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GIVING BREASTMILK
BODY ETHICS AND CONTEMPORARY BREASTFEEDING PRACTICE

Edited by
Rhonda Shaw and Alison Bartlett

DEMETER
TORONTO, CANADA

Breastfeeding and HIV/AIDS

Critical Gaps and Dangerous Intersections

PENNY VAN ESTERIK

THIS CHAPTER[1] EXPLORES THE role of breastfeeding and breastfeeding advocacy in the context of HIV/AIDS. The transmission of HIV through breastfeeding creates an excruciating dilemma for many mothers who are HIV positive. Often they are told to make a choice between breastfeeding and replacement feeding with infant formula without receiving sufficient information on the least risky way to feed their infants. In other places, they are not given a choice. In contrast, transmission of HIV through breastmilk is a relatively minor concern for AIDS researchers considering the importance of other modes of transmission, the overall demands for more effective prevention, and better access to treatment worldwide. However, the subject is of central importance to child feeding advocates who seek interventions to prevent HIV transmission that do not also undermine child feeding programmes.

Many health professionals, social scientists and breastfeeding advocates have made direct contributions to research directed towards preventing and treating HIV/AIDS. I have made no such contribution. I write from the edges of HIV/AIDS research, having been drawn to this work indirectly in the context of other work, first in Thailand dealing with gender issues, and second in relation to international advocacy work on breastfeeding. I have worked at the edges, in the spaces between, in a few of the gaps. But perhaps by focusing on the gaps, the spaces between and the pieces that don't fit the HIV/AIDS paradigm, we can bring new questions into focus. This chapter provides a personal response to attempts to understand HIV as a gendered public health issue by examining discourses surrounding breastfeeding and HIV/AIDS at two conferences: the first, at York University, May, 2006 on *Gender, Child Survival and HIV: from evidence to policy;* and the second, the *International AIDS Conference* (IAC) in Toronto, Canada, August, 2006. The chapter concludes with an assessment of the challenges of bridging the many divergent frames of reference exposed at these conferences, in order to create the possibility for an effective advocacy and policy response to breastfeeding and HIV/AIDS.

While epidemiological and biomedical research on the transmission of HIV through breastmilk and prevention-of-mother-to-child-transmission (PMTCT) is progressing, corresponding research on gender inequalities, embodiment, stigma and contagion is less well developed, and less integrated into broader discussions of maternal health and child survival. Since it was discovered that breastmilk could transmit HIV (Ziegler, Cooper, Johnson & Gold, 1985), there has been a concerted effort to discover the best infant feeding regime to keep the babies of HIV-positive mothers healthy and free of the virus. Although we recognize the fact of HIV transmission through breastfeeding, the exact mechanisms are still unclear.

To simplify the complex and ever-changing scientific evidence, it is often difficult to identify the timing and source of transmission of HIV. Even if we could be sure whether the transmission was intrauterine, perinatal or postnatal through breastfeeding, it is difficult to know if an infant is infected until they are about six weeks old.

Many women and infants have received single dose nevirapine to prevent transmission during labour and delivery. HAART reduces transmission through pregnancy, delivery and exclusive breastfeeding to around two percent. A child breastfeeding from a woman who is HIV positive has about a 14 percent risk of infection when neither receives any antiretroviral therapy (ART). Consider a community with a 20 percent HIV infection rate; only three infants out of 100 are likely to be infected through breastfeeding, leaving 97 who would benefit from breastfeeding. The 2006 updated WHO policy on HIV and infant feeding states:

> Exclusive breastfeeding is recommended for HIV-infected women for the first six months of life unless replacement feeding is acceptable, feasible, affordable, sustainable, and safe for them and their infants before that time. When replacement feeding is acceptable, feasible, affordable, sustainable, and safe, avoidance of all breastfeeding by HIV infected women is recommended. At six months, if replacement feeding is still not acceptable, feasible, affordable, sustainable, and safe, continuation of breastfeeding with additional complementary foods is recommended, while the mother and baby continue to be assessed. All breastfeeding should stop once a nutritionally adequate and safe diet without breastmilk can be provided. (WHO)

But because of difficulties surrounding both exclusive breastfeeding and exclusive replacement feeding, infants often receive mixed feeds, the option most likely to kill babies, particularly in the global south. However, replacement feeding is assumed to be easier in the global north where facilities for the safe use of replacement feeds are widespread. When the risk of an infant dying

from not being breastfed is greater than the risk presented by a HIV-positive mother's breastfeeding, then mothers are advised to exclusively breastfeed their infants.

Recent evidence has produced the surprising results that exclusive breastfeeding for three months led to the same transmission rates as exclusive replacement feeding (Coutsoudis, Pillay, Spooner, Kuhn, and Coovadia). In addition, programs that inform women of the dangers of mixed feeding, prevent and treat potential breast problems such as cracked nipples, and advise the use of condoms to prevent further infection during the period of lactation have been effective at reducing the transmission rate (cf. LINKAGES).

The dilemma for breastfeeding policy is that while we know that exclusive breastfeeding is the single most effective intervention to prevent infant death (cf. Jones et al.) when there are no effective vaccines to prevent transmission of HIV or cure AIDS, what boosts immunity and provides food security for infants—breastmilk—can also transmit HIV. While researchers are actively assessing the risk of transmission of HIV through breastfeeding, mothers and child feeding advocates are equally concerned about the long term survival and health of infants. These widely shared discourses around breastfeeding and HIV/AIDS permeated both conferences and should have provided a common basis for discussion.

THE YORK CONFERENCE

My experience of organizing and hosting a conference on *Gender, Child Survival and HIV/AIDS: From Evidence to Policy*, at York University (May 2006) revealed mammoth disconnections between how the infant feeing issue is framed in the global north and the global south. Sponsored by a number of academic programs at York University, local NGOs, and the World Alliance for Breastfeeding Action (WABA), an international NGO based in Malaysia, the conference aimed to bring together academics, women's health activists, HIV/AIDS workers and breastfeeding advocates. I was the conference organizer, ably assisted by Francoise Guigne (who is currently completing Master's research on breastfeeding and HIV).

Our conference at York focussed not on all those affected by AIDS, but on women; and not all women, but on mothers bearing children. And we drew attention to a particular route of transmission: through breastfeeding, rather than transmission during pregnancy or childbirth. We knew that the topic would not be easy to talk about. There were conceptual difficulties, scientific difficulties, political difficulties and advocacy difficulties, to name a few. Delegates had ample opportunity for participation, but we came from many different worlds and brought many diverse perspectives to the discussion, from local Canadian mother-to-mother support groups, to Christian NGOs working on AIDS education in African cities. Even Canadian and Ugandan doctors participating in the conference worked in very different worlds. We

viewed the conference as an opportunity to bring these diverse perspectives together for a critical examination of breastfeeding and the role of gender in health research, and how evidence is used (or not used) to direct policy relevant to women's health, infant health, and HIV/AIDS. We also wanted to address "the gender gap" in HIV research and prevention.

The transmission of HIV through breastmilk is only one small part of the problem facing women who are HIV positive. Nearly half the people living with HIV/AIDS are female. Women have higher viral loads, are often diagnosed later, and have poor access to care and medications. They are most often the caregivers for HIV positive family members, and most likely to be exposed to abuse and violence. Thus, gender inequity underlies the marginalization of women living with HIV, and discussions of child survival and feeding must be considered within the context of poverty, poor access to treatment, drugs and medical care. When ART is available, it is often given only long enough to reduce the risk of transmission during birth; the emphasis is often on preventing HIV transmission to infants rather than improving the health of mothers and infants.

Gender biases have had a profoundly negative impact on women through gender insensitive language that blames women for infecting their partners and infants; through inappropriate, authoritative counselling style; and through treatment that focuses only on reducing the transmission of the virus to the newborn, ignoring women's health needs in the process. Women are more vulnerable to HIV infections biologically because they are twice as likely as men to be infected from one act of unprotected sex, and culturally, because of pervasive gender inequalities.

The conference asked how women were moved aside and ignored for so long in HIV/AIDS policy and treatment. When attention was on women, we noted that it was often on sex workers, ignoring the fact that sex workers are also mothers. When attention was on mothers, treatment was often directed to them only to prevent transmission to their infants. In the early eighties, women, mothers and children were ignored when policy makers looked at risk categories—"the 4H's"—homosexuals, hemophiliacs, heroin addicts and Haitians, and when we shifted to talking about risk behaviours in the late eighties, breastfeeding mothers still didn't fit in.[2] When analysts focused attention on carrier fluids, most attention was on blood and semen rather than breastmilk.

When attention focused on semen as the carrier fluid, we learned a great deal about prevention and treatment from gay men's groups. When the circulating medium was blood, we also learned from hemophiliac support groups. We wanted the York conference to explore what gets revealed when we examine breastmilk as the carrier fluid. What new processes can be understood when we look at mothers who breastfeed and at breastfeeding support groups? How do the questions change? And how can groups working to support breastfeeding mothers further support the research and policy work of AIDS advocacy groups? To make this commitment visible, we handed out the red ribbons of AIDS

advocacy pinned together with the gold bow of the breastfeeding mother and child.[3] We took these arguments to the male dominated HIV support groups to attract them to the conference, and many were persuaded.

In preparation for the conference, we reviewed available literature on the subject. But when we reviewed HIV/AIDS materials, breastfeeding was mentioned only as part of PMTCT strategies, usually drug-based clinical trials; when we reviewed gender and HIV/AIDS materials, we found another gap; there was no reference to breastfeeding or the infant feeding problems faced by HIV-positive mothers. In fact, in the global north, many people expressed the belief that HIV positive women should not even have children.

A closer examination of the York conference illuminates the difficulties of meeting the lofty objectives to "fill the gender gap" and "fill the breastfeeding gap." The gaps didn't line up. What was a gap, an absence, for some, was a gaping wound for others. What is the significance of the fact that gaps exist, but that they do not line up? Never have I experienced such a disconnect between the way the problem of breastfeeding and HIV/AIDS was framed in industrial and resource poor countries, in the global north and the global south.

Among North American service providers, academics and NGOs, I was repeatedly told that breastfeeding for HIV-positive mothers was not an issue for research, treatment or prevention, and there was nothing to discuss. In fact most refused to enter into discussion. They thanked us for the invitation, but declined to participate in the conference, preferring to concentrate on other issues relevant for women—microbicides, female condoms, and sexual rights. They "solve the problem" for HIV positive pregnant women by providing ART in late pregnancy, and requiring exclusive replacement feeding from birth. No breastfeeding is permitted, and women who breastfeed a child knowing they are HIV positive could be accused of child neglect. For North American women, there is no choice, thus no problem, and no issue to debate. No consideration was given to the possibility that North American women might have difficulty accessing infant formula, or that some North American women wanted to breastfeed exclusively. Nevertheless some individuals and groups agreed to participate out of solidarity; others out of an interest in gender and HIV; and some came to the conference out of a desire to have a platform to complain about the fact that when treatment for women was discussed in North America, it was framed as necessary to prevent the transmission of HIV to their newborns, not "for them" as HIV positive women. Some came with a heavy chip on their shoulders ready to confront activists who were doing exactly what we were doing, drawing attention to mothers and newborns, rather than to women per se. From them, there was not just disinterest but active resentment.

In contrast, when the call for conference abstracts went out, the response from South Asia and African countries in particular was overwhelming. Finally, they said, a forum to help "fill the gap" with discussion of research and interventions on the important subject of infant feeding among HIV positive and negative women, and women who do not know their status. We received

abstract after abstract on how to handle the difficult choices HIV positive women must make. These included problems about lack of adequate counselling about infant feeding options, problems of maintaining exclusive breastfeeding as a viable option to reduce transmission of HIV, and the challenges of encouraging exclusive breastfeeding considering the fact that breastfeeding support had almost disappeared in those same countries and communities because of HIV/AIDS.

Many complained of the lack of follow up on the survival of infants of HIV-positive mothers given replacement feeds. And others, totally committed to replacement feeding in industrialized and developing countries, raised the problem of the fact that replacement feeding was not available when needed or it was too expensive for mothers to purchase.

In many resource poor communities, use of replacement feeds raises familiar problems—need for clean reliable water source, adequate conditions for sterilization or hygienic preparation, cash for purchase. Contaminated feeding bottles and over-dilution of infant formula do not disappear in the context of HIV/AIDS. But the discourse has changed from the early days of the Nestle boycott. The old rhetoric of the breast-bottle controversy becomes a tragic, ironic double bind, advocacy turned inside out, where companies supplying the replacement feeds of infant formula were heralded as "the good guys," and the breastfeeding advocates, "the bad guys" with their heads in the sand, ignoring, as one participant said, "the fact that breastmilk causes AIDS."

Many conference participants, particularly health activists, addressed the fact that the reduction in facilities to support maternal and child health generally was a direct result of American policies to remove support for services that could be construed as linked in any way to women's reproductive rights. The "ABC" (abstinence, be faithful, use condoms) criteria for PEPFAR (U.S. President's Emergency Plan for AIDS) funding was ridiculed by participants from the global north and global south, as insulting, ineffectual and unrealistic for women, offering nothing relevant to solving HIV positive women's problems, particularly infant feeding.

The extent to which the gaps did not line up was brought home to me in exchanges with a Ugandan doctor at the York conference. As we began to educate each other about the way we approached breastfeeding, one Ugandan doctor exploded with anger about what she called "a vicious double standard." She viewed PMTCT and AFASS, as global strategies that said a Ugandan baby's death didn't matter as much as an American baby's death and that was why Ugandan babies were allowed to be breastfed. But the death of a white American baby matters; therefore American mothers were told not to breastfeed. Marion Tompson, a founding mother of La Leche League, was devastated to learn how her work and the work of others to maintain breastfeeding support in the face of HIV/AIDS was interpreted. She wrote to her colleagues: "And then it all poured out, her perception that women in Africa were being encouraged to breastfeed because African babies were expendable and no one cared if they

got AIDS and died. But in industrialized countries, breastfeeding was strictly forbidden to prevent any of those babies from getting AIDS!"[4] The Ugandan doctor was surprised that some North American women who were HIV positive wanted to breastfeed their babies, even against "doctor's orders," risking having their children taken away from them. The heated exchange cleared the air somewhat, and increased understanding, as the American, Asian and African participants learned how their words and actions had been mutually misinterpreted.

The conference task of producing a consensus statement on transmission through breastmilk was particularly challenging. The conference exposed how the transmission of HIV through breastmilk evoked personal, emotional, political and cultural struggles over the value and meaning of maternal and infant bodies in the context of economic and gender inequalities. Nevertheless, we accomplished the task between May and July in time to bring the statement to the IAC.[5] (The struggle over language and the politics of track changes is another paper.)

THE INTERNATIONAL AIDS CONFERENCE (IAC), TORONTO

Breastfeeding and HIV/AIDS did not figure prominently at the *International AIDS Conference* (IAC) in Toronto, August, 2006; breastfeeding did not fit in well with the discourse on sexual and reproductive health, nor men having sex with men. The major scientific panel on PMTCT was rejected from the scientific programme, and was presented as a satellite panel at 7:00 am, at the cost of several thousand dollars (paid for by a health NGO who could have used the funds more effectively elsewhere).

While lining up to register for the IAC, I struck up a conversation with a representative from People Living With AIDS from Uganda. I wanted her to distribute the joint statement from the York conference. Her concern—no, anger—when I mentioned I represented a breastfeeding advocacy group was striking and painful. She repeated over and over, "if you are HIV positive, you must do everything you can to prevent the transmission of HIV to your child. Isn't it worth suffering for three or four months to save your child?" She discussed the clash between building up of immunity in the infant by breastfeeding and the breaking down of immunity by HIV. This was the heart of the anger-making tragedy for her. She took out this anger on breastfeeding advocacy groups, who, she said, should not be promoting breastfeeding, but should instead help break down the stigma in her country of not breastfeeding.

She spoke of her friend who didn't want to tell her partner she was HIV positive, so she breastfed her first baby who is now HIV positive. For the second baby she refused to breastfeed and the baby is free of HIV. Now the first child blames her mother, asking why her sibling is healthy and she is sick. The woman in line didn't know she herself was HIV positive and breastfed her daughter for four months. When they both got sick, they were both tested

and found to be HIV positive. Her daughter is a teenager now, and getting treatment. The woman tried traditional medicine and herbs first, but lost her appetite, and if she ate before she took the herbs, she vomited her food and wasted it. Now both she and her daughter give talks about preventing HIV infection. Not breastfeeding is included as a prevention strategy for avoiding HIV transmission. When I mumbled something about wanting to help, she asked me to help raise money to subsidize infant formula in the villages of Uganda. Needless to say, I kept the joint statement, pins and other advocacy materials from the York conference in my bag.

At the IAC, I also learned how upsetting it was to health workers in Maternal and Child Health who have been trained to support breastfeeding to be told now to advise women not to breastfeed. As one explained, we went from "breast is best" to "breastmilk is a poison that kills babies." South African researchers deplored the rate of burnout among HIV counsellors advising women on infant feeding options. They quit in large numbers. This lack of job satisfaction is a much bigger problem in the global south than in North America where support for breastfeeding is stronger at the level of rhetoric than practice, where breastfeeding is considered a lifestyle choice, and conditions for the safe use of replacement feeds are assumed to be universally available.[6]

Stephen Lewis's keynote address at the closing plenary summarized eighteen key points from the IAC conference. The gender activists anticipated a strong attack on gender inequality, and were not disappointed. Ending domestic and sexual violence against women is an unambiguous good. Increasing treatment and care for children and orphans is another unambiguous good. Everyone agrees in principle and in practice. There are no longer two sides to the question of violence against women. The breastfeeding activists hoped he would call for more research on mother to child transmission and support for exclusive breastfeeding, perhaps with a link to gender inequality. We were disappointed. Between violence against women and care for children was a brief point about childhood sexual abuse, a subject covered by children and violence. We were left to wonder why Lewis failed to address the complexity of the infant feeding dilemma, since he was key in initiating the subject at a breastfeeding and HIV/AIDS conference in Tanzania a few years before.[7] Perhaps it has something to do with the lack of interdisciplinary integration in research and policy development. While many researchers call for race, class and gender to be considered in HIV/AIDS research, medical science rarely trains health professionals to do class or gender analysis. It is the social sciences that specialize in this kind of analysis. Something very powerful happens when you take the best of the social sciences and combine it with clinical expertise, but health professionals should be cautioned against practising social science without a license.

The seventeenth IAC was held in Mexico City in August, 2008. As part of the committee organizing the social science track, I had the opportunity to review abstracts and meet other committee members, all with their own agendas for

the meetings. Once again, breastfeeding was of minor interest except for the PMTCT reports on drug trials considered relevant to clinical and scientific tracks. With a strong representation from gender networks, sexual and reproductive rights were prominent in the Mexican IAC program. But sexual and reproductive rights advocates pressed for discussion of rights to abortion, family planning and sexual pleasure, and did not consider breastfeeding as a reproductive rights issue. Breastfeeding advocates at the meeting reported that the WHO recommendations on breastfeeding were not discussed or questioned during the conference. NGO participants requested more information to disseminate in Latin America where HIV-positive mothers were forbidden to breastfeed, denying them the right to make to an informed choice.

Those working in international health or HIV/AIDS work know that present conferences are understood by reference to past conferences. HIV/AIDS research and policy is shaped by non-binding documents produced at earlier conferences and at United Nations' agencies:

> As 'language' is quoted and repeated from one conference document to the next and as states begin to conform their practices, or at least their discourse, to the norms expressed therein, some of what is agreed upon at global conferences gradually will become rules of 'customary international law'. (Riles 2008: 9)

IN SEARCH OF BRIDGES

These conferences revealed—at times painfully—some unstated corollaries about breastfeeding and HIV/AIDS. In the global south, breastfeeding matters and was hard to give up, both personally and socially. Giving up breastfeeding was a necessary sacrifice, "a sacrifice for the baby." Mixed feeding was often the result. Mixed feeding was not recognized as dangerous because it was accepted as the normal way to feed a baby before the HIV/AIDS crisis. There was no discursive space for recognizing that replacement feeding was killing babies. Instead, the message was that breastfeeding kills babies, and replacement feeding will save them.

In the global north, breastfeeding as a mothering practice is less valued, and was perceived as easy to give up, since medical professionals already viewed replacement feeding as equivalent or even better than breastfeeding. The distrust of breastfeeding and breastfeeding advocacy groups in Canada was re-enforced recently when *Chatelaine*, a leading Canadian women's magazine, published an article headlined, "Breastfeeding Sucks" (60). The article refers to the "pro-breastfeeding tyrants," the "evangelism" of the "boob squad" who use "scare tactics" to stifle women's choices, and concludes, "We might have to suck up the pain of breastfeeding, but we can spit out the piety of the breastfeeding bullies." This attitude explains in part why many North American women's groups concerned about HIV/AIDS were not willing to participate in the York

conference, and what makes international collaboration between global north and global south on gender and HIV issues so challenging.

How can we address the problems of infant feeding and HIV/AIDS policy when there are so many gaps in our knowledge and when the gaps do not line up? How can we build bridges when the issues in the global south/global north are conceptual inverses of each other, or to paraphrase Annelise Riles (2001), "the policy inside out"? I conclude with a few questions that need to be answered before we can "bridge the gaps":

1. What happens when the global north advises the global south on this issue? Many large international bilateral and multilateral projects send foreign experts to advise on gender and HIV issues in southern Africa and elsewhere. Infant feeding is often not included in the workplan. When breastfeeding doesn't matter in the global north, it may not be addressed appropriately in international projects.

2. Why is informed choice configured so differently in the global north and the global south? There is no choice of infant feeding for HIV positive women in the global north, and only the rhetoric of informed choice in the global south. While the numbers of women making these decisions, and their access to treatment differ by country, the concept of informed choice should be examined more seriously, and should not differ so dramatically in the global north and south.

3. How can breastfeeding advocates avoid being placed in the "dissenter box" when they call for surveillance of survivor rates for different feeding modes or more research on the mechanisms of transmission through breastmilk? Calling for more research on exclusive breastfeeding still feels like suggesting lemon and garlic as treatment for the disease. Can we avoid the dissenter/scientist split altogether, so that calling for more research on exclusive breastfeeding or monitoring HIV positive women who "break the rules" and breastfeed, is not interpreted as anti-science?[8]

4. How can we reconceptualize risk to find a compromise between the idea that any risk is unacceptable, and the everyday lived reality that we all live with a range of risks as a part of life? AFASS is part of a discourse of mastery that says any risk is unacceptable. Breastfeeding has risks; not breastfeeding has more risks. But actions to control risk often create other unnamed risks. Policies such as AFASS rarely deal with the complexities around different perceptions of risk, including emotional or psychological risk, and the potential for racial bias, as revealed by these conference stories.

5. What concepts and policies address the mother-infant dyad, rather than treating mothers and infants as separate competing individuals? The latter individualistic approach meets western feminist standards for treating women as individuals, but it does not address the synergetic interdependence of mothers and infants so crucial for all discussions of intersubjective experiences like breastfeeding. In the context of HIV/AIDS, keeping mothers healthy is the best way to keep infants and children healthy.

6. Why were alternatives such as pasteurising breastmilk not explored as rigorously as replacement feeds? Why was exclusive breastfeeding not originally supported as the best policy option for all mothers? Support for EBF does not pit HIV/AIDS objectives against other primary health care objectives, HIV negative women against HIV positive women, nor the global north against the global south; the most cost-effective intervention—EBF—also happens to be the best solution to a number of related problems.

7. How can universal health policies such as AFASS, other WHO documents and human rights issues be translated into local vernaculars that civil society NGOs can use or modify to meet local conditions? And how can they be wiped from those same vernaculars when they are found to be inadequate or need to be replaced, as with the various iterations of WHO guidelines on this subject?

8. How can we create solidarity and support among women and women's health advocacy groups, and other single-issue advocacy groups working on HIV/AIDS? Can we build on commonalities, try to meet regularly at international events to develop shared objectives, and maximize synergies by not working too narrowly on our "own issues"?

The 1990 *Innocenti Declaration* on the protection, promotion and support of breastfeeding was the first United Nations policy document related to infant feeding that did not target industrial and developing countries separately. This policy initiative had the potential to add new and powerful unifying language to breastfeeding protection and support. Similarly, the Code for the Marketing of Breast Milk Substitutes applies equally in the global north and global south, although consequences are greater in the global south.

Contexts differ, but the documents have universal relevance. International health policy such as AFASS carries many underlying assumptions, however: that all women in the global north can replacement feed safely, and do not value breastfeeding; that all women in the global south cannot replacement feed safely, and that breastmilk and milk or soy based replacement feeds are equivalent. As these conferences revealed, all these assumptions are false. Acting on such assumptions reveals the cracks in the myth of international solidarity.

Bridges appear when least expected, when we remain open to the opinions and experiences of others. On this subject, we need to avoid premature closure, with both biological and cultural explanations. Breastmilk may indeed be a dangerous fluid carrying virus into the bodies of uninfected newborns, but it is simultaneously food security for infants, and may, in future research, provide the key to understanding immune processes, suggested by the survival of infants exclusively breastfed; this makes gender-sensitive research and policy around exclusive breastfeeding a critical gap to fill.

[1]This title of this chapter is part of the title for the 2006 American Anthropology Annual meetings, where I presented an earlier version of this paper.
[2]A black, fuzzy stuffed animal made by Giant Microbes, for sale at a science

museum in Toronto, comes with a note that says HIV is transmitted through unprotected sexual contact, sharing needles, during pregnancy and childbirth, or through breastfeeding.

[3]WABA made these ribbon/pin combinations into pins and distributed them at the IAC conference in Toronto.

[4]I thank Marion Tompson for sharing these very personal email communications with me.

[5]The consensus statement can be accessed through the WABA website <http://www.waba.org.my/pdf/JointStatement_hiv.pdf>.

[6]More research is needed about how poor HIV positive women in the global north are expected to obtain and use replacement feeds.

[7]HIV and Infant Feeding: A Report of a WABA-UNICEF Colloquium, September, 2002.

[8]One of the most rewarding moments following the York conference was when members of two different groups who were considered dissenters said that this was the first time they had been given the opportunity to speak at a conference. Their positions were listened to respectfully, critiqued effectively and they were not shut down.

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From Maternal Love to Toxic Exposure

State Interpretations of Breastfeeding Mothers in the Child Welfare System

JENNIFER A. REICH

BREASTFEEDING HAS BECOME A symbolic marker of maternal commitment and has been endorsed in public health campaigns as unequivocally good. Simultaneously, the content and quality of breastmilk has been called into question as mothers' imperfect diets, alcohol or drug use, or disease status allow breastmilk to be seen as toxic to their infants. Nowhere are these complicated and contradictory meanings of breastfeeding more evident than in the child welfare system. This chapter uses qualitative ethnographic data collected in the child protective services system (CPS) to show how nursing mothers and breastfeeding as a practice are read in different ways.

Parents come to the attention of the CPS system because of a report that a child's safety is in jeopardy. The parents that enter the system are seen as inadequate care providers but are usually provided rehabilitative services. Judges and social workers then examine and reexamine parental progress toward state-defined rehabilitation and assess whether a child may safely return home. Many cases that enter the system involve infants and young children, in part because of state policy that defines prenatal and parental drug use as incompatible with parenting. As a result, mothers who wish to breastfeed are read in varying ways. In some cases, a mother's desire to breastfeed communicates a commitment to her baby and a symbolic desire to parent effectively. In other cases, judges view mothers' milk as dangerous—most commonly because of suspicions of maternal drug or alcohol use—and will legally bar a mother from continuing to breastfeed. In this chapter, I examine two cases of breastfeeding mothers to show the complicated ways state actors interpret the lactating mother. I then juxtapose these cases with my own treatment as a breastfeeding (and frequently pumping) researcher to illustrate the complex and contradictory meanings applied by state actors and examine how those interpretations differentially make breastfeeding practice visible.

BACKGROUND

Data come from a larger study of one unnamed Northern California county