Breastfeeding with the Bronson Mothers’ Milk Bank

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BREASTFEEDING WITH THE BRONSON MOTHERS’ MILK BANK

by
MaryKate K. Bodnar

A thesis submitted to the Graduate College
in partial fulfillment of the requirements
for the degree of Master of Arts
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Bronson Methodist Hospital in Kalamazoo is home to one of only 15 certified breast milk banks in the United States. Women have shared breast milk for centuries through wet nurses, but this institutionalized and regulated version of sharing is distinct from previous forms. Breastfeeding has become a symbol of successful motherhood; donor milk adds a new dimension to this aspect of idealized motherhood. This study explores how the milk bank works: its organizational structure within a hospital, how donors are selected, and how recipients qualify for donor milk. It is grounded in Feminist and Medical Anthropology literature. Using semi-structured interviews and discourse analysis, I investigate how giving and using donated milk affects mothers’ understandings of their own femininity and motherhood. Ultimately, I find donated breast milk is a produced good, given with altruistic motivation, valued in economic terms, and monitored and distributed by medical authority.
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CHAPTER 1: INTRODUCTION

Bronson Methodist Hospital in Kalamazoo is home to one of only 15 certified breast milk banks in the United States. Women have shared breast milk for centuries through wet nurses, but this institutionalized and regulated version of sharing is distinct from previous forms. Breastfeeding has become a symbol of successful motherhood; donor milk adds a new dimension to this aspect of idealized motherhood.

This study explores how the milk bank works: its organizational structure within a hospital, how donors are selected, and how recipients qualify for donor milk. I investigate how giving and using donated milk affects mothers’ understandings of their own femininity and motherhood. I also explore how mothers think about the donated milk: Is it a gift or a produced commodity? Who are the donors and the recipients, and why did they find themselves in those positions? Though this is not a systematic analysis of class as it relates to breastfeeding, socioeconomics proved to be an important factor as donors must be able to afford the time and equipment to pump extra milk. Regardless of social position, women’s views of donor milk are shaped by a multitude of overlapping and competing factors.

Popular and medical discourses pressure that “breast is best” and that good mothers are “good producers” of breast milk. To ascertain how donor milk complicates this discourse and affects mothers’ breastfeeding experiences, I rely on Feminist and Medical Anthropology literature to explore 1) how medical authority and technology affects women making infant feeding decisions. 2) If donor milk is a commodity, like sperm and eggs or more of a gift, like blood. 3) Why breastfeeding is so integral to a mother’s sense of identity and success and what factors encourage and deter that success.
**Background**

*Milk Banking History*

Milk banks as we know them today are very new, and they started slowly over time. The first human milk bank opened in 1909 in Austria (Jones 2003). In the next ten years two more opened: one in Boston and one in Germany. The Human Milk Banking Association of North America (HMBANA) was not established until 1985 (Jones 2003). However, the idea of sharing breast milk is hardly new because wet nurses have been an option for middle- and upper class mothers for centuries. The most desirable wet nurses “were calm, of good disposition, disease free, did not eat too many sweets or drink alcoholic beverages” (Barness 1987:168). From the beginning donor milk has been evaluated using donors’ health and social reputation. The affluent could afford to hire wet nurses, but those not as wealthy used “animal milk, beer, gruels, and paps made from breads and water” when maternal nursing was not an option and prior to the development of formulas in the early 1900s (Barness 1987:168). These mixtures had a low success rate. This reminds us that from the very beginning social class affected infant feeding options.

In the 1920s the Shepphard-Towner Act (also known as the Maternity and Infancy Act) supplied states with matching federal funds for educational health programming and preventative mother and child care. “Shepphard-Towner funds were also used to establish ‘milk stations’ so that infants and children could access sterilized milk. While milk stations usually distributed sterilized cow milk; some communities also supplied pasteurized donated human milk for sick and premature infants to ensure their survival” (Arnold 2008: 221-222). It took a long time to arrive at institutionalized milk banking,
but American society has been experimenting with ways to redistribute breast milk beyond wet nurses for over a century.

**Brief Introduction to the Bronson Mothers’ Milk Bank**

The Bronson Mothers’ Milk Bank was founded by a Registered Nurse and lactation consultant in 2006 after two years of planning. It is a non-profit milk bank under the umbrella of the non-profit Bronson Hospital. In the beginning, a letter of support for the bank circulated among Bronson pediatricians and family practice physicians; each and every one of them signed it. Today Bronson employs seven lactation consultants for the Bronson Breastfeeding Center and seven staff members to process milk in the Bronson Mothers’ Milk Bank. They have local donors, but also receive shipments of donor milk from neighboring states, such as Indiana, Ohio, and Wisconsin. Likewise, the milk bank ships donor milk to 30 other neonatal intensive care units (NICUs) across the region. Those outside NICUs who order milk from the milk bank are required to pay the cost of processing the milk, which works out to be $4.00 an ounce plus shipping. It is because of these processing costs that donors are required to commit to giving a minimum of 200 ounces of milk over their time as a donor. Most recipients inside Bronson Hospital are not charged for the milk. It is considered a standard of patient care.

From its very conception in 2004, the Bronson Mothers’ Milk Bank has been affiliated with HMBANA. Bronson’s is the only HMBANA bank in the state. In 2010 HMBANA started an accreditation program and now annually assesses all member milk banks to ensure their standards and processes are upheld. Because the Bronson Mothers’ Milk Bank is housed within a hospital system, it is subject to inspections each year from
the FDA, the Center for Medicare/Medicaid Services (CMS), the Joint Commission, and
the Health Department, in addition to the HMBANA assessment.

Donors

To supply the milk bank with enough milk to support the Bronson NICU and
fulfill orders to regional ones, Bronson maintains about 150 donors at any one time.
According to milk bank staff, more of the donors are regional (shipping in milk) than
local (within reasonable driving distance to drop off milk). However, most of them are
still from the state of Michigan. The Milk Bank supervisor hopes that a new advertising
and awareness campaign from Bronson’s communications department will help them
acquire more local donors, but she was careful to acknowledge that they do have many
local donors already. As they dispense more milk to more and more NICUs, they simply
need more milk coming in. Until this year, all donors were recruited from word of mouth
or Internet referrals. Currently many women find the Bronson Mothers’ Milk Bank by
Google-ing “milk donation” and navigating HMBANA’s webpage. The milk bank itself
has a webpage too, and part of the communication plan is to make it more “enticing and
user-friendly.”

Mothers who choose to donate milk are screened with a questionnaire similar to
one used for blood donors. It includes questions about sexual history and drug use. If they
are considered a viable candidate, they then undergo a blood screening for communicable
diseases. Bronson pays for all lab tests for their donors, including the HIV testing
required every three months by the state of Michigan. The bank makes sure that a
mother is only donating if she has extra milk to give by obtaining written permission from
her primary care physician and her baby’s pediatrician. This strategy is not always
effective. I will later discuss how many women are making extra milk by pumping specifically for the bank, instead of donating left over milk stocked in their freezer. Some mothers donate the minimum 200 ounces, and others have donated as much as 3000 ounces. There is a great range in individual productivity and how it relates to an individual baby’s needs.

Milk Processing

Donated milk is pooled and pasteurized in large batches after it is analyzed for caloric content and distribution of protein, fat, and lactose. Part of the reason for pooling is to increase caloric content. A 22 calorie/oz. milk and a 18 calorie/oz. milk mix together to make a 20 calorie/oz. milk. If donor milk is for the NICU, higher calorie milk, between 20 and 24 calories/oz., is selected and bottled into smaller volumes. Milk for healthier outpatient babies can have fewer calories because they tolerate larger volumes per feeding. Each portioned bottle is sealed with foil, like the seal on an over-the-counter medication bottle. Then the bottles are placed in the automatic pasteurizer. It fills with water that is heated to 62.5 degrees Celsius for 30 minutes. Even pasteurized donor milk offers some immune system benefits, according to a Bronson neonatologist. However, in the pasteurization process some of the immunological proteins are killed along with the “bad” bacteria. This makes donor milk second to unpasteurized own mothers’ milk.

The processed bottles are labeled with a batch number, a bar code, the caloric content, the date it was pasteurized, and the date it expires. Before any of it can be dispensed, one sample is sent to the lab, and it has to come back with a clean negative culture (no dangerous bacteria). Donor milk for Bronson is dispensed from the milk bank
directly. Any donor milk shipped out of the hospital is overnighted in coolers Monday-
Thursday.

Mothers pumping for their own babies in the NICU turn their milk over to the milk bank staff so it can be packaged for dose feeding, but it is not pasteurized and is kept separately from donor milk. Bronson’s new barcode unit dose feeding system ensures accuracy in matching a mother’s milk to her baby in the NICU. Apparently there have been problems across the country making sure that the milk a mother gives to the NICU actually reaches her baby and not someone else’s.

_Recipients_

Babies born prematurely and sent to the NICU are given first priority to receive donor milk, but occasionally it is available for outpatient babies as well. It just depends on the milk bank’s current supply. Mothers’ milk usually takes a few days to come in fully. Physicians will generally wait up to five days to supplement an infant’s own mother’s milk with either donor milk or formula, according to a Bronson NICU nurse and lactation consultant⁴. However, sometimes preemies, or even term babies with low blood sugar, need more nutrition more quickly than the mother can initially provide. This is where donor milk can “fill the gap.” The supervisor⁵ of the milk bank told me that the donor milk “has never been to replace own mothers’ milk. It’s been to supplement own mothers’ milk when there is not enough there.” A Bronson neonatologist⁶ in the NICU thinks of the milk as a resource for mothers who “can’t or won’t pump their own milk.”

Bronson policy is that every baby is entitled to free donor milk up to 34 weeks gestational age regardless of why they may need it. Parents must sign a consent form before donor milk is dispensed to their baby. It may be used to supplement own mothers’
milk while the mother works to build up supply by pumping. Anything the mother produces is given to the baby before supplementing with donor milk, even if it is just a few drops the baby suckles from a cotton swab. A mother who elects not to pump or breastfeed at all may request donor milk, and the neonatologists will write a prescription for it up to 34 weeks gestational age.

Depending upon supply, donor milk may be available to outpatient term babies and babies in the NICU beyond 34 weeks gestational age. Any milk distributed in-house at Bronson is offered free of charge. Sometimes babies are sent home with a small portion of donor milk while mother’s milk is slow in coming. Donor milk is occasionally for sale for mothers who want to supplement with it beyond discharge, or for situations like adoptive infants. However, the milk is $4.00 an ounce and only available when supply is abundant. In my interviews with recipient mothers and Bronson staff, the mother’s demonstration of breastfeeding effort also seems to factor into her eligibility for donor milk.

Vision for this Study

Donor human milk banks are a new phenomenon, and little is written about them at this point. So far most of the existing literature includes instructive and regulatory material for best practices for the establishment of a donor human milk bank. The subject lends itself to study by Anthropologists and other social scientists because it involves important cultural norms and values about the body, bodily substances, medicine, and motherhood. Though we should remember that even breastfeeding in general, without the new element of milk banks, has been slower to catch scholars’ attention than other aspects of motherhood, such as childbirth. Marilyn Porter and Diana L. Gustafson tell us
in *Reproducing Women*, “feminists have not taken up the issue of breastfeeding with the same fervor with which they have challenged other medicalized moments in women’s reproductive lives” (Porter & Gustafson 2012:107). As an anthropologist who strives to advocate for women, I take this as a call to action. In writing about the new milk banks, I also use theory from feminist sociologists and anthropologists to illuminate what milk banks mean in the context of breastfeeding as part of the motherhood experience. Breastfeeding is embodied and personal, but lactating women are judged against standards of morality and success largely determined by public discourse and medical authority.

American cultural values of motherhood drive public sentiment and medical rhetoric regarding breastfeeding. Breastfeeding and its connotations are tied to larger issues of morality and identity for mothers; so is donor milk. Mothers make feeding decisions under the influence of a myriad of competing forces like resources, employment, familial support, medical authority, and biology. Donor milk adds another layer to this already complex piece of motherhood, but the underlying tones of morality and medical authority remain. The seemingly new piece to the discussion is the question of donor milk’s status as a gift or a produced commodity. I use literature about blood banking and the markets for egg and sperm to contextualize the debate. However, milk banking is unique because it is forever tied to the contested and gendered realm of motherhood. Donor milk is a product, but it is also a gift. It can be given for the *right* reasons and sold for the *wrong* ones. The medical field fights to retain control over access to processed donor milk, yet some women continue to share milk informally with one another. The exchange of human milk exposes 1) medical authority’s continued attempts
to regulate women’s bodies 2) questions of commoditizing the body, and 3) the moral aspects of breastfeeding and motherhood.

Notes for Chapter 1
1 There are only 15 Human Milk Banking Association of North America (HMBANA) breast milk banks in the United States.
2 The current supervisor of both the Bronson Breastfeeding Center and the milk bank founded the Bronson Mothers’ Milk Bank. She has the following credentials: RNC, BSN, IBCLC.
3 Michigan is the only state in the U.S. to require HIV testing every three months.
4 All informant names have been changed to pseudonyms to ensure anonymity. Erica (Bronson employee), interviewed by MaryKate K. Bodnar (author), February 12, 2015.
5 Milk Bank Supervisor, interviewed by MaryKate K. Bodnar (author), February 4, 2015.
6 All informant names have been changed to pseudonyms to ensure anonymity. Dr. LeFebvre (Bronson employee), interviewed by MaryKate K. Bodnar (author), April 8, 2015.
CHAPTER 2: RESEARCH DESIGN

Research Orientation

Because breastfeeding is such a charged topic that touches on the identity of mothers and their perceived success fulfilling this role, I wanted to investigate how the milk bank interacts with this important aspect of motherhood. Throughout the study, I kept a pulse on the narratives and language women used to explain milk donation. Like blood banks, milk banks are regulated and donors are registered, so their “products” are screened for quality. Though milk sharing is a centuries old phenomenon, the institutional organization of the milk sharing is new. This study uncovered complex discourses relating to sociological and anthropological interpretations of altruism, cultural mores of motherhood, gift versus commodity, and biomedical authority.

I sought to learn what makes milk donation different from other biological donations and banking experiences, but I used the existing literature on moral motherhood, the value of bodily substances, and medical authority as a platform from which to start. The themes that emerge from the maternal literature are the image construction of good mothers as breastfeeding mothers, the taboo of the breast, and the authority of biomedical advice. Each of these themes surfaced during interviews with study participants. The literature on bodily fluid regulation and banking helped me frame the debate about breast milk’s status as either a produced commodity or an altruistic gift. Ever-present in all of this literature is the power of medical authority and rhetoric, which encourages particular ways of viewing women, motherhood, and breast milk in each historical moment.

Because the language of production is often involved in the discussion of women’s bodies and health, I was not surprised when women used production terms to
describe their experiences with breastfeeding and the milk bank. I was, however, taken
aback at the consistency with which both donors and recipient mothers used production
language to evaluate their own breastfeeding success. Therefore, I chose to investigate
donor and recipient experiences as if they were in dialogue with one another; they are
mutually constitutive sides of the same coin. Study participants indirectly discussed the
question of donated milk’s status as either a gift or a produced commodity. Women
openly shared their interpretations of the milk’s value, but it was more difficult than I
previously conceived it would be to place it firmly in either category. Still, themes
uncovered in the literature on blood banking and the market for eggs helped me explore
the question thoroughly. This short chapter is simply meant to give an overview of my
guiding research inquiries and a glimpse into how I frame my analysis. For a complete
list of research questions, please see Appendix A.

Study Design

I recruited and interviewed three separate groups of participants: employees of
Bronson connected with the milk bank, women who donate milk, and mothers of infants
who receive donated milk. I obtained both WMU and Bronson HSIRB approval (see
Appendix E) for this study and all protocols were respected. Because breastfeeding
information is considered health information, participants had to sign a HIPPA release as
part of their informed consent form (see Appendix D). The resulting five-page length of
the informed consent document did cause some raised eyebrows at the start of interview
meetings, but the necessity of discussing HIPPA protected information did not deter any
potential subjects from signing on as participants. All informants are represented in this
work with pseudonyms. Some women chose their own pseudonyms; when none was requested, I assigned a random one.

I conducted semi-structured interviews with all subjects. I started with my prepared list of questions for that particular study group (see Appendix B), but I followed up with individualized and clarifying questions when appropriate. Willingness to have the interview voice-recorded was not a study requirement, but each of the 12 study participants agreed to it, which meant I was able to analyze each transcript in detail after the interview was completed.

Recruiting

Recruiting proved to be the biggest challenge to conducting this study. I kept a locked drop box in the hallway outside the milk bank in which potential participants could drop off a slip of paper containing their first name and either their phone number or email address.

Recruitment drop box with flyers
Photos by MaryKate K. Bodnar

Recruitment flyer included in Appendix D
I checked this box regularly and followed up with interested women to schedule interviews. This method only resulted in a few interviews though. Women do not spend any significant amount of time at the actual milk bank. It is in the basement of the hospital, one floor below the Breastfeeding Center. Women drop off milk at the doorway to the milk bank as only authorized personnel are allowed inside. Many of these donors have small children with them and drop off quickly. The milk bank also receives much of their milk via UPS, overnighted from donors who live far away. So my flyers and box had limited reach. I posted flyers in the lactation consult rooms as well. My contact information and a study invite were included in informational donor packets that are sent to potential donors too. Mothers of young children tend to know other mothers of young children, and so snowball recruiting occurred throughout the course of the study.

The supervisor of the milk bank was wonderfully supportive of the study and distributed flyers to patients on the mother-baby unit and in the NICU as a push to recruit more recipient mothers. This endeavor showed real commitment on her part to making this study successful, but it did not result any additional recipient mother interviews. No one method proved overwhelmingly fruitful, but some interviews resulted from each method.

Donors were easier to reach than recipient mothers. I interviewed six donors. They are the only women who would spend any time at the milk bank or see donor packets, but I believe this is only part of the reason I was able to interview only three recipient mothers. These numbers are a little skewed because I counted one woman twice, once in each category, because her first child received donor milk, and she later became a milk donor with both of her children.
Most recipient mothers have babies in the NICU, and all of them have heightened stress in their lives. Using donor milk qualifies them for inclusion in the study, but it also evidences that they likely want to produce enough of their own milk and cannot. The stress of trying to increase milk production, being separated from baby, and/or worrying about her ill newborn is stress enough without being bothered for an interview. Moreover, the donor milk is shipped to 30 different NICUs across the region. I did not have access to any of these recipients separated from Bronson by geography. Because of the difficulty I had reaching donors, I opened the study to recipient mothers who received milk directly from an acquaintance, hoping this would increase the numbers of recipient mothers who qualified for my study. Two donors I interviewed shared milk with people they knew, but only one out of the three contacts I obtained this way resulted in an interview. Of the two remaining recipient interviews, one was the woman who interviewed as both a recipient and a donor. The other was also a referral from a donor, and she used anonymous milk from the milk bank. Both of these women were interviewed well after a year had passed from when their infants received donor milk. We should remember that they had significant time to reflect on their donor milk experience by the time I asked them about it and were far removed from the initial stress of not having enough milk. I do not have a large enough sample size to draw broad conclusions; however, the recipient mothers I did speak to expressed frustration with their lack of milk. This frustration combined with the perception of breastfeeding as part of moral motherhood likely makes recipient mothers more reluctant to declare their eligibility for the study and talk about their lack of milk with a stranger. It is a painful experience for these mothers who want desperately to supply their babies with enough milk. It is very
plausible there were a number of women who qualified for the study as recipients, but chose not to participate out of stress and shame.

The supervisor of the milk bank and breastfeeding center largely organized the Bronson staff participants. I initially approached her while planning the study, and she was very enthusiastic about it from the start. She was happy to connect me with both the NICU lactation consultant and the neonatologist who originally requested the foundation of a milk bank. The only Bronson informant I recruited myself is a pediatric nurse whom I knew personally from an extra-curricular club. For a full list of participants please see Appendix C.
CHAPTER 3: CONTEXUALIZING LITERATURE & THEORY

Feminist Theory, Medical Authority, and Motherhood

*Medical Authority*

Infant feeding more generally and breastfeeding specifically have been subject to a turf war between medical practitioners and mothers since the late 19th century. Until the development of pediatrics, “infants were treated as little adults and were expected to respond to illness, nutrition, and discipline like adults” (Barness 1987:168). Rima D. Apple traces the turbulent history of infant nutrition and fight for control in *Mothers and Medicine: A Social History of Infant Feeding, 1890-1950*. Until the turn of the century, medical discourse presented a narrative that “Physicians had ‘surrendered’ the children, and especially babies, to the care of ‘old women’ and ‘uneducated nurses’” (Apple 1987:53). These so called “old women” and “uneducated nurses” were most likely midwives and skilled healers that supported fellow women. However, formally trained biomedical physicians wanted more clientele, so they painted women healers in a negative light and tried to convince the public that they could offer better services in their place (Ehrenreich & English 1973). To that end, the medical field developed the new sub-specialty of pediatrics, which grew out of a focus on infant nutrition. With new focus, physicians fought to win control of infant feeding decisions and methodology by “convincing the public and the manufacturers of infant foods that infant feeding was a medical function” (Apple 1987:54).

Physicians not only took an active role in policing and developing artificial or manufactured infant foods, they also disciplined women’s bodies for better breast milk outcomes. In Apples’ words, “practitioners took it upon themselves to teach mothers the
rules of healthy living” because “mothers who lacked exercise, or who were nervous or easily excited produced poor, possibly poisonous milk” (Apple 1987:56). While stress can reduce breast milk production, it certainly does not contaminate it. Medical authorities placed this false accusation upon poor mothers to push their own practices and to recruit consumers for the new formula market they were creating. Even though the breast milk was not actually made poisonous, women started to internalize this message.

The vulnerability of poor women’s bodies to notions of inadequacy and contamination is common in medical discourse across time and geographic space (see Tapias 2006, Howard & Millard 1997). This is part of the legacy left by medical authority and patriarchy, serving ruling class agendas and attempting to monitor and control the lower- and working classes.

**Scientific Motherhood & Targeting the Poor**

In the U.S. women were stripped of the autonomy to discern for themselves what the consequences of stress would be for their nursing infants. Medical authorities spelled it out clearly in the early 1900s when they stepped into the food certification realm, instituting standards for infant feeding. Medical practitioners partnered with dairy farmers to form the American Association of Medical Milk Commission in 1907, and the association held dairies to cleanliness and quality standards in order to use the commission’s certified milk label (Apple 1987:60). This seems like a public health initiative that might have helped all consumers, but social class was intricately linked to the degree of difference it made for people. Certified milk was quite expensive.

Moreover, it was urban, and likely poor, city dwellers whom doctors were most concerned about receiving alternative feeding methods because these women “have many
causes of excitement and fright, ‘which the [cow] is free from’” (Boston physician qtd. in Apple 1987:61). If urban women were not already stressed enough after being “educated” that their milk was likely sub-par, the stress of not being able to afford the approved alternative only added to the problem. The legacy of double-edged stress continues to plague working-class women today. Formula is very expensive, but so is pumping. The only way to express milk at work away from an infant is with a pump. This whole scenario is really only a viable option for women in high status positions, complete with a private space in which to pump and adequate time to use it. Again, the women in this situation are probably better able to afford alternatives anyway.

Physicians not only scared women out of using perfectly good breast milk, but they weren’t providing a very good substitute for it either. For instance, even if the certified cows were free from city stress, infants do not easily digest cows milk. Doctors “solved” this problem, not by encouraging breastfeeding, but by inventing formula. In the late 19th century Dr. Thomas Morgan Rotch invented the percentage method to mimic the protein, fat, and sugar content of human milk by mixing cream with certain fat percentages, milk sugar, and water or lime-water (Apple 1987:25). This is where the term “formula” comes from; doctors would consult mathematical formulas to calculate individual mixtures to suit individual infants’ needs (Barness 1987:169). This method was individualized and required constant tweaking which ensured that doctors remained in control of the infant feeding, and that their practices grew and remained profitable. Doctors knew that breast milk was good for infants, but they wanted a way to modernize, quantify, and hopefully “perfect” infant feeding under their supervision.
It seems peculiar that physicians focused on making precise formulas to match the merits of breast milk for individual infants, like their individual mothers’ bodies were already doing, instead of focusing on helping mothers successfully nurse their children. The reasons for this are two fold. First, physicians were never considered authorities on lactation. This area of women’s health was left to midwives until physicians systematically attacked the reputation of midwives and pushed them out of medicine (Ehrenreich & English 1973:23). Second, they had a profit motive to invest time in formula because they were working closely with patent food companies. By the 1930s and 1940s, doctors and patent food companies had collaborated to improve the quality and efficacy of formulas while also simplifying them, so they did not require individualized mathematical equations (Apple 1987:76). The simple formulas could have been administered by mothers, but by the 1930s, the American Medical Association made it policy to only put their seal of approval on infant foods that distributed feeding instructions directly to physicians instead of including them in consumer packaging (92); this ensured physicians remained in control and that infant feeding remained a medical issue.

*Consumerism & the Medical Market Share*

Physicians created the profitable subfield of obstetrics, complete with accessory endeavors like formula development, because their practices faced increasing competition as more people graduated with medical degrees without an accompanying increase of rich women to keep them in business (Ehrenreich & English 1973:23). Before creating human milk substitutes and declaring the poor in need of them, medical professionals insured their new exclusive authority by clearing the field of midwives. Midwives had been the
peoples’ healers; they were common women with tried-and-true practical knowledge, which would have helped mothers solve breastfeeding issues instead of resorting to the supposed superior alternatives (Ehrenreich & English 1973). The physicians were not better trained in lactation or often even in general medicine than lay healers at the turn of the 19th century, but the doctors were shrouded in “the mystique of science…beyond criticism, beyond regulation, very nearly beyond competition” which was coming into vogue as American culture became obsessed with modernizing, efficiency, and technology (Ehrenreich & English 1973:33). In 1910 half of American babies were born with attending midwives, supporting a $5 million dollar segment of the market that doctors wanted for themselves (33-34). The doctors also knew that “every poor woman who went to a midwife was one more case lost to academic teaching and research” (33). Because they wanted to expand their pool of patients beyond the wealthy, doctors villainized supposedly less competent midwives, and pushed for licensing laws that kept only themselves in practice.

Post WWII American culture further exerted new pressures upon mothers with the celebration of scientific motherhood, psychology-informed childrearing manuals, and a burgeoning consumer class. The economy was booming with an onslaught of consumer goods “needed” to furnish a modern technological, home, like vacuum cleaners, formula, and baby bottles. While the image of the 1950s idealized housewife included more time at home and more consumer goods, working-class women felt the widening gap between their means and the picture of successful motherhood (Kaledin 1984:64). Not only did they have to work outside the home, but growing suburbia meant fewer economic and employment opportunities for those left in the cities.
Medical professionals developing formula wanted to convince as many women as possible, especially poor women, perceived as unreliable and ignorant, that they were in need of formula with frequent medical supervision. Mid century physicians used this established medical authority to popularize artificial means of infant feeding, namely formula bottle-feeding under their supervision. The modern home in the fifties was supposed to be technologically efficient and full of consumer goods, all kept in happy harmony by the merry housewife. The burgeoning middle class still valued the industrialized home, but instead of blindly following scientific motherhood protocols as they might have in the twenties, women increasingly wanted to know why practices were recommended to them. Psychology, in addition to medicine, now informed popular childcare manuals. Dr. Spock became a household name as intense mothering in which a “mother’s job was to respond to baby’s emotional needs, gratify its wants, tolerate its regressions, stimulate its cognitive development, and, above all, to feel personally fulfilled in carrying this out” became the goal (Thurer 1994:248). This permissive model of childrearing was “in keeping with the mood of the decade, which was responding to the horrors of war, death camps, and poverty” (259). Understandable as it might be, this fashionable motherhood model left many women feeling like failures because they could not uphold its requirements.

While middle- and upper-class families might have been supported by the husbands’ income alone, this was not the norm as popular iconography would have us believe. Millions of women entered the work force in the fifties “not so much pursuing careers as helping to pay for a mortgage, a second car, or a major appliance” (Thurer 1994: 250). The modern products came at a cost, which did not always allow families to
live the ideal of having a stay-at-home mother and a technological home full of consumer goods. Whether they could afford to uphold the ideal or not, women were judged against the ubiquitous and often unrealistic assumption that modern happy homes included a happy housewife, explained here by Rima D. Apple:

[quote]
This disjuncture between popular image and lived experiences provided fuel for the mother-blaming of the postwar era, when social critics denounced women who stepped out of their traditional role for creating many of the problems of the day, such as juvenile delinquency, the decline of the American home, and even child mortality and morbidity. Such criticism could, in turn, intensify the lack of self-confidence some mothers felt about their childrearing and the belief that they needed maternal education.

Whether or not infant formula, baby advice books, and frequent doctor visits were in reasonable financial reach for a family, women were pressured to either continue pursuing these things, or face blame.

It seems strange on the surface that so many women in mid-century were quick to call a doctor for advice. In many ways, Spock’s popular manuals allowed more flexibility and encouraged more application of common sense than earlier childrearing models. In fact, years after publishing, Spock admitted that his work was infused with practical experiential advice supplied by his wife (Apple 2006:118). However, with the pressure of ensuing mother-blame, doctors’ warnings not to trust neighborly advice, the massive advertising of formula, cultural focus on home economics and maternal education, and post war boom moving women into expanding suburbs away from their friends and family, mothers had a plentitude of reasons to doubt themselves. Even when they did disagree with doctors or medical advice, women felt the need to validate their choices with medical advice from another source, such as Spock’s book (130).
[/quote]
The Women’s Health Movement

By the 1980s women had had enough, and feminists pushed back against medical authority in the realm of women’s health and reproductive choices. The women’s health movement focused on educating women not only about mothering, but about their own bodies and health. One of the goals was to “de-center the physician and empower the patient” which necessarily required a different relationship between mothers and their doctors (Apple 2006:125). Blum points out that feminists’ challenges to medical authority encouraged more autonomy in women’s conceptualization of pregnancy, childbirth, and breastfeeding through the use of mother-centered language. This sharply contrasted with the focus on the benefits of breastfeeding for infants, which had previously dominated discourse circulated by popular culture and by medical professionals (Blum 1993:297).

The movement tackled issues like access to abortion and birth control, family leave legislation, and breastfeeding. Feminists struggled with how to couch breastfeeding in the women’s health movement though because the culturally constructed meanings it brings to motherhood can be confining, but it is also an embodied experience exclusive to women. Many second wave feminists chose to celebrate breastfeeding as a beautiful, natural, and valuable female phenomenon in a moment when they were challenging the medicalized motherhood of mid-century America. Not all feminists embraced this perspective because it rested on biological difference and lent itself to “the straughtjacket of romanticized motherhood” (Blum 1993:300). However, Linda M. Blum argues that embracing breastfeeding as a positive differentiator helps create a discourse valuing unique contributions of women.
Women & Work

Women in the 1980s had multiple governmental and non-governmental organizations vying for their attention and passionate allegiance. Finally medical discourse was supportive of breastfeeding because of its natural health benefits for both mother and infant. However while they vocalized support for breastfeeding, they simultaneously allowed the free distribution of formula to mothers upon discharge from the hospital. Some of the feminist popular literature agreed with the pro-breast medical discourse, but the moment also encompassed discourses that urged women to free themselves from the confines of maternity and domesticity, including breastfeeding.

In the eighties women entered the workforce in large numbers, and unlike their predecessors in the fifties, these women sought fulfilling careers. Breastfeeding sentiment seems inconveniently inversely related to labor patterns as breastfeeding was strongly encouraged in the 1980s when many women were earnestly pursuing employment, and formula was popularly preferred between about 1940 and 1970 when middle-class women were expected to stay at home (Blum 1993:296). In reality though, breastfeeding is never a black and white decision, cleanly tied to work patterns or popular discourse. In any era, mothers make infant feeding decisions according to the limitations of the resources available to them.

Breastfeeding viability and success are tied to socio-economic status and employment. “In the United States, while 69.5% of mothers initiate breastfeeding, only 10% of mothers who work full-time are still breastfeeding babies at six months (though this figure rises to just below 30% for ‘stay-at-home mothers’”) (Boswell-Penc & Boyer qtd. in Gatrell 2011:110). Neither the figure for working mothers, nor the figure for stay-
at-home mothers is optimal, but it is clear that it is more difficult to mesh breastfeeding with outside employment. Some women work by choice, some out of necessity, and there is a great range in the degree of support for breastfeeding in their various workplaces. Some studies suggest “organizational antipathy towards breastfeeding stems from employers’ fears about women’s ‘leaky’ bodies which are regarded, by employers, as unreliable and unpredictable, in a way which does not apply to the bodies of male employees” (Gatrell 2011:113). Breast milk in this case is only one example of the fluids that society deems unacceptable. The fear of leaking women is ever present.

Deciding to breastfeed or to bottle-feed with formula is a largely social and cultural process. There is no perfect “if this, then that” formulation for predicting breastfeeding intentions and outcomes. What the literature does agree on is the vast range of influences upon new mothers while they are weighing the pros and cons of breastfeeding. Generally “mothers who do seek to breastfeed infants, or to express milk, within the workplace face hostility and discouragement” (Williams 2011:113). In addition to employers’ concerns about “leaky maternal bodies” already discussed, they may also object to potential distraction of the nursing or pumping mother and her fellow employees (Williams 2011:113). Even if employers are not opposed to breastfeeding in principle, not all places of employment are created equally when it comes to their conduciveness for breastfeeding or pumping. For example, women with less economic security or education may be forced to take jobs with less flexibility and privacy than their counterparts with white-collar jobs. Taking time to pump breast milk is more feasible in a private office with a door that locks and access to a refrigerator than on a busy factory floor or in a catering job with a rigid time-sensitive schedule.
Whether we see breast milk as a moral symbol of successful motherhood or an out of control leak depends on context and perspective. In the United States the controversy over breastfeeding in public stems from the dominant perception of the breast as sexualized, and our insistence that lactating women conceal it. Even if mothers work through the dual function of the breast and bravely breastfeed in public, they are often shamed for it. Society unfairly judges mothers against a double standard; they better be breastfeeding if they want to be considered good mothers, but we prefer not to catch them in the act.

_Morality in Motherhood_

Breastfeeding discourse is not a simple nutritional debate; if it were, it makes little sense that physicians spent so much time mid-century trying to emulate breast milk without actually promoting it. Breastfeeding debates are about motherhood, medicine, profit, and control. Breastfeeding today represents healthy, moral, and successful motherhood, just as bottle-feeding with formula in the 1920s-1950s represented scientific, moral, and successful motherhood. Today medical authority champions the health benefits of breastfeeding, and educated mothers agree with this pervasive rhetoric. But, if breast milk is ubiquitously referred to as the best option for infant feeding, mothers who employ other feeding methods are seemingly choosing an inferior option; thus infant feeding showcases an ethical decision to provide either the best, or something worse. In their assessment of previous studies, Williams et al. assert that “the notion of ‘choice’ in infant feeding, which was once framed as a decision between two equal alternatives, has increasingly become limited through constructions of a good mother/bad mother dichotomy” (Williams et al. 3013:341). Effectively this translates to: good
mothers breastfeed, and bad mothers bottle-feed with formula. This is not an arbitrary fact, but a social construction built over time as discourses are made popular and norms are decided upon and enforced. “What breastfeeding means is the result of a complex cultural mediation of many different factors” (Hausman 2003:3, emphasis in original), and these factors include things like the instructive literature and medical authority explored earlier.

Once a norm or a standard is set, women are ubiquitously judged against it, regardless of their reasoning in making their decision whether or not to breastfeed. If the good/bad dichotomy holds, it increases the emotional costs of choosing not to breastfeed. The more breastfeeding is made to seem a natural and common sense choice, the more vilified mothers who bottle-feed are made to feel. “Good” mothers in dominant American culture are mothers who submit to the “guidance of scientific advice and subjugate their own perspectives to those of authoritative experts” (Hausman 2003:3). Women who are increasingly pressured to breastfeed seem to be convinced of the health benefits, but “exclusive breastfeeding rates in many high income countries decline dramatically following birth and at six months are reported as being less than 20%” (Schmied et al. 2012:1). Women in these high-income countries are likely the most educated on the biomedical benefits of breast milk for babies, and they are certainly the most bombarded with the persuasive discourse. So why are they electing to stop breastfeeding before the six-month mark if they even begin at all? In addition to employment concerns discussed earlier, the literature suggests possible answers are: a lack of familial approval, social stigma, pain, difficulty establishing latch, perceived lack of self-efficacy, and reluctance to ask for help (Furman et al. 2013, Marshall & Godfrey 2011, Sandy et al. 2009,
Discourses pressure women from public/popular spheres of life as well as private/familial spheres, and women weigh advice and influence from these distinct areas differently, according to what and whom they most value.

Mothers elect bottle-feeding for a variety of reasons, but not all of them are philosophical. Many arrive at that decision after having very negative personal experiences with breastfeeding. These include insufficient milk flow, trouble establishing latch, sore nipples, and difficulty finding time and privacy to express milk. Breastfeeding experiences are not necessarily natural and the work of breastfeeding is dynamically challenging; it is useful to conceptualize it as a “practice specific to each act” instead of as “homogeneous experiences between women or even for one woman over time and place” (Bartlett 2005:23). Breastfeeding takes practice, and even the most dedicated of mothers will have some bad days; maybe she is sick, maybe the baby is sick, maybe the two are just not getting along that day. The pervasive medical discourse urges women to choose breast over formula, but it is incomplete in encouraging them with practical tips for working through difficulties after they start breastfeeding because it assumes the process is natural and consistent.

When experiences fall short of natural and consistent expectations, women may be reluctant to reach out for assistance because of those very expectations. Sally Mennill analyzes the tone used in What to Expect When You’re Expecting and finds that maternal literature pushes mothers to take a passive role when it comes to understanding their pregnant and maternal bodies, relying on medical authorities to make sense of them and control them (Mennill 2012:308). For example, in the “Postpartum: The First Week” chapter, the authors address the topic of engorged breasts. “Happily, the engorgement and
its distressing effects gradually diminish once a well-coordinated milk supply-and-demand system is established—within a matter of days” (Eisenberg et al. 1996:381). The supply-and-demand system is not just magically established. The mother and baby work together to build this schedule by appeasing each other’s mutually beneficial needs. Engorgement is a discomfort that mother and baby solve, not a fleeting ailment that just goes away as the passive text may suggest. The What to Expect When You’re Expecting series is a popular instruction manual for moms-to-be, so this passive tone has the potential to negatively affect women’s willingness to reach out for help. In “The Ninth Month” chapter, the authors state boldly “all combinations of breasts and nipples have the capacity to produce and dispense milk—the quantity and quality of which are not in the least dependent on outward appearance” (Eisenberg et al. 1996:266). True, mothers should not stare at their breasts and speculate whether or not they will work well for nursing. However, the large sweeping statement that “all combinations of breasts and nipples” can accommodate breastfeeding is false advertising. Some women have medical conditions like hypoplastic breast tissue, which limits milk production; some babies never establish latch, especially when mom has inverted nipples. Breastfeeding may not be as intuitive as first time mothers expected it would be based on the nature-laden discourse persuading them to adopt the behavior. Mennill makes a convincing argument that the What to Expect series makes women question their own bodies, instead of problem solving and working through the discomfort, when they do not maternally function as expected.
The Breast & Social Stigma

To fully understand mothers’ complex experiences with breastfeeding, we must step back and examine how they conceptualize their own breasts and how American society understands breasts more generally. Even though many women agree with the credo “breast is best,” conforming to it requires a sharp shift in the role their breasts play. Women’s breasts are discussed in popular discourse far more for their sexualized connotations than for their infant feeding functions. The taboo of public breastfeeding stems not from widespread disapproval of the act of breastfeeding itself, but from the scandal of exposing a sexualized body part. In “Indecent Exposure: Self-objectification and Young Women’s Attitudes Toward Breastfeeding,” Johnston-Robledo et al. use self-objectification theory to explain how women internalize the classification of their bodies as sexual objects, evaluating their own bodies’ appearance by using the perspective of an outside observer (Johnston-Robledo et al. 2007:430).

In an attempt to fulfill the perceived ideal sexual body, women self-objectify their physical bodies and “monitor or sanitize their bodies so that they conceal evidence of bodily functions, such as menstruation, that are viewed as disgusting and incompatible with physical attractiveness and sexual availability” (Johnston-Robledo et al. 2007:430). Breast milk is a natural secretion and evidences a “maternally successful” bodily function (Dworkin & Wachs 2004 qtd. in Johnston-Robledo et al. 2007:430), but maternal success and sexual success are considered mutually exclusive in popular culture. Some worry about the possible negative effects breastfeeding will have on their breasts’ shape, affecting sexual appeal later on. Others worry about the public display of the breast during breastfeeding as violating mores about sexual exposure (Johnston-Robledo et al.)
Regardless of how women vocalize their discomfort with breastfeeding, especially in public, much of it can be traced back to the relationship between the woman and her sexual understanding of her breasts.

The pressure for women to conceal their breasts when used for maternal purposes as opposed to sexual appeal is deep-rooted in American culture. Caroline Jane Gatrell discusses the concealment of feminine bodily fluids and actions by referencing the work of S. Kitzinger in “Breastfeeding Under the Blanket: Exploring the Tensions Between Health and Social Attitudes to Breastfeeding in the United States, Ireland and the United Kingdom” (Gatrell 2011). “Fluids that are ‘specifically female [such as] menstrual blood and amniotic fluid, [which are treated by others as if] offensive too…they are not only polluting but dangerous…From puberty onwards, girls are educated to be secretive and ashamed about [female bodily fluids]. All women’s body products are to be hidden’” (Kitzinger 2005 qtd. in Gatrell 2011:113). The shame and discomfort with women’s secretions has multiple consequences on women’s experiences with breastfeeding. The most obvious is the impression that the act itself should be concealed. This public sentiment is further enforced by the legal categorization of breastfeeding. For example, “only 15 of the 50 states in the U.S. have enacted legislation that makes breastfeeding exempt from public indecency laws, and only 32 states allow women to breastfeed anywhere in public” (Johnston-Robledo 2007:431). The fact that legislation is needed to distinguish breastfeeding as distinct from indecent exposure tells of the public’s inability to separate the breast from the realm of sexuality.
Commoditizing the Body

Medical authority discusses breast milk as a product, and feminists discuss breastfeeding as an embodied experience. Furthermore the medical community treats mechanical pumps and rubber nipples as equivalents to a literal baby-to-breast breastfeeding experience (Blum 1993:302). This product-versus-experience debate is principally what makes breastfeeding a “thorny issue” for feminists. “Although emphasizing breast milk as product rather than process devalues the mother, emphasizing the embodied interaction veers toward essentialism and the trap of exclusive motherhood” (Blum 1993:301). Perhaps this is why breastfeeding has been a less popular discussion topic with third wave feminist writers, many of whom abhor gendered discussions of difference. Breastfeeding is not an equal opportunity experience for all parents and caregivers because it is dependent upon biological sex, the condition of pregnancy, and resources determined by social class. In donation situations, the embodied experience of baby to breast is replaced with the mechanical action of pumping to provide an altruistic gift to another baby. Is donated milk always a gift? Or because it is purposefully produced and pumped is it a commodity? How do we ascertain its value? To explore these questions I rely on discourse about other shared and redistributed bodily substances, like blood and eggs.

Body Fluid Banking

The Bronson Mothers’ Milk Bank screens donors with questionnaires. Multiple milk donors and Bronson staff members described the questions as “similar to those used for blood donors.” The comparison is meaningful to potential donors and clarifies what will be expected of them because charitable blood donation is now relatively mainstream.
However, blood is not strictly a gift over a commodity. Richard M. Titmuss’ landmark 1971 study on blood donation “The Gift Relationship: From Human Blood to Social Policy” attempted to prove that the British system of voluntary blood donation was superior to any market driven system in which donors were paid (Steiner 2003:147). Titmuss investigated voluntarily donated blood and its counterpart taken from a paid donor and determined that the quality of the voluntarily donated blood was much better. Beyond the quality debate, the central question in this blood donation research is about the nature of fluids and tissues as either gifts offered out of altruism or commodities available for purchase.

Many scholars in the social sciences focus on blood donation through the economic vocabulary of “gift, commodity, value, and market,” Steiner reminds us that they use this economic language in a way distinct from the way that economists use it. “Blood is collected; in this it is different from the produced goods usually discussed by economists” (Steiner 2003:148). Steiner’s caution is useful: there is a difference between the market for consumer packaged goods and the market for bodily substances, even though we often discuss them in the same economic terms.

It is important to keep this distinction in mind because though economic theories and phenomena may seem useful analytical tools in this realm, blood has a more complicated value than other marketable goods: it involves symbolism, contested value, and political elements as well. All of this could be said of breast milk too. Breast milk is discussed in terms of being produced by pumping mothers, but it is donated to the milk bank much like blood is collected for blood banks. It is not sufficient to say that blood is a different kind of good because it is “collected” instead of “produced.” Bodies must
produce the blood before it is donated; we just do not discuss it this way. Though I cannot answer why it is the case, I do find it interesting that we use production discourse for milk, but not for blood, and collection discourse for blood, but not for milk. One possible explanation is that the expression of breast milk for donation is an active process, where blood donors are more passive, lying on a table while medical professionals collect their blood.

Furthermore, the collection of blood is complicated because donated blood is processed for separate parts such as plasma (Steiner 2003:151). Additionally plasma can be sold for profit. The organizational and industrial components of giving (Steiner 2003:151) and subsequent distribution of bodily fluids must not be overlooked. These aspects continually arise when we consider the political aspects of who is in charge of blood regulation, collection, and distribution as well. “The industrial dimension of blood transfusion and organ transplantation, closely linked to the technological content of medical therapy, profoundly modifies the terms of the gift/market debate” (Steiner 2003:153). Whom we trust to regulate, collect, and distribute blood is closely linked to their claims for how to use the blood and blood products. Again, the institutional and regulatory aspects of banking apply to breast milk just as they do to blood because multiple governmental and non-profit agencies inspect the milk bank each year, so they can store and dispense from the trusted sterile hospital environment.

The very need for massive amounts of donated blood rests in the fact that the medical field continually advances to find new uses for donated blood, better ways to collect and screen blood, and then connect these two ends of the exchange. Donated breast milk is only required because neonatologists and mothers deem it appropriate to
nourish babies when own mother’s milk is not available or adequate, and they have
applied pasteurization technology to it to ease any concerns about its transferability
between donor and recipient. Similar concerns regarding donated blood are also
addressed by testing it for contaminants and diseases after it is collected from a screened
donor. The tests happen in a lab far removed from the actual act of donating blood or
milk, but both remain personal substances. Blood is collected from individual bodies
connected to whole persons who develop ways of thinking about said blood and have
motivations for donating it. Johanne Charbonneau and Nathalie Y-Lang Tran interviewed
donors and non-donors about their conceptualization of the blood they gave (or didn’t
give) in “The symbolic roots of blood donation.” They start their paper like many papers
on blood donation and define an altruistic system for blood donation, such as the one
operating in Quebec where they conducted their study. “In an altruistic system, blood
donation is conceived as an act of civic responsibility intended for an unknown ‘Other,’
rather than one motivated by profit or social pressure” (Charbonneau & Tran 2013:173).
However just because the given blood is going to someone unknown does not necessarily
mean that the donor thinks of it with ambivalence. “The blood-related vocabulary never
designates only the liquid but invariably touches upon the religious, medical, military, or
political realms” (Charbonneau & Tran 2013:173). People relate to donated blood and
develop attitudes about giving it away in range of ways, but most of them mention some
level of altruistic giving.

Donated blood is never just an exchange between an individual donor and
individual recipient. In addition to involving institutional management described earlier,
the larger public has varying conceptions of blood donation as well. Hartwig Von
Schubert explains donated blood as crossing between public and private goods. A public good is something everyone can enjoy “with no subtraction from any other individual’s consumption of that good” (Von Schubert 1994:201). In effect, I can go to the hospital and receive a blood transfusion without taking that opportunity away from the patient next to me who is also able to use the blood bank. But as soon as the supply is exhausted by demand, competition necessarily comes into the picture. Blood once used becomes a private good because it cannot be simultaneously used by multiple individuals (Von Schubert 1994:202).

Market factors of supply and demand, even if a less than perfect economic analogy, play a large part in blood and milk banking and storage. “The supply of blood is finite, because only half of a population is medically eligible to give blood, the amount of blood one person can donate in a year is limited, and blood can be stored for only so long” (Von Schubert 1994:202). Breast milk is in even shorter supply because fewer people can provide it. Even though supply and demand is a constant struggle in blood banking, many people freely and regularly donate their blood as a gift. When they do this with the altruistic motivations defined above, they are not seeking repayment of any kind. Schubert challenges this notion though, stating that donated blood is “never just a gift.” Instead, he claims there is a “multidimensional social contract” that facilitates the transfer of blood (Von Schubert 1994:204). The social contract implies that people give blood under the assumption that others will give blood for them to use in a potential transfusion after an unforeseen accident in the distant future. Essentially this means we have an unspoken and widely accepted agreement with each other to give enough blood to supply
it for others, and in return they give blood to supply it to us. The idea is to give blood now because you may need it later; we all help each other out this way.

This is where the question of altruism is very interesting when applied to the milk bank. Women donate their milk as a “gift” even when options to sell it as a commodity are available through websites. Their altruism cannot be explained by a social contract like Von Schubert’s because as adults, these women will probably never need breast milk. Though it occasionally happens that a recipient mother turns into a donor, either later on in the recipient child’s infancy or with a subsequent pregnancy, this is not a norm. Only one of the donors I interviewed had a child who had child received donor milk. Breast milk may be banked and stored much like blood, but its relationship to altruism more closely resembles that of egg donation. Additionally, Milk and eggs both go exclusively to other reproducing people, as opposed to blood, which is made available to any patient in need.

Rene Almeling explains the forces at work in the market for eggs and sperm through three theoretical frameworks: 1) feminist discourse of sex and gender, 2) economic market factors of supply and demand, and 3) the medicalization of assisted reproduction. The market for eggs and sperm is distinct from other bodily commodities because these particular materials are reproductive, and the bodies that produce them are gendered, carrying cultural connotations and structural expectations associated with those respective genders (Almeling 2007: 323). In the end, Almeling finds that more altruistic language is used to recruit egg donors and conceptualize eggs as compared to sperm donors and sperm (326). While searching for donors, “both egg agencies and sperm banks place advertisements listing biological requirements (e.g., age), but egg agencies
emphasize [the opportunity to help other people conceive], while sperm banks portray donation as a job, an early distinction shaped by gendered stereotypes of parenthood that is maintained throughout” (Almeling 2007:336). Here again, the question of production is interesting: a woman is born with a finite number of eggs that can be collected while men can continually replenish or produce more sperm.

Because of this difference in availability and the fact that egg donation is far more invasive than sperm collection, egg donors are paid far more than sperm donors. For example, in 2007 egg donors were paid an average of $4,200, regardless of how many eggs are harvested (Almeling 2007: 320). Men were paid $50-$100 per “sample deemed acceptable based on sperm count and quality” (Almeling 2007:320). Granted, sperm donors usually have a yearlong contract, obligating them to provide a sample once or twice a week. So after a year of producing sperm, a man might catch up to the egg donor’s monetary gain, but women’s reproductive gametes are worth more monetarily. Despite this market valuation, egg and sperm corporations recruit sperm donors using advertising that focuses on monetary incentives. For example, many posters include “cartoonish illustrations of sperm, and some even joke that men can ‘get paid for what you’re already doing’” (Almeling 2007:325). They also place advertisements and sperm bank locations close to universities to attract “cash-strapped college students” (325). These same agencies recruit egg donors with advertisements that urge women to consider the other in need of her precious eggs. “The egg agencies adorn their advertisements with images of plump babies and appeal to the joys of ‘helping’ infertile couples; some do not even list the amount donors will be paid” (326). This imagery is intended to appeal to women’s supposed nurturing nature and motherly instincts. The divergent advertisements
present a sentiment that women should *share* their eggs with others, while men can *sell* their sperm, even though both men and women are paid for their reproductive substances in institutional settings.

Sharing, selling, redistributing, or donating bodily substances is a moral affair, regulated by medical authority, and judged against cultural mores. Milk is produced, collected, donated, and distributed so it can serve as a gift and commodity simultaneously. The same four ounces of milk may seem like a product to a proud over-producer, or a painful reminder of a mother’s own insufficient milk supply once a milk bank exchanges the substance between the two parties. The donated milk is given as a gift, but mothers discuss “producing” it like they would a commodity. The production and commoditized language is characteristic of institutionalized banking and sharing of bodily substances. However, the weight of the words we use to discuss breast milk and thus the impact of breastfeeding and donor milk upon a mother’s identity are determined by cultural values of successful motherhood, which have long been influenced by medical authority over women’s bodies. The meaning of donor milk is significant, but it is also sometimes contradictory, between different stakeholders like recipients and donors. This study showcases the realities donors and recipient mothers face in their complex experiences with the Bronson Mothers’ Milk Bank.
CHAPTER 4: EQUIPMENT & PRODUCTION

Cora. My mother-in-law calls me a dairy cow.
Cora. My pump is a milking machine.

Breastfeeding is discussed as the moral and natural way to feed babies. The traditional conception of the nursing mother is a baby suckling at the breast. The technology of the breast pump changed breastfeeding by adding mechanical mediation between lactating mother and her infant. Pumping also complicates how women consider the image of an ideal breastfeeding mother. Pumps alter the moral focus on nursing by adding the idea that successful motherhood means the successful production of breast milk. Women in this study used the term “nursing” to discuss feeding a baby directly at the breast, but they considered both nursing and pumping as “breastfeeding.” Both baby-at-breast and mechanical pumping extract breast milk. However, milk production via pumping significantly changes what breastfeeding looks like for mother and baby and institutions.

Pumping is both a prerequisite to donation and the only way a mother can continue breastfeeding while working outside the home. When mothers talk about their pumping habits, they discuss the results of this production in volume. I could not separate quotes about pumping from quotes containing production language because the process of pumping and the production discourse are so inextricably linked. Women describe themselves as over- and under- producers, based on the volume of milk they pump, suggesting that they feel they need to achieve some standard for how much milk should be expressed while pumping. I will specifically revisit this production language later, but to understand the development of this discourse, we must first address the importance of
the equipment that is largely responsible for it. Later on, I will also explain how the advent of milk extraction was historically significant in transitioning from hiring wet-nurses as employees to acquiring breast milk first as commoditized product and then as an altruistic gift. What I want to focus on here is the active role pumps played in facilitating the discursive change to conceptualize women, not as breastfeeding mothers, but as producers of breast milk. Though I never planned to interview women specifically about pumping, the topic quickly proved to be important to women’s experiences with breastfeeding and milk donation. Pumping additionally served as an entry point to discuss socio-economic factors, such as employment and equipment costs, involved in infant feeding decisions.

Before breast milk can be frozen for future use at daycare or donation to the Bronson Mothers’ Milk Bank, it must first be expressed from the breast. Though this seems a rather self-evident statement, it is a truth that significantly influences who can become a milk donor. Moreover, access to a breast pump and the time and space required to use one greatly affects the success or failure of a mother to breastfeed her infant beyond maternity leave. As Megan Garber states in *The Atlantic* “A device that allows for mother and milk to be mechanically de-entangled from each other…helps breast milk to be transformed, essentially, from an intimacy to a commodity. The breast pump is a machine that makes human milk, in its way, marketable” (Garber 2013). The disentangling of mother and milk not only makes human milk marketable. Pumping offers mothers the freedom to feed babies breast milk when separated from their children. It allows mothers the option to feed their hospitalized infants breast milk through feeding tubes. Pumping allows other caretakers to share in the administering of feedings without
requiring formula substitution. It even creates a pool of milk donors who have expressed extra milk, which can then be made available for use by other babies in need of it. By “extra” milk, I mean to denote milk that is produced by a mother via pumping that her own infant does not consume. Breast pumps change the breastfeeding experience drastically (when women have access to them).

Manual breast pumps are available for as little as $30.00, and hands-free electric breast pumps can cost up to $400. The price range is wide, and the market for pumps is big enough to support several different brands with multiple models. Every woman I interviewed, donors and recipient mothers alike, talked about experiences with breast pumps, but none of them chose the manual option. The electric models are more convenient, easier to operate, and express milk more quickly, but they are also more expensive, barring some women from using them. The Affordable Care Act has changed this part of the breastfeeding equation by making breast pumps a mandatory part of insurance coverage. Erica is a lactation consultant and nurse in Bronson’s NICU, and she does her best to let women know about pump benefits available through their insurance providers. She said that most mothers can now get a “very decent pump. It’s about a $210 retail pump that is a perfect, very good pump” for free. For some women this makes breastfeeding past maternity leave an option for the first time. Other women are not affected by the change in coverage, even though they technically could be; multiple mothers I interviewed talked about buying their pumps out-of-pocket or receiving them as gifts because their insurance provider did not supply the specific pump that they wanted. Turning down a pump covered by insurance in order to purchase
another evidences the luxury of wealth necessary to make that choice. For mothers who are less well off, this legislation is a much more tangible game-changer.

In this study, pumps seemed most important to mothers who work outside the home. The working woman’s breastfeeding experience and feelings of success or failure in that endeavor are linked very closely with her access to a breast pump and a supportive work environment in which to use it regularly. For example, Cora was only able to become a donor with her fourth child because the Affordable Care Act mandated that her insurance company provide some kind of breast pump solution for her. She quit breastfeeding with her first two children because she could not afford a pump to keep her milk supply up after returning to her job as a manager at a fast food restaurant.

She knew what she was missing too because she had experience pumping to keep up supply when her first child spent a few days in the NICU due to meconium aspiration. Cora’s mother rented a pump from the Breastfeeding Center at Bronson, so she could keep her milk supply up while separated from the baby. She only had it for a week though because “[My mom] wasn’t made of money, and neither were we, so it had to go back.” She breastfed for seven weeks before she went back to work. The lack of a pump effectively decided the issue of how long she would breastfeed because she could not nurse her son while providing for him by working. She describes the experience of nursing her second son for only three weeks very similarly “I didn’t see the point I guess in trying to go until I went back to work when I was already having so many problems at three weeks.” With the inevitability of having to stop breastfeeding for her looming return to work, she felt too discouraged to work through the problems and pain she experienced while breastfeeding. To add insult to injury, making the switch to formula
made her feel depressed and without options until she had her third child and found a way to buy an affordable pump.

Cora bought a used pump from a woman who told her it had only been used for her children; it was only a couple of years old; and it was a really expensive model. Buying a used pump meant she was able to keep her third child on breast milk for seven months, even with the same job managing the fast food restaurant. Cora still experienced trouble with establishing a good latch, so about five weeks after the baby was born, she switched to exclusively pumping and bottle-feeding. In her own words:

It made sense to me. It only takes 10 minutes to pump, but it will take half an hour to feed the baby. Somebody else can feed the baby, and I can take 10 minutes to pump. I can keep taking care of the other two. I can do this.

Pumping milk gave Cora newfound freedom to feed her third baby what she felt was best while avoiding nursing frustrations, sharing the work of childcare, and working outside of the home.

Using a pump allowed her to not only feed her own child for seven months, but exclusive and frequent pumping built up an excess of milk. When she ran out of freezer room, an acquaintance suggested that she call the Bronson Mothers’ Milk bank. After a few successful donations, her biggest donation was declared un-usable because it came back with a positive culture for bacillus, a dangerous bacterium. In a period of four months she had successfully donated around 800 ounces of milk that tested clean before the final donation when the bacteria showed up. This last donation was 1000 ounces, and none of it could be distributed to other infants, nor could the milk bank return it to Cora. This experience combined with increasing home life stress and weakening pump suction ended her pumping endeavor. After this failed donation, she simply fed the baby what
was left in her own freezer for the remaining three months of breastfeeding. The milk bank informed her she could keep using the pump for her own daughter since she had not had an adverse reaction to the milk. However, the loss of the 1000 pumped ounces profoundly affected Cora. “It still just makes me feel sick thinking about all that milk that got thrown away. Between the stress of hearing such bad news and everything that was going on at home, yeah, that was pretty much the beginning of the end.”

Cora’s milk was rejected from the bank when it tested positive for bacteria. It is impossible to know where the contamination occurred: in processing, from a bacteria build up in the pump, from dirty hands setting up the pump, etc. But Bronson staff equated her contaminated milk with the use of a second-hand pump. Even though she had successfully donated 800 ounces before the bacteria showed up, Bronson blamed the pump for the issue and convinced Cora it was dangerous to use second-hand pumps. Multiple milk bank staff have used Cora’s story (without referencing her name) to educate me about the “dangers” of used pumps. Bronson tries to educate women about proper pump use and sterilization in distributed breastfeeding literature and their breastfeeding class, run by neonatal nurse and lactation consultant Erica. She tells her students “Please don’t use somebody else’s pump. It’s personal-use equipment. HIV, CMV\(^3\), HTLV\(^4\), and Hepatitis can all transfer through breast milk, and women and babies can get any of those diseases if infected breast milk is in their equipment.” When the price of new pumps is considered in combination with ignorance or ambiguity about the potential dangers of used ones, it is easy to understand why second-hand pumps may seem like a viable option. Even with the discouragement of the losing 1000 ounces
though, Cora kept a positive enough association with donating to become a milk donor again with her fourth child once her insurance provided a new pump.

When I asked how Cora learned her insurance would provide a pump, she explained that she never sought it out; the insurance company pursued her. She got a phone call from her insurance provider as part of her husband’s employer’s Life with Baby program. According to a press release about the program⁵:

The program is an initiative designed to give associates and their spouses personalized tools and education to help them have healthier pregnancies and infants. The comprehensive program touches on all phases of maternity, beginning with pre-pregnancy and continuing through prenatal, postpartum and child care. Throughout the phases, associates can receive immediate assistance from a registered nurse and materials tailored toward their individual needs.

The individualized care starts with a phone call from the insurance company after the first prenatal visit. Cora said, “One of the questions they asked me was ‘are you planning to breastfeeding?’ I explained about the pump and how I had one, but it wasn’t any good.”

Even though the pump was declared useless in the eyes of the milk bank, she said she couldn’t bring herself to throw it away. Perhaps her reluctance to discard the pump means she still viewed it as an expensive and valuable item even after she knew she couldn’t use it to donate. It was an item she had wanted through two pregnancies before being able to afford this used one. The insurance company answered her concerns by explaining they understood many positive statistics about breastfed babies becoming healthier babies, so they would provide a pump after the baby was born. She would just need to call and say the baby had been born, and they would send one directly to her. She responded with “Sure. I’ll take a free pump.” Cora was elated to have a pump. It would let her keep her fourth child on breast milk when she went back to work. She didn’t go back to work after
all but was still ecstatic about the pump. She had already developed a preference for pumping over nursing with her third child, and she additionally praised this pump as “saving me a fortune in formula.” Not only did the pump provide her own child with sustenance, but she regularly donates to the milk bank as well. At the time of the interview she had already donated almost 3000 ounces, and her fourth child was only four months old.

**Pumping & Employment**

Not all working mothers find the breast pump as freeing and convenient as Cora. I interviewed four mothers who are nurses: two donors and two recipient mothers. All of them described the nursing work environment as theoretically and technically supportive of pumping, but in practical reality, more difficult to achieve. Marms is a fulltime physician’s assistant who stopped breastfeeding about two weeks after returning to work from maternity leave. When asked if her employer was supportive of pumping at work she said:

> Well I didn’t do it at work. Probably they would give a 15 minute block. But the problem with our schedule is a 15 minute block isn’t really a 15 minute block. Patients show up at various times. I knew that it would be very stressful to try to do it at work. So I just did a morning and an evening pump.

Lactation consultant Erica said that in order to keep up a full milk supply and adequately feed a baby, the breast must be emptied at least eight times a day, be it via nursing or pumping. Marms was exclusively pumping and bottle-feeding for the three-month maternity leave because her child did not suckle at the breast. With only a morning and an evening pump and a fulltime job away from baby, it would have been nearly impossible for Marms to continue breastfeeding while working. Though her office would
have technically given her a 15 minute window for nursing, Marms felt that it was more of a formal nicety than an attainable reality. It is impossible to know if that was only Marms’ interpretation of their accommodation; if she works too hard to allow herself to take the breaks; or if her medical practice was actually incompatible with pumping. She said “I just weaned down on my pumping when I went back to work in the first couple of weeks. And then I had to stop. It was just too much.” Whatever the root cause, Marms felt she could not pump at work, and this contributed to her decision to stop breastfeeding at three months.

Claire⁷ is also a nurse who has struggled to pump at work. She is currently working in a sub-acute rehab unit as a nursing supervisor. She started as a fulltime nurse after having her second child and said, “It was stressful, and I was upset. Then while I was still breastfeeding him, I got the supervisor position. I got through the last couple months of breastfeeding him that way.” Like Marms, Claire finds the nursing environment difficult to combine with pumping. Nurses have to be responsive to changing situations and balance the many demands on their time. As a supervisor Claire is managing other nurses more than practicing hands-on patient care, and she finds this role more compatible with taking time out to pump. She said her employer is supportive. They provide a mother’s lounge space where she can go to pump. It is still a busy and dynamic environment though. She has to “make myself go” pump, “and that’s getting harder and harder to do at this point.” Claire does pump, but not more than absolutely necessary.

I really struggle to pump when I’m home. I don’t pump extra, like at all. My oldest sister does both [nursing and pumping], but I couldn’t do that. I wanted to do that because I think what she did is maintained the over-
fullness that you get initially after the baby’s born. She just pumped that right away and kept pumping that.

At the time of her interview Claire’s third and youngest child was 10 months old, and she was still breastfeeding, but needing to supplement with either formula or milk donated from her older sister Cora. She struggled to keep up supply with her second child as well and also supplemented with donated milk from her sister. They were nursing simultaneously, so she was able to fill the gap between her supply and her children’s appetites with her sister’s milk. She attributes her sister’s extra supply to extra pumping. Though she wanted a similar supply for herself, she did not feel she could attain it partly because she says she’s never been an “over-producer,” but also because of the difficulty to pump while working fulltime.

Two milk donors in the study also work as nurses. Molly is an E.R. nurse who works about one day a week. She is required to work 24 hours in a month and fills that time either with four or six hour partial shifts or a full 12 hour shift. She pumps at work with a successful enough yield to feed her baby and donate to the milk bank, but she said it is not easy to schedule pumping time in an emergency room.

We’ve got three women right now that are pumping at work. And we go when we can, and we balance the best we can. I would say I don’t pump as much as I would like to at work. But um, it’s not because they aren’t supportive of it. It’s just because of the environment that I’m in.

The fact that three employees are pumping in an emergency room environment evidences that the hospital they work for is supportive of their endeavor, but emergencies will never fit a rigid and inflexible schedule to consistently respect
pumping time. Fortunately for Molly, she is only subject to the demands of the emergency room about once a week.

Rachel is also a nurse who has managed to become a milk donor. She works 12-hour shifts and manages to pump four times a shift. This is no small task and takes advanced planning. Rachel explains, “I think it helps me prioritize and structure my day a little better. I say to myself, ‘I better get this done now because I’m going to have to pump.’” Rachel knows that her milk needs to be expressed at least every four hours, so she aims to pump every three hours, so that if she gets busy, and it is pushed into the fourth hour she is still ok. Though pumping while working as a nurse takes effort and intentionality on her part, she knows it affects her co-workers as well. “I would say the people it’s probably hardest on are my co-workers.” When they page her and ask for assistance, she often has to tell them, “sorry. I’m pumping. I’ll be out in 10 minutes.” Rachel shows real commitment to breastfeeding by sticking to her pump schedule even with the pressures of the medical environment, but it should be noted that this does not evidence a lesser demand on her time. She prioritizes pumping as an important demand on her time in addition to her nursing duties.

The milk donors I interviewed working outside of the medical field experienced far fewer challenges in pumping at work. Rin said, “I work for the federal government, so they know they have to give us time, and we get it.” It was interesting that she also clarified “It’s a mostly female office that I work in. Most of them have either been through it or know the drill.” She does not experience push back from her peers about pumping at work, nor does she worry about her milk stored in the office refrigerator. She at least partially associates this supportive environment with the fact that she works with
many women. It is not as though she has had negative experiences with men in the office regarding pumping, but she hinted at a sense of female camaraderie regarding breastfeeding. Rin’s breastfeeding story is not without it’s pumping challenges though. She said “As a mother who was going to go back to work, I should have pumped a little bit more” before returning to work from maternity leave. She called herself a “low producer,” and says this along with her lack of extra pumping put her “into situations where I had to start supplementing because I wasn’t making enough for what the baby wanted while separated from her.” This was a temporary issue as she now continues to donate to the milk bank and breastfeed her baby. Rin’s story proves that even with a supportive work environment, pumping enough to feed baby while working fulltime is a difficult task.

Samantha\textsuperscript{11} participated in this study while donating to the milk bank with her second child as a stay-at-home mom. She previously donated with her first child while working as an instructor at Western Michigan University. She insinuated that pro-breastfeeding sentiment in public policy ultimately quelled her supervisor’s negativity, but it was not an especially supportive environment for pumping. “My actual boss wasn’t very pro-children. But by the end of my pumping, the Affordable Care Act had been passed, and she said I could use a certain office to pump if I needed it.” Samantha did not suggest that working prevented her in any way from breastfeeding her child; she successfully nursed for two years. However, Samantha was extremely enthusiastic about breastfeeding, and it would take more than an apathetic work environment to keep her from achieving her breastfeeding goals.

\textit{Conclusion}
Breast pumps are breastfeeding tools. Like other tools, some use it religiously and others do not own one. There is a great range in how frequently women use pumps and the sentiment with which they consider the process. Some women prefer pumping to nursing. Some women hate pumping, but are obligated to pump if they want to continue breastfeeding after returning to work. Other women have enough access to their babies to never pump. Pumping preferences are predicated by a family’s ability to afford a pump and the mother’s employment.

The Affordable Care Act changes the breastfeeding picture by providing more women with breast pumps, but money is only one of many factors that influence the pumping experience. Whether women take advantage of this benefit is greatly dependent upon their wealth and the ferocity with which they want a certain pump. Some women view pumping as a time waster and others think it allows for better multitasking. Each woman balances nursing and pumping, according to the demands on her time. Her degree of control in the balancing act can be affected by factors such as income, environment, co-workers, older children, and her anatomy. Sweeping conclusions about the breast pump’s place in breastfeeding discourse would be ill-informed, but the complexity of its role in the equation, especially in relation to framing breastfeeding mothers as producers, is glaringly clear.

Notes for Chapter 4
1 All informant names have been changed to pseudonyms to ensure anonymity. Cora (milk donor), interviewed by MaryKate K. Bodnar (author), December 9, 2014.
2 Erica (Bronson employee), interviewed by MaryKate K. Bodnar (author), February 12, 2015.
3 Cytomegalovirus
4 Human T-Cell Lymphotropic Virus
Wal-Mart Stores, Inc.  

6 Marms (recipient mother), interviewed by MaryKate K. Bodnar (author), June 12, 2015.
7 Claire (recipient mother), interviewed by MaryKate K. Bodnar (author), January 30, 2015.
8 Molly (milk donor), interviewed by MaryKate K. Bodnar (author), March 19, 2015.
9 Rachel (milk donor), interviewed by MaryKate K. Bodnar (author), June 11, 2015.
10 Rin (milk donor), interviewed by MaryKate K. Bodnar (author), April 8, 2015.
11 Samantha (milk donor & recipient mother), interviewed by MaryKate K. Bodnar (author), November 25, 2014.
Breast milk and breastfeeding are discussed using economic production vocabulary. Women assess their breastfeeding success in terms of high- and low-“production.” Mothers not only judge productive success by their ability to satisfy their babies’ hunger, but by the volume of milk they express via breast pump, which they carefully record. Breastfeeding was once a source of employment and income: first for wet-nurses, and later for milk-sellers. The economic element of breast milk is still evidenced today in the value associated with milk donated as a gift. Over time, milk sharing became a part of an altruistic view of motherhood, but even the “gift” of donated milk is saturated in the language of production. Women are urged to give their milk away for free, but they talk about it in commoditized terms, acknowledging its rarity and significant value. While cultural norms dictate that moral mothers breastfeed, there is also a quantitative element to this standard. It is not enough anymore to just nurse her infant; successful mothers are bountiful producers. Women in this study spent almost as much time talking about themselves as producers of breast milk as they did mothers. They used the language of production to describe their breastfeeding experiences, demonstrating breast-milk-as-product sentiments that developed over time in American history.

**Historical Context of Wet-Nursing: Hiring a Person**

In the 18th and 19th centuries, poor mothers earned wages by working as wet-nurses, “weigh[ing] economic need against the health of their own babies” (Golden 1996:27). They earned money by feeding milk their own babies needed to other infants. Not all wet-nursing situations were the same, and a wide range of wages accompanied the circumstances. The best paid wet-nurses were hired by well-known and wealthy families
Sometimes the baby went to live with the wet-nurse; sometimes the wet-nurse lived with the family; and sometimes the wet-nurse worked for the city “Overseers of the Poor,” nursing orphans and abandoned infants (Golden 1996:30). Private jobs paid higher wages, but they also called for more particular standards. Historic records show that wet-nurses were hierarchically valued for a range of characteristics. For example, “private employers shunned women with older infants because their milk was ‘too old’” (Golden 1996:30). It is unfortunate that these women were deemed less desirable because they would have been most able to sacrifice breast milk as their older infants could tolerate other sustenance. Private employers in the 18th century were less likely than municipalities to hire non-white wet-nurses too (Golden 1996:30). As discussed in the literature review, all wet-nurses were employed based on their merits as seemingly upstanding and healthy women. Want ads used terms like, “full breasts of milk, of a healthy constitution, and good character” to advertise the kind of women sought for the role (Golden 1996:26). The woman not only had to provide nutrition to the infant, but also smoothly fit into the household “of a gentleman” without embarrassing or disturbing her employers. However, the most desirable wet-nurse did not have to worry about meshing with a household because she was employed while living in her own home, in a rural setting, where an infant could live-in and suckle. These rural arrangements were preferred because of the “beneficial effects of country living and parallel apprehensions about the detrimental influences of urban life” (Golden 1996:31). This sentiment echoes the perceived vulnerability of women’s bodies to contamination in city settings that spurred the earliest milk certification programs. Idealized clean country living made rural women the most desirable wet-nurses, but also the most expensive.
Whatever the wages, wet-nursing was an economic arrangement, classifying a lactating woman as an employee to some degree. Wet-nurses were hired workers, not sellers of milk. Two of the donors I interviewed for this study casually compared themselves to wet-nurses. Expressing milk to feed a baby other than her own, today’s donor mother is in a sense, a modern wet-nurse, but she approaches this “work” with no economic motive, and her experience is far more mediated than baby-to-breast wet-nurses who were employed by private homes, municipalities, and hospitals into the 19th century.

Donating: Milk as a Product

Today, breast milk quality is evaluated separately from the lactating mother, after it is removed from the breast. While women are screened before becoming donors, their milk can still be “contaminated” in pumping, bottling, or processing, so the milk itself is evaluated before it is distributed to infant recipients. Though the technology for collecting and evaluating the milk has developed, the decision to consider it as separate from the mother who provided it has been in place since the early 1900s.

Wet-nursing in America essentially ended as human milk was commoditized and re-conceptualized as “therapeutic merchandise” for use with medically “frail infants” in the early 1900s (Golden 1996:200). Once donor milk was bottled for use with sick infants, it was subject to medical distribution. The relationship between the lactating mother and another’s consuming infant was further mediated once women were no longer hired for service, but paid for the product of breast milk. It may seem like a slight distinction, but it sharply focused attention on the milk itself. No longer was the focus on the women providing the milk and their merits to do so, but instead, the popular and
medical discourse focused on the quality and necessity of the “product” they provided. American wet-nursing was essentially over, but even into the early 20th century, women could sell their breast milk to either milk collection agencies or new milk banks for a profit (Golden 1996). Working-class women saw this as a source of income, especially during the Great Depression (204). This trend was short-lived because public discourse later urged women to give the milk for free. As Golden says “the propriety of women selling something that babies needed for their survival began to be challenged during World War II, when blood donation started to be touted as a patriotic duty” (203). The idea was that women should be willing to give their milk to other babies if the country was pushing every able adult to give blood for their soldiers. Therefore, since mid-century, institutionalized milk banking has been based on altruistic giving, and public discourse encourages private milk sharing to be handled with altruism too. Though reality does not always match the ideal, and some women sell their milk to others, this is morally discouraged in popular discourse.

*Donating Milk: Embodied Process and Valued Product*

While many women in the study were aware of opportunities to sell their breast milk, either to other mothers privately or to improve formula research, none of them chose to do it. The overarching reason was simple: they wanted their milk to help other babies. This professed altruism also fits the dominant discourse that reproductively able women should voluntarily help other women as evidenced in the advertising strategies for egg agencies discussed earlier.

Five of the six donors I interviewed had some kind of connection to either the Bronson NICU or another NICU using Bronson milk. Three of the donors had infants
stay in the Bronson NICU after birth; one received donor milk while there. The fourth
donor mother had experience working as a nurse in a Grand Rapids NICU using Bronson
donor milk. The fifth donor mother had friends who relied on Bronson donor milk when
their own milk supply was lacking. These moms knew by experience or extension how
beneficial donor milk can be. The sixth donor mother I interviewed gave extra milk as a
tribute to twins she lost in an earlier miscarriage. All of the donors discussed the milk as
something very valuable and useful that they share in order to help nourish infants in
need. They used language that placed the milk in the category of gift, focusing on the
help it offered others. But their knowledge of its rarity and high price point in settings
where it is sold, evidences that they understood the milk could be seen as a commodity.

The perception of a need and the subsequent wish to fulfill it exemplifies C.
Daniel Batson’s Empathy-Altruism Hypothesis. The hypothesis states, “empathetic
concern produces altruistic motivation” (Batson 2011:11). I argue that the mothers in this
study donate milk because of altruism that was first inspired by empathetic concern for ill
and premature infants. When the mothers had extra milk to give, or even before they
were sure they would have extra, they considered the infants who needed it with feelings
of “sympathy, compassion, softheartedness, and tenderness” that typify empathic concern
(11). They subsequently gave the milk with the explicit goal of “increasing another’s
welfare,” classified as altruistic motivation (20). Though each of the motivations for
donating is altruistic, the women expressed them in uniquely personal ways.

Multiple women discussed how important it was to them that their milk actually
reach infants in need. Rin³ who donates as a tribute to her infants lost during an earlier
pregnancy wanted to do a “good deed to put some Faith⁴ and Grace” back into the world.
She was very intentional about finding an outlet for the milk that would fulfill this goal to her satisfaction, and had friends who relied on Bronson for donor milk. She told me “I never wanted to sell it…I like that it’s going to someone who is going to use it for babies, and not whatever else.” Her altruism was contingent upon the milk being put to moral, altruistic use, i.e. to feed sick infants. Cora has donated milk to the milk bank and directly to her sister. She initially looked into opportunities to sell her milk by searching online for “paid for breast milk” but was disappointed in the uses for purchased milk. She told me that it was either going to go to a formula company trying to replicate breast milk and improve their product, or to another mother in a private transaction. “My thing was, if you purchase it, you can afford to, but even if you can’t afford to, your baby still needs it.” She saw the potential for commoditizing breast milk, but she wanted to make sure her personal breast milk was only used as a gift for those in need. Cora wanted to help babies whose parents could not afford purchased donor milk, so Bronson’s policy of free donor milk for preemies satisfied her concern.

Samantha’s son received donor milk before her own milk came in. Now as a donor, she specifically pumps extra milk for the bank in addition to the supply she keeps for home use. She described this effort as “working for the milk bank.” In a strict sense, she is not working for the milk bank because she is not being compensated. However, the work allusion shows that she acknowledges her effort of pumping and donating as a productive endeavor; she is making a desired good for others, just as wage laborers do. It is a mixed metaphor because she feels much more warm and fuzzy about the milk than something mass-produced, and she is passionate about the unique nutrition it provides. Within this one donor’s story both altruistic and production language are used. In a way
they are mutually constitutive. Samantha is eager to give her milk with an altruistic attitude because of its scarcity, like that of a commoditized good. She produces the milk with not only her children, but with the milk bank, in mind. She wanted to start donating as soon as possible because “It’s for the preemies in the NICU, and the milk changes its composition over time. I had to get this early milk to them.” This mother was motivated not only by her own baby’s experience, but by the specific and time sensitive needs her gift could fulfill for preemies.

Samantha was not alone in focusing on the unique qualities donor milk provides that other charitable gifts cannot. Rachel gives milk because she feels it goes to better use there than sitting in her freezer.

“I may as well give it to [the milk bank], so they can use it…After learning how much better, how much more filled with nutrients and antibodies and good stuff…I just felt like NICU babies need this the most. So if I could give that to them, so they don’t have to have formula or whatever, then I’m happy to help.”

Rachel did not give her milk with ambivalence; she casually mentioned the milk “sitting in her freezer,” but it was her confidence that the milk would be put to good use that made her actually donate it. She wanted to help other babies; that is altruism in action. Specifically, she mentions the NICU babies, which shows her awareness of an institutional hierarchy in which sick babies are most deserving of donor milk. This shows her understanding of the high value and scarcity of her product. Rachel is consciously aware of the immunological benefits she can provide to babies in need.

Similarly, Molly’s story reminds us that only a very small subset of lactating mothers have extra milk to give. She donates milk as a way to fulfill her family’s goal to
“live intentionally for Christ, serving right where we are.” She told me, “I just feel like this is a way, being me, as a mom, that I can help other people.” Many babies in NICUs around the region need donated milk, and few women can provide it, so it was the perfect opportunity to serve needs “where [she was].” There is something unique about her identity as a mother that motivates her to help other mothers (and their babies); there is implied camaraderie here. The limited quantity of extra milk available and the small subset of mothers able to provide it both make the value of breast milk extremely high. Essentially, it is supply and demand that keeps the value of expressed breast milk high, but the donors perceive their unique capacity to help.

The use of economic discourse to describe lactation and milk sharing endures beyond the shift from wet-nursing, to milk-selling, and then milk-donating; to pump breast milk is to “produce” a very valuable good. Mothers donating milk in institutional settings, like the Bronson Mothers’ Milk Bank, have abstract ideas about the value of their breast milk. They know it is expensive for outpatients and that the babies who receive it really need it. They know it has special qualitative value because it is easily digested by babies and fosters immune system development. The Bronson Mothers’ Milk Bank staff knows the exact monetary value of donor milk because they calculate their milk processing costs and NICUs around the region pay $4.00/ounce for it, so the bank can break even. The realms of economic and the intrinsic value intersect in interesting ways in the processing of donor milk.

While donors are motivated to give their milk because of its unique healthful qualities, and as personal an accomplishment giving it might seem, the actual product that reaches babies in the NICU is far less natural and personal because it is pooled (generally
three to five donors in a batch, according to HMBANA) and pasteurized. Pieces of the
intrinsic value of breast milk remain, but the nature of its value changes. It is less
immunologically potent because of pasteurization. It is also a less intimate gift because it
is combined with milk from other women. For example, though Mandi made “two major
donations” to the milk bank to clear out her freezer, she found the three smaller donations
made directly to other women much more personal. She liked knowing the babies she
helped feed as opposed to the more institutional, anonymous milk bank donation. She
was clear that the milk bank personnel were never rude or intentionally cold, but the
hospital is a very sterile and institutional environment. She likes the personal nature of
the exchange where another baby drinks her intact bottled milk, as opposed to the pooled
and pasteurized mixture of milks provided to NICU babies.

Breastfeeding is embodied and personal, and this was especially important in
Mandi’s case. Mandi had hired a doula and written a birth plan. She was a health
conscious mother with very specific goals about how her delivery should go.
Unfortunately she went into labor prematurely and had an emergency C-section. She felt
robbed of an embodied and personal experience she had hoped to have more control over.
So when she found that her milk supply was abundant, she finally felt a sense of success
she had been missing before. She describes it this way:

There’s something [about breastfeeding] for me that was really healing
because I had my son not at all how I wanted. I wanted to have a natural
birth. I took this natural birthing class. It didn’t turn out at all like that.
And so there was a little bit of grief about that. So when I was able to
produce so much milk, there was something that was just like, ahh, I can
do some part of this and do it well. And not that I needed some kind of
accomplishment, but there was something for me that was really helpful in
the process of thinking, ok, I’m not a total...
Mandi caught herself before finishing her sentence with “total failure.” She continued “there was an irrational thought of feeling like a failure in some way by not being able to give him a natural birth.” The healing, embodied, and personal value of breast milk manifested itself most profoundly for Mandi when she nursed her own son and in the informal donations to acquaintances.

The healing and success language Mandi used to describe her breast milk production changed when she talked about formal milk donation. She was still very proud of the volume she was able to provide, but it was no longer personal. When I asked her if she ever thought about the recipients of her milk, Mandi told me, “Well what I understand is that it all goes into this larger container and is then pasteurized.” The pooling and pasteurizing alienated her embodied gift of milk into more of a commoditized product. She was still very conscious of the NICU need; she told me about thinking of all the babies she heard in the NICU when her own son was there. But she didn’t know them, and her milk would not be intact when it reached them; it would be mixed and pasteurized. She wondered if she would feel more personal about the milk bank donation if she saw more of the NICU babies while she was there, but Bronson’s NICU is divided into private rooms, so interaction between NICU parents is minimal. “It used to all be in one big room. So I thought about how different that would have been,” Mandi said. The institutional processing of milk has not deterred her pride in her ability to produce milk, but it has changed the way she thinks about it from a gift to an impersonal commoditized product.

Breastfeeding is personal, so not all women make the distinction between embodied personal donation and commoditized institutional donation like Mandi does.
Cora donated to the milk bank and gave milk informally to her sister. When I asked her which she preferred, she told me “I don’t feel any more warm and fuzzy about it than I would at the milk bank. But, you know, I feel pretty good about it. It’s something that I can do that somebody else can’t do.” For her, the exclusivity of producing something very few people can with a high enough volume to give it away, makes her proud, regardless of which infants receive her gift. Perhaps some women are just more ambivalent about institutional versus informal giving, but in the comparison of Mandi and Cora, I think there is more going on.

Cora discusses breastfeeding as an embodied experience, but she is equally pleased with the mechanical efficiency of pumping milk. She specifically pumps more milk than her baby needs in order to donate. She feels like nursing her fourth baby has been a really positive bonding experience. She said he strokes while nursing, “He’ll kind of just rub across me like, ‘Yup, yup, I’m good. I love you mom. Keep going. You’re doing good.’” But at the same time, she gets up between two and four times a night just to pump. She would not need to do this in order to feed her baby sufficiently; pumping keeps up enough supply to feed her own child and donate milk. Moreover, Cora pumps after feeding her baby each time. She hails the convenience of pumping because it is fast and lets her have more time to watch her other children. Mandi pumped when her son was in the NICU, then to have milk for him while she was at her part-time job, and finally because her supply was more than what he needed. They were all variations on necessity. She told me she thought of pumping as a “time-suck” because she would rather spend the time nursing her one child. So though pumping is very much linked to a woman’s breast milk supply, women rely on pumping to various degrees and for different
reasons. Some use pumping to consciously increase production and others begrudgingly pump to get rid of the milk they produce and their infants do not need.

**Receiving: Pressure to Produce**

Volume of production is not only a source of pride. For women who struggle to produce enough milk for their children, it can be a source of stress and shame. Claire\textsuperscript{10} is a full time nurse and mother of three. She received donor milk directly from her sister Cora with her second and third children. At one point in our interview she told me that supplementing breast milk with either formula or donor milk sometimes made her “feel like a failure.” Claire struggled with breastfeeding with all three children. She describes herself as “never having been an over-producer” and talked about the difficulty of keeping up enough milk supply to satisfy her infants. But she also describes herself as “possessive of breastfeeding.” She told me “I want to do it. I don’t want anyone to help me. But I have to…It’s so emotional for me, like extremely, extremely emotional for me. I don’t want to supplement at all, but at this point I have finally gotten ok with the fact that I have to.” Throughout our conversation, it seemed like Claire was trying to reassure herself and me that she had come to terms with supplementing, but I could still perceive it bothered her.

She talked about breastfeeding as “the most stressful thing in my whole life.” But in the same breath, she said “I absolutely love it, and it’s something that I looked forward to.” The battle that Claire faces is keeping up supply, especially while working full time as a nurse. She says that they are living “day by day,” pumping tomorrow’s milk at work each day, and it feels like a “constant struggle.” She went so far as to say that breastfeeding stress is a contributing factor to her and her husband’s decision not to have
any more children. Still, her third child was 10 months old at the time of the interview and getting multiple feedings of breast milk each day, even if supplemented. What was most interesting about the supplementation is that she did not seem to have much of a preference between supplementing with formula or her sister’s milk. Both were inferior to her own milk in her eyes. She said “I’m just really stubborn about it.” I don’t think she is “just stubborn.” Her possessiveness of infant feeding is a perfectly logical reaction to the long tradition in American society of assigning considerable moral value to maternal breastfeeding and using the language of production to evaluate success. Claire “wants to do it by herself” because she has internalized that this is the right way to feed her children. A good mother breastfeeds her baby; it is an embodied process. But quantity also matters; a good mother is an excellent producer, evidenced in the volume of product (breast milk).

Milk as Inventoried Product

The pride with which donors speak about giving and the frustration recipients feel about needing the help is often expressed in quantitative terms. Milk donation and the volume of production that predicates it often becomes a part of the identity of the women involved. They put significant time and effort into this volunteer work. They are purposeful about it and very conscious of production volume. Cora told me with pride that she keeps track of the ounces she donates (almost 3000 at last count). She uses an app on her phone to track how often she is nursing and pumping and on which breast. She also had a milk labeling and filing system in her freezer so all care-takers knew which milk should be used first. She went into great detail about how ramen noodle boxes work best to hold the bags in order and described it as “idiot-proof” it was so well organized.
Her sister Claire also keeps track of milk output and intake, but with a much more anxious attitude. She was trying to make sure she always had enough to feed her daughter and that no milk was wasted. She took an inventory each night of how much milk had been used during that workday, and then worked hard to keep up while pumping at work.

I would count how much was missing that day, so that I knew without having to say, or text my sister-in-law, “how much did she drink today?” Because my husband would never remember to ask. I’d come home, “how much did she have?” No body cares but me! And I’m here obsessing about this, you know? So I kept a log on the counter “milk at the end of the day” and how much was there, and I’d write it down.

She was “obsessing” about it because she did not want to have to supplement any more than necessary. She was trying to keep track of her daughter’s intake and match it as closely as possible with her milk production. Whether a proud donor or a stressed recipient, mothers talk about the volume of milk they make. When both groups talk about quantity they stop talking about themselves as mothers and describe themselves more as producers.

**Conclusion**

Regardless of how milk is expressed, where it is sent, or who consumes it, the value of breast milk is never overlooked. The personal exchanges Mandi experienced when giving milk to acquaintances did not involve pasteurization or an objective mathematic calculation to determine how much the milk is worth in dollars per ounce. However, recipient mothers in desperate need of the milk were very grateful for the precious substance they had been given and wanted to reciprocate with payment in some form. The recipient families wanted to thank Mandi for her gift. They offered to pay her, but Mandi was not comfortable with that. In exchange for her milk, Mandi got various gift cards, her driveway plowed of snow, babysitting, and home cooked meals. So though
the exchange is not strictly driven by an equation of the worth per ounce, the recipient families certainly felt they owed Mandi something in exchange for her milk even after she refused typical monetary compensation. The informal exchange of milk is accompanied by an informal valuation system. Mandi saw gift cards, food, and babysitting as more appropriate compensation than currency. Any compensation at all shows that the parties involved value the milk exchanged, but for some reason, Mandi felt discomfort in putting an actual cash value on the milk. She did not divulge why, but I would speculate that it felt like selling a piece of her, of her bodily fluids, which would be taboo and anti-altruistic. This way the exchange was more like a trade of favors.

Whether milk is processed by the milk bank and dispensed to other hospitals for a price, or traded for various other non-monetary gifts and services, milk sharing continues to entwine itself in various degrees of economic exchange. The nature of that exchange and who is in control of it seems to determine whether breast milk is a commodity or a gift in any given context. Ultimately women discuss breast milk in terms of their production of it, its value and scarcity (like a commodity), and the moral importance of altruistically giving it to those in need.

Notes for Chapter 5

1 Mothers were driven to wet-nursing by extreme poverty. Unfortunately, wet-nursing often resulted in the death of their own infants. Sometimes bereaved mothers became wet-nurses because “of circumstance: their own babies had died, leaving them free to suckle other women’s babies” (Golden 1996:98).
2 In formal, regulated, milk bank settings
3 Rin (milk donor), interviewed by MaryKate K. Bodnar (author), April 8, 2015.
4 The stillborn infants’ names were Faith and Grace.
5 (Cora milk donor), interviewed by MaryKate K. Bodnar (author), December 9, 2014.
6 Samantha (milk donor & recipient mother), interviewed by MaryKate K. Bodnar (author), November 25, 2014
7 Rachel (milk donor), interviewed by MaryKate K. Bodnar (author), June 11, 2015.
8 Molly (milk donor), interviewed by MaryKate K. Bodnar (author), March 19, 2015.
Mandi (milk donor), interviewed by MaryKate K. Bodnar (author), November 6, 2014.
Claire (recipient mother), interviewed by MaryKate K. Bodnar (author), January 30, 2015.
CHAPTER 6: MORALITY OF BREASTFEEDING

In popular and medical discourses, breastfeeding mothers are deemed “good mothers” while others are labeled worse mothers for using nutritionally inferior formula (Williams et al. 3013:341). In my literature review, I complicated this stark dichotomy by exploring the many factors that women consider while choosing an infant feeding method. In analyzing my data, I found quantitative milk production to be another part of perceived moral motherhood. A related theme that emerged in the interviews was effort; I found myself feeling empathy and respect for the mothers who could not breastfeed after trying to and facing significant adversity. Throughout the study, the concept of effort and determination came up in conversations with donors, recipient mothers, and medical staff as well. Here I want to consider how mothers conceptualize their own challenges and perseverance, and that of other mothers, within the harsh discursive environment surrounding breastfeeding. Not only are public discourses and medical professionals influencing how mothers feel about their success in that role, but their peers contribute to it as well. I also explore what constructions of moral donors and moral receivers look like.

Expectations & Effort

Popular and medical discourse tell mothers to breastfeed, but as we have seen in discursive analyses, such as Sally Mennill’s of *What to Expect When You’re Expecting* (Mennill 2012), this pressure comes with nature-laden language. Women are rarely prepared for difficulties that arise in the process of breastfeeding by what they hear and read. Here I want to introduce effort as another layer of moral motherhood as it pertains to breastfeeding; moral mothers try very earnestly and persistently to breastfeed even
when they run up against biological or circumstantial difficulties. My data suggest a sense that the public perception of the moral hierarchy is thus: the most moral mothers persevere through difficulties and successfully nurse their children. Next we have mothers who try very earnestly but with limited success. It is the mothers who do not even attempt breastfeeding that are subject to the most social and medical criticism. While many factors influence a mother’s success in breastfeeding, demonstration of effort greatly influences the medical and public assessment of her success as a mother.

Mandi is a very successful producer of breast milk and donated milk after her son was discharged from the NICU. This was an important piece of her identity and self-image as a good mother (see “Altruism & Production” chapter for details). It didn’t start this way; Mandi had to work for her breastfeeding success. Her experience fits the mold for successful and moral motherhood not only because she breastfed her own infant and donated to others, but because of her stick-to-it-iveness in the process. She discussed her friends’ breastfeeding experiences too, some of whom she shared milk with. Mandi feels there is a distinct difference between mothers who physically can’t breastfeed and those who she described as “giv[ing] up too easily.” She spoke very highly of her friends who gave up breastfeeding only after “having medical problems, taking supplements and being so determined to make it work.” She contrasted these diligent troubleshooters with women who say, “It’s not working. Screw it, let’s go to formula.” Mandi was careful not to dismiss the challenges of breastfeeding.

Her opinion about working on breastfeeding comes from a place of personal experience. “I continued to pump because…it was a long process of trying to figure out, trying to get him to learn how to eat.” Her son was in the NICU and originally too small
to breastfeed, so she slowly transitioned from pumping milk for distribution in a feeding tube, to breastfeeding. She partially contributes her success in making the transition to the accessibility of helpful lactation consultants. Mandi bonded with one lactation consultant in particular, “she just got in there, and I was like, please show me all the things to do. I have this preemie baby. I’m thinking I’m going to break him. And she was very hands on, so it was very good.” Mandi had to be open to receiving this help and put in significant hours of practice to get the results that she did. She got up in the morning, went to work, drove to the hospital, stayed as long as she could, went home to sleep, and started the cycle again the next day. Mandi allowed herself the vulnerability required to allow the lactation consultants access to her breasts and dedicated significant time to working on breastfeeding with her son, even when formula would have been more convenient. Mandi’s story is one of successful perseverance. For some mothers, their efforts are not as fruitful.

Marms is a physician’s assistant whose baby received donor milk for the first few days after birth. She was frustrated at how long it took for her milk to come in, saying “I thought there was something wrong with me and that it would never come in.” Multiple nurses that I talked to said it takes a few days for milk to really come in, but Marms had not received the message that this was normal; she was comparing herself to the idealized and natural-laden discourse. She was not naïve about all potential challenges though. One of the reasons she chose to deliver at Bronson was because of the milk bank; if she couldn’t use her own milk right away, she at least wanted the back-up of human donor milk. She planned “to nurse as long as possible. I really wanted to do it and thought it was important.” She told me that in reality, “It went terribly. He was born a
little bit preemie, so he wouldn’t latch, and I went to lactation consultant, after lactation consultant, and with no success. So I just pumped for about three months and then gave up.” Marms found her negative breastfeeding experience very frustrating “despite the best efforts,” she told me. So there is an implication here that if a mother is willing to put in the work, she should be able to expect good results; that was not her experience. She did not try any less than Mandi did; she just did not get the same results. Though effort may count toward morally upholding the role of “good mother,” it does not guarantee desired breastfeeding results that typify moral motherhood. Today Marm’s says that the experience “made me realize that breastfeeding is a lot harder than I initially thought it would be while pregnant. I changed from thinking of it as a natural thing to something that you really have to learn and work at.” Marm’s felt relief at the end of breastfeeding, or in her case pumping, because “it was so trying on me to keep it up. I tried not to feel guilt about it and tried to at least be positive about the three months he got my breast milk.” While she has a seemingly positive outlook on the results of her hard-fought breastfeeding accomplishments, she did say she “tried not to feel guilt,” implying a temptation to blame herself. This tendency likely stems from the popular and medical discourse about good mothers breastfeeding and the tendency to blame mothers when they stop (for more on mother-blame and guilt see Badinter 2012). However, she took comfort in the fact she kept pumping for three months. The effort she put in, including seeking out resources, may have also mitigated potential guilt about having to switch to formula.
Identity Consequences of “Failure”

Multiple women I spoke to had internalized the message that good mothers breastfeed their babies and are good producers, and they felt inadequate when they could not fit the mold. Cora is a mother of four and donated to the milk bank with her third and fourth children. She was not always so successful with breastfeeding though. She breastfed her first child for about seven weeks and her second for about three weeks.

Many aspects of Cora’s challenges with breastfeeding, such as pumping and conflicts with employment have already been covered, but here I want to highlight how she views the hard work of breastfeeding. When I asked Cora about her breastfeeding expectations and plans during pregnancy, she said:

I knew it was the best thing for the baby. And that was about it. There wasn’t a whole lot else that I already knew. I didn’t know it was going to hurt like the dickens. I didn’t know about getting swollen if you didn’t feed the baby. I didn’t know about let-down. I didn’t know about anything, except that it was the best thing for the baby, so that’s what I was going to try and do. And it wasn’t fun…

Cora’s expectations show that she internalized the “breast is best” message and that the discourse available to her left her uninformed about potential challenges and how to deal with them. I asked her when it got better, and she replied, “I didn’t keep going with them long enough for it to get any better.” Her remark suggests she believes more time working on breastfeeding would have produced better results. That was her experience with her third and fourth children. But with her first two children, she was very frustrated that she could not feasibly keep breastfeeding. Even if she was willing to put in more effort, she did not have the opportunity to:

It was horrible. I felt like, I mean, we couldn’t afford a pump, so there was no way I could go to work and have it keep going. We can’t go that long. It just wasn’t going to happen. You know financially I knew that there was
nothing else I could’ve done. There was no way I could’ve continued to be able to feed the boys. But um, ya know, you still feel like a pretty bad parent when you can’t keep doing that.

Cora worked as hard as she could within the confines of her resources and reality. She logically knew that she was out of time and money to make breastfeeding work when she had to return to her job. However, she had internalized the ideal that breast is best, so she felt like a “bad parent” when she couldn’t meet that standard. She could go so far as to explain why she had to stop too: there was no way to keep going without a pump. But knowing why she had to stop breastfeeding did not soften the blow it dealt to her conscience. Her disappointment was deeper than falling short of breastfeeding goals; she equated not breastfeeding with becoming a bad parent.

*Moral Receiving*

It is not only mothers who evaluate effort put into breastfeeding as part of what it means to fulfill successful motherhood. Medical professionals sometimes assess a mother’s effort when determining if her baby qualifies for donor milk; this precedent implies a moral component to receiving. Depending upon supply, donor milk may be available to outpatient term babies and babies in the NICU beyond 34 weeks gestational age (end of official policy eligibility). In my interviews with recipient mothers and Bronson staff, the mother’s demonstration of breastfeeding effort seems to factor into her eligibility for donor milk. Multiple times I was told stories about small amounts of free donor milk tiding mothers over while their milk came in, even for term babies, and even upon discharge. In each of these cases though, the mother specifically asked for the milk and was striving for a full milk supply with frequent feedings and pumping. Though the
milk bank has policies regarding who qualifies for milk, they are willing to bend those rules when the bank supply can support it and mothers are trying in earnest to produce. I gleaned from my interviews that there is a certain level of value judgment made by medical practitioners when deciding who does or does not qualify for donor milk. This demonstrates a moral component of milk receiving even if not crystalized in policy. Women prove themselves to be good mothers worthy of donor milk for an extended time if they demonstrate sufficient effort in pumping and breastfeeding (in the eyes of medical practitioners). Milk is distributed by the hospital milk bank, so the value judgments are made by its employees.

For example, I asked the NICU lactation consultant Erica if a mother could choose to pay for her baby to stay on donor milk past the 34 week cut-off, and she told me:

It’s usually $4.00 an ounce, so most do not. But these moms that are committed to using breast milk are usually pumping anyway. So if they’re really, really trying hard, and there is enough donor milk, then, and the moms are just begging the doctors to keep them on it, a lot of times the doctors and of course, the milk bank, this all has to work together. They will still allow some donor milk…It’s based…Each case is individual…

There are judgments being made by medical staff based not only on clinical need, but also on their perception of a mother’s dedication and effort in producing her own milk. These seeming exceptions to the rule are always dependent on supply too, but the frequency with which effort and intentions were mentioned did strike me. She continued:

You know I’ve had term twins, you know the moms are very sick, and they want to breastfeed like no tomorrow, and they are devastated because they are sick. I mean they are in trauma care or wherever: they are sick mamas. And they are doing the best they can. So for situations like that,
yes, if we have the supply, we’ve given them donor milk. Because we are trying to help; that’s the whole goal.

Erica did not present these moments of making judgments as cold clinical decisions, nor as favoritism. I got the distinct impression from Bronson staff that they are motivated by a desire to provide the best care they can for their infant patients. But I would be remiss if I did not highlight the phrases like “trying really hard,” “devastated by sickness,” and “begging the doctors” that surround the situations in which babies who are technically ineligible for donor milk continue to receive it. There is a complex construction of a moral recipient at work here. The idea of a moral recipient is not unique to breast milk; it is at work in some instances of organ donation as well (see Lock 2002). The moral recipient is constructed to prioritize and justify who gets the milk (or organs) because these bodily substances are framed as scarce commodities.

Identity Consequences of “Success”

Successful breastfeeding experiences are just as powerful as negative ones on a mother’s sense of successful motherhood, and the fortification of that piece of her identity as a woman. Mandi is very proud of her success in breastfeeding, especially in contrast to her difficult pregnancy. As discussed earlier, she found her breastfeeding prowess important to the healing process after such an emotionally draining birth experience when her son ended up in the NICU. Samantha was a recipient mother with her first child and later a donor with both her first and second. She describes the donor experience this way: “I’m really grateful I could do it. That’s a big deal to me because I do know people who really wanted to breastfeed and couldn’t…Because I know a lot of moms feel guilty, feel stressed, feel everything, and I didn’t have to go through that.”
only is Samantha proud that she could donate, but she tries to educate other expectant mothers about the opportunity to donate both milk and cord blood. She has taken on donating as a part of her identity. It is something she is proud of. She talked about herself as an “attachment mom” and “a little bit hippie, a little bit granola.” Samantha felt that milk sharing fit right in with this perception of her motherhood. She is so committed to donating that she located and researched the milk bank in Portland, Oregon in order to continue donating after her upcoming relocation.

**Purposeful Donation**

Many donors have internalized the productive ideal discussed earlier to the point that they have designated pumping schedules and systems in place to make milk specifically for the bank. Rin is getting up in the middle of the night just to pump three or four extra ounces specifically designated for the milk bank. She says it is a “slow go” to get to the minimum requirement of 200 ounces, but she is committed enough to doing it that she has dedicated time for it in the middle of her sleep schedule. When I asked her if she thought she would make it to the 200 ounce mark, she replied “I hope so. They basically make you promise in blood almost” and then laughed. This was the first time I heard a mother talk about the 200 ounce minimum as a concern. She is a volunteer donor, but it sounded like the minimum was a burden. When I said the bank could not accuse her of not trying, she replied, “haha. I don’t know if they care about the whole ‘how much you try’ aspect. But that’s definitely my goal.” I do not have enough data to explore this as much as I would like, nor do I know if her comment is representative. However, the contrast in the empathy with which the milk bank views recipients’ efforts and donors’ efforts in this vignette is striking. Rin is so dedicated to fulfilling her commitment to the
milk bank she said that “If I get to the point where my daughter will no longer nurse off me, which happened with my first one, then I will basically quickly get what I need, basically get to 200 ounces and go from there.” Even if nursing her daughter becomes a problem, she would still keep the commitment she made to the bank. That shows a remarkable level of purposeful dedication.

Donation changed how many women saw the act of pumping, and sometimes even motivated them to continue maternal nursing. They discussed how having to provide for the milk bank gave them extra reason to keep up their supply, which then helped them to continue nursing their own children. The stories of purposeful donation really struck me as I interviewed women. For example, Cora pumps for the milk bank after each time she nurses her son. Samantha was “pumping 25 ounces a day for the milk bank for a couple days while the milk was flooding.” This was in the very beginning of her daughter’s infancy too. I interviewed her just two weeks after having given birth. She could have just stocked up for her own child, but she was intentional about getting that milk to the bank. Molly told me “Pumping is not my favorite thing to do in the world, but I just feel like it has a purpose to it, so it makes it more joyful for me.” Rachel similarly told me that donating gives her additional motivation and accountability to keep breastfeeding. She said, “I want to go for a year, and if by 10 months I had 1000 ounces saved, I could just quit, and he could just eat that. But if I’m still pumping and donating, then it gives me a little bit of a reason to keep at it.” Basically, she will not have the option to use frozen milk and breastfeed her son past the point when her breasts stop producing because she will not have the necessary supply to do so; she will have given it to the milk bank. Donation gives mothers yet another sense of purpose in breastfeeding,
and I argue the volume-consciousness of it adds another level to the moral model of the breastfeeding mother.

Conclusion

Breastfeeding has solidly been a part of moral motherhood since the women’s health movement in the latter part of the 20th century. The opportunity to donate breast milk has given donor mothers another level of pride and purpose in their lactation. The availability of donor milk has given mothers the choice to use human milk when their own breastfeeding is not working out, but it does not absolve them from the shame associated with breastfeeding failure. Moreover, there is a moral component of receiving this milk. Medical authorities have set the parameters for who deserves milk and for how long. Breastfeeding effort is a part of this equation. Effort in breastfeeding does matter in how medical and public audiences judge the moral fortitude and success of mothers, but it does not guarantee desired lactation results. So while donor milk has affected the sentiments of pride and shame involved in breastfeeding, it has not expunged this moral component of infant feeding.

Notes for Chapter 6

1 All informant names have been changed to pseudonyms to ensure anonymity. Mandi (milk donor), interviewed by MaryKate K. Bodnar (author), November 6, 2014.
2 Marms (recipient mother), interviewed by MaryKate K. Bodnar (author), June 12, 2015.
3 Cora (milk donor), interviewed by MaryKate K. Bodnar (author), December 9, 2014.
4 Erica, RN, BSN, IBCLC (Bronson employee), interviewed by MaryKate K. Bodnar (author), February 12, 2015.
5 Samantha (milk donor & recipient mother), interviewed by MaryKate K. Bodnar (author), November 25, 2014.
6 Rin (milk donor), interviewed by MaryKate K. Bodnar (author), April 8, 2015.
7 Molly (milk donor), interviewed by MaryKate K. Bodnar (author), March 19, 2015.
8 Rachel (milk donor), interviewed by MaryKate K. Bodnar (author), June 11, 2015.
CHAPTER 7: CONCLUSION

Breastfeeding is an embodied and personal experience. For centuries women have supported each other as breastfeeding resources and even shared milk with each other. Original milk sharing started with hired wet-nurses: her whole person was considered, and based on her merits such as character and lifestyle, she was employed to nurse another woman’s infant. At the start of the 20th century, breast milk was sold after it had been expressed from the breast. It was rebranded as a medical substance under biomedical supervision and distribution. This milk selling was concurrent with the advent of pediatrics, the invention of formula and consequently popular scientific motherhood, and licensing laws that limited midwives’ ability to practice. Medical authority essentially commandeered infant feeding as a medical issue and worked diligently to convince mothers they should rely on medical advice for infant feeding instruction. By WWII, women were not only under the supervision of medical doctors when it came to infant feeding, but society at large was urging them to stop selling milk for a profit. Since mid-century, milk sharing has become an altruistic activity, with the paid alternative painted as morally repugnant as using formula is today.

The new institutionalized milk banks, like those associated with HMBANA, have maintained both medical authority and altruistic giving in the discourse surrounding breastfeeding and milk donation. Donated milk is supposed to be given altruistically with the intent to help other infants in need. However this same rhetoric includes allusions to the milk as a produced commodity: scarce, priced, valuable. The product is also subject to medical approval for cleanliness and quality (recall the pooling at Bronson Mothers’
Milk Bank to increase caloric content). The invention and popularity of the breast pump is what makes medical, moral, and production discourses compatible and perhaps mutually constitutive.

Mothers can increase and maintain successful milk production because of the pump; they are no longer limited to produce only what their babies consume. The expression of milk has been accompanied by a focus on the volume of production. No longer are moral mothers just breastfeeding mothers, they are also excellent *producers* of breast milk. Women in this study were so focused on their ability to produce milk and the volumes they recorded, that at times they stopped talking about themselves as mothers, or really even as people; they presented themselves as vessels of production.

Production can be a source of great pride for mothers with abundant enough supply to donate. It can also be a source of great stress for mothers who struggle to keep up enough milk supply to feed their own infants. Biology is of course a part of this equation. True, some women are capable of making more milk than others. But the language we use to discuss making breast milk is far from natural: it echoes production, manufacturing, and economic language. Women discussed themselves as natural over-under- high- and low- producers. Women evaluate themselves against the moral ideal of breastfeeding their infants, but also against a sense that they should be proficient producers of large volumes of milk. The morality of breastfeeding has expanded to include quantitative measures of success. The morality of receiving donor milk dictates that recipients truly *need* the milk and their mothers are working hard to increase their own milk supply. Effort is a sticky part of this moral puzzle; it qualifies some women’s infants to receive donor milk even past policy guidelines. However, effort is not always
considered for women who cannot breastfeed because of socioeconomic constraints, like unsupportive work environments or difficulty affording a pump.

The pride and shame women feel in regards to their breastfeeding success and challenges are now even more complicated by adding in the standard of production and the option to share milk institutionally. Women are urged to give extra milk away for free as a “gift” to help others. They internalize this altruism and do truly want to help babies in need. However, they are also aware of an anti-altruistic economic element that supports the scarcity and value of the product they give. The commoditized qualities of breast milk may actually persuade mothers to give it altruistically. Donated breast milk is a produced good, given with altruistic motivation, valued in economic terms, and monitored and distributed by medical authority.
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Wal-Mart Stores, Inc.  

Williams, Kate, Tim Kurz, Mark Summers, Shona Crabb  
Appendix A: Research Questions

- How does Bronson fit the milk bank into the larger hospital system, and how does the milk bank operate?
- How do women learn about the milk bank and breastfeeding center resources?
- How are donors recruited?
- How is the donation of milk similar to and different from blood or organ donation?
- Is donated breast milk a gift or a commodity?
- Why do mothers who have the ability to donate extra milk choose to do so?
- How do donors feel about the milk they donate to the milk bank?
  - Do they consider the recipient?
- How do mothers of infants who receive the donor milk think about the donor milk?
  - Do they consider the donor?
- Who has access to the donated milk through the milk bank?
  - What are the criteria for receiving milk?
  - Do recipients need a prescription? How does this vary across different recipient populations, such as adopted infants, infants in the NICU, outpatients, etc.
- What are the procedures for donation?
- How does the choice to use donor milk affect mothers’ own understanding of motherhood as they experience it?
- How does involvement with the milk bank alter breastfeeding experiences for both donors and mothers of recipients?
Appendix B: Interview Questions

A. For use with healthcare practitioners:
1. What is your role here at [insert healthcare organization/ Bronson Hospital department]?
2. What is your connection to the Bronson Mothers’ Milk Bank?
3. How do you feel about the milk bank?
4. How do you raise awareness about the Bronson Mothers’ Milk Bank among your patients?
5. What kinds of reactions do you get from those patients when they learn about the bank?
6. In your experience, why do the mothers of recipients of milk from the bank choose to utilize the milk bank?
7. In your experience, why do mothers who donate milk to the bank choose to do so?
8. How do potential donors approach you about the subject and what questions do they have?
9. How does the milk bank fit into the organization of Bronson Hospital?
10. How does the milk bank fund its operations?
11. What are the processes required for becoming a donor?
12. What are the processes required for acquiring donated milk?

B. For use with donors of breast milk:
1. How many children do you have and what are their ages?
2. What were your expectations and plans regarding breastfeeding when you were pregnant?
3. What were/ are your experiences with breastfeeding?
4. How did you learn about the Bronson Mothers’ Milk Bank?
5. How do you feel about the milk bank?
6. Why did you decide to donate milk?
7. How do you feel about the milk you donate?
8. Do you ever wonder about the recipient of your milk?
9. Does your connection with the milk bank affect your experience of motherhood? How so?

C. For use with mothers of milk recipients:
1. How many children do you have and what are their ages?
2. What were your expectations and plans regarding breastfeeding when you were pregnant?
3. What were/ are your experiences with breastfeeding?
4. How did you learn about the Bronson Mothers’ Milk Bank?
5. How do you feel about the milk bank?
6. Why did you decide to utilize the milk bank?
7. What do you think/how do you feel about the donated milk that your baby drinks?
8. Do you ever wonder about the donor?
9. Does your connection with the milk bank affect your experience of motherhood? How so?
Appendix C: Study Participants

Donors

Mandi\(^1\) has one child, aged 11 months old at the time of her interview. She has donated milk to the milk bank and informally to three individuals. She became a stay-at-home mother and quit her part-time job when her son was 10 months old. Her husband’s job at Western Michigan University became too inflexible to share the childcare load.

Cora\(^2\) has four children, aged eight, six, three, and four months at the time of the interview. She became a milk donor with her third and fourth, donating both to the milk bank and informally to her sister Claire. She worked as a manager at a fast food restaurant into her fourth pregnancy, but is now a stay-at-home mother. Her household also includes her mother-in-law and grandmother. They support the family on her husband’s salary. He is a manager of a local big-box store.

Molly\(^3\) has one five-month-old child. She works about one day a week as an Emergency Room nurse. She is a new milk donor, but learned about the milk bank when she did her clinical rotation for nursing school at a hospital NICU that uses milk ordered from Bronson.

Rin\(^4\) has two children, aged four years and seven months at the time of her interview. She became a milk donor with her youngest child. She works full-time for the federal government. She gets up in the middle of the night to pump extra milk in order to donate to the milk bank.

Rachel\(^5\) has two children, aged three years and five months at the time of the interview. She is a nurse with 12-hour shifts. With her youngest child, she became a donor for the milk bank. She describes herself as having developed a passion for breastfeeding while a regular attender at a breastfeeding support group.

\(^1\) All informant names have been changed to pseudonyms to ensure anonymity. Mandi (milk donor), interviewed by MaryKate K. Bodnar (author), November 6, 2014.
\(^2\) Cora (milk donor), interviewed by MaryKate K. Bodnar (author), December 9, 2014.
\(^3\) Molly (milk donor), interviewed by MaryKate K. Bodnar (author), March 19, 2015.
\(^4\) Rin (milk donor), interviewed by MaryKate K. Bodnar (author), April 8, 2015.
\(^5\) Rachel (milk donor), interviewed by MaryKate K. Bodnar (author), June 11, 2015.
Donor and Recipient Mother

Samantha is both a milk donor and a recipient mother. She relied on donor milk when her son, aged 2 and a half at the time of the interview, spent his first few days in the Bronson NICU. She pumped as well, but could not keep up with the quantity of breast milk her son was prescribed. Once her milk fully came in, she became a donor. She gave birth to her second child two weeks before the time of the interview, and was already donating again. Samantha worked as an instructor at Western Michigan University with her first child, but is now a stay-at-home mother. She describes herself as a “little bit of a hippie, granola” mother and looked forward to continuing her milk donation in Portland, Oregon after her upcoming relocation.

Recipient Mothers

Claire has three children, aged seven, four, and 10 months at the time of her interview. She struggled with milk supply for all three and received extra milk from her sister Cora to supplement her youngest two children. She works full-time as a nurse in a sub-acute rehab unit. Though she has had to supplement, her first child was breastfed for 12 months; her second for 14 months; and her third is still breastfeeding at 10 months.

Marms has one child, aged four years at the time of interview. Her child was born early, but did not stay in the NICU. She used donor milk for four days while waiting for her own milk to come in. She struggled with latch, so she exclusively pumped from five weeks after birth to three months, when she stopped breastfeeding and switched to formula.

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6 Samantha (milk donor & recipient mother), interviewed by MaryKate K. Bodnar (author), November 25, 2014.
7 Claire (recipient mother), interviewed by MaryKate K. Bodnar (author), January 30, 2015.
8 Marms (recipient mother), interviewed by MaryKate K. Bodnar (author), June 12, 2015.
The **Supervisor** of the Bronson Breastfeeding Center and the Bronson Mothers’ Milk Bank is Registered Nurse Certified (R.N.C.), a Bachelor of Science in Nursing (B.S.N.), and an International Board Certified Lactation Consultant (I.B.C.L.C.). She founded both the Breastfeeding Center and the Milk Bank and sat on the Human Milk Banking Association of North America, or HMBANA, executive board.

**Wendy** is a staff nurse in a pediatric primary care office within the Bronson system. She has a Bachelor of Science in Nursing (B.S.N.), is a Registered Nurse (R.N.), and a Certified Pediatric Nurse (C.P.N.). She is connected to the milk bank because she processes orders for donor milk when the pediatricians prescribe it. She also answers breastfeeding questions at the office and while working their triage phone. She also refers parents to the Bronson Breastfeeding Center when appropriate.

**Erica** is a neonatal nurse and lactation consultant for the Bronson NICU. She also teaches the Bronson Breastfeeding class. She is a registered nurse (R.N.), a B.S.N., and I.B.C.L.C. She has been with Bronson since 1988, with a nine-year break to raise her children between 1996 and 2003.

**Dr. LeFebvre** has been a neonatologist with the Bronson NICU for 28 years. He was also the first person to suggest starting a milk bank at Bronson and an important player in its creation. He is an M.D.

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9 Breastfeeding Center and Milk Bank Supervisor (Bronson employee), interviewed by MaryKate K. Bodnar (author), February 4, 2015.
10 Wendy (Bronson employee), interviewed by MaryKate K. Bodnar (author), February 6, 2015.
11 Erica (Bronson employee), interviewed by MaryKate K. Bodnar (author), February 12, 2015.
12 Dr. LeFebvre (Bronson employee), interviewed by MaryKate K. Bodnar (author), April 8, 2015.
Appendix D: Recruitment Flyer

Breastfeeding with the Bronson Mothers’ Milk Bank?
We would love your help!

The Study:
• explores breastfeeding and how it relates to ideas about motherhood
• looks at how milk is shared in Kalamazoo through the Bronson Mothers’ Milk Bank
• is part of a WMU master’s thesis

Who can participate:
• Mothers between the ages of 18 and 80
• who are now or have previously donated or received milk from the Bronson Mothers’ Milk Bank are invited to participate

What Happens:
1. All individuals interested in learning more about the study will be given an informed consent document to review. Individuals will have an opportunity to ask questions about the study. After reviewing the consent document, if individuals agree to participate they will be asked to sign the consent document prior to any data collection.
2. MaryKate K. Bodnar, a graduate student at Western Michigan University, will interview mothers about their experiences and ideas about donor milk.
3. The interview will take between 30-90 minutes and will be conducted in private; data will be kept confidential.
4. A voice recorder will be used only with your permission.
5. You may choose to not answer any question and you may stop participation at any time.

Interested?
Please fill out one of the informational slips provided and place it in the drop box.
OR contact MaryKate K. Bodnar at 810-923-8067 or marykate.k.bodnar@wmich.edu
Appendix E: HSIRB Approvals

Date: October 17, 2014

To: Ann Miles, Principal Investigator
    MaryKate Bodnar, Student Investigator for thesis

From: Amy Naugle, Ph.D., Chair

Re: HSIRB Project Number 14-07-09

This letter will serve as confirmation that the changes to your research project titled “Breastfeeding with the Bronson Mothers’ Milk Bank” requested in your memo received October 16, 2014 (to revise recruitment procedures, expand subject pool to include nurses, modify data protection in voice recordings, modify data retention procedures, and modify recruitment materials; consent document revised to reflect these changes) have been approved by the Human Subjects Institutional Review Board.

The conditions and the duration of this approval are specified in the Policies of Western Michigan University.

Please note that you may only conduct this research exactly in the form it was approved. You must seek specific board approval for any changes in this project. You must also seek reapproval if the project extends beyond the termination date noted below. In addition if there are any unanticipated adverse reactions or unanticipated events associated with the conduct of this research, you should immediately suspend the project and contact the Chair of the HSIRB for consultation.

The Board wishes you success in the pursuit of your research goals.

Approval Termination: July 23, 2015
October 9, 2014

Ann Miles, PhD
Department of Sociology
Western Michigan University
1903 W Michigan Ave
Kalamazoo MI 49008-5257

Dear Dr. Miles:

Subject: Protocol + Informed Consent ( Expedited Review)

Reference: BMH-2014-0738 "Breastfeeding with the Bronson Mothers’ Milk Bank"

This is your official notice that the referenced protocol has IRB approval; attached is the certificate of expedited approval signed by James W. Carter, MD, FACP, Chairman of the Bronson Methodist Hospital Institutional Review Board (IRB).

- Submit the approved protocol and attached signed and stamped informed consent to the WMU HSIRB for their approval.
- Submit the WMU HSIRB reapproval letter to BMH IRB.
- Submit a copy of the Informed Consent with both IRB’s signatures to BMH IRB. Please copy this informed consent for use when consenting participants for your study. Once all signatures are on the informed consent, the participant should be provided with a copy.

You are reminded that any unanticipated problems and adverse events should be reported to the IRB within 48 hours of becoming aware of the event. It is also your responsibility to apply for continuing approval before the expiration date.

The IRB has determined the Degree of Risk to be Minimal.

The review period for this protocol will be no more than 365 days and IRB approval will expire October 8, 2015.

Should you have any questions or concerns, please do not hesitate to contact the IRB office.

Thank you,

Lisa Beverwyk, BS
IRB Coordinator
Bronson Methodist Hospital

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