding (Applebee’s Draws Protest, 2007). Another mother at a café in New York was kicked out of the café when she breastfed her baby (Rutkoff, 2010). Yet another Florida mother was approached in 2010 for breastfeeding in the main office at her older children’s school (Arja, 2010). In 2011, a woman in Michigan was in the back of a court room discretely nursing when the judge called her out and accused her of being inappropriate (Hilliard, 2011). In a search for news articles on women being kicked out of places for breastfeeding, it was a surprise at just how many stories there were and how many lawsuits there are because women have been discriminated against for breastfeeding in public even though 45 states “have laws that specifically allow women to breastfeed in any public

or private location” (Breastfeeding Laws, 2011; WorldNetDaily (2008).

“Breastfeeding is an intensely intimate experience with emotional consequences, thus, the decision to initiate breastfeeding may be based on expectations of certain physical and/or emotional sensations” (Gengler et al., 1999: 174). The purpose of this paper is to explore and understand the attitudes towards breastfeeding that present barriers to breastfeeding. The author believe that attitudes in our society towards breastfeeding have created barriers to breastfeeding and that these attitudes are reflected in the resistance women face when breastfeeding in public. According to the United States Department of Health and Human Services (2011), “more research is needed on the barriers to breastfeeding among populations with low rates of breastfeeding” (p. 34). This review will address the attitudes and beliefs that create barriers to breastfeeding.

## **FEMINISM AND BREASTFEEDING**

Feminism offers understanding of why breastfeeding may not be widely accepted in the United States. Men want to control women as “women are projected as embodiments of nature’s unrelenting powers” and nature is posited as “a resistance to be broken. “External and human nature alike must be conquered by science, industry, the state – and other social forces” and as nature, women must be dominated by men (Davis, 2000: 148-149). The view of breastfeeding as natural strikes African American women particularly because nature was used for so long as a justification for oppression (Blum, 1999: 14), which may help explain why African American women are the least likely to initiate breastfeeding. In this male dominated society, men maintain control by “controlling women’s access to resources and their sexuality, in turn, allows men to control women’s labor power, both for the purpose of serving men in many personal and sexual ways and for the purpose of rearing children. The services women render men, and which exonerate men from having to perform many unpleasant tasks occur outside as well as inside the family setting” (Hartman, 1979: 11). According to Blum (1993: 291) “along with pregnancy and birth, breastfeeding represents both the cultural and natural mother; that is, the socially constructed and the biological are inextricably intertwined.”

## **EMBODIMENT**

Breastfeeding can be viewed by feminists “as a form of embodied interdependence that might allow for the positive relational experiences our biology affords” (Blum, 1993: 292). While some feminists argue that women are not born, but are rather made, looking at breastfeeding as

a thing our bodies can do that men's bodies cannot do, an embodied experience, is empowering. This ability of the female body to provide food for a child gives women a sense of pride and appreciation of this way that their bodies are uniquely female (Stearns, 2009: 68). Yet, Stearns (2009) calls breastfeeding "body work" saying "although breastfeeding is often described as natural in popular discourse, both the mother and the child work at breastfeeding" (p. 67).

Medicalization of motherhood disembodies mothers. Medicalization seems to be an attempt to use science to control nature and the ideology of women as embodiments of nature. Palmer (2009) states that it is no coincidence, that when the predominantly male medical profession took over management of maternal and infant health, the decline of breastfeeding was accelerated (p. 4). Hospitals lay down rules rather than encourage the mother herself to interpret the baby's needs, as well as her own, within the framework of their relationships and particular social circumstance (Maher, 1992: 1). Maher (1992) says that even the notion of demand feeding is interpreted differently at different hospitals. Mother's often feel like they have to follow the rules laid down by the hospital to be good mothers. According to Slusser and Lange (2002), free formula in the hospital is a barrier to breastfeeding (p. 187). In an attempt to increase breastfeeding in Rhode Island, hospitals in the state will no longer send mothers home with free formula bags (Associated Press, 2011). The governor's wife explains that "As the first 'bag-free' state in the nation, Rhode Island will have healthier children, healthier mothers, and a healthier population as a whole" (Associated Press, 2011), but as stated by Maher (1992), "by participating in the medicalization of their bodies and in the view of breast-feeding as desirable almost exclusively for nutritional reasons women lose touch with their own desire (or reluctance) to breast-feed their babies" (p. 32).

Medicalization further presents a barrier to breastfeeding if we look at hospital practices. The US Department of Health and Human Services (2011: 15) reports that in 2,687 hospitals in the U.S., it has been found that there is little or no support for breastfeeding in the hospital and education about it (Martens, 2000). Slusser and Lange (2002) report that lack of education to health providers serves as a potential barrier to breastfeeding (p. 186). The US Department of Health and Human Services - Surgeon General's (2011) report also states that it found that only 57% U.S. hospitals and birth centers allow newborns to room in with mothers (US Department of Health and Human Services, 2011: 15), a problem also identified by Slusser and Lange (2002). This makes it difficult for the mother and baby to learn to nurse and also take away an important time for mothers to learn to read their babies' cues. Furthermore, while "most physicians pay lip service to breastfeeding, studies show they are just as likely to simultaneously assure mothers" that "today's formulas are almost as good as

human milk" (Wolf, 2006: 398). There seems to be a barrier because when a woman is pregnant she sees an obstetrician and when the baby is born, the baby sees a pediatrician. This separation of maternal and infant health care is problematic.

Maher (1992) writes, "the stress of Western parents on conjugal intimacy and privacy, their fears for safety of the baby and for their own daytime efficiency, means that babies cannot sleep in their mothers bed and suckle at night" which is often the time for mothers to be able to make up for working at home during the day (p. 17). Here again medicalization of motherhood comes into play and stands in the way of breastfeeding. Hospitals make sure women know that their baby "must" sleep alone, in a crib on his or her back. Since the back to sleep campaign began, infant deaths have declined; however, according to McKenna (1996), "a survey of cross-cultural data and laboratory findings suggest that where infant-parent co-sleeping and breastfeeding are practiced in tandem in nonsmoking households" the chances of an infant dying is lower than if the infant sleeps alone on his or her back. Co-sleeping reduces the exhaustion faced by a breastfeeding mother. Breastfed babies feed more frequently than formula fed babies because breast milk digests more easily. A barrier to breastfeeding could be the perception of exhaustion from getting up several times a night to nurse, but this can be reduced by co-sleeping. Mother does not have to get out of bed to feed her child and the comfort of having mom nearby helps the child sleep better as well. The mother may still find herself unable to sleep with her infant if her husband feels this hinders his male sexual privilege.

## **MALE SEXUAL PRIVILEGE AND SEXUALIZATION OF THE BREAST**

The focus in Western culture is on the male female conjugal relationship rather than the mother child dyad (Maher, 1992). In the late eighteenth century women's bodies were legally men's property in the United States (Weitz, 2003). Throughout the 1800s women were depicted as objects of male desire. Women are viewed as sex objects and breasts are highly sexualized. The belief that women's bodies are products for male consumption and beliefs in male sexual privilege led to the use of wet nurses by middle and upper class women prior to the creation of formula, especially when it was believed that sexual intercourse spoiled the milk (Maher, 1992). In the 1940s, 1950s, and 1960s, breastfeeding rates fell as nursing was deemed dangerous in this era because "breastfeeding threatened to expose the breasts to the heterosexual gaze" and because women were afraid breastfeeding would affect the shapeliness of their breasts (Blum, 1999: 38).

Blum (1999) seeks to understand the stake men have in breastfeeding and mothers' bodies and in doing so

finds that “as partners or husbands, they have claims to women’s bodies, to their physicality and sexuality” due to the historical marriage contract which grants men a right to sexual access and ownership (p. 16). “The current construction of the good maternal body requires women to carefully manage the performance of breastfeeding in specific ways and with particular attention to the dominant notion of sexualized rather than nurturing breasts” (Stearns, 1999: 308). This contradiction may make it difficult for women to enjoy the embodied experience of breastfeeding, since their breasts are seen as sexual organs. Palmer (2009) questions if those people who are opposed to public breastfeeding, who are so shocked and/or disgusted by seeing a baby breastfeed, would be as taken aback by women who expose their breasts as sexual stimulation (p. 2). Blum (1999) draws attention to the fact that breasts are exposed everywhere in the media, while breastfeeding mothers are harassed (p. 18). Palmer (2009) says that “though any part of a woman’s body can be a focus of eroticism, our era is the first in recorded history where the breast has become a public fetish for male sexual stimulation (Palmer, 2009: 2). Blum (1993) writes that “we are a breast-obsessed culture with breasts as the major visual symbol of female sexual value” resulting in millions of women having breast implants though knowing the common side effects are hardening of scar tissue making cancer detection difficult; this results in low sensation and inability to breastfeed when nerves to the nipple are severed (p. 307).

A barrier to breastfeeding is the awareness of the erotic or sexual value of the breast for men (Stearns, 2009; Maher, 1992). Stearns (1999) says that because of the strong cultural preference for sexualized breasts, breastfeeding mothers are transgressing boundaries (p. 309). Maher (1992) writes of breastfeeding manuals where women were reminded not to let their husbands feel left out and to wear a good nursing bra to remind him that they wanted their breasts to look good for him for years to come (p. 14). Wolf (2006) writes that there is an “American tendency to define women in terms of their bodies” (p. 409) and this tendency seems to define us in terms of how our bodies look rather than what our bodies can do. In Blum’s (1999) field work, she was told by a breastfeeding mother, “I did not feel as good about my body before nursing. I feel my breast have a use now and I have much more confidence in my body. My breasts are not just there for men”, while another told her that “we experience our breasts predominantly as sex objects, objects to be looked at” (p. 71).

## THE WORKPLACE

In the nineteenth century and early twentieth century, women were increasingly entering education and employment, so doctors came up with justifications for keeping women unemployed and uneducated, such as

the president of the Oregon State Medical Society who stated in 1905 that hard study killed women’s sexual desire in women, took away their beauty, and brought on a host of mental illnesses as well as physical illnesses, and furthermore, that educated women would have difficulty bearing children because hard study arrested pelvic development while increasing the size of the child’s brain and thus the child’s head as well (Weitz, 2003: 6). In modern times, one of the ways men control women’s labor power, given 70% of women of childbearing age are in the labor force (US Department of Health and Human Services, 2011: 29) is by not accommodating breastfeeding mothers in the workplace. “Women’s bodies- female sexuality, their ability to procreate and their pregnancy, breast-feeding, and child care, menstruation and mythic ‘emotionality’ are suspect, stigmatized, and used as grounds for control and exclusion” in the workplace (Acker, 1990: 152). According to Acker (1990), abstract definitions of the typical worker are typically male and preferred for employees to have no other obligations outside of the job. This definition of the abstract worker of separate home and work, gives men another way to control women (Acker, 1990). Consequently, women are not given the time or space to nurse their infant or to pump while on the job.

As early as 1984, when the US Department of Health and Human Services, Office of the Surgeon General held a workshop on breastfeeding, the World Health Organization and the American Academy of Pediatrics noted that “the work environment in both policy and structure, is often not supportive of women who choose to breastfeed” (Barber-Madden et al., 1987: 531). Blum (1993) states that “tales of women’s attempt to breastfeed in the workplace, as well as in other public spheres, often read like horror stories of harassment, lawsuits, and job dismissal (p. 296). This makes it difficult for women to both work and breastfeed their children. Women feel they have to choose between work and breastfeeding. Even with medical technology, such as breast pumps which are supposed to help, women in many occupations are not afforded a place or the time to pump. The US Department of Health and Human Services (2011) reports that “women often face inflexibility in their work hours and locations and lack a privacy for breastfeeding or expressing (with a pump) milk, have no place to store expressed breast milk, and are unable to find child care facilities at or near the workplace, face fears over job insecurity and have limited maternity leave benefits” (p. 14).

According to Blum (1993), economists believe women choose low-paying jobs that are dominated by females because they tend to be more accommodating to childrearing and familial priorities, such as breastfeeding (p. 296). According to Crompton (2006), women do not actively pursue upwardly mobile occupations due to family responsibilities (p. 261). While the unaccommodating workplace seems to be a barrier to breastfeeding today, historical patterns of breastfeeding in the United States

show that rates declined dramatically between 1940 and 1970, a time period in which most mothers were at home with their children (Blum, 1993: 296); so while this may be an issue today, other factors have had a large impact on breastfeeding. While historical patterns may necessarily reflect the potential incompatibility between breastfeeding and maternal employment, Lindberg (1996) finds that full time employment is associated with reduced rates of breastfeeding, but that part-time employment has no significant association.

## LACK OF INFORMATION

Lack of information on breastfeeding affects whether a woman decides to breastfeed or not. Heck et al. (2006) state that “knowledge of the benefits of breastfeeding has been shown to predict breastfeeding” and that this is likely why higher educated parents are more likely to breastfeed because they are more likely to search out information on the health aspects of infant feeding (p. 52). Their study also revealed paternal education as a factor in breastfeeding outcomes (Heck et al., 2006). The US Department of Health and Human Services (2011) also recognizes that education about breastfeeding is not readily available or easily understood by many new mothers (p. 11) and that upon discharge from the hospital, little help is offered for women who do not know how to or cannot afford the services of a lactation consultant (p. 25).

The WIC program, a federal program, claims to promote breastfeeding in accordance with the WHO, the U.S. US Department of Health and Human Services, and the Healthy People 2020 Goals. The US Department of Health and Human Services (2011) states that “the USDA’s WIC program has always encouraged breastfeeding” and that there are federal regulations which specify actions that must be taken to ensure the prioritization of breastfeeding mothers and children in the WIC certification experience (p. 19). If one goes to any WIC office, they will find posters saying that breast is best and on the list of foods one can purchase with a WIC debit card; it tells you that breastfeeding is best, but as stated by Linda Blum (1993), “although it [WIC] will provide extra food vouchers to breastfeeding mothers, research indicates it does little to support breastfeeding” (p. 299).

As a participant in the WIC program for five years in three states, the author have never had a nutrition counselor discuss the benefits of breastfeeding and in the new client classes required when beginning the program; no major emphasis was placed on breastfeeding or support if a new mother were to have trouble breastfeeding. Information gathered by the author revealed that WIC would rent hospital grade breast pumps so that mothers could effectively breastfeed while working, but this was not made general knowledge.

Furthermore, the author was never notified of the extra food incentive the WIC program offered until the baby turned six months and the nutritionist revealed the author would get six months more of food for himself since he was nursing and also get three times more jars of baby food per month than a formula feeding mother. It is not an incentive, if participants are not made to be aware.

Stearns quotes Kelleher (2006), saying that “early breastfeeding is often marked by small and large body problems for the mother, including nipple soreness, mastitis, and low milk production” (p. 67), however, according to Spencer (2008), nipple soreness is usually a result of poor latching, which with a little help from a lactation consultant can be corrected and mastitis only occurs in 10% of American women (p. 727). The myth of insufficient milk further creates a barrier to breastfeeding. According to Tully and Dewey (1985), “insufficient milk syndrome is a cultural phenomenon, created by the lack of cultural and social support for breastfeeding” (cited in Wolf, 2006: 404). Beginning in the late nineteenth century, women started to report inability to produce sufficient milk and the need to “feed” their babies leading to concern by the American Medical Association in 1912 that women would no longer be able to nurse babies at all since evolution was leading to nonfunctioning mammary glands (Wolf, 2006: 404). Wolf (2006) states that “even today the complaint of insufficient milk remains a common one” (p. 404). In the seventeenth and eighteenth centuries, prior to industrialization, women did feed babies according to their cues seeming to acknowledge the supply and demand mechanism of the breasts (Wolf, 2006: 405). Gengler et al. (1999) found that one of the top reasons women discontinued breastfeeding was that they believed they were not producing sufficient milk (p. 181). If sufficient education were given, women would know that breast milk production is based on supply and demand. The more time a baby is at the breast, the more milk it will produce, but because of this myth, women often begin to supplement breast milk with formula or food and reduce the body’s ability to produce milk. Even when women do have access to information prior to childbirth, they may face problems in the hospital, as a mother reported to Bobel (2002) that she felt alone at the hospital after giving birth when she insisted no bottles be given to her son and was accused of starving the baby (p. 6).

## CONCLUSIONS

There are several attitudinal barriers to breastfeeding in U.S. society. Breastfeeding campaigns need to focus on specific attitudes such as the embodied experience created by breastfeeding, need to target workplace reforms to make breastfeeding easier for working mothers, and need to make sure women are well informed during pregnancy on the benefits of

breastfeeding and how to deal with common misconceptions. In the future, the author aims to look at how the sexualization of the breast impacts attitudes toward public breastfeeding because if breastfeeding was seen more often, it would likely become less taboo and attitudes would likely become more positive given the multitude of benefits.

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