

5-4-2016

(Un)Covering the Nipple: A Cross-cultural Comparison of Decisions Around Breastfeeding

Victoria St. Dennis
Skidmore College

Follow this and additional works at: https://creativematter.skidmore.edu/inter_aff_stu_schol



Part of the [International and Area Studies Commons](#), and the [Other Social and Behavioral Sciences Commons](#)

Recommended Citation

St. Dennis, Victoria, "(Un)Covering the Nipple: A Cross-cultural Comparison of Decisions Around Breastfeeding" (2016). *International Affairs Senior Theses*. 7.
https://creativematter.skidmore.edu/inter_aff_stu_schol/7

This Thesis is brought to you for free and open access by the International Affairs at Creative Matter. It has been accepted for inclusion in International Affairs Senior Theses by an authorized administrator of Creative Matter. For more information, please contact dseiler@skidmore.edu.

(Un)Covering the Nipple: A Cross-cultural Comparison of Decisions Around Breastfeeding
Victoria St. Dennis
IA 376 Senior Capstone
Thesis
May 4th, 2016

Abstract

Breastfeeding is thought to be the most beneficial resource for providing newborns with nutrition that will positively impact their growth and development, while also providing health benefits for the mother as well (American Academy of Pediatrics [AAP], 2005). However, the number of women that choose to breastfeed world wide is surprisingly lower than what would be expected. This paper will focus upon the reasons why women choose to not breastfeed, and go beyond the traditional assumptions of socio-economic class and ethnicity; instead looking at elements of social and cultural influence from the local and global levels.

Introduction

The decision to breastfeed at first glance seems unassuming, simple even, if you are able to lactate. Yet, there are several influential factors plaguing mothers-to-be, such as ideas coming from the individual, cultural, socioeconomic and governmental perspectives. The opportunity for a woman to decide not to breastfeed can occur easily, as breastfeeding is a time consuming, inconvenient and somewhat painful experience. However, breastfeeding provides infants and mothers with physical and emotional benefits that cannot be replicated by an alternative option. Alternatives to breastfeeding for women who are unable to breastfeed should ideally be combined with levels of support from the personal community, as well as public health and government institutions. Women who have the potential to breastfeed should be encouraged and supported by their communities to make a healthy decision for themselves and the infant that will result in bonding and nutrition. Support in this context should come not only from the individual, societal and global communities that women exist in, but also from their governments.

The decision for a woman to breastfeed goes beyond her socioeconomic exposure, and instead reflects influence from the personal, cultural, and political atmospheres in which she operates, as well as requires her own agency. Brazil, China and the United States address the decision surrounding breastfeeding from drastically different perspectives. The decision to not breastfeed includes multiple spheres of influence, which for this paper will be divided into the personal or individual, the cultural, which reflects the practices of the lived environment of the individuals both during youth and adulthood, the socioeconomic, including the media, other women's views on breastfeeding, workplace accessibility, maternity leave and the governmental, including government campaigns, laws, opinions of political leaders.

The decision to breastfeed revolves not only around the choice of the individual, but also the factors aiding to create that choice, which allies breastfeeding alongside of other women's health issues. The female body has been designed to create, produce and provide for its offspring in the most efficient and nutritional way. It embodies the physical and natural world, yet the female body can also symbolize sexuality, weakness and commodity. The dichotomy that exists between these embodiments comes largely from outside of the identities created by female bodies themselves. While in some cases the female body as "natural" can symbolize what is pure in nature, breastfeeding edges against that theory. As humans who are designed to produce and "leak" milk, women who are breastfeeding are perceived by society to lack control over their bodies (Blum, 1999). Demonstrating the inability for the female body to exist within multiple socially created constructs at the same time.

The current discourse surrounding breastfeeding focusses on the scientific, the decision and the rates in which breastfeeding occurs, this paper will attempt to contribute to the current

knowledge. The inclusion of influence outside of the social and familial, will aim to restructure the discourse by providing women who are able to, and decide to breastfeed with more agency. As the ultimate decision lies with the mother, her decision can be seen as a reflection of the multiple climates in which she exists. Through addressing these spheres by interrogating them and examining them in different locations with different narratives, the women presented with this decision will seem to be striving for more control over their choices. This paper aims to provide a culturally relative perspective as to why women decide against breastfeeding by incorporating perspectives from three different countries in tandem. An additional contribution to the current portfolio of research conducted on this topic, will be the introduction of “anthropology of the body” discourse, a supplementary approach to understanding the elements amounting to a decision surrounding breastfeeding.

Literature Review

The Anthropological Body

The anthropological study of the human body can be broken down into four specific parts; the individual body, the body politic, the social body and the mindful body. These characterizations of the body reflect both the internal and external forces pressed upon the human body and mind. The individual body is comprised of the personal and lived experiences of a person, while the body politic refers to the regulation, surveillance and control of bodies during processes such as reproduction. Noting back to embodiment, the social body is the representational use of the body as a natural symbol. Lastly, the mindful body refers to the immediate and most proximate terrain in which social truths and contradictions are played out (Nelson, 2016). It is within these spheres that the relationship between the woman and her

decision to breastfeed are examined by her, as well as her environment. In relation to breastfeeding, and the role of embodiment, the overlap between the four bodies represents the outcomes of the lived realities of women attempting to decide if breastfeeding is appropriate for them.

“both a medical gold standard for infant feeding and a moral gold standard for mothering”

(Knaak 2010)

The Natural or The Chemical

The decision to breastfeed for mothers, rather than using formula stems from a larger abstract debate, the natural versus the chemical. When introduced early and given exclusively throughout the first six months, the effects of breast milk can benefit the life of an infant. This is due to the hyper and hypo calories, leptin, and other nutrients that not only work to stabilize the infant's immune system but also provide the infant with information about their surroundings. Leptin, a body-fat derived hormone is transferred from the mother to the infant through breast milk. Leptin when transferred from mother to infant carries with it information about the mother's body-fat storage, thus building off of the information given to the infant through the placenta in the neonatal phase (Kuwaza and Quinn 2009). The transference of information from breast milk to the infant can provide the infant's body with knowledge about the environmental conditions it will be exposed to, while also providing nutrients that have been specifically tailored to the infant. Thus, breastfeeding has become the “natural” method for providing infants with the resources they need to grow. However, not all women are able to breastfeed either do to physical inability or to lack of time and resources. This resulted in alternatives to breastfeeding

as early as 2000BC (Davis 1993). In 1867 the synthetic alternative to breastmilk appeared on the market, comprised of cow milk, wheat and malt flour, and potassium bicarbonate (Stevens et al 2009). Since then the production of powder, instant and milk substitutes has been increasingly displayed as an alternative to breastfeeding. The incorporation of formula into the diets of infants has sparked a debate ensuing that infants fed by formula are being exposed to chemicals, while infants who were breastfed were receiving a more natural diet. As the nature of the debate suggests, the decision to breastfeed an infant is more appropriate as it is more aligned with the biological aspects of the human body and represents a direct transmission from mother to child.

The Breast Over the Bottle

The initial natural versus chemical debate transcended into two larger debates centered around “good parenting.” The first spiral began with the “breast is best” campaign designed to increase the number of mothers breastfeeding in the western world. This campaign not only reinforced the natural and chemical debate, it also created new ideas about bottle feeding. Bottle feeding, or using a bottle to substitute the use of a breast to feed an infant, does not inherently imply that within the bottle there will be formula. The major concern produced by non bottle user's, public health practitioners and doctors is that social interaction and bonding between the mother and child would be altered. While no direct evidence can substantiate this claim, research has found that mothers breastfeeding for three months postpartum have shown signs of increased sensitivity towards their offspring, which then results in an increased element of attachment in comparison to mothers who chose to bottle feed (Britton et al 2006). Breastfeeding mothers are known to have more physical contact with their infants, as well as longer periods of mutual gaze

than mothers who are bottle feeding (Else-Quest et al 2003). Again, suggesting that the breast is the best.

Mezzacappa & Katkin (2002) conducted a study in which mothers hormone levels were measured after breast and bottle feeding. Their findings demonstrated that mothers who breastfeed had a decrease maternal negative affect, while mothers who bottle fed had a decreased positive maternal affect. While these results demonstrate that there are hormonal fluctuations that occur during breastfeeding that are non existent when using a bottle, the research does not support the mentality that women who breastfeed are better mothers than women who decide against it. The bonding hypothesis from this perspective suggests that women who do not breastfeed are at risk from developing poorer relationships with their infants. However, the criticisms of this argument explain that women who are at risk of fostering weaker connections with their infants show signs of this outside of their decision to breastfeed (Else-Quest et al 2003). Additionally, research found that the connection between mothers and their infants when breastfeeding were stronger than bottle feeding at four months of age, but not twelve months. This suggests that initial bonding that does occur between mother and infant has short term results, which would not prove one mother to be “better” than another (Else-Quest et al 2003).

Are You a Good Mother?

The “moral gold standard for mother's” references the second debate spurred by the continuation of the natural or chemical debate, who is a good mother. The ideal mother, as produced by the literature, suggests a woman who breastfeeds exclusively for the first six months postpartum, and then continues to incorporate breastfeeding into her child’s diet well into the two year mark. As the moral standard for mothers involves breastfeeding, women must also

perform this aspect of motherhood but publicly and privately to achieve this gold standard (Else-Quest et al 2003). Research conducted by S.J. Knaak found that there was a “culture of pressure” surrounding breastfeeding, in that mothers felt there was pressure on them to breastfeed. While this pressure seemingly came from the influence of popular society and their peers, breastfeeding is commonly explained generationally, becoming an additional source of pressure. Success with breastfeeding for the participants of the S.J. Knaak study became an issue of identity. Being committed to the idea, and practice of breastfeeding, regardless of the obstacles represented being committed to motherhood. The possibility of failure to breastfeed or the need to use a bottle became synonymous with being a failure as a mother (Knaak 2010). Performing the identity of motherhood revolves around perceptions of mothers from mothers themselves, but also from the historical patriarchal lens. “Leaking milk” or appearing with stains from leaked breastmilk has created a dual appearance of mothers. Childbirth changes how women are viewed from the waist down, breasts are still hyper sexualized and therefore leakage or appearance of breasts in connection to breastfeeding forces women’s bodies to occupy dual spaces. Additionally, women are not allowed to have sexualized breasts and still be the ideal mother who breastfeeds. Women from the P. Mahon-Daly and G.J. Andrews study discussed how milk leakage relegated them to be unfit mothers, as leaking breastmilk symbolized their inability to cope with motherhood (P. Mahon-Daly, G.J. Andrews 2002).

The duality of women’s bodies, and what those dualities embody, shift the spaces in which women are allowed to perform their womanhood or motherhood. Who are women performing their lives for? And who is dictating the performance? Societies will vary in the ways in which they deem breasts and breastfeeding appropriate, but women themselves should have

the right to decide what is appropriate for them. Exposing one's breasts can be a potentially embarrassing event regardless of society's customs. Breasts inherently belong to the woman, yet the female body is constantly objectified in ways that removes it from the possession and agency of the woman. Breastfeeding, while in some ways reinstating a woman's agency over her body, still allows for objectification. The objectification that occurs from breastfeeding, aside from the hyper sexual and physical, can come in the form of mothering. The descriptions of their breasts from women who were mothers ranges depending on the research being conducted. The most common understandings of how their breasts were viewed by themselves reflected how some women saw their breasts as private, while others commented on them as sexual objects, and some saw them as feeding mechanisms (Willis et al 2012). The various ways in which women can be seen as good or bad mothers in relation to their breastfeeding practices, includes the spacial realities of women attempting to feed their infant. There is a debate amongst women (mothers and non mothers) that breastfeeding can prove more difficult and increase the risk of embarrassment when in public. Bottle Feeding however, with formula or breastmilk is more suitable as it is less troubling (P. Mahon-Daly, G.J. Andrews 2002). The encompassing debates surrounding breastfeeding circulate around the social construction of a "good mother." What and who a good mother is not only comes from her decisions to breastfeed but also her decisions to perform her motherhood in a manner that is deemed socially acceptable by her peers and her community.

Understanding Male Identities

The social support realities of breastfeeding which influence the choice of women to breastfeed come from multiple outlets. The role of the father, or paternal figure is highly

contested within the discourse surrounding breastfeeding. There is on one hand the belief that male partner should have a role in the decision and process of breastfeeding, as statistically women find the support of their male partners to aid in the process (Reeves et al 2006). On the other hand, feminist theories discuss the role of men as intrusive. Consequently, men have been found to be disenfranchised by their lack of a voice in the decision to breastfeed (Mitchell-Box, Braun 2012). A paradigm exists between the empowerment of women who choose to breastfeed and the empowerment of males who choose to support them. Research has shown that in multiple settings males find bottle feeding or formula to be more convenient than breastfeeding. There is an overall gap in the knowledge of male partners attitudes towards breastfeeding, which prevents the debate from fully engaging with the male perspective. The themes related to the role of male partners were: making the decision, making it work, feeling left out, and crossing the line (Mitchell-Box, Braun 2012). From the perspectives of the male partners, making the decision and making it work required their support and commitment but not their input on the decision, leaving them to feel left out. An additional debate arose surrounding the decency of women breastfeeding in specific spaces. Some male partners noted discomfort and sexualization of breasts as a reason why women should refrain from breastfeeding outside the home (Mitchell-Box, Braun 2012). In this scenario the female body symbolizes the sexual, the delicate and the property.

Limitations

The use of universal assumptions as to why women choose to breastfeed exists within the communities attempting to understand why various decisions occur. These assumptions are based on research citing socio-economic class, race and ethnicity; government and media

depictions or support of breastfeeding. The universality of these assumptions excludes certain populations from the discourse, as well as marginalizes the women whose identities exist outside of the ones presented. When discussing race as a potential influence of breastfeeding, the structural violence and social inequalities experienced by different racial or ethnic groups needs to be considered.

Problem Formulation

The female body embodies both the natural, physical and the sexual. Nevertheless, the female body cannot occupy all of these spaces at once. In order for the body (of a woman) to exist within different socio cultural establishments, her body must fit into one of the categories. Breastfeeding and its forceful representation of a woman's body as something strictly "naturally" physical challenges these notions of embodiment. Not by challenging the individual ideas themselves, but the ways in which the ideas are constructed. While breastfeeding alters the use of the breasts, it also allows for individuals to alter their perceptions of women who breastfeed.

The debates that have arisen surrounding breastfeeding constitute "the natural vs the chemical" and ideas about who a woman is, and what makes a woman a good mother. These debates isolate the individual from the practice and do not attempt to address the reasons in which a woman would choose to breastfeed outside of her "duty" as a mother. The factors that influence breastfeeding are widely encompassing of the various social, cultural, economic and policy beliefs that interact with women throughout their lives. However, these factors can be determined to be insignificant in comparison to the individual decision of the mother. While she may know the science and benefits of breastfeeding, as well as have positive influences and social support; it is ultimately her decision, which can exist outside of her social and cultural

experiences. Yet, there must always be a question of agency when discussing female bodies, suggesting that the individual decision may not be so individual in the end.

Methodology and Cases

Rates of exclusive, combined and mixed breastfeeding globally are dependent on certain cultural and historical factors. To reflect the social, cultural, individual and governmental influences upon women's decisions to breastfeed specific global perspectives will be observed. Brazil, China and the United States have differing degrees of tolerance and acceptance, as well as different occurrences of breastfeeding practices. These countries both separately and in comparison with one another demonstrate how breastfeeding can be constructed and deconstructed from each element of society. In addition to the use of secondary sources, this research incorporated independent interviews with mothers from the United States and Brazil to offer a more personalized element. Throughout the paper the informants will be referred to as Maria (Brazil) and Jennifer (United States).

Brazil

Amas de Leite

Breastfeeding in Brazilian culture, while varies depending on the individuals and the states, is an accepted and widely practiced event. Information gathered during the pre-colonial period in Brazil notes that the native populations would commonly breastfeed their children well into two years of age. Their ability to do so was not seen as problematic for either the women or the community as they were able to continue their daily tasks around the practice, or incorporate breastfeeding into their working lives (Barbieri, Couto 2012). Alternatives to breastfeeding arose during the period of colonization in Brazil, during which African slaves would breastfeed their

masters children. This practice was originally introduced by the Portuguese who had been following the European model of wet nurses for centuries prior to colonization. *Mucamas*, or the slaves tasked with this job were well represented in Brazilian society. Their roles as breastfeeders were not ashamed or discouraged but instead increased the demand for certain types of women. Newspaper articles from the 1830s-1870s in Brazil are commonly found to have ads seeking women to breastfeed or sales of women who have “quality milk” for breastfeeding (Gaspar 2013). The normalization of breastfeeding as a public and private action required to raise children can be seen in the modern discussion of breastfeeding in Brazil. Lei Áurea (Golden Law) ended slavery in Brazil in March of 1888, shifting the role of *mucamas* into the traditional concept of a wet nurse or a “milk mother” as they are recognized in Brazil.¹

Amas de leite (milk mothers) provided breastmilk for women who were unable to lactate themselves, or decided not to breastfeed. When slavery ended, women of African descent continued to provide breastmilk for wealthier, European women with compensation. Moving into the nineteenth and twentieth centuries, milk mothers provided breastmilk for mothers who were unable to produce breastmilk, mothers whose breastmilk was unsuitable for their children or for premature babies. The practice which remained prevalent until the twentieth century, after which the role of the milk mother shifted with the introduction of the *Banco de Leite Humano*.

The initial health campaigns surrounding breastfeeding in Brazil began in the 1980s in an attempt to reduce rates of infant mortality. In addition to the campaigns developed the *Banco de Leite Humano* or the human milk bank, designed to provide infants with human milk instead of formula. The milk banks have been cited as one of the main factors in the country’s 73%

¹ Appendices Image 1

decline in infant mortality since the 1980s (Pires, 2014). The milk banks alone did not contribute to this success, as the additional layers of support came from other Brazilian institutions.

B(eastfeeding)RICS

Brazil's attempt to reduce the high infant mortality rates occurred at a similar point in a large growth in the country's GDP. The early 1980s witnessed Brazil's second oil shock, but it also represented the highest phase of Brazil's GDP growth (Pineiro et al 2004). The *Desenvolvimentista* Era aimed at framing Brazil to be an emerging economy. Health related campaigns followed a similar trajectory in attempting to frame Brazil as a healthy, safe and modern country. As Brazil's emergence on the global stage as a world power has progressed, the breastfeeding promotional campaign has been doing just the same. Regulations initially put into legislation in 2006 were added to by President Dilma increasing the strength of advertising bans against formula promotions. The new legislation stressed the labeling of formula products, making it illegal to propagate phrases such as "ideal for your baby (Luiz 2015)." Legislation also became increasingly more aggressive against critics of breastfeeding. The cities of São Paulo and Rio de Janeiro both passed laws protecting women's rights to breastfeed in public, private, open and closed spaces. These laws, passed in 2015 were intended to reinforce the already heavily propagated idea that breastfeeding was an important practice by mothers and should be protected (Watts 2015). Under the new legislation, anyone who impedes or harasses a woman for breastfeeding, regardless of the location, will be subjected to a fine (\$143 USD). The forcefulness of these laws, aimed at protecting and encouraging breastfeeding rates among women demonstrate Brazil's emerging power as more than simply an economic or political force.

When considering Brazil's perceptions and projections of breastfeeding, it is important to look at their history. The role of women in society, and the appearance of women being natural with the exception of recent cases of tension, has allowed Brazil to become an example of an incredibly "pro-breastfeeding" country.

China

The population of women breastfeeding in China has been witnessing a slow and steady decline from its original rates of 93-98% during the 1940s and 1950s. The declining rates have been seen to correspond with the rise of breastfeeding substitutes that became prevalent during the 1970s (Bai et al 2007). The discussion of breastfeeding in Chinese medical practice has shifted to present breastfeeding as a spectrum in which "any breastfeeding" is still considered a positive occurrence. Until 2007 the Chinese medical description of exclusive breastfeeding included the use of water or other milk supplements, which is not in agreement with the international standard. The cultural beliefs held in regards to breastfeeding in China is reflected within the medical and national practices and approaches towards breastfeeding. The most popular cultural influences to breastfeeding in China are the traditional practices of *Zuo yuezi* and traditional Chinese medicine (TCM). As well as the rise in consumer trends towards formula.

Traditional Conceptions Around Breastfeeding

Zuo yuezi is regionally dependent and has variations as to how it is practiced. From the most universal sense, it is a month long period in which women who have recently given birth regain their strength (Raven et al 2007). In more traditional settings this can take the appearance of women enduring a month long period of reduced contact from their infants. However, since

increased separation between mother and early infant has been shown to result in an increased risk of infant death, such extreme practices usually do not occur. As this practice has modernized to remain an aspect of both rural and urban birth in China, the current elements include the mother remaining home for the thirty day period, as well as practices related to diet, activity and hygiene (Raven et al 2007). Mothers, depending on which regional cultural traditional practices they are adhering to, will have reduced physical activity, restricted bathing and dental hygiene and will eat diets that are more protein rich (Raven et al 2007). The ultimate goal of these practices is to increase the health of the mother postpartum. The role of the infant is also subject to regionality. As a general theory and traditional practice, *Zuo yuezi* encourages new mothers to engage with breastfeeding, however it also suggests incorporating additional items into the diet of the infant such as water and milk powder or allowing the infant to have honeysuckle (Raven et al 2007).

Traditional Chinese medicine, much like *Zuo yuezi* has shifted to incorporate modern medical theories and practices, frequently imported from the West. TCM through ancient literature and oral traditions has been strictly in favor of women breastfeeding, provided that the mother is consuming specific herbs and dietary supplements. Breastmilk in TCM is understood as being the woman's menstrual blood that was converted into milk. This conversion takes energy, which needs to be regained after the birthing process (Legatt 2009). If there is a problem in the shift of energy, or not enough energy to convert the blood into breastmilk, TCM suggests the use of herbal remedies and acupuncture to increase the lactation process (Legatt 2009). The use of formula as a supplement to breastmilk however, is not discussed as an immediate remedy to a lack of breastmilk.

Compensation? Formula as a Supplement

The interaction between Western biomedicine and the traditional Chinese medical practices resulted in, and continues to demonstrate the use of traditional herbal remedies along side of Western created products. The decreasing rates of women breastfeeding in comparison to the increase in foreign produced formula is consistent in both rural and urban areas. In response to both the 2008 “milk crisis” in which Nestle formula was the cause of several hundred infant deaths and the rising usage of formula products, the Chinese national government considered implementing an anti advertisement ban on formula companies (Minter 2015). The Chinese government has been attempting to address the low rates of women breastfeeding since the initial drop off period in the later 1970s. The first educational breastfeeding program began in Beijing in 1983, but breastfeeding rates remained low (Xu et al 2009). Following the failure of this project, the Chinese government launched the Baby Friendly Hospital movement between 1992 and 1998 (Xu et al 2009). The Baby Friendly Hospital movement intended to create and foster an environment that allowed Chinese women to breastfeed, and gain the support needed to continue breastfeeding during the post hospital period. This initiative, as well as many others (women and child health protection legislation, society support programs and breastfeeding education) resulted in a slow rise of the number of women breastfeeding in Beijing. This was then replicated in other cities (Xu et al. 2009).

Breastfeeding rates through rural and urban China have remained low post the 1970s, regardless of the cultural influence of TCM and government encouragement. While the general population seems to be indifferent towards the process, women are choosing formula over breastmilk more often than not; or choosing a combination of breastmilk and formula.

United States

The United States has an interesting relationship with breastfeeding. Historically, breastfeeding has gone through cycles of being considered popular and then dissipating. During the 19th century wealthy women would opt against breastfeeding as it interfered with their societal obligations, as well as prevented them from wearing certain clothing. Poor women then, would take employment as wet nurses after they had their own children (Wickes 1953). These early notions of breastfeeding as “unfashionable” demonstrate the influences surrounding the decision to not breastfeed such as convenience, and appearance. However, there was a large amount of criticism against using a wet nurse. Scientists of the era saw wet nurses as potentially harmful for children, as their milk could not be trusted (Stevens, Patrick, Pickler 2009). The transition away from wet nurses and mothers breastfeeding came along with the creation of instant formula, which promised to be more convenient and inexpensive. With the rise of advertising for chemically created formula trends in breastfeeding began to drop rapidly (Stevens et al 2009).

It's Just as Good

HealthStyles surveys are annual reports intended to gauge the community's attitudes towards public health related practices. The survey from 1999 and 2003 included questions surrounding breastfeeding. General findings from this report found that there was a lack of understanding how significantly better breastmilk is for infants than formula. The percentage of individuals who responded in agreement with the statement “Infant formula is as good as breastmilk” increased from 14.3% in 1999 to over 25% in 2003 (Li 2007). This statement seemed most true to individuals of Hispanic and African ethnic and cultural backgrounds, as well

as individuals from lower socioeconomic status. The initial decrease in breastfeeding trends also occurred in populations from lower socioeconomic backgrounds. While there is no direct correlation between socioeconomic status and likelihood to breastfeeding, communities residing under economic distress have less access to promotional educational campaigns that exist outside of hospitals.

The trend in public opinion towards infant formula being of the same quality as breastmilk could be connected to the increase in infant formula on US markets during the early 2000s (Li 2007). By placing Long-chain polyunsaturated fatty acids into formula, advertisers were able to label the formula as having the ability to positively mimic certain aspects of breastmilk, providing infants with similar cognitive and visual development (Kaplan et al 2008). Advertisements of formula then become more widespread after their appearance on TV commercials in 1989 (Kaplan et al 2008). The increased awareness of formula as an alternative method of infant feeding in the United States occurred in tandem with increased spending on advertisements advocating for the use of formula. Expenditures on formula advertising increased from \$29 million in 1999 to \$48 million in 2003 (Li 2007). The increased visual appearance of formula aided its normalization regardless of the public health sectors efforts against it.

Hospitals on Formula

United States formula companies increased advertising efforts resulted in new marketing techniques designed to entice health officials for their endorsement. Hospitals in the US are able to provide new mothers with exit care packages, most come with free infant formula. In addition to providing mothers with formula to take home, 78% of US hospitals routinely give formula to babies while they are in the hospital's care (McCarthy 2012). Formula manufacturing companies

provide them with free samples and products, increasing the likelihood that mothers will then use formula throughout the duration of infancy (Kaplan et al 2008). Educational information on breastfeeding also become a sector of marketing interest for formula companies during the 1990s. One survey found that 78% of women who received printed information on infant feeding reported that a formula company had published it (Kaplan et al 2008). The intersection between breastfeeding, formula and the hospitals have shifted the discussion of infant feeding in America, creating the perception that formula is as healthy as breastmilk for an infant.

Media Blitz

Within the United States there is a strong media presence with the ability to influence public opinion, health outcomes and identity constructions. All of which apply to breastfeeding. The media, whether through print, magazines, social networking, or television, portrays very specific images of women's bodies and the events of motherhood. The popular television show *Chicago Hope* displayed a breastfeeding baby dying from dehydration and starvation. The producers of the show noted that airing this rare condition (insufficient milk supply) would increase viewer knowledge of risks associated with breastfeeding (Bylaska-Davies 2011). However, the show did not attempt to explain the condition as something unique and unlikely to occur from breastfeeding, nor did it present alternatives to prevent the baby's death. Inaccurate representations of breastfeeding through the media does not educate viewers, as it instead misinforms them.

In a study aimed at addressing what the media's role in breastfeeding was, women were interviewed, and responded that they would like to see the media reinforce more positive images towards breastfeeding, changing attitudes and making the practice more socially acceptable (Bylaska-Davies 2011). Currently, the role of mothers in the media is dictated by the formula industry and the bottle feeding culture that exists within the US (McCarthy 2012). The media portrays mothers who use bottles as expected in society, and through the use of advertisements for bottle and formula related technologies can reinforce the image of the "good mother" bottle feeding (Bylaska-Davies 2011).

With the rise of social media in the United States, the role of performing motherhood has shifted to include social media websites. There are numerous examples of pro breastfeeding mothers creating Facebook pages in support of the practice, as well as mothers venting their complaints against businesses that try to shame their breastfeeding habits. In March of 2015 a journalist from BC Business magazine took to Twitter to share her experience on a United Airlines flight, in which a flight attendant asked her to cover herself while breastfeeding and threw a blanket at her husband (Cunha 2016). Her complaint on Twitter was then shared over 2,500 times and received support from other mothers, eventually procuring an apology from United (Cunha 2016). The use of social media has multiple functions in demonstrating how the American population perceives breastfeeding. In some cases there is a great amount of support, as well as an education and social kinship element in promotion of breastfeeding. However, there can also be the discrimination of women who breastfeed, which also gains support on social media, as there are constructed ideas as to what women should be doing with their bodies.

Hidden in Plain Sight

The hyper sexualization of women's bodies in America can be seen in media portrayals of women such as ad campaigns, clothing advertisements and Hollywood movies. The degree in which women's breasts are seen as sexual objects has influenced the way American citizens believe women should perform motherhood, specifically in relation to breastfeeding. The HealthStyle surveys conducted in 1999 and 2003 found high rates of agreement with statements like "Mothers who breastfeed should do so in private places only," and decreasing rates of agreement with statements such as "I am comfortable when mothers breastfeed their babies near me in a public place, such as a shopping center, bus station, etc." The public portrayal of breasts outside of the sexualized contemporary norms is seen as problematic in many communities within the United States (Li 2007).

The United States' relationship to breastfeeding is contingent upon the perspectives of the media, hospital personnel and mothering communities. The prevalence of formula marketing combined with the lack of educational outreach programs for lower socioeconomic groups has contributed to the decline of breastfeeding rates across the country. Additionally, surveys have shown that Americans are not comfortable with women breastfeeding in public areas, contributing to the decline of acceptance of breastfeeding. However, active mothers in social media communities, as well as midwives and breastfeeding positive campaigns are attempting to increase awareness and acceptability of breastfeeding in American society.

Findings and Analysis

"power is everywhere, not because it embraces everything, but because it comes from everywhere"

The role of biopower, as depicted by Foucault, is to act as regulator of social behaviors. Biopower attempts to control and regulate populations through discourse and production; managing births, deaths, reproduction and illness (Nelson 2016). Breastfeeding, as a naturally occurring process is frequently regulated in the form of controlling and manipulating the discussion around women's bodies. The discussions as well as the forces of biopower placed on them are mediated by cultural and societal norms.

Drinking Below Average

The World Health Organization suggests that women begin breastfeeding an hour or sooner after the baby is born, and to continue exclusively breastfeeding until six months of age at minimum. Breastfeeding rates in Brazil, China and United States, nationally are all below the recommended amount of time for an infant to be breastfed. This similarity between the three cases presents the idea that while one country may outwardly support the practice more than another, there are more influencing factors than just the perspectives of the national government.

Markets Against Mothers

Breastfeeding, at the most basic level is free, yet people all around the globe are choosing to purchase formula. While breastfeeding is the known superior option for infant feeding, hospitals, governments and traditional networks of support are both directly and indirectly promoting the use of formula as an alternative. Women who are given commercial formula packages upon discharging from the hospital are more likely to discontinue breastfeeding at the 10 week mark (Rosenberg et al 2008). One of the most common marketing methods of infant formula manufacturers is to provide financial support for fellowships, conferences and basic hospital supplies. Then manufacturing companies are able to provide free formula to be used

within the hospitals by creating brand loyalty partnerships (Rosenberg et al 2008). By placing coupons, advertisements or vouchers in physicians offices formula companies are commercializing the hospital process, as well as creating the appearance that physicians are promoting the use of formula (Howard et al 1993). Baby Friendly Hospitals attempt to work outside the formula partnerships, however, there are costs that would usually be covered by multinational corporations, which makes the shift from a traditional hospital to a Baby Friendly Hospital more difficult (Merewood et al 2000).

78% of US hospitals provide babies with formula after birth, deterring women from initially breastfeeding within and outside of the hospital. In a similar context, hospitals in China frequently provide mothers and newborns with formula. Chinese government health officials often blame this on the intense lobbying done by formula industries, as well as the perception that breast milk may not be enough to provide for an infant (Thomas 2015). This practice does not occur as frequently in Brazil. While in Brazil specifically this usually does not occur because of the access to human breastmilk in hospitals, the function of providing infants with formula in a hospital setting does not give women the support to initiate the practice. Providing commercialized care packages to women with formula or promotional materials reduces the number of women who exclusively breastfeed after the 6 week and 10 week marks (Donnelly et al 2000). While hospital staff regardless of their Baby Friendly status are required to inform and educate women on breastfeeding, by also providing women with formula the educational aspect becomes more complex. The complexities that arise challenge the biological notions of breastmilk being the preferred option by creating outlets of support for formula.

The Hospital as a Dividing Presence

The factors from an abstract level that influence a woman's decision to breastfeed come from specific spheres of thought; the cultural, the societal, the political and the individual. However, each sphere translates into an environment differently, depending upon the normal practices of a country. When considering the cultural influences in support of breastfeeding in the US, China and Brazil, there is a push to medicalize the practice in the United States from a strictly Western biological perspective. This perspective does not appear in the same way in China. In China, the prevalence of traditional medicinal practices interacts with Western medicine in an attempt to modernize older practices. This does not remove traditional knowledge and replace it with Western concepts of health. The role of the hospital in this function then changes. While Baby Friendly Hospital initiatives have been introduced in all three cases, the only examples of Baby Friendly hospitals having a positive impact on breastfeeding occurs in Brazil and the United States (Philipp et al 2001). Due to the already existing positive policies and practices around breastfeeding in Brazil, the Baby Friendly hospitals saw increased breastfeeding initiation, as well as increased longevity of the practice. In the United States, the introduction of Baby Friendly hospitals saw an increase in initiation rates but also required a Ten Step process to educate families on breastfeeding and breastfeeding support, something that was not seen in Brazil (Philipp et al 2001).

Visualizing Breastfeeding Practices

Historically, Brazil has been a more “pro-breastfeeding” country than any other Western nation or emerging economy. As stated previously, the country has been geared towards providing women with support as a method to cut infant mortality rates, normalizing the presentation of breastfeeding through educational outreach campaigns, advertisements and

through the development of the milk bank.² In addition to the visual normalization of breastfeeding, cities have put laws in place to protect a woman and her ability to breastfeed publicly.

“In the US the body is a myth, in Brazil, it's not that the body of the women isn't stereotyped, but there are laws to protect women and their decision to breastfeed” - Maria

The visualized perspectives around breastfeeding, both publicly and privately present diverging opinions between the three case studies. After speaking with Maria, she recounted a moment when she first moved to America in which her sister in law left the room to breastfeed her infant. In explaining how she found that interaction to be odd, she discussed how in Brazil it is very common for women to be engaged in a conversation or activity and then to begin to breastfeed without covering the child or leaving the setting. When discussing the public appearance of breastfeeding in America, Jennifer noted how different states have differing opinions on the practice, which further marginalizes women at both ends of the spectrum. In California, where she lived when she first had her son, she was presented with open spaces to breastfeed publicly without facing immediate stigma from the community.

The United States has engaged with visualizing breastfeeding through public support for breastfeeding mothers in the form of social media. Allowing women to have the ability to express their opinions surrounding breastfeeding publicly challenges the constructions of women in biopower. In the United States currently, it is illegal for women to be topless, breastfeeding included in 35 states. In response to the exposure of how women who breastfeed publicly are treated, social media campaigns arose such as “Free the Nipple.” The organization is argues

² Appendices Image 2

against the oppression and inequalities that exist for women in the United States and recently published images of women breastfeeding bathrooms as a form of protest.³

The Chinese government in collaboration with UNICEF and pro-breastfeeding organizations have attempted to increase breastfeeding rates in China over the last two years. The goals of this operation range from introducing a potential ban on formula advertising to creating safe spaces for mothers to breastfeed. While publicly breastfeeding in China is not now considered part of the cultural norms, it is largely dependent on the region. During the 2014 national breastfeeding week the Chinese government, along with UNICEF created mobile app as part of the “10m2 of Love” campaign. The mobile app allows mothers to download maps with safe and secure breastfeeding locations whenever they need one (Ang 2015). Several women’s groups throughout China have begun to publicly breastfeed as demonstrations for support of the practice. The Fuzhou Breastfeeding Mothers' Alliance for example, has held two demonstrations in public parks to raise awareness for women breastfeeding in public.⁴

In comparison to the United States example of visually expressing and interpreting support for breastfeeding, the Chinese and Brazilian examples incorporates more of the governmental perspective. As Jennifer discussed during her interview, she feels as if the United States government and politicians are less willing to take a stand on the matter of public breastfeeding, or public support of breastfeeding because they are less likely to engage in discussions surrounding women’s bodies.

Support for Support’s Sake

³ Appendices Image 3

⁴ Appendices Image 4

Incorporating the cultural, social, political and individual spheres, support is the most important element to encourage women to decide to breastfeeding. The success in breastfeeding rates globally are mirrored by increasing levels of a support for the practice. The World Health Organization requires that support for breastfeeding must come from the families, the health centers and society.

The most common introduction to breastfeeding in generational and occurs within kinship networks. As women become new mothers, they are exposed to the discourse surrounding breastfeeding from their own families, usually from a supportive and educational model. Both Jennifer and Maria explained that some of their knowledge of breastfeeding came from their kinship networks. Additionally, both noted how women in their families almost always breastfed. While in both Maria's and Jennifer's families the use of formula was not uncommon, the practice of breastfeeding was more prevalent in Maria's case.

The discussion of support for breastfeeding in the United States and Brazil occur differently. While the commonality of the practice in Brazil ensures women of the rights to breastfeed, it also allows for a different type of conversation to occur. For Maria, the practice of breastfeeding is so natural and obvious that discussions arise when women are forced to find alternatives to breastfeeding. For Jennifer however, the support in discussion for breastfeeding was determined by the communities in which the conversation took place. This suggests that the cultural and societal influencers for breastfeeding are shaping the discussions that are occurring not necessarily by what is being said, but by whether or not a discussion exists.

In each case study the decision to begin breastfeeding or to continue breastfeeding after being discharged from the hospital addressed the role of the father's support. Studies conducted

demonstrate that most women in hospitals (97%) believe that there will be support given both verbally and in the form of helping around the house. In TCM during the *Zuo yuezi* period women are culturally mandated to reduce the work they conduct around the house, and are given support by the father of the child, as well as the other female members of the family. This practice does not specifically exist within the other case studies, however the general belief that women will be supported by their significant other is held. Recent data has shown that partners of pregnant women would like more say in the decision making process in regards to breastfeeding. However, the data also demonstrates that male partners are more likely to suggest that women use formula or bottle feed as it is seen to be more convenient. This trend is most prevalent in the United States, where male beliefs around breastfeeding publicly also garner less support.

National policies aimed at maternity leave can have a number of effects influencing a woman's decision to breastfeed. Breastfeeding requires a woman to have time and access to their children throughout the day. The number of women in the workplace has globally increased, yet the policies related to breastfeeding, maternity leave and women's equality in the workplace has changed little. The "Burden of Time" theory explains that women are required to fulfill both career positions in the home and in the outside world, and are expected to do so daily. This does not account for the lack of time available to occupy each role. Nevertheless, women are expected to be both full time mothers and full time employees, or leave their career outside of childrearing. Society accepts and perpetuates this stereotype of women, creating the construct as to how women should perform motherhood. However, society very rarely allows women the space and time to do so.

The national periods of maternity leave for Brazil, China and the United States are 6 months paid leave; 98 days paid leave; and 12 weeks of unpaid leave respectively. Restricting the amount of time women are able to leave the workplace creates added pressures to the decision to breastfeed. Women are less likely to initiate breastfeeding when the amount of time available for them to dedicate to the practice is limited. Additionally, assuming that women have the ability to pump their breastmilk and then store it for later use, implies that all women are capable of doing that. This assumption disregards economic ability to purchase a breastmilk pump and to store breastmilk properly, isolating specific categories of women. By instituting national policies aimed at reducing the amount of time women are able to leave the workforce, the national government is not supporting the women's decision to breastfeed.

Discussion

Breastfeeding goes beyond the natural practice to determine how women are viewed by the societies in which they exist. Imposed social constructions of women and their bodies have been used to dictate the behavior of women. The decision to breastfeed, while ultimately in the hands of the mother, is influenced by the socioeconomic, cultural and political environments around her. The internal and external pressures that have been created surrounding women in many ways removes the individual agency each woman has when deciding how to feed her infant. The anthropological bodies are spheres created based on the constructions of society. Breastfeeding remains in the grey space between the individual, mindful, social and political body. As both a representation of the natural symbols of the physical world and the lived

experiences of women within the human condition; existing within a regulated body through biopower and struggling to resist the role of outside control over the body.

The cultural norms that concern breastfeeding are reflected by the laws, attitudes and beliefs of a population. In the cases of Brazil, China and the United States there are varying degrees in which breastfeeding is accepted and supported by the general population, as well as the national government and the scientific communities. These three cases demonstrate how something evolutionarily natural and constantly occurring can be transformed to embody the socially constructed identities of “woman” and “mother.” In turn, the placement of these constructs onto women changes the perception of breastfeeding as a role of a woman and mother, but a role that must be performed in acceptance with the cultural and social beliefs. These cases allow us to see the discrepancies that occur when there is a disconnect between the cultural, social and political settings surrounding the rights and practices of women.

The original aims of this paper were to address the influencing factors surrounding women’s decisions to breastfeed. While the paper presented the various influencers in relation to internal and external pressures that exist for women, the research sample was incredibly small. The presence of small case specific informants does provide information reflective of a larger population, but also risks generalizing a community's attitudes and isolating members who may have differing opinions. One of the largest limitations to this research, aside from a small interviewing population, was the lack of resources to pursue more questions surrounding decisions to breastfeed. Throughout the research for this paper different questions, concerns and themes arose which, given more time would have been addressed more in-depth.

The decision to understand influencing factors surrounding a woman's decision to breastfeed came from understanding that women's bodies are constantly being given structures and identities that do not reflect women but rather the social and cultural environments around them. The role of the patriarchy in creating sanctions upon female bodies has resulted in external pressures designed to limit the acceptability of a woman using her body as she would like. When considering Brazil, and their pro-breastfeeding governmental policies, one must also consider that the reasons those policies exist is because of the need for laws designed to protect women and their performance of motherhood. Potential research that could be conducted in the future could look at the acceptability of public breastfeeding in Brazil within the next fifteen to twenty years. Will the policies have changed? Will women still be protected in their right to breastfeed? Another interesting suggestion would be to see if similar laws are put into legislation in other countries, such as the United States. Additionally, when considering China's current surge in external formula purchases, will the government's initiatives against formula impact this trend? There are several potential opportunities for future research on breastfeeding trends, decisions and policing women's bodies.

The decision to breastfeed goes beyond singular characteristics or experiences felt by a woman, instead it is a decision that reflects the cultural, social, environmental and political conditions placing pressure upon her. The embodiment of a woman is swayed by the cultural norms that restrict how women should be allowed to operate. Thus, the decision to breastfeed is not always the decision of the woman. The political and environmental constructions of female bodies influences the way that women are viewed as both individuals and mothers, often conflating the two to be the same thing. The methods designed to increase rates of breastfeeding

amongst women are influenced by the created identities of women, encouraging top down and bottom up social approaches. While breastfeeding national health campaigns are aimed at education and awareness, without the support of the national government, hospitals and general public, the decision to breastfeed will always be contested.

Appendices:

Image 1



LUCILIO DE ALBUQUERQUE: *Mãe preta*, 1912.
Óleo sobre tela, 180 x 130 cm.
Salvador, Museu de Belas-Artes da Bahia.

Image 2



Image 3:



Image 4:



Interview Questions:

1. What are the ideas about breastfeeding held by your community (or communities)?
2. Do you believe there are cultural influences on a person's decision to breastfeed their children? Are cultural influences present for you?
3. Did or do other women in your family breastfeed? If not did they use formula?
4. If you breastfed, how long did you breastfeed for? Would you breastfeed if you had more children?
5. What are your opinions on formula vs breastfeeding?
6. Does the demand of your daily life (tasks, career, ect.) influence your decision towards breastfeeding?
7. Do you see an influence from your current local community, or from your previous community?
8. Do public policies have any influence on your decision; does public opinion on the topic?

Bibliography:

Stevens, Emily E, Thelma E Patrick, and Rita Pickler. "A History of Infant Feeding." *The Journal of Perinatal Education* 18.2 (2009): 32–39. PMC. Web. 9 Mar. 2016.

Davis FA." *Taber's cyclopedic medical dictionary.*" Philadelphia: F.A. Davis Co; 1993.

Fomon S. "Infant feeding in the 20th century: Formula and beikost." *The Journal of Nutrition.* 2001;131(2):409S–420S.

Wickes IG. "A history of infant feeding. Part II. Seventeenth and eighteenth centuries." *Archives of Disease in Childhood.* 1953b;28:232–240.

Bylaska-Davies, Paula. "The Role of the Mass Media in Women's Infant Feeding Decisions." University of Massachusetts. 2011.

Minter, Adam. "China's Growing Breastfeeding Problem." *The Bloomberg View.* 2015.

Liqian Qiu, Yun Zhao, Colin W Binns, Andy H Lee and Xing Xie. "Initiation of breastfeeding and prevalence of exclusive breastfeeding at hospital discharge in urban, suburban and rural areas of Zhejiang China." *International Breastfeeding*

Journal 4:1 2009.

Xu, Fenglian, et al. "Breastfeeding in China: a review." *International breastfeeding journal* 4.1 (2009): 1.

Ogbuanu, Chinelo A. et al. "REASONS WHY WOMEN DO NOT INITIATE BREASTFEEDING: A Southeastern State Study." *Women's health issues : official publication of the Jacobs Institute of Women's Health* 19.4 (2009): 268–278. PMC. Web. 9 Mar. 2016.

[Kuan LW](#), [Britto M](#), [Decolongon J](#), [Schoettker PJ](#), [Atherton HD](#), [Kotagal UR](#). "Health system factors contributing to breastfeeding success." *Pediatrics* 104. 3 1999.

McCarthy, Claire. "The top four reasons moms stop breastfeeding--and what we can do about them." MD Mama Blog, [boston.com](#) 2014.

Mascarenhas, Maria Laura W., et al. "Prevalence of exclusive breastfeeding and its determiners in the first 3 months of life in the South of Brazil." *Jornal de pediatria* 82.4 (2006): 289-294.

Susin, Lulie Rosane Odeh, and Elsa Regina Justo Giugliani. "Inclusion of fathers in an intervention to promote breastfeeding: impact on breastfeeding rates." *Journal of Human Lactation* (2008).

do Nascimento, Maria Beatriz R., et al. "Exclusive breastfeeding in southern Brazil: prevalence and associated factors." *Breastfeeding medicine* 5.2 (2010): 79-85.

Braun, Maria Luiza G., et al. "Evaluation of the impact of the baby-friendly hospital initiative on rates of breastfeeding." *American Journal of Public Health* 93.8 (2003): 1277-1279.

da Cunha, Antonio J. Ledo Alves, Alvaro Madeiro Leite, and Marcia Maria Tavares Machado. "Breastfeeding and pacifier use in Brazil." *The Indian Journal of Pediatrics* 72.3 (2005): 209-212.

Ryan, Alan S. "The resurgence of breastfeeding in the United States." *Pediatrics* 99.4 (1997): e12-e12.

Li, Ruowei, et al. "Breastfeeding rates in the United States by characteristics of the child, mother, or family: the 2002 National Immunization Survey." *Pediatrics* 115.1 (2005): e31-e37.

Else-Quest, N. M., Hyde, J. S., & Clark, R. (2003). Breastfeeding, bonding, and the mother-infant relationship. *Merrill-Palmer Quarterly* (1982-), 495-517.

Cernadas, J. M. C., Noceda, G., Barrera, L., Martinez, A. M., & Garsd, A. (2003). Maternal and perinatal factors influencing the duration of exclusive breastfeeding during the first 6 months of life. *Journal of human lactation*, 19(2), 136-144.

MacKean, G., & Spragins, W. (2012). *The challenges of breastfeeding in a complex world*. Alberta: Alberta Health Services.

Heinig, M. J. (2007). The Burden of Proof: A Commentary on “Is Breast Really Best: Risk and Total Motherhood in the National Breastfeeding Awareness Campaign”. *Journal of Human Lactation*, 23(4), 374-376.

Grant, A. (2016). “I... don’t want to see you flashing your bits around”: Exhibitionism, othering and good motherhood in perceptions of public breastfeeding. *Geoforum*, 71, 52-61.

Mitchell-Box, K., & Braun, K. L. (2012). Fathers’ thoughts on breastfeeding and implications for a theory-based intervention. *Journal of Obstetric, Gynecologic, & Neonatal Nursing*, 41(6), E41-E50.

Brouwer, M. A., Drummond, C., & Willis, E. (2012). Using Goffman’s theories of social interaction to reflect first-time mothers’ experiences with the social norms of infant feeding. *Qualitative health research*, 22(10), 1345-1354.

Britton, J. R., Britton, H. L., & Gronwaldt, V. (2006). Breastfeeding, sensitivity, and attachment. *Pediatrics*, 118(5), e1436-e1443.

Sheehan, A., Schmied, V., & Barclay, L. (2010). Complex decisions: Theorizing women’s infant feeding decisions in the first 6 weeks after birth. *Journal of advanced nursing*, 66(2), 371-380.

Rempel, L. A. (2004). Factors influencing the breastfeeding decisions of long-term breastfeeders. *Journal of Human Lactation*, 20(3), 306-318.

Reeves, C. C., Close, F. T., Simmons, M., & Hollis, A. (2006). Social Support Indicators that Influence Breastfeeding Decisions in Mothers of North Florida. *Florida Public Health Review*, 3, 1-7.

Rosenberg, K. D., Stull, J. D., Adler, M. R., Kasehagen, L. J., & Crivelli-Kovach, A. (2008). Impact of hospital policies on breastfeeding outcomes. *Breastfeeding Medicine*, 3(2), 110-116.

Lööf-Johanson, M., Foldevi, M., & Rudebeck, C. E. (2013). Breastfeeding as a specific value in women's lives: the experiences and decisions of breastfeeding women. *Breastfeeding Medicine*, 8(1), 38-44.

Knaak, S. J. (2010). Contextualising risk, constructing choice: breastfeeding and good mothering in risk society. *Health, risk & society*, 12(4), 345-355.

Barbieri, Carolina Luisa Alves, & Couto, Márcia Thereza. (2012). As amas de leite e a regulamentação biomédica do aleitamento cruzado: contribuições da socioantropologia e da história. *Cadernos de História da Ciência*, 8(1), 61-76. Recuperado em 28 de abril de 2016, de http://periodicos.ses.sp.bvs.br/scielo.php?script=sci_arttext&pid=S1809-76342012000100003&lng=pt&tlng=pt.

Marques, N. M., Lira, P. I., Lima, M. C., da Silva, N. L., Batista Filho, M., Huttly, S. R., & Ashworth, A. (2001). Breastfeeding and early weaning practices in northeast Brazil: a longitudinal study. *Pediatrics*, 108(4), e66-e66.

Meyer, D. E., & De Oliveira, D. L. (2003). Breastfeeding policies and the production of motherhood: a historical-cultural approach. *Nursing Inquiry*, 10(1), 11-18.

Pinheiro, A. C., Gill, I. S., Servén, L., & Thomas, M. R. (2004). Brazilian economic growth, 1900-2000: lessons and policy implications. Inter-American Development Bank.

Watts, Jonathan (2015). São Paulo breastfeeding law would fine those who try to stop nursing mothers. *The Guardian* 2015

Xu, F., Binns, C., Yu, P., & Bai, Y. (2007). Determinants of breastfeeding initiation in Xinjiang, PR China, 2003–2004. *Acta Paediatrica*, 96(2), 257-260.

Raven, J. H., Chen, Q., Tolhurst, R. J., & Garner, P. (2007). Traditional beliefs and practices in the postpartum period in Fujian Province, China: a qualitative study. *BMC Pregnancy and Childbirth*, 7(1), 1.

<http://www.milkmakers.com/milk-supply/traditional-chinese-medicine-and-the-support-of-lactation/>

Centers for Disease Control and Prevention (CDC). (2006). Racial and socioeconomic disparities in breastfeeding--United States, 2004. *MMWR. Morbidity and mortality weekly report*, 55(12), 335.

Ryan, A. S. (1997). The resurgence of breastfeeding in the United States. *Pediatrics*, 99(4), e12-e12.

Li, R., Rock, V. J., & Grummer-Strawn, L. (2007). Changes in public attitudes toward breastfeeding in the United States, 1999-2003. *Journal of the American Dietetic Association*, 107(1), 122-127.

Asiodu, I. V., Waters, C. M., Dailey, D. E., Lee, K. A., & Lyndon, A. (2015). Breastfeeding and use of social media among first-time African American mothers. *Journal of Obstetric, Gynecologic, & Neonatal Nursing*, 44(2), 268-278.

Cuhna, Darlena. (2016) Social Media Is Helping Moms Win the War Over Public Breastfeeding. *Time Magazine*. <http://time.com/3768321/public-breastfeeding/>.

Rowe-Murray, H. J., & Fisher, J. R. (2002). Baby friendly hospital practices: cesarean section is a persistent barrier to early initiation of breastfeeding. *Birth*, 29(2), 124-131.

Philipp, B. L., Merewood, A., Miller, L. W., Chawla, N., Murphy-Smith, M. M., Gomes, J. S., ... & Cook, J. T. (2001). Baby-friendly hospital initiative improves breastfeeding initiation rates in a US hospital setting. *Pediatrics*, 108(3), 677-681.

Thomas, C.F. (2015) China wants mothers to breast-feed, but they keep choosing formula. *The Washington Post*.
https://www.washingtonpost.com/world/asia_pacific/china-wants-mothers-to-breast-feed-but-they-keep-choosing-formula/2015/07/04/65114200-201d-11e5-aeb9-a411a84c9d55_story.html

Kuan, L. W., Britto, M., Decolongon, J., Schoettker, P. J., Atherton, H. D., & Kotagal, U. R. (1999). Health system factors contributing to breastfeeding success. *Pediatrics*, 104(3), e28-e28.

Wright, A., Rice, S., & Wells, S. (1996). Changing hospital practices to increase the duration of breastfeeding. *Pediatrics*, 97(5), 669-675.

Howard, F. M., Howard, C. R., & Weitzman, M. (1993). The Physician as Advertiser: The Unintentional Discouragement of Breastfeeding. *Obstetrics & Gynecology*, 81(6), 1048-1051.

Rosenberg, K. D., Eastham, C. A., Kasehagen, L. J., & Sandoval, A. P. (2008). Marketing infant formula through hospitals: the impact of commercial hospital discharge packs on breastfeeding. *American Journal of Public Health, 98*(2), 290-295.

Merewood, A., & Philipp, B. L. (2000). Becoming Baby-Friendly: overcoming the issue of accepting free formula. *Journal of human lactation: official journal of International Lactation Consultant Association, 16*(4), 279-282.