**UNDERSTANDING THE BABY-FRIENDLY HOSPITAL INITIATIVE**

**A MULTI-DISCIPLINARY ANALYSIS**

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**Abstract**

In the United States, roughly 1 out of 4 births takes place at a hospital certified as Baby-Friendly. This paper offers a multi-disciplinary perspective on the Baby-Friendly Hospital Initiative (BFHI), including empirical, normative, and historical perspectives. Our analysis is novel in that we trace how medical practices of “quality improvement,” which initially appear to have little to do with breastfeeding, may have shaped the BFHI. Ultimately, we demonstrate that a rich understanding of the BFHI can be obtained by tracing how norms of gender/motherhood interact with, and are supplemented by, other normative, historical, and institutional realities. We conclude with suggestions for practical revisions to the BFHI.

**Keywords**: Breastfeeding, BFHI, Baby-Friendly, natural mothering, medical institutions

**1. Introduction**

Over the past few decades, the Baby Friendly Hospital Initiative (BFHI) has contributed to a dramatic change in the postpartum experiences of mothers and newborns in United States hospitals1. The BFHI is a breastfeeding promotion program that encourages hospitals to achieve “Baby-Friendly” status through adherence to a specific set of guidelines meant to improve breastfeeding rates. For instance, Baby-Friendly hospitals must demonstrate that they provide lactation consultation and support, use formula only when medically indicated, and room the baby with the mother around the clock. In the U.S., the BFHI has seen widespread adoption. More than 25% of annual births in the United States occur in hospitals certified as Baby-Friendly and many more hospitals work informally to implement policies similar to those adopted by Baby-Friendly facilities. The U.S. effort has seen significant growth over the past 10 years, spurred on by efforts of the CDC, the U.S. Department of Health and Human Services, and The Joint Commission, all of which have implemented programs in support of the BFHI.

This essay aims to place the BFHI in normative, historical, and institutional context. As we will demonstrate, the BFHI has utilized maternal/gender norms in complex ways. While an appeal to norms of gender/motherhood must play a key role in understanding the BFHI, this paper demonstrates that a richer understanding of the current state of the BFHI is obtained by understanding how norms of gender/motherhood interact with, and are supplemented by, other normative, historical, and institutional realities. Our analysis is particularly novel in that we trace how institutionalized medical practices of “quality improvement” may have shaped the BFHI. In providing this account, we demonstrate the complexity of interactions between institutional realities and norms of motherhood; we also demonstrate how liberatory intentions, particularly when subjected to institutional norms, can be transformed in unanticipated and problematic ways2.

As mentioned above, the BFHI has had widespread uptake in the U.S. and abroad. Recently, however, a number of concerns have been raised about the BFHI, including questions about the BFHI’s safety and efficacy for both mothers and babies3. Central to the aims of this article, stakeholders have questioned whether the BFHI is sufficiently “mother-friendly”-- that is, whether the BFHI policies adequately consider the birthing mother’s interests and preferences (Grose and Boehmová 2014; Schulte 2014; MGH Center for Women’s Mental Health 2017; Schwartz 2017; Pearson 2016; Senapathy n.d.).

The popular concern that the BFHI is ‘mom-unfriendly’ may suggest an initial, relatively simple, conception of the role of norms of gender/motherhood in shaping the BFHI. That is, one might assume that the BFHI pays insufficient attention to maternal interests simply because, in society more generally, maternal interests tend to be subordinated to those of the infant/fetus. Moreover, it might be tempting to analyze the BFHI along the lines of other policies which sideline maternal interests, such as abortion policies, critiquing it as a male-dominated attempt to control women’s bodies.

The truth, of course, is much more complicated. As a complex social and institutional initiative, the BFHI has a rich and contradictory history, and it is situated within multiple normative and institutional layers. In the pages which follow, we unpack these layers. First, we provide background on the BFHI and its contemporary criticisms. We then briefly describe one salient normative perspective, taking as a starting point the work of Rebecca Kukla and Joan Wolf; both of these authors have argued that breastfeeding promotion programs, in general, fail to attend adequately to maternal interests. While this perspective sheds light on one type of criticism of the BFHI, we suggest that a fuller understanding of the BFHI can be obtained by introducing an additional normative layer: namely, the perception of breastfeeding as ‘natural.’ Second, we provide historical context for the BFHI, offering a number of insights. Most importantly, while popular criticism has labeled the BFHI as insufficiently mother-friendly, we demonstrate that there is deep historical irony in this criticism: the program’s roots lie in efforts by women to create new, more flexible options for mothers. Finally, we place the BFHI in institutional context, aiming to understand how the pressures on hospitals, as institutionalized medical settings, may have contributed to the spread of the BFHI despite its mixed evidence base. Here, we discuss norms of *quality improvement*, and consider how those norms may have shaped the uptake and character of the BFHI, including how the BFHI addresses the distinct needs of mothers at elevated risk of postpartum depression. We conclude with some suggestions as to how the BFHI might be modified to better meet the needs of mothers and their babies.

It should be noted that extensive work on breastfeeding already exists, including from a bioethical and feminist perspective; scholars have discussed the history, politics, economics, science and ethics of breastfeeding and breastfeeding promotion (e.g., Blum 2000; Hausman 2003; Kukla 2006; J. Wolf 2010; Smith, Hausman, and Labbok 2012; Koerber 2013; Jung 2015; Martucci 2015). This paper focuses on the BFHI, a specific breastfeeding program, and pulls together critical background on this program, contemporary criticisms, and its history. Our analysis is novel in its careful discussion of the role of institutionalized medical practices in shaping breastfeeding promotion. In particular, we describe how hospital practices of “quality improvement” and institutionalization may shape the character and uptake of the BFHI by hospitals.

It is important to stress at the outset that our discussion of the BFHI should not be read as a critique of breastfeeding or breastfeeding promotion efforts more broadly. Instead, this paper examines the history, context and institutional aspects of one, specific approach to breastfeeding promotion, the BFHI. This program has been perceived in popular writing as insufficiently attentive to maternal interests, and it has been critiqued on other grounds. However, there are a variety of other ways that public health advocates can and do promote breastfeeding, including informational campaigns, peer-to-peer programs, etc. We do not intend to generalize our arguments to breastfeeding promotion programs more generally. Similarly, we are not attempting to weigh in on “breast v. bottle” debates, nor make claims about the importance of breastfeeding for mothers, infants, or families.

Finally, in the interests of inclusivity, we should mention that, in most instances, we use the term “mother,” and not “woman,” throughout this essay. Mothers may identify with a wide variety of genders, and the term “mother” is meant to include all of these. Also, because there is no clear agreement on a fully inclusive term, we will use “breastfeeding” to refer to lactation by any mother; we acknowledge this to be imperfect, given that some trans parents prefer the term “nursing” or “chestfeeding.” Finally, it is important to acknowledge that these issues are more than terminological; beneath our choice of words lie important questions regarding how breastfeeding promotion programs like the BFHI do, or do not, respect the interests of mothers who do not identify as women. Unfortunately, due to reasons of space, we will not be able to fully explore these deeper questions in this essay.

**2. The BFHI: Background and Criticisms**

**a. What is the BFHI?**

The BFHI is a public health program that encourages hospitals and birth

centers to adopt policies and practices designed to increase breastfeeding rates. Through the implementation of the “Ten Steps to Successful Breastfeeding” (Ten Steps), healthcare institutions can gain “Baby-Friendly” designation, which provides recognition, prestige, and credibility as a “good” place to have a baby. Though the BFHI operates globally, this paper will focus on its influence within the U.S.

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| Ten Steps to Successful Breastfeeding   1. Have a written breastfeeding policy that is routinely communicated to all health care staff. 2. Train all health care staff in the skills necessary to implement this policy. 3. Inform all pregnant women about the benefits and management 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 they are separated 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 24 hours a day. 8. Encourage breastfeeding on demand. 9. Give no pacifiers or artificial nipples to breastfeeding infants. 10. Foster the establishment of breastfeeding support groups and refer mothers to them on discharge from the hospital or birth center.   NB: In April 2018, the WHO released revised BFHI guidance, including an update to the Ten Steps (see: <https://www.who.int/nutrition/bfhi/ten-steps/en/>). The update softens language around (3) and (7), and drops (9). However, at the time of writing (March 2019), BFUSA has indicated that it will continue using the original version of the Ten Steps, as written above, until further notice (“10 Steps And International Code” n.d). Since our focus is on the influence of the BFHI within the U.S., and the context which influenced its widespread adoption, we will focus on the original version of the Ten Steps. |

The core of the BFHI, the Ten Steps, has enjoyed widespread support. For instance, the Ten Steps have been endorsed by all major maternal and child health authorities in the United States, including professional organizations (e.g., the American Academy of Pediatrics) and public health entities (the U.S. Surgeon General)4.

In the United States, Baby-Friendly USA Inc (BFUSA) is the accrediting body and coordinator for BFHI activities. Hospitals and birthing centers which are interested in pursuing Baby-Friendly certification must work with BFUSA. BFUSA guides a facility by providing information and assistance to the facility as it implements the Ten Steps. At the conclusion of this work, the facility is reviewed by BFUSA and receives its Baby-Friendly certification (which must be renewed periodically). The 2018 fee for initial certification is roughly $12,000 (for facilities with more than 500 births annually); the facility also incurs two additional kinds of costs. First, there are costs in terms of training staff/providers, e.g. staff time, travel costs, payments to a training vendor, etc. Second, Baby-Friendly facilities may not receive free products such as breast milk substitutes, bottles, or nipples. Thus, facilities which pursue the Baby-Friendly designation can anticipate increased costs in terms of purchasing these products (R. Wright n.d.).

Despite the significant cost of pursuing the Baby-Friendly designation, many hospitals have chosen to do so5. Indeed, the number of Baby Friendly hospitals has grown to more than 500 hospitals across the 50 states, the District of Columbia, and the Commonwealth of Puerto Rico. In 2018, births in Baby-Friendly hospitals accounted for over 25% of all annual births in the U.S (“Find Facilities” n.d.). The majority of BFUSA’s growth has occurred in the last decade, spurred on by the integration of BFHI guidelines into the 2010 Healthy People objectives, a set of health goals issued every ten years by the U.S. Department of Health and Human Services (HHS). In 2000, HHS announced that its 2010 goals would include specific guidelines to increase breastfeeding initiation and duration rates that were modeled after the BFHI (Hill 2000). In 2010, HHS announced it would further incorporate BFHI practices when it stated that breastfed newborns should not receive formula for the first 2 days of life (National Center for Health Statistics 2012)6. In addition to governmental efforts, a leading accreditor of hospitals, The Joint Commission, began requiring reporting of exclusive breastfeeding rates in 2014 (Patterson, Keuler, and Olson 2018). As evidenced by these multiple initiatives, the BFHI enjoys broad-based institutional support in the United States and its impact continues to grow.

**b. Existing criticisms of the BFHI**

Despite this widespread support for the BFHI, concerns with it have been raised. First, some women claim that Baby-Friendly policies have contributed to negative postpartum experiences, arguing that Baby-Friendly hospitals are not “mom-friendly.” For example, some mothers report that they are being inappropriately pressured to breastfeed, or express frustration with hospitals who refuse to provide or support formula supplementation (Marcus 2016; Schwartz 2017). In addition, mothers have argued that 24-7 rooming-in practices do not take seriously the needs of mothers to rest and recover, particularly for those mothers who may have had difficult labors or who do not have partners or other support staying with them in the hospital (Austrew 2016; Senapathy n.d.; Pearson 2016; Marcus 2016).

Some quantitative data supports these concerns. For instance, in a survey of postpartum patients in a Baby-Friendly Hospital, 28% responded “neutral or disagree” when asked if they could rest and recover in the hospital. Among mothers who had decided to formula feed, 26% reported feeling shamed for the decision to formula-feed and 37.5% did not feel adequately informed about formula-feeding (Ebinger, Castleberry, and Cai 2017). Thus, BFHI policies can fail to be mom-friendly in a variety of respects.

A second, related critique focuses on the needs of specific populations of mothers, which can be in tension with overly-rigid breastfeeding policies. For example, staff at the Massachusetts General Hospital’s Center for Women’s Mental Health have described Baby-Friendly policies as being insensitive to the needs of patients who are at elevated risk for postpartum depression, as such mothers are particularly in need of time to rest and recover after delivery (MGH Center for Women’s Mental Health 2017). In some cases, they suggest, a mother’s recovery may be best facilitated if her partner conducts bottle feedings with formula, *contra* the Ten Steps.

In addition to concerns about impacts on mothers, some researchers have raised questions about the evidential basis for BFHI policies. For instance, a recent meta-analysis concluded that, that while there was some evidence the BFHI was effective, the evidence base was typically mixed (Howe-Heyman and Lutenbacher 2016). For instance, the review found that for long-term breastfeeding exclusivity, 5 studies of the BFHI demonstrated increased breastfeeding long-term exclusivity, 3 found that it did not, and 2 produced results that could not be interpreted. Even in cases where the evidence mix was more favorable, the author concluded that heterogeneity in study design and context made it difficult to draw strong conclusions7. Finally, the author notes that research by Cochrane and the Agency for Healthcare Research and Quality suggests that other interventions (such as peer support, formal prenatal breastfeeding education, and informal postpartum support) may actually be more effective in promoting breastfeeding.

Concerns about the evidential basis for the BFHI have been noted by other researchers. For instance, a 2018 article reviewing evidential support for the Ten Steps found significant gaps for some of its recommendations, including those which encourage rooming-in, prevent pacifier use, and ban supplementation (Gomez-Pomar and Blubaugh 2018). Such concerns are supported by the WHO itself. In 2018, the WHO convened a review of evidence for the BFHI and found little evidence for the effectiveness of certain components of the Ten Steps, including 24/7 rooming-in, bans on supplementation, and pacifier use (J. L. Bass, Gartley, and Kleinman 2018). Indeed, as mentioned above, the WHO has recently revised its version of the Ten Steps, softening the language around certain aspects of the Ten Steps, although BFUSA has yet to take up these revisions (“WHO | Ten Steps to Successful Breastfeeding (Revised 2018)” n.d.; “Baby-Friendly USA” n.d.).

Finally, some researchers have questioned the safety of BFHI recommendations for infants (J. L. Bass et al. 2018; J. Bass, Gartley, and Kleinman 2016). For instance, researchers have reported that there may be a link between skin-to-skin contact in the hours after birth, which is promoted by BFHI policies, and Sudden Unexpected Post-Natal Collapse (SUPC), a life-threatening condition for a newborn. Additionally, the emphasis on breastfeeding, together with rooming-in policies, may encourage unsafe co-sleeping practices by postpartum mothers, some of whom are recovering from major surgery. Finally, current Baby-Friendly policies ban pacifier use, even though pacifiers appear to lower the risk of Sudden Infant Death Syndrome (J. Bass, Gartley, and Kleinman 2016, 20)8.

**3. Normative Context for the BFHI: Total Motherhood and the “Natural”**

From the background given above, two features become clear. First, the BFHI’s influence within the U.S. has been expanding, particularly over the last 10 years. Second, the BFHI is not without problems--mothers have criticized it as contributing to negative experiences, medical workers have criticized it as inflexible, and researchers have cast doubt on its evidence base and its safety. This raises the question: why has BFHI seen such widespread institutional uptake, despite these issues?

The popular characterization of the BFHI as mom-unfriendly suggests a starting point for our analysis. A number of writers have pointed out that maternal interests and experience can get sidelined in public conversations about breastfeeding that focus on infants’ needs and health, even though breastfeeding, and in particular exclusive breastfeeding, can involve significant costs to mothers and families, including physical, emotional, psychological and social costs (Kukla 2006; J. Wolf 2010). Breastfeeding interrupts sleep, it takes significant time, it complicates returning to employment after childbirth, given the need to pump breastmilk multiple times per day, and breastfeeding for 6+ months (as recommended by medical authorities) is associated with more substantial and prolonged earnings losses than mothers who don’t (Rippeyoung and Noonan 2012). Breastfeeding impacts patterns of parenting and family life, since the breastfeeding parent will be responsible for feeding, and may undermine gender equity or simply run contrary to parents’ preferred division of labor in the home.

According to this critical feminist perspective, the costs to mothers of breastfeeding play little role in the creation of breastfeeding policy and in the breastfeeding promotion materials themselves (Kukla 2006; J. Wolf 2010)9. Joan Wolf explains the failure to consider breastfeeding’s costs to mothers as rooted in our normative conceptions of motherhood—in particular, in “an ethic of *total motherhood*” according to which good mothering is defined as behavior that reduces risks to children, even very small or poorly understood risks, and even at significant cost to mothers (J. Wolf 2010, secs. xv, Chapter 4, Chapter 5; J. B. Wolf 2007). She writes,

“One of the rare critics to challenge breastfeeding on both scientific and social grounds, Jules Law argues that risk analyses regarding infant feeding are based on the presumption of a gendered division of domestic labor and that breastfeeding advocacy reveals a ‘gendered double standard of risk assessment’ in which the costs of breastfeeding for women are downplayed or ignored because their labor as mothers is normative….If mothers do not own their emotional, mental, and physical time, then the costs to them are not real. If they do not exist as subjects independent of their babies, then trade-offs need not be calculated. Total motherhood, as Douglas and Michaels argue in regard to the new momism, ‘is not about subservience to men. It is about subservience to children.’ The double standard, in other words, is less about gender than it is about motherhood.” (103-04)

According to this analysis, our conception of motherhood makes us insensitive to breastfeeding’s costs to mothers, because these costs are seen as normative: it is normative for mothers to suffer significant burdens in order to provide even marginal benefits to their children, so we don’t really notice or assess these costs. Thus the downsides of breastfeeding to mothers are not even recognized; alternatively, they are recognized but framed as “barriers” to be overcome rather than costs to be considered (J. Wolf 2010).

This critical perspective offers an explanation for why the BFHI has flourished despite some of its negative effects on mothers: our normative conceptions of motherhood dispose us to undervalue and overlook maternal interests when benefit to children is at stake, and thus we overlook the costs of BFHI practices to mothers, or treat these costs as obviously acceptable given the potential health benefits of BFHI practices for infants.

While this critical perspective sheds important light on the BFHI, our goal is to demonstrate that a fuller understanding of the BFHI can be obtained by supplementing such considerations. For instance, an analysis in terms of total motherhood does not explain why the limited evidence base for the BFHI has not stood as a barrier to implementation; this is an issue we take up later in this article. As another example, the notion of total motherhood cannot shed light on why the safety concerns of the BFHI *for infants* are only just now gaining traction.

One potential explanation for the second of these issues--the question of why safety concerns for infants have not received more attention--lies in the cultural framework around modern breastfeeding, a framework which may tend to obscure safety concerns. Since the modern breastfeeding movement began in the 1950s, some advocates have embraced the argument that breastfeeding is natural, and that natural things are endowed with a kind of biological morality that makes them superior, better, and healthier by default (J. Wolf 2010, 82–86, 96–99; Martucci 2015). These breastfeeding advocates’ view of the natural is one instance of a more general phenomenon; empirical work has found that some people perceive natural things to be healthier, more pleasant, less risky, pure, and benign (Rozin et al. 2004). The veil of “the natural” has surfaced in multiple health arenas, from vitamins and supplements (Wagner 2011) to diet regimens (Shermer 2015) and beauty tips (Thomason 2017). This view of breastfeeding as natural, and of “the natural” as superior, healthier, and less risky may help to explain how questions of safety for mothers and infants have been left unasked, and may have shaped the creation, implementation and support for the BFHI10.

This analysis, then, demonstrates one way in which a fuller understanding of today’s BFHI can be obtained by placing norms of gender/motherhood in a larger normative context. Specifically, norms about the “natural” may help explain one aspect of the current state of the BFHI, namely why questions about the BFHI’s safety for infants have been largely unexplored.

**4. History of the BFHI**

In the previous section, we demonstrated that a fuller understanding of the current state of the BFHI can be obtained by attending to how norms of gender/motherhood interact with normative notions of ‘the natural.’ In this section, we turn to the history of the BFHI. We will focus on three themes which are important to understanding the BFHI today. First, we buttress our earlier discussion of the importance of the concept of ‘the natural’ by demonstrating its historical roots. Second, and most importantly, a full understanding of its history reveals the contemporary characterization of the BFHI as ‘mom-unfriendly’ to be deeply ironic. As we will demonstrate, through an original analysis of primary sources, the BFHI has its historical origins in the efforts women to *reclaim* motherhood and infant feeding from overly inflexible medical institutions; over time, however, these attempts to reclaim motherhood have themselves been institutionalized into the rigid policies which, today, are criticized as mom-unfriendly. Finally, given that some recent critics have questioned the evidential basis of the BFHI, we will describe the evidential basis which guided BFHI’s historical development.

**a. The historical roots of ‘natural motherhood’**

Despite contemporary criticism of the BFHI as mom-unfriendly, the fact that the program exists is largely due to the efforts of a woman-led movement to support breastfeeding. By the middle of the twentieth century, formula feeding under the direction of a physician had become the norm. In some regions of 1950s America, studies showed that fewer than one in five mothers breastfed their infants (Meyer 1958; Ryan et al. 1991). When mothers in this period did want to breastfeed, they often found that their hospitals, doctors and nurses stood as obstacles rather than as supports. That is why a group of white, middle-class mothers came together in the suburbs of Chicago, IL in 1956 to found a mother-based breastfeeding support group that they called La Leche League.11 With a medical advisory board made up of sympathetic doctors and breastfeeding researchers to help guide them, La Leche League quickly grew, putting out a breastfeeding manual that for many served as “the bible” of breastfeeding called *The Womanly Art of Breastfeeding* (1958). Much of what La Leche League’s founders did during the first two decades or more of the organization’s existence involved what they saw as two sides of the same coin: they supported and empowered other women like themselves with their mother-tested advice on breastfeeding and they worked to educate health practitioners and policymakers on the benefits of breastfeeding, the downsides to formula feeding, and on how to remove the barriers and obstacles that mothers faced when they wanted to breastfeed (Weiner 1994; Ward 2000). Their efforts to change breastfeeding practices were largely successful; La Leche League and other like-minded groups supported mothers through the most dramatic increase in breastfeeding initiation rates in America’s history, from 22% in 1972 to nearly 60% in 1984 (A. L. Wright and Schanler 2001).

For our purposes, it is particularly important to understand the La Leche League’s contribution to the historical underpinning of the notion of ‘natural motherhood’. In their work, La Leche League looked beyond the sciences of chemistry and nutrition, which had long worked in favor of industry, medicine, and scientific formula feeding by emphasizing the ability of scientists to adequately mimic and perhaps even surpass, mother’s milk (Apple 1987). Instead they found support for breastfeeding in the sciences of human development, psychology and animal behavior. It was there, in these burgeoning fields of study that League leaders discovered the language they needed to suggest that “natural” motherhood practices in childbirth and breastfeeding held something uniquely of value. In their hands, arguments for maternal instinct, bonding, love and attachment became central to the era’s evolving understanding of breastfeeding (Martucci 2015, 14–15). For them, breastfeeding was about cultivating a certain kind of mother, a *better* mother, and so they advocated for practices that supported intensely close and time-intensive mother-infant relationships including rooming-in, demand feeding, and infant-led weaning (La Leche League 1958). Contemporary claims about ‘natural feeding’ and ‘natural motherhood’ are thus shaped by the history of the League and its vision of motherhood.

**b. The origins of the BFHI: maternal empowerment**

Given its important role in breastfeeding promotion, it’s not difficult to imagine that La Leche League would have participated in the conversations, meetings, creation and implementation of the BFHI. Yet the role of the breastfeeding advocacy community in crafting this program has gone largely unexplored in existing historical work.

A careful reading of the historical record suggests that the BFHI was crafted in close conversation with individuals from La Leche League’s inner circle. First, early work by UNICEF and the WHO to develop the BFHI includes language which reproduces key components of La Leche League’s commitments. For instance, in early conversations during the years leading up to BFHI, the WHO and UNICEF tellingly described breastfeeding as, “an integral part of the reproductive process, the *natural* and ideal way of feeding the infant and a unique biological and emotional basis for child development (our emphasis)” (World Health Organization and UNICEF 1979, 10). That these ideas today are considered commonplace must not obscure how fresh and novel they remained at the time. This way of framing breastfeeding grew directly out of La Leche League’s work. La Leche League’s values are also imprinted in the Ten Steps. These guidelines emphasize supportive hospital staff, rooming-in, avoiding supplemental feedings, rejecting free formula samples, and minimizing the possibility of nipple confusion– these are all ideas that La Leche League developed first in its pamphlets, group meetings, newsletters, and books throughout the postwar era (Martucci 2015, 124-35).

In addition to this rhetorical and ideological overlap, it’s also possible to trace the influence of individual policymakers from La Leche League in the 1970s to UNICEF in the 1980’s. For instance, Dr. Audre Naylor, who was on the UNICEF nutrition team when the BFHI was developed, has described a series of lectures by La Leche League-affiliates Paul Fleiss and Kittie Frantz as having, “changed my life forever… [they were] the beginning of the 10 Steps and Baby Friendly” (Gordon 2014; WABA n.d.). In fact, the extensive connections between La Leche’s leadership and the WHO and UNICEF are well documented in the archival record of the League. These collections detail the involvement of the organization’s leadership, including its president Marian Thompson, in informing and developing global guidelines around breastfeeding and breast milk substitutes12.

Thus the BFHI is historically rooted in an important late-twentieth century transformation in which women worked to reclaim childbirth and infant feeding as natural biological processes. These efforts emerged as a response to the reach of medicine into the arena of childbirth, infant feeding, and childcare over the first half of the century (Leavitt 1988). Women’s advocates in these years worked to shift maternal processes back into the realm of the normal and the natural. Ironically, today the large-scale institutionalization of these philosophies does not always look mother-friendly in practice. What began as a grassroots movement of women seeking to empower other women has now arguably given rise to a set of policies and practices that can unfortunately be insensitive to the health and well-being of individual mothers.

**c. From lay movement to global health policy: the role of evidence**

Above, we argued that a careful review of historical texts reveals that the Ten Steps has roots in women’s efforts to reclaim (natural) motherhood. In this section, we turn to the question of the evidence base for the Ten Steps, which we noted above has been subject to criticism. The initial WHO/UNICEF publication of the Ten Steps, first issued in 1989, asserted that each step would result in superior outcomes for mothers and babies, but the authors cited no evidence in support of their claims, nor was the report clear about what those “superior outcomes” would be (World Health Organization 1989). By 1993, the WHO could point to a few scientific reports prepared by researchers at the Institute for Reproductive Health at Georgetown University in Washington D.C. that demonstrated “that breast-feeding can save more infant lives and prevent more morbidity than any other intervention strategy” (Saadeh 1993, 25–26). However, these reviews did not contain evidence that supported or explained why or how the particular guidelines outlined in the Ten Steps would actually achieve this goal.13

It was not until nearly a decade after the birth of the program, in 1998, that the WHO published a review of scientific evidence in support of the Ten Steps (Division of Child Health and Development 1998). Their review of the scientific literature at that point served not to inform or influence the design of the BFHI but instead to defend the initiative as it had been initially drafted. Acknowledging that the original design of the BFHI was lacking a clear scientific underpinning, the document’s authors stated that, “it is hoped that policies and practices in future *[sic]* will be based on research rather than on conjecture and custom” (Division of Child Health and Development 1998, 1). As noted earlier, the lack of robust research in support of the BFHI’s Ten Steps, however, has continued to trouble the conversations around the program. And yet, the Ten Steps have been in place, under the assumption that they are safe and effective, for nearly three decades (World Health Organization 2017, xi).

**d. A case study from the Ten Steps: rooming-in**

A case study of the “rooming-in” requirement of the Ten Steps provides an opportunity to better understand the overall dynamics of the BFHI. Tracing the history of this policy, we demonstrate its historical origins in well-meant efforts to provide an alternative to the rooming policies of the first half of the 20th century. However, over time, what began as a series of optional pilot programs, ones based on very little evidence, ultimately became normative healthcare policy with the BFHI.

Rooming-in requires housing healthy newborns in their mothers’ postpartum rooms instead of in nurseries, and it stems, in part, from maternal dissatisfaction with twentieth-century hospitals’ postpartum protocols. During the same decades in which healthcare professionals and other “experts” on children encouraged formula as scientifically superior to mothers’ milk, hospitals kept newborns from their mothers most of the time, with nursing and medical professionals caring for the newborns instead (Clifford et al. 1949; Clifford and Davison 1954). This style of newborn care was representative of most American hospitals throughout the twentieth century; babies born healthy in hospitals spent the majority of their first days or weeks not with their mothers, but in centralized nurseries with their fellow newborns. Visits to mothers’ rooms were infrequent and rigidly scheduled to facilitate a strict feeding schedule, one which often thwarted any attempts on behalf of the mothers to breastfeed. Outside of the few scheduled daily visits, mothers could see their newborns only through nursery windows facing into hospital corridors. Other family members and friends were entirely limited to these window viewings until the mom and baby were discharged (Dunham and Crane 1943).

**FIGURE 1. HERE**

Figure 1 caption: Newborns are shown behind a glass window. In the corner, a sign reads: “Babies are shown at this window 11:00 to 12:45 pm, 2:00 to 4:30 pm, 7:00 to 8:45pm.” Courtesy of the John P. McGovern Historical Collections and Research Center, Houston Academy of Medicine - Texas Medical Center (HAM-TMC) Library, Houston, Texas.

While some mothers certainly appreciated the opportunity to rest and were glad to have their newborns well cared for, others were frustrated with the forced separation from their newborns (Barclay 1955; Jackson 1948). With evidence that the infection-prevention goals of mother-baby separation had been ineffective, as well as mounting research (often from proponents of natural motherhood such as that promoted by La Leche League) that mother-baby contact in the first days after birth facilitated superior psychosocial development, a few American hospitals challenged the nursery model in the 1940s and ‘50s (Jackson 1955). These programs, termed “rooming-in” experiments, gave a small group of mothers the opportunity to have their babies with them whenever they wished (Jackson et al. 1948). Mothers and medical professionals alike responded favorably to these programs, with some mothers appreciating the ability to care for and feed their babies whenever they wished. New mothers, in particular, were often glad to be able to practice infant feeding and care techniques with the guidance of nurses and doctors (ibid).Except for a few examples relating to infectious outbreaks or emergency staff shortages, nearly all rooming-in programs were *optional* (ibid). In most cases, mothers who elected to room-in could send their babies to nurseries at any time they wished, and were even encouraged to do so at night. Rooming-in gradually grew in popularity during the last decades of the twentieth century, and was first written into major healthcare policy in the BFHI.

The evolution of rooming-in policies thus illustrates two themes from the larger story of the BFHI. First, while today’s critics of the BFHI point to the 24/7 rooming-in requirement as problematically insensitive to the needs of postpartum mothers, the history of this requirement ironically reveals it to be based in the work of women advocating on behalf of their own interests. Furthermore, whereas early initiatives envisioned rooming-in as an *option* for certain mothering populations, the BFHI institutionalizes this as the norm for all healthy mother-newborn pairs. Researchers behind the first major rooming-in program insisted that, “We are not holding a brief for rooming-in as a panacea. On the contrary, we believe there are many parents for whom it is not applicable” (ibid).

Second, the shift from optional and/or on-demand daytime rooming-in to 24/7 rooming-in was supported by little evidence. In the US context, with which this paper is primarily concerned, none of the three experimental studies offered as evidence for rooming-in in the original 1989 WHO report demonstrated increased breastfeeding as a result of rooming-in, none assigned rooming-in contrary to mothers’ wishes, and only one study, with a small n=11 in the rooming-in group, roomed infants with their mothers overnight (Ibid.; O’Connor et al. 1980; Keefe 1988; Norr et al. 1989). In addition, as noted earlier, recent reviews of evidence have suggested that the 24/7 rooming-in requirement is not well-supported by evidence (J. L. Bass, Gartley, and Kleinman 2018).

Although historically rooming-in stemmed from progressive efforts to reform maternity care and to individualize the postpartum hospital experience to better suit the needs of each mother-baby pair, the present-day implementation of the BFHI leaves little room for individual variation. Born out of a desire to counteract inflexible policies that kept moms and babies apart, today, the BFHI’s contemporary rooming-in requirement exemplifies the overall rigidity and unresponsiveness of the Ten Steps to contemporary mothers’ needs.

**5. Institutional Factors**

In the section above, we illustrated how understanding the history of the BFHI can help contextualize and deepen our understanding of it. In particular, we demonstrated that the history of the BFHI is largely that of women advocating on behalf of women, showing how the BFHI originated as a response to overly rigid medical structures. These women later recruited formal institutions, such as UNICEF, the WHO, and Baby-Friendly USA, Inc. to promote their vision. Thus the story of the BFHI is that of good--even liberatory--intentions that have had some unforeseen consequences; as these intentions were translated into concrete institutional practices, they have themselves become rigidified and problematic. If this is right, understanding the BFHI cries out for a careful examination of the norms of medical institutions, in order to better understand how advocacy efforts to reclaim motherhood can ultimately be distorted by these institutional norms. In particular, we will demonstrate how institutional norms can interact with norms of gender/motherhood in order to obscure and suppress the diverse interests and needs of birthing mothers.

To illustrate this, we will critically examine one kind of medical institution, U.S. hospitals, working to understand how that institutional context may have shaped the uptake and structure of the BFHI in the United States. In particular, we will suggest the following: first, that hospital norms encourage the quick adoption of interventions, which may form part of the explanation for BFHI’s widespread uptake despite mixed evidence; second, part of the explanation of why the BFHI fails to accommodate the needs of special populations (such as mothers prone to depression) lies in the distorting forces of institutionalization. Overall, this analysis buttresses on our earlier historical analysis, by tracing how contemporary institutional norms distort well-intentioned advocacy efforts, doing so in a context informed by powerful cultural norms around motherhood and ‘the natural.’

Overall, our goal is to illustrate that a full understanding of the BFHI requires understanding how norms of gender/motherhood interact with other, institutional forces. In our view, for instance, the explanation for why the BFHI has seen rapid recent growth in the U.S., despite mixed evidence, lies *both* in the fact that medical institutions do not take seriously the costs to mothers *and* institutional norms, specifically quality improvement norms, which encourage uptake of even weakly evidenced interventions. Similarly, we will argue that the BFHI fails to take into account the needs of depressed mothers *partly* because of a failure to take the needs of all mothers seriously, but also because forces of institutionalization, particularly a shift to a “compliance orientation,” place general pressure on institutions to provide one-size-fits-all care.

**a. Hospital norms: quality improvement subculture encourages the adoption of weakly evidenced interventions**

The BFHI operates as a hospital quality improvement intervention, i.e. a hospital-based program which is designed to improve care for patients.14 Quality improvement is an established subfield of U.S. medicine, operating with distinct institutional and normative structures.15 Many hospitals have quality departments, and the personnel from this department work with clinical personnel throughout the hospital to successfully implement changes in care routines. Quality improvement work is conducted in certain characteristic ways; in a typical case, once a goal is identified by an institutional leader, staff personnel will be expected to attend educational sessions, their performance will be reviewed for compliance, and hospital committees will tweak care processes over months or years to improve implementation.

Thus, in the case of breastfeeding, a hospital might identify breastfeeding as an area they wish to improve on, select Baby-Friendly USA as a contractor to facilitate their work, and then work for months or years to fully implement the Ten Steps. Some quality improvement projects, such as an effort to implement the Ten Steps, involve external contractors and result in nationally-recognized certification; other projects are conducted in-house and do not bear on certification or accreditation.

For our purposes, the important point is that quality improvement subculture has its own norms and expectations, which in turn have likely influenced the implementation of the BFHI. For instance, unlike research science, which emphasizes well-designed studies and careful analysis, quality improvement emphasizes quick implementation of what is termed “best practices.” The motivation for this approach is based on two beliefs: first, that healthcare faces a quality crisis in which patients are routinely poorly served and, second, that scientific research proceeds too slowly to be of practical benefit (Institute of Medicine 2000). Thus, instead of waiting for research science to conclusively prove the benefit of an intervention, the emphasis in quality improvement is on learning from “success stories” at other facilities. In the case of the BFHI, healthcare providers interested in improving breastfeeding rates would be expected to converse with peer facilities who had seen success and subsequently duplicate the intervention at their own facility. This process typically unfolds over a period of months, and it is contrary to the norms of the field to wait for an extensive evidentiary base to be developed. One researcher, for instance, contrasted the evidentiary norms of quality improvement (which typically focuses on changing practices and behaviors within applied healthcare contexts) with those found in evidence-based medicine (which typically focuses on more narrow questions of which drug or intervention is more effective for a specific disease, often within strictly regimented clinical trials). He writes, “The evidence base for interventions that work in healthcare quality improvement and the validation of methodology in quality improvement are at a ‘younger’ stage than for evidence-based medicine” (Banerjee et al. 2012).

Given these motivations, quality improvement norms are set up to encourage the rapid spread of practices, including those which do not yet have a fully developed research base. In saying this, we do not mean to malign these norms. The concerns that quality improvement practitioners are responding to, including the crisis in healthcare quality and problematically long timelines of research, are real, and a quality improvement approach can be applauded for catalyzing, in many cases, the rapid improvement of healthcare for patients (see for instance: Hutchins et al. 2009; Pronovost, Marsteller, and Goeschel 2011; Kaplan et al. 2010). However, the risk of rapid change is the possible adoption of ineffective policies or even policies which have mal-effects. Understood in this way, it is not particularly surprising that an intervention with a mixed evidence base would nonetheless have widespread uptake. Given the norms which govern quality improvement work, the existence of a number of success stories is enough to justify trying the intervention at one’s own facility.

Indeed, the BFHI is not the only instance in which concerns have been raised after a quality improvement initiative has been widely implemented. For instance, a recent working paper by the Congressional Budget Office details concerns that quality improvement efforts may have inadvertently contributed to the overuse of opioids; in working to ensure patients’ pain was controlled, and incentivizing this work through specific national programs, quality improvement programs may have led hospitals to inadvertently overprescribe pain medications (Hayford and Maeda, 2017). As another example, the Centers for Medicare and Medicaid Services (CMS) routinely retires quality improvement measures intended to measure quality of care for conditions such as heart attack, stroke and pneumonia; while there are a number of reasons to “retire” a measure, one reason to do so is that “the evidentiary basis for the measure has changed” or “the measure has been demonstrated to have minimal impact” (Conway and the Core Quality Measures Collaborative Workgroup 2015). In other words, measures are retired because they were designed to track interventions which have been shown not to work; that is, CMS routinely requires hospitals to measure interventions which later turn out to be ineffective.16

Returning to the phenomenon of the BFHI, in a well-designed quality improvement project, the hospital monitors progress to determine if the intervention is, in fact, having a positive result. In theory, then, a hospital which did not see progress (or identified mal-effects) would recognize that the intervention was ineffective and abandon it. However, in practice, it is often difficult for an individual institution to understand the origin of its successes or failures. For instance, if after implementation of BFHI, breastfeeding rates do not increase, then staff at the hospital may conclude that they have not faithfully implemented the intervention (as opposed to concluding that the intervention itself is ineffective). In contrast, if a hospital sees its breastfeeding rates increase, it is easy for staff to attribute this progress to the intervention—even if larger cultural contributions, such as “Breast is Best” campaigns, are driving the results. These complications, of course, are the reason that research studies are important; they disentangle the effects of the intervention from other, confabulating factors.17

A full understanding of the uptake of the BFHI by U.S. hospitals, then, can be aided by understanding both the role of norms of motherhood and the institutional norms of quality improvement. Specifically, an ethic of total motherhood means that the costs of the BFHI are largely obscured. At the same time, a quality improvement subculture emphasizes the quick uptake of promising strategies. The story of the BFHI, then, is a story of how neutral, even noble goals (to rapidly improve healthcare) and their associated norms (to act, even when the evidence base is not extensive) can end up sidelining maternal interests. The desire to improve healthcare licenses norms which allow for rapid adoption of weakly evidenced interventions; in a society that devalues costs to mothers, hospitals move forward quickly on the adoption of new policies which they believe improve healthcare, paying too little attention to the impact on the lives and choices of mothers.

**b. How the forces of institutionalization leave behind the needs of special populations: standardization and compliance**

One of the specific concerns raised by medical professionals is that BFHI is inadequately sensitive to the needs of mothers who are at increased risk for postpartum depression. For instance, providers have argued that mothers who have a history of depression may be particularly in need of rest, and they can benefit by relying on a partner to conduct night feedings, possibly with formula (MGH Center for Women’s Mental Health 2017; McIntyre, Griffen, and BrintzenhofeSzoc 2018). One explanation of why the BFHI fails to account for the needs of mothers with depression is simply that they are mothers, and, in general, the interests of mothers tend to be occluded by the interests of the fetus or neonate. However, it is useful to examine the question of depressed mothers in particular. Why, given their likely divergent clinical needs, are they being treated with the same one-size-fits-all approach? Considering this question allows us to trace another pathway by which institutional context may shape the BFHI.

A possible answer lies in two institutional phenomena: standardization and compliance-oriented quality improvement. First, quality improvement places great emphasis on the standardization of care pathways (Varkey, Reller, and Resar 2007). Within the subfield, it is a basic tenet that variation leads to mistakes; the more that care processes can be standardized, the more complexity is reduced for providers, and the better care will be for patients. Thus, one might hypothesize that the pressure towards standardization can lead providers to overlook subpopulations of mothers who are ill-served by the standard approach, such as those suffering from depression or anxiety.

To be fair, quality improvement—when conducted well—recognizes meaningful differences between patients. Thus, just as an infant and a teen will receive different care components at an annual check-up, a mother with depression and a healthy mother ought to receive different (albeit standardized) care components after delivery. This is where the phenomenon of *compliance-oriented* quality improvement is important. In brief, while some quality improvement initiatives are small and flexible (for instance, they may be conducted in single unit and led by the nurse manager on that unit), others are embedded in multi-layered institutional structures. For instance, breastfeeding promotion has been taken up by The Joint Commission (TJC), the largest accrediting body for hospitals in the U.S., and the breastfeeding initiation rate is now included as a measure for many birthing hospitals. As quality improvement work becomes more institutionalized, with multiple layers between practitioners and administrators, it also becomes less flexible. In the case we have been discussing, first-line practitioners have identified a potential problem with the existing intervention—it may not be well-suited for mothers with depression—but they are effectively powerless to act on this knowledge. If they stop following the standard protocol for these mothers, they will damage their TJC accreditation scores, and possibly endanger the accreditation of the hospital as a whole. The only solution is for providers to advocate for TJC to change how it scores hospital compliance, e.g. by omitting mothers with depression from the measure, but this process is complex and time-consuming. In brief, once quality improvement is institutionalized, individual providers (and facilities) are mostly powerless to adapt their care in cases where they identify unique or divergent needs.18

Once again, then, the story of the BFHI reveals layers of complexity. Part of the explanation for the sidelining of mothers with depression may lie with a failure to take maternal interests seriously, but part of the explanation lies in the phenomenon of institutionalization. The pressure to produce standardized care pathways contributes to the disenfranchisement of this group of mothers, making it more difficult for them to get the care they may need. As these standard care pathways become embedded in institutional layers, it becomes more difficult for care providers to vary their practice to address the needs of special populations of mothers. If this is right, then the reason that depressed mothers are poorly served is multifaceted. Part of the blame lies in norms of gender and motherhood, but part of the blame lies in institutional forces.

There is an added wrinkle to this argument: some BFHI supporters might argue that there is evidence that breastfeeding protects against postpartum depression (PPD). If this is right, then mothers at risk of depression are actually being well-served by standard BFHI protocols. There are several responses to this objection. First, the current state of the evidence on the relationship between breastfeeding and PPD remains unclear, with some studies showing a positive effect and others showing no effective/negative effects (Ystrom 2012; Kendall-Tackett, Cong, and Hale 2011; Kendall-Tackett 2007; McCoy et al. 2006; Hatton et al. 2005; Chung et al. 2004; Mezzacappa and Katlin 2002; E. Alder and Bancroft 1988; E. M. Alder and Cox 1983). Moreover, the evidence is particularly unclear regarding whether (and to what extent) breastfeeding protects against depression in women who did not intend to breastfeed or among women at high risk for PPD (Borra, Iacovou, and Sevilla 2015). Second, even if at-risk mothers are best served by breastfeeding and breastfeeding promotion, there is a further question of whether the Ten Steps is the healthiest way to promote breastfeeding in this population. For instance, as noted earlier, the evidential basis for the 24/7 rooming-in requirement and against (modest) supplementation has been subject to criticism. Given that providers have identified a need for additional flexibility for this population, it seems reasonable to explore whether such women might be better served, and indeed more likely to succeed at breastfeeding, if providers were granted additional flexibility beyond the Ten Steps. Understood in this way, the pressure towards standardization and institutionalized, compliance-oriented quality improvement can help us understand the barriers preventing substantial exploration of more flexible policies and the development of more nuanced options for mothers. Finally, even if one believes that mothers at risk of depression are best served by the Ten Steps, one might consider the needs of other mothers, e.g. mothers with insufficient glandular tissue (IGT), trans individuals, sexual abuse victims, etc. These mothers would arguably benefit from more flexible Baby-Friendly policies.

In summary, we have consider the case of mothers with depression to articulate two specific facets of the BFHI’s institutional context: the demand for one-size-fits all policies and the increased distance between providers and policy-makers. In addition, in the previous section, we argued that the rapid spread of the BFHI despite mixed evidence may be (partly) powered by norms of quality improvement, which encourage rapid uptake of interventions. Taken together, these two points argue for the importance of attending to institutionally-based norms and practices, and understanding how they interact with norms of gender/motherhood.19 The BFHI is implemented within hospitals, which are institutions that have their own norms and dynamics. As we have demonstrated, just as larger society-wide gender/motherhood norms have shaped the uptake of the BFHI, the norms of hospital micro-culture have likely played a role.

**6. Conclusion**

We have argued that to fully understand the evolution and growth of the BFHI, particularly the question of why the BFHI has been widely adopted despite its treatment of maternal interests, safety issues, and gaps in evidence, one must understand how norms of gender and motherhood operate in larger normative, historical, and institutional contexts. First, we suggested that while an ethic of total motherhood can help us understand why maternal concerns are given short shrift, norms of naturalness shed light on why *infant* safety concerns have not been more closely examined. Second, we explored the historical origins of the BFHI. Most importantly, this history reveals an important historical irony: despite the today’s popular criticism of the BFHI as mom *un*friendly, the program began as an effort to enlarge birthing options for mothers, responding to overly rigid, institutionalized practices. Thus the history of the BFHI demonstrates that liberatory intentions can be transformed by social and organizational structures in unanticipated ways. Finally, we pointed to how institutional factors may have interacted with norms of gender/motherhood. Quality improvement norms, especially against a backdrop of total motherhood and normative conceptions of ‘the natural,’ can help explain why the BFHI has seen broad uptake, despite gaps in evidence. In addition, quality improvement norms, again operating against a backdrop of normative assumptions about mothering, can help explain why the disparate health needs of some postpartum mothers are not attended to. In offering this multidisciplinary analysis of the BFHI, we aimed to demonstrate the complex ways that norms of gender/motherhood interact with, and are supplemented by, other normative, historical, and institutional realities. In particular, one novel component of our analysis was our focus on quality improvement norms within hospitals.

To conclude, we want to emphasize that despite our characterization of the BFHI as insufficiently attentive to maternal interests, we are not rejecting breastfeeding promotion efforts more generally. We believe that it is possible for breastfeeding promotion policies to adequately account for maternal interests. Such approaches generally center on the notion of supporting a mother’s informed choices in infant feeding, a notion which has been recognized by a variety of bodies. For instance, in a 2016 opinion on breastfeeding, the American College for Obstetricians and Gynecologists wrote, “Obstetrician–gynecologists and other obstetric care providers should support each woman’s informed decision about whether to initiate or continue breastfeeding, recognizing that she is uniquely qualified to decide whether exclusive breastfeeding, mixed feeding, or formula feeding is optimal for her and her infant”(American College of Obstetricians and Gynecologists 2016, e86). In addition, the WHO has gestured towards the importance of promoting maternal choices around breastfeeding, writing, “Restriction of women’s autonomy in making decisions about their own lives leads to violation of women’s rights to health, and infringes women’s dignity and bodily integrity. In helping women make informed choices about breastfeeding, states and others should be careful not to condemn or judge women who do not want to or who cannot breastfeed.” (World Health Organization 2017, 8). This language of supporting and empowering women is inspiring; however, without appropriate implementation, it remains merely words.

The analysis we have offered in this paper, one which stresses the role of multiple normative, historical, and institutional forces, can help us understand how better to counteract pressures which distort breastfeeding promotion efforts into mom-*un*friendly policies. To that end, we suggest the following as revisions to the BFHI.

First, because an ethic of total motherhood encourages new mothers to downplay their own interests, the BFHI should counteract this tendency by including language which recognizes and values the interests of mothers. For instance, Step 3 currently reads, “Inform all pregnant women about the benefits and management of breastfeeding.” This language suggests the promotion of a mother’s autonomy through informed consent, similar to that advocated by the WHO and ACOG. However, informed consent requires the disclosure of both benefits and risks, and this is particularly necessary given that an ethic of total motherhood will encourage women to ignore or downplay risks to themselves. Moreover, the Ten Steps includes no language describing breastfeeding as a mother’s choice; including such language could help emphasize to health care providers and mothers themselves that respecting women’s autonomy and encouraging them to choose for themselves is a paramount ethical consideration. Notably, even the 2018 revisions of the Ten Steps by the WHO—revisions which have softened some of the original language, but which have not yet been adopted in the U.S.—still do not go as far as to invoke the language of choice. While feminists have pointed to concerns with the language of “choice,” and rightly worried that rhetorical changes are not enough to ensure that mothers have genuine options given the material and cultural constraints surrounding breastfeeding mothers (e.g., Hausman 2008), we believe that introducing such language into the Ten Steps is a useful first step.

Second, we have argued that institutional pressures tend towards one-size-fits-all policies which become institutionally rigidified. One way to counteract this would be to explicitly acknowledge, within the Ten Steps, that mothers have diverse needs and preferences. For instance, guidelines might be developed which encourage health care workers supporting mothers through breastfeeding to learn about, and discuss with the patient, their medical history (e.g., past depressive episodes) and relevant personal experiences (e.g., prior experience with breastfeeding, sexual assault). Again, such changes are no panacea, but they constitute a practical step in the right direction.

Third, while we believe it is possible for breastfeeding promotion to be conducted in ways which respect the full diversity of maternal interests, we are pessimistic about breastfeeding promotion within medical contexts which are subject to compliance-oriented quality improvement. That is, the problem is not so much the Ten Steps or the BFHI, which we have suggested might be appropriately modified; the problem lies in the institutional context in which such programs are implemented. In particular, implementing the Ten Steps as a certification process, or linking breastfeeding rates to payment programs which reward “good” compliance, introduces institutional constraints which predictably distort such programs, e.g. by penalizing providers for tailoring their care for the divergent interests of mothers. Such programs need to be redesigned in order to allow for more flexibility. In particular, organizations like Baby-Friendly USA should be focused on providing support to hospitals so they can implement effective, caring breastfeeding promotion policies; they should shift away from a focus on inspection and certification.

Finally, we turn to the question of how future research might be informed by the work we have done here. Our discussion of the BFHI points to the importance of understanding institutional context, particularly quality improvement norms, and this raises the question of how future research could develop a fuller understanding of the ethical issues raised in this context. As we have argued, quality improvement norms are designed to respond to a genuine need – to provide better care for patients, making changes to institutional practice as quickly as possible. Hospitals are, therefore, responding to genuine ethical considerations in making these changes. Similarly, as much as we have maligned institutional rigidity in these pages, consistent policies can have benefits—they serve to ensure that all patients receive adequate and fair treatment, and they allow the organization to operate with reasonable efficiency. Thus, as with any public health institution, hospitals must conduct a delicate balancing act across various considerations which are sometimes at odds: improving practice as quickly as possible, serving patients consistently, and tailoring care for divergent patient needs. Future research should therefore build on existing recommendations within public health (Kass 2001), by working to understand how hospitals and other institutions can navigate these multiple considerations and offering guidance as to how to strike an ethical balance.

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**Notes**

1. We are grateful to our anonymous reviewers, who provided valuable feedback. Their influence over the paper has been substantial, and the paper is stronger because of it.

2. Thanks to anonymous reviewer #1, whom we are paraphrasing here.

3. Worries about the adequacy of evidence for the BFHI have recently been raised by (Gomez-Pomar and Blubaugh 2018) and (Howe-Heyman and Lutenbacher 2016). However, as demonstrated later in this article, concerns about gaps in the evidence base for the BFHI have been present since early in its history. In addition, at least one article in feminist bioethics previously examined a BFHI-inspired program(Barnhill and Morain 2015).

4. Entities which have endorsed the Ten Steps include: the American Academy of Pediatrics, the American Academy of Family Physicians, the American Academy of Nurses, the American College of Obstetricians and Gynecologists, the U.S. Surgeon General, the U.S. Preventive Services Task Force, the National WIC Association, and the Centers for Disease Control and Prevention (CDC), and others (“Baby-Friendly USA” n.d.). In addition, some state health departments have adopted the Ten Steps for local use, offering governmental recognition to facilities that follow some or all of the steps. See, for example, the work of Ohio (<http://www.odh.ohio.gov/ohiofirststeps>), Texas (<http://texastenstep.org>), Pennsylvania/s Keystone 10 Initiative <http://www.health.pa.gov/My%20Health/Womens%20Health/Breastfeeding%20Awareness/Pages/Keystone-10-Initiative.aspx#.WZTvUq3Mx8d>, and New York City’s Latch On NYC Program (<https://www1.nyc.gov/assets/doh/downloads/pdf/ms/initiative-description.pdf>).

5. There isn’t good published data on why, despite the costs, hospitals and birthing facilities choose to pursue the Baby-Friendly designation. We speculate that much of the answer lies in the rest of our paper: total motherhood/the natural tend to foreground the benefits of breastfeeding, and the culture of quality improvement creates a dynamic in which hospitals are urgently seeking to improve care, including postpartum care. In addition, one of us (Preston-Roedder) has worked in this area and can report anecdotally on the institutional dynamics of such choices. In a number of cases, hospital personnel have already identified breastfeeding as an area where they would like to improve, and BFUSA has a widely recognized brand identity as “the best” way to pursue this designation. Hospitals are often deeply competitive with each other; if another hospital has achieved Baby-Friendly designation, ob-gyn personnel will use this to advocate to senior management for similar support for their own department.

6. Support includes other actors as well: In 2011, the CDC announced a $6 million, 3-year initiative to help grow the number of Baby-Friendly hospitals. The 2011 *Surgeon General’s* *Call to Action to Support Breastfeeding* lent additional weight to these efforts when it argued that the U.S. could save $13 billion each year if 90% of U.S. mothers breastfed their babies exclusively for 6 months (U.S. Department of Health and Human Services 2011).

7. For instance, the most favorable results were around long-term breastfeeding duration, where 9 of 11 studies indicated an increase associated with the BFHI. However, a close look revealed that all but one of these studies were conducted outside the U.S. and therefore may be of limited applicability.

8. In addition to concerns regarding SUSP and pacifier use, some anti-BFHI advocacy organizations (such as Fed is Best) have argued that there is inadequate monitoring of other potential safety risks, such as malnourishment. These groups argue that the monitoring of the safety of the BFHI is less rigorous than that of other large-scale health interventions.

9. While there are many feminist analyses of breastfeeding, and some are broadly supportive of breastfeeding, there are also some prominent critiques. We focus on Wolf and Kukla’s work, because we are trying to make sense of the popular criticism of baby-friendly as mom *un*friendly. Thus, we are selecting the scholarly literature which helps us understand a current cultural phenomenon

10. Certainly, publications promoting breastfeeding often emphasize its naturalness. See, for instance, a 2012 pamphlet published by the American Academy of Pediatrics which characterizes breastfeeding as “a natural gift” (Available at: <http://www.healthychildren.org/English/ages-stages/baby/breastfeeding/Pages/Why-Breastfeed.aspx>; Accessed: 1st June 2017); See also the following publications: World Health Organizations. Breastfeeding. WHO (2017). Available at: http://www.who.int/maternal\_child\_adolescent/topics/child/nutrition/breastfeeding/en/. (Accessed: 2nd June 2017); Office on Women’s Health, U.S. Department of Health and Human Services. It’s Only Natural. It’s Only Natural | womenshealth.gov (2013). Available at: https://www.womenshealth.gov/itsonlynatural/. (Accessed: 2nd June 2017); California Department of Public Health. California Infant Feeding Guide: Infant Feeding for Children Birth to Age 1. (2016). Available at: https://archive.cdph.ca.gov/programs/NutiritionandPhysicalActivity/Documents/California%20Infant%20Feeding%20Guide%20JAMA%20FINAL%203.3.17.pdf. (Accessed: 15th June 2017)

11. It should be noted that in the work of the League the experiences and concerns of women of color, low-income families, and working-class mothers were generally, and often painfully, overlooked (Martucci 2015, 168).

12. See La Leche League International records in the Special Collections and Archives at DePaul University in Chicago, IL (https://archives.depaul.edu/repositories/2/resources/13). One example of the leadership’s direct involvement in appears on p.56 of *La Leche league NEWS* (May-June, 1983). Under the heading “WHO/UNICEF CODE” the author, Margaret Bennet-Alder, details the participation of president Marian Thompson and La Leche board member and nurse, Betty Ann Countryman, in the 1979 WHO/UNICEF Geneva meetings to develop the Code on Marketing of Commercial Breastmilk Substitutes. The 1979 “Statement of Recommendations” from the WHO/UNICEF Meeting on Infant and Young Child Feeding confirms their participation as La Leche League representatives on p.44-45.

13. The 1993 report cites: C Lutter (ed). Towards global breastfeeding. Washington, D.C., Institute for Reproductive Health (Institute Issues Report), 1990; and R. Sharma et al. A comparative analysis of trends and differentials in breastfeeding. Washington, D.C. Institute for Reproductive Health (Institute Issues Report), 1990.

14. For instance, Baby-Friendly USA, the accrediting organization for U.S. hospitals, asks hospitals to use a “PDSA” cycle in its implementation. The PDSA cycle (Plan-Do-Study-Act) is a specific quality improvement methodology, widely used within this subfield.

15. For instance, multiple peer-reviewed journals specialize in publishing quality improvement articles, including research studies, management advice, conceptual work, and more, e.g. The Joint Commission Journal on Quality and Patient Safety, BMJ Quality & Safety, Quality Management in Health Care, The American Journal of Medical Quality, Implementation Science, and more.

16. This claim may seem surprising to those who do not work in healthcare, but it is common. CMS updates its guidance on quality reporting requirements for hospitals each year in the Federal Register, and it is common to add/remove measures as the science behind quality improvement changes.

17. An added complication is that coordinating groups, such as Baby Friendly USA, spread success stories—but typically do not spread failure stories. So, just as publication bias makes it harder to identify unsuccessful clinical interventions, the incentive structure of the QI world is not set up to identify poor interventions. Groups such as Baby Friendly USA often rely on fees paid by facilities who participate in their programs; thus there is financial incentive to spread success stories, and little incentive to spread ‘failure’ stories.

18. A story from outside women’s health may shed light here. One of us (Preston-Roedder) worked with a provider who once told the story of a woman, visiting her dying father in the ICU, who was distraught at seeing him receive a preventative vaccine shot. “I just don’t understand,” she said (in tears), “Why did they have to stick him again? He’s dying. It’s no use to him. It doesn’t make sense.” The answer is that the hospital was complying with institutionalized quality standards.

19. For instance, another institutional phenomenon which may have influenced the BFHI is measurability. Breastfeeding initiation rates are measurable, as is the percent of women rooming with their child. In contrast, it is difficult to measure the percent of women whose feeding preferences are fully supported. This may help explain why, as it became embedded in hospitals (and faced institutional requirements to provide data), the BFHI came to focus on concrete, measurable rates of breastfeeding initiation, and not maternal empowerment.

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