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Introduction

In the nearly two decades since the last integrative review undertaken by Penny Van Esterik (2002), research on lactation in biological and sociocultural anthropology has grown substantially (Tomori et al. 2018). Much of the sociocultural anthropological scholarship resides in articles and edited volumes (Liamputtong 2011; Cassidy and El Tom 2015; Tomori et al. 2018; Van Esterik and O’Connor 2017). A small, but growing body of ethnographic monographs based on multi-year sociocultural anthropological research and with a significant emphasis on breastfeeding now exists (Mabilia 2005; Dykes 2005; Faircloth 2013; Tomori 2014; Falls 2017; Gottschang 2001; Wilson 2018; Carter and Reyes-Foster 2020). These works address many central themes in the anthropology of reproduction, including embodiment, sexuality, kinship, personhood, gender, medicalization, biocapitalism, the role of the state, and local-global relations, among others. However, these works rarely engage the anthropology of reproduction as a key framework. Despite its critical importance to the human reproductive continuum, (Mullings and Wali 2001; Schulz and Mullings 2006; Colen 1986) lactation1 has remained underdocumented and undertheorized within the anthropology of reproduction.

Within biological anthropology, lactation has been more substantively integrated into work on reproduction through the unifying framework of human ecology and evolutionary theory (Quinn 2016; Power and Schulkin 2016; Hinde and Milligan 2011; Milligan 2013). Biological anthropologists studying breastfeeding and human milk use both ethnographic methods and bench science to examine human biological diversity through analyses of human milk and related infant feeding practices (for review see Miller et al. 2013). At the same time, there is growing anthropological interest in human milk as a material object, or product, separate from the process of breastfeeding, as Van Esterik (2003) has previously discussed. Some of this scholarship is inspired by the salience of human milk expression in the US and the UK, which also happen to be two countries in which the anthropology of reproduction is primarily located. Expressed human milk has emerged as a material substance that may be gifted, bought, and sold (Palmquist 2015; Palmquist and Doehler 2015; Palmquist et al. 2019; Reyes-Foster and Carter 2018; Carter and Reyes-Foster 2020). New technologies have also diversified both the techniques that parents use to make milk, express it, and feed their infants, which have far-reaching implications for conceptualizations of gender and identity, relationships, kinship, political econ-
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omy, community formation, and much more (Carter and Reyes-Foster 2020; Wilson 2018; Falls 2017; Walks 2018).

Integrative biocultural perspectives that bridge anthropological subfields are essential in understanding the many facets and complexities of human lactation (Tomori, Palmquist, and Quinn 2018). Biological anthropological research plays a key role in highlighting the diversity of human populations and provides a biocultural perspective on lactation that is sorely lacking from much of the biomedical research on breastfeeding and human milk. One example of this integrative perspective is Hewlett and Winn’s (2014) review of allomaternal nursing in humans, which brings together biological anthropological and ethnographic insights to frame new questions about the evolutionary, historical, and contemporary cross-cultural importance of alloparental investment through lactation practices, such as human milk sharing and cross-nursing (see Herlosky and Crittenden in this volume). Ethnographic insights and critical anthropological studies of lactation can also inform careful, ethical, and contextualized laboratory-based investigations of issues related to human milk and infant feeding. Such approaches have been successfully applied by Perrin et al. (2018), Hawley and Gorrepati (2018), Veile and Kramer (2018), Martin (2018), Tully (2018), and Rudzik et al. (this volume). A more integrated biocultural approach to studying human lactation, which also includes comparative and cross-cultural perspectives, generates powerful insights that can destabilize Western hegemonic controversies about the value of breastfeeding. They also raise important questions regarding ethics and implications of reductionistic laboratory-based studies of human milk along with the commercialization of human milk–based products that are now intensifying across science, technology, engineering, and medical fields (Palmquist et al. 2020; Perrin et al. 2019).

In this chapter, we review major theoretical contributions in the sociocultural, biological, and integrative approaches to studying human lactation. We suggest that greater attention to breastfeeding, along with other human lactation and infant feeding topics, is still needed within the anthropology of reproduction. Similarly, current research endeavors related to human lactation will be greatly enriched through deeper engagement with core anthropology of reproduction scholarship, particularly intersectional feminist theories. Finally, we map out some ways that transformative anthropological perspectives grounded in the scholarship of Black and Indigenous scholars from around the world can expand and reshape dominant framings of lactation in public discourses.

Medicalized lactation at the nexus of colonialism and capitalism

Medicalization is the broadest lens employed within the anthropology of lactation and has often been paired with the examination of the interrelated processes of colonialism and capitalism. Colonial violence, genocide, and other efforts to control reproduction among enslaved and colonized populations played a key role in disrupting cultural breastfeeding knowledge and practices among Indigenous peoples. Primarily documented by historians, the violent family separations, forced breastfeeding and caregiving to infants that were not their own (i.e., “wet nursing” during slavery), and exploitive labor practices that interfered with lactation were characteristic of these systems (Jones-Rogers 2019; Roberts 1997; Theobald 2019; Glover and Cunningham 2011; Palmquist 2020). A crucial part of colonial efforts to regulate populations’ health included medicalization that undermined Indigenous knowledge and medical practices that sustained health, including lengthier periods of breastfeeding and responsive feeding (Hunt 1988; Glover and Cunningham 2011; Theobald 2019).

Anthropologists and historians have also described the undermining of breastfeeding by medicalized systems, especially in the context of the suppression/transformation of midwifery (Theobald
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2019; Glover and Cunningham 2011; Fraser 1998) and in relation to obstetric racism (Davis 2019). Obstetrics and gynecology in the US were built on the control of reproduction among enslaved people through violence, including experimentation on enslaved African women as a means to develop surgical techniques and instruments (Owens 2017). An outgrowth of medicalization rooted in colonization and slavery may be found in the history of US midwifery that explicitly targeted Black, Indigenous, and other ethnic minority communities in order to bring these midwives under the control of White nurses and physicians, ultimately marginalizing midwifery altogether (Fraser 1998; Theobald 2019). The medicalization of childbirth through obstetrics and gynecology had far-reaching effects in the movement of birth from homes to hospitals in many areas around the world (see Cheyney and Davis Floyd and El Kotni in this volume). Hospital births led to the systematic separation of mothers and infants and the regimentation of breastfeeding to a limited number of intervals, directly undermining the physiology of lactation and setting the stage for the promotion and distribution of commercial milk formula (CMF) (cf. Apple 1987; Dykes 2006).

A key element of the medicalization and capitalist transformation of breastfeeding is the hierarchical power relations wherein medical expert knowledge is valued over community knowledge shared by women as well as their embodied experiences. Ironically, this “expert” knowledge may claim to support breastfeeding while undermining it in practice. Millard (1990) documented the significance of the clock in pediatric advice that persisted throughout much of the twentieth century, and Whitaker’s (2000) historical account of fascist Italy provides another excellent case study, along with numerous other works from the US and UK (Leavitt 1988; Apple 1987; Golden 1996; Wolf 2001; Tomori 2018; Dykes 2006). Tomori’s (2014) ethnographic findings in the US reflect the historical legacies of medicalized breastfeeding promotion that treated breastfeeding and infant sleep as discrete processes (see also Rudzik, Tomori, Ball, and McKenna, this volume). Health professionals recommended breastfeeding with renewed vigor, but often provided inaccurate or contradictory advice that limited night-time proximity and regimented the frequency and timing of breastfeeding, which made breastfeeding difficult in practice.

Professional lactation supporters, or lactation consultants, play a complex role in medicalized approaches to lactation, particularly in hospitals. They provide skilled lactation support and often end up challenging the conceptualization of lactation and breastfeeding as health conditions, or diseases, that require medical interventions and how that acts to pathologize certain aspects of lactation. At the same time, lactation consultants’ attempts to gain authority within the medical system also leads to the further medicalization of lactation by, for example, managing lactation and breastfeeding issues with the use of medical devices, technologies, and medications (Palmquist et al. 2020). Torres (2013, 2014) has described this tension and duality between medicalization and de-medicalization of lactation support in biomedical settings. Furthermore, medicalization has led to training systems that privilege White, wealthier, cisgender women as the predominant members of this profession, which can perpetuate breastfeeding disparities and inequities in racialized and structurally marginalized groups. Racism, bias, and discrimination in healthcare settings translate into significantly disparate population-based breastfeeding rates by race/ethnicity (Robinson et al. 2019; Thomas 2018). Public health scholars have noted that receiving lactation support from healthcare providers that are culturally congruent and have similar lived experiences is particularly important for Black mothers in the US (Asiodu and Flakerud 2011; Asiodu et al. 2017; Kozhimannil et al. 2013), a population whose reproductive health is most negatively impacted by systemic racism (Davis 2019) that undermines equitable access to skilled lactation support (Thomas 2018). It was estimated in 2015 that only 27.9% of Black women in the US are breastfeeding at six months compared to 45.1% of white women (Jones et al. 2015). Too often, existing literature posits these disparities as the product of “a lack
of social, work, and cultural acceptance, language and literacy barriers, lack of maternal access to information that promotes and supports breastfeeding, acculturation, and lifestyle choices, including tobacco and alcohol use” (Jones et al., 2015: 189–190) without fully investigating the ways in which racism within the profession act to shape women’s experiences with lactation consultants (Paine 2013). It has been well documented that physicians and nurses offer less education on breastfeeding to Black patients (Beal, Kuhlthau, and Perrin 2003), setting up barriers to breastfeeding initiation and success from before birth. Asiodu and Flaskerund (2011) have described the ways in which women’s breastfeeding goals are undermined by social, economic, and medical practices outside of their control. Many of these experiences that result in breastfeeding as an early health disparity are reflected in the previously described barriers to support systems, either through professional lactation consultants or by trained breastfeeding peer counselors (Johnson et al. 2015).

These medicalized regimes associated with access to professionally trained lactation support (as distinct from skilled lactation support that may include peer counselors) stand in stark contrast with breastfeeding in cultures where it remains a normative practice supported by community knowledge. For instance, in Gottlieb’s (2004) ethnography of infancy of the Beng in Côte d’Ivoire, no one counts how many times infants are fed or the duration of each feeding. The infants are breastfed whenever they appear to need it and a breast is offered to soothe them when they are upset. Whereas feeding infants is often considered incompatible with other activities in Western settings, Beng mothers go about their day while carrying their infants. They sleep next to their infants and breastfeed them along the way as they need it. Moreover, they have traditionally received support from the community in the form of taking over labor for a period after birth in order to rest and recover, and others may breastfeed their infants while they are gone or carry them when they are in the fields as the babies grow. Importantly, growing poverty and changing capitalist labor regimes threatened these forms of community supports at the time of Gottlieb’s fieldwork.

The far-reaching influences of capitalism in medicalized breastfeeding

Penny Van Esterik (1989) has argued that a feature of medicalized/capitalist regimes of infant feeding is the increasing focus on human milk as a product of lactation rather than on the process of breastfeeding itself. Rudzik’s (2015) work in Brazil found that the medicalized, product-oriented conceptualization of breastfeeding displaced relational models and community knowledge, facilitated by the historical ties between medicine and the formula industry. This resulted in a limited understanding of the embodied process of lactation, an internalized language of capitalism production, and a sense of bodily inadequacy. Some mothers were able to restore a more intersubjective embodied approach through practice, but others were left feeling inadequate—as if their bodies were failed machines in the factory model of lactation.

Although Van Esterik has since refined her argument to highlight connections between human milk and breastfeeding (Van Esterik 2015), this fragmentation remains evident in the growing medical literature on human milk that treats this milk entirely abstracted from breastfeeding and the relationships in which it is a part. This process both reflects and reinforces structural conditions where women are expected to work apart from their babies, in the US with few if any paid accommodations (Hough, Prussing, and Applegate 2018). This results in an emphasis on lactation where during the day, mothers express milk via the breast pump. Ryan, Team, and Alexander (2013) have critiqued the growing emphasis on human milk expression (pumping) as a form of alienation, leading to a separation of breastfeeding and human milk. They argue that this alienation also facilitates the increasing medicalization and commodification of human milk,
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as evidenced by recent global trends to extract milk from LMIC countries for use elsewhere. Although human milk is increasingly viewed as a monetarily valuable commodity and therefore subject to great scientific-commercial interest, few anthropologists have examined its commodification in detail (Palmquist et al. 2019, 2020).

Medicalization, risk narratives, and moral obligations

In medicalized regimes of lactation, breastfeeding and human milk become incorporated into powerful narratives of “risks” and “benefits” that simultaneously idealize lactation and paradoxically portray it as a source of danger. Mothers primarily bear the weight of moral work to manage these perceived risks (Palmquist and Doehler 2015; Carter et al. 2015; Reyes-Foster and Carter 2018; Carter and Reyes-Foster 2020). In this system, enormous work needs to be done to “prove” the importance of lactation. Its value is constantly questioned in Western privileged settings, and its practice is “controversial.”

Much of the ethnographic work in these Western privileged settings shows that lactation is framed as an individual “choice” with the weight of moral responsibility to comply with health recommendations to breastfeed according to medical expectations shouldered by mothers (Faircloth 2013; Reyes-Foster and Carter 2018; Tomori 2014). There is little attention to the structural reasons why breastfeeding is challenging in certain settings, especially in the US where there is no paid parental leave, or in other settings such as China where these accommodations are limited (cf. Gottschang 2018; Wilson 2018; Falls 2017). Even where community knowledge transmission has been broken and people rely on medical experts who often have minimal knowledge of breastfeeding, the physical challenges of breastfeeding in a certain setting are treated as the consequences of women’s inadequate bodies rather than the result of insufficient structural and cultural support (López 2019). With limited or no insurance coverage provided, economic barriers often limit access to skilled lactation care in Western privileged settings.

Finally, cultural ideologies are often embedded in these biomedical risk narratives, lending authority to existing ambivalence about lactation. Lactation practices that align with biomedical assumptions may be more acceptable, while others are stigmatized (Tomori, Palmquist, and Dowling 2016; Wilson 2018; Falls 2017; López 2019; Walks 2018). These practices are quite frequent across cultures and history, but threaten dominant US assumptions about kinship (Palmquist 2015, 2020). They violate cultural expectations and the medicalized assumptions about breastfeeding, which often reflect and further regiment these ideologies.

Lactation, the state, and reproductive governance

Anthropologists have shown that biomedicalized capitalist concepts play a central role in health policy and public health guidance and have also highlighted the punitive power of the state when lactation practices are not aligned with health guidance. While the concept of reproductive governance has been productively employed in other areas of reproduction, especially in studies of Latin America, few scholars have applied these insights to lactation (López 2019). However, Fiona Dykes’ (2006) ethnography of breastfeeding in a UK hospital after the implementation of the Baby Friendly Hospital Initiative (BFHI) demonstrated the pervasive medicalized, capitalist approach to breastfeeding in an ostensibly supportive environment. For instance, staff used the language of “supply” and “demand,” and emphasis on timing and measurement remained central. Dykes’ findings played a key role in changing breastfeeding support in the UK towards a more mother–infant relationship–centered
model. Gottschang’s (2018) ethnography of the implementation of BFHI in China in the
1990s makes a similar critique about the pervasive medicalization of breastfeeding promotion.
Although breastfeeding was presented as “natural” by education materials in these hospitals,
it was presumed to necessitate medical intervention. Moreover, the educational material cen-
tered only on the infant and the moral obligations of mothers to provide “the best” for them,
yet mothers’ needs were often overlooked. The ethnography documents little actual skilled
support provided for breastfeeding.

Medical guidance on lactation also forms the basis of punitive state intervention when lac-
tation practices are deemed “risky.” Certain kinds of breastfeeding are prohibited by the state;
for example, in the US, breastfeeding a foster child or even intending to do so could sabotage
an adoption (Wilson 2018). Even as the properties of human milk are lauded, sharing human
milk informally (in contrast with receiving from and donating to milk banks) is deemed inher-
ently “dangerous” and “risky” regardless of its context. As a result, many individuals end up
hiding lactation practices that are stigmatized from health authorities, state agents, and even
family members and friends (Wilson 2018; Tomori et al. 2016). Families’ social position, in
turn, shapes whether they are able to successfully hide their practices or instead are policed and
punished by the state. White middle-class heterosexual couples are more able to navigate these
controversies than racialized groups, or LGBTQ families, for example.

On a broader scale, states regularly intervene in lactation practices when they are perceived
to conflict with other public health imperatives. Literature on breastfeeding in the context of
infectious disease further exemplifies these themes globally. Despite low levels of transmission
especially in the context of exclusive breastfeeding even before the introduction of antiretroviral
therapy (ART), breastfeeding mothers living with HIV were treated solely as a source of risk
for transmission without consideration of the consequences of not breastfeeding (Moland et al.
2010). The result was policies that prohibited breastfeeding and introduced infant formula in
settings with inconsistent access to the resources necessary for safe formula feeding, resulting in
more infant deaths and stigmatization of mothers who used breastmilk substitutes (Van Hollen
2011). Although the policy was reversed in 2010, the legacies of conflicting advice remain
(Desclaux and Alfieri 2015; Moland et al. 2010; Koricho et al. 2010). Moreover, breastfeeding
with HIV is still not recommended in the US even with ARTs—a policy that disproportio-
nately affects poor, racialized communities (Gross et al. 2019). Similar logics were manifest in
the implementation of COVID-19–related policies whereby hospitals in the early stages of the
pandemic routinely separated COVID+ mothers at birth from their newborn infants (Tomori
et al. 2020). These examples further highlight the contradictory stance of state policies towards
lactation. Despite its enormous impact on infant and maternal health, lactation is often not
prioritized and in fact is seen primarily as a potential source of danger and ultimately as easily
replaceable by CMF.

The manufacturing, industrial production, and predatory promotion of CMF have been
products were promoted not only within Euro-American settings, but taken all over the world
where they caused enormous damage by undermining breastfeeding and resulting in the deaths
of thousands of infants (Wolf 2001). Gottschang’s (2018) ethnography in China also presents a
wealth of ethnographic material on the pervasive manner by which formula company materi-
als infiltrated BFHI, which was explicitly designed to better support breastfeeding. Gottschang
notes that the state seems to have a conflicted relationship about breastfeeding—promoting it
on the one hand, while also supporting the expansion of formula companies in China. There
is little anthropological work on how state policies, international trade deals, and global health
entities shape how families engage with lactation—an important area of reproductive govern-
Challenging the biocapitalist model

In contrast to biocapitalist models of lactation, the sociocultural literature emphasizes that breastfeeding is involved in not only providing nourishment and protection from illness, but also in creating persons and reproducing family relationships. Ranging from classic works by Janet Carsten (1997) to more recent work by Palmquist, numerous ethnographies document that breastfeeding and communal lactation practices are one of the central ways of producing kin relationships (Palmquist 2015, 2020, 2018; Palmquist et al. 2019; Tomori 2014; Cassidy and El Tom 2015; Falls 2017; Wilson 2018; Van Esterik and O’Connor 2017). Although queer theory has played a limited role in the anthropology of lactation, Walks (2018) work also challenges biologized and heteronormative understandings of lactation in studying chestfeeding, an alternative term for breastfeeding used by some queer, transgender, and non-binary communities to consider lactation and infant feeding as a gender-fluid practice. Walks found that chestfeeding played a central role in producing kin relationships (Tomori 2014; Cassidy and Tom 2015; Falls 2017; Wilson 2018; Van Esterik and O’Connor 2017).

The rich recent anthropological literature on human milk sharing in the US has system-atically critiqued medicalized concepts of breastfeeding (Palmquist 2015; Reyes-Foster and Carter 2018; Falls 2017; Wilson 2018; Carter and Reyes-Foster 2020). Importantly, Palmquist’s work (2015, 2018, 2020) demonstrates that human milk sharing is a powerful way to challenge some of these narratives and to de-medicalize breastfeeding. She shows that human milk sharing is a “liminal practice, situated betwixt and between the extremes of medicalization and demedicalization” (2015: 36). Participants in this process resist medical definitions of breast milk as a “biohazard” full of danger and risk and enact an alternate model based on generosity, gratitude, and connection. In this process, they also challenge biologized understandings of breastfeeding, gender, and kinship. Similarly, Carter and Reyes-Foster’s (2020), Wilson’s (2018) and Fall’s (2017) ethnographies emphasize the forging of bonds through milk sharing and through a broad array of breastfeeding/lactation practices. The networks of bodily substance and relationships entailed in milk sharing also undermine the product/process binary that is associated with medicalized constructs of human milk (Palmquist 2018). Van Esterik’s and O’Connor’s (2017) recent work has reaffirmed the importance of centering nurture in the study of infant feeding.

Biological perspectives on lactation

To date, the contributions of biological anthropology to the study of human lactation have received limited attention within the anthropology of reproduction, especially in the context of lactation and infant development. Yet, biological anthropologists have produced a great deal of insight into the evolution of lactation in humans and non-human primates and how lactation impacts infant growth and development and maternal health in humans (Gribble et al. 2011; Quinn and Childs 2017; Martin et al. 2012; Miller and McConnell 2015) and non-human primates (Hinde and Milligan 2011; Bernstein and Hinde 2016; Power et al. 2017; Tilden and Oftedal 1997).

A key area of work in the biological anthropology of lactation has focused on the significance of breastfeeding in developmental programming. Developmental programming is the term for the ways in which exposures to programming stimuli result in changes to
the epigenome and/or behavior of the organism that in turn result in permanent changes to the phenotypes of an individual. Such changes or adaptations may contribute to human biological variation. The term is used to describe a myriad of exposures and outcomes; in humans, developmental programming is often associated with long-term changes to health and subsequent disease risk (see Kramer et al. and Thayer and Gildner in this volume). Prenatal exposures, indexed by measures such as birth weight, are frequently the focus of research linking birth size (especially low birth weight) to increased metabolic disease risk in later life (Knop et al. 2018). Although development programming has been conflated with biomedically defined health outcomes resulting from prenatal experiences, there is considerable evidence that in fact, developmental programming occurs across the entire continuum of pre- and postnatal experiences and is a key part of human biological adaptation and production of the adult form (Wells 2012; Kuzawa et al. 2010; Fried et al. 2017; Thayer and Kuzawa 2014).

Nutritional exposures, first through the placenta as indexed by birth weight and later through milk, are key programming mediums during these early critical periods (Kuzawa and Quinn 2009). However, developmental signals and nutritional exposures during breastfeeding have not been investigated as in depth as similar measures during gestation. Breastfeeding is actually a highly variable process, which may mean different metabolic exposures depending on length and intensity. However, under current biomedical research paradigms, research fails to consider the variation within breastfeeding (Gillman et al. 2001; Owen et al. 2005; Kramer and Greaves 2007), although there has been some attempt to include at least duration (Singhal et al. 2002; O’Tierney et al. 2009). The natural variations in breastfeeding behaviors such as frequency, exclusivity, and duration have instead largely been dichotomized into breastfed or formula-fed, reflecting the culturally specific belief systems (described earlier) for infant feeding.

The biomedicalized emphasis has primarily been on disease outcomes in later life, such as “protective” effects of breastfeeding against overweight/obesity, Type 2 diabetes, cardiovascular disease, and other metabolic diseases commonly associated with nutritional challenges during early life. In fact, it is not that breastfeeding has protective effects, but that formula feeding represents an increased risk of these metabolic disorders. Experimental designs in animal models have shown that key metabolic hormones in milk, are associated with metabolic programming and reduced disease risk (Vickers et al. 2005); observational studies in humans have shown that these hormones are associated with infant growth, especially weight gain (Miralles et al. 2006; Koletzko and Kries 2001). There is limited evidence that this early exposure to milk may have long-term impacts on later clinical health outcomes (Singhal et al. 2002; Meyer et al. 2017). Variation in milk’s nutritional and hormonal composition may provide the developmental stimuli for such metabolic programming; previously, Quinn (2016) has argued that because of the natural variation in milk hormones, their absence from commercial infant formula may (mis) signal maternal malnutrition leading to phenotypic changes in the infant. Kuziez et al. (2020) have also recently demonstrated not only that human milk is a programming stimulus, but also that there is good evidence that human milk itself is programmed by early nutritional and environmental exposures of the mother.

Much of the language around programming is heavily tied to capitalist frameworks of production (see earlier discussion). Moreover, the emphasis on outcomes of clinical significance (such as “obesity”) act to obfuscate the true continuous nature of the processes. This language reflects broader concerns that conceptualizing bodily processes in biomedical and capitalist frameworks obscures their complexity and may lead to problematic, ethnocentric analyses and conclusions.
Moving forward

Biocultural studies of lactation merit the same kind of sustained attention as the rich and diverse anthropological studies of fertility, pregnancy, or birth. While lactation has been largely an afterthought in the anthropology of reproduction, it is time to reclaim lactation’s place as integral to the anthropology of reproduction. In turn, the lens of reproduction can illuminate the social processes and ideologies that are reflected in our own disciplinary approaches to lactation and bridge perspectives across the subfields.

Existing literature highlights conflicted perspectives about lactation that are common in Western settings. On the one hand, the historical resurgence of breastfeeding has been partly driven by feminist movements. On the other hand, breastfeeding has also been the subject of extensive feminist critique because of concerns over gender-based oppression (see summaries in Tomori 2014; Wilson 2018; Tomori et al. 2018). Critics have also questioned the importance of breastfeeding for health and argued against the state-sponsored promotion of breastfeeding. Notably, this literature devotes little attention to the broader evolutionary, historical, and political-economic context of breastfeeding. Moreover, there is inadequate anthropological work on the infant formula industry, its marketing strategies, and the complex ways in which they are embedded in national and international governmental and nonprofit organizations and policies. Greenhalgh’s (2019a, 2019b) work on the International Life Sciences Institute, a nonprofit that serves to promote the interests of big food corporations in state policies (including CMF manufacturers), can serve as a model for this work. In a similar vein, there is insufficient anthropological work on the commodification of human milk and the exploitation of structurally marginalized and racialized communities around the world for the prized qualities of human milk (Palmquist 2019).

The global landscape of lactation beliefs and practices has been indelibly shaped by the colonial destruction of lifeways led by European and American powers, and subsequent oppression, resulting in contemporary inequities across the entire spectrum of reproduction and lactation. Yet, “breastfeeding disparities” are still often framed as an internal deficit in the contemporary public health literature (cf. Glover and Cunningham 2011). In social movements around the world, racialized populations have been fighting to reclaim breastfeeding traditions that were violently disrupted during colonialism and marginalized in postcolonial regimes (cf. Glover and Cunningham 2011; Cidro et al. 2018). These communities recognize breastfeeding as life-sustaining and a key part of attaining reproductive justice (Davis 2019; Ross 2006; Ross and Solinger 2017). This chapter is a call to action for a shift in anthropological research approaches to disrupt dominant tropes and “decolonize” lactation research (Asiodu and Palmquist 2019; Wilson 2018). This transformation is necessary for anthropology to avoid perpetuating neocolonial relationships and thereby to discontinue the reproduction of these power relationships.

Additionally, there is an urgent need to deepen anthropological engagement with intersectionality, critical race theory (CRT), and reproductive justice (RJ) (Davis 2019; Mullings and Wali 2001; Mullings and Shulz 2005; see Mullings this volume) in lactation research that addresses disability; queer and trans experiences with lactation especially among people of color; weaning; refugee/immigrant experiences; incarceration; substance use; balancing work and lactation among diverse groups; infants with special needs; and environmental exposures/environmental justice. The combined lenses of CRT/intersectionality and RJ and strengthen biocultural anthropological examinations of structures that perpetuate/reproduce inequities in diverse societies. Centering community voices, concerns and questions, and supporting anthropological scholarship by community members who have been traditionally subjects of anthropological research is a key step in this process.
Note

In this chapter, we use the term lactation to refer to the full range of topics pertaining to the physiology of milk production, feeding infants with human milk, and the scientific study of human milk, including, but not limited to, its evolutionary, ecological, sociocultural, historical, political-economic, comparative, and cross-cultural dimensions.

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