

2015

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Recommended Citation

Andrea Freeman, *"First Food" Justice: Racial Disparities in Infant Feeding As Food Oppression*, 83 Fordham L. Rev. 3053 (2015).

Available at: <https://ir.lawnet.fordham.edu/flr/vol83/iss6/8>

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“FIRST FOOD” JUSTICE: RACIAL DISPARITIES IN INFANT FEEDING AS FOOD OPPRESSION

Andrea Freeman*

I. TABITHA WALROND’S STORY

Tabitha Walrond gave birth to Tyler Isaac Walrond on June 27, 1997, when Tabitha, a black woman from the Bronx, was nineteen years old.¹ Four months before the birth, Tabitha, who received New York public assistance, attempted to enroll Tyler in her health insurance plan (HIP), but encountered a mountain of bureaucratic red tape and errors.² After several trips to three different offices in the city, Tabitha still could not get a Medicaid card for Tyler.³ Tabitha’s city caseworker informed her that she would have to wait until after Tyler’s social security card and birth certificate arrived to get the card.⁴ No doctor would see him without the Medicaid card.⁵

Following her caesarian section, Tabitha developed a fever and blood clots that prevented her from breastfeeding for ten days while she was on medication.⁶ Four years earlier, at age fifteen, Tabitha had undergone

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1. See Nina Bernstein, *Placing the Blame in an Infant’s Death; Mother Faces Trial After Baby Dies From Lack of Breast Milk*, N.Y. TIMES, Mar. 15, 1999, at B1.

2. *Id.* One writer suggests that the delay reflected then-New York City Mayor Rudolph Giuliani’s deliberate policy to make Medicaid more difficult to access, thereby cutting down on costs to the city. See Allen Whyte, *Young Mother Convicted of Criminally Negligent Homicide in her Baby’s Death: New York Authorities Victimize the Victim*, WORLD SOCIALIST WEB SITE (May 22, 1999), www.wsws.org/en/articles/1999/05/walr-m22.html; see also BICH HA PHAM ET AL., FED’N OF PROTESTANT WELFARE AGENCIES, THE STATE OF NEW YORK’S SOCIAL SAFETY NET FOR TODAY’S HARD TIMES 10–11 (2009).

3. Bernstein, *supra* note 1.

4. *Id.*

5. *Id.*

6. *Id.*

surgery.⁷ In 1997, during her extended post-birth hospital stay, Tabitha's doctors failed to inform her that these two factors put her at significant risk for problems with breastfeeding.⁸ In the first few weeks of his life, Tyler steadily lost weight, but Tabitha did not realize it.⁹ It is normal for nursing mothers not to notice weight loss in their infants, even when it is significant, because they see them every day.¹⁰ Tabitha therefore continued to breastfeed Tyler exclusively until his death from malnutrition on August 27, 1997, only seven weeks after his birth.¹¹ Tabitha finally received Tyler's Medicaid cards and HIP membership several months later.¹²

A similar tragedy struck a mother in Ohio, where dehydration after exclusive breastfeeding led to her infant's leg amputation;¹³ in Virginia, where insufficient breast milk supply caused permanent brain damage;¹⁴ and in Colorado, where Zion Cox, the son of a white nurse, Ann, and a minister, died of malnutrition.¹⁵ In Zion's case, doctors saw him shortly after his birth, but assured Ann that nothing was wrong, until a blood clot caused by dehydration cut off oxygen to his brain when he was only ten days old.¹⁶ Driven by a desire to create something meaningful from Zion's death, Ann went on to devote her life to providing medical care to impoverished rural communities.¹⁷ A Denver newspaper lauded her efforts and portrayed her as a selfless woman seeking to honor her child's memory.¹⁸ Other similar incidents around the country involving white families prompted some states to change their laws regarding minimum hospital stays.¹⁹

Following Tyler's death, however, there was no outcry to reform the medical system through legal channels to ensure provision of adequate care for low-income black mothers and children. The media did not seize upon

7. Tabitha required breast reduction surgery. *Id.*

8. *Id.*

9. *Id.*

10. *Id.*

11. *Id.* Tyler may have suffered from congenital adrenal hypoplasia, a birth defect that may have contributed to his dehydration and caused loss of appetite. See *Report on Baby's Death Prompts Delay in Trial*, N.Y. TIMES, Mar. 18, 1999, at B8.

12. Bernstein, *supra* note 1.

13. *Id.*

14. *Id.*

15. Karen Augé, *Town's Ills an Uphill Struggle for Practitioner*, DENVER POST (June 18, 2006), http://www.denverpost.com/news/ci_3950524.

16. *Id.*

17. *Id.*

18. *Id.*

19. New Jersey and Maryland increased their minimum post-natal hospital stays. See Stacey Burling, *One Day and Out the Door*, CHI. TRIB. (Nov. 2, 1994), http://articles.chicagotribune.com/1994-11-02/news/9411030185_1_breast-feeding-robin-carter-dehydration; Mike Dorning, *Insurers Rush Out New Moms*, CHI. TRIB. (June 18, 1995), http://articles.chicagotribune.com/1995-06-18/news/9506180351_1_hospital-door-cost-conscious-insurance-companies-hours-of-hospital-care; see also *Deliver Then Depart*, SHARON BEGLEY, <http://www.sharonbegley.com/deliver-then-depart> (last visited Apr. 23, 2015); Ellen Meara et al., *Impact of Early Newborn Discharge Legislation and Early Follow-Up Visits On Infant Outcomes in a State Medicaid Population*, 113 PEDIATRICS 1619, 1619 (2004).

the story of a good mother who attempted to provide her infant with the benefits of breastfeeding but tragically lost him due to systemic racial disparities in medical treatment.²⁰ And Tyler’s death did not serve as a rallying point for advocates to push for increased resources—such as lactation consultants in underserved hospitals and clinics—for black women who want to breastfeed.

In contrast, the New York prosecutor brought charges against Tabitha for second-degree manslaughter.²¹ Based on accounts from Tyler’s paternal relatives, who described Tabitha as a “monster,” the prosecutor theorized that Tabitha deliberately starved Tyler to death in retaliation against his father, Keenan Purcell, who left Tabitha for another woman after she informed him that she was pregnant and refused to get an abortion.²² Later, in the waiting room for her six-month prenatal appointment, Keenan told Tabitha that his new girlfriend was pregnant.²³ At the beginning of her appointment, Tabitha asked the doctor if it was possible to get an abortion, then immediately dropped the request.²⁴ The prosecution argued that Tabitha’s inquiries about abortion to the doctor, and to a friend when she first learned of her pregnancy, were evidence of her desire to kill Tyler.²⁵

During the trial, the prosecution and local media focused solely on Tabitha’s behavior, with no mention of the systemic obstructions to her diligent attempts to obtain care for Tyler. Instead, the Bronx district attorney sought to prove Tabitha’s guilt by contrasting photos of Tyler from immediately after his birth to ones taken post-autopsy. As reported by CNN:

Bronx District Attorney Robert Johnson, in closing arguments Wednesday, showed jurors a photograph depicting a round-faced Tyler, taken just after birth, along with graphic autopsy photographs showing a gaunt and skeletal baby. “On June 27, 1997, God gave Tabitha Walrond a baby boy,” Johnson said, as he showed the birth photo. “And in eight weeks,” he continued, lifting up the autopsy photos, “this is what she did to him.” “What god-awful sound does a crying baby make (when starving)?” Johnson asked the jurors. “Who heard it?” he went on. “The

20. See, e.g., Rob Stein, *Race Gap Persists in Health Care, Three Studies Say*, WASH. POST (Aug. 18, 2005), <http://www.washingtonpost.com/wp-dyn/content/article/2005/08/17/AR2005081701437.html> (“Black Americans still get far fewer operations, tests, medications and other life-saving treatments than whites . . . blacks remain much less likely to undergo heart bypasses, appendectomies and other common procedures. They receive fewer mammograms and basic tests and drugs for heart disease and diabetes. . . .”); see also, e.g., Vanessa Ho, *Doctors Treated Black Patients Worse in UW Study*, SEATTLEPI (Mar. 19, 2012, 9:00 PM), <http://www.seattlepi.com/local/article/Doctors-treated-black-patients-worse-in-UW-study-3419063.php> (“Studies have shown that white patients are more likely to get pain medication—and be in less pain—than minority patients. Other studies have shown that health providers are more likely to stereotype black patients as being more likely to abuse pain pills than white patients.”).

21. Bernstein, *supra* note 1.

22. *Id.*

23. *Id.*

24. *Id.*

25. *Id.*; Karen Houppert, *Nursed to Death*, SALON (May 21, 1999), <http://www.salon.com/1999/05/21/nursing/>.

defendant.” Johnson concluded by telling the jury to “do what he (Tyler) couldn’t do. You speak for that little boy.”²⁶

Assistant District Attorney Robert Holdman also claimed, “The only thing that little boy knew in his short and helpless life was hunger and pain.”²⁷ In May 1999, the jury convicted Tabitha of criminally negligent homicide.²⁸ In September 1999, the court sentenced her to five years of probation.²⁹

The New York daily papers closely followed Tabitha’s trial, featuring multiple headlines sensationalizing Tyler’s death by “starvation.”³⁰ They also devoted a substantial amount of space to reporting on the case of Tatiana Cheeks. Tatiana had an experience similar to Tabitha’s, with a dramatically different result. Tatiana sought medical assistance for her daughter, Shannell Coppage, at a clinic in Brooklyn when she was one week old, but the clinic turned Tatiana away because she did not have a Medicaid card or money to pay the \$25 fee for clients without Medicaid cards.³¹ In March 1998, Shannell died at six weeks old.³² After her death, the Brooklyn district attorney charged Tatiana with criminally negligent homicide.³³ However, after Tatiana received support from prominent

26. *Jury Convicts Mother in Starved Baby Trial*, CNN (May 19, 1999), <http://www.cnn.com/US/9905/19/breastfeeding.trial.02/>.

27. Rafael A. Olmeda & Marty Rosen, *Tot’s Slow Death Recounted at Trial*, N.Y. DAILY NEWS (Apr. 28, 1999), <http://www.nydailynews.com/archives/news/tot-slow-death-recounted-trial-article-1.835343>.

28. Houppert, *supra* note 25.

29. Nina Bernstein, *Mother Convicted in Infant’s Starvation Death Gets 5 Years’ Probation*, N.Y. TIMES, Sept. 9, 1999, at B3.

30. See, e.g., Merle English, *Breast-Fed Infant’s Death Sparks Debate*, NEWSDAY (May 29, 1999), <http://www.newsday.com/news/new-york/queens-diary-breast-fed-infant-s-death-sparks-debate-1.239935>; Rafael A. Olmeda, *Jurors See Photos of Starved Infant*, N.Y. DAILY NEWS (May 1, 1999), <http://www.nydailynews.com/archives/news/jurors-photos-starved-infant-article-1.836938> (“Deputy Chief Medical Examiner Yvonne Milewski . . . who has visited mass graves in Yugoslavia, was visibly shaken and her voice began to quiver when she looked at the pictures of Tyler.”); Olmeda & Rosen, *supra* note 27 (“Walrond, wearing a fleece sweater over a blue denim dress, remained calm yesterday even during the most critical testimony.”); Ikimulisa Sockwell-Mason, *Breast-Feeding Mom Recalls Watching Underfed Baby Die*, N.Y. POST (May 19, 1999), <http://nypost.com/1999/05/19/breast-feeding-mom-recalls-watching-underfed-baby-die/> (“The prosecutor asked her how Tyler felt in her arms the week before his death. ‘He felt like Tyler, he felt like my baby,’ Walrond said. ‘Did you feel his ribs?’ Holdman pressed. ‘When you changed his diaper did you move away the folds of skin around his butt? Did you feel his spine?’”); Ikimulisa Sockwell-Mason, *Jurors Shaken by Pix of Infant Who Starved*, N.Y. POST (Apr. 29, 1999), <http://nypost.com/1999/04/29/jurors-shaken-by-pix-of-infant-who-starved/> (stating that Tyler’s “leg was no bigger than a man’s finger” and implying that Tabitha had ignored Tyler’s paternal grandmother’s advice on clinics that would see him without a Medicaid card and lied to Marcia Purrell about him being seen by a doctor).

31. See Jake Pearson & Kevin Deutsch, *Tatiana Cheeks, Mother Wrongly Accused of Murder After Her Baby Starved, Wins \$2M Payday*, N.Y. DAILY NEWS (Apr. 22, 2011), <http://www.nydailynews.com/new-york/tatiana-cheeks-mother-wrongly-accused-murder-baby-starved-wins-2m-payday-article-1.111744>.

32. Cara Buckley, *13 Years Later, a \$2 Million Award*, N.Y. TIMES, Apr. 23, 2011, at A14.

33. Rachel L. Swarns, *Baby Starves, and Mother Is Accused of Homicide*, N.Y. TIMES, May 29, 1998, at B3.

community members, such as city councilwoman Ronnie Eldridge, the prosecutor dropped the charges.³⁴

Tatiana later brought a suit against the City of New York and a jury awarded her \$2 million in damages in 2011.³⁵ Although Tatiana fared better than Tabitha in the justice system, the media's portrayals of both women's experiences served as warnings—particularly to black women—that breastfeeding could be dangerous or fatal. Much of the media coverage also reinforced stereotypes of black women as uncaring, lazy, ignorant, and selfish mothers, making systemic support for breastfeeding black women appear unnecessary because black women themselves, not institutional failings, make breastfeeding problematic.

Moreover, the experiences of Tabitha and Tatiana reveal a stark contrast between the response to white mothers whose infants suffered from insufficient malnutrition—empathy, glorification, and the opportunity to become a champion of legal change—and the reaction to black mothers who experienced the same trauma—criminal prosecution. This contrast further illustrates the power of the myth of black women as bad mothers that fosters indifference to structural factors that impede black women's ability to breastfeed successfully. This indifference, in turn, supports the formula industry's project of increasing profits by enlisting the government to promote formula feeding through a policy framework that causes disparate harm to black women, who breastfeed at significantly lower rates than white or Latina women.

To avoid criticism, this framework requires people to believe that black women are unfeeling, cold mothers who would or could not breastfeed, and who are completely distinct from the pervasive images of nurturing, breastfeeding white women who symbolize maternal best practices.³⁶ The origins of this myth are in slavery, when slave owners benefitted from a narrative about black mothers that provided moral justification for wresting them away from their own infants in order to breastfeed white babies.³⁷

In modern times, Tabitha Walrond's case represents the retelling of this myth about black mothers' inability to nourish their own children in order to support racially imbalanced social structures. Tabitha's story thus justifies the government's failure to provide adequate support for breastfeeding black mothers, because their breast milk, in contrast to white women's breast milk, is not nourishing but is instead, as in Tabitha's case,

34. Buckley, *supra* note 32.

35. See Pearson & Deutsch, *supra* note 31.

36. See, e.g., ETHNIC NOTIONS (California Newsreel 1986); see also, e.g., Richard Delgado & Jean Stefancic, *Images of the Outsider in American Law and Culture: Can Free Expression Remedy Systemic Social Ills?*, 77 CORNELL L. REV. 1258 (1992); S. Plous & Tyrone Williams, *Racial Stereotypes from the Days of Slavery: A Continuing Legacy*, 25 J. APPLIED SOC. PSYCH. 795 (1995).

37. WILMA A. DUNAWAY, THE AFRICAN-AMERICAN FAMILY IN SLAVERY AND EMANCIPATION 140 (2003) ("[W]et nursing claimed the benefits of breastfeeding for the offspring of white masters while denying or limiting those health advantages to slave infants . . . wet nursing required slave mothers to transfer to white offspring the nurturing and affection they should have been able to allocate to their own children.").

deadly. The prosecution drew on the stereotype of black mothers as cold and uncaring to bolster its portrayal of Tabitha as a cruel mother who savagely starved her child to exact revenge on her former partner.³⁸ The prosecution's use of this racial trope against Tabitha illustrates how the demothering of black women can serve to sanction a policy framework that disproportionately harms black women and children.³⁹ Tabitha's story thus reveals how the social, medical, and legal systems fail black women, and then punish them for this failure.⁴⁰

Her story also demonstrates how corporations exploit institutional failings and vulnerabilities for profit and the consequent harms to black women. The formula companies teamed up with a media outlet to increase formula sales by using Tabitha's story to deliver a message that breastfeeding is hazardous. A partnership among CBS, Johns Hopkins School of Medicine, and the Pharmaceutical Research and Manufacturers of America (PhRMA)—an organization that includes the major infant formula companies—resulted in the dramatization of Tabitha's story on the then-popular medical drama, *Chicago Hope*.⁴¹ Interestingly, the producers decided to cast Tabitha's character as a white, middle-class woman in the episode, instead of low income and black.⁴² This choice served to divert attention away from the structural issues that prevented Tabitha from accessing proper medical care. Instead, the episode emphasized the “criminality” and “danger” of breastfeeding. Had the character been black,

38. See, e.g., Liena Gurevich, *Patriarchy? Paternalism? Motherhood Discourses in Trials of Crimes Against Children*, 51 SOC. PERSP. 515, 519 (2008); Sandra Chung, Note, *Mama Mia! How Gender Stereotyping May Play a Role in the Prosecution of Child Fatality Cases*, 9 WHITTIER J. CHILD. & FAM. ADVOC. 205, 219 (2009) (questioning why Tyler's father, Keenan Purcell, was not considered negligent after he observed his son's emaciation but failed to act on it).

39. For an excellent discussion of how narrative can serve to illuminate the experiences of black women with the law, see Mario L. Barnes, *Race, Sex, and Working Identities: Black Women's Stories and the Criminal Law: Restating the Power of Narrative*, 39 U.C. DAVIS L. REV. 941 (2006).

40. Tabitha's story is also about the criminalization of black mothers. This criminalization begins in pregnancy and continues throughout motherhood, justifying the prosecution and punishment of black mothers. See, e.g., Kimberlé W. Crenshaw, *From Private Violence to Mass Incarceration: Thinking Intersectionally About Women, Race, and Social Control*, 59 UCLA L. REV. 1418 (2012); Paula C. Johnson, *At the Intersection of Injustice: Experiences of African American Women in Crime and Sentencing*, 4 AM. U. J. GENDER & LAW 1 (1995); Priscilla A. Ocen, *Punishing Pregnancy: Race, Incarceration, and the Shackling of Pregnant Prisoners*, 100 CALIF. L. REV. 1239 (2012); Dorothy E. Roberts, *Prison, Foster Care, and the Systemic Punishment of Black Mothers*, 59 UCLA L. REV. 1474 (2011); Dorothy E. Roberts, *Punishing Drug Addicts Who Have Babies: Women of Color, Equality, and the Right of Privacy*, 104 HARV. L. REV. 1419 (1990).

41. See Katie Allison Granju, *Formula for Disaster*, SALON (July 20, 1999, 12:00 PM), <http://www.salon.com/1999/07/20/formula2/>.

42. *Chicago Hope: The Breast and the Brightest* (CBS television broadcast Oct. 21, 1998); Jane D. Brown & Sheila Rose Pechaud, *Media and Breastfeeding: Friend or Foe*, INT'L BREASTFEEDING J., Aug. 2008, at 2, available at <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2518136/pdf/1746-4358-3-15.pdf>.

the notions of criminality and danger would have remained attached to the mother, instead of to the act.⁴³

In the *Chicago Hope* episode, a white mother and father rush their baby into the emergency room, where the baby dies seconds after getting onto the table.⁴⁴ One of the show's regular characters, a white woman named Dr. Diane Grad, has just returned to work, leaving her infant at home with her husband.⁴⁵ Grad is outraged by the emaciated appearance of the baby and declares loudly that the mother should be charged with murder.⁴⁶ Another doctor, a black man named Dr. Keith Wilkes, asks her to calm down and wait for the autopsy report to determine the true cause of death.⁴⁷ The report reveals that the baby died of cardiac arrest resulting from dehydration due to insufficient breast milk.⁴⁸ The parents, however, assert that the true cause of death was the hospital's baby-friendly contract, which they claim discouraged them from formula feeding even when it was medically necessary.⁴⁹ The couple then sues the hospital for entering into the baby-friendly contract with them.⁵⁰

Meanwhile, Grad experiences the challenges of new motherhood acutely when she meets another new mother, a black neighbor who has not returned to work and appears to be able to manage her home life successfully.⁵¹ Grad's baby then develops a fever and Grad rushes her to the emergency room.⁵² A black doctor, Dr. Dennis Hancock, reassures Grad that she is not a bad mother.⁵³ Grad then apologizes to the mother of the infant who died for accusing her of murder, but the mother is indifferent to Grad's words because she is consumed with guilt over her failure to keep her baby alive.⁵⁴

43. Generally, when a person who appears to belong to a racialized group commits a crime, society views the criminal act as consistent with or evidence of the person's bad traits, which arise from their group membership. Their actions, in turn, confirm these stereotypes about their race. This phenomenon operates in a variety of social contexts and across many racial lines. For example, when people of Middle Eastern descent caused the World Trade Center to collapse during the attacks on the United States on September 11, 2001, many media outlets and people began to view all people who appeared to be Muslim as terrorists. See, e.g., Muneer I. Ahmad, *A Rage Shared by Law: Post September 11 Racial Violence As Crimes of Passion*, 92 CAL. L. REV. 1259 (2004); Jon Tehranian, *Compulsory Whiteness: Towards a Middle Eastern Legal Scholarship*, 82 IND. L.J. 1 (2007); Leti Volpp, *The Citizen and the Terrorist*, 49 UCLA L. REV. 1575 (2002). On the other hand, when Timothy McVeigh, a white man, detonated a bomb in front of the Oklahoma City federal building, society viewed him as an anomaly, not representative of his race, and people did not begin to perceive all whites, by extension, as murderous terrorists. See, e.g., MELANIE E.L. BUSH, *EVERYDAY FORMS OF WHITENESS: UNDERSTANDING RACE IN A POST-RACIAL WORLD* 92–93 (2011).

44. *Chicago Hope*, *supra* note 42.

45. *Id.*

46. *Id.*

47. *Id.*

48. *Id.*

49. *Id.*

50. *Id.*

51. *Id.*

52. *Id.*

53. *Id.*

54. *Id.*

PhRMA asserted that it sponsored the episode in order to educate viewers about “the risks associated with breastfeeding.”⁵⁵ The story line successfully framed baby-friendly hospital policies as extremely harmful, cast a negative light on efforts to decrease the distribution of formula in hospitals, and portrayed the white mother as innocent. Through a powerful medium that reached millions of viewers, the episode reconfigured Tabitha’s story to allow the demonization of black mothers to remain in place while furthering the agenda of the formula corporations and discouraging government intervention to promote breastfeeding. Deflecting attention away from the structural challenges faced by Tabitha Walrond and Tatiana Cheeks as low-income black women, it portrayed hospitals and breastfeeding advocates as the “bad guys.” It also relied on the racial trope of the “magical negro,” embodied here by the wise black characters (the two black doctors and the black new mother) who guide the white woman (Dr. Grad) to a spiritual revelation.⁵⁶ Once the white woman achieves her epiphany, the audience can then experience the black characters’ wisdom as truth. In this case, the “truth” revealed is that breastfeeding kills and formula saves babies’ lives. In reality, however, formula feeding leads to thousands of deaths a year and deprives countless more infants of the immunological benefits of breastfeeding.

Unfortunately, the real-life failure of any state or city to pass legislation that requires hospitals to adopt baby-friendly practices reinforces the *Chicago Hope* episode’s message and supports the formula industry’s goal to promote formula feeding.⁵⁷ This lack of regulation, in addition to a host of other law and policy decisions that comprise a policy framework related to breastfeeding, disproportionately harms black women.⁵⁸ Analysis of this problem under a food oppression paradigm demonstrates that this policy framework, developed in large part in response to the political influence of the formula industry, contributes to racial disparities in breastfeeding that lead to significant health disparities. Racial stereotypes and common perceptions that the choice of whether or not to breastfeed is an individual, not structural, one render this disparate harm invisible. These ideologies make successful breastfeeding appear to be a natural result of personal and cultural attributes instead of deliberate legal and policy choices.

This Article analyzes racial disparities in breastfeeding through a food oppression lens. Part II describes the health benefits of breastfeeding and discusses racial disparities in breastfeeding and related health outcomes. Part III applies the elements of food oppression and argues that cooperation between the formula industry and the government creates a breastfeeding policy framework that leads to poor health outcomes for black infants and

55. Margaret Bentley et al., *Breastfeeding Among Low Income, African-American Women: Power, Beliefs and Decision Making*, 133 J. NUTRITION 305S, 306S (2003); see also Granju, *supra* note 41.

56. See, e.g., Susan Gonzalez, *Director Spike Lee Slams ‘Same Old’ Black Stereotypes in Today’s Films*, 29 YALE BULLETIN, Mar. 2, 2001, <http://www.yale.edu/opa/arc-ycb/v29.n21/story3.html>.

57. See *infra* Part III.

58. See *infra* Part III.

women. The Article concludes by identifying some implications of this analysis, which lays the groundwork for a larger project that explores in depth how the histories of racism and infant feeding intersect and contemplates the possibility of legal, political, and social reforms that might dismantle food oppression.

II. BREASTFEEDING: HEALTH BENEFITS AND RACIAL DISPARITIES

Breast milk contains living cells, active hormones, antibodies, and 400 other unique components that provide the best nutrition for infants.⁵⁹ It also provides active immunity from disease.⁶⁰ Formula, on the other hand, is a highly processed food that is essentially a junk or fast food for infants. Research links formula consumption to a host of illnesses, including cancer; ear, respiratory and blood infections; asthma; gastroenteritis; diabetes; impaired speech, language, motor, and brain development; and eczema.⁶¹ Even more alarmingly, studies associate formula feeding with significantly increased rates of infant mortality.⁶² Formula, first invented as an emergency substitute for breast milk when mothers could not breastfeed, can still save infants’ lives when necessary.⁶³ It also facilitates women’s active participation in society, particularly in light of the structural barriers to breastfeeding imposed by poverty, employment demands, welfare laws, workplace conditions, insufficient protection for working mothers, and lack of resources. Nonetheless, from a purely health perspective, formula causes harm to infants, and denies women and children the substantial benefits of breastfeeding.⁶⁴ In short, formula is unequivocally inferior to breast milk.

59. See Graham Chance, *Premie Nutrition: Mother’s Milk May Be Best*, 124 CANADIAN MED. ASSOC J. 1247, 1247–48 (1981); see also James W. Anderson, *Breast-Feeding and Cognitive Development: A Meta-Analysis*, 70 AM. J. CLINICAL NUTRITION 525, 534 (1999); Nobuyoshi Kosaka et al., *microRNA As a New Immune-Regulatory Agent in Breast Milk*, SILENCE (Mar. 1, 2010), <http://www.silencejournal.com/content/pdf/1758-907X-1-7.pdf>; Pat Thomas, *Suck on This*, 36 ECOLOGIST 22, 24 (2006).

60. See generally Chance, *supra* note 59.

61. Lawrence M. Gartner & Arthur I. Eidelman, *Breastfeeding and the Use of Human Milk*, 115 PEDIATRICS 496, 496 (2005); see also Ginna Wall, *Outcomes of Breastfeeding*, EVERGREEN PERINATAL EDUC. (Feb. 2013), http://www.lli.org/docs/cbi/outcomes_of_breastfeeding_jan_2013.pdf (collecting studies on how breastfeeding reduces the risk of suffering from sixty-eight different conditions).

62. Press Release, Nat’l Insts. Health, *Breastfeeding Decreases Infant Mortality* (May 2, 2004), available at <http://www.nih.gov/news/pr/may2004/niehs-02.htm>.

63. Thomas, *supra* note 59, at 22.

64. See, e.g., Gartner & Eidelman, *supra* note 61, at 500; Arne Høst, *Frequency of Cow’s Milk Allergy in Childhood*, 89 ANNALS ALLERGY ASTHMA IMMUNOLOGY 33, 33 (2002); Kirsi-Marjut Järvinen et al., *Cow’s Milk Challenge Through Human Milk Evokes Immune Responses in Infants with Cow’s Milk Allergy*, 135 J. PEDIATRICS 506, 511–12 (1999); Johanna Paronen et al., *Effect of Maternal Diet During Lactation on Development of Bovine Insulin-Binding Antibodies in Children at Risk for Allergy*, 106 J. ALLERGY CLINICAL IMMUNOLOGY 302, 304–05 (2000); Hugh A. Sampson, *Food Allergy. Part 1: Immunopathogenesis and Clinical Disorders*, 103 J. ALLERGY CLINICAL IMMUNOLOGY 717, 718 (1999); see also, e.g., Bonnie Rochman, *Why Pediatricians Say Breastfeeding Is About Public Health, Not Just Lifestyle*, TIME (Feb. 29, 2012), <http://healthland.time.com/2012/02/29/why-pediatricians-say-breast-feeding-is-about-public-health-not-just-lifestyle/#ixzz2ka6TDASs>; *Breastfeeding*, WORLD HEALTH ORG., <http://www.who.int/topics/>

Ideally, for the health of mothers and babies, women should breastfeed exclusively for six months.⁶⁵ They should continue to breastfeed while providing complementary foods until a child is two years old, and beyond two years as long as the mother and child desire.⁶⁶ Unless a mother is able to stay home with her child twenty-four hours a day to perform breastfeeding on demand, or bring her child to work, she must pump milk into bottles that other caregivers can feed to her infant. Mothers must pump at regular intervals that generally coincide with the baby's individual feeding schedule and demands. Although women can pump by hand, the most efficient method is through use of an electric pump.⁶⁷ Pumping, or "expressing milk," requires a sink to wash hands, an electric outlet to plug in the pump, a private space in which to use the pump, and a cool place to store the bottles of expressed breast milk.⁶⁸ A pumping session can last up to thirty minutes. To breastfeed a baby while outside the home, a mother requires a comfortable, private place where she can sit for the duration of the feeding and will not experience harassment.⁶⁹

If mothers lack access to these requirements, they have few options for feeding their babies. Traditionally, mothers who did not breastfeed used wet nurses to feed their children. A wet nurse is a woman who is lactating due to recently giving birth who feeds another woman's child with her breast milk. During slavery, black women often served as wet nurses for

breastfeeding/en (last visited Apr. 23, 2015) (advising mothers to breastfeed exclusively up to six months and with complementary foods for a minimum of two years); *Breastfeeding Frequently Asked Questions*, CTNS. DISEASE CONTROL & PREVENTION, <http://www.cdc.gov/breastfeeding/faq/> (last visited Apr. 23, 2015) (highlighting the American Academy of Pediatrics recommendations).

65. *Breastfeeding*, *supra* note 64 (advising mothers to breastfeed exclusively up to six months and with complementary foods for a minimum of two years); *Breastfeeding Frequently Asked Questions*, *supra* note 64 (highlighting the American Academy of Pediatrics recommendations).

66. *Breastfeeding*, *supra* note 64.

67. *Breastfeeding*, OFFICE ON WOMEN'S HEALTH, U.S. DEP'T OF HEALTH AND HUMAN SERVS., <http://womenshealth.gov/breastfeeding/pumping-and-milk-storage/> (last updated Aug. 1, 2010).

68. *Id.*

69. Mothers too often become targets of harassment for breastfeeding in public. Examples of these types of incidents are manifold. *See, e.g.*, Emma Grey, *Natalie Hegedus, Mom, Kicked out of Courtroom for Breastfeeding*, HUFFINGTON POST (Nov. 14, 2011, 12:26 PM), http://www.huffingtonpost.com/2011/11/14/natalie-hegedus-courtroom-breastfeeding_n_1089271.html; Meghan Hollohan, *Victoria's Secret Store Bans Mom from Breastfeeding*, TODAY PARENTS (Jan. 21, 2014, 4:57 PM), <http://www.today.com/parents/victorias-secret-store-bans-mom-breastfeeding-2D11968546>; Scott Keyes, *Shelter Allegedly Threatened to Kick Out Homeless Mother for Breastfeeding in Public*, THINKPROGRESS (June 30, 2014, 3:55 PM), <http://thinkprogress.org/health/2014/06/30/3454827/homeless-shelter-breastfeeding/>; Meredith Ley, *Local Woman Kicked Out of Church for Breastfeeding Baby*, WSAV (Feb. 18, 2012, 6:45 PM), <http://www.wsav.com/story/21212674/local-woman-kicked-out-of-church-for-breastfeeding-baby>; Carolyn Pesce, *Mom Says Cops Kicked Her Out of Concert for Breastfeeding*, USA TODAY (July 12, 2014, 7:19 PM), <http://www.usatoday.com/story/news/nation/2014/07/12/police-boot-breastfeeding-mom/12567443>; Caitlin White, *Mom Kicked Out of Restaurant for Breastfeeding*, EXAMINER.COM (Apr. 7, 2010, 1:40 PM), <http://www.examiner.com/article/mom-kicked-out-of-restaurant-for-breastfeeding>.

white women’s babies.⁷⁰ Performing this role forced black women to stop nursing their own children, because slave owners compelled them to stay with the white infant all day, making it impossible for the black woman to feed her own child on demand or express milk.⁷¹ This act of removing mothers from their children at such a young age required moral justification in the form of stories about black women as bad and uncaring mothers.⁷² These stories, as illustrated by Tabitha Walrond’s case, continue into the present.

Privileged women of other eras hired poor women of color to act as wet nurses to their infants because society considered breastfeeding to be low class.⁷³ In many rural communities, however, women served as wet nurses to each other’s children to facilitate community goals of work and harvesting.⁷⁴ The breakdown of these communities, due to industrialization and the Great Migration of black families from the South to the North, eliminated the support system of wet nurses and forced women to turn to breast milk substitutes.⁷⁵ Cow’s milk was a common breast milk substitute during industrialization, but lack of pasteurization caused many infant deaths due to contamination of the milk during transport from rural farms to urban areas.⁷⁶ Later, evaporated milk, which is milk mixed with sugar, became a popular breast milk substitute.⁷⁷ Today, infant formula, which consists of chemicals mixed with either cow or soy milk and added sugars, is the most common breast milk substitute, and formula is a multibillion dollar industry.⁷⁸

By 2020, the U.S. Breastfeeding Committee seeks to increase the proportion of infants who are ever breastfed to 81.9 percent and the proportion still breastfed at one year to 34.1 percent.⁷⁹ In light of these targets, the disparities in breastfeeding between black women and other racial groups are dramatic.⁸⁰ According to data from 2008, approximately 75 percent of white mothers and 80 percent of Latina mothers report trying breastfeeding, while only 59 percent of black mothers ever try, with only 12 percent still breastfeeding at one year.⁸¹ In contrast, 26.3 percent of Latinas

70. See DUNAWAY, *supra* note 37, at 139.

71. *Id.*

72. *Id.* at 140.

73. Emily Stevens, *A History of Infant Feeding*, 18 J. PERINATAL EDUC. 32, 34 (2009).

74. E. MELANIE DUPUIS, NATURE’S PERFECT FOOD: HOW MILK BECAME AMERICA’S DRINK 54–55 (2003).

75. Stevens, *supra* note 73, at 34.

76. DUPUIS, *supra* note 74, at 46–50.

77. Stevens, *supra* note 73, at 36.

78. In 2005, the global market for infant formula was estimated to be worth \$7.9 billion. Markos Kaminis, *A Growing Boost for Baby Formula*, BLOOMBERG BUS. (Jan. 10, 2005), <http://www.bloomberg.com/bw/stories/2005-01-10/a-growing-boost-for-baby-formula>.

79. *Healthy People 2020: Breastfeeding Objectives*, U.S. BREASTFEEDING COMM., <http://www.usbreastfeeding.org/p/cm/ld/fid=221> (last visited Apr. 23, 2015).

80. See Bentley et al., *supra* note 55, at 305S–309S.

81. *Progress in Increasing Breastfeeding and Reducing Racial/Ethnic Differences—United States, 2000–2008 Births*, 62 MORBIDITY & MORTALITY WKLY. REP. 77, 77–78 (2013), available at <http://www.cdc.gov/mmwr/pdf/wk/mm6205.pdf>.

and 24.3 percent of white women still breastfeed at one year.⁸² This stark difference does not result purely from income disparities. Latinas generally experience poverty rates similar to black women yet breastfeed at the highest rates.⁸³ Additionally, black women's breastfeeding rates are low at all socioeconomic class levels.⁸⁴ The low breastfeeding rates of black mothers thus require an understanding of how and why race, isolated from socioeconomic status, affects infant feeding.⁸⁵ Other legal scholars have strategized to increase breastfeeding generally,⁸⁶ but the legal academy has yet to confront the problem of racial disparities in breastfeeding.

Breastfeeding has a significant impact on the health of the black community. Black infants suffer from almost double the mortality rates of white infants in the United States, and more than double the mortality rates of Latino, Asian/Pacific Islander, and American Indian/Native Alaskan infants.⁸⁷ Low breastfeeding rates deprive individuals and communities of many "health, nutritional, immunologic[al], developmental, psychologic[al], social, economic, and environmental benefits."⁸⁸ Further, black women may derive unique benefits from breastfeeding. An epidemiologist's study found that breastfeeding could counteract a specific form of breast cancer to which black women are particularly susceptible

82. *Id.* at 78.

83. *See, e.g.*, SUZANNE MACARTNEY ET AL., U.S. CENSUS BUREAU, POVERTY RATES FOR SELECTED DETAILED RACE AND HISPANIC GROUPS BY STATE AND PLACE: 2007–2011, at 3 (2013), available at <http://www.census.gov/prod/2013pubs/acsbr11-17.pdf> (reporting poverty rates of 25.8 percent for blacks and 23.2 percent for Latinos).

84. Elizabeth Brand et al., *Factors Related to Breastfeeding Discontinuation Between Hospital Discharge and 2 Weeks Postpartum*, 20 J. PERINATAL EDUC. 36, 38 (2011) ("Black women had both lower initiation and duration rates than White women regardless of other demographic and socioeconomic variables."). Additionally, "[w]hen demographic variables were considered, race or ethnicity . . . emerged as a factor in breastfeeding cessation: Some women from racial or ethnic minorities (Black and Hispanic) stopped breastfeeding in greater proportions than White women." *Id.* at 40.

85. For a discussion of the intersection of empirical methodology and critical race theory, see Kimani Paul-Emile, *Foreword: Critical Race Theory and Empirical Methods Conference*, 83 FORDHAM L. REV. 2953 (2015).

86. *See, e.g.*, Heather M. Kolinsky, *Respecting Working Mothers with Infant Children: The Need for Increased Federal Intervention to Develop, Protect, and Support a Breastfeeding Culture in the United States*, 17 DUKE J. GENDER L. & POL'Y 333 (2010); Benjamin Mason Meier & Miriam Labbok, *From the Bottle to the Grave: Realizing a Human Right to Breastfeeding Through Global Health Policy*, 60 CASE W. RES. L. REV. 1073 (2010).

87. Donna L. Hoyert & Jiaquan Xu, *Deaths: Preliminary Data for 2011*, 61 NAT'L VITAL STAT. REP. 1, 9–15 (2012), available at http://www.cdc.gov/nchs/data/nvsr/nvsr61/nvsr61_06.pdf. In 2011, 1051 out of 100,000 black infants died as compared to 523 white infants, 458 Latino infants, 445 American Indian/Alaskan Native infants, and 378 Asian/Pacific Islander infants. *Id.*

88. Gartner & Eidelman, *supra* note 61, at 496; *see also* Wall, *supra* note 61 (collecting studies on how breastfeeding reduces the risk of suffering from sixty-eight different conditions including sudden infant death syndrome, cancer, ear, respiratory and blood infections, asthma, diabetes, impaired speech, language, motor and brain development, and diarrhea).

after multiple childbirths.⁸⁹ Although race-based medical studies are problematic on many levels,⁹⁰ this type of research may be helpful because it has the potential to lay a medical and scientific foundation for efforts designed specifically to increase breastfeeding in the black community.

The factors contributing to racial disparities in breastfeeding are manifold, complex, and interconnected. They include comfort with formula; lack of information about infant behavior; cultural norms, including discouragement of breastfeeding; media influence; race-targeted marketing; disproportionate representation among the poor and in federal programs to assist women and children; unequal distribution of resources for new mothers; immigration status; and historical and present discrimination.⁹¹ Underlying many of these factors is the symbiotic relationship between the U.S. government and formula corporations that invests the government in formula use over breastfeeding.⁹² This

89. See Melissa Healy, *Breastfeeding Counteracts Risk for a Type of Cancer*, *Study Says*, L.A. TIMES (Aug. 16, 2011), <http://www.latimes.com/health/boostershots/la-heb-breastfeeding-cancer-black-women-20110816,0,6211906.story?track=rss#axzz2rMB1xSk5>.

90. See DOROTHY ROBERTS, *FATAL INVENTION: HOW SCIENCE, POLITICS, AND BIG BUSINESS RE-CREATE RACE IN THE TWENTY-FIRST CENTURY* 64–66 (2011) (noting that among multiple genetic studies, “none support dividing the species into discrete, genetically determined racial categories”); Rene Bowser, *Race As a Proxy for Drug Response: The Dangers and Challenges of Ethnic Drugs*, 53 DEPAUL L. REV. 1111, 1112 (2004); Lundy Braun et al., *Racial Categories in Medical Practice: How Useful Are They?*, 4 PUB. LIBR. SCI. MED. 1423, 1423 (2007); Andrea Freeman, *The Unbearable Whiteness of Milk: Food Oppression and the USDA*, 3 U.C. IRVINE L. REV. 1251, 1254 (2013); Duana Fullwiley, *Race and Genetics: Attempts to Define the Relationship*, 2 BIOSOCIETIES 221, 223–24 (2007); Shubha Ghosh, *Race-Specific Patents, Commercialization, and Intellectual Property Policy*, 56 BUFF. L. REV. 409, 449–54 (2008); Ian F. Haney López, *The Social Construction of Race: Some Observations on Illusion, Fabrication, and Choice*, 29 HARV. C.R.-C.L. L. REV. 1, 13–14 (1994); Sharona Hoffman, *“Racially-Tailored” Medicine Unraveled*, 55 AM. U. L. REV. 395, 400–03 (2005); William M. Richman, *Genetic Residues of Ancient Migrations: An End to Biological Essentialism and the Reification of Race*, 68 U. PITT. L. REV. 387, 388 n.3 (2006).

91. See, e.g., Sara Afflerback et al., *Infant-Feeding Consumerism in the Age of Intensive Mothering and Risk Society*, 13 J. CONSUMER CULTURE 387 (2013); Amy M. Burdette & Natasha V. Pilkauskas, *Maternal Religious Involvement and Breastfeeding Initiation and Duration*, 102 AM. J. PUB. HEALTH 1865 (2012); Ann C. Celi et al., *Immigration, Race/Ethnicity, and Social and Economic Factors As Predictors of Breastfeeding Initiation*, 159 ARCHIVES PEDIATRICS ADOLESCENT MED. 255 (2005); Laura Duberstein Lindberg, *Women’s Decisions About Breastfeeding and Maternal Employment*, 58 J. MARRIAGE & FAM. 239 (1996); Elizabeth Hildebrand Matherne, *The Lactating Angel or Activist? Public Breastfeeding As Symbolic Speech*, 15 MICH. J. GENDER & L. 121 (2008); Marianne Neifert & Maya Bunik, *Overcoming Clinical Barriers to Exclusive Breastfeeding*, 60 PEDIATRIC CLINICS N. AM. 115, 127 (2013); Laurie A. Nommsen-Rivers et al., *Comfort with the Idea of Formula Feeding Helps Explain Ethnic Disparity in Breastfeeding Intentions Among Expectant First-Time Mothers*, 5 BREASTFEEDING MED. 25 (2010); Phyllis L. F. Rippeyoung & Mary C. Noonan, *Is Breastfeeding Truly Cost Free? Income Consequences of Breastfeeding for Women*, 77 AM. SOC. REV. 244 (2012); Jean-Anne Sutherland, *Mothering, Guilt and Shame*, 4 SOCIOLOGY COMPASS 310, 317–18 (2010); Erin N. Taylor & Lora Ebert Wallace, *For Shame: Feminism, Breastfeeding Advocacy, and Maternal Guilt*, 27 HYPATIA 76 (2012); *Are You Mom Enough?*, TIME, May 21, 2012 (cover).

92. See *infra* Part III.D.

partnership harms women and infants in all communities but has a disproportionately negative impact on black women and children.⁹³

III. RACIAL DISPARITIES IN BREASTFEEDING AS FOOD OPPRESSION

Food oppression theory serves as a useful framework for this problem because it provides the tools to deconstruct the collaboration between industry and government, identify government priorities that trump individuals' health needs, and expose the myth of race and class neutrality in policy and legal choices. As I have previously argued, food oppression is "institutional, systemic, food-related action or policy that physically debilitates a socially subordinated group."⁹⁴ Breastfeeding is a food justice issue involving our first, and perhaps most important, food. Many infants grow up in first food deserts, similar to the fast food deserts where many low-income black communities face structural challenges to healthy eating.⁹⁵

Food oppression has five elements: (1) facially neutral food-related law, policy, or action; (2) disproportionately harmful impact of this law, policy, or action on the health of a socially marginalized group or groups; (3) health disparities in food-related conditions between this group and the dominant one; (4) corporate/industry influence over the government that causes or contributes to the enactment or continuation of the law, policy, or action; and (5) the existence of cultural values and/or racial stereotypes that make racial disparities appear natural and frustrate efforts to institute structural reform.

A. *Facially Neutral Laws and Policies That Affect Women's Ability to Breastfeed*

The policy framework that affects women's ability to breastfeed consists of policies that serve to promote formula and laws that act to discourage breastfeeding. Policies that affirmatively promote formula include the distribution of formula through the Special Supplemental Nutrition Program for Women and Children (WIC); the failure of the United States to adopt the World Health Organization's standards for marketing breast milk; the lack of baby-friendly requirements for hospitals, and the FDA's decision not to place warning labels on infant formula.⁹⁶ Laws that make breastfeeding difficult, particularly for low-income women, include welfare reform and workplace accommodation of breastfeeding laws. All of these

93. See *infra* Part III.

94. See Freeman, *supra* note 90, at 1253; see also Andrea Freeman, *Fast Food: Oppression Through Poor Nutrition*, 95 CAL. L. REV. 2221, 2222 (2007) ("Food oppression is structural because it is not the product of individual acts of discrimination, but stems rather from the institutionalized practices and policies of government and the fast food industry.").

95. Fast food deserts are one example of food oppression. See generally Freeman, *supra* note 94.

96. See Tara Swenson, *Insuring a Healthier Society: The Need for Breastfeeding Promotion and Support Through Private Insurance and Government Initiatives*, 16 KAN. J.L. & PUB. POL'Y 20, 25, 35, 39–40 (2006).

laws and policies are facially neutral regarding race. They do not explicitly mention or purport to target any particular racial group. Some of them, however, refer to socioeconomic class. Eligibility for WIC and welfare depends on socioeconomic standing, as these programs seek to provide benefits for individuals living in or near poverty. The legislative history of workplace accommodation laws similarly reveals an intention to assist low income women.

1. Distribution of Formula Through WIC

The government purchases more than half of the formula sold in the United States to distribute to WIC participants at no cost to them.⁹⁷ The government pays only a fraction of the retail cost of formula, however, because it receives large rebates on its purchases, ranging from 85 percent to 98 percent.⁹⁸ Because of the high profit margin on formula, the formula companies have wide latitude to “lose” money on government sales in order to gain profits in sales to regular consumers.⁹⁹ The formula companies compensate for the losses incurred from the rebates by raising retail prices, creating a cross-subsidy by non-WIC clients of WIC participants’ formula purchases.¹⁰⁰ By creating brand loyalty through government distribution of their product, formula companies also create a wide customer base of ex-WIC recipients.¹⁰¹ In 2013, 53 percent of all infants born in the United States received WIC.¹⁰² Women in the WIC program breastfeed at a rate of one half to one third the rate of non-WIC clients.¹⁰³

Distributing formula through WIC represents a powerful endorsement of its use, and the program does not distribute based on individual circumstances, such as difficulties with breastfeeding or work responsibilities. Additionally, formula companies provide strong incentives to WIC staff members to supply formula to their participants: the funds that

97. Ruth Marcus, *Lobbying Fight over Infant Formula Highlights Budget Gridlock*, WASH. POST (July 14, 2010), <http://www.washingtonpost.com/wp-dyn/content/article/2010/07/13/AR2010071304634.html>. In 2009, infant formula accounted for \$850 million of WIC’s \$7.3 billion budget. *Id.*

98. George Kent, *The High Price of Infant Formula in the United States*, AGROFOOD INDUSTRY HIGH TECH, Sept./Oct. 2006, at 21 [hereinafter Kent, *Infant Formula*]; George Kent, *WIC’s Promotion of Infant Formula in the United States*, INT’L BREASTFEEDING J., Apr. 2006, at 4 [hereinafter Kent, *WIC’s Promotion*], available at <http://www.internationalbreastfeedingjournal.com/content/pdf/1746-4358-1-8.pdf>.

99. Kent, *Infant Formula*, *supra* note 98, at 22.

100. *Id.*

101. *Id.*

102. *Women, Infants, and Children (WIC)*, U.S. DEP’T OF AGRIC., <http://www.fns.usda.gov/wic/about-wic-wic-glance> (last updated Feb. 27, 2015).

103. Kent, *WIC’s Promotion*, *supra* note 98, at 6.

In 1990, the breastfeeding rate for non-WIC people was 15.4 percentage points higher than that for WIC clients, while in 2002 that difference rose to 21.1 percentage points. In terms of ratios, the data show that the breastfeeding rate at six months for WIC participants has consistently been only one third to one half the rate for non-WIC participants. The differences, and also the ratios, suggest that on balance WIC participation *retarded* breastfeeding rates for its clients.

Id.

the program receives in the form of rebates increase the program's budget, thereby allowing for service to a wider community, which fulfills one of WIC's core program objectives.¹⁰⁴

Agricultural subsidies also provide the Department of Agriculture (USDA), the agency that administers WIC, strong motivation to distribute formula to participants. The Farm Bill, also administered by the USDA, provides financial support to both dairy and soybean farmers.¹⁰⁵ This support results in a surplus of both commodities.¹⁰⁶ To dispose of these surpluses, the USDA seeks to create or support secondary markets for milk and soy.¹⁰⁷ Formula products all contain either milk or soy. The USDA is therefore able to satisfy one of its primary mandates, the sale of subsidized commodities, by using the WIC program to create a significant, in fact the largest, domestic market for formula.

On their part, in connection with the rebates offered for WIC purchases, the formula companies have succeeded in pushing for legislation that increases their profits. In 2002, the formula corporations began to offer some products with new additives designed to mimic the fatty acids in breast milk.¹⁰⁸ The addition of these ingredients rendered formula products that contained them more expensive.¹⁰⁹ To ensure continued sales at these higher prices, when Congress reauthorized WIC in 2004, it introduced language into the Act prohibiting states from requiring manufacturers to include or omit specific ingredients in their formula bids.¹¹⁰ Formula companies consequently "began submitting bids only for the costlier products," resulting in an additional \$91 million annual cost to the government, representing more than one-tenth of the infant formula budget.¹¹¹ The Food and Drug Administration approved these additives' safety but has not researched the companies' claims that the additives enhance brain development.¹¹²

2. The U.S. Failure to Adopt the WHO Ban on Advertising of Breast Milk Substitutes

In 1981, 118 countries voted to adopt the World Health Organization's (WHO) International Code of Marketing of Breast-milk Substitutes.¹¹³ The

104. *Id.*

105. The dairy program is Subchapter III, Agricultural Act of 2014, 7 U.S.C. § 9051 (2012). Soy is a "covered commodity" eligible for subsidies. *Id.* § 8702(4).

106. Michael Pollan, *You Are What You Grow*, N.Y. TIMES MAG., Apr. 22, 2007, available at <http://michaelpollan.com/articles-archive/you-are-what-you-grow/>; see also Andrea Freeman, *Farm Subsidies and Food Oppression*, 38 SEATTLE L. REV. (forthcoming 2015).

107. See Freeman, *supra* note 90, at 1266–68; Pollan, *supra* note 106.

108. Marcus, *supra* note 97.

109. *Id.*

110. *Id.*

111. *Id.*

112. *Id.*

113. Dale D. Murphy, *Interjurisdictional Competition and Regulatory Advantage*, 8 J. INT'L ECON. L. 891, 913 (2005).

WHO developed the code in response to evidence of high infant mortality rates linked to formula feeding internationally and evidence that advertising increases formula feeding rates.¹¹⁴ Three countries abstained from the vote to adopt the code; the United States was the only country to oppose it.¹¹⁵ This opposition went against the intention of the State Department and resulted from heavy lobbying efforts by the formula industry.¹¹⁶

The code prohibits the promotion of breast milk substitutes to the general public and direct or indirect contact between marketing personnel and pregnant women or mothers of infants and young children. It sets standards for pictures and information on formula labels, the distribution of information and educational materials about infant feeding, the provision of free samples and supplies, and the interaction between companies and the health care system.¹¹⁷ More specifically, the code prohibits the advertising and promotion of formula to the general public,¹¹⁸ formula promotion by a facility of a health care system,¹¹⁹ donations or low-price sales of formula to health care institutions or organizations,¹²⁰ and financial or material inducements to health care workers or their families to promote formula.¹²¹ Designed to guide governments in regulating corporate advertising, it did not anticipate marketing by governments themselves, such as in the United States, where the federal government disseminates materials with infant formula logos and images in its WIC program, in addition to distributing formula itself.¹²²

Because there is no ban on formula marketing in the United States, formula companies pursue a number of marketing strategies. When formula first appeared in the 1860s, manufacturers advertised directly to consumers in magazines with claims that breast milk was insufficient for complete nourishment.¹²³ Companies also gave out free samples and instructed women on infant care and feeding.¹²⁴ The first infant formula television commercial aired in 1989.¹²⁵ Now, the industry’s primary marketing strategy is the distribution of formula through hospitals and the

114. *Id.* Exposure to formula promotion increases breastfeeding cessation during an infant’s first two weeks of life. Cynthia Howard et al., *Office Prenatal Formula Advertising and Its Effect on Breast-Feeding Patterns*, 5 *OBSTETRICS & GYNECOLOGY* 296, 296 (2000). Among women with uncertain goals or breastfeeding goals of 12 weeks or less, exposure to formula promotion shortens exclusive, full, and overall breastfeeding duration. *Id.* at 297.

115. Murphy, *supra* note 113, at 913.

116. *Id.* at 914–15.

117. WORLD HEALTH ORG., *INTERNATIONAL CODE OF MARKETING OF BREAST-MILK SUBSTITUTES* 10 (1981), available at http://www.who.int/nutrition/publications/code_english.pdf.

118. *Id.*

119. *Id.* at 11.

120. *Id.*

121. *Id.* at 12.

122. See Kent, *WIC’s Promotion*, *supra* note 98, at 7.

123. Deborah Kaplan & Kristina Graff, *Marketing Breastfeeding—Reversing Corporate Influence on Infant Feeding Practices*, 85 *J. URBAN HEALTH* 486, 489 (2008), available at <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2443254/>.

124. *Id.*

125. *Id.*

WIC program.¹²⁶ This tactic creates brand loyalty and effectively wins over significant percentages of women who would otherwise breastfeed.¹²⁷ Formula companies also successfully target pregnant women by creating and disseminating information pamphlets about the benefits of breastfeeding that display infant formula logos.¹²⁸

3. The Lack of Baby-Friendly Certification Requirements for Hospitals

Campaigns for legislation that would require hospitals to engage in baby-friendly practices arose in response to evidence that the free distribution of formula in hospitals, in combination with other practices that discourage or create obstacles to breastfeeding, negatively affects breastfeeding rates.¹²⁹ Hospitals promote formula use by giving away coupons and formula samples to new mothers during hospital stays, as well as in discharge bags upon their departures.¹³⁰ Providing new mothers with free formula strongly influences their infant feeding decisions because women who are recovering from birth rarely request information about breastfeeding beyond what their physicians provide.¹³¹ Further, insurance policies that require women to leave the hospital within twenty-four hours of a vaginal birth and forty-eight hours of a caesarian section eliminate or reduce the time necessary to guide parents through lactation and other forms of care.¹³²

The international standards for baby-friendly certification require hospitals to: (1) communicate a written breastfeeding policy routinely to all health care staff; (2) train all health care staff in the skills necessary to implement this policy; (3) inform all pregnant women of the benefits of breastfeeding; (4) help mothers initiate breastfeeding within one hour of birth; (5) show mothers how to breastfeed and how to maintain lactation, even if the hospital separates them from their infants; (6) give infants no food or drink other than breast milk, unless medically indicated; (7) practice rooming in—allow mothers and infants to remain together twenty-four hours a day; (8) encourage breastfeeding on demand; (9) give no pacifiers or artificial nipples to breastfeeding infants; (10) foster the establishment of

126. Kenneth D. Rosenberg et al., *Marketing Infant Formula Through Hospitals: The Impact of Commercial Hospital Discharge Packs on Breastfeeding*, 98 AM. J. PUB. HEALTH 290, 290 (2008); Kaplan & Graff, *supra* note 123, at 489.

127. Rosenberg et al., *supra* note 126, at 290.

128. CTRS. FOR DISEASE CONTROL & PREVENTION, THE CDC GUIDE TO STRATEGIES TO SUPPORT BREASTFEEDING MOTHERS AND BABIES 43 (2013), *available at* <http://www.cdc.gov/breastfeeding/pdf/BF-Guide-508.pdf>.

129. *See, e.g.*, Rosenberg et al., *supra* note 126.

130. *See* CTRS. FOR DISEASE CONTROL & PREVENTION, BREASTFEEDING REPORT CARD—UNITED STATES 1 (2010), *available at* <http://www.cdph.ca.gov/data/statistics/Documents/MO-BFP-BreastfeedingReportCard2010.pdf>.

131. KATHERINE R. SHEALY ET AL., THE CDC GUIDE TO BREASTFEEDING INTERVENTIONS 1 (2005), *available at* www.cdc.gov/breastfeeding/pdf/breastfeeding_interventions.pdf.

132. Burling, *supra* note 19; Stacey Burling, *Mothers Brood As Hospital Time After Labor Is Cut*, PHILA. INQUIRER, Sept. 8, 1994, at A1; Begley, *supra* note 19.

breastfeeding support groups and refer mothers to them upon discharge from the hospital or birth center.¹³³

Conversion to baby-friendly practices does not result in any significant increase in expenses for a hospital.¹³⁴ On the contrary, the costs of treating the broad range of illnesses and conditions that result from lower breastfeeding rates, including increased infant mortality rates, are far higher.¹³⁵ Nonetheless, no state or city legislature has enacted these requirements, despite the efforts of breastfeeding advocates across the country. To date, the hospitals that have implemented these bans have done so voluntarily, after city and state initiatives have failed.¹³⁶

133. BABY FRIENDLY USA, INC., GUIDELINES AND EVALUATION CRITERIA FOR FACILITIES SEEKING BABY-FRIENDLY DESIGNATION (2010), available at <https://www.babyfriendlyusa.org/get-started/the-guidelines-evaluation-criteria>.

134. Jami Dellifraie et al., *Cost Comparison of Baby Friendly and Non-Baby Friendly Hospitals in the United States*, 127 PEDIATRICS 989, 993 (2011), available at <http://pediatrics.aappublications.org/content/127/4/e989.full>.

135. “If 90% of U.S. families complied with the medical recommendations to breastfeed exclusively for 6 months, with continued breastfeeding for one year, \$13 billion could be saved and approximately 911 infant deaths could be prevented annually.” U.S. LACTATION CONSULTANT ASSOC., CONTAINING HEALTH CARE COSTS HELP IN PLAIN SIGHT 5 (2014), available at <http://uslca.org/wp-content/uploads/2013/02/Containing-Health-Care-Costs-3rd-edition-7-2014.pdf>. As a group, baby-friendly hospitals have around a 2 percent higher cost structure than non-baby-friendly facilities, but this was not found to be statistically significant. JIM LANGABEER II ET AL., AN ECONOMIC COST ANALYSIS OF BECOMING A BABY FRIENDLY HOSPITAL 1 (2009), available at http://www.breastfeedingor.org/wp-content/uploads/2012/10/baby_friendly_cost_analysis.pdf.

136. Seventy-six percent of New York City hospitals, under a program designed by then-Mayor Bloomberg, agreed to remove formula from new mothers’ sight and deliver it only upon request, accompanied by information about the significant advantages of breastfeeding. Inae Oh, *Bloomberg’s Breastfeeding Program, ‘Latch on NYC,’ Wants Hospitals to Change Baby Formula Protocol*, HUFFINGTON POST (Aug. 18, 2012, 1:17 PM), http://www.huffingtonpost.com/2012/07/30/bloombergs-breast-feeding-latch-on-nyc-hospitals-hide-baby-formula_n_1718664.html.

In 2012, former NYC mayor Bloomberg introduced “Latch On NYC,” a program that encouraged hospitals to make it difficult for new moms to obtain formula “goody bags.” Instead of traditional take-home being handed out, mothers have to request them like medication, and listen to a lecture from hospital staff discouraging formula feeding, unless absolutely necessary. At the time, the initiative faced its own backlash. Many argued that Bloomberg’s tactics would make mothers feel guilty, and as blogger Lenore Skenazy put it, “suck the choice out of parenting.” *Breastfeeding Is Now Required by Law in the United Arab Emirates*, HUFFINGTON POST (Aug. 26, 2014, 10:59 AM), http://www.huffingtonpost.com/2014/01/30/united-arab-emirates-breastfeeding-law_n_4689740.html. In 2012, Massachusetts hospitals implemented a statewide ban through their Public Health Council, after having the ban overturned when then-Governor Romney replaced council members in favor of the ban in 2005. Jessica Samakow, *Massachusetts Hospitals Ban Free Baby Formula Gift Bags 7 Years After Mitt Romney Said No*, HUFFINGTON POST (July 18, 2012, 7:10 PM), http://www.huffingtonpost.com/2012/07/18/massachusetts-formula-ban_n_1684259.html. Rhode Island hospitals ended the practice of handing out free formula in 2011. Oh, *supra*. California has introduced a bill to incorporate baby-friendly practices. Juliet Sims & Sarah Mittermaier, *Governor Brown: Make California a Baby Friendly State*, PREVENTION INST. (Sept. 17, 2013), <http://preventioninstitute.org/ca-blog/1072-governor-brown-make-california-a-baby-friendly-state-.html>.

4. Welfare Reform

In 1996, Congress instituted significant reforms to the welfare system through the Personal Responsibility and Work Opportunity Reconciliation Act¹³⁷ (PRWORA).¹³⁸ The PRWORA dismantled the Aid to Families with Dependent Children program and replaced it with the Temporary Assistance to Needy Families (TANF) program.¹³⁹ Part of the motivation behind this change was the desire to create a path from welfare to work.¹⁴⁰ To this end, TANF gives states wider latitude to impose conditions on recipients, including work requirements and lifetime limits on receiving welfare.¹⁴¹ For example, the PRWORA mandates work requirements in all states but allows for exemptions for mothers of young children.¹⁴² TANF accordingly allows states to grant reprieves from job-related activities to women with children under the age of one, but almost all states require women who have infants six months or older to meet all TANF requirements.¹⁴³ For example, Michigan requires women to report to work after their babies are six weeks old.¹⁴⁴ As a result of the welfare-to-work shift implemented by TANF, breastfeeding rates significantly decreased, particularly after babies reach six months of age.¹⁴⁵

5. Inadequate Workplace Accommodation Laws

Mothers who work full time breastfeed at lower rates than part-time or unemployed mothers do.¹⁴⁶ Without sufficient accommodations for breastfeeding at work, including a private place to express milk, a

137. Pub. L. No. 104-193, 110 Stat. 2105 (codified in scattered sections of 7, 8, 21, 42 U.S.C.).

138. See Rebecca M. Blank, *Policy Watch: The 1996 Welfare Reform*, 11 J. ECON. PERSPECTIVES 169, 169 (1997).

139. *Id.* at 170.

140. Personal Responsibility and Work Opportunity Reconciliation Act, Pub. L. No. 104-193 (1996) (codified at 42 U.S.C. § 601). The goals of TANF are to

(1) provide assistance to needy families so that children may be cared for in their own homes or in the homes of relatives; (2) end the dependence of needy parents on government benefits by promoting job preparation, work, and marriage; (3) prevent and reduce the incidence of out of wedlock pregnancies and establish annual numerical goals for preventing and reducing the incidence of these pregnancies; and (4) encourage the formation and maintenance of two parent families.

Id.

141. H. COMM. ON WAYS AND MEANS, 104TH CONG., SUMMARY OF WELFARE REFORMS MADE BY PUBLIC LAW 104-193, at 14 (Comm. Print 1996) [hereinafter WELFARE REFORMS], available at <http://www.gpo.gov/fdsys/pkg/CPRT-104WPRT27305/pdf/CPRT-104WPRT27305.pdf>; Steven Haider et al., *Welfare Work Requirements and Individual Well-Being: Evidence from the Effects on Breastfeeding* 3 (RAND, Working Paper No. 02-01, 2002).

142. WELFARE REFORMS, *supra* note 141, at 15.

143. Diane R. Pagen, *Breastfeeding Is a Must . . . for Moms Who Can Afford It*, CITY LIMITS (Feb. 25, 2011), <http://www.citylimits.org/conversations/129/breastfeeding-welfare>.

144. MICH. COMP. LAWS ANN. § 67.1 (West 2013); Pagen, *supra* note 143.

145. See Haider et al., *supra* note 141, at 9 tbl.1.

146. See *id.* at 6; see also Marcy Karin & Robin Runge, *Breastfeeding and a New Type of Employment Law*, 63 CATH. U. L. REV. 329, 330–31 (2014).

refrigerator to store expressed breast milk, and sufficient and flexible breaks to allow for pumping, working women simply cannot continue to provide their infants with a sufficient supply of breast milk.¹⁴⁷ Therefore, because breastfeeding accommodation laws do not require employers to provide nursing mothers with all of these things, they are inadequate. In particular, these laws fail to protect low-income women, who possess less power to negotiate for policies that meet their needs in the workplace.

Amendments to the Fair Labor Standards Act (FLSA) in 2010 sought specifically to increase breastfeeding rates for low-income women because higher-income women “have the highest rates of initiation and continuation of breastfeeding.”¹⁴⁸ These amendments require an employer to provide “a reasonable break time for an employee to express breast milk for her nursing child for one year after the child’s birth each time such employee has need to express the milk” and “a place, other than a bathroom, that is shielded from view and free from intrusion from coworkers and the public, which may be used by an employee to express breast milk.”¹⁴⁹ There is an exception for employers with fifty employees or less if the employers can prove that the provisions would impose an undue hardship.¹⁵⁰

Unfortunately, because these amendments are not comprehensive, they are unlikely to increase breastfeeding rates for low-income working women significantly. The FLSA fails to require employers to provide storage for a breastfeeding pump, supplies, and expressed milk, all of which are necessary to pump at work.¹⁵¹ Also, it does not protect breastfeeding women from workplace discrimination and does not apply to exempt employees.¹⁵² Finally, the FLSA does not require employers to compensate employees for time spent pumping,¹⁵³ rendering pumping economically infeasible for women who cannot afford to give up any of their wages.¹⁵⁴

147. See Lisa Hansen, Note, *A Comprehensive Framework for Accommodating Nursing Mothers in the Workplace*, 59 RUTGERS L. REV. 885, 893–96 (2007).

148. See Karin & Runge, *supra* note 146, at 334.

149. 29 U.S.C. § 207(r)(1) (2012).

150. *Id.* § 207(r)(2).

151. SHEALY ET AL., *supra* note 131.

152. Maryn Oyoung, *Until Men Bear Children, Women Must Not Bear the Costs of Reproductive Capacity: Accommodating Pregnancy in the Workplace to Achieve Equal Employment Opportunities*, 44 MCGEORGE L. REV. 515, 529 (2013). Also, for a comprehensive analysis of women’s and infants’ immediate post-partum needs, see Sarudzayi M. Matambanadzo, *The Fourth Trimester*, 48 U. MICH. J. L. REFORM 117 (2014). Exempt employees earn a salary instead of an hourly wage. Employers do not need to provide them with minimum wage, overtime, and other protections. These positions are generally classified as administrative, professional, or executive. See 29 U.S.C. § 207(r)(2).

153. 29 U.S.C. § 207(r)(2).

154. *Id.* § 207(r)(1); see also Brit Mohler, Note, *Is the Breast Best for Business?: The Implications of the Breastfeeding Promotion Act*, 2 WM. & MARY BUS. L. REV. 155, 177–78 (2011) (“[T]he law does not require the employer to pay the employee for additional time taken”); *Fact Sheet #73: Break Time for Nursing Mothers under the FLSA*, U.S. DEP’T OF LABOR, <http://www.dol.gov/whd/regs/compliance/whdfs73.htm> (last updated Aug. 2013) (“Employers are not required under the FLSA to compensate nursing mothers for breaks taken for the purpose of expressing milk.”).

Twenty-five states, the District of Columbia, and Puerto Rico have their own laws related to breastfeeding in the workplace.¹⁵⁵ In the other twenty-five states, the FLSA controls.¹⁵⁶ The FLSA does not preempt the laws in six states that offer greater protection than federal law provides.¹⁵⁷ For example, Indiana compels employers to provide refrigeration or other cold storage for expressed milk¹⁵⁸ and to offer employees paid breastfeeding breaks.¹⁵⁹ Colorado requires employers to provide unpaid breaks for milk expression for up to two years after birth, instead of the one year mandated by the FLSA.¹⁶⁰ Both Maine and Vermont require pumping breaks for nursing mothers for up to three years.¹⁶¹ Oregon's statute provides for break time for up to eighteen months, applies to employers with twenty-five employees or more, and offers additional protections for school board employees.¹⁶² Oregon's law also contains statutory civil penalties for employers who fail to comply.¹⁶³ Tennessee's statute applies to employers with one or more employees.¹⁶⁴

Three states incentivize their protections for nursing mothers by creating the opportunity for employers to earn the label of mother- or infant-friendly.¹⁶⁵ To achieve this designation, an employer must allow for a flexible work schedule, provide a private location for pumping, give mothers access to a clean, safe water source and a sink, and offer a hygienic storage place for expressed milk.¹⁶⁶ Puerto Rico provides tax incentives to businesses that give women time to nurse.¹⁶⁷ Nonetheless, despite some promising advances in workplace accommodation laws, these laws generally do not protect women who work several jobs or for small businesses.

155. See *Breastfeeding State Laws*, NAT'L CONF. OF STATE LEGISLATURES (Jan. 12, 2015), <http://www.ncsl.org/research/health/breastfeeding-state-laws.aspx>; see also Matthew Williams, *Let 'Em Work, Let 'Em Nurse: Accommodation for Breastfeeding Employees in West Virginia*, 111 W. VA. L. REV. 1017, 1040 (2009).

156. For a discussion of the breastfeeding laws of various states, see *Breastfeeding State Laws*, *supra* note 155.

157. *Fact Sheet #73*, *supra* note 154.

158. IND. CODE § 22-2-14-2(b) (LexisNexis 2013).

159. *Id.* § 5-10-6-2(a).

160. COLO. REV. STAT. § 8-13.5-104(1) (2013).

161. ME. REV. STAT. ANN. tit. 26, § 604 (2013); VT. STAT. ANN. tit. 21, § 305(a) (2014).

162. OR. REV. STAT. ANN. § 653.077 (West 2013).

163. *Id.* § 653.256.

164. TENN. CODE ANN. § 50-1-305(a) (2012).

165. TEX. HEALTH & SAFETY CODE ANN. § 165.003 (West 2013). North Dakota and Washington allow employers use the designation "infant friendly" if it complies with similar requirements to those in the Texas statute. N.D. CENT. CODE § 23-12-17 (2013); WASH. REV. CODE ANN. § 43.70.64 (West 2014).

166. TEX. HEALTH & SAFETY CODE ANN. § 165.003; N.D. CENT. CODE § 23-12-16; WASH. REV. CODE § 43.70.64.

167. P.R. LAWS ANN. tit. 29, § 478g (2011).

*B. Disproportionate Harm to Black Women and Children
Resulting from Breastfeeding Laws and Policies*

The preceding breastfeeding policy framework causes disproportionate harm to black women because they experience unique forms of subordination and marginalization that make them more vulnerable both to the promotion of formula and to structural obstacles to breastfeeding. The policy framework also exacerbates intersectional harm, causing low-income women to experience greater burdens on their ability to breastfeed than higher income black women, although disparities in breastfeeding between black women and white and Latina women exist at all class levels.¹⁶⁸

Black women confront the harms of the breastfeeding policy framework in the context of simultaneously facing discrimination in almost every aspect of life, including housing, employment, education, and the criminal justice system. Historical oppression has led to a wealth gap between whites and blacks, producing a one-to-twenty ratio in black-white wealth by 1984 that continues to increase.¹⁶⁹ The poverty that results from this wealth gap, unequal pay for equal work, fewer job opportunities, mass incarceration, and employment discrimination leads to a lack of political power to challenge inequities in treatment by state institutions such as child protective services (CPS). CPS targets black women and more frequently removes their children from the home.¹⁷⁰ According to data from 2003, although black children make up only 41 percent of the country’s child population, they represent over 59 percent of the children in the foster care system.¹⁷¹ When CPS removes a child from her mother, breastfeeding is not possible. High incarceration rates in the black community also impede breastfeeding. Incarcerated women face many challenges to breastfeeding.¹⁷² Additionally, when employed black males become incarcerated, their partners must work. Also, mass incarceration of black men, historic devaluation of black women as mates,¹⁷³ and other social and

168. See Brand et al., *supra* note 84.

169. See MELVIN OLIVER & THOMAS SHAPIRO, BLACK WEALTH/WHITE WEALTH: A NEW PERSPECTIVE ON RACIAL INEQUALITY 25 (2006).

170. See DOROTHY ROBERTS, SHATTERED BONDS: THE COLOR OF CHILD WELFARE 6 (2002); Jessica Dixon, *The African-American Child Welfare Act: A Legal Redress for African-American Disproportionality in Child Protection-Cases*, 10 BERKELEY J. AFR.-AM. L. & POL’Y 109, 110 (2008).

171. Dixon, *supra* note 170, at 112.

172. See, e.g., Doug Schneider, *Wis. Woman Complains She Wasn’t Allowed to Breastfeed in Jail*, USA TODAY (Mar. 3, 2014), <http://www.usatoday.com/story/news/nation/2014/03/03/breastfeeding-not-allowed-in-jail/5968445/>; see also Katy Huang et al., *The Significance of Breastfeeding to Incarcerated Pregnant Women: An Exploratory Study*, 39 BIRTH 145, 152–53 (2012) (“Although most women wanted to breastfeed, being incarcerated created uncertainties in their breastfeeding plans. Removal from their familiar social and support context and uncertainty about possible separation from their infants were viewed as barriers to breastfeeding.”).

173. See ANGELA ONWUACHI-WILLIG, ACCORDING TO OUR HEARTS 136 (2013) (discussing, for example, statistics that black women have the lowest marriage rates and experience discrimination when they are in public with their white partners).

economic factors cause black communities to have more single mothers than any other racial group.¹⁷⁴

Single parents frequently work at jobs that are exempt from breastfeeding protection laws, and employees in these sectors, where employers often view their employees as fungible, cannot risk losing their jobs by making demands on their employers, however reasonable.¹⁷⁵ Black women, particularly single mothers, disproportionately hold low-income positions and work for multiple employers and for small companies.¹⁷⁶ As a result, many low-income black women do not have health insurance policies that allow for extended hospital stays after birth, where they would get assistance with lactation. Further, hospitals in black neighborhoods engage in fewer practices that promote breastfeeding than hospitals in white neighborhoods.¹⁷⁷ The greatest disparities are in early initiation of breastfeeding, limited use of breastfeeding supplements, and rooming-in.¹⁷⁸

Many black women also live in first food deserts that lack support for breastfeeding women in the form of weekly support groups, breastfeeding cafes, strong La Leche chapters, board-certified lactation consultants, or community support for public breastfeeding.¹⁷⁹ First food deserts also do not have child care facilities properly trained in handling human milk, and their public health clinics frequently refer breastfeeding women back to hospitals, which usually do not provide outpatient lactation support.¹⁸⁰

All of these realities render black women more vulnerable to a policy framework that promotes formula use. For some women, this promotion

174. See *Children in Single-Parent Families by Race*, KIDS COUNT DATA CENTER, <http://datacenter.kidscount.org/data/tables/107-children-in-single-parent-families-by#detailed/1/any/false/868,867,133,38,35/10,168,9,12,1,13,185/432,431> (last updated Jan. 2015). In 2012, black families were 67 percent single parent, Native Americans 53 percent, Latino 42 percent, white 25 percent, and Asian/Pacific Islander 17 percent. *Id.*

175. See NAT'L P'SHIP FOR WOMEN & FAMILIES, *EXPECTING BETTER: A STATE-BY-STATE ANALYSIS OF LAWS THAT HELP NEW PARENTS* 6 (3d ed. 2014), available at <http://www.nationalpartnership.org/research-library/work-family/expecting-better-2014.pdf> ("The combination of a pervasive gender based wage gap, inadequate workplace protections for pregnant women and the absence of guaranteed access to paid leave creates a precarious financial situation for too many women and their families.").

176. *African Americans*, STATE OF WORKING AM., <http://www.stateofworkingamerica.org/fact-sheets/african-americans/#sthash.681JyBYd.dpuf> (last visited Apr. 23, 2015) ("In 2011, 36 percent of blacks, including 38.1 percent of black women, were employed in low-wage jobs (earning poverty-level wages or less). Among the white labor force, 23.4 percent were employed in low-wage jobs.").

177. JENNIFER N. LIND ET AL., CTRS. FOR DISEASE CONTROL & PREVENTION, MORBIDITY AND MORTALITY WEEKLY REPORT: RACIAL DISPARITIES IN ACCESS TO MATERNITY CARE PRACTICES THAT SUPPORT BREASTFEEDING—UNITED STATES, 2011 (Aug. 22, 2014), available at <http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6333a2.htm>.

178. *Id.*

179. Kimberly Seals Allers, *Too Many U.S. Communities Are 'First Food Deserts,'* WOMEN'S ENEWS (Feb. 20, 2013), http://womensenews.org/story/sisterspace/130219/too-many-us-communities-are-first-food-deserts#.Uu2N_BaD4II. Allers's study found that New Orleans, Louisiana; Birmingham, Alabama; and Jackson, Mississippi were first food deserts. *Id.*

180. *Id.*; see also *Science You Can Use: Moms in "First Food Deserts" Are Hard Pressed to Breastfeed*, BEST FOR BABES (Apr. 16, 2013), <http://www.bestforbabes.org/science-you-can-use-moms-in-first-food-deserts-are-hard-pressed-to-breastfeed/>.

begins before they give birth, when clinics and physicians provide them with information about pregnancy and delivery through pamphlets designed and sponsored by formula companies.¹⁸¹ It continues after birth in hospitals that do not engage in baby friendly practices. Black women often face pressure from their partners not to breastfeed,¹⁸² and free formula distribution by hospitals disproportionately lowers breastfeeding rates for mothers of color.¹⁸³ Also, because doctors often give more attentive care to white women than black women,¹⁸⁴ black women may not receive the lactation support they need in the crucial first few hours of their babies’ lives. Finally, hospitals send mothers home with a discharge “gift” of formula, and many black women, upon returning home, rely on WIC for assistance.

WIC is free to distribute formula to participants because of the United States’ failure to sign on to or adopt the standards of the WHO Breast-milk Substitutes Code. The distribution of formula through WIC disproportionately harms black women because, although blacks make up only 13.2 percent of the U.S. population, black women represent 19.8 percent of WIC recipients.¹⁸⁵ The failure to adopt the code standards also allows the formula companies to engage in race-targeted marketing to black women who are pregnant or have infants.

Welfare and breastfeeding accommodation laws also disproportionately harm black women. Welfare was originally designed primarily to benefit white families.¹⁸⁶ However, due to the historical and present discrimination against black women described above, black women are disproportionately represented as TANF recipients.¹⁸⁷ Welfare-to-work laws force black

181. See U.S. DEP’T OF HEALTH & HUMAN SERVS., *THE SURGEON GENERAL’S CALL TO ACTION TO SUPPORT BREASTFEEDING* 43 (2011), available at <http://www.ncbi.nlm.nih.gov/books/NBK52682/pdf/TOC.pdf>.

182. In their study of low-income black women in Baltimore, Maryland, researchers Bentley, Dee, and Johnson found that breastfeeding rates are strongly influenced by the opinions of fathers and grandmothers. Bentley et al., *supra* note 55, at 307S. Fathers’ views had a greater impact on women’s decision to breastfeed than any other family member’s. *Id.* While fathers whose own mothers had breastfed often looked upon nursing favorably, others discouraged it due to feelings of ownership of their partners’ breasts or a sense of danger in having her breasts exposed in public. *Id.* at 308S (“I think that breastfeeding out in the public will cause you to get raped or something.”).

183. SHEALY ET AL., *supra* note 131, at 3. It also has a disproportionately negative effect on first-time mothers, ill mothers, and mothers with less than average education. *Id.*

184. See Stein, *supra* note 20.

185. “Race data show that Whites are the largest group of WIC participants (58.2 percent) followed by Blacks or African Americans (19.8 percent).” *Women, Infants, and Children (WIC) Participant and Program Characteristics 2012: Summary*, U.S. DEP’T OF AGRIC., http://www.fns.usda.gov/sites/default/files/WICPC2012_Summary.pdf (last visited Apr. 23, 2015). Blacks are only 13.2 percent of the U.S. population. U.S. CENSUS BUREAU, STATE AND COUNTY QUICK FACTS <http://quickfacts.census.gov/qfd/states/00000.html> (last updated Feb. 5, 2015).

186. For a history of welfare, see KARYN GUSTAFSON, *CHEATING WELFARE: PUBLIC ASSISTANCE AND THE CRIMINALIZATION OF POVERTY* (2011). As the color of welfare recipients changed from white to black and brown, the amount given declined to an amount insufficient to support a family. See *id.*

187. In 2010, 31.9 percent of TANF recipients were black and 85.2 percent were women. See OFFICE OF FAMILY ASSISTANCE, *CHARACTERISTICS AND FINANCIAL CIRCUMSTANCES OF*

mothers with young children who receive TANF benefits out of the home and into jobs that usually do not offer adequate protections for breastfeeding mothers. Women receiving TANF must therefore usually terminate breastfeeding after they begin work, making it impossible for them to reach the breastfeeding benchmarks recommended by the World Health Organization and the American Academy of Pediatrics, or for black TANF recipients to match the breastfeeding rates of women in other racial groups.

All of these structural challenges to breastfeeding, in interaction with black women's unique experiences of subordination, result in disproportionate harm to black women from the facially neutral breastfeeding policy framework. The first two elements of food oppression are thus satisfied.

C. Health Disparities in Illnesses and Deaths Linked to Breastfeeding

The most dramatic disparity in conditions related to breastfeeding is in infant mortality rates. Significantly, increased breastfeeding by black women could cut the deaths of black infants in half.¹⁸⁸ Black women and children also experience disproportionately poor health outcomes in a number of other conditions linked to formula use over breastfeeding, including diabetes,¹⁸⁹ obesity,¹⁹⁰ high blood pressure,¹⁹¹ asthma,¹⁹² and

TANF RECIPIENTS, FISCAL YEAR 2010, at tbl.A (Aug. 8, 2012), <http://www.acf.hhs.gov/programs/ofa/resource/character/fy2010/fy2010-chap10-ys-final>; Z. Fareen Parvez, *Women, Poverty, and Welfare Assistance*, SOCIOLOGISTS FOR WOMEN IN SOC'Y (Jan. 2009), http://www.socwomen.org/wp-content/uploads/2010/05/fact_00-2009-welfare.pdf. Blacks are only 13.2 percent of the U.S. population. U.S. CENSUS BUREAU, *supra* note 185.

188. Hoyert & Xu, *supra* note 87, at 9–15.

189. *Health Disparities—Background and Research Summary*, CAROLINA GLOBAL BREASTFEEDING INST., <http://breastfeeding.sph.unc.edu/what-we-do/programs-and-initiatives/toolkits/breastfeeding-and-health-disparities-toolkit/health-disparities-toolkit-background-and-research-summary/#Health> (last visited Apr. 23, 2015) (“According to the 2009 Behavioral Risk Factor Surveillance System (BRFSS) report, from 2006 through 2008, blacks were 51% more likely and Hispanics were 21% more likely than non-Hispanic whites to be obese.”).

190. About 56.6 percent of African American women are obese compared to 32.8 percent of white women. CYNTHIA OGDEN ET AL., NAT'L CTR. FOR HEALTH STATISTICS, PREVALENCE OF OBESITY AMONG ADULTS: UNITED STATES, 2011–2012, at 2 (2013), *available at* <http://www.cdc.gov/nchs/data/databriefs/db131.pdf>. Similarly, from 1999 to 2012, 35.1 percent of African American children ages two to nineteen were overweight, compared to 28.5 percent of white children; and 20.3 percent were obese compared to 14.3 percent of white children. TRUST FOR AMERICA'S HEALTH, THE STATE OF OBESITY: BETTER POLICIES FOR A HEALTHIER AMERICA 2014, at 90 (2014), *available at* <http://healthyamericans.org/assets/files/TFAH-2014-ObesityReport%20FINAL.pdf>.

191. Non-Hispanic blacks had a higher rate of hypertension (41.3 percent) than non-Hispanic whites (28.6 percent) based on data from 2007 to 2010. Cathleen Gillespie & Kimberley Hurvitz, *Prevalence of Hypertension and Controlled Hypertension—United States, 2007–2010*, CTNS. FOR DISEASE CONTROL & PREVENTION (Nov. 22, 2013), *available at* <http://www.cdc.gov/mmwr/preview/mmwrhtml/su6203a24.htm>.

192. *Minorities and Asthma*, NAT'L MEDICAL ASSOC., <http://asthma.nmanet.org/members1.htm> (last visited Apr. 23, 2015) (“Research has shown that African-American

cancer.¹⁹³ Racial disparities in breastfeeding rates that arise in part from purportedly neutral laws and policies thus appear to contribute to significant racial disparities in incidences of serious illnesses and deaths.

D. Corporate Influence over Breastfeeding Law and Policy

There are three major players in the infant formula business. Mead Johnson ("Mead"), which manufactures Enfamil products, has a 50 percent share of the market.¹⁹⁴ Abbott Laboratories-Ross ("Abbott"), the manufacturer of Similac products, has a 39 percent share.¹⁹⁵ Nestlé, which makes Gerber products, has a 10 percent share, with other companies accounting for the remaining 1 percent of the market.¹⁹⁶ Formula prices are generally high relative to production costs, and Enfamil and Similac cost more than other formula brands.¹⁹⁷ In 2015, a can of Enfamil or Similac that lasts approximately one week for one average size baby costs between \$15 and \$20.¹⁹⁸

Nestlé was a late entrant into the domestic market.¹⁹⁹ Initially, Nestlé dominated the international market until research revealed that mixing contaminated water with powdered infant formula was responsible for millions of infant deaths in Africa.²⁰⁰ The publication of this information led to an international boycott of the company that significantly reduced its sales.²⁰¹ Nestlé attempted to compensate for its subsequent losses by gaining a larger share of the United States market.²⁰² In response, the

children die from asthma at a higher rate than other children, and that asthma is the most common chronic disease in children, affecting more than 4 million in the United States.").

193. In the period between 2007 and 2009, African American women were more likely to die from breast cancer than white women (3.25 percent compared to 2.73 percent). AM. CANCER SOC'Y, CANCER FACTS & FIGURES FOR AFRICAN AMERICANS 2013–2014, at 2 tbl.2 (2013), available at <http://www.cancer.org/acs/groups/content/@epidemiologysurveillance/documents/document/acspc-036921.pdf>.

194. ECON. RESEARCH SERVICE/USDA, THE INFANT FORMULA MARKET 6 (2015), available at http://www.ers.usda.gov/media/861515/err22d_002.pdf.

195. *Id.*

196. *Id.* For an in-depth discussion of the historical market competition between Abbott and Nestlé, see Linda Fentiman, *Marketing Mothers' Milk: The Commodification of Breastfeeding and the New Markets for Breast Milk and Infant Formula*, 10 NEV. L.J. 29, 70–71 (2009); Murphy, *supra* note 113, at 912.

197. See *Enfamil Newborn Formula-Powder-12.5 Oz Can*, WALMART, http://www.walmart.com/ip/Enfamil-Newborn-Formula-Powder-12.5-oz-Can/17179641?action=product_interest&action_type=title&placement_id=irs-2-m1&strategy=PWVUB&visitor_id=Op0aW6IrjRoFbo45PNVg-8&category=&client_guid=d1e16c17-ba55-4dd0-8ace-6a6c1b1063ec&customer_id_enc=&config_id=2&parent_item_id=15063551&parent_anchor_item_id=15063551&guid=dd3b3282-9a5c-4d2f-8a33-23b1219a5789&bucket_id=irsbucketdefault&beacon_version=1.0.1&findingMethod=p13n (last visited Apr. 23, 2015);

198. *Id.*; Hobar, Comment to *How Long Would I Tube of Formula Last a Baby!?*, BABY CENTER (Feb. 12, 2012), http://community.babycenter.com/post/a31661809/how_long_would_1_tub_of_formula_last_a_baby.

199. Murphy, *supra* note 113, at 914.

200. Julie E. Artis, *Breastfeed at Your Own Risk*, 8 CONTEXTS 28, 29 (2009).

201. *Id.*

202. Murphy, *supra* note 113, at 912.

Abbott-Mead duopoly sought to block its entry by lobbying for domestic restrictions on infant formula advertising.²⁰³ Abbott and Mead simultaneously opposed similar restrictions on international advertising as they sought to fill the gap in the international market created by the boycott against Nestlé.²⁰⁴

To secure the support of the American Academy of Pediatrics (AAP) for the domestic restrictions, Abbott and Mead

contributed heavily to the [American Academy of Pediatrics], paying about one-third of the construction costs of the Academy's headquarters in the 1980s, providing grants to the AAP, underwriting pediatric conferences, and offering loans to medical students and pediatricians. In the 1980s, facing the imminent entry of Nestlé into the American infant formula market, Abbott and Mead Johnson worked with the AAP to oppose [direct-to-consumer] advertising citing its negative impact on breastfeeding rates.²⁰⁵

As part of this joint effort, Abbott and Mead donated \$1 million a year to the AAP for nearly a decade.²⁰⁶ In an attempt to end this relationship, Nestlé sued the AAP, Abbott, and Mead under the Sherman Act in 1993, claiming they conspired to prevent Nestlé's entry into the American formula market by jointly developing opposition to direct-to-consumer advertising.²⁰⁷ The jury found for the defendants and the Ninth Circuit upheld the decision on appeal.²⁰⁸ Additionally, Abbott and Mead's efforts to restrict domestic formula advertising succeeded temporarily. Abbott and Mead then raised formula prices sixfold.²⁰⁹ Both the restrictions and the inflated prices terminated, however, with an antitrust suit filed by prosecutors alleging price collusion, bid rigging, and conspiracy to prevent advertising.²¹⁰ The suit culminated in a settlement of \$230 million, one of the largest antitrust settlements in history.²¹¹

1. Influence over Government Action

Abbott, Mead, and Nestlé maintain strong relationships with the government through campaign contributions, aggressive lobbying, and a revolving door of employees who, at different times, hold key positions in the corporation and in government administrations. For example, over a twenty-five year period, Abbott donated over \$18 million to political

203. *Id.*

204. *Id.*

205. Fentiman, *supra* note 196, at 71.

206. Murphy, *supra* note 113, at 915. Mead and Abbott relied on distribution through hospitals, doctors, and health workers, so they did not need to advertise domestically to increase their sales. *Id.* at 913.

207. *Id.*

208. *Id.*

209. *Id.* at 915.

210. *Id.*

211. *Id.*

campaigns.²¹² In 2008, Abbott gave the greatest percentage of its contributions to Barack Obama’s presidential campaign, although it otherwise supported only Republican candidates.²¹³ Several lobbyists employed by Abbott previously or subsequently held important positions in government administration.²¹⁴ For example, Austin Burnes went from being the Director of Legislative Operations as House Minority Whip to being an Abbott lobbyist.²¹⁵

Similarly, seven out of Mead’s nine lobbyists previously held positions with the government.²¹⁶ Their main lobbying efforts concerned the reauthorization of WIC.²¹⁷ Nestlé employs similar tactics. Fourteen out of Nestlé’s twenty-two lobbyists previously held government positions.²¹⁸ Also, Nestlé spent nearly \$5 million dollars on lobbying in 2013²¹⁹ with a focus on the reauthorization of the Supplemental Nutrition Assistance Program (formerly known as the Food Stamp program) and regulation of nutrition labeling and food safety.²²⁰

Before WIC came into existence in the 1970s with strong support from the formula industry, formula companies relied on the “medical detailing” model to market their product.²²¹ This method, traditionally employed to sell pharmaceutical products, built a customer base by persuading hospitals, physicians, and health workers to give formula to their patients and clients.²²² This model relied on extensive legwork, time, and expense.²²³

212. *Abbott Laboratories*, INFLUENCE EXPLORER, <http://influenceexplorer.com/organization/abbott-laboratories/5f5e9875e0c64328baf13e6f5e83814c> (last visited Apr. 23, 2015) [hereinafter INFLUENCE EXPLORER]; *Abbott Laboratories*, CENTER FOR RESPONSIVE POL., <http://www.opensecrets.org/orgs/summary.php?id=D000000383> (last visited Apr. 23, 2015); *Abbott Laboratories*, NAT’L INST. FOR MONEY IN STATE POL., <http://www.followthemoney.org/database/topcontributor.phtml?u=14> (last visited Apr. 23, 2015); *Lobbyist Registrations: Abbott Laboratories*, SUNLIGHT FOUND. REPORTING GRP. (Mar. 5, 2015), <http://reporting.sunlightfoundation.com/lobbying/client/abbott-laboratories>.

213. INFLUENCE EXPLORER, *supra* note 212.

214. See *Employer Search: Abbott Laboratories*, CENTER FOR RESPONSIVE POL., https://www.opensecrets.org/revolving/search_result.php?priv=Abbott+Laboratories (last visited Apr. 23, 2015).

215. *Burnes, Austen*, CENTER FOR RESPONSIVE POL., https://www.opensecrets.org/revolving/rev_summary.php?id=78108 (last visited Apr. 23, 2015).

216. *Lobbyists Representing Mead Johnson Nutritional, 2014*, CENTER FOR RESPONSIVE POL., <http://www.opensecrets.org/lobby/clientlbs.php?id=D000018653&year=2014> (last visited Apr. 23, 2015) (listing seven lobbyists as “revolvers”).

217. *Specific Issues: FOO*, CENTER FOR RESPONSIVE POL., http://www.opensecrets.org/lobby/clientissues_spec.php?id=D000018653&year=2014&spec=FOO (last visited Apr. 23, 2015).

218. *Lobbyists Representing Nestle SA, 2013*, CENTER FOR RESPONSIVE POL., <https://www.opensecrets.org/lobby/clientlbs.php?id=D000042332&year=2013> (last visited Apr. 23, 2015).

219. *Annual Lobbying by Nestle SA*, CENTER FOR RESPONSIVE POL., <https://www.opensecrets.org/lobby/clientsum.php?id=D000042332&year=2013> (last visited Apr. 23, 2015).

220. *Food Industry*, CENTER FOR RESPONSIVE POL., https://www.opensecrets.org/lobby/issue_spec.php?id=FOO&year=2013 (last visited Apr. 23, 2015).

221. Kent, *WIC’s Promotion*, *supra* note 98, at 5.

222. *Id.*

223. *Id.*

Replacing it with distribution through the WIC program thus represented significant savings for the formula manufacturers.²²⁴

Additionally, agricultural corporations employ campaign contributions, lobbying, and a revolving door to influence Congress to continue to support the soybean and dairy industries in the Farm Bill.²²⁵ These efforts result in the surpluses of milk and soy for which formula companies provide a market. Agribusiness' influence therefore also contributes to the promotion of formula products, particularly through the WIC program.

2. Influence over Medical Professionals

In addition to corporations' influence over the government through lobbying, campaign contributions, and a revolving door, and their partnership with media, as demonstrated in the joint creation of the *Chicago Hope* breastfeeding episode, they wield considerable influence over pediatricians. The formula industry is the largest financial contributor to the AAP.²²⁶ These donations give the industry the power to shape some of the actions and decisions of the professional association. In 1986, an internal AAP executive committee confirmed its dependency on the corporations' funding in a memo regarding their request to support efforts to restrict domestic advertising, asserting, "[T]here is a need to make this statement reaffirming the AAP's position on marketing, breast milk, lay advertising, etc. If there is a marketing war, there may be a shift in industry's distribution of funds and the AAP may have to cut back on anticipated income from industry."²²⁷ Although the AAP already opposed formula advertising because of the dangers it posed to infants and mothers, it increased this opposition in response to industry pressure.²²⁸ The formula corporations, in turn, used the AAP to attempt to obscure their anticompetitive goals.²²⁹ Although compatible with the AAP's own objectives in this case, the corporations' ability to use the AAP to further their own agenda has the potential to effectuate more harmful results under different circumstances.

For example, in 2003, after Alabama physician Carden Johnston became president of the AAP, he met with formula company executives who expressed concern about an imminent national government campaign to promote breastfeeding.²³⁰ The Department of Health and Human Services (DHHS) Office on Women's Health had developed this campaign in response to the publication of over a thousand research papers over four

224. *Id.*

225. See Freeman, *supra* note 106.

226. Fentiman, *supra* note 196, at 70 ("[F]ormula manufacturers contributed heavily to the Academy, paying about one-third of the construction costs of the Academy's headquarters in the 1980s, providing grants to the Academy, underwriting pediatric conferences, and offering loans to medical students and pediatricians.").

227. Murphy, *supra* note 113, at 915.

228. *Id.*

229. *Id.*

230. Katie Allison Granju, *Milky Way of Doing Business*, JAY GORDON, MD FAAP (Feb. 23, 2010), <http://drjaygordon.com/breastfeeding/milkyway.html>.

years revealing dramatically different health outcomes for breastfed children.²³¹ The campaign sought to impress upon the public the urgency of this issue by equating breastfeeding with non-smoking, car seat use, childhood vaccinations, and SIDS prevention.²³² After Johnston's meeting with the formula representatives, he sent a letter to the DHHS raising objections to the campaign on behalf of the AAP.²³³ The letter did not, however, include any medical or scientific support for his position.²³⁴

By expending considerable resources on supporting politicians and pediatricians, corporations exert influence over decisions and practices that encourage, facilitate, and promote the use of formula over breastfeeding. The resulting laws, policies, and actions, in turn, disproportionately increase black women's use of formula. Corporations can increase their profits by taking advantage of existing racial inequalities and misperceptions about black mothers that make black women more vulnerable to industry sales tactics. The formula companies therefore have a stake in the relatively low breastfeeding rates of black women. They also appear to be indifferent to the harmful consequences of their actions to the health of black women and children. Corporations' role in the enactment of law and policy that contributes to racial disparities in breastfeeding meets the fourth element of food oppression.

E. Myths and Stereotypes That Mask Structural Harm

Since slavery, a cultural belief that black women lack maternal instincts has served to justify laws and policies that alienate black mothers from their children. "[W]et nursing required slave mothers to transfer to white offspring the nurturing and affection they should have been able to allocate to their own children."²³⁵ Moral justification for this brutal separation of mother and child came through the creation of stereotypes of black women as highly sexualized (Jezebel), cruel (Sapphire), or caring only for white children (Mammy).²³⁶ These stereotypes laid the foundation for an enduring social belief that black women could not or would not nourish their own children through breastfeeding. This myth has continued to support practices that impede breastfeeding by black women into the present.

Politicians also use modern stereotypes about black women, particularly the welfare queen, to justify the reduction of government assistance to families in need.²³⁷ The welfare queen is a constructed identity that paints

231. *Id.*

232. *Id.*

233. *Id.*

234. *Id.*

235. DUNAWAY, *supra* note 37, at 140.

236. See Marilyn Yarbrough & Crystal Bennett, *Cassandra and the "Sistahs": The Peculiar Treatment of Black Women in the Myth of Women As Liars*, 3 J. GENDER, RACE & JUST. 625, 635–36 (1999); ETHNIC NOTIONS, *supra* note 36; Plous & Williams, *supra* note 36; Delgado & Stefancic, *supra* note 36.

237. See ANGE-MARIE HANCOCK, THE POLITICS OF DISGUST: THE PUBLIC IDENTITY OF THE WELFARE QUEEN (2004); Ashley Sayeau, *The Myth of the Welfare Queen*, 139 NEW

all welfare recipients as immoral free-loading degenerates because of their association with a mythical poor, black, unemployed woman who defies social norms by being single with children.²³⁸ She feels entitled to take money from the government and, in fact, has children only to collect free welfare checks to support a life of luxury.²³⁹ Another common stereotype of blacks as lazy or shiftless²⁴⁰ operates to bolster the myth of the freeloading welfare queen.²⁴¹

Racist myths of black women as selfish or ignorant²⁴² also support the idea that they breastfeed at lower rates than other mothers because they simply do not want to or that, if they do, like Tabitha Walrond, they do it wrong. These stereotypes, reinforced by the lack of positive images of black women breastfeeding, shift the responsibility for low breastfeeding rates from institutions to individuals, making structural change appear unnecessary or futile.²⁴³

STATESMAN 38 (2010); *see also* VIVYAN CAMPBELL ADAIR, FROM GOOD MA TO WELFARE QUEEN: A GENEALOGY OF THE POOR WOMAN IN AMERICAN LITERATURE, PHOTOGRAPHY AND CULTURE (2000); DAVID ZUCCHINO, MYTH OF THE WELFARE QUEEN: A PULITZER PRIZE-WINNING JOURNALIST'S PORTRAIT OF WOMEN ON THE LINE (1997); Catherine R. Albiston & Laura Beth Nielson, *Welfare Queens and Other Fairy Tales: Welfare Reform and Unconstitutional Reproductive Controls*, 38 HOW. L.J. 473, 477–80 (1995); Bridgette Baldwin, *Stratification of the Welfare Poor: Intersections of Gender, Race, & "Worthiness" in Poverty Discourse and Policy*, 6 MOD. AM. 4, 4 (2010); Rose Ernst, *Localizing the "Welfare Queen" Ten Years Later: Race, Gender, Place, and Welfare Rights*, 11 RACE, GENDER & CLASS 181 (2008); Carly Hayden Foster, *The Welfare Queen: Race, Gender, Class, and Public Opinion*, 15 RACE, GENDER & CLASS 162 (2008); Michele Estrin Gilman, *The Return of the Welfare Queen*, 22 AM. U. J. GENDER SOC. POL'Y & L. 247, 247 (2014); Ange-Marie Hancock, *Contemporary Welfare Reform and the Public Identity of the "Welfare Queen"*, 10 RACE, GENDER & CLASS 31 (2003); Karen Johnson, *Myth of the Welfare Queen*, 25 ESSENCE 42 (1995); Premilla Nadasen, *From Widow to "Welfare Queen": Welfare and the Politics of Race*, 1 BLACK WOMEN, GENDER & FAMILIES 52 (2007); Beth Reinhard, *The Return of the Welfare Queen*, NAT'L JOURNAL, Dec. 12, 2013; Rose Weitz & Leonard Gordon, *Images of Black Women Among Anglo College Students*, 28 SEX ROLES 19, 20 (1993); John Blake, *Return of the "Welfare Queen"*, CNN (Jan. 23, 2012), <http://www.cnn.com/2012/01/23/politics/welfare-queen/>; Laurel Parker West, *Soccer Moms, Welfare Queens, Waitress Moms, and Super Moms: Myths of Motherhood in State Media Coverage of Child Care* 14 (Marial Center, Emory Univ., Working Paper No. 16, 2002), available at http://www.marial.emory.edu/pdfs/wp016_02.pdf.

238. *See* Hancock, *supra* note 237.

239. Gilman, *supra* note 237, at 247.

240. *See, e.g.*, K. SUE JEWELL, FROM MAMMY TO MISS AMERICA AND BEYOND: CULTURAL IMAGES AND THE SHAPING OF THE US SOCIAL POLICY 37–47 (1993); Linda L. Ammons, *Mules, Madonnas, Babies, Bath Water, Racial Imagery and Stereotypes: The African-American Woman and the Battered Woman Syndrome*, 1995 WIS. L. REV. 1003, 1006; Zanita E. Fenton, *Domestic Violence in Black and White: Racialized Gender Stereotypes in Gender Violence*, 8 COLUM. J. GENDER & L. 1, 23 (1998); Yarbrough & Bennett, *supra* note 236.

241. I explore the role of the myth of the welfare queen and other racial stereotypes in racial disparities in breastfeeding in depth in a forthcoming article.

242. *See, e.g.*, JEWELL, *supra* note 240, at 37–47; Geneva Brown, *Ain't I A Victim? The Intersectionality of Race, Class, and Gender in Domestic Violence and the Courtroom*, 19 CARDOZO J.L. & GENDER 147, 161–63 (2012); Yarbrough & Bennett, *supra* note 236.

243. Tabitha's story is also about the criminalization of black mothers. This criminalization begins in pregnancy and continues throughout motherhood, justifying the prosecution and punishment of black mothers. *See, e.g.*, Kimberlé W. Crenshaw, *From Private Violence to Mass Incarceration: Thinking Intersectionally About Women, Race, and Social Control*, 59 UCLA L. REV. 1418 (2012); Paula C. Johnson, *At the Intersection of*

Similarly, the common paradigms of biomedical individualism²⁴⁴ and healthism²⁴⁵ frame health decisions, including the choice to breastfeed, as the manifestation of an individual’s preferences and will. These ideologies attribute poor health outcomes solely to individuals’ bad choices and obscure the role that structural forces play in determining health.²⁴⁶ These paradigms, however, commit a fundamental error by attributing choice to individual strengths and proclivities. Research in social psychology indicates, instead, that individuals’ actions reflect their environment to such an extent that they do not vary according to personality at all, only by situation.²⁴⁷ The common belief in dispositionism, the understanding that action reflects personality or will, therefore further masks the power of policy to shape individual decision making, and the high profits that

Injustice: Experiences of African American Women in Crime and Sentencing, 4 AM. U. J. GENDER & LAW 1 (1995); Priscilla A. Ocen, *Punishing Pregnancy: Race, Incarceration, and the Shackling of Pregnant Prisoners*, 100 CALIF. L. REV. 1239 (2012); Dorothy E. Roberts, *Prison, Foster Care, and the Systemic Punishment of Black Mothers*, 59 UCLA L. REV. 1474 (2011); Dorothy E. Roberts, *Punishing Drug Addicts Who Have Babies: Women of Color, Equality, and the Right of Privacy*, 104 HARV. L. REV. 1419 (1990). This criminalization includes the prosecution of Raquel Nelson, a black mother whose four-year-old son was killed by a drunk driver in front of her while she held her two year old in her arms. See Julianne Hing, *Jezebels, Welfare Queens—and Now, Criminally Bad Black Moms*, COLORLINES (Aug. 8, 2011), http://colorlines.com/archives/2011/08/the_criminal_justice_systems_hit_and_run_of_black_moms_in_the_us.html. An all-white jury in Georgia convicted Nelson of vehicular manslaughter. *Id.* Two black mothers, Kelley Williams-Bolar in Ohio and Tanya McDowell in Connecticut, received felony convictions for using relatives’ addresses to enroll their children in better schools out of district. Julianne Hing, *Raquel Nelson’s Absurd Prosecution Was Common for Black Women*, COLORLINES (Aug. 2, 2011), http://colorlines.com/archives/2011/08/raquel_nelson_prosecuting_moms.html. Shanesha Taylor, a homeless black woman, faced charges of child abuse when she left her children in her car, unharmed, while she attended a job interview. *Arizona Mother Arrested After Leaving Kids in Car During Job Interview*, CLUTCH MAG., http://www.clutchmagonline.com/2014/03/arizona-mother-arrested-leaving-kids-car-job-interview/?doing_wp_cron=1395762533.6188149452209472656250 (last visited Apr. 23, 2015). Black women on welfare often face criminal fraud charges for working extra jobs to afford food for their families. See GUSTAFSON, *supra* note 186.

244. See Elizabeth Fee & Nancy Krieger, *Understanding AIDS: Historical Interpretations and the Limits of Biomedical Individualism*, 83 AM. J. PUB. HEALTH 1477, 1481 (1993); Lisa C. Ikemoto, *Abortion, Contraception and the ACA: The Realignment of Women’s Health*, 55 HOW. L.J. 731, 746 (2012).

245. See JULIE GUTHMAN, *WEIGHING IN: OBESITY, FOOD JUSTICE, AND THE LIMITS OF CAPITALISM* 52–55 (2011) (describing the origin and evolution of the term “healthism,” and crediting sociologist Robert Crawford with originally coining the phrase).

246. See Freeman, *supra* note 106 (“Under the healthism framework, a person who is fat is a bad person because his girth is an outer manifestation of his laziness, stupidity, and lack of will power. Similarly, under the biomedical individualism model, a person who is sick deserves to be ill because she brought the disease upon herself through irresponsible behavior. There is little incentive for the state to intervene to heal the ill, first because it is wrong to expend the money of good (skinny, healthy) taxpayers to correct the mistakes and weaknesses of (fat, sick) would-be freeloaders. Second, government intervention would be futile because the freeloaders, not having suffered the consequences of their bad choices by paying to correct them, would simply make these choices again, and repeat this cycle endlessly.”).

247. See Jon D. Hanson & David G. Yosifon, *The Situation: An Introduction to the Situational Character, Critical Realism, Power Economics, and Deep Capture*, 152 U. PA. L. REV. 129 (2003).

corporations gain as a result. Throughout society, across race and class lines, there are mistaken but powerful beliefs that good mothering and good health are reflections of willpower, determination, strong character, and intelligence.²⁴⁸ Therefore, even when individuals encounter structural obstacles to breastfeeding, others, and even themselves, may attribute the decision to use formula to individual preference, assuming the exercise of choice and free will even where these do not exist.

CONCLUSION

Although it is clear that food oppression contributes to racial disparities in breastfeeding, it is far from clear how to dismantle this oppression. While legal and policy reform has the potential to create some positive change, most structural reform seems unlikely in the present political climate. For example, a clearer division between industry and government would allow the United States to sign the WHO Breast-milk Substitutes Code and subsequently enact a series of regulations to distance formula companies from new mothers. Reduced corporate influence could also eliminate the agricultural subsidies that compel the USDA to support secondary markets for milk and soy. This separation, however, would require limits on campaign contributions and resources spent on lobbying to prevent industry capture of government policy. Supreme Court decisions such as *Citizens United v. FEC*,²⁴⁹ instead, signal a trend in the opposite direction. Similarly, as wealth inequality continues to deepen, it is unlikely that lower-income citizens will be able to leverage the political power necessary to spearhead changes to welfare laws.

Other aspects of this oppression present even more serious challenges. Centuries of racial stereotyping of black women as bad mothers will require extensive “counter-programming” and the near ubiquitous attribution of personality and will as responsible for individual health and well-being will be extremely difficult to dislodge. Racism has such deep roots in our society that Derrick Bell declared its permanence.²⁵⁰ Assuming he was correct, there may be little hope of eradicating racist attitudes toward black women, reducing corporate influence over government policy, creating greater rights and benefits for the poor, and advancing feminist policies to benefit women and children. Nonetheless, incremental steps toward change, a thorough analysis of the problem, and attempts to raise awareness may have some impact.

To that end, in other parts of this project, I examine how history shaped this problem, beginning with slavery; the evolution of infant feeding practices, the rise of the role of pediatricians and lactation consultants as experts in relation to mothers; the medicalization and whitening of motherhood; the relationship between overt racism and structural

248. See generally “BAD” MOTHERS: THE POLITICS OF BLAME IN TWENTIETH-CENTURY AMERICA (Molly Ladd Taylor & Lauri Umansky eds., 1998).

249. 558 U.S. 310 (2010).

250. See generally DERRICK BELL, FACES AT THE BOTTOM OF THE WELL: THE PERMANENCE OF RACISM (1993).

inequality; feminist critiques of breastfeeding promotion; the influence of cultural beliefs on breastfeeding choices; the role of racial stereotypes and understandings of human behavior in the public’s attitude toward this issue; and the exploitation of black babies, girls, and mothers for the purposes of advertising and marketing. I also explore legal and social approaches to breastfeeding, internationally and domestically, and attempt to design a program of structural reform that will lead to a reduction in racial disparities in breastfeeding and their health consequences.