Belonging in the Margins: Mothering as Citizenship Among Resettled Refugees in Chicago, Illinois

BY

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THESIS

Submitted as partial fulfillment of the requirements for the degree of Doctor of Philosophy in Anthropology in the Graduate College of the University of Illinois at Chicago, 2015

Chicago, Illinois

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This thesis is dedicated to my children Sebastian and Zoe, my invaluable research partners.
ACKNOWLEDGEMENTS

Anthropological fieldwork is the culmination of training and experiences as we, as anthropologists engage in meaningful conversations that attend to our research interests but also inevitably draw on our own experiences making our research, ultimately, biographical. Therefore the list of people to whom I owe thanks for teaching and supporting me along the way is extensive. First and foremost I must thank the mothers who participated in this study for being so generous with their time and opinions, for welcoming me into their homes, and for supporting me in my own time of need. I also could not have done this project without the support and participation of Heartland Alliance Refugee Health Programs. Thank you to Erin Hantke, Linda Graf, and all who supported and participated this project and the lives of pregnant refugee women.

My dissertation research was funded by the Graduate College of the University of Illinois at Chicago Provost Award for Graduate Research, Grant-In-Aid of Research from Sigma Xi, The Scientific Research Society, and the UIC Department of Anthropology’s Charles Reed Award. I would like to thank these funders for their support, generosity, and belief that this project was worthy of study.

Within the UIC Anthropology Department and School of Public Health I could go on and on but special thanks to Dr. Kathleen Rizzo, Melanie Kane, and David Brand for their advice and counsel. Warm thanks of course to my committee members Drs. Mark Liechty, Molly Doane, Nadine Peacock, and Alma Gottlieb for their guidance, careful reading and thoughtful advice. I thank Dr. Brian Bauer for reading countless drafts of my grant proposals and for his everlasting support. Additional thanks go to Dr. Nadine Peacock for her guidance and methodological training, without which this project would not have been possible. My appreciation and thanks to
my advisor and champion Dr. Crystal Patil are difficult to put into words. From the first day she has opened doors, encouraged, and pushed me to be a better and more thoughtful scholar. Her involvement and guidance from the first day has pushed me to write this dissertation of which I am incredibly proud.

I also must thank Dr. Cheryl Nakata in the Department of Managerial Studies at UIC for her continued support and collaboration on scholarly work unrelated to this dissertation but which motivated me through the difficult fieldwork and writing process and for guiding me through the writing and publication process. Thanks also to Nik Prachand for his guidance and demand for excellence when introducing me to the world of Public Health at the Chicago Department of Public Health.

My friends and colleagues at UIC have pushed and supported me critically, theoretically and personally, making me a better scholar and person. Particularly I thank (alphabetically) Emily Baca Marroquin, Paul Bick, Zachary Blair, Rebekah Ciribassi, Kimberly Garza, Ruth Gomberg-Munoz, Maggie Kaufman, Caleb Kestle, Molly McGown, Dylan Lott, John Michels, Jim Meierhoff, Laura Nussbaum-Barbarena, Damian Peoples, Matt Piscitelli, Erin Rice, Evin Rodkey, Luisa Rollins, Matt Schauer, and Neslihan Sen. I sincerely apologize to anyone I missed. Finally thanks to my family, particularly my husband for his patience and support and the best fieldwork companions anyone could ask for, my children Sebastian and Zoe.

EJPA
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PREFACE

My interest in breastfeeding grew from my own experiences breastfeeding my first child, Sebastian. In the process of preparing to have my first child I was confronted first hand with the dilemmas facing all new mothers, infant feeding. Though I had engaged in the subject in my graduate coursework in medical anthropology and public health, the public and academic rhetoric surrounding breastfeeding took on new meaning when I entered my own breastfeeding relationship. In preparing for the birth of my first child my husband and I participated in a childbirth preparation class. The class was run by a certified lactation consultant. Thus, exclusive breastfeeding promotion played a dominant role in the childbirth preparation. Though I was in favor of exclusive breastfeeding due for reasons commonly cited by mothers (the health benefits for the mother and child, the bonding relationship, the ease of breastfeeding compared to preparing bottles), by the end of the class both my husband and I were fervent breastfeeding advocates. These preconceptions I had about breastfeeding were challenged by the birth of my first child and by the experiences of the many mothers I talked to in the course of my fieldwork. Through my own experiences and the experiences of my participants, my perspectives on the role of breastfeeding and bottle feeding have gone through several transformations that I address in chapter six.

My interest and relationship with the refugee community in Chicago began prior to my academic career. Prior to entering graduate school I worked in the hospitality industry, which put me in contact with immigrants from a variety of backgrounds, many of whom were refugees. The invisibility of power structures became visible in the summer prior to entering graduate school when I worked in a high end hotel in downtown Chicago. As many hotels in Chicago do, this hotel employed a significant number of resettled refugees in low skilled positions such as dishwashing and housekeeping. Being a curious person I befriended many of my coworkers, who in turn shared their incredible stories with me. The stark contrast between their experiences and those of the hotel patrons, many of whom were celebrities, business and political leaders, and foreign dignitaries, were vividly juxtaposed, particularly since they were in such close proximity and separated by a wall. Though these refugee employees and patrons were in reality only a few feet from one another, they were rendered invisible from one another by the physical wall separating them. Upon entering graduate school I had a clear idea of what I wanted to study, though the group of “refugee” was not a traditionally conceptualized group. Soon after, Dr. Crystal Patil came to the Anthropology Program and had experience conducting research among the resettled refugee community. Beginning in 2007, I began a long term relationship of both research and volunteering with the refugee community in Chicago. My interests grew to include the experiences of refugees prior to resettlement, which I examined in my capstone in Public Health, titled, “An Ecological Community Assessment of Urban Refugees in Tanzania: Suffering and Somatization in Dar es Salaam.” This project resulted from the intersection of my dual interests in breastfeeding promotion and the experiences of refugees.
SUMMARY

This dissertation examines how refugee mothers negotiate the complex terrain of mothering in the United States as they struggle to define themselves and citizens and subjects. I begin my research with a simple but broad question: do refugee mothers breastfeed after resettling in the United States? The answers is equally broad, yes, no and sometimes. I attempt to contextualize breastfeeding within broader structures of power. I argue that breastfeeding is a microcosm of mothering practices employed to differentiate good worthy mothers and practices to maintain normative ideals of motherhood within existing notions of race, ethnicity and class. The the stories mothers tell about their breastfeeding experiences will demonstrate how each woman understands and positions her subjective self. In this dissertation I argue that questions about mothering, infant feeding in particular, are about citizenship, national and global politics and as such should be at the center of scholarship.

The debates around breastfeeding reflect complex social relationships that position mothers as citizens and subjects. Anthropological investigations reveal that mothers are subject to expanding regimes of health and the political-economic web of structural inequalities. I employ multiple theoretical approaches to develop a deeper understanding of how refugee mothers negotiate day to day decisions about infant feeding. I begin by contextualizing the history of refugee resettlement in the United States and the push towards self-sufficiency and “personal responsibility” as efforts to craft refugees into ideal citizen-subjects. I propose that prior notions of development and current conceptions of citizenship influence how each refugee mother positions herself as a good mother and citizen-subject. I continue by reviewing the paradigm of scientific mothering that dominates mothering discourse in the United States and introduce the maternal education group that each of the refugee mothers participated in. I propose that scientific mothering discourse acts as a disciplinary mechanism deployed by medical authorities, public health practitioners and middling modernizers to craft good citizen-subject mothers. Within these discussions, I introduce several refugee mothers from Bhutan, Burma, the Democratic Republic of Congo, Sudan and Iraq. Through these refugee mother’s stories for the six months following birth, I demonstrate that each critically and selectively incorporate aspects of scientific mothering, positioning breastfeeding as a meaning-making practice based on their sense of belonging. Using the everyday experiences of my participants as the core of my analysis, I demonstrate how infant feeding choices offer a lens to examine the negotiation of subjectivity and reproduction of inequalities within the modern biopolitical project to craft ideal citizen-subjects. Throughout I propose that the embodied decisions mothers make about breastfeeding are enmeshed in larger processes of citizenship and motherhood and that each mother actively reformulates these processes of which they are a part.

The experiences shared by the refugee mothers in this dissertation share many common themes with mothers as a whole in the United States. Notions of race, ethnicity and class permeate discussions and perceptions of “good mothering” in regards to all mothers. While refugee mothers are united by some important characteristics (experiencing violence or the threat of violence, accumulative stress from the experience of being a refugee and separation from family), I argue what unites mothers’ experiences in the United States outweighs what separates us. Therefore I also argue that refugee mothers contribute to transformations in mothering practice as a whole in the United States, leading to potentially greater genuine freedom in infant choices and mothering practices. This ethnography will make significant contribution to studies of health and subjectivity and offer important opportunities to engage anthropological inquiry in public health advocacy and open new directions for research.

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INTRODUCTION

1.1 Overview

This dissertation is an anthropological study of breastfeeding and mothering in the United States as a complex site for the production of subjectivity. My research offers a fresh perspective on negotiations of subjectivity by examining infant feeding as a lens to explore the increasing trend towards what scholars have characterized as the medicalization of mothering in the context of citizenship discourse (Clarke et al. 2003; Davis-Floyd and Sargeant 1997; Lock and Nguyen 2010). As mothering has come under medical scrutiny, experts have positioned themselves as authorities on all aspects of pregnancy, breastfeeding, and motherhood as aspects of cultural reproduction (see Apple 2006 and Murphy 2000). In the era of neoliberalism in the United States, breastfeeding and mothering have become new realms of health, ripe for discipline and control (Murphy 2000; Wolf 2011). Much attention has been given to the intersection of maternal subjectivities and behavior in optimizing infant and children’s health, and ultimately the nation (Ginsberg and Rapp 1995; Lock and Kaufert 1998; Browner and Sargeant 2011). Mothers are active participants who resist, internalize, and negotiate subjectivity through their own social, historical, cultural and political experiences.

The debates around breastfeeding reflect complex social relationships that position mothers as citizens and subjects. Anthropological investigations reveal that mothers are subject to expanding regimes of health and the political-economic web of structural inequalities. As refugee migrants, the mothers who participated in this research have navigated exclusionary political systems that have continually defined them as non-citizens through violence or regulation. Their path to resettlement in the United States offers a permanent solution and end to histories filled with discrimination and exclusion. My research examines how refugee mothers
negotiate the complex terrain of mothering in the United States as they struggle to define themselves and citizens and subjects. This ethnography will make significant contribution to studies of health and subjectivity.

~

Mahnin is sitting cross-legged on the floor of her one bedroom apartment cradling her five day old son in her arms. She is nervously rocking back and forth, pulling his blanket tighter and adjusting his small cap, whispering to him. As I sit across from her, Mahnin’s two young daughters squat beside me, quietly watching their mother and new brother. I ask how she is feeling and she tiredly comments that her stitches from her c-section hurt and she is tired. I sympathetically offer that it is tiring having a new baby and she laughs half-heartedly. I ask her how he is eating. She says that he is eating a lot but that he is not gaining enough weight. When I ask how she knows she replies that she saw the doctor earlier that day and she does not think he is gaining enough weight, though the doctor thinks he is normal. Her face looks strained as she tightens the blanket. The baby makes a gurgling sound and she offers her breast, to which he latches immediately.

“He seems hungry! Is he eating well?” I query. “Yes, he eats a lot. He is very hungry,” she replies, never looking up from her son’s gaze. “What is he eating, only breast milk?” I ask, noting the small bottles of prepared infant formula sitting in the corner. “No, this too, from the hospital,” she replies reaching back for a bottle and handing it to me. “Does he like both?” I ask. “Yes, he likes it a lot, he eats both,” she replies, still never raising her eyes from her son’s gaze. I ask if she plans to give him formula as well. “As soon as I get my WIC I will get more formula. The doctor said he can give me some if my WIC doesn’t come before I am finished with this,” as she gestures to the prepared formula bottles from the hospital. I ask if her doctor suggested she
supplement with formula and she replied no. “He tells me my breast milk is enough but look how small my baby is. I know he needs formula too.” Knowing from previous conversations that she exclusively breastfed her previous four children I asked why she was sure that her infant needs formula in addition to breast milk, if her previous children only had breast milk.

“I would have given them formula too if I could, but in Burma I could not afford it. They were also small and they were not healthy. Look at them now, they are still small. He needs formula too, to be healthy.”

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“Welcome,” Jala says as she gives me a warm hug. She reaches down to pick up her infant son, swaddled on the bed to show me. He is wrapped in the swaddling blanket from the hospital. “My son” she says proudly and gestures for me to sit. I sit on a mattress on the floor and she sits next to her son who is across from me, on another mattress. I ask how much he weighs and if he is eating well. “5 pounds and some ounces, I think. He eats a lot.” I ask what he is eating. “Just, my milk” she says, gesturing to her breast. I ask if he had ever had formula and she rolled her eyes. “Yes, they gave it to him in the hospital. They said he was too small and he spent two days in the nursery [neonatal intensive care unit]. I gave him my milk but they kept giving him formula.” I asked her how she felt about the formula. She rolled her eyes again and said with irritation, “What can I do? I fed and fed him and I pumped and pumped but so little milk came they said they had to give him formula, that he was too small.” I asked if she was going to give him more formula. “The doctors tell me to give it to him because he is too small and it will make him grow but ehh,” and she gestures with a flip of her hand above her head. “But no, he only needs milk [breast milk]. He will grow. I am his mother, I know what he needs.”
Bhakti leans forwards onto the table resting her head in her hands. At her request we met at a playground instead of her apartment as we had before. I ask “So how is it having two children instead of just one?” It the first time I had seen her since she had her baby, two weeks prior. “So different,” she replied with a mixture of irritation and authority. “You just wait and see, you will know,” and she gestured towards my belly knowing that I was pregnant with my second child. “Let me tell you, not a moment of peace, not a moment of sleep. My baby is crying all the time and my son (3 years old) is jumping and jumping and jumping. This is why I wanted to leave today, for a moment of peace. If it was not for my mother-in-law I would go crazy.” I rubbed her shoulders sympathetically. I asked how her baby was doing. “He is fine, getting big, eating a lot. Just not sleeping!” I asked what he was eating and she replied formula and breast milk. “It is the same as before,” she lamented. “Again I am not having enough breast milk. I am trying but each time it is not enough. He cries and cries, even when I am done feeding him so what can I do? I give him some formula. My mother-in-law says to drink more tea, have more soup and the milk will come but it is two weeks now and still the same. I know in the class they said to keep breastfeeding and more milk will come but still no milk! I pump it and I measure it and I know it is not enough.” I ask about her doctor’s advice about breastfeeding. “He says the same, to keep breastfeeding and I will. But if my baby is hungry I am going to feed him! I am his mother after all, I am experienced! I know what my baby needs.”

The above vignettes offer a glimpse at the varying reactions mothers experience when making decisions about feeding their infants during the crucial period following birth. These scenes illustrate the major themes that will recur throughout the remainder of the dissertation: the
personal experiences of the mothers, all of whom are refugee women of color who recently immigrated to the United States, and how those experiences shape her decisions about infant feeding, mothering, and medical advice; the intersection of personal experiences with the imposition of a dominating medical authority that promotes conflicting messages about infant feeding, and parenting in general; and the struggles refugee mothers experience as they reconcile their mothering practices with norms and standards imposed in their new cultural home. Using a person-centered ethnographic approach as advocated by Kathleen Barlow and Bambi Chapin (2010) among others (Hollan 2001; Hollan and Wellenkamp 1994; Levy and Wellenkamp 1989), I examine how individual mothers make choices and negotiate different goals, motives and understandings about breastfeeding and mothering. Through these negotiations and choices we see the internalization and contestation of cultural values, codes and rules as refugee mothers struggle to situate themselves as mothers in their new cultural home.

1.2 Why Breastfeeding? Why Refugees?

I walked into the office of the associate director of Refugee Health Programs and immediately recognized the woman behind the desk. She had worked at a different refugee agency five years prior, where I was first introduced to the refugee community in Chicago. I introduced myself and we laughed about how small the refugee community is. We briefly chatted about our lives. We had both gotten married and I had my first child. She had no children and had been awarded a Fulbright award to go to Haiti, her husband’s homeland. I began to describe my project and my interest in participating in the pregnancy support group she had organized two years prior. The purpose of the group was to improve maternal literacy by offering health education seminars to pregnant women and to decrease social isolation that many
refugees experience following resettlement, pregnant women in particular. My intention was simply to recruit participants from the group for my own project. I explained that I was interested in whether refugee mothers breastfeed, for how long and why some of them might choose to use formula instead. Her response echoed the most common response I received. “Why?” Why does breastfeeding matter, and furthermore, why does it matter among resettled refugees in Chicago, IL? She followed up with the second most common response, “Don’t they just breastfeed anyway?” When asked if she knew how many of her past participants breastfed or bottle fed, she looked dumbfounded and responded that she had never asked.

This response was repeated by nurses, doctors, social workers, refugee aid workers, and other mothers. Though always well intentioned, this response reflects broader assumptions about both breastfeeding and about immigrants in the United States, refugees in particular. The first assumption is that breastfeeding is a personal choice and not an exigent issue among a population that faces numerous health challenges. Breastfeeding has experienced a resurgence in popularity in the United States, initially driven by a feminist “back to nature” movement and followed by public health initiatives to promote breastfeeding and improve maternal and child health (Crowther and Tansey 2007; Grummer-Strawn and Shealy 2009,; Tomori 2011; Wright and Schanler 2001). Employing scientific evidence that established the superiority of breastfeeding compared with artificial or formula feeding, breastfeeding is positioned as the optimal choice for infant feeding which conversely positions formula feeding as leading to potentially detrimental consequences (Tomori 2011). The Center for Disease Control and Prevention’s (CDC) Division of Nutritional and Physical Activity and Obesity recommends exclusive breastfeeding for the first six months of the infant’s life, followed by complementary feeding and breastfeeding for two years or as long as the mother and infant wish (CDC 2014).
Objectives of the Healthy People 2020 initiative are to increase the proportion of infants who are breastfed and to reduce the proportion of breastfed infants who receive formula supplementation in the first two days of life (CDC 2014). While these efforts have led to an increase in breastfeeding in the time shortly after birth, the proportion of mothers continuing to breastfeed for the recommended two years fall short of the targeted goals. In the United States, 79% of infants begin breastfeeding, a rate that drops to 49% by 6 months (and a much lower rate of 18% for exclusive breastfeeding at six months) and then to 27% by 12 months of age (CDC 2014). In Illinois, 77% of infants begin breastfeeding, a rate that drops to 47% by 6 months and then to 26% by 12 months of age (CDC 2014). Furthermore, these national and state level statistics conceal differences in breastfeeding rates along racial, ethnic, and class lines, particularly among immigrant and refugee women (CDC 2014). Despite these national public health goals, I discovered that prioritizing breastfeeding research in the United States can be a struggle. Assumptions persist that breastfeeding is a “natural” or “biological” act that must be learned by women who are scientifically minded and separated from their bodies while women who are perceived as less scientifically minded know how to breastfeed “naturally.” Primarily coming from developing countries, refugee women are often assumed to be “closer to nature,” therefore can and choose to breastfeed instinctively or “naturally,” precluding the need to include a focus on breastfeeding promotion or support. This assumption was repeated over and over as I discussed my project with social workers, nurses, midwives and lactation consultants that were involved with refugees.

The assumptions that permeated every aspect of the lives of refugee mothers I came to know intimately also uncovered how the naive and sometimes paternalistic assumptions—that some women necessitate more medical intervention and supervision than others—persist within a
culture where racial disparities exist in nearly all measures of maternal and infant health. The aforementioned differences in breastfeeding are striking, but not as striking as the fact that the infant mortality rate for black infants is almost twice what it is for white infants in the United States (Bridges 2011). Black mothers are more likely to give birth to low birth weight babies, which puts them at greater risk for a host of other health complications (Dailey 2009; Rosen 2013). Multiple studies have shown that Black women and other racial and ethnic minorities are more likely to undergo an unplanned cesarean section than white women, even when the women were low-risk, indicating an overuse of cesarean surgery among racial and ethnic minorities (Edmonds et al. 2013; Roth et al. 2012). Medically necessary cesarean delivery due to pregnancy-related health risks are also more common among racial and ethnic minorities and is often attributed to low socioeconomic status and inadequate health care (Roth et al. 2012). Cesarean delivery has been widely accepted to have a negative impact on establishing breastfeeding due to post-operative pain and delay in breastfeeding initiation (Cakmak 2007; Karlstrom et al. 2007; Perez-Rios et al. 2007; Prior et al. 2012; Zanardo et al. 2010). It is unsurprising that higher cesarean rates among racial and ethnic minorities correspond with lower breastfeeding rates. Further research has found racial and ethnic minorities are more likely to have formula introduced in the hospital and less likely to receive breastfeeding support from hospital lactation consultants and the U.S. Department of Agriculture’s Supplemental Nutrition Program for Women, Infants and Children (WIC) (Beal et al. 2007; Celi et al. 2014; Demota et al. 2012; Evans et al. 2011; Petrova et al. 2007; Singh et al 2007; Tender et al. 2008). The structures of racism that produce these well documented racial disparities in health permeate the everyday lives of the refugee mothers in this dissertation in unexpected ways. It is worth noting now that within my group of 20 refugee mothers, ten had a cesarean delivery and of these ten,
seven were unplanned. All engaged in some form of breastfeeding but none breastfed exclusively for six months. Though I was only able to gather data anecdotally from the mothers on fourteen of the babies included in this project, nine would be considered low birth weight, defined as less than 2500 grams or five and a half pounds. The ways in which efforts to create equity within the health and social service system can be credited with medical racism is a subtle but recurrent theme of each participant’s life.

My path to the pregnancy support group at Heartland Alliance was somewhat surprising to me. My interest initially was spurred by an article I had come across by Becky Straub, Cathy Melvin, and Miriam Labbok (2008), reporting that Cambodian refugees living in Chicago ceased breastfeeding quickly due to a lack of confidence in their ability to breastfeed. The discovery of this article coincided with the birth of my first child, my own breastfeeding journey, and curiosity about breastfeeding promotion. I had been exposed to strong pro-breastfeeding messaging during my prenatal appointments and during a birth class my husband and I attended. Though I was aware of the numerous benefits breastfeeding offered and the political and theoretical aspects of breastfeeding from my global health and anthropology training, breastfeeding took on a new meaning when I was faced with breastfeeding my own child. I became a staunch breastfeeding advocate and was aware that in industrialized countries such as the United States and Canada, researchers report variation in breastfeeding rates among different social and ethnic groups with immigrants generally reporting higher rates of breastfeeding than the general population (Celi et al. 2005; Bonuck, Freeman and Trombley 2005; Groleau, Souliere and Kirmayer 2006). In addition there is increasing evidence that with each year migrant mothers resides in a host country the duration of breastfeeding decreases (Schmied et al. 2012). Of the numerous studies examining breastfeeding among immigrant groups, only a few
qualitative studies have examined breastfeeding practices among refugees specifically. All studies report that refugees tend to breastfeed at lower rates than the general population in their home country and host country.

Inconsistency in the definitions of breastfeeding have led to difficulties in comparability within breastfeeding research as pointed out by Miriam Labbok and Kathleen Krasovec 25 years ago (1990). The need for consistent and precise definitions of breastfeeding and infant feeding are necessary to ensure accurate conclusions and allow for comparability across communities, countries and regions. While the term infant feeding is commonly used within public health to encompass all methods of infant feeding aside from exclusive breastfeeding, breastfeeding is commonly used within anthropological and biomedical disciplines and breastfeeding advocacy groups to characterize breastfeeding in contrast to artificial or formula feeding. As proposed by Labbok and Krasovec (1990) the term “breastfeeding” can be divided between full, partial and token breastfeeding. Full breastfeeding is also known as exclusive breastfeeding, meaning that the infant receives only breast milk. Partial feeding is also known as mixed feeding, supplementary feeding and complementary feeding, meaning that the infant receives both breast milk and infant formula and / or solid foods. Token breastfeeding means that the infant continues to breastfeed but receives his or her primary nutrition from solid foods and infant formula. “Infant feeding” encompasses all infant feeding methods including all forms of breastfeeding, though exclusive breastfeeding is usually distinguished from other forms of breastfeeding. Within this dissertation I use the term breastfeeding to encompass all forms of breastfeeding (full, partial and token) and infant feeding to discuss broader feeding behaviors that include the addition of formula, tea, water, cow’s milk, and solid food in addition to breastfeeding. I use the
term exclusive breastfeeding to refer to full breastfeeding and the term mixed feeding to describe the combination of breastfeeding and formula feeding.

Do immigrant women modify their breastfeeding behaviors upon arrival in the United States, refugee women in particular? Differences in cultural practices are often cited as a likely culprit, described by Parin Dossa (2002) as the “cultural-barriers-to-health” paradigm. Though Dossa, and later Marina Morrow (2008) and colleagues, apply this paradigm to mental health, the paradigm is used as a lens to analyze a broad range of immigrant health needs. The paradigm assumes that immigrant women face barriers to achieving well-being and health care and that the root of these barriers is cultural. This “barriers” approach aims to remove barriers in order to improve health and health care as opposed to focusing on the politics of health and health care. Inherent in the cultural-barriers-to-health approach is the assumption that assimilating to dominant American behaviors and values will lead to desired outcomes. Other important factors that are not considered central to this paradigm are the strong correlations between health and well-being and socio-economic factors, and that immigrants have their own perspectives and agency to effect change (Dossa 2002).

Breastfeeding research among immigrants is in its infancy in the United States, and few researchers have examined the relationship of immigration on refugee mothers specifically. One recent study by Virginia Schmied and colleagues (2012) identified several factors that lead to breastfeeding cessation including lack of access to traditional postpartum practices, tensions with family members, and clashes between individual beliefs and dominant host country practices. The few studies that have specifically examined breastfeeding behaviors among refugees have also taken a barriers approach. In an exploratory study, Cynthia Reeves Tuttle and Kathryn Dewey (1994) designed an intervention to overcome barriers to breastfeeding initiation among
Hmong refugees in California. They identified barriers to breastfeeding including the introduction of formula in hospitals, separation from the infant after birth, access to formula through WIC, perceptions that formula feeding is preferred in the United States, and perceptions that formula feeding is healthier and more convenient. In a follow up study, Reeves Tuttle and Dewey (1996) found that targeting these barriers through prenatal classes led to greater breastfeeding initiation. Similarly in an exploratory study of breastfeeding among Cambodian refugees in Chicago, Becky Straub, Cathy Melvin, and Miriam Labbok (2008) examined cultural reasons for introducing formula and concluded that a combination of structural and social barriers prevented exclusive breastfeeding such as the introduction of formula by a nurse or doctor in the hospital, perceptions of a low milk supply, and the need to return to work. These studies indicate that refugees do not breastfeed due to changing perceptions of breastfeeding that refugees have once living in the United States.

Though it is tempting within the discipline of medical anthropology to look to cultural beliefs that inform behavior first and structural systems second, embedding personal experience within systems of power is challenging and difficult to translate in a way that speaks to more than a small defined group. More and more, researchers are finding that situating the experiences of non-dominant groups within systems of power relations, more similarities than differences exist between the groups themselves. Recently international health literature has transitioned from focusing on the “exotic” belief systems of different cultural groups and treating each group as a distinct entity, to examining the power relations that exist between dominant and non-dominant groups that redefine meaning and dictate social structures, including health care promotion and delivery (Anderson et al. 2003). This movement away from the culture of the patient towards the broader “society that it operates within and the power dimension of race,
class, gender, and immigrant status and how these shape health inequities” (Viruell-Fuentes, Mirada and Abdulrahmin 2012:2) was a journey that I experienced during the course of my fieldwork. This necessitated a reframing of both the issue and the social and physical environment within which refugee women make decisions about mothering overall, breastfeeding in particular. It also necessitated a reexamination of my own choices about breastfeeding and mothering.

At my first meeting with the associate director of Refugee Health Programs, during which I proposed my project, I was informed that though she supported the research project, the pregnancy support group would be canceled even though funding had been secured. She was leaving her position to go to Haiti. A replacement had not get been appointed and it was unlikely that they would be able to start the group. Seeing my project slowly slip away, I volunteered to organize and facilitate the group. This put me in the position to design the curriculum, promote certain topics, and assert a particular health promotion agenda. This put me in an unusual position as an anthropologist, as I would be more involved in the subject of my research than is classically defined. More than a fly on the wall, I would not only be a participant in the group, I would design and structure the very group that would allow me to gain entry into the community. Using the existing template from the 2011-2012 cohort as a model, like researchers before me I followed the dominant public health model by employing a “barriers-approach” to the design of the 2012-2013 pregnancy support group, which I will discuss in more detail in Chapter 3. I also interviewed the community health promoters to identify barriers to health and health care within the refugee communities. Though breastfeeding was not a topic suggested by the community health promoters or present in the previous design, I included a session dedicated to breastfeeding for the 2012-2013 cohorts (see Appendix A).
I felt confident in the design of the curriculum as I combined research on the barriers-approach to health promotion among pregnant immigrants with my own experience as the mother of a one year-old. I also held and employed the dominant assumptions present in breastfeeding literature regarding reasons that mothers do not breastfeeding (though these assumptions have been critiqued by Apple (2006), Blum (1999), Carter (1995), and Wolf (2011) to name a few). Employing the assumption that breastfeeding is the optimal form of infant feeding, I assumed that women wanted to breastfeed exclusively and there were barriers that inhibited their ability, such as working outside of the home, introduction of formula by hospital staff, a lack of support, or inability to complete cultural customs associated with birth. Another assumption I held was that women who do not want to breastfeed are unaware of the numerous benefits and presenting them with the information would modify their behaviors and intentions. Throughout the course of my fieldwork I would discover that the barriers-approach was both inadequate to address the needs of the communities as well as to describe the experience of being a mother in a new cultural home. Rather, the combination of the power dimensions present in the health and social service systems and lived experience of breastfeeding and mothering were more powerful forces shaping women’s breastfeeding practices.

Over the course of the next 22 months (August 2012-May 2014) I designed, organized, and facilitated the pregnancy support group for both the 2012-2013 and 2013-2014 cohorts. In addition, I became part of the community by participating in other Heartland initiated health events including field trips to area museums, walking groups, monthly cooking classes, yoga classes, and Women’s Health week. In addition to structured activities, I also provided some participants with a ride to and from the hospital during delivery, arranged for hospital tours, served as an interpreter, and accompanied women on daily tasks such as shopping, taking our
children to parks, and drinking endless cups of tea. I was able to recruit 20 women to participate in a series of in-depth semi-structured interviews about breastfeeding and mothering. In addition to my fieldwork I also became pregnant and gave birth to my second child, renewing my personal relationship with breastfeeding and adding a strong reflexive element to my analysis of breastfeeding and mothering. But first I will review the history of refugee resettlement in the United States to contextualize my participant’s experiences.

1.3 Contextualizing Refugees and Resettlement

The designation of refugee was first given to Huguenots fleeing persecution in France and seeking individual freedom (Adelman 1999). The difference between refugee migration prior to the twentieth century and after is that prior, refugees were not considered a threat to the nation. They were considered an alien nationality and were expelled to their territorial homeland in order to cleanse the nation. They either had to return to their designated homeland or seek entry in a different territory, often a colonial territory (Adelman 1999). Refugees were identified collectively, not as individuals whose rights had been violated, and collective measures were taken to address migration such as population exchange and territorial negotiation (Adelman 1999; Zetter 1999). During the colonial era, when the globe was territorially divided, and after the Bretton Woods conference when the global system of nation-states was institutionalized, refugees were both expelled by the nation-state, for violating perceived affinity, and excluded from other nation-states from which they were not members, leading refugees to be characterized as “the Achilles’ heel” of the nation-state system (Adelman 1999:93).

The first test of the post-World War II nation-state system was the plight of the 11 million Europeans displaced after World War II, including Jewish holocaust survivors (Zetter
It was debated in the United Nations whether Jews should be considered refugees or displaced peoples, in which case they would have to be returned to their countries of origin. It was decided that the Jews were refugees in which case they could seek resettlement in another country or territory (Zetter 1999). The 1951 Convention Relating to the Status of Refugees was drafted and the United Nations High Commission for Refugees (UNHCR) was established in response to this situation and was approved on July 28, 1951 by the United Nations. The convention provides parameters for defining who is a refugee, legal protection and social rights ratifying states are obligated to provide, and parameters for exclusion from refugee status, such as war criminals. A refugee is defined as “a person who is outside his or her country of nationality or habitual residence; has a well-founded fear of persecution because of his or her race, religion, nationality, membership of a particular social group or political opinion; and is unable or unwilling to avail himself or herself of the protection of that country, or to return there, for fear of persecution” (UNHCR 1951). In addition to protection, the convention also protects the refugee from being returned to the country from which they fled and guarantees freedom of religion, freedom of movement, the right to work and to education. The rights guaranteed under the agreement indicate that they should enjoy the same rights as foreign nationals living legally in the given host country (UNHCR 2007). The document was drafted in response to protecting the rights of European refugees post World War II and the document originally recognized Europeans displaced prior to 1951. European groups were designated to be refugees if they were involved in events occurring before 1951 (UNHCR 2007; Zetter 1999). Due to the provision that states have discretion when admitting refugees, many Jewish refugees were denied admittance in European nation-state and most settled in the newly founded state of Israel. The consequent conflict between Jews and Palestinians attempting to sort themselves out territorially and
politically is ongoing (Abu-Lughod 1988; Adelman 1999). A 1967 protocol enabled the document to extend to worldwide displacement by removing limitations on geographical origin or the time of displacement. Importantly these documents distinguish between refugees and internally displaced people (IDPs), those who are persecuted but have not crossed the border of the country of origin, and economic migrants, those migrating “voluntarily” in search of employment.

While initial models of refugee aid and placement tended towards integrative models of self-sufficiency, these trends have shifted to authoritarian welfare models fostering a “discourse of vulnerability and dependency” attracting “helpers whose interests are served by pathologizing, medicalizing, and labeling the refugee as ‘helpless and vulnerable’" (Harrell-Bond 1999:153; Veney 1997). Emphasis on refugee vulnerability as a medical humanitarian intervention by humanitarian organizations coupled with increasingly exclusionary citizenship laws in Western states have cultivated “a more cynical and racist attitude in the developed countries in Europe, North America, and the Pacific Rim, where in different degrees, a world of refugees appears to threaten living standards, ethnic hegemony, or even a country's independence” (Zetter 1999:72). These attitudes have led to prolonged refugee displacement and narrowing of the definition of a refugee, leading some to claim that “those who successfully claim refugee status are the lucky ones” (Zetter, 1999:48-49).

1.4 A Nontraditional Path to Resettlement

The path of refugees to resettlement in the United States is understood to be linear in nature and based on the experience of one of the largest waves of refugee immigration, the exodus of the Indochinese during and following the involvement of the United States military in
the 1960s and 70s (Hung and Haines 1996). As one of the largest refugee groups to be resettled in the United States, they have acted as a de facto model of perceptions and possibilities for refugee resettlement (Hung and Haines 1996; Ong 2003). The circumstances of their paths to the United States is different in many ways, though it established the experience of refugee flight as being progressive and linear. Between 1975 and 1995, over one million Indochinese refugees, two-thirds of whom were Vietnamese, had fled Southeast Asia by boat or plane and to the Philippines where they were received in refugee camps. They were then flown to Guam and then the United States where they were taken to refugee camps and awaited sponsors to find permanent homes (Hung and Haines 1996). The experience of the Indochinese of fleeing persecution in their country of origin to a temporary host country where they were recognized and processed as a refugee, the Philippines in the case of the Indochinese, and then permanently resettled in a third country establishes the expectations of a linear path from flight to resettlement for all refugees.

However, this traditional path from flight to resettlement does little to represent the experience of most refugees worldwide. The number of refugees who are permanently resettled in a host country hardly represents a fraction of the worldwide refugee population. In 2012, of the estimated 10.5 million refugees worldwide only a fraction of refugees are permanently resettled, less than one percent (UNHCR 2012). Resettlement is considered only one “durable solution” by the United Nations High Commission for Refugees. The others solutions would be to seek naturalization in the country they are currently residing or voluntary return to their country of origin termed repatriation. Ongoing conflict in many countries of origin such as the Democratic Republic of Congo, Sudan, and Syria, coupled with fear of persecution prevent many
refugees from considering repatriation a viable option. Regulatory barriers in many host countries prevent many refugees from becoming naturalized citizens.

These barriers have led to two phenomena. The first is termed “protracted refugee situations,” where refugees have been living in exile for five years of more without a durable solution. At the end of 2012, 6.4 million refugees were living in protracted refugee situations. The second is that refugees have become active and mobile in seeking a durable solution, often moving in and out of refugee camps, their country of origin, and urban areas in an effort to seek a permanent solution. This mobility makes it difficult to estimate the total number of refugees living outside of refugee camps but as we will see, it represents the experience of the majority of refugees. The number of refugees living in urban areas is largely unknown by either the host governments or international agencies such as UNHCR. The most recent estimate is nearly a decade old, 2.5 million or 18% of the total refugee population in 2006 (Jacobson, 2006). A handful of studies conclude that refugees became frustrated with the options available to them in refugee camps and desired better access to education (for themselves or their children) and employment (Amisi and Ballard, 2005; Campbell 2006; Dryden-Peterson 2006; Mann 2002; Peberdy and Majodina, 2000; Sommers 1992, 2001a; 2001b). Findings consistently revealed that daily life for refugees living outside of refugee camps is difficult. Refugees are subject to hostile or abusive treatment by authorities, inefficient recognition systems, exclusion from healthcare and education, xenophobic treatment by nationals, inability to access assistance or justice mechanisms, and exclusion from the formal sector.

In an examination of refugees living in Dar es Salaam, Tanzania, Marc Sommers (1999) identifies four different “categories” of urban refugees; (1) Refugees living in urban centers with official recognition and sanction, (2) refugees who have migrated from camps to urban centers
without sanction, (3) asylum seekers who enter a city in search of recognition, and (4) those who identify as refugees but lack official recognition or legal sanction. Though those living in urban areas with legal sanction are often the only urban refugees accounted for by governmental and nongovernmental organizations, Sommers argues that the bulk of the urban refugee population is comprised of refugees or asylum seekers seeking sanction or living without legal sanction and sometimes recognition. With few to no mechanisms of support in place, persistent xenophobia, police harassment, and lack of assistance, refugees living outside of camps are forced to maintain a high level of self-sufficiency (Campbell, 2006; Dryden-Peterson, 2006; Jacobson, 2006; Sommers, 2001). The traditional linear path of flight to a temporary (and brief) stay in a refugee camp followed by permanent resettlement does little to represent the experience of the majority of refugees. Refugees frequently move between the camps and their home, their camps and urban areas, and their homes and urban areas in search of safety, better opportunities and a permanent solution (See Appendix C). Consequently many refugees move in and out of technologically advanced environments and experience “development” first hand. The theme of how refugees perceive “development” emerged as participants each had their own notion of what development means and how it affects them. Far from the stereotype of the refugee who arrives in the United States having never seen an escalator, many refugees become technologically savvy and adept at navigating dramatically different environments.

1.5 Push Towards Self-Sufficiency in the United States

Receiving refugees, defined as people fleeing persecution, has a long tradition in the United States. Prior to the 1951 Convention Relating to the Status of Refugees, there was no distinction made between immigrants fleeing persecution and those not fleeing persecution. In
the period following World War II until 1980, refugees granted admission and resettlement were primarily from communist countries. In the first four decades of refugee resettlement, voluntary organizations were established to assist and arrange for refugee resettlement with no governmental programs in place to provide support. As a result several programs arose in response to the different groups according to national origin which received federal funding. In 1980, Congress passed the Refugee Act of 1980 which removed the requirement that refugees must have fled from Communist countries to be considered for admission and to “provide permanent and systematic procedures for the admission to this country of refugees of special humanitarian concern to the United States and to provide comprehensive and uniform provisions for the effective resettlement and absorption of those refugees who are admitted” (Holman 1996:13).

The Refugee Act of 1980 also established the Office of Refugee Resettlement within the Department of Health and Human Services to fund and administer domestic refugee programs, a continuation of the public-private partnerships that characterized prior refugee programs. These programs are known as voluntary agencies, or VOLAGS, and often work within religious or civic community organizations. VOLAGS facilitate the administration of the different forms of assistance to refugees, including targeted assistance, social services, cash and medical assistance, and in many cases supplement the assistance provided. Since the inception of the Office of Refugee Resettlement, the trend of resettlement has been a steady decrease in financial support and reduction in federal funding despite increases in the overall number of refugees admitted yearly. Initially refugees were granted a 36-month period of guaranteed cash assistance in order to allow them acclimate and “seek as much education and training as possible” (Holman 1996:24). Since 1980, cash assistance has decreased to a guaranteed 18 months, then to 12
months, and finally to 8 months in order to decrease the disparity between assistance made available to refugees and other citizens living in similar circumstances.

Aihwa Ong (2003) argues that during this time, characteristic of the era of Reaganomics, refugees were recast as welfare recipients and welfare cheats as part of social goal of convincing impoverished immigrants that their class position is temporary. During this period of decreased financial support, the rhetoric shifted from personal achievement to self sufficiency and personal responsibility with the overt goal of getting refugees off welfare and into gainful employment as quickly as possible. For most refugees this means entry-level minimum wage labor, so that when refugee assistance ends many still qualify for welfare assistance, particularly those who are pregnant or with small children. The continued reliance on VOLAGS to facilitate and administer refugee resettlement has led refugee aid workers to adopt a folkloric imagery of immigration where the newcomer must “be helped to be modern rather quickly” by the social worker or volunteers who see themselves as “educative, judgmental and corrective” (Ong 2003:89). The reduction in cash assistance has led many VOLAGS to support refugees monetarily in other ways such as housing, food and clothing drives and language and educational training, though the amount of time refugees are eligible for assistance is limited as we will see. The tensions produced in the power dynamics between refugees and service workers becomes visible in the everyday actions of mothers as they adopt or deflect disciplinary measures deployed to craft them as citizens, however subtle and well intended measures may be. Through the stories they shared, refugee mothers responded to these measures and in doing so subtly transform mothering practices.
1.6 Methodology

My fieldwork for this project began in Fall 2012 and concluded in Spring 2014, totaling approximately 22 months. The overarching purpose of this research was to gain insight into how mothers made decisions about breastfeeding and bottle feeding. Traditionally, research that has included analyses of breastfeeding has employed observation or semi-structured interviewing (see Blum 1999; Carter 1995; Gottlieb 2004; Melvin, Straub and Labbok 2008; Reeves Tuttle, and Dewey 1994, 1995; Scheper-Hughes 1992; Tomori 2011). Following this tradition I collected data via participant observation and a series of in-depth, semi-structured interviews.

Another tradition of ethnographic fieldwork is to live in the same community as their participants in order to become enmeshed in their day to day lives. Similarly to my participants I lived in the north side of Chicago with my family, but due to the size of the city I could not feasibly interact with my participants spontaneously or on a day to day basis. However, due to the proximity of my dwelling to the neighborhoods where many participants live as I will describe below, I did run into my participants spontaneously through the course of daily life at public venues such as the grocery store, playground, and schools.

In addition to attending and participating in the pregnancy and parenting groups, which will be described in greater detail in Chapter 3, participant observation included visiting participants in their homes for the primary reason of “play dates,” or getting together so our children could play. During these visits, endless cups of tea were drunk and we compared notes on mothering based on the ages of our respective children. I would also accompany my participants out in the community to the playground, the lakeshore, or the grocery store. Fieldwork relationships were foundational to learning about mothering, especially breastfeeding. I learned that what mothers say and what mothers actually do on a day to day basis are often very
different and heavily influenced by how they choose to present themselves as a mother. These presentations can range from emulating what they perceive to be good “citizen-subjects” to being in need of continuous intervention and support which I will explore in Chapter 2. Mothers also employ a variety of strategies to encourage or deflect inquiry into their private lives. These strategies and presentations became apparent over the course of my fieldwork as my relationships with my participants changed and the power dynamic transitioned from me being seen as an experienced and knowledgeable mother to an inexperienced novice mother. During the course of my fieldwork my son grew from a 15 month-old toddler to a three year-old, I became pregnant, experienced a pregnancy loss, became pregnant again, and became a mother of two children. My relationship with each participant grew and changed over the course of my fieldwork. As a first time mother when my fieldwork began, other first time mothers looked to me for advice or validation. Mothers of multiple children began to see me as a novice and shifted to advising me on my own practices. Through these exchanges, and the transformations in these exchanges, the meanings of mothering and breastfeeding became apparent.

In addition to participant observation I conducted semi-structured interviews flexibly targeted for shortly before birth, shortly after birth, two weeks after birth, three months and six months. Though my plan was to recruit only pregnant women, in order to meet my goal of 20 participants I also included women who had children younger than six months when my fieldwork began and focused on reconstructing a breastfeeding narrative (approximately six women). Each interview ranged from 15 minutes, for the interview immediately following birth, to 2 hours. All were voice recorded with the exception of two participants who preferred not to be recorded. In order to honor each participant’s schedule and personal needs following childbirth as well as the occurrences of everyday life I remained flexible with the demands of
interviewing. In more than one occasion I was prevented from visiting immediately following
birth due to sickness. I tried to be conscious of the demands of interviewing so that they did not
feel my visits were an unwelcomed imposition. As Aihwa Ong remarks, contemporary
anthropology is characterized “by respect for people’s privacy and one would not expect to be
intruding into people’s lives and observing them outside of carefully defined schedules” (2003, xvi).

Beyond my core participants, I also talked informally with agency volunteers and staff,
lactation consultants, nurse-midwives, attended breastfeeding related meetings, attended a
conference on refugee issues, and followed media coverage of breastfeeding, mothering, and
refugee issues. I also drew on my involvement with different aspects of refugee resettlement,
beginning in 2007, and research conducted with refugees living in Dar es Salaam, Tanzania in
2009. I also was involved with other aspects of the Heartland Alliance Refugee Health
Programs. I helped facilitate and attended cooking classes, yoga classes, mental health meetings,
and women’s health week. In short, I tried to familiarize myself as much as I could about the
experiences of breastfeeding, mothering and resettlement for my core participants while
positioning these experiences in a larger context. By anchoring this study in the lives of my core
participants I hope to provide an ethnographic examination of breastfeeding and mothering in the
larger context of immigration experiences.

1.6.1 The Field Site

In conducted my research primarily in neighborhoods on the Chicago’s north side, with
two exceptions when participants moved outside of the city limits. Chicago is a major
Midwestern city of just over two and a half million residents according to the most recent census,
making it the third most populous city in the United States (US Census 2010). Of the 2.7 million residents, 1.2 million (44%) self-identify as White, with 887,608 (32%) as African American, 778,862 (28%) as Hispanic or Latino, 147,164 (5.4%) as Asian, 13,337 (.5%) as American Indian, and 360,493 (13.4%) as Other with approximately 3% self-identifying in more than one category.¹ The northernmost neighborhood, Rogers Park, is home to all but one participant who lives in an adjoining neighborhood. The neighborhood is the most diverse community in Chicago. Most resettlement agencies maintain offices in Rogers Park, including Heartland Alliance. Meetings for the pregnancy and parenting groups also took place in a church located in Rogers Park. According to recent census data, 24% of the Rogers Park population self-identify as Hispanic, 26% as Black, 39% as White, 6% as Asian, and 4% as Other. 37% of children in Rogers Park live below the poverty level and 55% of children under the age of five live below 185% of the poverty level (Illinois Children for Action 2011). Rogers Park has been a popular housing location for newly arrived refugees due to the diversity of the community, relatively low housing costs, and proximity to public transportation and social service organizations.

My research was done in cooperation with Heartland Alliance Refugee Health Programs, a branch of Heartland Alliance’s Heartland Health Outreach. Heartland Alliance is a large anti-poverty organization that has multiple branches. One branch assists refugees with adjusting to life in a new country by providing culturally and linguistically appropriate services to meet the health and education needs of newly arriving refugees (RHP, 2012). Chicago is the third largest resettlement city in the United States (Singer & Wilson, 2006). Refugee Health Programs is located in the Uptown neighborhood of Chicago about two miles south of the Rogers Park neighborhood, though the health outreach center is located in Rogers Park.

¹ The totals do not equal 100% due to the difference the category of Hispanic/Latino as ethnicity and the other identifying categories as race. Individuals are permitted to self-identify under multiple categories.
Recognizing that many refugee women arrive in the United States pregnant or become pregnant shortly following resettlement, Refugee Health Programs began a multicultural pregnancy and postpartum support group in 2010. The group was formed to help women overcome numerous challenges related to the migration experience and pregnancy that include a lack of health information, language barriers, financial obstacles, social isolation, and loss of support networks, separation from family, and pre-migratory traumatic events and losses (Agnew, 1996; Allotey, 1998; Bibeau et al., 1992; MacLeod & Shin, 1990; Sheikh-Mohammed, MacIntyre, Wood, Leask, & Isaacs, 2006). Many refugee women lack the social support system they may have had in their home country, such as female relatives and friends who would have assisted them during pregnancy, childbirth and after. Studies have found that poor social support and language barriers can make accessing health care difficult and can lead to depression (Edwards et al., 1997; Gorst-Unsworth and Goldberg, 1998; Harper Bulman and McCourt, 2002; Lawrence and Kearns, 2005; Sheikh-Mohammed et al., 2006; Stephenson, 1995; Thonneau et al., 1990). The goals of the group were to improve maternal health literacy, build capacities to navigate the healthcare system, and decrease social isolation among pregnant and post-partum refugee women (Polutnik 2012).

1.6.2 Participants

The core participants of this study were 20 refugee mothers and their children, all of whose names have been changed to protect their privacy. On a few occasions the husbands were also present and active participants, often asking why they were not also included in the research. An overview of the participants can be found in Appendix D.
I recruited a total of 20 participants. All were refugees, ranged in age from 20-34 and had been living in the United States for three years or less. All spoke some English with eight participants being fluent enough to prefer to speak without an interpreter present. Though I intended to recruit only women who were pregnant at the time of the first interview, I recruited six women who had a child younger than six months at the time of my first interview in order to meet my goal of 20 participants. At the conclusion of my fieldwork, the participant’s children ranged from six months of age to 26 months of age. Half of the participants had a cesarean delivery and only one gave birth prior to immigrating to the United States. My participants immigrated from a variety of secondary host countries and countries of origin. One hailed from Iraq, immigrating from Syria. One hailed from Sudan, immigrating from a refugee camp in Kenya. Two immigrated from the Democratic Republic of Congo, immigrating from a city in South Africa. Seven hailed from Myanmar, which I will refer to throughout the dissertation in the same manner as my participants, Burma. The Burmese participants immigrated from either refugee camps in Thailand or a city in Malaysia. The most numerous were from Bhutan, nine total, immigrating from refugee camps in Nepal. Though the women who participated in this research originate from many different countries and backgrounds they are united by their forced migration and the experience of resettlement in the United States.

All participants planned to breastfeed their infants, though none of them claimed that they would not add formula if they deemed it was necessary. With the exception of one participant who gave birth prior to immigrating to the United States, all infants were given formula in the hospital and all mothers departed the hospital with formula to feed the baby at home. All reported initiating breastfeeding in the hospital as well. One infant remained in the hospital for supervision for one week following birth, though the mother was discharged after three days. All
participants engaged in mixed feeding at some time during the first six months. All mothers, with
one exception, supplemented with formula during the first week due to perceptions of low milk
supply and/or waiting for their milk to “come in.” The exception was advised to formula feed
due to a serious medical condition that required medication that had potentially serious side
effects for the baby. This mother chose to delay her medication for three days to ensure the infant
received the colostrums and then switched to exclusive formula feeding. By one month, two
mothers were exclusively breastfeeding and three mothers were exclusively formula feeding. The
rest engaged in mixed feeding, a combination of breastfeeding and formula feeding. At three
months, four mothers were exclusively breastfeeding, five mothers were exclusively formula
feeding, and 11 were mixed feeding. At six months three mothers were exclusively
breastfeeding, five mothers were exclusively formula feeding, and 12 were mixed feeding. The
most surprising discovery was not that so many mothers chose to engage in mixed feeding, but
that in three cases mothers began by supplementing with formula for the first month and by three
months had reverted to exclusive breastfeeding. In two of these instances the mothers had older
children and supplemented with formula “to help them grow,” stating that if formula had been
available for their older children they would have supplemented with formula as well. In the
other case it was the mother’s first child after struggling with breastfeeding for the first two
weeks she engaged her physician who prescribed a medication to increase her milk supply. By
two months she was exclusively breastfeeding and ceased supplementing with formula. In only
one case did the mother exclusively breastfeed for the first three months and decide to
supplement with formula by six months, “just to see if he likes it.”
1.7 Positionality and Theoretical Approach

My own position in my fieldwork was complex, though complexity is not an uncommon characteristic of fieldwork. Many anthropologists who have studied aspects of reproduction and motherhood have done so through their own life experiences and as such their research is self-reflexive (Barlow and Chapin 2010; Davis-Floyd 2004; Gottlieb 2004; Layne 2000, 2003; LeVine and LeVine 1979; Tomori 2011). Recognizing one’s own positionality within fieldwork constitutes an important component in ethnography and ultimately theory. As Naomi Quinn highlights, theory is more than “thick description,” but the attention to “where the description is thick” (2010: 441). This attention is guided by the theoretical perspective of the ethnographer who first decided what to notice and then how to interpret the data drawing on theoretical, personal, experiential leanings.

My position as a mother during my fieldwork was an integral component of my fieldwork. This project would have been very different if I had not been a mother for a number of important reasons, some theoretical and some practical. My personal history figured into my encounters in several ways. For example, without the experience of breastfeeding a baby the questions I would have asked would have been very different. Without my most important fieldwork tool, my son, I would not have gained the type of access to the private lives of mothers if I had not also been a mother. The mothers with whom I spent the most time had a young child in addition to their own infant living in the house, whether that child was their own, a family member, or a charge they were watching. My son opened the door to get together and just “hang out” and drink tea while the children played, during which time we the conversation would inevitably turn to mothering. In a practical sense, the ability to have my child accompany me
during my fieldwork enabled me to complete my fieldwork. As a student, anthropologist and mother I also grappled with both the financial and emotional aspects of childcare.

My personal history played a large role in my ethnographic interactions in several ways. Though I was the mother of a young child, 15 months at the beginning of my fieldwork and 3 years at the conclusion, my positionality changed from mother to mother. Some mothers were expecting their first child and looked to me as a seasoned expert as I had recently experienced the things they were experiencing. Some mothers had children already and viewed me as a novice, only having one child (and rightly so), positioning themselves as the teacher and expert. During the course of fieldwork I became pregnant twice. The first pregnancy ended in a miscarriage which elicited a level of empathy toward me that I had not expected. This experience turned the tables on our relationship and rather than me checking in on my participants they began to check in on me. The miscarriage made my participants see me as vulnerable in a way they had not before. The inherent dangers of pregnancy and birth were aspects that many of them attributed to a lack of “development” and poverty, something they did not attribute to women living in the United States. When I became pregnant the second time, I was again repositioned as the vulnerable subject which elicited a stream of advice about how to stay healthy during pregnancy, turning the tables again as I had previously been in the position of “expert.” The impending second birth also positioned participants, such as Bhakti and Noor who had recently had their second child, as seasoned expert mothers to my position of only having one child. When I arrived at the pregnancy support group for the first time after having my second child, I was scolded for not dressing my baby warmly enough and wrapping her in enough blankets.

I also held the position of an anthropologist studying breastfeeding who advocates that breastfeeding is an embodied process that deserves support. Though I was careful not to
promote breastfeeding it was evident to my participants that I personally breastfed my son and daughter. I was open and honest about my own decisions, challenges, and obstacles I experienced as a mother, such as if and how to breastfeed in public, at night, sleeping arrangements, crying, bathing, feeding, interactions with my own doctors, whether to use formula and when to stop breastfeeding. Aware of their likely perception of me as an expert on breastfeeding and mothering, a cultural expert at least, I was careful to portray myself as a friendly and supportive fellow mother rather than an expert. I also came to realize over the course of my fieldwork how much of a novice I was as a mother. I was continuously asked to share my own experiences which I did openly, but always careful not to offer more than I felt was necessary or appropriate. I tried to position my experiences as that of a first time mother, often falling back on the phrase, “I don’t know, this is my first time.” I was consciously supportive, caring, and importantly avoid judgment which I believe resulted in my participants feeling comfortable and more willing to share their own experiences and dilemmas.

My own perspective on infant feeding changed through the course of my fieldwork as well because of the closeness of my interactions with my participants, I believe because I shared my own embodied experiences with them openly. I did not assume that my own experiences, mainly sleep and breastfeeding, were the same as those of my participants. Though I experienced some difficulty breastfeeding my first child, I continued up to the birth of my second child. Unlike some of my participants, neither of my children ever went on a “nursing strike” when they refuse to breastfeed or an eating strike. Importantly my husband was also supportive of my long term breastfeeding, sleeping arrangements and was an active participant in infancy which was not characteristic of all the participants. As Cecelia Tomori (2011) points out, since embodied experiences occur within specific cultural and interpersonal contexts, experiences that
may appear similar can actually be radically different. Therefore I was attentive to my participant’s voice to avoid misrepresenting their own accounts based on my own assumptions and perspectives. Through the course of my fieldwork and mothering my two children, my own perspective on infant feeding discourse shifted.

Throughout I was determined to make this a person-centered ethnography of mothering, though the circumstances of examining the relationship to infants is a challenge. As Robert LeVine (2010) acknowledges capturing both sides the mothering relationship, the mother’s and the child’s, is always a challenge. When examining the mothering relationship between a mother and a newborn is even more challenging, which is perhaps why so many infants are absent from anthropological inquiry (Gottlieb 2000). Therefore I focused on the point of view and experiences of the mother and her interpretation of her infant’s needs and wants. Through this interpretation my own theoretical approach became apparent as I considered the construction of refugee women as mothers, subjects and citizens within dynamics of power and knowledge in the United States. Throughout the course I my fieldwork I maintained a critical-cultural interpretive approach to the stories and experiences my participants shared with me, which I will briefly describe.

1.7.1 Cultural Interpretive Approach

The cultural interpretive approach to understanding health and disease arose in response to the questioning of western science as a social construction and Foucault’s analysis of the power/knowledge relationship in shaping subjectivities (Good 1994). Arthur Kleinman critiqued the dominant biomedical model of disease where existing categories of illness are known and the culture-specific codes corresponding to physiological processes need only be discovered. He
further stated that searching for universals based on a core set of symptoms is a self-fulfilling prophecy simply by excluding what does not fit the prescribed parameters (Kleinman 1977). A meaning-centered approach to disease was advocated by Arthur Kleinman (1980) and Byron Good (1994) in recognition that “the biomedical model did not account for the meaning contexts of sickness, nor was it self-reflexive” (Kleinman 1980:18). A cultural-interpretive, or meaning-centered, approach focuses on the phenomenological account of the way health is experienced. In this model health and well-being are fundamentally cultural constructions, interpreted by sufferers and healers, but ultimately knowable through interpretive activities such as the use of illness narratives and explanatory models (Baer et al. 1997; Kleinman 1980; 1986; 1988; 1995). Illness narratives are read as metaphors used to express illness within social realities. Though this does not consider disease to be located in nature, this perspective does not deny that cultural constructions of disease are biologically constrained (Good 1994). The meaning of the experience in the social context, over the reality of the illness in the empirical sense, is the subject of inquiry. As Allan Young highlighted in his inquiry of Post Traumatic Stress Disorder (PTSD), “the reality of PTSD is confirmed empirically by its place in people’s lives….my job as an ethnographer is not to deny its reality” (1995:5).

The cultural-interpretive approach has traditionally been employed in the study of “folk illness” and “culture-bound syndromes” as experiences of illness and disease in “folk” societies, or non-western societies, by eliciting categorizations of illness experiences that “did not fit neatly into western diagnostic formulations” (Hughes, 1996:141) or within western biomedical psychodynamic theories of illness causation (Kirmayer and Young 1998). Within psychiatry, culture-bound syndromes are conceptualized as either culture-specific, whereby each society distinguishes normal and deviant forms of experience and behavior, or as merely psychiatric
illness in disguise (Good 1994). They are also often interpreted as a cultural performance or as a form of resistance to social norms by acting out “hidden transcripts of social contradiction” (Lock 1993). Common characteristics of “folk illnesses” include the manifestation of mental and, or bodily distress with no recognizable underlying biological cause (Hughes 1996). Among many folk illnesses, such as nervos/nervosa (Low 1985, 1994; Schepfer-Hughes 1992), move san (Farmer 1988), and neurasthenia (Kleinman 1977; 1980), reference to primarily somatic symptoms, over psychological symptoms, are common. In his early work on neurasthenia in China, Kleinman observed that “somatization appears to be more common in traditional societies” (1977:6) and that culture bound syndromes and folk illnesses are often presented as cases of somatization, a case of trying to map cultural idioms onto already known diagnostic categories.

The concept of somatization follows western psychodynamic theories of illness causation where psychological distress is transformed into bodily distress (Kirmayer and Young 1998) and the western model of illness and disease where illness is characterized as the subjective experience of distress and disease as an objectively verifiable organic disturbance (Fabrega 1991). Somatization within medical anthropology, as defined by Kleinman, is “the substitution of somatic preoccupation for dysphoric affect in the form of complaints of physical symptoms and even illness” (1980:149) and is used to characterize a broad range of situations where there is “medically unexplained bodily distress related to underlying psychiatric, psychological, or social problems” (Kirmayer and Robbins 1991:1). Somatic symptoms, expressed as somatic dialogues, are viewed as replacing emotional expression. In brief, it is characterized as a variation in illness behavior where there is illness in the absence of disease (Fabrega 1991; Kirmayer and Robbins 1991; Kleinman 1980). Within medical anthropology, somatization is
viewed as a cultural construction whereby cultural meaning frames the construction of disease (Baer et al. 1997; Csordas and Kleinman 1996; Good 1994; Kleinman 1980). Somatization and somatic dialogues are considered to be a common mechanism for expressing distress worldwide, especially as a “means of accumulating or consolidating power in relationships, particularly for those whose other avenues to power are blocked” (Kirmayer and Robbins:209). Marc Nichter (1981) characterizes these somatic responses as “idioms of distress,” which are considered to be the most common clinical expression of emotional distress worldwide (Kirmayer and Young 1998). In the forthcoming stories refugee mothers tell, idioms of distress surfaced again and again in my relationships with refugee mothers and nearly all addressed the breastfeeding relationship in reference to perceptions of insufficient milk or infant hunger that necessitated additional feeding methods.

1.7.2 Critical Interpretive Approach

Articulated by Margaret Lock and Nancy Scheper-Hughes (1996) the critical-interpretive perspective in medial anthropology first and foremost challenges the way in which knowledge of the body, health and illness is culturally constructed and reconstructed, especially through the practice of biomedicine and its universalizing assumptions. Like the cultural-interpretive approach, the critical-interpretive approach challenges the universality of western science and the Cartesian division of the mind and the body. The body takes a central role as it is, like in the cultural-interpretive approach, a cultural construction subject to social and political representations while still constrained by known biology. As such, the critical-interpretive approach emerged in response to the need to link the relationship of suffering to social constructions of power (Sargent and Johnson 1996). The significance of the body within the critical-interpretive approach emerged from the work by medical anthropologists among people
suffering in the margins of society from sickness, madness, pain, disability, and distress, and the recognition that they were “often negatively and oppositionally situated in relation to a given social and moral order” (Lock and Scheper-Hughes 1996:42). Examples of this work include Scheper-Hughes work with sugar cane cutters suffering from hunger in Brazil (1992), the despair of a child living in the aftermath of war in Nicaragua (Quesada 1998) and victims of rape in post-war Bosnia (Olujic 1998). The primary difference between this and former approach is the linked processes of the “Foucaultian Body,” the collective socio-political body devoid of subjectivity, and the “existential lived experience of the practical and practicing human subject” (Lock and Scheper-Hughes 1996:64). Uniting the “lived experience” of suffering with the broader social context attributes bodily agency as a form of resistance to the social order whereby “the social origins of many illnesses and much distress and the sickening of social order itself come into sharp focus” (Lock and Scheper-Hughes 1996:65).

The classification of somatic expressions of suffering as somatization has multiple consequences for linking embodied distress to relations of power. On the one hand it validates the psychiatric nosology by uniting psychiatric and somatic symptoms, fitting the sufferer firmly into the biomedical system. This may result in the sufferer being provided an appropriate outlet to express suffering, resulting in a reduction of stigma and, or suffering, and, or validating the sufferer’s experience, illustrated in the example of the validation experienced by Vietnam veterans with the inclusion of PTSD in the DSM-III (Young 1995). On the other hand, recasting somatic communication of the body as cultural metaphor can undermine the experience by interpreting the metaphor according to culturally prescribed (western) diagnostic categories, denying the sufferers their collective experience and political statement (Csordas and Kleinman 1996; Kleinman 1995).
Throughout my fieldwork I was conscious of the expression of stress, prior trauma, and social experience to emerge through the embodied experience of breastfeeding. The practice of breastfeeding is a felt or embodied experience that is also an intensely emotional experience occurring in the highly emotional postpartum period. I remained conscious of the power-dynamic encompassing my participant’s lives, differing interpretations of aspects of breastfeeding such as insufficient milk, and breastfeeding as an avenue to communicate social distress throughout my fieldwork. As I became more enmeshed in my participant’s lives the emotional, embodied, and practical aspects of breastfeeding became more and more visible. In this examination of breastfeeding and mothering I pursue the following claims, which I will discuss in an overview of my dissertation chapters.

1.8 Chapter Overviews

First, rather than interpreting the actions or practices of refugee immigrants as struggling to break from an idealized past, I propose that refugee’s decisions, actions and practices represent the reality of their prior conception of “development.” As subjects engaged in a perpetual dance of subjectification, refugees are simultaneously a subject of governmentality and engaged in a struggle of negotiation against it within an analytics of power that defines citizenship. Aihwa Ong (2003) introduced a flexible model of citizenship not based on the granting or denial of a legal designation of belonging, but where actors define their own citizenship the everyday practices, attitudes, behaviors and aspirations of belonging. This broad model “problematicizes the connection between the rationality and the action, the command and the effect” of the actor/subject (Ong 2003:15) to allow for a complex negotiation of subjectivity. As I will demonstrate in each of my participant’s stories, resettlement in the United States offers
them the opportunity to participate in “development” in a way they had only imagined previously, often stating “Here in the America, we are developed now.” How each subject/actor imagines, experiences and responds to the dance of being-making defines their new role in the United States as a citizen-subject. In chapter 2, I will discuss the nature of subjectivity and governmentality as an analytics of power as it applies to resettled refugees and how development discourse and citizenship discourses influence how each subject/actor engages this analytics of power. I introduce the contrasting experiences of two refugee mothers. The first is Mary, a Sudanese refugee mother of four who idealized the freedoms promised in the United States but struggled against the subjection that is demanded of “citizens.” The second is Salma, an Iraqi refugee mother of four who embraced an ethos of self-making and personal responsibility in an effort to become an ideal citizen-subject.

The second claim is that medical knowledge about mothering and breastfeeding is deployed as a disciplinary mechanism to delineate ideal citizen/subject mothers. In chapter 3, I review the paradigm of scientific mothering and the breastfeeding discourse known as “breast is best” to frame the design, implementation and deployment of the two health promotion groups aimed at molding refugee mothers into worthy “citizen-subjects.” I provide an overview of how the paradigm of scientific mothering came to be the dominant paradigm within the United States and how knowledge about mothering and breastfeeding is used to construct ideal citizen/subject mothers. As put forth by Rima Apple (2006) scientific motherhood has never simply represented the imposition of medical authority into the private lives of women, but an ongoing dance of complicity and resistance to medical authority in the everyday lives of women. As such scientific motherhood has mirrored the changing values of middle-class mothers who have largely come to embrace notions of discipline and personal responsibility in pregnancy and infant feeding as the
“right choices” for “good mothers.” In this era, following the dictates of medical authority to optimize your infant’s health and well-being through exclusive breastfeeding are emblematic of citizen-subject mothers. In chapter 3, I introduce influential players in the pregnancy support group, termed “middling modernizers” by Paul Rabinow (1989), who stress the importance of discipline and personal responsibility in becoming good citizen-subject mothers.

The third claim is that breastfeeding is an embodied and lived experience situated within relations of power that stress disciplining the body and assuming personal responsibility for optimal infant health. In chapters 4 and 5, I introduce a series of refugee mother’s experiences with breastfeeding and demonstrate that none fully embrace or reject the paradigm of scientific mothering. Rather, each refugee mother selectively incorporates and gives meaning to aspects of scientific mothering, personal responsibility and self-sufficiency, which are firmly entrenched in the context of particular power relations. While all refugee mothers critically and selectively incorporate aspects of scientific mothering to a degree, I demonstrate that the degree to which they favor medical authority in child rearing exists along a continuum, which influences their breastfeeding choices. In chapters 4 and 5, I examine the choices they make in their early breastfeeding relationships, which positions breastfeeding as a meaning-making practice in which mothers embody the type of mother they wish to become.

Throughout these chapters I attempt to put forth a person-centered ethnography centered on the period following birth by examining of the interactions of everyday life. Following Kathleen Barlow and Bambi Chapin (2010), I position mothering as a practice “responsive to, although not dictated by, surrounding cultural, social, economic and political context and changed in those domains” though it “often appears ‘natural’ and ‘practical’ to participants and observers” (2010:329). The day-to-day decisions mothers made about infant feeding and the
rationales given for their responses to their perceptions of low milk supply offered an avenue for mothers to exert their own power and agency. I paid careful attention to not just what people say but what they do to learn about how a mother defines and communicates herself as a mother, citizen and subject. All mothers engaged in breastfeeding for some period of time and all supplemented with formula at some point during the first six months. While some supplemented with formula following the advice of their doctors, others supplemented with formula against the advice of their doctors. For others it was casually given simply “to see if he likes it.” For all, breastfeeding demanded a greater scrutiny of their intended mothering practices positioning breastfeeding and mothering as processes present in an everyday practice, a variable but essential component of cultural reproduction (Barlow and Chapin 2010).

I argue that within an era of neoliberal governmentality, negotiating personal responsibility entails a process of subjectification, the dual process of being subjected to control and dependence and the struggle against it. Within this terrain of knowledge and power, personal responsibility is valued when individuals choose behaviors that are best for the collective good by reducing their burden on society rather than representing a true freedom of choice. Within the contemporary neoliberal society of the United States, choices and behaviors are evaluated in terms of their health implications and subjected to medical expertise. In this examination of refugee mothers, I demonstrate that the notion of personal responsibility extends to cultivating optimal health and well-being for her children by incorporating the latest scientific and medical knowledge as part of the modern biopolitical project to craft ideal citizen-subjects.
“What key cultural values, codes and rules are internalized and contested in the process of learning to belong?” (Ong 2003, xvii).

In *Buddha is Hiding: Refugees, Citizenship, and the New America*, Aihwa Ong (2003) follows a group of Cambodian refugees in their negotiation with citizenship after resettling in the United States. Rather than utilizing a static notion of citizenship based on the granting or denial of a legal designation of belonging, Ong applies the notion of citizenship to the everyday practices, attitudes, behaviors and aspirations of belonging. This broad model of citizenship situates citizenship firmly within Foucault’s “analytics of power” which “problematizes the connection between the rationality and the action, the command and the effect” of the actor/subject (Ong 2003:15). Within this analytics of power the actor/subject is engaged in a perpetual dance of subjectification where they are simultaneously a subject of governmentality and engaged in a struggle of negotiation against it. While Ong conceptualizes this struggle as a break or a rupture between an idealized past in Cambodia and the present life of refugees in America, I propose that it is in fact a continuation of the refugee’s idealization of development. Just as their experience following flight is more a series of ruptures than linear transition from flight to refugee camp to permanent resettlement, their experience negotiating subjectivity is equally complex. Far from the popular notion of the refugee from a less developed environment arriving at O’Hare airport never having seen nor heard of elevators or escalators, most refugees will have traveled in and out of major cities in their journey. Importantly their resettlement in the
United States offers them the opportunity to participate in “development” in a way they had only imagined previously, often stating “Here in the America, we are developed now.” How each subject/actor imagines, experiences and responds to the dance of being-making they must engage in defines their new role in the United States as a worthy citizen.

In this chapter I will discuss the nature of subjectivity and governmentality as an analytics of power as it applies to resettled refugees who are citizens of non-industrialized and often postcolonial nations transplanted to the United States. Next, I will discuss how development and citizenship discourses influence how each subject/actor imagines, experiences and responds to the dance they must engage in as they are defined (or not) as a worthy citizen. Finally I will conclude this chapter while foreshadowing chapter 3, how technologies of government continue the process of development by attempting to instill citizen-subject values rooted in neoliberalism and how these values are often contradictory. In this chapter I will introduce Mary, a Sudanese refugee mother of four who idealized the freedoms promised in the United States but struggled against the subjection that is demanded of “worthy citizens,” and Salma, an Iraqi refugee mother of four who embraced an ethos of self-making and personal responsibility in an effort to become an ideal citizen-subject.

2.1 An Analytics of Power

Foucault’s framework of biopolitics describes how it becomes the interest of the modern state to produce, manage and regulate the health of individuals and populations. In The History of Sexuality Vol. 1, Foucault describes how the body becomes subjected to power that “exerts a positive influence on life, that endeavors to administer, optimize and multiply it, subjecting it to precise controls and comprehensive regulations” (1978:137). Within this analytics of power he
applies his theory of governmentality to the production of desirable individuals and describes this power as ubiquitous. In Reproducing Race, Khiara Bridges suggests that within this analytics of power the production of worthy citizens is less ubiquitous and random than Foucault describes (2011). She suggests that disciplinary mechanisms exist in a world “shot through with stratifications in the name of nation, citizenship, class, race, gender, disability, etc.” (2011:71) delineating those who are worthy of discipline and those who are not. Though Ong suggests that the refugee is designated as a worthy subject, I suggest that rather than being aimed towards those worthy of discipline as Bridges suggests it is also aimed at those who are willing to be subjected. In order to examine this possibility it is first necessary to review the role of subjectivity and governmentality to understand how some refugee mothers are identified as worthy citizens and others are not.

2.1.1 Subjectivity

The idea that the individual experience of the world is socially produced as a fundamental aspect of the human condition is a foundation of contemporary social theory, generating a wealth of literature (for example see Biehl 2007; Biehl, Good and Kleinman 2007, Good et al. 2008….). Any critique of this literature can only be partial due to the extent of its influence, therefore I offer an overview in order to situate my analysis of mothering more broadly as relates to the exercise of social power that induces being-made and being-making.

Subjectivity is conceptualized as “complex ways in which people’s inner states reflect lived experience within everyday worlds” (Biehl et al. 2007:5), or as “everyday modes of experience, the social and psychological dimensions of individual lives, the psychological qualities of social life, the constitutions of the subject, and forms of subjection” (Good et al.
Subjectivity cannot be understood absent of an organizing framework that provides our “everyday world” (Loomba 2009) and is more than a “synonym for inner life processes and affective states” (Biehl and Moran-Thomas 2009, 270). The continued inquiry into the nature of subjectivity reveals that as “both a strategy of existence and a material means of sociality and governance (it) helps recast the totalizing assumptions of the workings of collectivities and institutions. It also holds the potential to disturb and enlarge presumed understandings of what is socially possible and desirable” (Biehl and Moran-Thomas 2009, 270). Thus the relationship between subjectivity and these totalizing assumptions, and the extent to which assumptions are internalized, demands a deeper look at the complicity and resistance inherent in subjectivity.

The “totalizing assumptions of the workings of collectivities and institutions” Biehl and Moran-Thomas refer to have previously been conceptualized as ideology by Marx and Engels (1970), Gramsci (2006) and Althusser (2006) and more recently by Foucault (2007) as governmentality. Marx and Engels (1970) proposed that ideology is a distorted, or false, consciousness that obscures people’s relationship to their world where the interests of the dominant class are reproduced. Gramsci (2006) suggested that although in general, ideology maintains social cohesion and expresses the interest of the dominant class through consent and coercion (hegemony), ideology can also express the protest of the oppressed via a dual consciousness of complicity and resistance (counter-hegemony). Althusser (2006) linked ideology, domination, and subjectivity by theorizing the importance of ideological apparatuses, such as schools and churches, which constructs subjects who have internalized the values of the dominant class, and then reproduce those views spontaneously. Social welfare programs have risen to be powerful tools in shaping subjectivity since Althusser theorized the role of ideological state apparatuses. Marx and Engels in the Communist Manifesto and Marx in Das Capital
foreshadowed the increasing role of capital in reproducing the values of the dominant classes through ideology (Rose 1999). As capital assumed a larger role in society, it would in turn delineate deserving and undeserving subjects and subjectivities by conflating economic self-interest, property ownership, and rational subjectivity as the tenants of acceptable conduct in society (Ong 2003). This ethos, the combination of rationality and economic self-interest, positioned liberalism and the bourgeois individual as the ethical citizen or “worthy citizen.” In *The Protestant Ethic*, Max Weber (1998) observed that the American stress on individualism, materialism and pragmatism represent an ethos of the bourgeois individual that is specifically an American incarnation of the “worthy citizen-subject.” Aihwa Ong argues that the American ideal of the “worthy citizen-subject” is a product of individualistic ethics that gird the specific incarnation of governmentality in the United States.

### 2.1.2 Governmentality

In his series of lectures delivered at the College of France between 1978 and 1979, Michel Foucault argues that advanced liberal societies utilize human-science policy and biopolitics to govern and regulate - as opposed to disciplinary techniques - in a concept he refers to as governmentality. Governmentality encompasses both the role of ideology and the mechanisms used to reproduce the views of the subjected in advanced liberal societies, whereby institutions of authority generate and then communicate knowledge about the population in an effort to make society operate more efficiently (Foucault 2007). The analytic framework of governmentality provides the means to discuss the dual processes of “being-made and self-making” as cornerstones of subjectivity (Rose 1992). By defining ideals through the “conduct of conduct” via official programs and unofficial practices, citizen-subjects are induced to desire the
tenants of the bourgeois individual as evidence of their rationality: individualism, materialism and pragmatism. Foucault refers to these official programs and unofficial practices as social technologies of government and a form of productive power that he calls “bio-power” (1980).

Foucault identifies “bio-power” as the backbone of the liberal society via the use of civic institutions of authority to generate and then communicate knowledge about the population. The rational individual and “worthy citizen-subject” is cast as a subject who is healthy and productive to the security and strength of the state. Importantly, Foucault recognizes that “the state is nothing more than the mobile effect of multiple regimes of governmentality” (1980). Governmentality, or population governance, therefore relies on the techniques of multiple sources dedicated to making the mind, body and will of individuals, families and collectivities governable, which Foucault refers to as productive power. This exercise of government delineates the normal from the deviant in society, the desirable from the undesirable. In the United States these biopolitical norms follow a neoliberal market logic making areas of social life follow an economic logic that would not otherwise be judged on economic terms. In this delineation, “worthy citizen-subjects” are autonomous and economically rational who best serve the state by reducing their burden to it. Activities and behaviors that are profitable are valued and those that do not are marginalized. As Aihwa Ong recognizes, neoliberal market-driven logic has shaped family and welfare policy and refugee and immigration politics since the 1970s and relies on a politics of difference to delineate “worthy citizen-subjects” from unworthy along racial, ethnic, and class lines (2003). Within this framework of governmentality, a seemingly innocent group organized to provide refugee women with information about health, well-being, pregnancy and mothering can be recast as a site to introduce governmentality to the lives of refugees at best and at worst as a technology of social control.
Foucault’s notion of productive power (1980) and governmentality (2007), where domination is achieved via institutions and knowledge constructing representations of social reality and acting through the body, is useful for approaching the extent to which individuals hailing from developing and postcolonial nations are constructed as objects of knowledge within the United States. Aihwa Ong describes this construction as firmly rooted in the legacy of racial bipolarism at home and American Imperialism abroad (2003). Through a combination of paternalism and subordinating care Stuart Miller calls “benevolent assimilation,” social technologies are employed among immigrants and refugees in the United States in order to transform them into loyal subjects. The adherence to the values set forth in the process of “benevolent assimilation” leads to refugees being recast as reformed worthy citizen-subjects, “whitened,” or degenerate unworthy citizen-subjects, “blackened” to employ Ong’s characterizations. Ong traced the process of whitening back to the refugee camps where refugees destined for resettlement were given classes by the Overseas Refugee Training Center (ORTC) on topics such as health, English, transportation, and cultural expectations. Ong’s portrayal of the disciplinary structures in place is a very straightforward incarnation of subject-making with overt disciplinary goals in mind: financial independence as soon as possible. While the expectations set forth by the ORTC are clear, Ong’s linear model of resettlement does not capture the nonlinear experience many refugees experience which situates their interaction with and reaction to disciplinary structures not as a process of whitening for their final destination in the United States, but as a continuation of colonial discourse not unlike the legacy of racial bipolarism. Colonial discourse, and its later incarnation of development, instituted the process of subject-making by casting non-European subjects as the “Other” long before refugees were destined to be resettled in the United States.
Bhaba describes colonial discourse as a form of governmentality where the object is “to construe the colonized as a population of degenerate types on the basis of racial origin in order to justify conquest” (Bhaba 1990:75). Colonial discourse was repressive physically and psychologically. The “Other” was constructed according to binary oppositions, thus defined by difference (Loomba 2005; Said 1994; Vaughan 1991). The opposition of irrational-rational, feminine-masculine, black-white, and primitive-modern dichotomies structured the European as dominant by reifying the modernist framework of superiority-inferiority, articulated through scientific discourse on race, gender, and medicine (Loomba 2009; Said 1994; Vaughan 1991). This discourse of difference was essential to establishing the representation of the West as the modern “model of social progress” and the colonial state as the vehicle of modernization (Hall 1992). In addition this representation justified the wealth differential between colonizer and colonized and the necessity of subordination (Vaughan 1991). Fanon called this inherently western construction of modernization the “colonization of the mind” (Fanon 1967). Fanon countered racist biological and psychological theories of difference, claiming that colonialism, rather than modernization, annihilates the colonized sense of self and leads to “madness” (1967; 1986). Fanon posited that the colonized self is split along binary opposition where the white “Other” defines all that is desirable leaving the black self to desire whiteness, making the racialized subjectivity the most prominent marker of difference. “Whiteness” is the primary structure defining difference and power, reinforcing the desirability of the modern and the psychic oppression of the “Other.” Though Fanon does not incorporate the way different aspects of society, such as class and gender further influence subjectivity, or how or if psychic oppression is experienced differently individually and collectively, linking the notion of psychic
oppression and modernity illuminates the manner in which theorists have approached the postcolonial condition.

In his analysis of farmers in northern India, Gupta uses the concept postcolonial condition to characterize the ways institutions and discourses position subjects and configure their experience along the dichotomy of modern and traditional in the Third World or postcolonial nation-state, and the ways postcolonial peoples negotiate that dichotomy (Gupta 1998). Gupta’s characterization of the “postcolonial condition” incorporates Fanon’s “colonization of the mind” by demonstrating that the colonial past continues to gird subjectivity along binary oppositions. Loomba critiques this concept for not allowing diversity of experience (class, caste, gender, race, location) among those it claims to describe (2005:19). De Alva advocates de-linking the concept of postcolonial from formal decolonization, as people living in formerly colonized and colonizing countries are still oppressed by colonial structures (De Alva 1995). These conditions have been characterized as the crisis of postcoloniality (Gandhi 1998; Loomba 2005). Gupta characterizes people he encountered as displaying a “distinct lack of fit” with the modern-traditional dichotomy and that the contradictions of the “postcolonial condition” must be understood through the entwining of subjectivity, governmentality, and development discourse.

The ideology of colonialism has since been largely replaced by the ideology of development, critiqued by Arturo Escobar (1995) as the process by which market-driven capitalism is employed to dispossess subjects of developing nations and enforce governmentality globally.

Notions of hybridity, creolisation, or mestizaje are different ways theorists have conceptualized the complexity of the postcolonial condition to overcome the limitations of the binary basis of difference, especially in regards to diasporization and migrancy. But for the purposes of this dissertation, the degree or reconciliation of Otherness is not my primary
concern; rather I will focus on the extent to which refugees conceptualize and employ binary concepts such as developed/less developed and modern/traditional. I will also focus on how they seek (or not) their new role as the worthy subject ready to embrace what Ong described as “benevolent assimilation,” which I argue are a continuation of the process of development. (Escobar 1995; Gupta 1998; Hall 1992; Jefferess 2008; Loomba 2005).

2.1.3 Mary

“Karibu, Karibu sana! Come in come in!” A skinny little girl of about 8 years ran down the hallway from her apartment door as I climbed the stairs, carrying my 16-month old son in my arms. “Oh, you have a baby!” she squealed. I looked behind her as I climbed the stairs and saw Mary smiling in the doorway, her swollen belly stretching the seams of her dress, a traditional Sudanese formal attire of a long, tight-fitting skirt, top, and head wrap made from the same printed cloth. Her husband stood behind her, smiling with his hand on her shoulder and held a small child in his other arm, who buried her face in his neck. A son of about 10 years stood behind him, barely visible. “You are welcome!” Mary said inviting me in.

“You are welcome,” Mary’s husband greets me shaking my hand warmly and inviting me in. I enter into the apartment and smell the onions and cumin cooking on in the kitchen. The room is dimly lit with only sunlight peeking through window shades that are almost closed. Two large couches occupy both sides of the small room. With the coffee table between them I had to inch between the couch and the table to find my seat. “Please sit,” Mary offers as she leans to lower herself onto the other couch, her pregnant belly straining against her dress. George sits next to her and the youngest girl starts to climb on him, warily eyeing my son. George plays with her hands and tickles her belly. She giggles and buries her head in his chest. The older children
retreat to the kitchen a few feet away, peeking around the corner. Their earlier exuberance seems to be gone. George is looking at my son and making silly faces. My son giggles in response. “Such a beautiful boy” he comments. Mary looks over the interaction with a proud and serene smile.

“Do you know when you want to go to the hospital?” I asked. I have come to Mary’s apartment today to discuss the details of going to the hospital once labor begins. Mary attended only one session of the pregnancy support group. She arrived late, wearing a tattered winter coat over the same brightly patterned dress and matching head wrap. At six feet tall she towered over the other members of the group and her pregnant belly barely protruded from her form fitting dress. I was surprised when she approached me about my offer made to the group to drive them to the hospital when labor began. It was December and Mary told me her due date was in January, only a few weeks away. Though the pregnancy support group had been meeting for a few months already, this was first time Mary had come saying that she had been told to come by her case worker to “find help.”

Unlike some of the other women in the group Mary readily accepted any offers of assistance and was not shy of asking for additional things such as rides to and from the clinic, supplies for her new baby or older children. It is this reason that I had the opportunity to become so close to Mary as I would weekly receive a call asking for a ride to the grocery store, the clinic or other errands that needed to be completed. These requests were always accompanied by a welcoming to share tea, come to visit and just let the children play together as she had a daughter the age of my son. These frequent requests also became a source of friction between her case worker and me. The tensions between Mary’s case worker, Mary and myself helped to crystallize the dance of being-making and self-making as a project of refugee resettlement. One thing that
was abundantly clear from the start was that in terms of being prepared to give birth, at 26 Mary was already very experienced.

“Oh yes, I know,” she replied confidently. “I know when it is time.” She gestured to her three children. We agreed that she would call me to drive her to the hospital and that I would wait until she was checked in.

Mary had an air of maturity and a quiet calmness that belied her youth as she had already experienced a lifetime’s worth of turmoil. Her oldest child, her son, was 12 years old. She also revealed that her current pregnancy was actually her fifth pregnancy. As described in chapter one, Mary’s life as a refugee began soon after the birth of her first child. Coming of age in Sudan Mary had never known a Sudan that was not in the grips of conflict but until she became a mother the conflict had never been on her doorstep. After the birth of her first child she set out alone to cross the border into Kenya in search of a refugee camp. For the next 12 years she would make that journey numerous times as she traveled back and forth between the refugee camp and her home as circumstances allowed. Just as important as her physical safety was the planting, tending, and bringing in of the harvest as without a harvest she had neither food nor money for necessities. Though food was provided at the refugee camp it was barely enough to keep her and children from starving and she needed to supplement it. When things quieted down she took her children back to her home. If the conflict came close to her home she and her children returned to the refugee camp. Sometimes she returned to her land alone, leaving her children in the care of her mother, a sister, or George who was similarly in and out of the refugee camp working odd jobs to support the family. Sometimes her mother would return.

Each journey was treacherous and risky and it was on one of these journeys where her daughter passed away en route to the refugee camp. She was pregnant with her daughter who
was now two years old, the age of my own son, and her daughter at the time was two years old. It
was because of her pregnancy that she could not carry her two year old daughter as she otherwise
would have. She was forced to walk along side her older sister and brother, eight and ten years
respectively, neither sibling old enough or strong enough to carry a two year old the many miles
to the refugee camp. Mary did not offer details about her daughter’s death. She simply asked me
one cold and snowy day as our children were playing with a dark tone in her voice, “Have you
ever seen a dead body? Have you ever seen a person die?” I replied that I had not. “My daughter
died one day. One moment she was there and the next her life slipped away as she lay in my
arms. After that I never returned home. After that I knew I could never go back, that there was no
life for me or my children there.” Mary never did return home. She filled out the request for
resettlement and within two years migrated to the United States with her husband and children.

2.1.4 Salma

“Come in, you are most welcome,” Salma greeted my interpreter, Zarifa, and me from the
door of her apartment. A young girl of about 10 took my hand and led me into their living room
saying nothing, but smiling at me. Three chairs from the dining table had been pulled up to a side
table, close together. On the floor were couch cushions, but no couch. Noticing my gaze, Salma
laughed and explained, “Ah! Here we prefer to sit on the floor like in Iraq, you see? Also we are
getting ready to move. As you can see we are organizing.” Looking around boxes were stacked
in the corners. Asking where she was planning to move, Salma said Michigan where friends
were already established.

Salma’s daughter brought me a small cup of juice on a silver tray. “It is date juice, from
our country,” she explained. It was the last day of Ramadan and Salma was busy preparing food
for the feast that night, so the juice was for me alone. The smell of onions and rich spices permeated the small apartment. It was a hot day and the windows were open, letting in a cool breeze from the lake. I thanked Salma for inviting me on such an important day but she replied that she was happy to share with me. She was wearing a hijab with sequins on it, framing her face and kept a broad smile throughout our visit.

Salma was the only mother I did not meet through the pregnancy group, rather through an interpreter who worked with the agency. She was friends with Salma’s husband, who she had first contacted and who thought the project was a good idea. The interpreter described Salma’s husband as “progressive, not like other Iraqi men.” The Iraqi community proved to be the most difficult community to reach, despite the fact that they comprised the largest percentage of new arrivals for the previous two years. They rarely attended any of the programs offered by the agencies. It was explained to me that they preferred to hear information in a one on one format from community health workers who would visit their homes. Zarifa, my interpreter and herself an Iraqi refugee, had a different explanation. “It is the husbands,” she said, “They won’t let them out of the house.”

Zarifa was volunteering with the agency as part of her studies pursuing a Masters in Public Health. Already a licensed and practicing physician in Iraq, she was unsure if she wanted to pursue becoming licensed in the United States. Zarifa described herself as a progressive woman, endlessly frustrated with the treatment women and girls experienced by the hands of their husbands and fathers, in Iraq and in the United States. In her early 40s and unmarried, Zarifa chose a path of autonomy. However, as Salma will describe, this did not entail turning her back on her own values. Family was the cornerstone of life and Zarifa lived and cared for her aging mother while attending school full time and volunteering with the agency. Zarifa was
driven to improve the lives of other Iraqi refugees and by pursuing a public health degree she felt she would be able to focus on the broader health needs of the community without being consumed by the day to day minutiae of practicing medicine. Zarifa had worked tirelessly to encourage women to attend the pregnancy and parenting groups. Despite her efforts very few women attended and those who did would often attend only once. Though Zarifa attributed the poor attendance to domineering husbands, the lack of interest coupled with the lack of participation in the pregnancy support group and nearly all other health promotion activities may also be attributed to resisting the disciplinary mechanisms employed by resettlement agencies to craft ideal citizens. As Salma will emphasize, the project of self-making for herself and her family was already underway prior to resettlement.

Like Mary, resettlement was not the first option Salma and her family sought when “things got bad” in Iraq. However, rather than moving in and out of refugee camps Salma moved her family in and out of other family’s homes, evaluating the situation each time. Like Mary, an event led her and her family to reevaluate their ability to continue living in Iraq. The birth of her third child led Salma to leave Iraq and seek resettlement.

The birth of her third child in 2008 occurred when “things were getting really bad” in Baghdad. Her first two children were born prior to 2006 when, “the situation in Iraq was OK, the health system was still sort of together. After 2006 the civil war started and the massive destruction of everything.” Her first child was “a normal delivery” but her second child was delivered via cesarean because “she was a big baby, 5 kg.” Despite having a prior cesarean, neither she nor her doctor planned to have a repeat cesarean for her third child. Circumstances changed the course of events for her third delivery when a car bomb exploded close to the hospital when Salma was in labor.
“When I had the contractions I went to the hospital, everything was normal, the baby was healthy and the baby was going down. But when the bomb outside happened the obstetrician who was responsible for me… one of her relatives was injured by the bomb so she left and left me with the nurses and midwives…and you must understand that there is no health system in Iraq. With the war all the infrastructure was destroyed. The nurses and midwives are not equipped to deal with delivery on their own. They called a junior physician, or maybe he was a medical student, I don’t know. And they just did cesarean section! And the same day my doctor called me to make sure I am fine. She talked to my husband and he told her they did a cesarean section and she was very mad. “Why cesarean section, why operation!?!?” I never saw the physician again because of these unseen circumstances.”

Left weak by the unplanned and poorly executed cesarean, Salma and her family reevaluated their ability to stay in Iraq. The “massive destruction of everything” and the breakdown of the healthcare system led Salma and her family to leave Baghdad for good and seek resettlement. Two years later, they arrived in the United States.

2.2 Attaining Development and Citizenship

Gupta asks "what makes for a specifically postcolonial experience of modernity?" (1998:33). Development can be conceptualized as self-representations of modernity being deployed to the Third World where modernity references the historical construction of power and knowledge and the west represents the rational civilized self in binary opposition to the colonial “Other” (Gupta 1998; Hall 1992; Vaughan 1991). To speak of modernity is to reify that progress occurs along a trajectory, that western nations have already always been the end of the trajectory, and that the sovereign-territorial nation-state is the self-affirmation of the trajectory
towards progress (Gupta 1998). The progression towards modernity was instituted through governance and domination of the colonial world, and continued “virtually unchanged” after the demise of colonialism in a new discourse of development (Gupta 1998:36).

The notion of development must be understood as occurring at specific historical conjunctures and in relation to intellectual and economic trends (Cooper and Packard 2005). Though notions of development can be located in the emergence of industrial capitalism, development discourse emerged after World War II (Leys 2005), which is what I will focus on. The development era was initiated by the approaching denouement of colonization when the economies of a quarter of the world’s population would be delinked from European economies, and the World Bank and the International Monetary Fund (IMF) were created at the Bretton Woods Conference in 1944 (Edelman and Haugerud 2005). In the “Truman Doctrine,” President Truman introduced the notion that the lives of the “primitive and stagnant” impoverished peoples of the “developing” world could be revolutionized by replicating the features of advanced societies: industrialization, urbanization, adoption of modern education and cultural values etc. (Escobar 1995:4). Though originally a civilizing mission, in the waning years of colonialism modernization or development was used as a justification for Western intervention (Edelman and Haugerud 2005). While modernity was a self-fulfilling and self-justifying idea that “desires universal applicability for itself” (Appadurai 1996:1), “development” remains an unstable term that connotes improved standards of living, processes of modernization, globalization, commodification, via imitation of the west (Edelman and Haugerud 2005:1). In the tradition of social science, it is a phenomenon that claims that imitation of the west is the only solution to challenges facing societies that has drawn criticism from a wide range of social theorists for promoting global capitalism (Amin 1989; Escobar 1995; Rose 1999).
The ethos behind modernization theory was that a change in one domain of life implied the creation of a new modern person, characterized as rational over superstitious, and that change should come through the economic growth of the nation-state (Cooper and Packard 2005). Modernization theory maintained an evolutionary perspective derived from Weber’s observation that modernization demanded a transition from “particularistic, collectivity-oriented practices and beliefs to universalistic and self-oriented ones” (Edelman and Haugerud 2005:15). In effect it reified "the colonizer's conceit that 'other' people needed to adopt new ways of living” (Cooper and Packard 2005:129) and followed colonial models of diffusing modern values and technologies through the education of elites, reinforcing existing class and social tensions (Burton 2005; Giblin 2005; Gupta 1998; Leys 2005). Modernization theory’s use of binary opposition to define the traditional person relied on a politics of difference in order to represent the west as the modern “model of social progress” economically and culturally, imbuing an element of inferiority (Hall 1992). The always present self-representation of the experience of modernity is deployed through development discourse (Gupta 1998:38) through the representation of the underdeveloped subject as powerless, passive, impoverished, ignorant, dark, and oppressed by its own tradition (Escobar 1995; Mohanty 2003).

In this sense traditional becomes a condition as well as being underdeveloped becomes a condition, based on as set of indices measuring the health and wealth of the nation-state’s economy (Escobar 1995). In this sense, to be developed and underdeveloped as a nation-state is to reinforce colonial dichotomies of colonizer-colonized, where to be underdeveloped is to be “inferior, backward, subordinate, deficient on capital and resources” and “a shabby imitation of the ‘developed’” (Gupta 1998:40). In contrast, to be developed is to have always been modern (superior, dominant, wealthy, rational, etc.) individually and collectively. In this sense the
looming individual and collective self-representation of the west defines postcolonial peoples as subjects of difference. By constructing representations of the “Third World” or “developing country,” the modern state confirmed its own social reality by establishing inter-dependence between development institutions and state apparatuses and constructing a new form of governmentality, where the actions of development affirmed their own existence through the production of knowledge about them and exercise of power over them. Quoting Ivan Illich (1978) in describing this subject position, Gupta comments when writing in 1998 that “Scarcely twenty years were enough to make two billion people define themselves as underdeveloped” (1998:39). Nearly three decades have passed since Illich made this observation, meaning that individuals coming of age in this time have only defined themselves within the competing frameworks of development and its critique as we will see.

In addition to seeing themselves as “underdeveloped” or hailing from an environment that is “less developed” or “underdeveloped,” as discussed in the previous chapter, refugees become refugees because their rights of citizenship are revoked, denied, or ignored in the countries of origin. Rather than utilizing a static notion of citizenship based on the granting or denial of a legal designation of belonging, Aihwa Ong’s notion of citizenship encompasses the everyday practices, attitudes, behaviors, and aspirations refugees harbor of belonging (2003) and suggests that within the United States belonging is governed by a racial logic along a black-white continuum that has historically classified immigrants as according to their perceived whiteness. According to Ong, Asian immigrants fall along different ends of the continuum with ethnic Japanese and Chinese Americans earning the designation of the model minority while Southeast Asian Americans were painted as the underclass.
Khiara Bridges (2011) points to the concept and associated attributes of “culture” as signifying radical and deterministic otherness in contemporary American society in a concept she calls “culturalist racism.” In this conception conventional uses of the culture concept stand in euphemistically for traditional notions of biological racism predominantly because of their perception as value-free by the general public. While intended to obscure the racial basis of perceived otherness, Bridges highlights that by relying on cultural difference to signify otherness, especially radical otherness, otherness based on static and unchangeable cultural attributes reinforce prevailing perceptions of insurmountable difference that surface in cultural stereotypes. Just as deterministic as biological and racial determinism, within health care, promotion and medical practice emphasis on cultural difference often acquire a biological connotation that exclude certain groups from fully practicing citizenship. Bridges points out that recently inquiries into racial and ethnic health disparities often examine how “the “culture” of the victims of health disparities produces different rates of mortality and morbidity” rather than how physicians’ ideas about the “cultures” of their patients contribute to health disparities (2011:135). Refugees, mothers particularly, experience culturalist racism as traits and practices they are assumed to possess are assigned to them on a daily basis. From the stories shared with me by the myriad of social workers, case workers, and health promoters I have encountered in the past seven years refugees are assigned a myriad of contradictory traits and practices that obstruct full practicing citizenship. For example, refugees are the most grateful people you can hope to meet and yet ungrateful for all the hard work that enables their resettlement. Also, refugees are more inherently maternal and yet unable to care for their children properly without supervision; refugees are interested in their health but uninterested in changing their unhealthy practices; refugees are eager to work but no interested in attending to a “Western clock.” In one instance, a
refugee case worker who was at the end of his rope trying to place a Congolese refugee in employment, shared his frustrations with me that he had found his client three jobs and his client had been fired from all within a week because he continually showed up for work at the wrong time. He finally lost his temper to discover that his client arrived according to “Swahili time,” when the first hour of the day starts at sunrise, or six o’clock, rather than midnight, or twelve o’clock. “I mean, after he was fired from the first two jobs it never even occurred to him to wonder if he was able to read the time correctly!” Statements like this, made in frustration, demonstrate that attitudes about how groups of people think, behave and feel can be attributed to cultural differences and creates a wall that prevents mutual understanding, cohesion, and full inclusion of cultural Others.

Though Ong outlines an ideology of belonging based on racial difference and Bridges identifies “culturalist racism” as the current mode of denying groups of people full citizenship, within the current economic era, belonging is increasingly assessed in terms of one’s duty to build his or her own human capital and reduce their burden to society. Self-reliance, individualism and a hearty work ethic are the neoliberal criteria that form the backbone of belonging in advanced liberal democracies, termed by Nikolas Rose as the “capitalization of citizenship” (1999). These citizenship ideals also germinated in the post-World War II era as a bedfellow of development discourse. Just as stereotypical images of poverty are associated with need and benevolence abroad via development discourse, negative stereotypes of dependency and laziness in the United States stigmatize bodies and behaviors as deviant and in need of reform. As a facet of subjectivity, the designation of being “vulnerable” or “at-risk” was not a new category my refugee participants had to contend with. In fact, many of them utilized these categories in their efforts to find resettlement in the United States. How each refugee mother
embraced or rejected the expectations of the worthy citizen mirrored their expectations of what it meant to be developed. For some like Mary, development meant features of advanced societies: industrialization, urbanization, education, health care, and civil protections. It did not entail a new ways of living to build one’s human capital in line with a Western ethos. For others like Salma, development entailed the development of the self, the building of human capital for the purpose of upward class mobility, in addition to industrialization, urbanization, education, health care, and civil protections, etc.

2.2.1 Mary

When I walked into Mary’s apartment and she was dancing around, the TV playing the same work VHS tape of people jumping up and down, singing to a steady and driving African drum beat. She ran out from the kitchen where the aroma of cumin and meat permeated the apartment.

“Do you know this music?” she asked cheerfully. “Come, dance with me, I will show you!” She grabbed my hand and rhythmically jumped up and down. “I spoke with my mother earlier today and she told me my sister is pregnant again. It will be her ninth child she told me if I am going to make it to ten I have to get going!” This statement from Mary was surprising for a few reasons. The first was that Mary’s new baby was only six weeks old. Secondly she was in a particularly jubilant mood as she had tossed her husband out of their apartment after he had abused her and become violent. After an encounter she had called an ambulance which took her to a nearby emergency room where they suspected a fractured jaw. For Mary that was the last straw. “He can come after me, but my children, tsk tsk! I cannot watch him do that anymore!” The occasion for my visit was to take her to the hospital to obtain a record of her visit to the
emergency room earlier that week. And finally, her six week old baby was her fifth birth and fourth surviving child. Her chief complaint was that she did not have enough money to take care of her children and move the five of them from their small one bedroom apartment to a two bedroom apartment.

“Without George?” I asked. “How will that happen?”

“Ahh!” she replied in an irritated voice, waving her hand in the air as if to toss him away. “If comes back let him, but tsk tsk! I can do without him. I am 26 after all. I do not have much time left if I am going to make it to ten.” I asked how many children was enough, or a good number for a family. She replied in the optimistic manner that I had come to find familiar when talking about childbearing and family size, “as many as God allows.” But as I had also come to expect she followed up with her own ideas of the number of children she desired. In this case, “ten is a good number. Ten is an accomplishment with a nice mix of boys and girls. I had my first when I was 14 and now I am 26. I have time but without George, eh, I will need to meet somebody else I think. Did I ever tell you how George I and became married? Oh let me tell you from the beginning.”

Mary revealed for the first time that her marriage to George had been a scandal and had put her at odds with her family. Her mother had arranged for her to marry a man who had been living in the United States. He was much older she recalled, around 40 years old and she was only 13. He had returned to Sudan to arrange the marriage and give a dowry for the marriage in the form of gold jewelry. The arrangement was for Mary to remain in school until she was 15 when he would return to marry her. Mary was resistant to the marriage and took up with George, a local boy of her own age. She left school and they ran off together. Mary became pregnant. “It was quite a scandal.” This also meant that her mother would have to return her dowry and she
was furious. She sent Mary to live on her own for remainder of her pregnancy. Mary recounted the circumstances of her first labor when she was 14 years old. “I just sat on the floor of my house and I pushed and pushed. Finally when the baby was out I called mother and told her to come over. I did not know how to cut the cord or anything. When she heard my voice she came running. She scolded me harshly but allowed me and the baby to come home after that. After the baby was born they accepted my marriage to George.”

Her marriage to George had always been rocky. Mary had always deemed it permissible for George to take up with other women after the birth of their children as Mary practice abstinence for at least 2 years following birth, the length of time she was breastfeeding, in order to prevent another pregnancy. But when breastfeeding had ceased and she was prepared for another child she welcomed him back and he was expected to maintain his role in the family. While he was always expected to contribute to the family’s well being, it was clear that Mary assumed the responsibility and made the primary choices for herself and her children. When she was still living in Sudan, she decided when to leave her home and go to a refugee camp when circumstances became dangerous and when to return. She traveled between her home and the refugee camps several times, often returning to plant or to harvest food. She would often leave her children in the care of her mother in the refugee camp or her mother would take on the responsibilities of the harvest.

After moving to the United States, the flexible housing and financial arrangement she and George had maintained while having children and moving in and out of the refugee camp had shifted to a permanent apartment that required a heavy monthly burden. Mary became pregnant within two months of arriving in the United States leaving George to find a job. Nearly a year after arriving George had still not taken a job causing the family to continue to rely on the
resettlement agency for financial support and exhaust their meager savings. Given that Mary assumed so much responsibility in Sudan it was not surprising to her that George failed to find a job and earn money for the family but it was definitely a sore point for their relationship.

In a new country, Mary was now caught in the difficult position of wanting to find a job but not wanting to leave her children with strange people, as her mother was still in Sudan. Compounding the difficulty was the cost of childcare, which would likely exceed any income that she would be able to earn. Without a high school education, Mary would likely be eligible for minimum wage work. Now that George was gone he was no longer an option for watching the children either. Additionally, Mary and her family had exceeded the amount of time that the resettlement organization typically assists families with the costs of living before they find employment. Though the resettlement organization typically assists families for three months they had already been assisting Mary’s family for a year, the maximum they claimed they would allot resources towards. They had continued their assistance for the year due to the circumstances the family faced. In March when Mary had kicked George out and retained a restraining order against him for abusing her and her children, her new baby was six weeks old and she had been in the United States for one year, meaning that her resettlement organization was prepared to discontinue financial support. Without the ability to pay rent Mary and her four children could soon be homeless. In the words of her social worker who was trying to convince Mary to move her family into a shelter before it was too late, this made Mary “a difficult case.”

How is it that Mary, with all of the difficulties that she was facing, was jubilantly talking about how she would reach ten children? Mary’s experiences demonstrate that clashes that many women face when reconciling their own values and ideas of parenting with the demands of a market-driven society. Mary’s refusal to shed her own “traditional” ways lead her social worker
to label her a “difficult case,” where success in the system and one’s “worthiness” is attributed to their ability to reduce their burden on the social welfare system, adopt an ethos of self-sufficiency and engage in a project of “benevolent assimilation” by adopting the ideals and practices of the dominant class. The difficulty of Mary’s case, from her case worker’s perspective, is in a very practical sense as a single parent it would be difficult for Mary become economically self-sufficient with four children. As it was her case worker’s directive to push Mary towards economic self-sufficiency knowing full well the unlikelihood of success, the fact that Mary was talking about having more children seemed counterintuitive. The core of Mary’s case, as her case worker shared with me, was that “she just didn’t get it.” Like the frustrated caseworker whose client didn’t intuitively adopt the Western clock, Mary’s case worker understood Mary to be fundamentally culturally different. Mary did not feel the urgency that her case worker felt to move off of the resettlement agency’s financial support, nor did she “get” that her financial troubles were compounded with each child. In order to be a “good citizen” in the eyes of her resettlement agency, Mary would need to begin working to support her family and find someone to replace her day to day as the primary caregiver.

2.2.2 Salma

“The first day in my marriage, I decided I wanted to be a mother. During the engagement period we planned for our children. We planned for the first baby and then a year later we would have another so there would be some spacing. This was our original plan. When we got married we worked on this original plan. The plan was going well until whatever happened back in Iraq.”

Salma and her husband were well on their way to what she characterized as a “modern life” in Baghdad when the United States invaded Iraq. She and her husband discussed at length
the kind of life they wanted to have, what they wanted for their children, and how they wanted their relationship with their children to be. Together they determined that three children was an ideal family size before they even married. They both felt that three children was the ideal number because it would allow them to give them a good life financially, as well as allow the parents to have a close personal relationship with each child. Salma also reflected on her own mother’s experience having 10 children when she thought about how many children she preferred. While Salma acknowledged that her mother was very loving and never had a harsh word for her children she thought about the amount of work her mother had every day and the lack of time for herself. “We grew up in a rural area with no development. Our life was very traditional. My mother as well was very traditional.” Salma attributed her mother’s hard work to a lack of development and a lack of technology to assist her mother with her daily tasks, such as washing dishes and clothes and cleaning the house, difficulties which were compounded by the number of children she was caring for.

“The difficulty my mother faced during her motherhood, I took it into consideration and this is the main reason I think just 3 children because we are a big family, 6 sisters and 4 brothers. So we were a big family and my mother had to do everything by herself with no technology, no development! She did all the washing, all the dishes, all the cleaning by hand! Can you imagine? With no vacuum, no washing machine, no dishwasher? And for 10 children! We had to carry the water from the well. My mother, she was always so tired, so exhausted… So this was an impression, I will have 3 kids, that is enough. I will have enough time and everything… I think 3 is a good number, boys or girls. 3 is enough. The parents will have their own lives. Like for me if I want to do something else in life, like continue my education I can.
Also for the kids, to have enough time for everyone. We are new here. I know the number is not changing, 3 is enough.”

The division between modern and traditional, developed and not, entailed more than simply acquiring technology to assist with household tasks; it entailed a smaller family that would allow Salma to spend more time on herself and giving her individual children attention. Seeking what Salma described as a more “modern lifestyle” was in part what attracted Salma to the living in Baghdad, a large city, as opposed to a smaller rural community.

“The difference in 20 or 30 years ago in Iraq, a lot of women are like me, they want to upgrade their education and their lifestyle. Number one for me is to teach them Islam and to build their personality to be independent, and to have the best education they can have. And my main concern is that they [her children] be independent in their psychology so that they can decide for themselves and what they want, with the help from others, in their time.”

For Salma, advancing her own education was something she pursued alongside starting her family. She describes education as a lifelong pursuit of self-improvement, as important to her own life as it is for her children. She expressed a desire to attend a university “to become a doctor or a lawyer or something.” In order to achieve these goals she and her husband carefully planned her pregnancies back in Iraq, considering both her health, medical advice, and the impact the age differences would have on their children’s relationships.

“Spacing depends on the nature of the pregnancy and delivery and the physical health of the mother. In an ideal world 1 ½ years is good enough. The mother will return to her physical health and she is ready for another baby. The space between Sajat and Danya is 1 year and 3 months which is good. Because that time is enough and I talked to my physician and she advised such a thing. It is good for the kids as well because this is what we are thinking, me and my
husband. You should not be alone, you should be friends, sister and brother. They are friends, share their toys. They are playing all day with each other, passing a good time with whatever toys they have. And he helps me watch his sister. When he was less than 1 ½ year he started to watch his sister. He was just sitting and looking at her, guarding her. They always have a good relationship. They never quarrel as kids. Sajat was trying to be the bigger brother from an early age.”

Her most recent pregnancy was an unplanned pregnancy and Salma openly discussed that she considered having an abortion. “Originally I did not want this pregnancy. I was trying to have an abortion but it did not happen.” Salma was the only one who openly shared that an abortion was even a consideration for an unplanned pregnancy. There were multiple reasons for this consideration. The first was that she worried she would not be able to give her children the individualized attention that they each needed, “This last baby was, a surprise, unintended, unplanned. A surprise for me. I wanted to have time for my kids. Because the reason I came here was for the best, best education in the whole world in America. We want the best education for kids and it’s not easy. They want our help, our support. We share our time, the homework, the school. So I think another kid, another baby, will take my time. So now I work hard to make the balance with all my kids.” Salma explained her unusual practice of having her children call her by her first name rather than “Mommy.” “Although this is unusual it gives me a sense of closeness, friendship. You know when you have friends you tell them a secret and can take it to their room? I don’t want any barriers between us. They can tell me everything, no barriers. I took good lessons from my older sisters. One of them gets mad at her kids so easily, shouting or talking in a loud voice. Not physical of course, but I don’t want that. I want to have more of a friendship with my children.”
A second pressing concern was that Salma developed diabetes during her pregnancy and experienced a stroke, which was the cause of death for her mother. This frightened her as she imagined leaving her three children without a mother. “It was a shock for me. I immediately remembered my mother and I remembered that I have another 3 kids and this is something serious. This is kind of… a very, very difficult situation. I was six months at this time.” Only 32 years of age, a serious health concern was not something that Salma expected. She blamed her emergency cesarean back in Iraq with the birth of her third child as contributing to her stress. However she felt that in the United States she had access to “modern medical technology” and would receive “the best care in the world,” which would enable her to carry the baby to term and live with the condition.

Finally she considered her own identity as a mother and whether she would be able to give the best to each of children in the way that she wanted. The pressures of being a “good mother” and living up to cultural standards and personal standards of what she wanted to give were a lot of pressure for Salma. However, these pressures were lessened by “modern technology” and “development” living in the United States.

Ultimately it was her husband who convinced her not to have an abortion. Salma shared that even though they discussed her health, their prior plans and how it would impact her identity, deep down her husband revealed to her that he truly loved children, especially babies, and was excited about the surprise pregnancy. He persuaded her by saying, “Why give us the baby now? It’s a gift, a gift from God. Nobody say no to God.”
2.3 Personal Responsibility

While the sense of one’s duty to build his or her own human capital and reduce their burden to society is the backbone of belonging in Ong’s broad incarnation of citizenship, the criteria of self-reliance, individualism and a hearty work ethic (values characterized by Ong as the “Weberian work ethic) are neoliberal in nature. While the concept of neoliberalism has generated a wealth of literature that centers on markets, the world economy, and uniting regulation and private industry to create development, I will restrict my use of the concept to the relationship between neoliberalism and notions of personal responsibility within governmentality. While neoliberalism has differing implications in different contexts, in American culture it draws on the notion of personal freedom associated with traditional liberal philosophy. Colin Gordon outlines a fundamental transformations in the neoliberal incarnation of personal freedom (1991). In the classic sense, personal freedom entails limited regulation and maximizing individual rights and choice. In the neoliberal era, personal freedom entails an overarching paternalist political authority and personal responsibility. In the neoliberal state, the state creates conditions within which individuals choose the behaviors that are best for the collective good rather than exercising a true freedom of choice. In the United States, neoliberalism functions alongside governmentality by valuing those who choose behaviors that are best or the collective good that reduce their burden on society. Those that do not are expected to feel shame. Shame, Anthony Giddens writes, derives from “fears that the narrative of self-identity cannot withstand engulfing pressures on its coherence of social acceptability” (1991:65). As Joan Wolf characterizes this transformation, “Liberal individuals do what they want and neoliberal individuals choose to do what they are supposed to do” (2011:61) and those who do not or cannot are expected to feel the requisite shame.
Governmentality entails the process of subjectification, the dual process of being subjected to control and dependence and the struggle against it, as well as the practices of control that are employed to meet that end. Foucault termed these practices “techniques of the self” and Ong termed the employment of these techniques “technologies of government.” Ong characterizes “technologies of government” as the grids of knowledge/power, mechanisms of surveillance, and hierarchical categories employed in the everyday molding of subjects into citizens. In a practical sense, refugee camps, welfare offices, resettlement services, and health education groups as innocuous and well-intentioned that they may be, operate to determine who is to be marginalized or supported, welcomed or shunned, valued or shamed by society. These groups are operated by an army of professionals, who Nikolas Rose (1999) calls “experts of subjectivity” and Paul Rabinow calls “middling modernizers,” whose job it is to teach others to develop new ways of thinking about the self, acting upon the self, and making the choices they are supposed to make. In short, their job is teaching individuals to be subjective beings by inducing them to become self-sufficient beings for the collective good through “benevolent assimilation.” Within the realms of refugee resettlement and maternal and child health these “middling modernizers” are experts on health (nurses, midwives, lactation consultants), resettlement workers, community health workers, public health workers, and importantly students (myself included) eager to flex their pastoral muscles or advance social justice in the everyday tasks of improving the quality of life of the poor and marginalized.

Also central to the employment of technologies of government are the paradigms that exist to define behaviors as normal, desirable and supportive of the collective good. Increasingly technologies of the self rely more and more on contemporary science and medicine to identify good and bad behaviors in a process known as medicalization. Medicalization characterizes the
process when choices and behaviors are evaluated in terms of their health implications and subjected to medical expertise. In the neoliberal culture of the United States, health programming and interventions are a form of disciplinary mechanisms that position the recipient of such programs as personally responsible to the collective good by internalizing good and responsible choices. These good and responsible choices are often the subject of public discourse on mothering and breastfeeding where personal responsibility is emphasized according the paradigm known in academic discourse as “scientific motherhood.”

The paradigm of “scientific motherhood” is a product of the medicalization of parenting by defining good mothering as utilizing modern science and medicine to inform childrearing practices. However, as Rima Apple outline in Perfect Motherhood (1995), scientific mothering has undergone multiple transformations as the social conditions which encompass mothering have also transformed. Throughout the 19th and 20th centuries the growth of the medical field led to the production of more and more expert medical advice. The current incarnation of scientific mothering therefore mirrors the transformations of the previous 30 years as neoliberal values have come to the fore. The growth of scientific mothering and breastfeeding discourse will be the focus of the next chapter as I examine how the paradigm of scientific mothering, with breastfeeding discourse an essential component, represents a form of authoritarianism necessary to the modern biopolitical project. But first I will conclude the stories of Mary and Salma.

2.3.1 Mary

Mary’s small apartment was dark as she sat across from me on the couch holding her now 10 week old baby. She offered the baby a bottle who batted it away. “Tsk tsk,” she replied and offered it again. Her face was strained and she sighed heavily. Her two year old tentatively came
to play with my son, who was unusually clingy on this visit. Her older two children were home from school and sat at the table looking at me with wide eyes. Her son brought an onion and a knife to Mary, who rested the baby on the couch and proceeded to peel and cut the onion into quarters which were shared among her older three children.

The occasion of my visit had been prompted by a dire call. The power had been turned off in their apartment. Mary had called the power company and was informed that there was no record of anyone living in the apartment so they had disconnected the unit. There would be a minimum of five days for service to be reestablished. Mary had asked for my assistance in speaking with the power company to try to connect the power more quickly as they were only able to use candles after dark.

“It is scary when it is dark,” Mary’s son said quietly, with a haunted tone in his voice. “Don’t they know it’s scary?”

Mary asked if I had ever had this happen and I revealed that I had, once, when I had been unable to pay the bill. My response made her tense up a bit, with the additional knowledge that if a bill is unpaid the power will be disconnected. “I have no money to pay the bill,” she said. “How much does it cost?”

I asked if she had paid a bill before. She had not. It became apparent that when setting up the apartment for Mary’s family the agency had established service for the unit but had never transferred it to her or her husband George’s name. As the one year of assistance had expired two weeks after Mary’s child had been born the agency had stopped paying the power bill without notifying Mary, leaving Mary’s family in the dark (literally and figuratively). After calling the electric company on Mary’s behalf, I was able to set an appointment to establish service in three
days, after pleading her case. I informed them that there were children in the apartment, including a baby, and that her husband was absent.

“The milk is spoiled. I had meat in the freezer. It is spoiled,” Mary informed me in an irritated tone. “All of it spoiled! And I will not have more food stamps until next week. My social worker told me if I come to the office they will give me emergency food stamps, but how will I get there? I have no money for train cards. I will have to walk, but how will I walk? Tsk, tsk!” She started rocking her baby back and forth, intensifying her gaze upon the baby who had given up on the bottle. Even though it was early April it was unseasonably cold. The temperature still hovered around freezing. Her children had winter coats, but did not have mittens, hats, or boots. She had no cold weather clothing for the infant. The only thing she had to keep her baby warm was the receiving blanket she brought home from the hospital. In order to receive emergency food stamps she and her 4 children would have to walk the three miles to the agency and back in the cold.

I asked if there was a friend she could call to watch the older children so I could drive her to the agency. She replied there was no one but her aunty, who lived two miles away.

“If my mother was here everything would be different. My mother could watch my children. Then I could get a job. I could work and I would not have to pay for babysitting. I could move out of this place to two bedrooms. I could work in a hotel and everything would be better,” she said with tears in her eyes. “One hand cannot clap the other!”

“Here we have development,” she continued. “But what does it mean? Here there are schools and electricity and water and food but it means nothing, nothing! It is only about money, always money! My case worker keeps telling me work! The only answer is work! But how can I
work when I have these babies at home? Who can watch them? I could live with my Auntie but I am told I must have more bedrooms! How can I move if I have no money? Tsk tsk!”

Noting the bottle, I asked her how breastfeeding was going. “It is fine, it is easy. But I need to go to work, that is what my case worker tells me. Work, work, work. So she must get used to formula. You can see she (the baby) does not like it. But what to do? She must like it because I must go to work,” Mary said with tears welling in her eyes. For Mary breastfeeding was the last thing on her mind, though it had been going well and she was easily able to exclusively breastfeed her baby. The pressure from her social worker to find employment was ever present and she was introducing formula for that sole purpose.

Mary’s continued reliance on her case worker was a sore point for her. From Mary’s perspective the answer was always the same, find a job. The recommendation was always find a job but it was never coupled with a realistic solution for her children. Any childcare possibilities were financially out of reach. To receive subsidized childcare she needed to be currently employed and she had no savings to pay for childcare while looking for a job. Her case worker was cold and uncaring, Mary told me. She didn’t have children so she didn’t understand what it meant to take care of them.

From the case worker’s perspective, the situation looked quite different. I met her case worker the day of Mary’s court hearing to file a restraining order against George. She called late the night before. As it was an unseasonably cold winter even though it was March the temperature was not predicted to rise above zero the next morning. She asked if I could drive her somewhere and gave me the address. When I picked her up the next morning at six A.M. she and the kids were waiting at the door for me, which was unusual. Typically, I would arrive and we would have a leisurely cup of tea and chat. But she was in a hurry. We also had to make a
stop at her Auntie’s to drop her children. Traffic was thick, which was normal but completely unexpected for Mary as she had never traveled in a car during rush hour. “We must get there, we must go faster Erinnn!” she said tensely over and over. She had an eight a.m. court appearance and she had been warned not to be late. She was supposed to meet her case worker in front of the building. But when we arrived she was not there.

Mary called her and had a curt discussion on the phone. Within minutes a young woman in her twenties rushed up to the car and gave me a confused look. “Did she ask you to drive her?” she asked with a confused tone. Before I could answer she snapped “we’ll talk about this later!” She and Mary rushed into the court house at 7:56 A.M.

Later that day I received an email from her caseworker. She apologized for her tone and to my surprise asked me to discontinue my relationship with Mary as I was “being taken advantage of” and “interfering with Mary’s self-reliance.” Surprised by the case worker’s response, I replied that due to the extreme cold and the need to take the children outside I thought it was the responsible thing to do since neither of them had appropriate winter clothing and the baby was only two months old. Her reply was that they had discussed at length how to use the bus and how much time to allow in order to arrive at the court on time and by asking me to help her Mary was “leaning on someone else yet again.” She went on to tell me that she was trying to move Mary and her children into a shelter for victims of domestic violence since she had not paid her rent in months and the agency would no longer support her as she had exceeded the year. Mary was resistant which frustrated her case worker to no end. She revealed to me and the end of her email, “I can’t wait to be done with this case!” Despite her frustrations, Mary and her children would not be resettled into a new apartment for an additional six months.
“Welcome Erinnn!” Mary squealed from the doorway of her new apartment in a shelter for families of single mothers operated by the same agency that handled Mary’s resettlement. It was the end of summer and sunlight poured in through the windows. Far from the dark and cold apartment she had during the winter her new home was as light and airy as her disposition. She showed me her “new apartment” with pride.

The move also resolved her relationship with her case worker who continued to communicate with me, eventually enlisting me in the cause to persuade Mary to move. This was actually the third shelter she had secured for Mary. The first Mary would not move to because it was located on the far South side of Chicago, more than 15 miles away from her current apartment. This meant that the children would have to switch schools during the school year and that she would be too far to attend her church, shop at the local markets which stocked African foods and visit with her Auntie. Though her case worker pressed and pressed Mary resisted. The second shelter was closer but would not allow her to bring any of her furniture. Mary had amassed a stockpile of furniture, baby year such as swings and strollers, and other household items from cast offs she found in the alleys. She was unwilling to leave her belongings behind. In the end it was determined that the location was too near her current apartment which would put her in danger of George.

The final location was location near her old apartment but in closer proximity to the church, the resettlement agency, her Auntie and the markets she preferred. The arrangement was more like a housing co-op. Like the first location, this was a domestic violence shelter with the specific aim to keep families out of homelessness and the foster care system. It was run like an apartment complex with an extra layer of security and with access to social welfare systems within it, such as WIC, employment support, after school support for the children, etc. Mary was
allowed to bring her belongings and in the end they had a larger, cleaner, nicer home for themselves.

While Mary’s resistance left her case worker feeling exasperated and exhausted, it was Mary’s lack of shame and expectations of continued support that frustrated her the most. In a chance run-in, prior to Mary’s final move, the case worker revealed to me her frustrations after I complimented her on her patience. I told her how happy Mary was to be able to live separately from George and know that she and her children won’t be abused anymore.

“Oh sure you get to hear all the nice stuff!” she retorted with frustration. “All I hear is I want to go back, my place isn’t big enough, I can’t get a job, no one will watch my children, I need my mother to come over! All I hear is give me, give me, give me!”

The case worker’s frustration is understandable given the nature of her relationship with Mary. As a “middling modernizer,” her primary goal was to teach Mary to develop new ways of thinking about herself, acting upon the self, and making the choices she was supposed to make in order to become self-sufficient. Mary’s resistance to her case worker’s efforts of “benevolent assimilation” seemed to her case worker that she was failing at her job and consumed more time than others. It seemed as though she would take a long time to become self-sufficient enough that she would not necessitate the amount of attention the case worker was giving.

From Mary’s perspective her acts of resistance were a strategy used to secure the most ideal home for her and her children. He was keenly aware of her subject position in the United States, having had to assume a similar position of subjection moving in and out of the refugee camps back in Sudan. She was well practiced in when to employ the oppositions of irrational-rational, feminine-masculine, black-white, and primitive-modern to evoke inferiority as an inducement to continued aid. Stating that she would move her children from their school and
being fearful of being too close to George as her reasons for resisting previous attempts to move
her to a public shelter Mary was able to gain a larger, private dwelling that was close to the
friends she had made and was able to keep the material items she had accumulated. By resisting
development and modernization she positioned herself to be continually in need of development
and modernization. While Fanon characterized this as a racialized subjectivity and as the
colonization of the mind that would ultimately lead to madness, recognition of this difference
can also be a powerful tool, a tool which Mary was very practiced at employing to gain her
desired end. While it might be tempting to cast Mary’s case as exemplary of the postcolonial
condition as the inability to reconcile traditional ways of thinking and being within a modern
society, I argue that reconciling the basis of difference is not a goal for Mary. She understands
how these concepts are employed very well due to her time moving in and out of refugee camps
in Sudan, contact with development agents, and now welfare agents in the United States and has
become adept at employing them when necessary. By resisting the attempts of “benevolent
assimilation” she understands that assuming a subject position of “always in need of
development” she will continue to receive the financial support she deems necessary for her
family.

2.3.2 Salma

“I really enjoyed breastfeeding. The best moments with the baby are when they are on the
breast and you can see that they are also enjoying breastfeeding. The first feeding as in the
hospital at like, 10 minutes of age. So they had not cleaned him. The nurses were telling me to be
a little bit careful because maybe he won’t latch. But once I put him on my breast immediately
he latched, like he was so thirsty. I can’t explain my feeling, I was so happy I was crying. I knew I was a mother. I knew that I was no longer a girl. No, now I am a lady.”

Tears welled in Salma’s eyes as she remembered the feeling of breastfeeding her first child. Sitting at her kitchen table with her new baby, now 4 months old, on her lap, she was more relaxed. Her freshly washed hair was flowing freely, revealing a reddish hue from the henna she used to dye it. Wearing sweat pants and a large T-shirt, she was enjoying a moment of respite as her husband had taken her older children out for the morning to give her some rest. Though it had been several weeks since Salma informed me that her family would be moving she did not mention it on this visit and the boxes were still stacked in the corner. Her apartment was immaculately clean. She now brushed off my queries into their intentions to move.

“There are many things here that are good,” she told me. The first was that she was unhappy about leaving her doctor that had seen her through the difficulty of her last delivery. “She is Arabic” she informed me, with a tone that indicated that was reason enough to stay. Salma continued to experience health difficulties, though she felt they were all manageable. The first was that she was taking heart medication that prevented her from being able to breastfeed her infant. Knowing in advance that she would need to choose between taking the medication and breastfeeding her new baby, Salma chose to take the medications with no regret. “I breastfed (her) just four days and then I started on the injections, the medications, so I cannot do both at the same time. I didn’t feel very bad though, it was fine. The first formula I give her, she likes it.” With the memory of her mother’s death still weighing heavily on her mind and causing tears to well in her eyes, the choice was easy for Salma.

It was important for Salma to breastfeed her baby immediately following birth, citing the benefits to the baby and herself. “It is good for the baby,” she told me, “and it is good for the
mother. It cleans out the womb and it also increases the bonding between the mother and the baby.” Balancing the needs of the baby and her own needs was something Salma did with each of her children. She breastfed her first until she became pregnant with her second at six months, at which time she ceased breastfeeding and introduced a bottle. With her second she stopped breastfeeding around six months as well, even though she was not pregnant again. She stopped at six months with her third as well. She cited reasons such as “I was so busy” and “there was no one to watch the other children.” Her primary reasons were “I was so busy, I did not have time for myself.” In order to ease the transition away from breastfeeding she introduced solid food at three months of age with all of her children, which she acknowledges is earlier than recommended by medical experts but attributed it to her “parenting style.” She also took an approach at solid food introduction that she acknowledged was different from standard parenting advice, either medical advice or the advice of her sisters and mother, which she describes:

“When the baby is three months and older I start solid food and I will give them, not baby food, but food, okra with lamb and meat (laughing). Just half a spoon, so they get to know the taste (laughing). My husband’s mother, my mother, my Aunt, everyone older taught me to feed them bananas and eggs from six months. I know all that. But I have decided to let them have a taste and let them decide if they like it. That’s my view. I wanted her just to know Iraqi food just to see if they like it or not. And she is a good eater. And banana, I gave her banana, rice, tomato soup. These are classic foods in Iraq… I think at the age of three months her stomach is ready to accept food. She is not ready for every food. When I gave her meat it was too much. She likes cereal. The first cereal I mix with milk or juice, Sunny-D. You know Sunny-D? I mix it with cereal and she likes. Some biscuits with our juice. But her milk is when she wants to sleep at bedtime, I give her. When the baby does this (mouthing chewing), the baby cannot swallow yet.
When the baby does this I will put her on the chair and I will feed her. If she accepts it she must be ready.”

By allowing the behaviors and reactions of the baby to guide what types of food she introduces and how much, Salma demonstrates how central “rational” thinking is to what she describes as her “parenting style.” Rather than conceptualizing her baby as a non-agent whose needs must be anticipated and crafted, Salma considers the baby an individual with whose individual needs and wants can be expressed, even in infancy. Conceptualizing the baby as an individual, she is eager to interpret her baby’s actions as demonstrations of her individuality and rationality, which Salma considered to be modern values that are important to succeeding in the United States. As such, promoting modern values of individuality, self-sufficiency and rationality are important to Salma in differentiating them from her childhood in a small village, which she characterized as traditional, powerless, passive, impoverished, ignorant, dark, and oppressed by its own tradition. Salma strove to have a different experience from her mother who toiled endlessly without conveniences of running water or electricity only to die from a heart condition at a relatively young age. Continued self-improvement and achievement are core strategies for Salma and her family, despite the challenges they impose.

While Salma continued to cite education as being most important for her children, she continually expressed a desire to continue her own education and the numerous universities in Chicago offered an enticing reason to stay. She mused that when her new baby was older she could return to her own studies and pursue a medical or a law degree. When I commented that I was having difficulty finding balance with just one child, soon to be two, she asserted that focusing on herself and her own fulfillment, as a part of the family, was as important as encouraging her children although being a mother (and all it entails) is central to her identity.
“The priority as a mother is my identity number one. To work hard for the best interests of my family. I identify myself as a mother number one. This is built in our religion and tradition in Iraq as Muslim and Arabic people. The family the center, the core of the life of women. So I was planning from the beginning when I was engaged to my husband to have a planned life for my kids. To have the best we can have for them. The details now are different. Here, and even in Iraq, I was comparing my life as a wife and mother to the life of my mother. Now there is the technology to help the mother. Like there is a dishwasher, there’s a washing machine, vacuum, microwave. But in Iraq for the last 20 or 30 years we didn’t have the technology to help the mother to do the house chores which impact the life of the mother of the house. She was physically exhausted. She was under pressure to give the best possible to every single person in the family. Now I don’t have this excuse so I can give better to my family. It is real pressure, you have to wash the clothes, you have to wash the dishes, you have to clean the house all by hand. And this is just exhausting and I am just a human being. She has to give love to everyone in the family, she has to take care of everything, solve problems. And the husband too also needs some attention. Now I have more time and I am more relaxed to give better care for my kids.”

She identified as a mother, which she describes as a traditional value, but the opportunities provided by the “development” and technology she has access to in the United States allowed her to focus on herself as well. Unlike her mother who was overwhelmed with 10 children and having to maintain a house through physical labor, she could rely on technology for the manual chores and continue the true aim of development: the development of the self.

Like Mary, Salma was well aware of the opportunities available outside of Iraq and her move to the United States opened to opportunity to access them. While she continually returned to the importance of “technology” in helping with manual chores such as washing dishes,
washing clothes, and cleaning the house, the real opportunity presented was the opportunity to continue her own “development” which was unavailable to women with children in Iraq, even more so due to the “massive destruction” caused by the invasion. Already holding the values of self-reliance, individualism, a hearty work ethic and personal responsibility Salma and her family shunned the efforts of the “middling modernizers” at the refugee agencies and welfare agencies preferring to seek out support that already matched their own goals, such as Salma’s Middle Eastern physician. For Salma, the project of development was underway prior to resettlement in the United States and her family’s move allowed her to complete her own project of “having it all:” motherhood and self-fulfillment.

The experiences of Mary and Salma represent the extremes of negotiating motherhood with resettlement that the participants experienced. It is also worth noting that they each attended the pregnancy group the least of the participants. Mary attended only once utilizing the strategy she employed with all the middling modernizers she came into contact with, to assess how they could assist her. In the case of the group she had heard that items such as clothes and strollers were given away. On the particular day she attended there were no items to give away. She did find one useful asset, it is where we met. More than any other participant, Mary called upon me to help her navigate the web of social services. Salma, on the other hand, did not attend once. She had heard about the group and it had been suggested by her case worker that she attend but she did not deem it beneficial. According to Salma, it was a health education group and she was already an expert in mothering, having three children already. It is also worth noting that though they both introduced formula early and for different reasons, the introduction of formula while breastfeeding represents the average experience for my participants, though for a variety of reasons. Though Mary and Salma represent the extremes experiences along the continuum of
negotiating subjectivity in the United States, they are still operating within a paradigm where the tenants of scientific mothering serve to define their choices as good and responsible or not within the modern biopolitical project. In the next chapter I will examine the paradigm of scientific mothering and the utilization of breastfeeding discourse alongside the deployment of the maternal health education group.
As I arrived at the office as the weekly morning meeting was concluding. Marilyn, a refugee herself and community health worker for the Burmese community, informed me that a woman in her community was pregnant. “And she already has three kids!” she stressed. “What is she thinking? She cannot feed the kids already!”

“It is like these women don’t think ahead,” Chimi, the Bhutanese community health worker offered in her quiet voice. “Me, I realized I could not take care of my two children and here in the United States it is so expensive. I could not have more than my two children. How many children do you want?” Chimi asked, looking at my pregnant belly. “Personally I think I will have my second baby and think about it afterwards,” I responded and we all laughed. I suggested that maybe this woman thinks of children differently and that children are a blessing, referring to my own family where I am one of four children. “Yah, if they can afford it! Not living on public aid and the kids already not being taken care of,” Marilyn replied, sounding exasperated. I further offered that children can be a woman’s source of joy and pride if life, referring to my own grandmother who had six children. Sarah, the associate director of Refugee Health Programs, defended Marilyn and Chimi’s exasperation, “But this is different. If they’re living on welfare don’t they have the responsibility to take care of the children they already have?”

“Things are different for them now.” Marilyn continued, “The last time I was there on a home visit, the children’s hair was not combed, they were dirty. She can’t even take care of them now. It is like they don’t even think of how they can support them. They just keep having kids!”

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The exasperation experienced by Chimi and Marilyn represents a glimpse at how quickly the process of becoming a dutiful subject embodying neoliberal values can happen. Both Marilyn and Chimi were community health workers employed at Heartland Alliance Refugee Health Programs. They were both refugees themselves, Chimi from Bhutan and Marilyn from Burma. They had only been living in the United States for a few years but they could both be considered “success stories.” In the previous chapter I discussed how official programs and unofficial practices termed techniques or technologies of government employ biopower, a form of productive power where knowledge is generated and communicated about the population, to define and produce worthy “citizen-subjects.” Governmentality utilizes multiple techniques of governance dedicated to making the mind, body and will of individuals, families and collectivities governable, which delineates the normal from the deviant in society, the desirable from the undesirable. Increasingly in the United States these biopolitical norms follow a neoliberal market logic which defines “citizen-subjects” as autonomous and economically rational individuals who best serve the state by reducing their burden to it. This market-driven logic has shaped family and welfare policy and refugee and immigration politics since the 1970s. In this chapter, I will examine how technologies of government can be viewed as a technique of social control via the two groups organized to provide refugee women with information about health, well-being, pregnancy and mothering. I will examine the actors involved and the implementation of the groups within the paradigms of scientific mothering and breastfeeding discourse. First I will introduce two actors integral to the implementation of the two groups, the community health workers Chimi and Marilyn.

Both Marilyn and Chimi had been living in the United States for a few years but came from very different backgrounds, but both can be characterized as good citizen-subjects and
“success stories.” Importantly they both assumed a level of “personal responsibility” by working menial jobs soon after their resettlement and saving money that enabled them to be economically self-sufficient by the time their support from the agency ended. Their economic self-sufficiency was due in a large part to their employment with the agency. Marilyn actually began working with the pregnancy support group as an interpreter from another refugee resettlement agency. When the Burmese community health worker left a few months after the group began meeting she joined Refugee Health Programs full time as a community health worker for the Burmese community. Unmarried and in her 40s, Marilyn grew up in a relatively wealthy and educated family. She was considering returning to university to obtain a graduate degree and was considering the options of public health or social work. These few facts already separated her socially from many of the refugee clients she worked with as many came from agrarian backgrounds with little access to education. Marilyn was also relatively lucky in that some of her family was also living in Chicago and often assisted her with translating documents. Her sister even filled in as an interpreter on the few occasions when Marilyn could not attend the pregnancy support group.

In contrast, Chimi was the mother of two teenagers and shared the agrarian background of many other Bhutanese refugees. However, setting her apart was that her husband was a licensed nurse and worked full time at a local hospital emergency room. Secure, relatively high paying, full-time employment was an essential component of Chimi and her family reaching a level of self-sufficiency quickly. At the end of my fieldwork Chimi and her husband had purchased a home in cash and were preparing to send their oldest child to college. Chimi characterized her experience in the United States as “really being the American dream! I mean sometimes I can’t believe that five years ago I was living in a refugee camp and I had nothing.”
didn’t know what future I could have or my kids could have. And now my husband and I bought a house! A real house with a yard. I just can’t believe it. But it shows that you just don’t know how quickly your life can change. That’s what I try to tell my clients, especially when they are feeling very down and depressed. ‘You are in America now. You don’t know just how quickly things can change, but you have to change them yourself.’”

The position of Community Health Worker utilizes the Lay Health Worker Model, which uses a member of a targeted population or community to bridge the cultural gap between professional agencies and community members (Eng and Young 1992). The idea of the model is that the worker will provide more culturally sensitive and competent interaction and information than would someone of a different ethnic background (Earp et al. 1997; Hinton et al. 2005; Rhodes et al. 2007). The use of Lay Health Workers employs the notion that influential members of one’s community are more effective in convincing other members to believe and adopt new healthy behaviors. In short, as “middling modernizers” they will be effective in molding newly arrived refugees into citizen-subjects by inducing them to make the choices they are supposed to make in order to reduce their burden on the social welfare system. In the case of the example above, Marilyn and Chimi are frustrated by the “irresponsible” choice of the refugee mother for not considering herself too poor to have additional children.

Both Chimi and Marilyn were passionate about their work as community health workers, often working close to 60 hours per week and on occasion working “off the clock” so they wouldn’t be penalized for their additional labor. They also made themselves available to their clients at all hours of the day, often receiving phone calls late and night and early in the morning and even the occasional knock on the door. Their role in the community was prominent and occasionally came with some backlash as they were constantly being monitored for favoring
some over others within the community. In the event that there was a large item donated, such as a crib or a stroller, Chimi would always ask me to choose the recipient as anyone chosen by her would generate rumors of favoritism, regardless of how objective the selection may appear.

As community health workers for Refugee Health Programs Chimi and Marilyn were not trained professionals in the health sector but considered optimal health and well-being to be an integral component of, and primary reason for, the immigration experience. Encouraging refugees to assuming personal responsibility for their own health through proper choices was a constant battle for them, often leading to frustration. Chimi and Marilyn gained their unofficial authority from their own experience as “success stories.” They were successful in the sense that they reached a level of self-sufficiency quickly and aspired to a middle-class lifestyle. Their success was due in no small part to being employed by the refugee agency as community health workers. With no previous experience in health promotion, their primary qualification for the job was that they spoke English well and could write in both English and their native languages. Even more importantly they embodied the values they were supposed to pass on to newly arrived refugees, personal responsibility and self-sufficiency. They also addressed practical concerns such as dress, personal cleanliness and cleanliness at home, and importantly they provided a crucial link between newly arrived refugees and other social welfare systems through translation. Of their many duties, one was to sit in the waiting room of the clinic which processes newly arrived refugees and assist new refugees in filling out the necessary forms as some will have little to no knowledge of English upon arrival. They also make appointments for them, accompany them on health appointments and visit them at home. For many refugees, Marilyn and Chimi are a welcomed and crucial component in navigating the social service system.
The home visits provided the primary venue where Chimi and Marilyn could flex their muscles as “middling modernizers” in their efforts to help new refugees adjust to life in the United States. They provided a safety net between them and further intrusion from social welfare systems in situations that are often awkward to address. For example, if they notice insects such as roaches or flies, they will encourage the family to take the garbage out more frequently and keep the kitchen clean before the landlord gets involved. If they notice they are not wearing clean clothes, they will encourage them to wash their clothes more often and demonstrate multiple times how to use the washing machine. They will frequently suggest the use of deodorant and shampoo, forcefully if necessary, particularly if school aged children appear dirty or unkempt in an effort to keep the school and the Department of Child and Family Services (DCFS) from becoming involved. They will also take note on these home visits if the families have enough food and both help them obtain additional emergency food, apply for aid, and instruct them on how to maximize their food aid as they are often receiving a combination of SNAP and WIC.

In addition to the home visits, Marilyn and Chimi helped to organize and importantly recruit refugees to attend the various health promotion groups. They also attended them to provide translation and a recognizable face for the attendees. In addition to the pregnancy support group there were also nutrition and cooking classes, yoga and walking groups, health fairs, senior outings, a garden, and a parenting group that began in the winter of 2013 and was attended by many of my participants. Like many of the participants, though Chimi and Marilyn did not read popular or scientific literature on parenting, mothering or breastfeeding, they were well versed in what was considered to be ideal parenting in the United States based on their own experiences and contact with social welfare organizations in United States and prior to
resettlement. The norms they promoted in regards to parenting and breastfeeding drew heavily on the dominant public health promotions, particularly the “breast is best” approach to breastfeeding. This did not mean, however, that they strongly encouraged breastfeeding among mothers their community. As described by Aihwa Ong, in transitioning from newly arrived refugee to “middling modernizer” both adopted and deployed the neoliberal market-oriented values of self-sufficiency, self-improvement and personal responsibility and began to view their clients through the same lens. Although they were able to identify with their clients in terms of their own immigration experiences, they maintained similar expectations of transformations in subjectivity. Those who did not adopt the recommendations outlined by the various health promotion groups were categorized as “lazy,” “dirty,” or “too uneducated to change.”

Categorizing their client’s behavior and their ability to change and adapt to life in the United States along the lines of desirable and undesirable behavior mirrors their view on mothering behavior. The wider cultural trend in which a scientific and medical discourse underlies the correct or appropriate behaviors termed medicalization extends to mothering discourse (Andrews and Knack 2013; Apple 2006; Lee 2011). These trends have been referred to as “scientific motherhood” or “modern motherhood,” (Apple 2006), “medicalized mothering” (Andrews and Knack 2013), “exclusive motherhood” (Blum 1999) and “intensive” or “total mothering” (Hays 1996; Knack 2009; Wolf 2011). These models all describe a paradigm that is a tool used in the deployment of disciplinary mechanisms to delineate those who are in need of discipline, worthy of discipline and accepting of discipline.

In the next section, I will introduce the paradigm of scientific mothering and the breastfeeding discourse known as “breast is best” to frame the design, implementation, and deployment of the two health promotion groups aimed molding refugee mothers into worthy
“citizen-subjects:” the pregnancy support group and the parenting support group. My intention is not to provide a historical analysis of the medicalization of mothering nor infant feeding as they have been investigated extensively (Apple 1987; 2006; Blum 1999; Carter 1995). Rather my intention is to provide an overview of how the paradigm of scientific mothering came to be the dominant paradigm within the United States and how knowledge about mothering and breastfeeding is used to construct ideal citizen/subject mothers. Scientific motherhood has never simply represented the imposition of medical authority into the private lives of women. Rather it has been the result of the negotiation of the everyday lives of women in concert with medical authority as they have been complicit and resistant to medical authority (see Apple). Similar to the reach of neoliberalism and governmentality through development discourse, the paradigm of scientific mothering through breastfeeding promotions known as “breast is best” have a global reach. The mothers you will meet in this chapter and the next have all been exposed to “breast is best” breastfeeding promotion prior to resettlement in the United States.

First, I will discuss the emergence of scientific motherhood as the dominant paradigm in the United States and how infant feeding has been at the heart of mothering discourse. Next I will discuss the “breast is best” approach to breastfeeding promotion and a recent critique, the design and implementation of the pregnancy support group and the parenting support group. I will conclude by discussing my participants’ responses to the group itself, the presenters, the material presented, and the “middling modernizers” as participants in the group as well.

3.1 Scientific Mothering and Infant Feeding

Motherhood has long been a subject of anthropological study (see Barlow and Chapin). Within anthropology the focus is largely on the role of the mother in the socialization of children
(Bateson and Mead 1942; Benedict 1974; Briggs 1970; Erikson 1950; Mead 1939) with exceptions (see Gottleib 2000, 2004 and Levine 1979). This focus on the socialization of children can at best position the mother as a subject of disciplinary mechanisms and at worst leave her unexamined or absent altogether. As Nancy Chodorow outlined in *The Reproduction of Mothering* (1978), the intense focus on children as the object of motherhood overlooks the role of the mother as an agent. Sherri Ortner (1996) further challenged that the construction of the mother as an idealized or symbolic figure disempowers the women as “self, actor, agent, experience” and strategist. Emerging from this critique is recognition that although mothering often appears “natural” or intuitive to the outsider, mothering is a practice that draws on and is shaped by aspects of culture and agency (Barlow and Chapin 2010; Bourdieu 1997; Chodorow 1994). My examination of the mothering practices and breastfeeding choices of resettled refugee women aims to continue this tradition.

The shift towards medicalized mothering mirrored the broader trend towards governmentality. The rise of the medical profession and medical authority provided a platform from which individual and social bodies can be surveilled and regulated through what Foucault terms the “medical gaze” (Foucault 1991). Within this new medical gaze, a new approach to disease was taken, greatly expanding the definition of what was considered medical and the power of medical authority. In this new paradigm, as described by Joan Wolf, “health and well-being were conceptualized ecologically, which meant that everything about individual lives was potentially significant to health status or was a possible risk factor for poor medical outcomes” (2011:7), which meant that nothing should be shielded from medical scrutiny. Individual behaviors could be measured and monitored by medical science for the benefit of the individual, social and body politic. Martin Hewitt observes that the rise of biomedical authority assisted in
constituting the normative attitudes and practices of individuals as biopolitical subjects of the modern state (1991:248). One avenue that enabled the surveillance and monitoring of the private lives of subjects, as well as the consolidation and exercise of medical authority, was birth, infant feeding, and childrearing giving rise to the paradigm of “scientific motherhood.”

“Scientific motherhood” is a relatively new phenomenon outlined in detail by medical historian Rima Apple in *Perfect Motherhood: Science and Childrearing in America* (2006). Apple details the transition from practice of raising children with common sense and the help of extended family serving as role models to the total replacement of socially passed knowledge with “all-important medical and scientific advice,” beginning in the mid-nineteenth century (Apple 2006:2). Apple tracks the rise in “scientific motherhood,” of the deference to medical authority in aspects of child rearing, alongside the medical professions efforts to increase their own authority by creating professional organizations and consolidating what could be deemed in need of medical care. Recognizing infant death as a terrain in which medical science could influence, physicians brought under their gaze women’s bodies and breasts for scrutiny and regulation (Apple 1987). Simultaneously physicians forged the new fields of medicine, which professionalized and medicalized all aspects of pregnancy, birth, infant feeding, and childrearing which had been the domain of women via nurses and midwives. Birth was relocated from the home to the hospital where women and babies could be subjected to a continuous medical gaze and subjected them to technological interventions (Blum 1999). By supplanting a female-dominated trade with a hierarchal, patriarchal and monetized profession, obstetricians and pediatricians could identify, categorize, and regulate the inner lives of women and bodies of women and children, crafting new subjects and redefining what it meant to be a good citizen/subject-mother. Within this new model of scientific motherhood, “Parents, particularly
mothers, clearly require the knowledge of experts in order to raise their families healthfully and appropriately, in order to be good mothers” (Apple 2006:2). Apple further cites the rise in parenting literature to be emblematic of the widespread acceptance of this paradigm by medical professionals and parents in the United States.

Physicians were not alone in their efforts to relocate the care of women and babies from the home to the hospital, from the tradition of knowledge passing from woman to woman to realm of medical expertise. While white middle-class women were the clients of the new medical professionals, maternalist reformers, and other elite women actively worked to increase medicalization in pregnancy, birth, infant feeding, and childrearing. At the turn of the 20th century, maternalist reformers were predominantly white elite and middle-class women who became actively engaged in the public health promotions aimed at “race betterment” and nation-building amidst the rapidly changing environment of the early 20th century which included mass immigration, industrialization and urbanization. Maternalist reformers in the United States actively worked to promote the white middle-class ideal among poor and working class immigrant and African-American mothers. Maternalists also discouraged both wage-earning and artificial feeding, seeing it as the root of high rates of infant mortality (Apple 1995). Though maternalists recognized that poverty was at the root of many causes of infant mortality such as lack of money to prepare, sterilize, heat and store artificial formula, bottles and nipples, the practices of the mother were implicitly blamed (Ladd-Taylor 1994). The goal of the maternalist movement was to “educate, educate, educate,” mothers to stop their wage-work and assimilate to the white, middle-class ideals of the United States (Mink 1995). While the maternalist movement did succeed in lowering infant mortality rates and raising questions regarding society’s obligations to families, aligning themselves with state policies meant that mothers became
subject to a reign of expertise that had long been considered a facet of the private or domestic realm. From this intensification on the domestic realm arose questions of morality within a nation-building climate of “who should mother, how they should mother, and with what resources,” (Blum 1999:26).

Questions about “who should mother” and “how they should mother” brought women under the scrutiny of the medical gaze and the project of “baby-saving,” or reducing infant mortality, a goal of the maternalist movement and of the state (Blum 1999; Ladd-Taylor 1994). In concert with the rise of biomedicine and advances in disease theory, infant mortality in the United States was at a high of 10% in 1900 (Mahnke 2000). During this period, women had little choice but to feed the baby from her own breast or from the breast of another lactating woman in the form of a wet nurse. While mothers were encouraged to breastfeed, upper class women frequently turned to immigrant or African American wet-nurses, raising fears about cross-class and cross-race relationships. Infant mortality was often blamed on the inferior morality of lower-class mothers and wet nurses due to their unwed, disreputable, or non-white status. The class divisions between mothers and wet nurses became symbols of changing ideals of morality within the United States (Blum 1999), while turning a blind eye to infant feeding behavior being a product of the socioeconomic environment. Infant feeding became the focus of official state-initiated programs and unofficial social movements, enabling the intrusion of state into the private lives of mothers. In their efforts to craft good citizen/subject-mothers, they found a partner in the emerging medical profession in their alliance to change infant feeding.

Infant feeding has long been a morally and class-charged project as it is the first culprit in infant mortality, therefore potentially detrimental to the long-term viability of the modern state (Blum 1999; Wolf 2011). Infant feeding also played a central role in the emergence of pediatrics
as a distinct and separate branch of medicine. In order to promote the professionalization of pediatrics, pediatricians presented themselves as uniquely qualified to supervise infant feeding (Blum 1999). To support these claims they developed milk substitutes, oversaw milk stations to ensure quality and pasteurization, and instituted routine weight checks and well-baby visits to monitor infant growth and development. During this time artificial infant feeding did become safer with the discovery of pasteurization and implementation of hygiene standards. Pediatricians began to recommend artificial substitutes more and more the decrease the practice of wet-nursing. These recommendations served to maintain a separation between classes, as well as establish themselves as authorities on infant feeding (Apple 1995).

The success of the alliance between the emerging field of pediatrics and the maternalist movement in reducing infant mortality enabled the consolidation of medical control over infant feeding (Apple 1995). It also reflects broader changes in attitudes regarding the ability of science and medicine to determine what is socially valuable and appropriate. Doctors positioned themselves as reformers and morally elevated science and medicine, insisting that scientific expertise was not only a necessary component to child-rearing, but a moral endeavor as well. Thus the acceptance of medicalized mothering, or scientific motherhood, has been the dominant paradigm determining “who should mother” and “how they should mother” for the past century in the United States. Consequences to this trend towards medicalized mothering are that mothers are increasingly dependent on expert advice and assistance in their day to day mothering decisions, which can undermine their own confidence (Andrews, 1999, 2003, 2006; Andrews and Knack 2013). However it can also frame knowledge in mothering, childrearing and infant feeding that exists outside of dominant medical discourse as non-scientific and invalid. Experiential or lay knowledge, within the paradigm of scientific mothering, is framed as
illegitimate, and in need of reform. The conflict between experiential knowledge and scientific knowledge becomes crystallized in infant feeding discourse.

3.2 “Breast is Best,” or is It?

The assumption that breastfeeding is beneficial permeates public health, global health, anthropological, and medical literature. It is common for books and articles about breastfeeding to begin with the statement “The benefits of breastfeeding for both mother and infant are well documented” (Sloan et al. 2006:283), followed by a list of the cited benefits such as a reduction in gastrointestinal disease, obesity, asthma, and allergies. These benefits are so widely accepted that this is a common and sufficient introduction to breastfeeding research. These statements are supported by organizations and institutions such as the World Health Organization (WHO), United Nations (UN) and the United States Agency for International Development (USAID) and seen as unbiased (Rippeyoung 2009). These assumptions reflect the “breast is best” discourse, which dominates health promotion efforts nationally and globally and recommends breastfeeding exclusively for the first six months until a minimum two years. The consensus that breastfeeding is superior to bottle-feeding is so dominant in breastfeeding discourse that formula is framed by some breastfeeding advocates as harmful to babies, thus not an alternative to breastfeeding (Wolf 2011). However, supplanting breastfeeding with formula feeding was a driving component of the medicalization of mothering and the baby saving campaign of the early 20th century. In addition to her historical analysis of scientific mothering, Rima Apple has detailed the efforts to switch the populace to bottle-feeding in *Mothers and Medicine: A Social History of Infant Feeding 1890-1950* (1987). How the populace has been entreated to switch back to breastfeeding has had a rich scholarship (Apple 1995; Blum 1999; Carter 1995; Wolf 2007, 2011). To contextualize the
current state of breastfeeding promotion I will review the history of infant feeding in the United States.

3.2.1 Breast to Bottle and Back Again

As part of the deployment of the maternalist movement and their baby saving campaign the promotion of artificial feeding became popular for a several reasons. The first was that infant mortality was high at the turn of the century, around 10 percent (Mahnke 2000). The second was that upper, middle, and lower-class women sought a substitute to breast milk for different reasons. Upper-class women tended not to breastfeed themselves because it was a popular practice to hire wet-nurses and socially disadvantaged women to breastfeed their children. However the widespread belief that a woman’s morality would be transmitted to the infant caused many upper-class women to seek a substitute to wet-nurses. Some middle-class women found breastfeeding immodest or exhausting, positioning themselves as too physically weak to sustain breastfeeding. Lower-class women were increasingly entering the workforce, sometimes and ironically as wet nurses, and finding a suitable substitute was crucial to the survival of the infant. During this period scientific advances, including pasteurization of milk, the development of powdered infant formula, and overall improvements in sanitation, did decrease the infant mortality rate (Apple 1987).

The success of breast milk substitutes did not change the attitudes towards infant feeding overnight to the extent that artificial feeding became preferred to breastfeeding. Rather the utilization of cow’s milk or formula was likely in the form of “relief bottles” when the mother had to be away or was too tired or busy to breastfeed. The combination of breastfeeding and formula feeding is known as mixed feeding or complementary feeding. The utilization of
formula did open the door more widely to physicians, pediatricians to be precise, who “presented themselves as uniquely qualified to oversee feeding and argued that infant mortality would decline only if mothers gave themselves over to their authority” (Wolf 2011:2). Pediatricians supervised milk stations and weighing stations, eventually instituting the practice of “well-baby” check-ups to supervise the growth and development of the baby, as well as monitor the practices of the mother.

The emergence of artificial feeding and the field of pediatrics go hand in hand and reflect the social elevation of science in the era of “scientific motherhood” so that by the end of first World War most women were bottle feeding to some degree, or at least most pediatricians assumed mothers were bottle feeding (Wolf 2011). It is in the implementation of artificial feeding in the context of scientific motherhood that mothers position themselves as agents complicit in the construction of the paradigm. While the implementation of baby-weighing stations and well-baby check-ups were intended to supervise, monitor and educate lower-class mothers, middle-class mothers soon demanded the same care and were willing to pay for it. The willingness of mothers to seek and follow medical advice brought mothers under the care and control of the pediatrician. Mothers demanded the latest “scientific and medical expertise” to assist the rearing of her children and positioned themselves as the submissive recipient of medical authority. Those who did not were chastised as endangering their child’s health. As Rima Apple states, “Mothers needed education—but not too much education—and also they needed the right education” (2006:57). The right education meant education from their male physician alone and not lay education from advice columns, friends, relatives or other women.

This demand for constant supervision and dispensation of medical and scientific advice also positioned the “modern” or “scientific” mother as the mother who could afford the
numerous visits to the doctor’s office, positioning middle-class white mothers as the most interested and capable of raising strong healthy children. In short, positioning themselves as the ideal citizen/subject–mother. The privatization of well-child medicine marked the beginning of preventative medicine within pediatrics (Pawluch 1996). The scientific mother not only responded quickly to illness, but created an environment to optimize her child’s health and well-being. However, scientific motherhood was not a single ideology, but rather a paradigm that allowed for a broad spectrum of interpretation.

Characterized by Apple as “contingent on a multiplicity of factors” and “viewed from a range of perspectives,” women’s relationships to scientific motherhood have always been dependent upon social and environmental factors such as class, race and ethnicity (2006:89). Poverty was the primary barrier as new standards of sanitation required money, primarily the amounts of water needed for modern sanitation. Although some mothers simply felt they did not require medically directed care as their behaviors and had served them well in the past. However by the 1950s, the majority of women felt that scientific advice was the most modern advice on health and childrearing, separating them from a traditional past. However, this also left women feeling they lacked even the basic information in childrearing and turned to their pediatricians for more and more guidance and advice. By the 1950s, the advice of pediatricians was overwhelmingly to bottle-feed over breastfeed, as bottle-feeding allowed for close monitoring of the mother’s behaviors through precise measurement and scheduling of feedings along with other caretaking practices such as bathing and sleeping (Apple 2006:94). Within this environment the white, middle class experience of motherhood came to exemplify the idealized citizen/subject-mother; educated enough to understand and follow the direction of the authoritarian physician and wealthy enough to afford it.
By the middle of the late 20th century, two movements began that resisted the authoritarian realm of the physician in favor of mothers as active participants in childrearing. These movements, La Leche League and the Boston Women’s Health Collective, did not decenter the role of science and medicine in mothering practices. Rather they reinforced the tenants of scientific motherhood of deference to medical and scientific expertise, particularly in their advocacy of breastfeeding over bottle-feeding. As Apple clarifies, though La Leche League and the Boston Women’s Health Collective are often romanticized as a group of proto-feminists rejecting the hostile paternalistic medical profession in favor of their own natural maternal instincts, “the point is often missed in these analyses that La Leche league was not rejecting medical advice…La Leche justified its stance both with traditional arguments drawn from contemporary scientific literature, actively soliciting the support of physicians who promoted breastfeeding” (Apple 1995, 136). The Boston Women’s Health Collective similarly embraced and employed scientific and medical evidence to support the validation and experiences of women. Through their use of medical and scientific evidence to validate the experiences of mothers, both La Leche League and the Boston Women’s Health Collective moved the relationship of women and their practitioners away from an authoritarian-subservient relationship in American society. However, in their efforts they emphasized the paradigm of scientific motherhood, though they recentered the mother as the authority in evaluating scientific and medical information about childrearing.

Alongside the La Leche league there were other movements to promote breastfeeding that did not seek to reinforce their “back to breast” movement with scientific or medical information, but rather in the counterculture and feminist movements. Often characterized as the “hippies,” the “back to breast” movement favored separating from the medical community by
advocating liberation from medical hegemony (Blum 1999). Framing breastfeeding as epitomizing their “back to nature” ethos they also advocated for home births and “natural” healing techniques. Adding to the politicization of breastfeeding was the boycott of Nestle after it was discovered that their promotion of formula in the developing world and discouraging of breastfeeding likely caused an increase in infant mortality (Solomon 1981; Van Esterik 1989).

By 1978, the social influence on the medical community led to a change in the official stance on breastfeeding. In 1978 the American Academy of Pediatrics (AAP) stated that “human milk is superior to infant formulas” and that “breast milk should be the only source of nutrients for the first four to six months” (Clark et al. 1978). This change of the medical community’s stance on breastfeeding versus bottle-feeding did not mean that mothers adopted breastfeeding unquestionably and that obstetricians and pediatricians recommended breastfeeding to all of their patients. Rather it marked a change on the official policy of the medical community. Changing the cultural norms in the United States is a public health project still in the making. The change in the official policy of the AAP was accompanied by the rise of neoliberal social and economic policies of the Reagan era in what Linda Blum calls a “Machiavellian plot,” the dramatic increase of wage-earning mothers in the workforce and the revival of breastfeeding (Blum 1999:42).

### 3.3 Breastfeeding, Mothering and Personal Responsibility

Public discourse on breastfeeding reveals the emphasis on personal responsibility characteristic of neoliberal subjectivity as discussed in chapter 2. While individuals are responsible for their own health and well-being, mothers are also responsible for the health and well-being of their children and in turn, the health of the social body and subject to forms of
governmentality (Peterson and Lupton 1996). In a neoliberal society, women who subject themselves to discipline and exercise personal responsibility will be “good mothers” who produce healthy children (Avaishi 2011). As such, mothers are expected “not only put their children’s needs first, but provide labor- an emotion-intensive care to protect them from a harsh, impersonal, market-driven society” to optimize their child’s well-being in an ideology that sociologist Sharon Hays calls “intensive motherhood” (Blum 1999:4). While scientific motherhood validates mothering practices with scientific discourse, intensive motherhood redefines the personal responsibility so that “women who are mothers must first act as mothers and that their self-identity is dependent on optimizing their children’s lives” (Wolf 2011:68).

Contemporary discourse on breastfeeding and parenting combine these views where the “breast is best” and the mother makes necessary sacrifices to continue breastfeeding (Avaishi 2011; Obermeyer and Castle 1995; Meyer and de Oliveria 2002; Marshall et al. 2007; Ryan and Grace 2001; Schmeid and Lupton 2001). However, the details of enacting breastfeeding are not accounted for in this view of mothering and the context of breastfeeding and mothering continues to be wedged in the Machiavellian plot where financial needs are pitted against breastfeeding. In a context where refugee mothers are expected to be good citizen/subject-mothers they are simultaneously supposed to make the “right choices” for their babies- to breastfeed- and the right choices for society- getting off welfare as soon as possible. As we saw in the case of Mary, as with other poor women in the United States these are contradictory directives.

This contradiction positions breastfeeding as marker of not only “good motherhood,” but privileged motherhood in Western nations (Ahluwalia, Morrow, Hsia, and Grummer-Strawn 2003; Apple 1987; Blum 1999; Ryan et al 2002). The exaltation of breastfeeding as part of the
standard of good mothering has numerous drawbacks. First, by positioning breastfeeding as evidence that a mother demonstrates personal responsibility, it faults women who cannot or do not wish to comply with this standard (Blum 1999; Ryan et al 2002). Secondly, Joan Wolf argues that the evidence “is not nearly as compelling as various advocates insist” (2011:16). Upon examination of the scientific evidence for the superiority of breastfeeding, Wolf argues that “epidemiological research does not demonstrate persuasively that breast milk is medically superior to formula for babies in the developed world” (2011:16). Wolf finds that aside from reducing the risk of GI infections, other health benefits are plagued with uncertainty and confounding variables, and though this is common for any research in the case of breastfeeding research the more carefully studies control for bias and confounding variables the less significant the benefit of breastfeeding becomes. Wolf does not suggest that breastfeeding is not advantageous in some ways, rather highlights that the recommendation to breastfeed has been largely unchallenged and many of the health benefits may be attributed to behaviors surrounding breastfeeding (Wolf 2011). While breastfeeding is promoted as optimal, anything less than exclusive breastfeeding for the first six months is painted as damaging in the extreme practice of intensive mothering or scientific mothering. Therefore faulting women who do not breastfeed, or engage in mixed feeding, is less a problematic than breastfeed advocates would allow. Exclusive breastfeeding may not represent “natural” or “traditional” practices, rather is representative of contemporary incarnations of “intensive mothering” and representative of neoliberal discourses favoring personal responsibility. Breastfeeding becomes “moral stories, cautionary tales about maternal bodies, good or bad mothers” (Blum 1999, 2).

Characterizing exclusive breastfeeding as a “natural” or “traditional” practice is also problematic (Blum 1999; Ladd-Taylor and Chiminsky 1998). Challenging the assumption that
exclusive breastfeeding for the first six months of life represents the “natural” or traditional mode of infant feeding, Obermeyer and Castle (1996) argue that many cultures maintain a degree of uncertainty about breast milk and that exclusive breastfeeding does not represent a “natural” pattern. For example, Alyson Young describes the uncertainty Datoga women in western Tanzania feel about exclusive breastfeeding during bouts of infant illness, undermining their claims to “being a good mother” for undermining biomedical standards (Young 2012).

Obermeyer and Castle (1996) observe that the cultural meaning of breastfeeding is tied to many aspects of the social structure and is often reflective of social forces challenging a mother’s role as observed among rural women in Haiti (Farmer 1988), impoverished women in Brazil, (Rudzik 2012; Scheper-Hughes 1992) and Bolivia (Tapias 2006). Whereas breastfeeding is often framed as being inherently easy, natural and symbolic of social experience for “Others,” breastfeeding is framed as mechanically challenging for women living in the United States on a personal level such as being diagnosed with insufficient milk syndrome (Obermeyer and Castle 1996) and a lack of confidence in a mother’s ability to breastfeed (Adair et al. 1993; Flower et al. 2008; Kelleher 2006; Kosmala-Anderson and Wallace 2006; Sellen and Smay 2001). This dichotomy reinforces assumptions made in the early twentieth century that breastfeeding is experienced differently by women in different circumstances, where upper and middle-class women necessitated technological and medical intervention and lower-class women did not as they were “closer to nature.” In this inception, immigrant and refugee women, as women from developing countries, are assumed to be “closer to nature” in contrast to their American counterparts, leading to the often assumed “don’t they just know how to breastfeed?”

As discussed in chapter 1, breastfeeding researchers do recognize that there are differences in breastfeeding practices among women, often based on their socio-economic background.
Within high income countries, such as the United States and Canada, there are variations in breastfeeding practices and immigrants generally reporting higher rates of breastfeeding (Celi et al. 2005; Freeman and Trombley 2005; Groleau, Souliere and Kirmayer 2006). However, there is increasing evidence that with each year immigrant mothers reside in a host country the duration of breastfeeding decreases (Schmied et al. 2012). In a recent review of immigrant and refugee women’s breastfeeding experiences, researchers identified several factors or barriers that lead to breastfeeding cessation that could be classified as “cultural practices” including lack of access to traditional postpartum practices, tensions with family members and clashes between individual beliefs and dominant host country practices (Schmied et al. 2012). The few studies that have examined breastfeeding behaviors among refugees specifically also identify barriers. In an exploratory study, Cynthia Reeves Tuttle and Kathryn Dewey (1994) designed an intervention to overcome barriers to breastfeeding initiation among Hmong refugees in California and identified barriers to breastfeeding such as introducing formula in hospitals, separating the infant from the mother after birth, easy access to formula through WIC, perceptions that formula feeding is preferred in the United States, and perceptions that formula feeding is healthier and more convenient. In a follow up study Reeves, Tuttle and Dewey (1995) found that targeting these barriers through prenatal classes led to greater breastfeeding initiation. Similarly in an exploratory study of breastfeeding among Cambodian refugees in Chicago, Becky Straub, Cathy Melvin, and Miriam Labbok (2008) examined cultural reasons for introducing formula and concluded that a combination of structural and social barriers prevented exclusive breastfeeding such the introduction of formula by a nurse or doctor in the hospital, perceptions of a low milk supply, and the need to return to work. These studies indicate that the reasons refugees do not breastfeed could be the result of structural barriers and changing perceptions of breastfeeding.
once in the United States. Differences in rates of breastfeeding are predominantly attributed to difficulties or barriers rooted in health promotion, health care, or health literacy or cultural differences (Schmeid et al. 2012). These practices are not framed as their experiences as subjects and agents seeking to define themselves (or not) as good citizen/subject-mothers. As we have seen from the experiences of Mary and Salma, breastfeeding practices draw on individual understandings of breastfeeding and infant health, as well their understandings of good mothering in the United States.

3.4 The Pregnancy Support Group

The Pregnancy Support group was started in 2010 to address the needs of pregnant refugee women in the United States by increasing their maternal health literacy. Recognizing that scholarship on the pregnancy-related health needs and health outcomes of resettled refugees in the United States is limited and that few health promotions existed targeting pregnant refugee women, Evelyn, the assistant director of refugee health programs that originated the group responded to her own observation that “there are just so many pregnant refugees!” Reviewing the literature on maternal health interventions among refugee women Evelyn found little information. Most information regarding the health of refugees points to a lack of English and “low health literacy,” defined as one’s ability to gain access to, understand, and employ information to promote and gain good health, as the root of most problems (Merry, Gagon, Kalim, & Bouris, 2011; Nutbeam, 2006). Despite her initial incredulity at the lack of breastfeeding among resettled refugee mothers, when researching the pregnancy support group Evelyn gathered information that identified low health literacy among expectant mothers leading to less breastfeeding, depression, and less knowledge about the effects of smoking on the baby
(Arnold et al., 2001; Bennett, Culhane, McCollum, Mathew, & Eho, 2007; Kaufman, Skipper, Small, Terry, & McGrew, 2001).

In addition to a language barrier and low health literacy, Evelyn also cited cultural factors as making it difficult for new refugees to navigate the health system. “It’s hard,” she explained to me, “most of the time when they are at the clinic, they don’t really understand what they are being told. Sometimes they are being scolded but they don’t know why. Everything is just foreign to them.” Working in close contact with the health clinics the majority of refugees attended, Refugee Health Programs was often in the position of addressing problems identified by the clinic, by other agencies, or by the community health workers. Their observations confirmed what other studies on immigrants and refugees have found, that a lack of English and low health literacy, combined with different cultural beliefs led to difficulties for pregnant refugee women (Allen, Matthew, & Boland, 2004; Kandula, Kersey, & Lurie, 2004).

While there were programs in place to teach refugees English, Refugee Health Programs was in the position to address health based needs. Recognizing low maternal health literacy among refugees and cultural differences, they employed the “cultural-barriers-to-health” paradigm as described by Parin Dossa (2002). Though Dossa, and later Marina Morrow (2008) and colleagues, apply this paradigm to mental health, the paradigm is used as a lens to a broad range of immigrant health needs. The paradigm assumes that immigrant women face barriers to achieving well-being and health care and that the root of these barriers is cultural. This “barriers” approach aims to remove barriers such as low health literacy, lack of English speaking and different cultural beliefs in order to improve health and health. Inherent in the cultural-barriers-to-health approach is the assumption that assimilating to dominant American behaviors and values will lead to desired outcomes. Not speaking English and either not being knowledgeable
about Western perspectives on health are considered to be “cultural” within this model (Dossa 2002). Evelyn also cited poor nutrition as a “cultural” barrier “Nutrition is a big one,” Evelyn explained. “I mean after having such a restricted diet for so long (in the refugee camps) it’s hard to say, no wait you have to eat healthy! And then there’s all the American food and fast food. Not good when you’re pregnant.” While poor nutrition was a major “barrier,” lack of knowledge overall was described as more problematic. “In general they just don’t know about their bodies, like basic biology. You know? They were just never given the opportunity to learn.” Factors that are not considered central to this model are socio-economic factors and that immigrants have their own perspectives and agency (Dossa 2002).

In addition to improving maternal health literacy, an additional overarching goal of the pregnancy group was to decrease social isolation. “It is so hard for refugees to get out of the house and then throw pregnancy on top of it! They can be so alone and isolated” Evelyn explained. A few studies point to the positive influence social support can have on health and well-being during resettlement (Ahearn, 2000; Beiser, 1999; Creese, Dyck, McLaren, 1999; Marmot & Syme, 1976; Menjivar, 2000; Simich, Beiser, & Mawani, 2003) and anecdotally, isolation and depression among refugees were a continuous point of concern among the community health workers. Social support is also recognized as being important among pregnant women, leading to better labor outcomes, lower postpartum depression, higher birth weight and overall better maternal health (Collins, 1993; Elsenbruch et al., 2006; Feldman, Dunkel-Schetter, Sadman, & Wadhwa, 2000; Gjerdingen, Froberg, Fontaine, 1991; Oakley, Rajan, & Grant, 1990; Raymond, 2009; Webster et al. 2000). As Evelyn explained to me, “The main goal is to get them out of the house. And hey, if they can walk away with some good information, even better.”
Breastfeeding promotion was not an overarching goal of the pregnancy group in its initial inception. Having no children herself, Evelyn responded with what I came to find was the typical response of “don’t they already know how to breastfeed?” Happy to learn that the Pregnancy Support Group would continue in her absence, Evelyn shared her perspectives on what was successful about the group. “The most popular days were definitely the field trips, to the hospital and to the children’s museum. Both times, they were all like, whoa! Everything was so new and foreign to them.” In addition to the field trips the curriculum included prenatal yoga, tips of baby safety and hygiene, information about pelvic health and mental health, three sessions on nutrition, a session on child development, a demonstration on CPR and choking, a cooking class, and an arts and crafts day. Evelyn also explained that although some sessions were better attended than others the most popular aspect of the group was knitting. “Man, everyone came for the knitting!” Evelyn strongly recommended a strong crafts-based element to encourage the participants to attend the group, otherwise, “if it is just for the information, they are just a lot a less likely to come.”

3.4.1 Incorporating Scientific Mothering, Breastfeeding, and Parenting

As described in Chapter one, though my intention was to become involved with the group for the purposes of recruitment rather than outright health promotion, the Evelyn’s departure put me in the position to implement any model I desired. Knowing that a “barriers-approach” dominates in research focusing on immigrant and refugee women’s breastfeeding experiences and that barriers are often framed in terms of cultural difference, I sought to implement a different model. Reflecting my own values as a middle-class American mother of a breastfeeding
baby, I drew on a recent model that incorporates self-reliance and personal responsibility to design the curriculum for the 2012-2013 year.

Centering Pregnancy is a model of prenatal care designed by nurse-midwife Sharon Schindler Rising to “empower the pregnant woman and her support persons (Reid 2007:2). The Centering Pregnancy model unifies health assessment, education and support to reframe the power relationship between the provider and the patient and encourage women to “take responsibility for their own health” (Rising 1998). In the model, women are recruited in the group between 12 and 16 weeks gestation so that they are all at a similar stage in their pregnancy. After joining she will attend 10, 2 hour sessions that run between 90 and 120 minutes. Partners are also encouraged to join and attend. At each session, the woman assesses her own health as part of the group and can meet privately with a clinician if she has questions. The participants are given a health assessment sheet to complete that corresponds to the educational topic of the session. In order to encourage group education and participation, between 8-12 participants are recommended. It is also recommended that education take place in a circle with the group leader assuming a facilitative presentation style rather than a lecture-style. The group education style is intended to stimulate peer support as well.

Though there are numerous strengths to model I would be unable to implement all of the necessary components. For example, health assessment is a large component of the model that would not play a role in the pregnancy support group. In the Centering Pregnancy Model, women are participants in their own health assessment by weighing themselves, taking their own blood pressure, and charting their own data in cooperation with their provider, ideally their nurse-midwife. Though the majority of the participants attended the same clinic, all had different providers and planned to deliver in different hospitals. I was also warned that attendance would
not be regular and some attendees may not be pregnant, they may attend just for “free stuff.” Therefore assembling a cohort of women of similar gestational age would exclude a majority of the women who wished to attend. In addition, the group was only held once a year and allowed for continuous attendance to include women as they arrived in the United States and as they discovered their pregnancies.

Unable to include many of the components of the model, I incorporated other elements of the model. I drew heavily on the education and support components. Empowerment and social support were also primary objectives of the group. Empowerment has been defined as a process that leads to transformation which enables people to gain elements of power and control over their lives (Falk-Rafael 2001) and is considered a strength of the Centering Approach. Social support is also well documented to have positive outcomes on pregnancy (Logsdon and Davis 2003) and social isolation is a widespread problem within refugee resettlement (Ahearn 2000; MacLeod and Shin 1990; Polutnik 2012; Schwarzer, Jerusalem, and Hahn 1994). I encouraged a facilitative style of interaction, conducted the group in a circle, had an educational topic for each session, made socialization a part of each group, provided a healthy snack, and encouraged self-care and self-assessment at home. With enough funding to implement 16 sessions, I had would be able to include a variety of topics. I also incorporated “topic experts” for each session in order to frame each topic to reflect the latest knowledge and to position myself as a peer and facilitator, rather than an authority figure, as much as possible. Topics included: what to expect during pregnancy, how to prepare for baby, breastfeeding, four sessions on nutrition, mental health, pelvic health, domestic violence, infant first aid, CPR, and field trips to visit labor and delivery wards and the Chicago Children’s Museum (see Appendix A). These topic experts included, a
lactation consultant, dietitian, mental health counselor, CPR instructor, and importantly a nurse-midwife.

As “middling modernizers,” the influence of the topic experts and their own perspectives and values would influence how the values and practices of good citizen/subject mothers would be framed. As experts practicing in their fields, all of the presenters would incorporate the latest in scientific research and knowledge about mothering. While some were very strict in their prescriptions others were more open, but all had firm notions of proper mothering practices. All stressed the importance of self-reliance and personal responsibility. The perceptions of the presenters and the addition of a parenting group would influence how the refugee mothers understood the paradigm of scientific mothering, what it takes to be a good citizen/subject mother and breastfeeding in the United States.

While the numerous presenters influenced the group, two participants in the group had the most influence. One was a nurse-midwife who presented several sessions in the 2012-2013 year and the majority of the sessions in the 2013-2014 year. As a nurse-midwife, Laura was well-versed in all aspects of pregnancy. In her late 50s she had been practicing for 30 years and “had seen just about everything.” Attracted by the “back to nature” ethos of the “back to breast” movement of the 1970s, Laura advocated a “natural” or non-interventionist approach to pregnancy and birth. Far from the “hippies” commonly associated with the back to breast movement, Laura was described by a friend and colleague as “more of a Mary Kay-type.” She had flaming red hair and often wore bright make-up, like purple eye shadow and pink lipstick. She had a positive and bubbly personality. She was also the mother of three and used her own mothering as a constant reference point. I proved to be another influential presence in the group, both because I was present at all the sessions and perhaps more importantly because my toddler
son always accompanied me, often strapped to my chest or back sleeping. Unlike the other presenters, Laura and I were the only ones who emphasized our own motherhood in the context of the discussions and relationships with the participants in the group. This fact defined our relationships with them, how they viewed mothers in the United States, how they responded to the information presented and how they viewed scientific motherhood.

Though the session began at 10 a.m. the first participant did not typically arrive until 10:05. They would trickle in for the next hour, greeting their friends as they arrived. A relatively empty room soon filled with the heated bodies of 25-30 women and so less than six or seven children. The sessions were held in the basement of a church which donated the room free of charge to the group. The room was the church library and had one small window. Though the room was relatively large the aged oversized furniture, worn through in some corners with the stuffing popping out, made the room feel cramped. The participants would grab their own folding chair and form a circle, being sure to sit with a familiar face and catch up on the latest gossip while the children played in the center of the circle. The sessions usually got started around 10:15 and Chimi and Marilyn would try to quiet the group. Depending on the attendees, I would also interpret the discussion into French or Swahili as necessary. The discussions were vibrant, with questions constantly interrupting the presentation of the topic.

“What if my baby is not getting enough milk?” a Congolese participant shouted out during the session on breastfeeding. She was rocking her sleeping newborn in a car seat. Though I had been interpreting the session in French she shouted out her question English. Laura was holding up a diagram the anatomy of a breast and describing how the milk ducts are stimulated to feel like the milk is “coming down” or “coming in” following delivery. “Ah yes, my baby is also not
getting enough milk. She is always hungry!” another participant shouted out. This was followed by a cacophony of 25 women each relaying their own lack of milk.

“Quiet, quiet!” Chimi yelled over the crowd. “Let us ask Laura”

All eyes rested on Laura who proceeded to ask “How do you know your baby is not getting enough milk?”

“Because he is always crying, even after I feed him. He is always hungry!” The mother responded.

“Well, he could be crying for many reasons. A wet diaper, he might be tired, he might need to burp…

“No, no!” the mother interrupted. “He is going like this” as she made a motion of mouthing and sticking her tongue out. “He is hungry!. I feed him but won’t stay on!” she continued with an exasperated tone.

“All the time?” Laura asked.

“Not all the time. Mostly at night.” This response was followed by murmurs of agreement from the crowd.

“Yes, it is always at night,” Chimi chimed in.

“How old is your baby?” Laura asked.

“Six weeks” the mother replied.

“Oh, some of the hardest times,” Laura continued with a sympathetic tone. She then continued to reassure her that as the baby grew he would be able to eat more and sleep more at a time. She described the time known as “the witching hour,” the late afternoon when babies become voraciously hungry and irritable before going to sleep for the night. Laura explained how important it was to breastfeed through these bouts of irritability because the constant
breastfeeding would stimulate more milk production which the baby needed. Laura assured them that these times would come and go as the baby grew and experienced growth spurts. She also referred to a handout she had passed out earlier in the class that showed the different types of discharge one could expect with a new baby. On the back of the handout was a chart where you could chart the number of wet and soiled diapers the baby produced each day. Laura asked if the baby was making the minimum of three soiled diapers a day and seven wet diapers. The mother replied that the baby was. Laura reassured her that her baby was fine and to keep breastfeeding him. If she continued to worry, Laura suggested tracking the number of wet and soiled diapers and if the baby stopped making enough diapers to call the doctor.

“I know how worrisome it can be” Laura continued. “Going to formula is easy, you can always make a bottle and the baby might sleep better. But then you miss out on all the good stuff you can get from breastfeeding.” Laura recounted the benefits to breastfeeding she had discussed earlier in the session. “Fewer ear infections, better health for the baby, less sickness for the baby, the baby will get all of your good antibodies to protect him, it will be better for you, and you and the baby can have that closeness.” This was followed by murmurs of agreement in the crowd that “breastfeeding is good,” and “less sickness for the baby is worth not sleeping” and “my baby never had an ear infection until I gave him formula.”

Though the Congolese mother stopped asking questions she looked discontented. After the session I asked her how things were going with the new baby. “Ah, he won’t sleep!” she said with a frustrated tone. “And you?” she asked. “Did you give him formula?” she asked motioning to my son, who was 18 months at the time. I replied that I did not but that he did not sleep as a newborn either. I replied that I kept breastfeeding and that it got better around 3 months of age. She left and did not return to the group but I met her later that year in a yoga class for refugees.
When I asked about her baby she said that he did start sleeping, but only because she started giving him formula as well as breast milk. When I said that I missed her at the group she replied that she had gone back to work and could no longer come in the mornings.

The experience of the Congolese mother would be repeated over and over in the group as participants had their babies. Though the topics changed from session to session, questions about breastfeeding were raised at each session and were often about how to be certain that the baby was getting enough nourishment, usually from a mother who had just returned to the group from giving birth. Frequently waking at night, crying or being fussy were cited as telltale signs that the baby was likely hungry. I responded the same way each time, to track the number of wet and soiled diapers, keep breastfeeding if they suspected the baby was still hungry and not to expect the baby to sleep through the night for a few months. I would reassure them that I experienced a similar situation with my own baby. They would bring in the charts they filled out, tracking the number of soiled diapers to show me, unsatisfied with it being evidence of the sufficiency of breastfeeding. These continuous questions about breastfeeding and crying I came to realize, though common with many new mothers who are not refugees, are idioms of distress signifying stress from many sources which I will address further in the next chapter.

Half way through the 2012-2013 pregnancy group it was recognized that the number of women who had already had their babies or had older children outnumbered the number of pregnant women in the group. The new associate director of refugee health programs also learned of another social service organization that provided parenting classes geared towards immigrant communities. They agreed to pilot a parenting group for refugees using their own funding and existing curriculum. I was asked to attend the group as well to encourage participants from the pregnancy group to transition to the parenting group.
The parenting group differed from the pregnancy group in several key ways. The first was that while the pregnancy group had a focus on health education, self-care and self-assessment, the parenting group was focused on promoting behavioral norms. The second difference was that the pregnancy group was designed for group learning while the parenting group was more of a traditional presentation style. A third difference was that the presenters did not have children of their own, therefore did not present themselves as mothers or draw on experiential knowledge.

Though the meetings were held in the same church, the parenting group secured a room on the top floor of the church, a large auditorium. The large empty room, echoed with the footsteps and hushed chattering of the large group, often 20-25 people. At the first meeting of the group, the mothers sat quietly, not knowing what to expect. One of the presenters, Eliza, came out and put on a large floppy sun hat.

“When I wear this hat I am going to play a Mom” she explained. She picked up a baby doll she brought. The other presenter, Cindy, started saying “wah, wah, wah!”

“I will playing the baby,” Cindy explained. “Wah, wah, wah.”

Eliza proceeded to play act with her baby. She put her baby on a folding chair explaining that it was a crib. She sat on a folding chair next to it, crossed her legs and pretended to hold a TV remote and flip through the channels, occasionally looking at the baby with an annoyed look when Cindy would chime in with “wah wah wah!” Then she pretended to accept a phone call on her cell phone and arrange to go out with a friend later that night to dance at a club. Throughout the 3 minute sketch then baby continued to cry. At the end of the sketch Eliza said to her friend on the phone, “Hold on, this baby just won’t stop crying!”

Eliza then took her floppy hat off to signal that she was no longer pretending to be the Mom in the sketch. “Ok, let’s talk about what just happened in this sketch.” The room was silent.
Looking around the room the mothers all had confused looks on their faces. “Can anyone tell me what happened in this example?” Eliza continued.

After a long silence, Bhakti, a Bhutanese mother raised her hand. “This mother does not love her baby!”

“Mmm hmm, what makes you think so?” Eliza asked, nodding her head.

“Well, the baby is crying and she won’t pick her up. She won’t comfort her. She is only concerned about herself!”

Eliza continued about the importance of showing love to your baby and comforting the baby when crying. Each session of the parenting group began in this way, with a sketch demonstrating the “wrong” or improper behavior based on current dominant norms in American society. Other topics addressed included the importance of staying home with your baby instead of hanging out with your friends, the importance of playing with your baby, reading to your baby, feeding your baby nutritious food, etc. Each session ended by making a toy for the baby to encourage the mother to play with their babies. The parenting group was well attended, which was taken as a confirmation that the group was valued by the refugees and the information provided from the group was valued. The parenting group was a popular topic of discussion among the refugee mothers, often looking to me to explain what they experienced in the group.

“Is this why American mothers don’t love their babies? They would rather go out to clubs than stay home and take care of them?” a Bhutanese mother of two asked me.

“Is this why American children are always crying? Don’t mothers know how to comfort their children here?” asked a Burmese mother of three with a concerned look on her face.
“It is because American women don’t breastfeed their babies,” another Burmese mother explained to me. “If they breastfed their babies more the babies would not cry as much and the mothers would not want to go out and leave them as much.”

The parenting group and the pregnancy support group both operated as “technologies of governance” by presenting the most current information about mothering based on scientific research and in response to cultural norms. Both groups are well-intentioned and seek to enhance the lives of refugee mothers as they settle into their new lives in the United States. Both groups are also popular among refugee mothers. However, both groups constitute a platform from which individual and social bodies can be surveilled, regulated, and constituted as biopolitical subjects of the state. Firmly promoting the tenants of scientific motherhood, the groups promote normative attitudes and the reliance on medical authority and knowledge in all aspects of pregnancy, birth, infant feeding and childrearing. The “middling modernizers” reinforce the neoliberal market-oriented values of self-sufficiency, self-improvement, and personal responsibility as essential components of scientific motherhood in order to help refugee mothers transition from the assumed practice of raising children based on common sense and socially passed knowledge. They also provide a platform for the dissemination of “culturalist racism,” where mothers attending the groups are assumed to be in need of knowledge and education in order to adopt the “correct practices.” In the instance described above, where Eliza and Cindy play-acted how to not ignore your baby, they demonstrated their assumption that mothers (non-white, non-middle class mothers) would ignore their crying baby due to cultural reasons. Within this environment the white, middle class experience of motherhood exemplifies the idealized citizen/subject-mother, educated enough to understand and follow scientific mothering advice and wealthy enough to afford it. By presenting aspects of mothering as the latest in scientific and
medical knowledge, mothers are expected put their children’s needs first and provide labor- an
emotion-intensive care to optimize their child’s well-being. This representation of scientific
motherhood redefines the personal responsibility so that women as mothers make the “right
choices” for their babies- to breastfeed.

Rather than responding as docile subjects to the prescriptions of scientific motherhood
presented in the pregnancy and parenting groups, the refugee mothers viewed the practices of the
idealized citizen/subject-mother as representing the typical American mother. Combined with
their personal experiences with American mothers, the predominant view of American mothers
was that they did not love their babies, or at least did not love their babies as much as they
personally did. As such, the tenants of scientific motherhood—emphasis on personal
responsibility and making choices based in scientific discourse rather than social knowledge—
framed the practices of American mothers as being cold and calculated rather than based on love.
Refugee mothers recognized that despite the emphasis on breastfeeding, most American mothers
do not breastfeed, or at least do not breastfeed in public or for more than a few months. This
stereotype in turn created a set of assumptions that the refugees attributed to an unchanging
cultural attribute of American mothers. This contradiction—that American mothers know that
breastfeeding is superior but overwhelmingly do not do it—indicates to refugees that American
mothers do not love their babies and do not want to do the best they can for them. The notion
that American mothers just do not love their babies as much as non-American mothers is a
suspicion and enactment of “culturalist racism” that many refugee mothers had prior to attending
the groups. Bhakti, a Bhutanese mother of two recalled a time when she was working as a
housekeeper in a hotel in downtown Chicago and discovered that putting a baby’s crib in a
bathroom was commonplace for the patrons of the hotel.
“I was working in the hotel and I saw a lady with a baby only 6 or 7 months. She was putting the crib in the bathroom! Can you imagine? This type of crib was provided, I was ‘why are you keeping this crib inside the bathroom? You don’t need it for tonight?’ I was very innocent. She said ‘no, it’s for the baby, because my baby sleeps in the crib at night in the bathroom.’ And I thought, ‘oh my god, why did I ask this question! This lady put her child in the bathroom and the bathroom was right by the main door! Keeping their baby the whole night in the bathroom which was right by the door! I was thinking all children they don’t want to stay with their families after 18 years, that is right. How are they loving towards their child? I ask my husband when I got home, this is the custom? He has been working there 5 years and he says yes! This is the custom. He is usually the one who puts the crib inside the bathroom for the babies. Everybody they do that! I feel so pitiable. I look at the baby and think, maybe you didn’t get the right parent. Their bedroom is far from the baby. Even if their baby cries they cannot hear. These suites have 2 bedrooms and 2 bathrooms and the bathroom is all the way by the corner by the door. I don’t like that. It makes me sad. And they leave me $10 tips and think, I don’t want to take it. Just keep your baby with you. At least keep it in your room. Inside the bathroom, the bathroom is nasty. They have the space. They don’t want to hear the baby’s cry at night.”

The contradiction of the emphasis on breastfeeding but lack of practice among American mothers lead refugee mothers to be critical and suspicious of scientific mothering as a practice. The emphasis on personal responsibility and individualism also led many refugee mothers, like Bhakti, to identify this approach to mothering as being the root of other social ills they witness in the United States, such as children not caring or listening to their parents and parents treating their children poorly. Rather than fully embracing or rejecting the paradigm of scientific
mothering, refugee mothers became adept at selectively incorporating aspects of scientific mothering in order to support the type of mother they wished to become. The degree to which they embraced aspects of scientific mothering mirrored the way they imagined their new role in the United States as a citizen-subject. Often framed as a reaching “development,” being personally responsible by internalizing good and responsible choices led some refugee mothers to define their mothering through the selective adoption of medical advice and self-education. Other refugee mothers remained more critical and dismissive of scientific mothering, preferring to trust their own practices and rely on socially generated knowledge to define their mothering practices.

The degree to which mothers chose to selectively incorporate scientific mothering discourse mirrored the degree to which they envisioned resettlement in the United States as concluding their path to “development,” and demonstrates that rather than acting as a totalizing discourse, development is constructed and reconstructed by the subjects themselves. How each refugee mother responds to the paradigm of scientific motherhood as a form of “benevolent assimilation” as a continuation of the process of development reflects extent to which each mother engages in the dance of being-making to define themselves (or not) as citizen/subject-mothers. How they conceptualized their role as citizen/subject-mothers influenced their breastfeeding decisions. Their responses to scientific mothering and “breast is best” breastfeeding discourse varied along a continuum with some refugees, like Salma, embracing many aspects of scientific mothering in their efforts to define themselves as good citizen-subject mothers and others, like Mary, relying on their own experiences and knowledge. In the next chapter I will examine the early postnatal period, recognized as a time of redefining the self and making breastfeeding central to how a women develops herself as a “good mother” (Hartrick
1997; Larsen et al. 2008; Maclean 1990; Marshall et al. 2007; Mercer 1995; McVeigh and Smith 2000; Nelson 2006; Schmied and Lupton 2001; Sheehan 2006). Focusing on the first three months, I will introduce the stories of refugee mothers as they give birth, initiate breastfeeding, and make decisions about breastfeeding and mothering as they seek to decide what kind of mothers and subjects they strive to be; good citizen-subjects who make the “right” choices or subjects who continue to frustrate middling modernizers like Chimi and Marilyn, making choices that continue their reliance on systems of economic and social support.
Isabelle and Cecile entered the room where the pregnancy group was being held and cautiously walked to the back of the room. They held hands tightly and sat down gingerly, looking around at the numerous Bhutanese and Burmese women, some in saris, some in colorful pants and shirts with bright scarves draped around them, some wearing hijab, others not, but all with bulging bellies. Marilyn and Chimi were speaking loudly over the commotion of four languages competing for airspace. Isabelle and Cecile provided a stark contrast with their skinny legs and bellies, tight jeans, weathered shirts, and their hair wrapped in African printed fabric.

They looked as though they could have been sisters, though what they shared went beyond physical appearance. They both fled the Democratic Republic of Congo when they were in their early teens with their families and after several refugee camps traveled to South Africa where they attended school and worked afterwards. South Africa is where they met each other and met their husbands. They married their husbands only a few months apart and discovered that they were pregnant only two weeks apart. They also received the news a month later that ten years after applying for resettlement, their families had been selected. They were given five days to make the difficult of choice of immigrating to the United States with their families or remaining in South Africa with their husbands and the fathers of their unborn babies. If they chose to stay they would likely forfeit any opportunity to resettle in a third country where, unlike in South Africa, they could hope for citizenship and an end to traveling as a refugee from country to country. If they chose to leave they would have to leave their husbands behind with no certainty of being able to live in the same country again, as their husbands were not included on the resettlement application made ten years prior by their parents. They were assured that they
could apply for a family reunification and had hopes that they process could be completed before the babies were born. The process of reunification would prove to be a longer and more difficult task than they anticipated. Although the similarities in their experiences were striking, their journeys after resettlement would take different paths.

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The paths Isabelle and Cecile followed in the effort to define themselves as “good mothers” entailed making the “right choices” for themselves and their babies. As we will see, they made different choices in regards to breastfeeding. Both attended the pregnancy group regularly and listened attentively. While both embraced the notions of discipline and personal responsibility in pregnancy and infant feeding advocated by scientific motherhood, they had differing ideas about what optimizing their child’s life entailed. While they both upheld the notion that the “breast is best,” they also faced the “Machiavellian plot” that in order to become financially independent it would be difficult to exclusively breastfeed for the recommended six months. The ways that Isabelle and Cecile interpreted scientific mothering discourse, including breastfeeding discourse, mirrored how they envisioned their resettlement in the United States as completing their path to development. They ways that they imagined their role as citizen/subject-mothers and the ways that they defined what a “good mother” is both strongly influenced and were influenced by their experiences breastfeeding in the first three months.

The early postnatal period is recognized as a time of redefining the self, which positions breastfeeding as central to how a women develops herself as a “good mother” (Hartrick 1997; Larsen et al. 2008; Maclean 1990; Marshall et al. 2007; Mercer 1995; McVeigh and Smith 2000; Nelson 2006; Schmied and Lupton 2001; Sheehan 2006). In this chapter, I will focusing on the first three months as refugee mothers give birth, initiate breastfeeding, and make decisions about
breastfeeding and mothering as they seek to decide what kind of mothers and subjects they strive to be. In these stories, I will examine how rather than fully embracing or rejecting the paradigm of scientific mothering, refugee mothers selectively incorporate and give meaning to aspects of scientific mothering, personal responsibility and self-sufficiency. The meaning each mother attributes to her responsibility to herself, her child and her breastfeeding relationship are firmly entrenched in the context of particular power relations. While all refugee mothers critically and selectively incorporate aspects of scientific mothering to a degree, the degree to which they favor medical authority in child rearing exists along a continuum. In one extreme, some refugee mothers embrace scientific and medical advice to evaluate their breastfeeding practices and in the other extreme, they follow their own intuition and experience, contradicting medical advice. The choices they make in their early breastfeeding relationships positions breastfeeding as a meaning-making practice in which mothers embody the type of mother they wish to become.

In this chapter, I will introduce the stories of five refugee mothers as they give birth, initiate and establish breastfeeding in the first three months. All mothers will struggle with breastfeeding and all will introduce formula at some point. In these struggles we will see how breastfeeding, especially difficulty breastfeeding, is a meaning-making practice that shapes how we see, interpret and treat the body within relations of power. I will also discuss how breastfeeding, its presence or absence, is a defining aspect of embodied mothering. Finally, I will discuss how breastfeeding stories become moral stories mothers tell themselves as they struggle to place their choices and practices in a larger context. I will continue the stories of Isabelle and Cecile. Next, I will review the concept of embodiment to position breastfeeding as an aspect of embodied mothering within the context of scientific mothering. I will conclude with the stories of Jala and Mahnin, two refugee mothers who contradicted medical advice to make decisions
about what was best for their babies. But first I will introduce Bhakti, a Bhutanese mother who had just given birth to her second child.

4.1 Bhakti

The first thing you notice about Bhakti is her determination. She exudes a confidence that borders on intimidation, without seeming overbearing. At 29 years old and having lived in the United States for almost four years, Bhakti felt comfortable living in the United States. She and her husband had been economically self-sufficient for most of that time she relayed to me proudly. Only four weeks after giving birth to her second child, Bhakti was already feeling the financial pressure to return to work.

“Two is enough!” Bhakti proclaimed with exasperation. “How can anyone have more than two! Even if I wanted more than two, the expense, the clothes, the shoes, the food, and school! How can anyone afford to have more?”

Bhakti’s certainty was surprising considering that her youngest was merely four weeks old. But she was certain enough that she had arranged for a tubal ligation during the c-section for the birth of her second child, a son. Money and the high cost of living in the United States justified her certainty. “Already I cannot wait to return to work. Diapers, oh, so expensive! How we are supposed to have enough with just one income I do not know. I think I am spending $40 a week!”

When asked how breastfeeding was going Bhakti replied “Still no milk, just like before. I am pumping and pumping and nothing. Not even two ounces! Ah! But with working he will need formula anyway. I am trying so we will see.” Bhakti was disappointed that as with her first son, she was not producing milk to her satisfaction. Both of her children were born via c-
section and with both she felt had not produced enough milk and began supplementing with formula shortly after birth so that the children would still “be healthy.” Based on her experience with her first son she had expected to have difficulties producing milk with her second and her expectations proved to be true.

Though it had only been four weeks since she had given birth, Bhakti was focused on returning to work. She had worked as a teacher in Bhutan and although her husband was currently employed full-time, she was also eager to supplement the family income. She also expressed her desire to work, as she had never envisioned herself as a housewife or mother who stayed at home all day. This was partly due to the fact that her mother-in-law lived with them, as was common for many Bhutanese families. The presence of her mother-in-law negated concerns over the cost of childcare and offered Bhakti the option to “enjoy a little freedom.” Having worked as a hotel maid prior to her second pregnancy, Bhakti was eager to return to work and explore her options for future employment.

“$14 per hour!” she told me. “The work could be difficult but it was good money! I would like to return to being a teacher or working in an office. If I can save enough money I can do that.”

Eager to take on the role of a working mother in a two parent and two income household, Bhakti embraced the role of the citizen/subject who was eager to fit into the neoliberal landscape of the United States. She had high aspirations for her children, whom she envisioned as becoming doctors or lawyers. Aware that college educations were costly and eager to move into a larger apartment, Bhakti strove to embody the role of the citizen/subject-mother so that her children could accomplish the goals she envisioned for them. This not only included working to
contribute to the family’s income and limiting their family size, but also included incorporating many aspects of scientific mothering, including in her approach to breastfeeding.

Like all the mothers I interviewed, Bhakti valued breastfeeding and was eager to breastfeed both of her children. She recited the numerous benefits to breastfeeding as contributing to her desire to breastfeed such as “fewer ear infections, better immunity, better intelligence.” After arriving in the United States in 2008, Bhakti and her husband were eager to start a family but cost was a concern from the very beginning. “I was thinking of having babies soon, but I didn’t know. How can I make it? How can I afford it?” As a consequence Bhakti worked until the end of her first pregnancy, which she described as a difficult one. She was two weeks overdue and labored for 36 hours ending in a c-section. She felt prepared for the labor and delivery, as she had attended the pregnancy support group during her first pregnancy, but was unprepared for the challenges of breastfeeding. Namely that following her c-section, she experienced complications which inhibited her ability to breastfeed. She recalled, “I couldn’t even breath. They did a CT scanning and found fluid in my lungs. They gave me 100 percent oxygen, I could not breath! They also gave me some medications for the fluids and with that medication I could not breastfeed for two days. So after two days he was habituated with that formula. After that he don’t want it! He didn’t suck. He didn’t latch. When I came home I tried a lot. I did not give milk, one whole day and he was crying so bad. He did not latch, he did not want it.”

Determined to breastfeed, Bhakti took the advice of the hospital nurses and began pumping her breast milk in order to bottle feed her baby. In the hospital she was instructed to measure and closely monitor the amount of milk she produced to ensure her son was receiving enough, and to supplement with formula if she was not able to produce enough. Dutifully, Bhakti
followed the nurse’s instructions but found pumping to be very painful and difficult, never able
to pump enough to avoid supplementing with formula. “(With my first baby) I had no idea about
breastfeeding. I pumped for at least 2 months but only got, like, 2 ounces and it was very
painful.”

Upon returning home, Bhakti turned to her mother-in-law for help but found her
knowledge to be limited in the new landscape of the United States. Bhakti’s mother-in-law
prepared a special spicy soup that was supposed to induce milk production. When that failed to
increase her milk, “she had no idea…She says to me, ‘I was able to feed your husband and your
sister in laws. My breasts were full! But yours are not producing milk.’” In Bhutan, Bhakti
describes, “We don’t have formula in my country, all breastfeeding. In my country, if no milk,
right away they would give the cow milk. But here they say one year.” After pumping for two
months, Bhakti did not see her milk supply increase and stopped, expressing guilt over in failure
to breastfeed, saying “Already I am regretting my first one. I am thinking, oh my god, I am bad.
I didn’t do that. Though my baby is healthy ‘til now, but I never know. I don’t know about his
ear infections or what not. I never know.”

Another consequence of Bhakti introducing formula was that her mother-in-law was able
to assume care of Bhakti’s first son, for which Bhakti was grateful. “I didn’t have any idea about
how to care for babies or pregnancy before (my first child). I had some ideas in my home
country but I had no ideas of how to have babies in the US.” Bhakti relinquished much of the
responsibility to her mother-in-law in order to learn how to care for her infant and felt well cared
for. Bhakti’s mother-in-law even began co-sleeping with the baby, instead of Bhakti, so that
Bhakti could sleep through the night as Bhakti was not breastfeeding. But relinquishing those
tasks had unanticipated consequences as well. Namely that now, Bhakti feels her son is closer to
his grandmother than to her, stirring feelings of jealousy and resentment towards their relationship. “She (mother-in-law) did everything for me for my first baby. I did not have to do anything. Still, he wants to be still with his grandmother because he loves his grandma more. More than me.”

Bhakti points to her inability to breastfeed her first child as the root of the division between her and her oldest son, feeling that if she had been able to breastfeed she would have had to care for her son more personally and not relinquish as much responsibility to her mother-in-law. With her second child she was determined to have a different outcome and turned to the pregnancy support group for instruction in scientific mothering. “This time I planned,” she said, “I don’t want to repeat the same experiences.”

Bhakti did not miss a single pregnancy support group meeting, listening intently each time. She was active in preparing for her delivery, importantly opting to look for a different hospital and plan for a repeat c-section to try and avoid a repeat of her first birth experience, saying confidently, “this time, I am ready.” Bhakti was also determined to have a different breastfeeding experience saying a week before her second delivery, “Again I’m gonna try as much as I can because everywhere they say breastfeeding is much healthier than formula.” However she was also wary that she would be able to exclusively breastfeed. “If I have difficulties I have to stop right? If I produce milk, this time I have no idea how it will be, if I will be having the same problem.”

Bhakti described her second birth as smoother than the first, in part because she knew what to expect and felt more in control. “My delivery time in the hospital was better than the first one. The thing is I didn’t stay in labor for many hours like the first one…. I agreed to do c-section and it was better than the first one. I changed hospitals from the first one. Everything was
different, the service was different and I liked it more. The difference was that I went to the hospital at two in the morning, when contractions were five minutes apart. Every five minutes my contractions were going. At nine o’clock they took for the c-section and everything was done within the hour. After, I was not that much tired as before. I was eating good and drinking good. I was not nervous like before. Yes, I knew what to expect. Now I am ok, after ten, fifteen days I was feeling normal but with my first baby I was not.”

Despite having a smoother delivery and no complications from her c-section, Bhakti experienced difficulties breastfeeding again. However this time she found herself disagreeing with the nurses in the hospital on whether to introduce formula.

“From the beginning I did not produce enough milk. A little bit of colostrum but it was not enough for me so I talked to them (at the hospital). At the second day at feeding time I talked to the nurse. ‘I think milk is not coming from the breast. I think it is not coming out because he’s hungry, Maybe he’s not sleeping because of the hungriness.’ And then she said, ‘Are you sure?’ So I said, ‘Let me try with the formula. Do you have formula?’ And then they give it to me. When I gave him once the formula, oh my god! Baby sleeps for three hours and the diaper was wet. Before that, in 24 hours only one wet diaper! Even they didn’t say your baby is not getting enough. They didn’t say! But I said I know it is not enough! Then they said ‘Ok, you can try.’ So I tried it and now the baby is having more wet diapers. I didn’t see even within three days, I didn’t see any poop. And after three days he had poop and was urinating frequently. So I started doing both things, breastfeeding as well as formula.”

Unlike her experience with her first baby when she turned to others for help and advice, Bhakti felt that as an experienced mother she knew the best course to take when caring for her baby. Relying on the information she garnered in the pregnancy support group she watched for
the signs that her baby was in good health following delivery, namely wet and soiled diapers and
signs of being satiated following breastfeeding. Unlike her experience with her first baby, Bhakti
found herself disagreeing with the advice of her nurses. The fact that her nurses failed to show
concern that her baby had not urinated or soiled his diapers in the first 24 hours demonstrated to
Bhakti that she was more informed than the nurses, because of her experience with her first baby.
She pushed to introduce formula, against the advice of her nurses. The fact that following the
introduction of formula her infant ceased crying and produced wet and soiled diapers as she
expected confirmed Bhakti’s confidence that she was the most capable person to make decisions
for her infant. Unlike with her first baby, when she relied on her mother-in-law’s expertise, she
now relies on herself based on her experience and knowledge of the “new technologies” and
information available in the United States. As such, Bhakti kept a careful eye on the amount of
breast milk her infant son was receiving with each feeding by pumping and feeding him with a
bottle. She recognized quickly that she was unable to pump enough milk for each feeding and
mixed her breast milk with formula, leading her to observe that she doesn’t produce enough milk
to feed her baby. She explains how she decided to mix formula and breast milk,

“Breastfeeding…I’m not producing enough milk now. If I pump, just one and a half, not
even two ounces. That’s not enough. I mix, I do breastfeeding first and then formula. He’s
crying and crying so every time breastfeeding, and then formula. Breastfeeding, (then) formula.”

“Do you think he’s still hungry after breastfeeding?” I asked.

“Yes, he uses his mouth action and he goes on crying.”

“When did that start? How many days old when you started doing both?”

“Just after 3 days.”
Confident in her decision to mix breast milk and formula, Bhakti recognized that her baby eats more frequently and gained weight more rapidly than her first baby, which she attributes to the fact that she (not her mother-in-law) is solely responsible for feeding him. “This baby, I have to feed him frequently. My first baby I didn’t have to feed him frequently but this time, every two to three hours he gets up and he wants to eat more. Now he weighs ten and a half pounds now. Yes, he’s growing faster than my first baby.”

Bhakti describes her confidence in her mothering as drawing on both her experience as a mother and her understanding of the new “technologies” available to mothers in the United States, such as breast pumps, electric swings, bassinets, and cribs. Though Bhakti was eager to mother her first baby, her lack of knowledge about scientific mothering and “modern technologies” caused her to allow her mother-in-law to assume the responsibilities of mothering with her first child, including nighttime formula feedings and co-sleeping with the baby. With her second baby, the combination of her access to scientific mothering practices through the pregnancy support group and her experience with her first baby made Bhakti confident to exercise her role as the mother by controlling the baby’s feeding and sleeping arrangements. The ability to measure the amount of breast milk she pumped, formula she prepared and soiled diapers the baby produced offered Bhakti a mechanism for document and validate her mothering practices. “I am the experienced mom I already had a baby. I know how to handle him this time. So it is more easy. But I know, harder than before because I have two babies. But the way of doing things is much more easy than the first baby. I know already I did like this I have to do like this, I know already. We know what to do after that. With my first baby it was my first experience.”
Importantly Bhakti wants her second baby to sleep in a crib rather than co-sleep with her or her mother-in-law, even though she admits that she doesn’t think her baby wants to sleep in a crib. Before the birth of her second child, Bhakti relayed why she was planning to use a crib with her second child. “According to my experience my (first) baby does not want to sleep in a crib. I had a crib but he did not like it. He was crying and uncomfortable. But when we bring him to us he is comfortable. But with my next one I am planning to sleep in the crib. With the big one, if I am sleeping with the baby he might climb in. My doctors said ‘DO NOT SLEEP WITH THE BABY!’ (laughing) But as moms we have to be conscious right? I can do that and my mother-in-law she can do that (co-sleep with her older son). My mother-in-law has three children, and in my home country we did not use the crib.” Despite recognizing that babies seem to sleep more comfortably with parents rather than a crib, Bhakti was determined to follow the advice of her doctors to use a crib, rather than the experience of her mother-in-law, because “according to technology and advice, babies will sleep better and they will not die of smothering or SIDS.”

Despite her determination to use a crib, after eight weeks she continued to co-sleep with her baby citing that she was eager to bond with her baby and that it would be easier to breastfeed at night. Though she upheld that eventually she would transfer her baby to a crib to sleep she was wary of losing the bond with her baby, as she felt she had with her first son. She was also suspicious that the “American way of using a crib” was to blame for her observation that “so many American mothers do not love their babies.” Having observed so many patrons of the hotel where she had worked not only put their babies to sleep in a crib, but then put the crib in the bathroom, Bhakti surmised that separating from the baby at night would diminish the love that existed between the mother and baby. The fact that she observed American mothers preferring to put their babies in a separate room to sleep demonstrated to Bhakti that following the
recommendations of her doctors and adopting American mothering practices uncritically would lead to less love between her and her children.

Though Bhakti was determined to breastfeed her baby as long as she could, after two months she was feeding her baby only formula. Though her mother-in-law encouraged her to continue breastfeeding she reasoned that her baby was still hungry afterwards. In lieu of feeding at the breast Bhakti started pumping her breast milk and feeding her baby from a bottle, mixing it with formula so there would be enough. The few ounces of breast milk she was able to express each time verified to Bhakti that she was not producing enough milk.

“Only one or two ounces each time,” she explained, “no wonder he was still hungry! And the doctors say he should eat 4 ounces, six ounces each time! I am trying but it is not enough.” Bhakti looked to her own body as “failing to produce enough milk.” Bhakti’s lack of confidence in her maternal body echo dominant medical metaphors of women’s bodily processes as failed production analyzed by Emily Martin (1987). Though scientific mothering discourse, particularly in the model of La Leche League, has worked to transform mother’s bodily images into sites of positive production rather than failed production (Blum 1999), Bhakti’s experience demonstrates that whether framed as positive or negative within scientific mothering discourse all aspects of mothering (breastfeeding, love, aspirations for her children) are productive and embodied.

4.2 Embodied Mothering

Within the field of anthropology, it is widely agreed that the body can be understood as a cultural text; that is, as a symbolic form on which the norms and practices of a society are inscribed (Turner 1980; Scheper-Hughes and Lock 1987; Zola 1991; Martin 1992, 1994; Stoler 1995, Conboy and Medina 1997) and has been the focus of social theory for decades as through
phenomenological (Merleau-Ponty 1962), symbolic (Douglas 1966), structuralist (Bourdieu 2003) and post-structuralist (Foucault 2007) approaches. Moreover, understandings of the body transform over time along with changes in, the market economy, political circumstances and power structures (Ong 1987; Csordas 1994; Martin 1994; Lancaster and di Leonardo 1997, Rose 2007). Embodiment concerns the way people come to ‘inhabit’ their bodies (Schepert-Hughes 1992:184). Csordas observes that if the effect of the Foucaultian critique of the body as a “fixed material entity subject to the rules of biological science” challenged the notion of the body as a natural ‘object,’ then the notion of the body as a subject was also problematic (1994:1). In response to Foucault’s positioning the body as a “text upon which the power of society is inscribed” (Lyon and Barbalet 1994:60), the paradigm of embodiment offers an approach to understanding the body within medical anthropology when the body is understood as “as much a cultural entity as a biological being” (Csordas 1994:4). Embodiment is conceived as a construct, process, framework or paradigm of anthropological research rather than a theory of subjectivity (Csordas 1990; Kleinman 1986; Krieger 2005). Embodiment as a framework, in theory, collapses Western dichotomies: mind-body, nature-culture, subject-object, and practice-perception. The body itself can exist simultaneously as a cultural being and biological reality, and therefore experiences of health and illness do as well (Krieger 2005). Embodiment does not deny the role of social structures in producing social bodies; rather it posits that there are additional forces as well.

A dimension of how a mother constructs her body and her infant’s is the “inter-embodied experience,” or felt bodily dimension as described by Kath Ryan (2011). Philosopher Eugene Gendlin (1981) describes a “felt sense” or intuition experienced by the body that are more than words could express, yet influenced our experiences. The mother-baby dyad is recognized to be
attuned to each other in an embodied way through women’s “ways of knowing” (Belenky, Clinchy, Goldberger, and Tarule 1986; McBride-Henry 2010; Ryan 1998; Winnecott 1996). Linda Blum characterizes the continuous and exclusive interaction between the mother and baby as “embodied motherhood” (1999). The felt bodily aspect of breastfeeding is the preverbal and preconceptual ways of “knowing” about breastfeeding that lead to immediate and intimate reactions in the infant/mother dyad. Kath Ryan (2011) and others (Burns et al. 2010; Ryan, Todres and Alexander 2011; Schmeid and Lupton 2001) advocate emphasis on the pre-reflective emotional, experiential and embodied dimension of breastfeeding through breastfeeding narratives to include the mother’s internal reactions and demonstrate her relationship to the world. However, Blum (1999) demonstrates that emphasis on “embodied motherhood” acts as a normalizing discourse that preferences white middle-class mothering practices by advocating a continuous and exclusive physical relationship that is out of reach, or not desired, for working class mothers. This concept of “embodied motherhood” is contrasted with the medical model in which mothers and babies behaviors and practices are scrutinized and regulated. Scientific motherhood draws on both models by demanding the regulation of mothering practices and assuming the time, resources, and availability of the mother’s body to optimize infant development. It is this assumption that leads breastfeeding scholars to position breastfeeding practices as a class-enhancing project that demonstrates the hegemony of white, middle-class values in mothering discourse (Ahluwalia, Morrow, Hsia, and Grummer-Strawn 2003; Apple 1987; Blum 1999; Carter 1995; Ladd-Taylor and Umansky 1998; Ryan et al. 2002; Wolf 2011). Linda Blum writes, “Breastfeeding does not have inherent truth but meanings determined out of power relations, various disciplining practices, and conflicting needs and interests, which are inherently political” (1999:200). Nancy Scheper-Hughes and Margaret Lock (1987) offer a
paradigm within which the bodily practices can be understood and contextualized as the embodiment or felt experience of everyday social and political experiences.

Scheper-Hughes and Lock (1987) present “three bodies,” or levels of analysis: (1) the individual level or body, where lived or embodied experience is assessed, (2) the social body, where the body symbolically represents social relationships, and (3) the body politic, where the body interacts as a subject of the political world. Collapsing the dualist mind and body approach, this framework considers a single entity: the “mindful-body” (Scheper-Hughes and Lock 1987), the “embodied subject” (Turner 1994), the “body-self” (Van Wolputte 2004) and / or “being-in-the-world” (Csordas 1994). This paradigm has been applied differently in ethnographic research, varying primarily on utilization of the mind-body concept in relation to the ‘body politic,’ though there are unifying features. One feature of embodiment is that the bodily experience is always changing as "one continually learns and relearns to live with as much as through one's body, in its various states of health and illness, youth and old age, boredom and trauma, routine and instability" (Biehl et al. 2007:9-10). Another is the inclusion of the experiential aspect, or practice, in order to advance three critical claims put forth by Nancy Krieger (2005:1): (1) bodies tell stories about—and cannot be studied divorced from—the conditions of our existence; (2) bodies tell stories that often—but not always—match people’s stated accounts; and (3) bodies tell stories that people cannot or will not tell, either because they are unable, forbidden, or choose not to tell. Within the embodiment literature the term “lived experience” has been used to capture the experiential aspect of everyday experiences rather than referring to the mind-body (or a variation of that), though it is not always used uniformly.

Virginia Schmeid and Deborah Lupton (2001) argue that as an embodied relationship between a mother and infant, breastfeeding has strong implications for subjectivity. Often framed
as a feminine subjectivity where breastfeeding can be an “identity tool” to define the maternal self (Dignam 1995), Schmeid and Lupton (2001) found in their examination of first time breastfeeding mothers that the representation of breastfeeding as bonding experienced was overly romanticized, leading mothers who did not embrace an interdependent relationship to respond negatively to breastfeeding. Asking why so many women responded negatively to breastfeeding when they had been so positive about the prospect of breastfeeding prior to delivery, they posit that the Western division of the self and other is transgressed in the breastfeeding relationship, making the maternal body an abject body. As an embodied relationship, the maternal body and lactating is subjected to discipline by the mothers themselves and others (medical professionals, health professionals, “middling modernizers,” friends, family, etc.). How mothers respond to disciplinary discourses in their everyday practices reflect these shifting meanings of the body and the terrain of culture, power, and history (Orbach 1986; Smith-Rosenberg 1986; Bordo 1993; Farmer 1998; Kaler 2006; Labuski 2008), making the embodied self central to breastfeeding discourse.

Embodiment has proven to be a useful theoretical framework to approach the processes, negotiations, and encounters with economic and social structures as variations of breastfeeding are practiced as part of motherhood. In his description of the affliction move san among women in Haiti, infant feeding in Brazil and Bolivia, Paul Farmer (1988), Nancy Scheper-Hughes (1992), and Maria Tapias (2006) identified the body as the site in which the script of disempowerment was expressed by women’s inability to breastfeed. When breastfeeding is central to cultural constructs of the “good mother” among western women, Elizabeth Murphy (2000) found that women who cease breastfeeding will cite reasons such as insufficient milk supply or poor infant growth to divert attention from the “good mother” discourse, again locating
the body as central to the issue. In a study of low income mothers in Brazil, Alanna Rudzik (2012) found that unintended pregnancy had a strong influence on mother’s physical experience of breastfeeding. Rhonda Shaw (2004) suggests that breastfeeding itself is best conceptualized as an embodied practice as the physical mechanical practice is inseparable from the culturally evaluative interpretation of that act that differs across space and time. Deborah Lupton (2012) addresses the importance of the cultural nature of the embodied act of breastfeeding where the connection and division between the self and the other, the breastfeeding infant/mother dyad, is differently interpreted as “pure” or “dangerous.” These unclear divisions influence the mother’s interactions with her infant and how she constructs her own body as a site where larger social narratives are expressed through the act of breastfeeding.

As Bhakti demonstrated in her experience with “failing to produce enough milk,” breastfeeding is as much an emotional and interpretive interaction as it is a physical interaction between the mother and the baby. Bhakti’s desires and attempts to breastfeed did not stand alone. They were a continuous negotiation of her lived experience of breastfeeding (sensing that her baby was hungry after breastfeeding), her social experience of fulfilling her path to development by incorporating a scientific approach to mothering and breastfeeding (carefully measuring the amount of breast milk produced and expressed), and striving to embody citizen-subject values by exercising personal responsibility (switching to formula when she evaluated that her production was insufficient). In striving to embody the role of citizen/subject-mother, Bhakti evaluated her breastfeeding and mothering practices with the paradigm of scientific mothering and determined that her body “failed to produce enough milk.” Understanding breastfeeding to be the site where larger social narratives can be expressed which demonstrate her relationship to the world, Bhakti’s previous experience of failing to fully bond with her first baby due to returning to work
quickly as a good citizen-subject mother left her frustrated with her experience of “development.” This frustration and failure to fully embrace what she saw as the outcome of “development”—physical and social distancing leading to a loss of love-- resulted in framing her own breastfeeding experience as a “failure of production” as well.

In this period of redefining the self, refugee mothers like Bhakti are forced define their own motherhood, which for some entails making sacrifices to become citizen/subjects in their pursuit of “development. For Cecile and Isabelle, embracing the ethos of personal responsibility, self-sufficiency and self-sacrifice is an important goal for both. Their breastfeeding relationships will both influence and be influenced by how they choose to redefine themselves through their mothering practices and their different social and material circumstances.

4.3 Isabelle and Cecile

“Please come in, you are welcome” Cecile said, beaming from ear to ear. She lived in a small one bedroom apartment with her sister. The floors gleamed and the room was spotless. A small loveseat sat against the wall and a laptop sat on a coffee table, along with a vase containing imitation gold carnations for decorations. The walls were bare and the only other furniture in the room was a twin bed pushed up against the wall.

“Nice to meet you. Excuse me but I am off to work!” Cecile’s sister greeted in flawless English me as she hurried out the door, wearing fashionable tight jeans, a button up top, and sandals. Her hair was neatly braided and was pulled up in a bun. I asked where her sister worked and Cecile informed me that she was already working in a downtown hotel as a housekeeper, a popular employment opportunity for refugees. As they had been living in Chicago for less than one month I remarked that it was impressive.
“Yes, but the money we have is so little and the rent for here is $800 every month,” Cecile replied making a “tsk tsk” sound of annoyance. “If only I could work as well we could save so much money but with the baby, how can I?” Cecile patted her belly, not yet showing any signs of her pregnancy in the fourth month. I motioned to the laptop on the coffee table. “Ah, I was skyping with my husband,” she informed me. “He will join me soon. I just have to fill out the paperwork. Before the baby comes for sure.”

“It took a long time to apply to come here, almost 10 years. I was a child then. And I thought I can’t keep waiting. My life has to start so I got married and then I found out I was pregnant. It was on Thursday when they tell me you are going to America on Wednesday. And I was so happy and so sad because I have to leave my husband because he was not in our family when we made the application. So I didn’t have a chance to add him, it was too late. It was so bad. I was not happy. But he said I have to come. Because if I don’t my come my other family cannot come. But I did apply already for reunification. I filled out some forms with Catholic charities.”

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“Karibu sana, you are welcome,” Isabelle greeted me at her door in Swahili. Living just a few doors down from Cecile, Isabelle reached to help me carry in parts of a donated crib that she had won in a raffle at the pregnancy group. The small studio apartment was cluttered with odds and ends; a twin bed pushed against the wall. Three end tables pushed against another and 2 mismatched chairs. There was no sofa or loveseat as was included in most refugee homes by the resettlement agencies, likely due to the fact that it was a studio. I leaned the parts of the disassembled crib against the wall.
A young man of about 20 came out from the kitchen and silently shook my hand. “My cousin,” Isabelle explained. We looked at the crib. Having just picked it up from the refugee agency I had not had the opportunity to examine it prior to delivering it. With a closer look it became apparent that assembling it would require a Philips screwdriver, which I did not have. Luckily the screws and bolts were included, but instructions were not. Isabelle looked at me dumbfounded as the crib had yet to look like a crib. I also realized an important element that was missing, a mattress. Unable to help her assemble the crib I offered to return the next day with a screwdriver but Isabelle waved me away. “No, no,” she said motioning to her cousin. “He can help.” So I left them to assemble the crib.

I returned two weeks later and the crib had been assembled but still lacked a mattress. In it sat numerous cardboard boxes, each overflowing with various things such as picture frames, lamps, and electronics. I asked where they had come from and Isabelle shrugged off my query.

“My son is here,” the text read along with a picture of Cecile’s new baby. “You are welcome,” it continued inviting me to visit her new son. Cecile no longer lived in the cramped one bedroom apartment. She and her sister had moved to the West suburbs the month prior, causing Cecile to change her hospital the month prior to delivery. Three interchanges later, I turned on a wide open road driving past a vitamin and supplement factory on one side and open grassland on the other. Half a mile later I came to a solitary apartment complex.

“Karibu sana,” a young girl welcomed me. Cecile’s new apartment was a garden level, meaning it was half submerged underground. The living room was spacious and contained a new sofa and loveseat. A pack and play was set up and stood in front of a fireplace. The young girl led me down a short hall way where it forked off into two bedrooms. Cecile sat upright in her
twin bed, with a bassinet beside it, holding her newborn son swaddled in a blanket with small blue elephants. The bedroom also had a dresser and a desk, the tops of both overflowing with bottles of vitamins and supplements, which I recognized as bearing the same label as the factory I had just passed. The room was crowded as I was not the only visitor. Cecile’s older sister was there and a woman I didn’t recognize, a white woman.

Cecile’s sister introduced the girl as her niece, her brother’s daughter, who was currently living with Cecile’s mother in the adjoining apartment. The white woman was introduced as a friend, who I would later discover they had met through their church and was credited for their move to the suburbs. “It’s so wonderful,” she said, “After such a precarious delivery to be home safe with a small bundle of joy.” Cecile nodded her head tiredly and gazed at her son. The woman motioned at the young girl. “We must be off,” she said and she and the young girl departed.

“After school program,” Cecile’s sister explained. “I must go to work as well.” Cecile’s sister, I learned, had taken a second job at the vitamin factory down the road and worked the afternoon shift from 3-11 p.m. The factory was owned by the white woman and employed many refugees. They were introduced to her by a resettlement agency, a Christian based resettlement agency, located in the same suburb. They had been approached by an employee of this agency at their church and were promised help finding work, housing and healthcare if they agreed to relocate to the suburbs. Cecile also had a job waiting for her when she was ready to leave the baby. “I am blessed,” Cecile said as she held her newborn, “to have work. I am blessed.” As the baby nodded off to sleep, Cecile recounted her birth experience which ended in a surprise c-section.
“It’s very scary for the first time because I didn’t know how it felt until I get it and then I know how it felt…They took me to the hospital I thought only God is going to help me out. I did not know if I was going to make it, if I was going to come home with my baby. Because all my family, by the time I went to the hospital, they were all praying... I had pains for 9 hours. They didn’t offer any pain medications and I didn’t ask because I didn’t want it. I was in labor for 9 hours and then the doctor came and checked me. Then he said that my baby’s taking time to come out. Then he give me 30 minutes and said if the baby’s not going to come down then I have to choose for c-section or epidural. I was like no, I don’t want epidural, I don’t want c-section. So the doctor gave me some more 30 minutes. He went and come back and he said the baby’s head going up and the doctor was worried. He said then there was no more option and he has to do the c-section to save the baby and to save me. So I said yes, no problem, no choice. Then I went for c-section. Then after few minutes my baby come out and I was so happy. I felt so bad because I didn’t want that to happen to me. I was like, God, why me? I want to give birth naturally. But it came to no other option than c-section so I had no option, I have to accept. But, so bad, the c-section, it’s painful after the baby… I was so excited to come home with my baby.”

Cecile’s disappointment with her delivery was still a fresh wound that she said, “I must accept, what else can I do?” She relived the experience as being both frightening and angering as she was rushed into the process of having a c-section so quickly. She was given forms to sign but did not have time to read them, all the while her family praying in the hall outside her room. The pain of the c-section would impact the beginning of her breastfeeding relationship as well as she would also have to negotiate her wishes with her nurses in regards to the baby’s health.

Cecile’s experience having the emergency c-section was repeated again and again by several refugee mothers, who described laboring for several hours and then suddenly being given
“no choice” but to have a c-section. Some refugee mothers requested pain management from the beginning and others neither asked nor were offered pain management, like Cecile. In the words of another refugee mother, Latika, a young Bhutanese mother having her first child, the doctor’s decision to order a c-section seemed to be sudden. “I asked for pain medication when I arrived and was laboring for many hours, but because of the pain medication I didn’t really feel anything so I felt fine, happy. And then after a few hours the doctors came in and said I was taking too long and I needed to have surgery to have the baby! I was like, why? I still don’t know why. I was in no pain. Everything seemed fine. Then all of a sudden they are taking me off to have a surgery. They didn’t even ask, I had no choice.”

Cecile and Latika’s experience sheds light on previous research indicating that racial and ethnic minorities are more likely to undergo an unplanned cesarean section, even when considered low-risk. The sense that they had little understanding of the decision that led to a c-section and little say in whether or not to have a c-section left them feeling powerless and angry, still wondering months later why a c-section was necessary. Not all refugee mothers I spoke with regretted their unplanned c-sections. Mahnin and Mu, who I will introduce in the next chapter, were grateful for their c-sections stating “If I had been home I would not have been able to have surgery, I would have died.” Both Mahnin and Mu had had difficult deliveries with previous children in Burma and Bhutan respectively, knowing that medical help was unavailable. The fear they experienced during those previous deliveries left them feeling deeply grateful that medical intervention was available when it was determined that it was needed. Though they were grateful for the c-sections they also described the decision to have one being made suddenly by the doctor with little explanation as to why, similarly to Cecile and Latika’s experiences. The number of unplanned c-sections in this cohort of refugee mothers, though small, does point to questions
about why their doctors were both quick to recommend one and reticent to explain the cause for the c-sections to the mother’s themselves. If there were medical indications that necessitated a c-section, that information was not shared with the mothers. If there were no medical indications, then Cecile, Latika, Mahnin, Mu, Kamal, Hema and Thi became another component of the statistics that demonstrate racial and ethnic minorities receive different qualities of care during labor and delivery.

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It was only 30 minutes after Isabelle delivered when a stream of visitors flooded the delivery room bringing plates of food. Isabelle introduced them as her Uncle, Aunt, and cousins. One of her cousins, a young woman of 17 or 18, sat on the bed beside Isabelle and began finger combing her still-disheveled hair, now bright with neon yellow streaks, seemingly oblivious to the seven pound baby cradled in her arms. Isabelle’s visitors commented on the size of the room, the private bathroom, the private closet and the numerous machines beeping and flashing.

Isabelle’s delivery had been quick. She felt delivery pains at 10 pm and by 2:30 am had called a cab to take her to the hospital. She progressed quickly and delivered her son at 11 am that same morning. She progressed quickly enough that she was able to deliver without pain medication, opting instead to push through the pain. Her son was seven pounds and had difficulty breastfeeding from the beginning, which the lactation consultant at the hospital attributed to small nipples, thus a difficult latch. Though she received counseling from the nurses and lactation consultant in the hospital, they gave the infant formula and recommended that she supplement with formula at home despite her wishes to exclusively breastfeed.

Now living with her Uncle’s family, she faced a three story climb to the two bedroom apartment. Her twin bed was now shoved into a small bedroom housing her cousin’s twin bed
and the crib for the baby, leaving just enough room to squeeze through walking sideways. In the crib, now with a mattress, were piles of formula, diapers and baby clothes, having no other convenient place to keep them and illustrating the crib’s lack of use as sleeping quarters.

With wide misty eyes Isabelle lamented how much she missed Cecile. Her Uncle, as it turns out, what not her Uncle by birth but a family friend met in South Africa. Unlike Cecile, whose mother, sister and brother resettled with her, Isabelle’s mother had passed away years back after the application for resettlement had been made, so Isabelle came alone. Unable to take a job so close to having a baby and exceeding the three months of rent support provided by the resettlement agency, she was unable to pay rent on the $600 a month studio the resettlement agency had arranged for her. She had been approached by the same suburban resettlement agency as Cecile, but would be unable to work in the vitamin factory prior to delivery and did not welcome the prospect of living alone with a new baby. She had little choice but to live with friends.

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“My first time I was trying to breastfeed him my breast was hot and I was trying to breastfeed him but it wouldn’t go in and I was nervous because my baby wants to eat. So no milk, and I couldn’t do it. I felt so bad but I didn’t want to give him the formula but I did for 2 days. The nurse suggested the formula. I told her I didn’t want the formula but they said since the milk is not coming out they have to give him the formula… On the third day my milk was coming but before that I was giving him formula. A nurse came to advise me about breastfeeding. They told me breastfeeding is the most important thing for my baby because it’s more healthy than anything else. Everything that my baby needs is from my milk. He is eating good now.”
The fact that following her c-section the nurses were simultaneously advising her to breastfeed her baby and to give him formula did not seem confusing to Cecile as it did with other new mothers. To her it was clear that she her milk had yet to come in and her baby was hungry as he was constantly crying. By the third day Cecile was breastfeeding under the watchful eye of the nurses but neither she nor the nurses were satisfied that the baby was properly latching or getting enough milk. The nurses brought Cecile a breast pump to relieve her engorged breasts and allow her to bottle feed her son breast milk. When Cecile was discharged five days after delivering her son she was still uncomfortable breastfeeding. Her mother, living next door, advised Cecile who was noted that it was similar to the information she had received from the lactation consultant in the group four months prior.

“My mother...she always give me the advice, how to take care of my baby, how to breastfeed him, how to change him, all of those things. It’s almost the same things that lady told us. When you are breastfeeding it must take time, it takes a long time. Just take out the breast and let the baby to breastfeed until the baby takes it off. When he’s on this breast and he takes long, I can switch to the other breast. It was the same advice as the woman who came to talk about breastfeeding, so that gave me confidence but I was nervous the first time. Because when I went the first time I didn’t know how to hold the breast and the baby was so small. So I didn’t want to and it was so full I had to go to see the doctor. It was so painful I couldn’t sleep. When I went to see the doctor they gave me a pump and they gave me some medicine to take the pain away. After like two or three days it went down. But I kept on breastfeeding from that breast even though it was so painful.”

The combination of her mother’s advice and the advice of the lactation consultant gave Cecile confidence to continue breastfeeding rather than switching to formula, even through a
painful breast infection. The feeling of being engorged and having “hot” breasts was a common plague that Cecile experienced, and turned to her mother who advised her to massage her breast prior to nursing and apply a hot compress, mirroring the advice of the lactation consultant. After a couple weeks at home, Cecile began to feel confident about breastfeeding.

“For the first time it wasn’t easy. But after I started nursing well, it was easy. I think it took me to 2 ½ weeks to breastfeed well. I was very excited because until that time I was struggling. I was feeling so bad because the baby wanted to eat but I couldn’t be able to feed him to breastfeed him I was feeling so bad he would start crying. My mom was helping me out to hold the breast and ahh, it was so difficult. But it is ok now.”

Despite her confidence in her breastfeeding Cecile was already considering adding formula as well as breastfeeding. “Even though I have more milk I am thinking it is not enough. So I am thinking maybe if I can give him formula too it will be enough. So I am thinking maybe I will mix. So I spoke to this other lady this morning as well. And they said it is fine you can mix if you want to. But if your milk is enough, you can leave it.” The lady Cecile spoke with was a lactation consultant referred by her doctor. She had a free phone consultation rather than a costly in-home visit. Though she was content with his growth, gaining four pounds in six weeks, his sleeping patterns indicated to her that he was not getting enough from her breast milk. “When I feed him he can sleep, that is how I know he is full. If I breastfeed him and he sleeps for like 30 minutes and wakes up I know he is not full. So I will feed him again so he can be more full.”

Cecile described sleep was the most challenging part of being a new mother. Though her sisters and her mother were available to help her during the day she was alone at night. She would not wake her sister, who was working two full time jobs, and her mother and other sister lived in the adjacent apartment. “I can hardly keep my eyes open some nights. I just need to
sleep.” The prospect of mixing formula with her breast milk to extend his sleep was enticing as
she was feeling exhausted. She was already thinking about beginning work in a few short weeks
and was weighing her options for feeding her son which included beginning solid food,
supplementing with formula and pumping at work, all of which seemed daunting to Cecile.

“...” Isabelle said with a quiver in her voice. “He is only breastfeeding. Sometime he has formula when he cries a
lot, if he’s really crying, and then he stops crying. Only once in a day.” Isabelle described the
experience of sleeplessness and worry that many new mothers have when bringing their new
baby home for the first time. “Now I don’t sleep anymore. I used to sleep so well now I can’t
sleep ever. That’s really difficult... Yeah, I am afraid too, all the time. When he’s sleeping, and
if he sneezes. What I do, if the baby’s sleeping I go in every five minutes to check on the baby. I
think it’s normal because it’s my baby, I think it’s part of having a baby. I think it will be like
this all the time. I’ll be fine at two years.”

Compounding the difficulty of Isabelle’s lack of sleep was the feeling of isolation. Now
living with her Uncle, his wife and teenage daughter, she felt as isolated and alone as when she
was living by herself in a studio apartment, despite the fact that she described their relationship
as good and supportive. She had little to do all day and night but think about difficulties she
faced and the overarching pressure to get a job and become self-supportive. “I don’t feel well,
emotionally.” She continued with tears welling in her eyes, “I keep all my feelings in my heart
because I don’t go out, I don’t see anyone. I’d like to tell somebody. I can’t tell anybody else,
only a person that can really help, maybe friends. I am here by myself, my husband is not here, I
think about my situation a lot. I think all the time how long is it going to be like this because I
Isabelle’s difficulties breastfeeding were adding to her feelings of loneliness and failure. Her long nights lying awake with a crying baby and painful breasts led her to continue the practice initiated in the hospital; to supplement with formula to calm the baby enough to sleep. “Starting (breastfeeding) was very difficult because my nipples were too small for the baby to latch to. So there was a lot of pain, even now, they get so hard and painful.” The fact that her baby would only stop crying after taking formula demonstrated to Isabelle that her milk was insufficient, an observation that was confirmed by her doctor. “My milk is very small, he is still hungry after. We started the formula here, at home. When he was two weeks and he would not stop crying. My doctor gave me the milk because at the hospital, for a check-up, the baby was crying so hard that the doctor gave me the formula and said to give it to him at home. When the doctor saw how the baby cried, she said, ‘Take the milk. He may be hungry.’ He’s fine now, but his tummy is hurting him, because he crying so hard. Sometimes his tummy is hard, it is maybe gas. He has a lot of gas. His doctor gave me some medicine for his gas too.”

Isabelle turned to her Auntie, who she lived with, and to her friends Cecile and Mary for advice as well about infant care, breastfeeding, and her son’s apparent difficulty with gas. “I ask my Auntie sometimes when I am stuck. I ask my friends also, Mary and Cecile, sometimes they tell me what to do. For example, I ask my friend Mary about my baby’s tummy and she showed me the medicine I can buy at the Walgreens. (gripe water) It helps. The baby has normal gas now. So it helps a lot.” Despite having friends to turn to and a live-in Auntie to depend on, Isabelle lamented her isolation and loneliness as her husband was absent. “There is no one there at night to help me,” she said. “I am all alone.”
Like her friend Cecile, Isabelle too wished to file the paperwork for reunification with her husband. However unlike Cecile, the financial roadblocks were insurmountable for Isabelle. The minimal costs of filing the paperwork, making copies of the documents, and costs of talking with her husband on her cell phone were more than she could afford on her own. Unlike Cecile, she did not own a laptop and could not take advantage of the communication capabilities a laptop enabled, namely using Skype or other free face-to-face applications that avoided costly international fees. She felt that until she was able to get a job the process was on hold.

It was surprising that two weeks later Isabelle had turned a corner. Her son was sleeping soundly and rather than relying on formula feeding she was exclusively breastfeeding. The fact that he was sleeping changed Isabelle’s mood. “Now the baby is sleeping and now I can sleep. The baby is sleeping well at night but in the daytime, not too good. I have more energy. He is eating well, very very well. He is growing well, fourteen pounds.” Isabelle attributed this change to the fact that she was exclusively breastfeeding now, a change which both made her son more at ease and positively affirmed her ability to take on the challenges of mothering.

“He is just breastfeeding now. I was giving him formula before. Before, breastfeeding was not too much but now I have too much milk. The doctor gave me medicine to make more milk. I explained to the doctor how I did not have enough milk, so the doctor gave me medicine, a pill, a prescription, to help me make more milk. So I finished the medicine and now I have enough milk. When the baby is crying I always give the breastfeeding. In my case I only gave my baby a little formula, slow, so I could go back to just breastfeeding. You told me to just keep going, just keep going. All my friends gave the baby the formula instead. It was important because in our group they told me breastfeeding is better than formula…I plan to breastfeed for two years, because in two years the baby will be big I think. I think two and a half or three years
is too much. Back home they stop by two years, but there is not formula in Africa. I want to continue because breastfeeding is good for the baby’s brain, many women say that. Here people say six months is enough, but six months is not enough. It is really short. When I am breastfeeding my baby I am happy, I don’t know why… But if I get a job I will give the baby formula because if I leave the baby all day breast milk isn’t going to be enough. When I get a job I will give the baby formula but when I am home I will still breastfeed.”

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Cecile was eager to begin working in the vitamin factory. She sat comfortably on her sofa in gleaming white jeans, a stylish top and bright white hat. She felt ready physically to begin working, her pains from her c-section were long gone and at four months her son was sleeping longer stretches which allowed her to rest as well. She was contemplating when to introduce solid food and the logistics of pumping so that she could begin working. Knowing that her shifts would be 8 hours long, she knew that continuing breastfeeding would be difficult and painful. She had already procured an electric pump from the WIC office. She was already feeling nervous about the prospect of pumping her milk. “My milk is too much. If I don’t nurse him for two hours my milk is full, it’s painful…I was thinking I will be going with the pump at work so during breaks, even if it is only like ten or fifteen minutes, I can pump.”

Cecile was also preparing to begin work by leaving her son with her mother for short intervals to test whether she could leave him or not. She was both eager to work and nervous about leaving her son. “I was trying with my mom and with my sister because now I am wanting to work. They had the bottle and he didn’t cry. Because now I am ready to work. It will be a big change because always I will be panicking at work. Always I will be wondering if he is crying,
are they changing him? I will think, what if he falls down? I think I will lose weight because it is already in my mind, thinking about it. But maybe after two months I will be used to it.”

The time initially following her move to the United States was a memory filled with anxiety, primarily because of the looming costs of having a baby and an inability to work due to her pregnancy. She described it as a time when she was constantly “panicking,” wondering how she could pay rent, much less purchase things for her baby like a stroller, a crib, diapers and clothes. “I was so concerned and nervous because I was not working and my sister was not working. I was so panicking because we were still new to the country. We were not used to here yet. That is why I was like panicking a lot.”

Compounding her worries was the fact that she was separated from her husband who would have been able to provide financial support from the start, in addition to emotional support and companionship. “I was thinking of my husband, if he was here things could be this other way.” Cecile was focused on the reunification process. She filed the appropriate papers within a week of resettling in Chicago. She quickly discovered that it was going to be a lengthy and costly process. Each form filed, “costs $75 or $80 dollars each time. So I can’t even file the forms until I am working.” Her sister and given her money to begin the process but the costs continued to mount as she had to prove their marriage and identity by making copies of their marriage certificate, birth certificates, passports and other documents. She also had to gather and copy additional items to “help her case” such as photos from the wedding and a video from wedding which her husband was shipping to her. Despite the fact that Cecile initiated the process and was eager to move it along she was advised that it would likely take twelve to eighteen months at the earliest for the process to be complete and her husband allowed to join her. So for the time being, Cecile would have to figure out how to make it on her own. This included beginning work as
soon as possible, leaving her son with her mother, pumping and work and supplementing with formula when necessary.

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“Karibu sana!” beamed Isabelle. It was a cold winter evening and snow was piled high by the front door. Isabelle was now living in Des Moines, Iowa with her Uncle and his family. Isabelle led me up the rickety stairs to the second story floor of a house, divided into two apartments. She proudly showed me her son’s newest development, sitting on his own. “I don’t like it,” she said. “I wish I lived back in Chicago. There is no one here and, eh, you have to have a car to go anywhere. I don’t have a car, so I can’t go anywhere.”

Isabelle was unable to find a job in Des Moines but the pressure to find one was weighing less on her shoulders. She was taking English classes at the local community college three days a week. Her Uncle’s family had a laptop she could use and internet access in the house so she was able to communicate with her husband easily. She found a church to attend which provided a social outlet and some of the church members had begun the process of filing the reunification paperwork, alleviating the financial barriers. Isabelle knew from speaking with Cecile that the process of being reunified with her husband would take time but she was content that the process was underway and that she had found a way to communicate with him daily so he could be a part of his son’s life.

Though Isabelle described her situation as being on her own she no longer felt as alone and isolated as she had in Chicago. She had found a solid support group through her church and was able to see a hopeful future. Though she was eager to work she was happy to be able to attend English classes to improve her English. She was confident that she would be able to work soon. She was also content to start the baby on formula when she found a job, though at six
months old she was giving him solid food and doubted that he would need much formula. He was breastfeeding well and she was content to continue as long as he wanted.

4.4 Rationalizing Infant Feeding Choices

In a study of first time mothers who expressed human milk in the weeks immediately following delivery, researchers found that milk expression is an integral to reinforcing biomedical breastfeeding discourse and notions of “good mothering” (Johnson et al. 2013). They found that milk expression, and feeding the baby with a bottle, is a strategy used by mothers to address the period immediately following birth before the milk has “come in,” as a way of deflecting accusations of poor mothering, as a way of regulating the amount and quality of milk, and as offering the mother freedom (Johnson et al. 2013). As experienced by Bhakti, Isabelle and Cecile, milk expression and/or formula feeding immediately following birth is a commonplace solution to difficulties initiating breastfeeding even when the emphasis is placed on breastfeeding. Breastfeeding difficulties often cited are pain and discomfort, problems latching the baby to the breast as in the case of Isabelle, and the baby not feeding well, as in the case of Cecile and Bhakti. These difficulties are often framed by the nurses and the mothers as a “desperate” response to a difficult situation (Johnson et al. 2013). Framing these issues as “problems” or “difficulties” rather than a natural response to delivery reinforces a Western construction of the lactating body as mechanistic, responsive, and predictable (Johnson et al. 2013; Martin 1987). Rather than solely responding to discipline and regulation placed on breastfeeding (Blum and Desussen 1996; Van Esterik 1996; Dykes 2005; McCarter-Spaulding 2008), it also entails forging a solution based on different demands and priorities and exerting a degree of control (Bartlett 2003; Carter 1995; Johnson et al. 2013; Murphy 2000).
Elizabeth Murphy (2000) stresses the moral significance of breastfeeding decisions as moral mothers or good mothers know, understand, and follow the rules of scientific mothering discourse. Within scientific mothering discourse, the mantra “breast is best” rests on the short and long term benefits of breastfeeding and the opportunity to optimize the health of the infant. As Murphy points out, breaking the social rule of exclusively breastfeeding out of ignorance is sufficient to elicit accusations of “poor mothering,” but knowingly breaking the rule is sufficient to elicit accusations of deviance (2000). Deviance, as Murphy highlights, is a charge of a violation of public morality but also open to refutation (McHugh 1970). In a study of infant feeding decisions of first time mothers, Murphy found that women who introduced formula engaged in “repair work” to account to for their decision and deflect possible accusations of maternal deviance (2000: 192). Common reasons given for introducing formula included the need to return to work, doubt in the superiority of breast milk, and emphasizing “maternal autonomy” or a “mother knows best” approach.

While Murphy frames the moral work breastfeeding mothers engage in as a means of justifying foregone conclusions—that formula would be used at some point—she does not connect this moral work with how breastfeeding mothers give meaning to or engage in moral work as a response to unexpectedly experiencing difficulties breastfeeding. In a study among middle-class breastfeeding mothers in the United States, Orit Aviashi (2011) found that women treated their lactating bodies as projects to be managed. Any difficulties they encountered were rationalized as the result “poor body management” and a failure to of the “system” to work properly by producing enough milk. Emphasis is given to the act of production and is carefully monitored by the mother where supplementing with formula is the appropriate response to low milk production and an act of personal responsibility. Bhakti’s emphasis that she was able to
pump “not even two ounces” was reason enough to rationalize the introduction of formula. Cecile had a similar response and rationalization for adding formula, recognizing that her return to work would likely make her milk production decrease. She rationalized that introducing formula before returning to work was asserting control and personal responsibility over the situation. In contrast, Isabelle responded to breastfeeding difficulties by exerting more control over the need to produce more milk, turning to friends and her physician for help.

Though Cecile, Isabelle and Bhakti all experienced difficulties breastfeeding in the days immediately following birth, their response to their difficulties were different. More than a reflection of their desire to continue breastfeeding or the value they placed on breastfeeding, it appears to be about balancing different sets of demands and exerting their own control. The period following birth is recognized as a precarious period in the establishment of breastfeeding and has been theorized by some to challenge the mother’s sense of control and individual choice (Bartlett 2003; Carter 1995; Johnson 2012; Murphy 2000). The value placed on the notion of individual control over or a highly “disciplined body” is a facet of the viewing the self as rational, autonomous and independent being able to exercise personal responsibility in neoliberal societies (Barlett 2003; Johnson 2012; Schmied and Barclay 1999). While Cecile, Isabelle and Bhakti exercised their personal responsibility by following the dictates of scientific mothering and carefully monitoring and managing their lactating bodies, Jala and Mahnin also exercised personal responsibility in their breastfeeding practices but defined them very differently.

4.5 Jala

“I saw them bringing out a tray of equipment, so I pushed it away and started pushing. Only three pushes later and my son was born.”
Jala’s quiet intensity made the telling of the birth of her son all the more prescient. “I have two other children,” she said. “I know how to have a baby.” Though Jala appeared quiet upon first meeting, that initial impression would prove to be false. She was only two months pregnant when she began attending the pregnancy support group and was a stark contrast to Bhakti’s overt jovial manner. Small in stature, even in comparison to her fellow Bhutanese refugees, she seemed smaller, often shrinking into her chair and rarely smiling or conversing with anyone. She dutifully attended several meetings, quietly listening in the back. When I invited her to be part of my project, I was genuinely surprised when she agreed. Interestingly, she was one of the few participants who did not consent to our conversations being voice recorded.

Jala’s quiet demeanor hid the difficulties she was facing, particularly with her husband. Prior to resettling in the United States she described their relationship as acrid, maintaining several girlfriends and not providing her with financial support for her two children. Though he was currently employed, he did not give Jala money to take care of her two children, aged fourteen and twelve, or to prepare for the new baby. She was bothered that she couldn’t work during her pregnancy to support her children and did not expect to afterwards due to needing to stay with the baby. She predicted that she alone would care for the baby. “I don’t expect any help from my husband or my children. It is not my children’s job to take care of the baby. And my husband, he doesn’t give me any support with the children,” she said matter-of-factly.

When asked whether she had concerns about giving birth in an American hospital she replied that she had heard from other Bhutanese women that they offered pain medication during birth so “you don’t feel anything.” She was confident that she would not use it because, “I have already had babies, I know how to do it.” She was concerned about the pain she experienced
with a previous episiotomy, “scissoring,” as she called it. “I still have pains from the scissoring so I am scared that I will have that again.” Prior to the birth, Jala did allow that if she faced any form of “surgery,” she did plan to use pain medication.

Jala was also confident that breastfeeding her baby would not be difficult as she breastfed her older two children with the help of her sister-in-law. She did not plan to breastfeed her baby for a defined period of time, but assumed she would for two to three years unless there was a medical problem. “I breastfed my son well (for three years) but with my daughter I had to stop after two years because my milk was too thin. At the clinic they told me she was not gaining enough weight and that my milk was too thin so I should switch to cow’s milk. So I did and she started gaining weight.” However, unlike in the Nepalese refugee camps, “here there is formula and that’s ok.”

Jala’s apparent confidence and comfort with the options available to her made her actions all the more surprising after the birth of her son. Delivered at 37 weeks and weighing five pounds, four ounces, Jala’s son spent his first week in the neonatal intensive care unit. Despite this, Jala described him as a “healthy baby” beaming with pride. Wrapped tightly, Jala’s son was dwarfed by the two thick blankets she swaddled him in, despite the fact that the temperature was over 90 degrees outside and they only had a fan in their cramped apartment.

“I had pains for three days. Three days and nights I had pains here, in my home. I did not go to the hospital right away because it wasn’t time yet. I know when it’s time, I have 2 other children. I only went when they got very bad. So when I went to the hospital they asked me, “how long have you had pains?” I told them three days. They said, “three days! You are too tired to push now!” I could see they were planning for a surgery, a c-section. Suddenly there were many doctors and nurses in the room and they were all running around. They brought out a tray
with sharp instruments and they brought a form to sign, like they said they would in the group. And I said ‘No!’ and I pushed they form away and I pushed the instruments away (motioning with her hands) and I just started to push! They (the doctors) came running to me saying ‘stop!’ but I just kept pushing. After three pushes my baby was born.”

The quickness with which her doctors decided on a c-section left Jala with the impression that her doctors and nurses were quick to find a medical solution rather than a common sense solution to problems. Immediately she experienced difficulties breastfeeding her son as he was in the NICU rather than her room. Unable to feed him on demand as she wished, she was forced to use a pump in the hospital and was only able to express a few drops of milk, not enough to exclusively feed the baby according to her nurses. Against her will the nurses began giving her son formula. With the addition of formula “he did gain weight” she conceded. Even more disturbing to her was that she was discharged from the hospital before her baby was, so she made several trips a day to the hospital to continue pumping and to be with her baby.

Jala was advised by her doctor to continue formula and breast milk but Jala threw her hands up in the air. “The doctors in the NICU want me to give him formula but, what do they know? I know my breast milk is enough.” Motioning to the small bottles of prepared formula in the corner of the room she said confidently, “they gave me those, but I won’t need them.”

Within the month Jala had begun using formula at the urging of her sister-in-law. “He is not growing well,” she admitted. “How can he? When he was away from me in the hospital!” She blamed the separation in the first week for her “thin milk.” “My milk is too thin,” she relayed. “You can see when you pump it, it comes out watery, not thick. That is why he is not gaining enough weight. Even in the hospital you could see the milk was too thin. After the hospital it never became thick again. That is why I must use formula now.” By two months Jala
said that her milk was completely gone and she could only use formula. “It’s ok,” she said with
disappointment. “What can I do when I have no milk?”

4.6 Mahnin

Mahnin is sitting cross-legged on the floor of her one bedroom apartment cradling her
five day old son in her arms. She is nervously rocking back and forth, pulling his blanket tighter
and adjusting his small cap, whispering to him. As I sit across from her, Mahnin’s two young
daughters squat beside me, quietly watching their mother and new brother. I ask how she is
feeling and she tiredly comments that her stitches from her c-section hurt and she is tired. I
sympathetically offer that it is tiring having a new baby and she laughs half-heartedly. I ask her
how he is eating. She says that he is eating a lot but that he is not gaining enough weight. When I
ask how she knows she replies that she saw the doctor earlier that day and she does not think he
is gaining enough weight, though the doctor thinks he is normal. Her face looks strained as she
tightens the blanket. The baby makes a gurgling sound and she offers her breast, to which he
latches immediately.

“He seems hungry! Is he eating well?” I query. “Yes, he eats a lot. He is very hungry,”
she replies, never looking up from her son’s gaze. “What is he eating, only breast milk?” I ask,
noting the small bottles of prepared infant formula sitting in the corner. “No, this too, from the
hospital,” she replies reaching back for a bottle and handing it to me. “Does he like both?” I ask.
“Yes, he likes it a lot, he eats both,” she replies, still never raising her eyes from her son’s gaze.
I ask if she plans to give him formula as well. “As soon as I get my WIC I will get more formula.
The doctor said he can give me some if my WIC doesn’t come before I am finished with this,” as
she gestures to the prepared formula bottles from the hospital. I ask if her doctor suggested she
supplement with formula and she replied no. “He tells me my breast milk is enough but look how small my baby is. I know he needs formula too.” Knowing from previous conversations that she exclusively breastfed her previous four children I asked why she was sure that her infant needed formula in addition to breast milk, if her previous children only had breast milk.

“I would have given them formula too if I could, but in Burma I could not afford it. They were also small and they were not healthy. Look at them now, they are still small. He needs formula too, to be healthy.”

Mahnin’s concern over the health of her new baby was one more concern in a long line of concerns. Her husband, who had experienced a serious injury while working in Thailand, continued to suffer from health problems which made working difficult. Her four older children had all been malnourished prior to resettlement in the United States and were small for their size. Mahnin suffered as well. Her legs were swollen, making it difficult for her to walk. The source of her injury was unclear but she attributed them to her difficult life prior to resettlement. The most difficult period followed the birth of her last child, causing her and her husband to flee Myanmar to a refugee camp in Thailand.

Mahnin described her life in Myanmar as always being difficult. Pregnancy was a precarious time and there were no health clinics in the area she lived with her family. In order to give birth in a clinic, she had to travel several miles and the journey was difficult. Still, Mahnin described giving birth in a clinic as preferable to giving birth at home where “there is no one to help you if something goes wrong.” The births of her first three children were difficult but occurred without incident. However, the birth of her fourth child caused her to decide that they had no future in Myanmar.
Unsure of the details, Mahnin was certain of one thing, that she was close to death and that the delivery injured her, perhaps for life. Unlike her first three births, the birth of her fourth child happened quickly and a few weeks prior to her due date. Unable to make the journey to the health clinic she labored at home. Her husband called for a midwife, who assisted Mahnin. Mahnin, and described the labor as long and difficult - so difficult that at some point she was sure that she was going to die. She was unsure how the labor ended and if she was conscious throughout as she could not remember. She does remember losing consciousness and waking up weak and with pain in her legs. The pain in her legs persisted and her legs have been swollen since, making it difficult for her to walk. The loss of blood made breastfeeding her new baby difficult, as she described her milk as “thin and weak.” Born small, her daughter did not gain weight quickly and Mahnin remembers feeling anxious every day, uncertain of her daughter’s future. Still underweight at two years old, Mahnin described her worries as lessened now that they are in the United States. “Here we have food stamps, we have WIC. I know we will have food at least.”

Mahnin turns her focus back to her new baby. She continues to hold him tightly and rock him back and forth, whispering to him and offering her breast which he suckles intermittently as he goes in and out of sleep. I ask when she will give him formula and she answers that when her milk is done she will switch to formula.

One month later, Mahnin strode into the pregnancy support group with her two younger daughters and her new baby, now just over a month old. Pushing her two older daughters in a double stroller, which she had procured in the group, she was carrying her son in a wrap underneath her winter coat. She greeted me with a hug and her face was beaming, bearing no signs of the tensions and the worry she had before. I commented that I was surprised to see her
out so soon after having the baby and in such cold weather. Though it was March, the bitter chill of winter persisted. Unzipping her coat she began to unwrap her son who was wrapped in a thick blanket and was wearing a thick, full body coat. I commented that he looked “huge” and estimated that he was twice as big as before. She proudly confirmed that he had gained a lot of weight, now almost eight pounds (from a birth weight of barely over five pounds). Proudly stating that he was a good eater, Mahnin was still breastfeeding and following each milk feed with a bottle of formula until he refuses the bottle. She also proclaimed that her milk was not thin as it was with her previous babies and attributed his rapid growth to the combination of the two.

Mahnin continued to attend the pregnancy and parenting groups dutifully, with all three of her younger children (her older two were in school). She also continued to breastfeed and supplement with formula for son’s entire first year. Not finding any difficulty managing breastfeeding and formula feeding, she recalled the constant anxiety and worry she experienced breastfeeding her older four children, never being certain that they were getting enough nourishment. Unable to afford formula she started her older four children on solid food, rice porridge, at three months old to supplement their diets. With her new baby she said that she intended to wait until he was six months old as was recommended in the pregnancy group because she was sure that he was gaining enough weight.

4.7 Maternal Autonomy and Personal Responsibility

There are a few to insights be drawn from the accounts of Jala and Mahnin. For one, as illustrated by Mahnin’s comment, “He needs formula too, to be healthy” formula is not viewed as nutritionally less superior but can often fill an essential gap in breastfeeding. Unlike prevailing views of formula within popular “good mothering” discourse where formula is viewed as not
only nutritionally less superior, but in negative terms (Knaak 2005, 2010), the refugee mothers
do not embrace the popular trend of idealizing breastfeeding and devaluing formula feeding.
Rather, each mother is selectively adopting aspects of scientific mothering discourse and
exercising personal responsibility in her own way and within her own circumstances, leading to
different breastfeeding practices.

Secondly, the addition of formula was not only not seen as negative, but was largely seen
as a positive addition to infant feeding, so long as it did not supplant breastfeeding overall. The
mothers were accepting of the benefits of breastfeeding and did not view the addition of formula
as detracting from the benefits of breastfeeding or their desire to breastfeed. Rather, the addition
of formula offered a safety net for the baby to ensure that the baby was receiving enough
nutrition. This safety net contrasted to their experiences prior to resettlement where formula was
either unavailable or financially out of reach. In this context, any difficulties breastfeeding would
lead to serious health consequences for the baby. All mothers in this study supplemented with
formula at some time during their infant’s first year of life for many different reasons. Some
mothers, like Jala and Isabelle, were reluctant supplement but did so out of fear that their baby
was not receiving enough nutrition and other mothers, like Mahnin, saw formula as a
confirmation that their baby was receiving enough nutrition. Other mothers, like Bhakti and
Salma, treated their body as a site of production to be carefully monitored and managed which
lead to the conclusion that their body was failing to produce enough milk making formula a
welcomed addition. Some, like Cecile, saw formula as offering a degree of freedom and the
ability to aspire to a middle-class lifestyle. As we will see in the next chapter, many
supplemented with formula not in response to a recognized need such as fear that the baby is not
gaining weight, low milk supply, or returning to work, but simply because it was readily available and not perceived as harmful. As one mother simply said, “Why not?”

As we can see, breastfeeding is indeed an embodied act, influenced by corporeal, social and political forces. The period immediately following birth is a period of uncertainty when the interembodied experience of breastfeeding is powerful. The baby is constantly at the breast and never seems satiated. The experience of the milk coming in—and not enough milk—challenges the mother’s perception of her body and her body as a mechanism of production. How each mother interpreted her body’s abilities rested heavily on how they perceived their body to be a site of production to monitored and managed and how they understood medical authority and technology (pumping breast milk and formula) as able to step in where the maternal body fails. Bhakti and Cecile attributed their lack of milk immediately following their c-sections as failures due to the intersection of technology. Jala also attributed her failure to produce enough milk as the result of the intersection if technology and the intrusion of medical authority. Mahnin, however, framed her son’s hunger as evidence that he needed more “technology” via the addition of formula. Her body did not fail, but technology was welcomed nonetheless. Isabelle, was less certain than Bhakti or Cecile, about the benefits of technology and development in the United States and her desire to continue breastfeeding even when she had the challenges of low milk rested on her experiences in the pregnancy support group and how breastfeeding was presented as an integral component of mothering and optimal for the baby. Also framing her body as a failure to produce enough milk, she took the route of remedying that with the goal of fixing her failed maternal body.

The day to day decisions mothers make about infant feeding demand constant evaluation and revaluation of the maternal body by the mothers themselves. This constant monitoring of
one’s milk production and infant health and growth is an exercise of personal responsibility and maternal autonomy. The ways that mothers selectively embrace aspects of scientific mothering serves as a way for mothers to exert their own political power in a relatively powerless situation by exercising maternal autonomy or “mother knows best.” For some, like Bhakti and Cecile, it is embracing the middle-class practices while for others, like Mahnin and Jala, it is pushing back against medical authority based on experience and felt intuition about what is best for the baby. For all, as the experience of Isabelle demonstrates, it can be a period of redefinition of the self where the act of breastfeeding demands a greater scrutiny of what type of mother she wants to be. If as Foucault posits, the body is indeed a “text upon which the power of society is inscribed,” the decisions made in the early stages of breastfeeding influence and are influenced by the type of mother they each want to be. As we will see in the next chapter, each mother differently defines their own mothering practices as they strive to situate themselves within the neoliberal landscape of the United States.
5- BREASTFEEDING AND THE PRACTICE OF MOTHERING

“[Mothering] is a project responsive to although not dictated by surrounding cultural, social, economic, and political context and to changes in those domains.”

(Barlow and Chapin 2010:320).

In the previous chapters, I examined how the day to day decisions mothers make about infant feeding demands constant monitoring of the mother and infant’s bodies as an exercise of personal responsibility. The rationales given for their responses to their perceptions of low milk supply offered an avenue for mothers to exert their own power and agency. For some mothers, like Cecile and Isabelle, it entailed supplementing with formula on the advice of their doctors. For others, like Mahnin and Bhakti, it was giving formula against the advice of their doctors. For all, breastfeeding demanded a greater scrutiny of their intended mothering practices. From the narratives of Isabelle and Cecile we see that like breastfeeding, mothering is emergent process present in an everyday practice, a variable but essential component of cultural reproduction (Barlow and Chapin 2010). As such, it is not only important what people say, but what they actually do that defines how mothers communicate “crucial cultural understandings about personhood, community, motivation and consequence” (Barlow and Chapin 2010:2). As in the case of Bhakti and Mahnin, the decision to supplement with formula was a decision that was neither coerced nor flippantly made. As an exercise of personal responsibility, infant feeding decisions were intentional with the immediate and long term consequences weighed. By examining the day to day decisions mothers make about infant feeding we can see how each mother embodies the notion of personal responsibility. I argued that within a neoliberal era of
governmentality, negotiating personal responsibility entails a process of subjectification, the dual process of being subjected to control and dependence and the struggle against it. Within grids of knowledge and power, personal responsibility is valued when individuals choose behaviors that are best for the collective good by reducing their burden on society rather than representing a true freedom of choice. Within the contemporary neoliberal society of the United States, choices and behaviors are evaluated in terms of their health implications and subjected to medical expertise. For mothers, personal responsibility extends to cultivating optimal health and well-being for her children by incorporating the latest scientific and medical knowledge as part of the modern biopolitical project to craft ideal citizen-subjects. Those who do not are supposed to feel shame.

In a special issue of Ethos subtitled “Mothering as Everyday Practice,” Kathleen Barlow and Bambi Chapin sought to address the ongoing questions about mothering and culture, “despite much valuable and enlightening work on mothers, children and culture” (2010a:321). Through the examination of the microinteractions of everyday life, they sought to address the gap between psychological theories of mothering and child development and the diversity of child-rearing practices across cultures and attempt to address the question of whether there are cultural universals in the practice of mothering as defined by Naomi Quinn (2005). Rather than addressing the question of cultural universals head on, they define mothering as a “project undertaken in different ways by different people…characterized by responsibility for promoting children’s well-being and development through nurture and physical care, as those terms are locally defined” (Barlow and Chapin 2010:329). Mothering as a practice is “responsive to, although not dictated by, surrounding cultural, social, economic and political context and changed in those domains…and often appears “natural” and “practical” to participants and
observers” (2010:329). Mother-child interactions, they argue, often fly in the face what is known about child development and often result in an outside observer responding “That wasn’t what I thought/expected/felt should have happened” (Barlow and Chapin 2010a:322). As such, they make a case for examining “not just what people say but what they do” to learn about how a mother defines and communicates herself as a good mother. As psychological anthropologists, their efforts are squarely situated within psychodynamic theory and address theories of personhood.

In their collection of ethnographic accounts of mothering, mothering is conceptualized as a series of seemingly mundane or “everyday” mother-child interactions. Acknowledging that these everyday activities are embedded within larger cultural contexts, the mother is positioned as an actor, agent, and strategist negotiating the economic and political terrain of the everyday. This collection does not address how choices and practices during pregnancy, birth and early infancy, expose different meanings and purpose (DeLoache and Gottlieb 2000). As we have seen in the stories of Cecile, Isabelle, Bhakti, and others, the period of early infancy and infant feeding choices are a crucial component of the formation of the mother-subject and offers a close look at subject formation. The choices made by Bhakti and Mahnin to give formula despite the assurances of doctors and nurses that it was not medically necessary was as surprising and unexpected as was Jala’s resistance to using formula and Isabelle’s return to exclusive breastfeeding after supplementing with formula. Linda Blum argues that due to the urgency of infant feeding, early infancy is a period filled with “meaning-making practices” that develop in the context of power relations (1999:2). Through the unexpected turns of each mother’s breastfeeding journey I have demonstrated that the period of infant feeding is a series of everyday and potentially mundane choices and practices that are filled with meaning. Through
the examination of these everyday practices, stories people tell, and the future they envision, I argue we can see the entwinement of the embodied experience of breastfeeding and the enactment of subjectivity in the “lived experience” of mothering or in the practice of mothering as characterized by Barlow and Chapin (2010).

In this chapter I will examine how refugee mothers are defined (by themselves and others) as citizen/subject-mothers variably in need of discipline, worthy of discipline and accepting of discipline by their everyday practices. In this chapter we will meet Noor, a Burmese mother of two embodies the idealization of the citizen-subject through her aspirations for herself and her children, Aye, a Burmese mother of three who struggles under the unwelcomed pressures of expectation, and Mu a Burmese mother of three who blissfully disregards the expectations of scientific mothering. We will see how each mother embodies the personal responsibility of nurturing her children through the lived experience of enacting the day to day practices of mothering. But first I will review the concept of the lived experience within medical anthropology as I employ it.

5.1 Lived Experience within Medical Anthropology

Arthur Kleinman called for an emphasis on the micro contexts of daily life, within which illness experiences and suffering are constructed, which he refers to as the ‘lived flow of experience” (1986:123). Described as the “felt flow of intersubjective mediums of social transactions,” Kleinman uses Bourdieu’s conception of experience as a process (1995:97). According to Kleinman, for Bourdieu experience is “the social matrix out of which habitus is structured and where shared mental - bodily states in turn structure social interactions” (1995:97). The meaning and flow of the process is interpreted and represented by the
ethnographer. By conceptualizing experience as a process, the “lived flow of experience,” later termed “lived experience,” maintains a social constructionist and cultural-interpretive meaning.

Thomas Csordas advocates utilizing the term “lived experience” to explicate individual phenomenological experience and, referencing his use of the embodiment paradigm as a theoretical approach to the body, as “the existential ground of culture” (1990:5, 1994). Responding to poststructuralist theories of the body, Csorhas is concerned with “contributing to a theory of culture and self grounded in embodiment” (1994:13) rather than focusing on experiences of affliction or suffering. He considers the body to be explicitly the subject of culture, the body the seat of subjectivity, therefore the “lived experience” refers to the subjective experiences of the individual (Csordas 1994). Like his use of the embodiment paradigm, by considering the “lived experience” as a mode of being-in-the-world, or existential immediacy, his usage of “lived experience” implies a representational, or cultural interpretive, meaning since being-in-the-world can only exist as an object of the perception of others.

Nancy Scheper-Hughes and Margaret Lock utilize the concept “lived experience” to refer to the individual body, conveying the “phenomenological sense of the lived experience of the body-self” (Scheper-Hughes and Lock, 1987:7) in their presentation of the perspectives necessary for conceptualizing the body in anthropological theory. Referencing Marcel Mauss’ observation that “there has never been a human being without the sense not only of his body, but also of his simultaneously mental and physical individuality” (Mauss, 1979:61), Scheper-Hughes and Lock assume a recognized individual embodied self as a universal as a first step to collapsing the Cartesian division of the intuitive conscious mind and material body-self. They posit that the mindful intuition of the body is an integrative “lived experience” that is understood via social history. Thus, Scheper-Hughes and Lock’s use of the concept of a “lived experience”
is mediated by social practices. Understanding that social practices refer to unconscious representations of the experience of self, where the body is a physical and cultural collective representation or metaphor of society (conceptualized as the social body), as well as power and control exercised through the body (conceptualized as the body politic), the “lived experience” integrates the social forces into the individual phenomenological experience. Scheper-Hughes and Lock’s use of the term “lived experience” references the three bodies as simultaneously a subject and object of culture. Their conceptualization of the “lived experience” of the individual body posits that perception and practice act in concert, such as in emotive responses and physical experiences of illness and disease, thus convey the existential immediacy that Csordas was advocating. Scheper-Hughes and Lock utilize the term “lived experience” conveying that “the individual body should be seen as the most immediate, the proximate terrain where social truths and social contradictions are played out, as well as a locus of personal and social resistance, creativity, and struggle,” (1987:31), but also acknowledge that the body politic “inscribes the body” via metaphor and representations of affliction. Like their paradigm of embodiment, the “lived experience” is both subject to, and an object of, socio-political power.

Following Scheper-Hughes and Lock, the term “lived experience” has been utilized to convey the phenomenological experience of social suffering in concert with the socio-political presence of power, as a descriptive tool by Setha Low (1994) and Janis Jenkins and Michael Hollifield (2008), and to characterize social creativity by Scheper-Hughes (1992), Joao Biehl (2007) and Linda Green (1998). Veena Das (2007) and Erica Caple James (2009) have similarly utilized the concept “everyday experience” within the medical anthropological discourse to explicate the inseparability of bodily experience and cultural meaning. Byron Good (2012) also advocates the approach in order to link the political and the psychological in more clearly
theorized ways to push the boundaries of current modes of constructing subjectivity. Therefore I will also use the term “lived experience” in this manner to encapsulate both the phenomenological aspect of experience and the social contributors to subjectivity.

5.2 Noor

“I want my son to get a diploma or a degree, so I am thinking like that. I want to help my child to go (to school). Education is very important because in our country we cannot give education to our children so here education is very good. So education is first and then whatever they want they can do it. Like my son, he say, “Mom I want to become a doctor.” So I am so happy. I say first you have to get education.”

Standing barely five feet tall, Noor exuded a quiet confidence and command over those around her: her husband, father-in-law, five year-old son, and six month old daughter. The fact that her son was only five and announced his wish to be a doctor when he grew up did not diminish the weight of his wish at all. She diligently announced her plan to send him to college so that he could achieve that dream. Even though her dreams for him had been “small,” she had imagined him going into business, the fact that he announced his desire to reach what she considered to be the pinnacle of achievement filled her with pride. For her six month-old daughter, she wished that she become a lawyer though she admitted that she has only seen them on TV and doesn’t really understand what they do. In order for her children to achieve these goals Noor says the key is money for college so she must save and save.

The trajectory from being a refugee living day to day in Malaysia to a watching her son and daughter graduating from college was perfectly plausible for Noor, as her life had already changed so quickly in a short time span. After fleeing persecution in Burma, day to day life in
Malaysia was difficult and fraught with difficulties because “we don’t have any agency or anything...because we are refugee over there in Malaysia, they don’t like refugee.” Living in a city, as opposed to a refugee camp, Noor and her family received no support from international agencies and learned to make their way day to day, primarily by scraping together odd jobs and looking toward the future. When Noor was pregnant with her son she described aloof and icy treatment from the hospital staff in Malaysia, and sharp difference compared to the doctors and nurses she encountered in the United States. “Here all the nurses and doctors help us with what we need. And when I go check up for the pregnancy, they give advice like what should we eat what should we take. But back home, no.” In the span of one year Noor and her family had gone from living in day to day uncertainty and being a persecuted minority to living in a secure apartment with support from multiple agencies, being reliably employed, and most important to Noor, her son was in school.

Though there were five family members living in a cramped two bedroom apartment, Noor’s focus and determination to plan and save for the future was evident. A computer sat on a desk in the corner of the living room and she proudly showed me educational games her son played. She had also established an email account and was learning to navigate the internet. Most telling was the fact that she had just purchased a used minivan, the first for the family. Noor had a maternal Aunt living in Milwaukee and the minivan would enable them to visit her easily. Noor had also purchased a GPS navigator in order to facilitate their upcoming trip, an unthinkable expenditure just a few months prior.

Though Noor had begun to learn English prior to immigrating to the United States, she diligently attended English language classes at the refugee agency and supplemented them with computer based ESL programs. Her diligence had been rewarded with a job as an interpreter for
her refugee agency. Now she and her husband were both employed part-time and able to trade off working and watching the children. Soon she would be able to work full time, as her sister’s family would be joining them in Chicago soon. Her sister’s family had been granted resettlement and was due to move within the month. As her sister did not want to work, she would be able to watch Noor’s children, freeing Noor to find full-time employment.

Noor diligently fulfilled the Aihwa Ong’s (2003) role of the “citizen-subject” by building her own human capital and being an entrepreneur to herself. In addition to adopting and embodying the neoliberal-American dream of valuing education and work as a social-generational stepping stone, she also highly valued the paradigm of the “scientific mother” who looked to expertise in child-rearing. The fact that she had her first child, her son, in a venue where though she had her entire extended family surrounding her to advise and help her with her child stood in stark contrast to her experience with her second child. With the birth of her first child Noor describes herself as being a novice and reliant on her mother and the doctors for advice. She was advised to have a c-section due to her baby’s size.

“My son was 2 ½ pounds and the doctor say he is too small to deliver. My mother say, “What can you do? You should do what the doctor tells you,” so that’s why I do that. And then after I have a baby and I am so happy. But I don’t know how to catch (hold) and how to breastfeeding, so that part is difficult. Then my mother show me and my mother stay in my house for 2 months and she show me how to do it. She show me how to catch the baby and how to breastfeeding and she say you should do like that and you should not do like that. And I learn from my mother.”

Under her mother’s guidance, Noor breastfed her son three months and then switched to formula. Noor also heeded her mother’s advice on how and when to bathe, where and how long
the baby should sleep, and how warmly to be dressed. In addition to guiding Noor on infant care she also cared for Noor by allowing her to rest and preparing food for her. Importantly she prepared a spicy soup of black pepper, garlic, ginger, greens, and fish that is “special, just for new mothers to heal the body and help make the milk.” Nourished by this special soup Noor was able to easily breastfeed her infant son. Noor’s mother was the cornerstone for guidance on childrearing while Noor’s doctor played a supporting role. Importantly while Noor’s mother was quick to offer advice, Noor’s doctor was rarely available and did not provide enough care in Noor’s opinion. Noor explained that her son experienced some developmental delays, such as not crawling until eight months old. Though her mother expressed concern, when Noor sought the advice of her doctor her concerns were dismissed. This stood in contrast to the attentive care she received for her daughter the United States where the doctors kept close tabs on the development of her daughter, a sign of “development” to Noor.

“Back home I ask because my son, at 8 months my son started crawling. I ask at 6 months why is my son not crawling and the doctor said it is fine. But here at 6 months the doctor ask me! Did your daughter sitting? I say no. Is your daughter crawling? I say no only a little bit. The doctor say oh no, you have to take a referral because it is a development delay. I say what, back home not like that? Not for 1 year. So I tell my husband and he say, “That is great job.”

Noor’s five year-old son was also diagnosed with a developmental speech delay and received a referral for speech therapy. “They come here (to her apartment) three times a week and such improvement!” Unlike Mary, Noor sought out and welcomed the advice of her doctors regarding her son’s development. The fact that they inquired and diagnosed delays demonstrated to her that they were attentive and validated the role that “scientific advice” could play in mothering. The reliance on a medical diagnosis was also evident to Noor that the extension of
medical authority was part of living in a “developed” society stating, “Here with this
development they recognize that my son is delayed. Back home they would not recognize these
delays, they would just say ah! It is just fine! But here they recognize it is not just fine and can
give him a doctor.” This was important to Noor as she felt she had forgotten everything in the
five years between her two children and her mother was not with her for the birth of her second
child to guide her. “(My mom) she showed me how to get the baby dressed, give massage, how
to give shower. But I forget everything, because now my son is five years. So after 5 years I
am, like, new again. What should I do? I forget everything!”

In lieu of her mother’s hands-on guidance, Noor turned to her sister-in-law, who lives in
Chicago as well, her doctors, advice books and the pregnancy support group where she felt she
received expert advice about infant care and what to anticipate. “The group showed me how to
eat and how to breastfeeding the baby, and how to give milk. I learned a lot from the pregnancy
group and I am happy about that because when I was pregnant, Oh my god, I don’t have
anything and anyone to help me. But I learned more from the group. Like what should I eat and
what should we do after we have the newborn.” She describes how she felt confident assessing
her infant daughter’s health in the first week, based on the anticipated changes in her stool which
she and her husband were unaware of due to her mother’s care of her son. “Sometimes it is
green, sometimes it is yellow. So I learn from the pregnancy group they give me the pictures of
the poop (Shows the pamphlet distributed in the group). So when she is pooping my husband
says why is it green? Why is yellow? I can say, no, no it is fine. Here is the pictures of what it
will look like. So I say ok, it is good. So if there is bleeding we can call the doctor. But this, this
is fine.”
“For my husband it is new again too.” Her husband shared in her reliance on “expert” guidance and took a more active and hands-on role than he had in Malaysia where he worked long hours. Unable to attend the pregnancy group he turned primarily to the popular advice book *What to Expect When You’re Expecting* to prepare for the baby and Noor described him as a partner in decisions about infant care and sometimes more prepared than her. “When my new baby was born, without my family, I had difficulty, like, what should I do? So how can I catch like, my baby? My husband is some help to me. My husband also teach from some people how to catch baby, how to wash baby, so that’s why my husband is a help to me… He goes with me to the hospital for check up and he reads the books, he knows a little bit. He reads *What to Expect*. Then when she is doing poo poo, I go what do I do? My husband say, ‘You have to take the wipes and do like that.’ (Laughing). My husband had one friend, he is actually Iraqi, he said you can actually catch the baby, give the baby shower. Oh my gosh, I forget everything!”

Noor relied on her husband for support trying to breastfeed her daughter as well. She experienced difficulties from the beginning and was concerned that her baby was small, weighing only 5 pounds at birth. Noor expressed a strong desire to breastfeed as she had done with her son under the guidance of her mother, though like with her son she took cues from the baby’s reactions and weight gain to guide her decisions. Like her daughter her was less than 6 pounds when he was born. He cried often and was restless. She struggled to maintain a latch while breastfeeding. “My son breastfeed for 3 months, but after 3 months he doesn’t like. I don’t know why. He didn’t like. After he doesn’t breastfeeding, he doesn’t want I feel sad. My mom said some kids feed for 2 years and some kids doesn’t like. After 3 months I tried to give a little formula, but he like more, formula. After 2 months, my mom said maybe he doesn’t eat enough with your milk so I tried with a little bit. But then he liked the formula more.” The addition of
formula calmed her son and caused him to gain weight more quickly which, on the suggestion of her mother, Noor asserts demonstrated that he liked formula more than breast milk and soon she was only feeding him formula. When she began noticing the same behaviors when breastfeeding her daughter, crying and restlessness while breastfeeding, she suspected that like her son her breast milk might be the cause and introduced formula.

“I think with breastfeeding it was not enough. So I start with the formula. She’s just like, oh, more formula. Because when I put my breast, she doesn’t like. She is crying when I put my breast near. When I put formula she like. That’s why I think my daughter she like more formula…One day like 2 times, she doesn’t like breastfeeding. She likes the formula. At first she drink my milk. But after 1 month I started the formula and now she doesn’t like (my milk). I feel like, sad, because I see all mothers breastfeeding. And now she doesn’t like. Now she is born she was too small so I think, I will try the formula and the breastfeeding. What is good for my daughter? So she gain the weight… But I am happy because the weight is good. My one friend she has one 10 months old, but the weight is still 15 pounds. But my daughter is now like 12 pounds… the doctor says she is healthy. But I don’t know. Still I try to do the breastfeeding. But she doesn’t want. When I try to do the breastfeeding she is crying and crying. I am still trying though.”

Saddened by the revelation that like her son, her daughter also “doesn’t like” her breast milk, Noor transitioned from breastfeeding to exclusively formula feeding by the second month. Her daughter rapidly gained weight which was applauded by her doctor as a sign of good health. Though she felt that formula feeding was in some ways more difficult, needing to measure out the formula, prepare bottles, and track how much she ate every day to ensure it was enough, Noor felt confident in her formula feeding. “I learn from our pregnancy group and from my
family doctor, how many times to feed him. And I learn from WIC, they give me a paper and ask how many times do you have to feed him?” She kept careful track of how much her daughter ate and when and was applauded by her doctor, her social worker, and the counselors in the WIC office for her mastery of scientific mothering. In addition to keeping a chart of her daughter’s food intake she also kept careful track of how much she slept and when, writing it in a journal. Noor’s daughter rested in a swinging bassinet in the living room, but was light enough to move to the bedroom when needed. Noor admitted to “occasionally” sharing a bed with her baby but insisted that she was looking for a larger crib so that she “can learn to sleep by herself.” At nearly 6 months, Noor’s daughter had grown from 5 pounds to 14 pounds on a diet of formula, but she was still smaller than other babies her own age so, on the suggestion of her doctor, she introduced solids to help her grow faster.

5.3 Aye

Sitting cross legged on a small chair, Aye looked small in her sparse apartment. The heat was oppressive and the fan in the window offered little relief. Though I was sweating, Aye seemed comfortable. From her third floor apartment, Aye could hear her older children playing soccer in the small courtyard of the building through the open window. Inside, dinner was finished and the smell of fried fish hung in the air. Her son, now 12 months old, ran from corner to corner of the small living room. Occasionally he would climb up on his mother’s lap and tug at her shirt, after which she would offer him her breast. After a brief suckle he was off again. Though only 26, Aye’s face showed years of fatigue in the rose colored light of the setting sun. The day was drawing to a close, but not yet over. The children had to be put to bed and the remnants of dinner lingered. Aye had been living in the United States less than a year. Life was
hard, harder than she expected. She had escaped the military oppression in Burma to Thailand, where she met and married her husband. Though the situation was better than Burma, in the refugee camps in Thailand fear of the Thai police still hung over them “like a heavy blanket.” Freedom from that fear is what she and her husband were hoping for in the United States. After less than a year, the potency of their newfound political freedom was fading as Aye felt the weight of new customs and expectations.

“If it’s possible I want to go back over there. Here it’s hard. Time is really important. They don’t like if we are late, even one second! They will not even let us be late even 10 minutes! So we have to be on time. So we have to move, move, move! Over there we don’t have jobs or money, we still have a place to live. Here if we don’t have a job and we don’t have money we don’t have a place to live.”

The lament to return is one that those working with refugees often report is common. As one case worker shared with me, “All I hear is ‘I want to go back, send me back!’ And I’m like, ‘Give it a year! It’s only been a few months! You’ll get used to it and things will get better.” Aye has been told this over and over by her case worker and Marilyn, who was visiting with me today. “Aye is having a really hard time,” Marilyn shared with me, “I try to get her to come to the group, and come to the parenting group but it is so hard. She is scared and doesn’t know the language. She has kids so she can’t come to English class.”

The orientation process that refugees experience is intended, on a practical and everyday level, to ease their transition into American society. Learning English, in addition to customs and hygiene standards, is a cornerstone of that process. Attending these sessions is contingent on having a small degree of personal freedom, a freedom that Aye did not have as the mother of a breastfeeding child. Though steps are taken to accommodate mothers of small children by
providing free childcare during these classes, Aye felt isolated and trapped in her home by the needs of her family and the expectations of American standards she learned about prior to leaving the refugee camp in Thailand. Importantly, the importance of time, cleanliness and hygiene, which was very different than the daily life she and her family had in Thailand.

“The standards are different. Over there if I don’t want to do laundry I can leave it. If I don’t want to mop the floor I can leave it because this is my own house. But here I am renting, so I want to keep the landlord happy too, and my neighbors. So the standards are up here (motioning upward). So I have to keep it clean, I have to do laundry, I have to have clean clothing for my children and me. So even if I don’t want to do it, I have to do it.”

As the mother of three children Aye was constantly busy, but unlike in Thailand she felt busy due to expectations that she did not fully understand. Prior to immigrating to the United States, and following her initial arrival, she was lectured on American standards in hygiene and housing and she strove to maintain those standards. Apart from easing their transition into American society on a practical level, orientation also introduces the inner workings of the American legal system, namely the role of the police and the Department of Child and Family Services (DCFS) as they are the departments with whom refugees may have contact outside of refugee, nutrition and health services. According to a case worker at a resettlement agency the purpose of this is to prevent the intrusion before it begins and to protect the welfare of women and children in the United States as refugees come into contact with the police and DCFS in response to domestic violence. Neighbors will call the police in response to sounds of domestic violence and teachers are trained to report signs of domestic violence or neglect that can include physical signs and poor hygiene. The message that the police or DCFS could intrude on their lives at any moment was not lost on Aye. The wooden floors in her small apartment gleamed.
Her daughter’s clothes were spotless and their hair was neatly tied back. Aye’s own hair was rumpled and her clothes were spotted and torn. Her 12-month old son wore only his diaper. Aye described mothering as being very different in the United States where she had less freedom to care for herself and had to watch over her children more carefully than before. The threat of the police intruding in their lives, which was her primary reason for seeking resettlement, followed her to the United States.

“It’s really different. Huge differences being a mom here. Over there, back home, when they went to school in the morning, after they have breakfast, they go the school. I don’t have to escort them. Here I have to escort them to the school and take them to the playtime. Over there I don’t have to take them, they can take themselves to play. Here I have to be watching them all the time, keep my eye on them all the time. It’s a big responsibility. Over there we don’t have to watch them, it’s different. Here I have to. I am worried the police will take them. Sometimes I wonder if they go somewhere by themselves I have to really worry about them. If they misunderstand they won’t know how to come back home and the police will come and get me. Over there we didn’t have to worry about things like that. What if I am questioned by the police? I don’t know how to answer them, I don’t know their language. It’s a lot of fears, not only police. We live upstairs so if my kids are outside playing I am afraid the neighbors will say something to us. Over there we had our own house.”

Aye described the biggest change to mothering was the need to constantly supervise her children and the feeling that she was being watched over as well. She recalls how she was prepared for the changes in what was expected of parents and children in the pre-resettlement orientation sessions in Thailand. “Before we came to this country, back home before we come here they told us when you go there you have to learn everything and you have to learn how to
walk again. I am like a baby again, I have to learn these things step by step.” Although Aye has two older daughters she feels the pressure to modify her mothering to the expectations in the United States. However these new expectations do not lead her to rethink the way she mothered her children prior to immigrating to the United States. Aye feels the need to follow guidelines for mothering outlined by the structural forces around her, the resettlement agencies, the pregnancy and parenting groups, her children’s school, etc. Aye recognizes that adhering to these recommendations is more difficult than when she relied on her own intuition. Aye describes the constant advice she receives from well-meaning people in the various agencies she comes into contact with as intrusive and undermining her confidence. “Back home people didn’t give me advice all the time. Over there we know each other. Here everyone is scared so everyone is advising each other so we don’t get in trouble. Over there I had some worry but it was easier. Here everywhere I have to worry, how they are going to grow up, are they going to be a good person? Back there I just had confidence.”

Aye describes her struggles with her confidence as challenging own agency as a mother. Used to making daily decisions for her children without the constant stream of advice and input from others, well meaning though it may be. In Thailand she allowed her children to exercise their own agency in the same way she and her husband did without worrying about what type of mother she was. “Over there, I don’t worry, whatever they want to eat, eat! How long they want to sleep, sleep! Whatever!” Now in the United States, the constant stream of advice challenged her confidence in her decision making in a way she had not experienced before and found difficult to adhere to. “Here I have to worry,” she says, “feed them milk two times a day. So I have to feed them two times a day. No less than eight hours sleep. So I have to make sure they sleep eight hours a day.” Aye was further frustrated as she did not think that her daughters were
thriving more in their new home. If anything they are experiencing more difficulty because her need to adhere to outside influences has usurped her role as the authority figure, particularly when disciplining her children.

“I want to talk about this. Over there we don’t have any freedoms but here we have development and freedoms. We have to be everywhere on time. Over there if we don’t have hard time with a soldier or that kind of thing, over there it is easier than here. Parenting in this country is a lot different than my country. If we discipline our kids we cannot use stick or something like that, we can discipline by mouth only. So we have to be a different kind of mother. Over there, back home, if we say one or two words if they don’t listen we just get a stick and spank them. Here if we say three or four words and they don’t listen we have to persuade them, we have to beg them. So here it is too difficult…Really frustrating. For example when I first arrived in here I took them to school and they didn’t want to go to school. So I had to beg them and persuade them, “oh I am going to buy you this and this,” until the door closed and I had to bring them back with me. And I thought, no, this is not right. I have to do something. They have to go to the school. I couldn’t even sleep when I am thinking about how to discipline my kids.”

Although Aye struggled to modify her mothering for her school-aged children who were under daily public scrutiny at school, she was critical of advice she received in regards to her 18-month old son who stayed with her at home daily. She describes some of the mothering practices she observed in the United States as absurd. Aye offered one example in the constant reliance on strollers over carrying children or letting them walk.

“I was told that here they do not carry the kid, they just put in the stroller. So I came and I see a lot of people with the stroller…People said that the kid has to be in a stroller until five
years so I think I must carry my son until five years (laughing)… Over there after three years my kids run around. But here if you let your kid go, walking around the police will arrest you, the people told me. People over there told me that. I thought, ‘It’s too much, I cannot carry him.’ So I thought maybe I will use a strap, a leash (laughing). If people let the kids go walking around by themselves. It’s better. I don’t have to carry. If he’s walking it’s better for him as well, he’s going to be strong. If he wants to walk I let him walk. I don’t want to carry him all the time.”

Aye’s frustration with the social custom to use strollers for children who are able to walk on their own demonstrates that though she describes her confidence as shaky and is willing to adopt the subjectivity she is expected to in public, in private with her son she is still comfortable exerting her own agency and mothering her son on her own terms. A large component of the exercise of her agency is breastfeeding her son though she recognizes that few women in the United States breastfeed babies who “can walk.” She recounts how she was advised not to breastfeed in public and to use a bottle in the United States during her pre-resettlement orientation. “Here we are not allowed in public to feed our kids, on the street or anything. So here it is better to have a bottle. I was told that you shouldn’t feed your kids on the street or in front of people. You should go to the bathroom. You should use a bottle. They told us in orientation. It is better to be breastfeeding, you don’t have to carry a lot of extra stuff.”

Rather than use a bottle or any additional “stuff” Aye prefers to continue mothering her son in the same way she mothered her older daughters. Particularly in regards to breastfeeding, which she describes as “easy, I didn’t have any problems breastfeeding.” She acknowledges that she feels pressure to stop breastfeeding, particularly when she breastfeeds in public, because of the stares she receives from people on the street. These stares led her to stop breastfeeding in public and delay her son by offering him a snack of solid food until they return home. When
asked how long she planned to breastfeed her son she would not give a time table of when she would like to stop aside from allowing that she would continue until her son decided to stop.

“I don’t know how long he wants to breastfeed (laughing). I don’t know how long, he is really attached to me. I don’t know how long he will want to. I want to stop it, but he is really attached so I don’t know how to stop. With the first one the baby said no more at a year and nine months. The second one went for five years. Up to two years is the most you need to breastfeed but the baby wanted to keep going until five years.”

When asked if she would continue for five years with her son Aye said yes without hesitation. Aye’s commitment to breastfeed her son until he (and she) decided to stop could be lauded as admirable and as a commitment to breast is best platform to continue breastfeeding until mother and baby wish to stop. Noticing the formula in the kitchen, Aye admitted that she also gave him formula on occasion because “he likes it,” seeing no contradiction between breastfeeding and giving her some formula now and then. In light of Aye describing her confidence as being undermined mothering her older daughters in the public arena, Aye’s dedication to breastfeeding in the private arena could also be read as a form of resistance to practice mothering on her own terms. Relatively isolated from public instruction, Aye could continue a bit of the life she had known prior which included being a confident mother and feeling free from the pressures of “time” and conformity.

Aye accepted that to acquire political freedom and “development” meant adopting new practices that she did not agree to become a good citizen-subject such as not using physical discipline and being subjected to monitoring and scrutiny. She also recognized that the intrusion of outside authority figures was most present in the schools and that she had already lost much of the autonomy she had in mothering her two older daughters. With her son, she recognized that
she still had some autonomy which made her hesitant to attend the pregnancy and parenting groups that Marilyn continued to push. While Marilyn viewed it as an opportunity to “get out of the house and meet some more people,” Aye saw it as yet another opportunity for “middling modernizers” to intrude and persuade her to change her mothering practices. While she was constantly being asked to help her older daughters with projects for school and answer questions such as “what do you want for your child when they grow up?”—for which Aye didn’t have an answer—-with her son she said she could “just relax.”

As we sat in the stifling heat of the setting sun her son walked in to the room, naked, and peed on the hardwood floor. He then ran off giggling. Aye’s husband who had been sitting in the kitchen walked in silently with a towel and wiped it up. I mentioned that I too was having difficulty potty training my son, who was just under two years old. Aye just waved her hand and laughed. “I guess I am just lazy with this one!” Marilyn’s face tensed up and I laughed and relayed an experience that happened earlier that day with my own son. He was 18 months old and we had decided to try potty training. We had a small training potty that he sat down on but jumped up when he began to urinate and ran off, spraying a stream of urine down the hallway. We all laughed at the story and Aye chimed in that “children will use the potty when they want to.” Outside of Aye’s apartment, Marilyn did not let the incident pass without comment. “Could you believe it?” she asked. “No diaper on the baby, just peeing on the floor! This is why I try to get her to come to the parenting group!”

5.4 Mu

“You are welcome,” a young woman in her early twenties greeted me at the door. She was introduced to me as the sister-in-law of Mu, who had just returned from the hospital after
having her third child, a son. Mu was finishing a shower and I could hear her new son crying from the next room. Mu’s sister-in-law Sui rushed into the next room to retrieve the baby, bouncing and cradling him to comfort him. His cries faded to whines and whimpers. Mu emerged from the bathroom in a robe with her hair dripping wet to take the baby. She immediately took him into the bedroom, sat on the bed and offered him her breast to which he latched hungrily.

“He is hungry” she said. “He is always hungry but I don’t have milk yet.” He son started squirming and whimpering while latched to the breast. “You see? You see how he is so hungry and getting no milk. He is angry.” At five days old and barely over five pounds, her tiny son did indeed seem frustrated as his little jaw feverishly moved up and down. After about five minutes he started making grunting noises and kicking his feet. Sui came into the room with a bottle of formula she had prepared. Mu accepted the formula and her son drank it hungrily.

“Some people say when you are breastfeeding they are going to learn more and be healthier. Breastfeeding is so good because they are going to sleep for three hours or more and it is better,” Mu said to me as she fed her son the bottle. “With this baby I drink a lot of soup so I make my milk but he is crying and crying so he is still hungry. He is crying and crying more than my other kids so I give him some formula and he stops crying. I don’t have more milk coming out. So I give him more formula. I am making less milk. Because I have c-section I could not drink enough soup so the milk is coming less. I couldn’t eat any rice or anything. With my other babies I could eat rice. More rice makes more milk but with this one I couldn’t eat rice.”

“Why couldn’t you eat rice?” I asked.
“They didn’t have rice in the hospital” Mu replied matter-of-factly. “They brought me food but I did not know it. Bread and noodles and sauce. No rice. No soup. Finally Sui brought me soup and rice but it was not enough for my milk. So I have no milk now.”

Mu attributed her lack of milk to the fact that she could not have the foods she expected to have that, like Noor described, are used to induce milk production in Burma: spicy soup and rice. Mu also had an emergency c-section, her first, which made her stay in the hospital longer than she expected, five days as opposed to two or three days. Though worried about her milk production Mu said she was relieved and grateful to be in the United States.

“I would have died in Burma,” she said with a quiver in her voice. Needing a c-section had been her biggest fear that hovered over her first two pregnancies. She had learned about her most recent pregnancy prior to being granted resettlement in the United States, while living as a refugee in Malaysia. “In Burma and Malaysia, if you don’t have money you have to have the baby vaginally, no c-section. So a lot of mothers die in childbirth. They push and push and the mothers die and the babies die. So when I first found out I was very scared because we didn’t have any money, so in my mind I was scared.” The fear she felt with her first two pregnancies became even more potent with her third pregnancy as her situation was even more dire. Having had her first two children in Burma, she experienced a lot of fear about the birth itself and what might happen if she couldn’t “push the baby out,” knowing that medical assistance was financially out of reach. That fear, Mu described, was even more potent than the fear of harassment by the police. As part of the Chin ethnic group, a minority in Burma, Mu and her family were subjected to random harassment and attacks by the military police, which led them to flee Burma for Malaysia. It was interesting to me, that when describing her fear, Mu was more emphatic about her fear of dying in childbirth than of the military police. “Over there, there
is no development. Doctors will come to your house but if you have no money they won’t come, they won’t help.’’

The help available to Mu was her sister, who lived nearby and had her own children. She was able to care for Mu for a month after the birth of her first two children. She made Mu spicy soup, fed her lots of rice and taught her to care for the baby, including how to breastfeed the baby. With the first two babies Mu remembers her milk coming in right away, so quickly that she was painfully engorged which made breastfeeding difficult. “Yes the first baby was really difficult, breastfeeding, because I have pain. Because I have pain and the milk is coming out and it is so full. It is so painful. As soon as I am breastfeeding it feels better. My sister say when your son is going to breastfeeding it is going to be better. When I have my first baby I have my sister so she can show me. After four years I have the second baby and I have the pain again, it was the same. The first and the second baby are difficult. But the third baby is fine for me. No pain but no milk.”

Mu had considered giving her first two babies formula but it was financially out of reach. “And anyway,” Mu explained,” they seemed healthy.” She breastfed her oldest daughter for one year and five months and her second, a son, for one year and seven months. “Breastfeeding is good. My friends tell me and my sister tells me. My doctor tells me too. That is how I know. I learned from my doctor.” Mu was determined to breastfeed her infant son, despite the fact that her milk had not yet come in and she was supplementing with formula. “Breastfeeding is good,” she repeated. “But he is so hungry, what can I do?”

Six weeks later I returned to visit Mu and was again greeted by Sui at the front door. “You are welcome” she said with a big smile on her face. She balanced a basket of laundry on her hip and excused herself and she took the laundry downstairs. Mu also had a big smile of her
face, sitting on the couch breastfeeding her baby. I commented that she was breastfeeding and she replied that after eating a lot of soup and rice, her milk had finally come in. However she still fed him formula in addition to breastfeeding.

“The baby takes formula three times a day now but breastfeeding whenever he is hungry. But Mom’s milk is more. Whenever I go out of the house I give him formula but when I am in the house I give breast milk. I don’t know if formula is good or no, but my friends all say to give formula. He is thirteen pounds now. Breastfeeding is better than formula though, so at home I only give breastfeeding. Outside only I give formula. Breastfeeding is easier. With formula I have to wake up and I have to make the formula. At nighttime I give breastfeeding but if he doesn’t want to eat or my milk is not coming out I give formula. Mostly he like formula, but sometimes when he is sleeping he likes the breast milk. He likes most formula because he could not get more milk with breastfeeding but now the milk is coming more. I am sad but what should I do? My milk is less even though I try a lot. I am going to eat chicken soup mostly. I try to eat more rice and more soup. I don’t have anyone to ask for help. The doctor say that when I give my son more breastfeeding will give more milk but it does not happen. I have an appointment tomorrow and maybe I will ask the doctor.”

The fact that she continued to feed her baby formula and breast milk posed no contradiction for Mu. She cited the baby’s growth as evidence that he was healthy. She said that she was committed to breastfeeding her baby, as she had her first two, except for “maybe two or three years because he is a smaller baby.” With the addition of formula he cried less and slept more. Mu showed me a crib they had procured which was in her room next to her bed. “He takes his naps in there and then I can cook or clean or whatever.” The pain from her c-section had diminished and she was beginning to do some of the household chores again, which Sui had
dutifully taken over. Sui was taking English classes at the refugee agency and was preparing to enroll in classes at a community college so she needed more time to do those things, Mu explained. I asked if the baby was sleeping at night as well. “Yes, he sleeps well at night,” Mu replied. I expressed that I was surprised that he would sleep in a crib so well at such a young age. “No he doesn’t sleep in the crib at night” Mu chuckled. “Babies cannot sleep on their own at night. They need to be with their mother to sleep. He only sleeps for his naps in the crib.” Why get a crib then, I asked. “Oh everyone tells me that the baby must sleep in a crib. My doctor tells me and helped me to find the crib. She even called me at home to ask if I had gotten the crib and put the baby in it. Of course I said yes. But babies need to sleep with their mother. How do I feed at night otherwise? If I give formula I have to get out of bed to make a bottle and the baby is crying. That is too hard. Even if he is in the crib I have to get up to breastfeed and put him back down. But if he is in the bed I can just breastfeed him and go back to sleep. It is easy.”

Like Aye, Mu was finding adjusting to living in the United States as a mix of emotions. “Before [in Burma] I could go outside, I could go anywhere. But with the kids I don’t feel like going anywhere, maybe to the park. I remember a lot my mother and it makes me sad to think she is not with me. In Burma, my mother was there to help me. But in Malaysia, I remember my mother, but she was not with me. It’s a mix of emotions. Sometimes we are happy and sometimes we are more sad, it’s a mix. Now I am thinking because my daughter is going to school and my husband is going to work, how can I live with 2 kids in the home? I have to take these 2 kids to school and I have to pick up.” Unlike Aye, however, Mu did not feel that she was constantly being watched over, though she did feel pressure to get her children to school on time and make sure they were clean. The household addition of her sister-in-law Sui relieved her of that pressure, she said. “I can do it or Sui can take of it. Or even my husband will do things
around the house, like some laundry. Sui can go to the store or watch the kids while I go to the store. It is easier.”

Unlike Aye, Mu did not feel the need to follow guidelines for mothering or advice given by well-intentioned people around her. Being a mother of three, she explained that she can rely on her own intuition. Like the advice from her doctor about putting her baby to sleep in a crib, Mu learned to smile and nod and quietly brush off the streams of advice that continued to come her way from her social worker at the resettlement agency. Like Aye she was given advice from her social worker and the school about how to care for her children in the form of pamphlets and newsletters which Sui translated for her. But she brushed them off as unnecessary. “They tell me how many fruits to feed them or vegetables how many times a day. Children will eat when they are hungry and at dinner. They will sleep when they are tired.” Mu said smiling and waving her hand in the air as if to brush off the advice. “Here there are so many decisions and choices. But it is easy! Children know what they want to do.”

Mu’s approach to caring for her infant followed the same pattern. “He knows when he wants to sleep,” Mu explained. “He will rub his eyes or cry, then he is tired. The doctors asks me when he naps and how many hours he sleeps every day. I don’t know how many! Why does it matter how many if he can sleep when he’s tired. Also asks how many times he eats? When he is hungry! With the bottles I can tell her how many and she always asks, how many bottles, how many ounces. With breastfeeding I can feed him when he is hungry and then he is happy again!”

The constant inquiry and requested monitoring of her infant’s behaviors by her doctor were amusing to Mu. “Americans pay so much attention to eating and sleeping but what about to love? You [Americans] have to be taught to eat and sleep and also to love, like that lady in the class! Not picking up a crying baby and not showing the baby love. You have to be taught
everything rather than just doing.” The parenting groups she had attended prior to giving birth were amusing to Mu as they demonstrated what she had long suspected, that the constant monitoring, regulating and planning that was promoted by scientific mothering discourse interfered with the instinctive and intuitive interactions mothers and babies have. “To love is natural” she explained. “To love is easy. If you have love you can understand what the baby needs, if he is hungry or tired. Even when they are older if you have love they will be happy children.”

Raising happy children was Mu’s primary goal, not to find a job to give additional financial support to her family which she commented with a hesitant laugh, “that won’t make her [her social worker] happy!” “Maybe I will have a job in two or three years” Mu said a few months later, brushing off the comment that her social worker was encouraging her to find a job. Her son was now four months old, old enough in her social worker’s estimation to leave him with a caregiver. Mu acknowledged that Sui could care for her children while she was working and she could be home with the children while Sui was working. Mu felt no need to rush to find a job, which she viewed as violating her role as a mother which she described as being home with the children until they went to school. She also viewed it as potentially violating her breastfeeding relationship with her infant son. “My son was smaller than my first two babies, so he will need to breastfeed for at least two or three years. After that, maybe I will find a job.”

The notion that she should not be home with her children to constantly nurture them and give them love was not something that Mu had even considered prior to moving the United States. Now that her social worker was proposing that she look for a job, Mu was forced to confront that the environment in the United States was different. The primary difference for Mu was money as she said, “development costs money.” In order to help her children realize their
dreams would cost money she acknowledged and was part of her responsibility as a mother. “My children have to decide what they want to be. Like if we decide they want to be a doctor but they do not want then it is not good. It is important what they want. So it is important that we save money. The mother and father have to say to them what is important and what is good. So it is important to go to school. “

Just as important as their aspirations in the United States was their future as parents and Mu was already planning her role as the matriarch of a larger extended family. When discussing what her ideal family size would be she admitted that she might like to have a fourth child, especially since she learned that having a baby after having a c-section was permissible in the United States (it is not in Burma). But she also admitted that she felt she might be too old to have a fourth baby. Not yet 30 years old I asked why she felt she was too old and she responded that it was important to her to be able to help her children with their own families and she did not want to be too old and tired to do that. With her oldest daughter already eight years old, waiting a preferred four years between children would mean that she could have a young child to care for when her daughter is starting her family, which could be as young as 15 years old. She did not want to be in the position of caring for a young child while also trying to help her daughter start her own family, though she admitted it was better for her daughter to wait until she was a little older before starting a family. “20 years old is a good time to have a family. Back home some people, 15 years old. It depends on them, what they want. If they want to have a family at 15 years, when they are ready for a family, I will ask of the boyfriend, can you take care of my daughter or not? If they say yes, then it is ok.”
5.5 Breastfeeding Practice

The degree to which Noor, Aye and Mu chose to selectively incorporate scientific mothering discourse mirrored the degree to which they envisioned resettlement in the United States as concluding their path to “development.” Each recognized that the seemingly friendly advice on mothering practices was a form of “benevolent assimilation.” The extent to which each mother engages in the dance of being-making to define themselves (or not) as citizen/subject-mothers rested on the how they responded overall to what they conceptualized as “development.” While Noor described development as offering access to the latest in scientific advice, material goods and opportunities for class mobility, Aye and Mu envisioned it as offering political freedom and personal autonomy. While Aye understood that political freedom came with a cost and was willing to modify her mothering practices to fit expectations in the public sphere—while maintaining her autonomy privately in her home—Mu was aware of the expectations placed on her and was dismissive and oftentimes critical of them.

As we have seen within these mothering narratives, how each mother conceptualized her role as a citizen/subject-mother influenced their infant feeding decisions as each strove to develop herself as a good mother and do what is best for her baby. While some, like Mary, Aye, Mu, Jala and Mahnin relied on their own experience and knowledge, others like Bhakti, Cecile, Isabelle and Salma looked to medical advice and authority. All supplemented with formula to a degree at some point and all rationalized it as exercising some form of personal responsibility—whether it was responsibility to allow the baby to thrive or the responsibility to give their baby what it wants. However, there is an element of validation inherent in each of these choices. Breastfeeding takes place primarily in the home, therefore is rendered invisible to the public and watchful eye of medical authority. Infant growth, weight gain, and crying (or lack of crying) are
visible measures of infant well being that can be assessed by others and validate mother’s practices as “good mothering” reinforcing the embodied nature of mothering practices. The choices made about infant feeding are intimately tied with the desire to be perceived as a good mother.

In a 2005 article “Universals of Child-Rearing,” psychological anthropologist Naomi Quinn posited that there are four universals in childrearing practices utilized by mothers across cultures. The four claims are that child-rearers (1) engineer their environment so that lessons are constantly and consistently enforced; (2) rely on emotional arousal for motivation; (3) employ approval and disapproval for additional motivation; and (4) utilize simple versions of lessons as a foundation for later, more complex lessons. In a commentary to the special issue of Ethos, “Mothering as Everyday Practice,” Quinn acknowledges that her four universals are challenged by conflicting ethnographic accounts of mothering in a variety of cultural settings. While Quinn acknowledges that there may be variation in the employment of universals in childrearing, neither Quinn nor any of the contributors to the special issue address child-rearing in the context of social and cultural transformation, particularly in the context of immigration. Each assumes the cultural context of child-rearing remains constant rather than changing.

An additional neglected aspect of mothering is the period of infancy, the first 12 months, the time I argue is a period of the redefinition of the self as a mother. The absence of babies from ethnographic inquiry of mothering is not a defining feature of this special issue, rather representative of a neglect of infants within mothering discourse leading anthropologist Alma Gottlieb to query “Where have all the babies gone?” (2000:121). Gottlieb observes that within anthropology infants are conceptualized as lacking scholarly promise, constituting “a non-subject, occupying a negative space that is virtually impervious to the anthropological gaze”
This neglect of infants seems to extend to the mothering of infants, with notable exceptions (Gottleib 2002; Hewlett 1991; Levine 1976; Levine et al. 1994). Gottleib offers explanations for this neglect. The first is the relative youth of anthropologists in the field, often occurring prior to parenthood. Another is the difficulty assigning agency to infants. Another is relative neglect of women from anthropological inquiry and even with a reorientation to include a focus on women’s reproductive lives, the babies themselves remain in the background. Finally babies are conceptualized as unable to communicate and not as rational beings able to assert their own agency (Gottleib 2000).

Breastfeeding discourse also, strangely, seemingly excludes infants as subjects, focusing instead on the social and historical constructions of mothering and infant feeding (Apple 1987, 2006; Blum 1999; Carter 1995; Thulier 2009), critiques of mothering and breastfeeding discourse (Aviashi 2011; Johnson et al. 2013; Knaak 2010; Murphy 1999; Schmeid and Lupton 2011; Wolf 2007, 2011) or biomedical investigations into the benefits of breastfeeding. This research also does not focus on the lives or agency of infants, but does attempt to move infants back into the realm of inquiry. As we have seen, mothers do conceptualize their infants as having their own agency and ability to express their own desires through continued crying, refusal of the breast, and refusal to sleep contentedly. Therefore infants should be considered an important player in infant feeding discussions. While I do not attempt to address the concept of infant agency within this dissertation, I do attempt to conceptualize mother’s responses to their infants within social and political constructs. The close attention and response to their infant’s needs is, in fact, an important aspect of each mother’s notion of personal responsibility.

While the field of child-rearing can span different time frames across cultures, as can the period of infancy, there are aspects of mothering during the period of infancy that remain
constant. While I will not attempt to categorize them as universals per se, I do suggest that there are aspects of mothering during infancy that are constant and that these aspects may set the foundations for the child-rearing universals suggested by Naomi Quinn. These aspects of infancy that emerged as the central concern to each mother in this project are infant sleep and infant feeding. How each mother responded to each of these concerns was embedded in her own ideas and responses to her felt, intuitive or embodied notion of what her infant needed, the social expectations as she understood and interpreted them, and the larger political context of constructing herself as a citizen/subject-mother.

### 5.6 A Word on Sleep

When proposing that there are four universals in childrearing practices utilized by mothers across cultures, Naomi Quinn focused on the teaching of cultural values through lessons, the environment and emotional responses (2005). Like many scholars of mothering, Quinn assumes that mothering is between a responsive or communicative child and a care giver rather than including mothering a preverbal infant. In addition, Quinn does not account for child-rearing practices in the context of social and cultural transformation, particularly in the context of immigration. Rather establishing a constant and consistent cultural context of child-rearing is cited as a universal. However, despite the differences cited in child-rearing across cultural contexts or the changes that may occur during period of cultural transformation, certain elements of mothering during the infant period are shared across cultures. I will conclude this chapter by addressing a constant partner to breastfeeding practices of the mothers participating in this project and, I argue, all mothers-- sleep.
When discussing this project with a friend and colleague, himself a father of three teenagers, he threw up his hands and said “Ah, it is so hard to read about this period! All I can think about is sleep, the lack of sleep and the constant crying! I kind of forgot about it but thinking back, that is the part I wouldn’t want to do again! Oh and the frustration! Constantly wondering are you hungry? Are you tired? Do you need a new diaper? Go to sleep! When all I want to do is go back to my own bed!” The difficulty many parents have deciphering their babies nonverbal communications may seem or feel universal to the parent, but as Alma Gottlieb points out, interpreting infant communication is a cultured act. While within Western cultures infants are conceptualized as non-subjects, nonverbal, and therefore noncommunicative, outside of Western contexts other forms of communication are not excluded from conveying meaning (Gottlieb 2000). The babble, somatic communications—“leaks” as Gottlieb phrases it—and sleeping patterns are all culturally significant and couched in cultural patterning and interpretation.

In an examination of infant sleep and breastfeeding, Cecilia Tomori questions the dominant model of infant sleep in the United States. Tomori investigates the consequences of contradictory medical guidelines governing breastfeeding and infant sleep among middle-class parents and proposes that the heated debates about breastfeeding and infant sleep arise from the social histories of biomedicine and capitalism in the United States (2011). Tomori tracks the transformation of childbearing practices in the United States over the last two centuries to have two lasting consequences. By moving childbearing from the home to the hospital where it could monitored and measured by medical experts artificial feeding mostly replaced breastfeeding and the infant was separated from the mother, a pattern that mirrored other Western societies (Davis-Floyd and Sargent 1997). The medicalization of birth was partner to the industrialization of
society that moved many into wage-earning and time regulated labor, including women (Lock and Nguyen 2010). Accompanying the trend of one or both parents moving into time-regulated labor was pediatric advice promoting solitary, regulated sleep away from the parents, disrupting the previous pattern where infants would either share a bed with their parents or sleep in the same room in either a bassinet or crib, both arrangements which facilitate nighttime breastfeeding. This practice was propelled by the rise in wage-labor and employment outside of the home and the need for laboring parents to get a “good night’s sleep” (Kendall-Thackett et al 2010).

The practice of solitary infant sleep in the United States stands in stark contrast to cross-cultural comparisons of infant sleep where sleep is considered a social act and an important component of social relationships (Jenni and O’Connor 2005; McKenna, Ball and Gettler 2007, Wolf et al. 1996, Worthman 2008). Co-sleeping—whether bed sharing or room sharing—has also been documented to be a partner to nighttime breastfeeding (Dettwyler 1988, 1995; Gottlieb 2004; Morelli et al. 1992). Biological anthropologists James McKenna and Helen Ball argue that co-sleeping is an adaptive behavior that the mother’s body plays an integral role in regulating the sleep of both the mother and infant. The close proximity of bed sharing facilitates nighttime breastfeeding by allowing the mother to respond to subtle infant cues and initiate breastfeeding with neither the infant nor mother fully awakening while also regulating the infant’s body temperature and breathing (Gettler and McKenna 2010, 2011; McKenna 1986, 1993, McKenna et al. 1997, McKenna et al. 1999, McKenna, Ball and Gettler 2007, Mosko et al. 1997, Mosko et al. 1993, Richard and Mosko 2004). James McKenna further challenges dominant medical advice suggesting that mutual regulation of sleep in co-sleeping and nighttime breastfeeding arrangements can actually reduce SIDS, advocating integrating nighttime breastfeeding and sleep
(Ball and Klingaman 2007; McKenna and Ball 2010). As Tomori (2011) points out, though pediatric advice continues to promote solitary sleep and the majority of parents in the United States continue to adhere to this advice—or publicly claim to adhere to this advice—the practice of bed-sharing or room sharing is increasing (Kendall-Thackett et al 2010; McKenna, Ball and Gettler 2007). Bed-sharing, or “co-sleeping”—a term used in popular media to describe bed sharing rather than room sharing—has increased alongside the increase of breastfeeding in the United States with nearly 50% of mothers in a recent National Infant Sleep Position Study admitting to sleeping with their infants for at least part of the night (Willinger et al. 2003).

Bed-sharing, Tomori argues, is a controversial and morally charged practice in the United States that violates medical authority and Western constructions of personhood and individuality leading to what she terms a “moral dilemma” (2011). Though the majority of medical advice advocates solitary infant sleep for concerns over Sudden Infant Death Syndrome (SIDS) and fears of suffocation, parental sleep interruption is also at the foreground of any discussions about infant sleep (Zimmerman and Bell 2010; Fallone et al 2002). The continued focus on the well-being of parents perpetuates the relations of capitalist production where parents are expected to regulate their sleep and return to productive activity as soon as possible (Tomori 2011). Tomori highlights that the idealization of breastfeeding within the scientific mothering paradigm exists in a cultural terrain that does not structurally support it. Her investigation of nighttime breastfeeding in a capitalist society results in, as she terms it, an “American-capitalist morality lesson” where women’s options are pitted against one another (Tomori 2011). I argued that within a neoliberal era of governmentality, negotiating personal responsibility entails a process of subjectification where individuals are induced to choose behaviors that are best for the collective good by reducing their burden on society. In order to cultivating the optimal health and
well-being of her infant mothers are directed to exclusively breastfeed for six months, yet return to work as soon as possible, often within three months or less, yet continue to exclusively breastfeed an infant through the night while not bed-sharing.

While the everyday practices of mothering have received little scholarly attention until recently, the subject of infant sleep has received even less with the exceptions being the recent dissertation by Cecelia Tomori (2011) and Alma Gottlieb’s ethnography of a culture of infancy among the Beng in West Africa (2004). In a comparative analysis of her own experiences of mothering her infant children and the experiences of Beng mothers, Gottlieb posits that the space within which sleep and breastfeeding occupy convey important cultural values. While co-sleeping is the standard practice between an infant and his or her mother, the co-sleeping relationship can continue through childhood with the mother or another caregiver. Nighttime crying and nursing are as matter-of-fact aspects of infancy for the Beng as are bathing and bodily eliminations, during which time Gottlieb argues parents must “convince their children to leave the afterlife and remain with them.” In contrast to this religious ideology where infants must be continually cared for and enticed to stay, within American middle-class ideology the separation of spaces conveys values stating, “at the sociological level, the lesson conveyed by the bassinet, cradle, or crib that is placed in its own room at some point in the infant’s first year is in keeping with the American-capitalist morality lesson that individuals ought to make their own way in the world on the basis of their own courage and efforts” (Gottlieb 2004:184).

Like breastfeeding, sleeping arrangements were recognized as a mothering practice with which they were expected to comply. The efforts to prevent mothers and babies from bed-sharing were repeated time and time again, so that refugee mothers learned to report that they did not bed-share, sometimes to the extent that they would secure a crib or bassinet to demonstrate
that they did not bed-share. The intrusion of medical authority into the bedrooms of refugee mothers began in the hospital where several mothers reported that they were admonished by nurses and doctors for taking their newborns into their hospital bed “even though I was exhausted” said Anshula, a 22 year old Bhutanese mother of two. “I am trying to breastfeed and the baby is crying, I can hardly get out of bed and the nurse came into my room and took the baby from me, crying, and put the baby back in the bassinet! Can you believe it?” she said with her voice shaking. The monitoring of infant sleep extended beyond the hospital with several mothers reporting that their doctors called them when they returned home to “check in,” inquiring if they had a crib or a bassinet for the baby. “My doctor, she called me at home,” Mary told me chuckling. “The first thing she asked was “where is the baby sleeping?” Not how are you feeling, are you recovering, but where is the baby sleeping? So worried that I would take her in bed with me. And ya, I told her that she had a little bassinet next to my bed, not to worry, and she seemed fine. But of course the baby sleeps with me! What do you American mothers think? That babies can sleep by themselves? How can they sleep by themselves without their mother there? No, they must sleep with their mother. But these doctors are so worried, so I tell them she has her own bed to make them feel better.”

The issue of infant sleep was addressed several times in the pregnancy support group by visiting nurses and social workers. When participants were asked where and how an infant should sleep, like Mary, they were practiced at giving the expected response: in a crib or bassinet, on their back with no blankets or pillows. However during one session on infant safety after reviewing the recommended guidelines for infant sleep I asked “what if it is nighttime and the baby is crying, and just won’t stop crying? You are so tired and want to go to sleep. What are you going to do?” I received blank stares and after a period of silence one mother replied
“you will take the baby to bed with you of course.” The room exploded with a cacophony of voices shouting out that of course the baby should sleep in the mother’s bed at night and that using a crib or bassinet was only for daytime napping.

Cribs were one of the most expensive items refugee mothers in the group sought and were difficult to procure. Cribs that were donated to the group to be given away were raffled off to an attendee. All mothers were eager to win a crib, even those who had privately stated that they planned to bed-share. When asked why they rationalized that they would use it for naps and that their social worker would not continue to admonish them for not having a crib. Like Mary many, or most, refugee mothers I spoke with learned to respond to questions of bed-sharing with the expected response of “my baby sleeps in a crib” or “no, my baby does not sleep with me” to avoid criticism and additional intrusion into their lives. Though all refugee mothers reported that they bed-shared all or part of the time. Many had cribs or bassinets in their homes, claiming that they before the birth they had planned to use a crib or that they used the crib for daytime napping. Often, as in the case of Anshula, the crib was treated as a storage space for extra diapers, clothing, or toys.

The concern of co-sleeping or bed-sharing directed at refugee mothers points to widespread assumptions that women of color co-sleep at higher rates than their white counterparts and that it is more dangerous for some groups. Accidental death is a leading cause of death for all infants with half of these deaths due to accidental suffocation, overlaying while co-sleeping being the primary culprit (Hauck et al. 2011). In the United States, Black infants die at 2-3 times of white infants and 4-6 times the rate of Asian and Hispanic infants. A review article by Hauck et al. (2011) found that the vast majority of co-sleeping deaths occur among black infants while Hispanic infants have a very low incidence of death while co-sleeping. This
discrepancy led researcher to conclude that reasons and methods of co-sleeping are primarily cultural, therefore the risks of co-sleeping dangerously are also primarily cultural. A study by Fu et al. (2008) of 708 mothers (2/3 of whom were Black and 85% were non-White) who were enrolled in WIC found that co-sleeping was the most common infant sleep arrangement. Like the review by Hauck et al. (2011), Fu et al. concluded on the basis of bed-sharing alone that the reasons for co-sleeping must be either economic (inability to afford a crib) or cultural, or both, leading to recommendations that co-sleeping be recommended against in low-income populations. The conclusions that co-sleeping must have a “cultural” basis due to the widespread practice (or reported practice) among some groups of mothers (low-income Black and Hispanic mothers) and not others (middle to high income White mothers) demonstrates the ease of relying on aspects of “culture” over other variables such as income to reinforce assumptions based in “culturalist racism.” The fact that Fu et al. intentionally conducted their research among low-income mothers—intentional in that they recruited participants from WIC offices—did little to influence their interpretations that Black mothers are more likely to co-sleep and co-sleep in a dangerous manner. The fact that Mary’s doctor went out of her way to call her at home to question her about co-sleeping despite the fact that Mary had co-slept with her four older children without smothering them offers a window into the extent that culturalist racism informs medical practice and health promotion.

Like breastfeeding, when examining the day to day decisions made about infant sleep the difference between what mothers say and what they actually do can illuminate how a mother defines herself through her mothering practices. Within the seemingly mundane decisions, we can see that the mother is an actor, agent and strategist navigating the economic and political terrain that includes monitoring and regulation of their practices. As we have seen in the stories
presented in this ethnography, mothers make day-to-day decisions based on the lived experience of mothering, that is the phenomenological response to interactions with their infants and consideration of larger social, political and economic contexts. Decisions to bed-share all or part of the time were made by all refugee mothers in this project for a variety of reasons. For some it was to solidify kinship and bonding, as Bhakti recognized the strong role it played in the close relationship between her older son and her mother-in-law. For others like Mary, Anshula, Mahnin, and Jala, it was because it was conceived of as the best thing for the baby, stating “how else can they sleep?” For others, like Isabelle and Cecile, it was desperate last resort when they could simply no longer keep their eyes open during late nights of crying. And for others like Noor and Salma, bed-sharing was reserved for early infancy, the first few weeks, but the transition to independent sleep in a separate bed was an important step towards establishing independence. All recognized that bed-sharing made breastfeeding at night easier and those that switched to exclusive formula feeding found it easier to move the baby into a crib or bassinet. The subtle differences in mothering practices in the early infancy signals the negotiation of each mother’s subjectivity through the decisions she makes regarding infant feeding. In this period we see both the mother and the infant emerge as agents in a negotiation that include subject formation of both the mother and the infant. Through the lived experience of mothering, refugee mothers (indeed, all mothers) experience the social truths and social contradictions conveyed by the scientific mothering paradigm, primarily that breastfeeding is best except when it’s not. Other contradictions emerge in the realm of infant sleep where infants are directed to sleep separately from the mother yet maintain breastfeeding through the night. Mothers are expected to begin or return to work and maintain a breastfeeding relationship. Through each mother’s story, we can see that the seemingly mundane, everyday mothering practices are a locus of
personal and social resistance, creativity, and struggle. These everyday decisions are indeed meaning-making practices that develop in relation to the body politic. Every decision, such as when to feed, if to feed, what to feed and where to sleep, was embedded in her own ideas and responses to her felt, intuitive or embodied notion of what her infant needed, the social expectations as she understood and interpreted them, and the larger political context of constructing herself as a citizen/subject-mother. The day to day decisions made in each mother’s everyday practices create a foundation for the embodied experience of breastfeeding and the enactment of subjectivity. Through these stories we can see that like their paradigm of embodiment, the “lived experience” is both subject to, and an object of, socio-political power. As subject-actors, the construction of their own lived experience of mothering is more powerful in shaping women’s breastfeeding practices than are disciplinary forces trying to shape them as worthy citizens.
6-CONCLUSION: PRACTICING CITIZENSHIP THROUGH MOTHERING PRACTICE

In this dissertation I have drawn on multiple theoretical approaches to develop a deeper understanding of how refugee mothers negotiate the complexity and uncertainty in day to day decisions about infant feeding. I began by contextualizing the history of refugee resettlement in the United States and the push towards self-sufficiency and “personal responsibility” as efforts to craft refugees into ideal citizen-subjects and proposed that prior notions of development and current conceptions of citizenship influence how each refugee mother positions herself as a good mother and citizen-subject. I continued by reviewing the paradigm of scientific mothering that dominates mothering discourse in the United States and introduced the maternal education group that each of the refugee mothers participated in. I proposed that scientific mothering discourse acts as a disciplinary mechanism deployed by medical authorities, public health practitioners and middling modernizers to craft good citizen-subject mothers, though have demonstrated that it not a totalizing discourse. Finally I followed a series of refugee mother’s experiences feeding their infants for the six months following birth demonstrating that each critically and selectively incorporate aspects of scientific mothering, positioning breastfeeding choices as a meaning-making practice based on the mother they wished to become. Using the everyday experiences of my participants as the foundation of my analysis, I demonstrate how breastfeeding choices influence the negotiation of subjectivity, reproducing inequalities within the modern biopolitical project to craft ideal citizen-subjects. Throughout I have proposed that the embodied decisions mothers make about breastfeeding are enmeshed in larger processes of citizenship and motherhood and that each mother actively reformulates these processes of which they are a part.
I began my research with a simple but broad question, do refugee breastfeed after resettling in the United States? The answers is equally broad, yes, no and sometimes. Following in the steps of breastfeeding researchers Linda Blum, Pam Carter, and Joan Wolf, attempts to examine breastfeeding holistically point to the futility of considering breastfeeding itself as a singular choice. Breastfeeding research is instead, a microcosm of mothering practices employed to differentiate good worthy mothers and practices to maintain normative ideals of motherhood. To focus on the variable of breastfeeding in isolation of the myriad of social determinants which enable or inhibit the ability and desire to breastfeed ignores what I argue is the encompassing frame of choice: how each woman understands and positions her subjective self. Consideration of a mother’s subjectivity is neither a popular nor easy entry into breastfeeding promotion or research. Though I argue this consideration does not outright contradict the dominant “breast is best” public health approach to breastfeeding, it allows for a great deal of flexibility to define one’s infant feeding practices.

This work contributes several different insights related to anthropology, public health and other related disciplines by examining how mothers respond to power relationships in the day to day experiences of breastfeeding and mothering. Though I did not undertake an examination of the science of breastfeeding and the outcomes associated with it, I submit three propositions. First, I proposed that refugee’s decisions, actions and practices represent the reality of their prior conception of “development” and continues the production of a flexible and adaptive biological citizenship. The second is that breastfeeding is an embodied emergent practice mothers employ to empower themselves as mothers in novel ways. The third is that the deployment of medical knowledge about mothering and breastfeeding as a disciplinary mechanism in order to promote uniformity creates both doubt and possibilities for maternal autonomy. These propositions draw
on diverse bodies of literature and build upon scholarly work on citizenship and subjectivity, medicalized mothering, and breastfeeding discourse. Next, I will address how my research builds upon these bodies of literature and address foundational works within each.

In “Conceiving the New World Order: The Global Politics of Reproduction,” Faye Ginsburg and Rayna Rapp proposed that anthropological theory be redirected to encompass the “power relations by which some categories of people are empowered to nurture and reproduce, while others are disempowered” (1995:3). This approach has been widely adopted to include the effects of class, race, and gender in the study of health and oppression, such as poor birth outcomes (Bridges 2011; Mullings 1997; Mullings and Schulz 2006; Mullings and Wali 2001). Employing this approach to frame reproduction as a form of the production of political power, the extension of reproduction—breastfeeding and mothering—provides an avenue into examining inequality on a broader scale. As suggested by Cecilia Tomori (2011), though the examination of breastfeeding and racial inequality within public health campaigns has focused primarily on the African American community, it can also be employed to examine the construction of privilege for white middle class families. By employing the foil of privilege and whiteness as a constructed ideal for the categories of people who are “empowered to nurture and reproduce” highlights the ways in which other categories of people are disempowered.

The empowerment and disempowerment of categories of people through the creation of medical models is neither new nor a phenomenon of the West. As Lock and Nguyen (2010) assert, the deployment of biomedicine and medical racism played an important role in colonialism. The practice of colonial medicine increased the understanding of how the deployment of bureaucratic interventions could manage populations, or biopower to employ Foucault’s term. Through historical and current large scale efforts to manage epidemics, hunger
and infertility, Lock and Nguyen propose that the practice of biomedicine in the colonial and
now post-colonial world reinforces and perpetuates inequalities resulting in what Nikolas Rose
and Carlos Novas (2002) term “biological citizenship.” Rose and Novas propose that the
relationship between the state and its citizens has undergone a fundamental transformation in the
era of neoliberalism and these transformations have had a global reach. Alongside the spread of
free market capitalism is the emphasis on personal responsibility and the pulling back of social
welfare programs. These economic reforms also laid the groundwork for public health initiatives
and citizenship projects to promote “technologies of the self” to actively shape his or her life
course through acts of choice. Rose and Novas (2002) argue that the active creation of persons
with a certain kind of relation to themselves are a national priority, evidenced by the multitude of
state funded health programs and promotions. Rose and Novas characterize this fundamental
transformation in the ways that people understand themselves as a new kind of “biological
citizenship” that is both individualizing and collectivizing in that it refers to relationship the
individual has with him or herself and that it is of national and political concern. Within this
framework of governmentality, a seemingly innocent group organized to provide refugee women
with information about health, well-being, pregnancy and mothering can be recast as a site to
introduce governmentality to the lives of refugees at best and at worst as a technology of social
control.

In this conception, as Khiara Bridges (2011) writes in her analysis of resistance among
poor pregnant women in a publicly funded clinic in New York, the exercise of power is
inherently and fundamentally ambivalent. The ambivalence is that the goal, to produce docile
bodies, is unachievable as productivity and repression will always be produced concurrently.
Within this system, Bridges constructs both the compulsion of the state to provide prenatal care
to those whose fertility has been condemned and the very act of poor women being pregnant as acts of resistance. Following Ginsberg and Rapp’s formulation of stratified reproduction, where “some categories of people are empowered to reproduce and nurture, while others are disempowered” (1995:3), Bridges suggests that the “discursive condemnation” of mothers of color depends on the “always already Blackness of the undeserving poor” where reproductive value is framed by a black/white binary. Within this framework, Bridges constructs the fact of pregnancy, birth and unconditional love mothers of color give to their babies as a “powerful, material act of resistance” (2011:257). In this formulation of resistance, Bridges positions the very act of reproduction as mothers of color refusing to engage in the “techniques and strategies” of powerful discourses that paint their reproduction as undervalued within the body politic. As poor women of color, refugee mothers like Mary who refused to leave her children to work a menial job and planned to have more children, would also be seen as resisting these demonizing discourses.

However, resistance as Bridges positions it, the resistance to the social category of non-reproducer and non-nurturer, does not fully account for the dual production of productivity and repression within the body politic. In short, Foucault never fully addresses the role of resistance or agency within power relationships. Stratified reproduction, as Ginsberg and Rapp delineate, depends on “defining normative families and controlling populations” (1995:3). Aihwa Ong also suggests that deservingness exists in the United States along a black/white continuum where incoming waves of refugees seek to define themselves. During the rise of neoliberal economic policies in the Reagan era and decrease in economic support to refugees, new waves of refugees were recast as welfare recipients, and subjected to what Ong calls an “ideological blackening” because of their shared characteristics with the underclass in the United States. These shared
characteristics include lower levels of education and low wage laborers, thus low in human capital potential. As Ong points out, these characteristics were a function of the decrease in economic support they received than previous waves of refugees who received enough economic support to seek education and training that raised their human capital potential. This repositioning of refugees embeds their arrival and experience within the history of immigration threat narratives, the most recent being the “Latino Threat Narrative” as described by Leo Chavez (2013), where the newcomers are positioned as “always and already” despised. However, as Chavez and Ong point out, within the current era of neoliberal economic policies and globalization, the need for cheap labor both drives and necessitates a negative immigration discourse and vilification of immigrant mothers. Ong concludes her analysis of Cambodian refugees in the United States by locating the transformation of refugees to permanent welfare recipients as entrenching refugee’s position in the United States a permanent low wage laboring class.

The entrenched position of low wage laboring supports assumptions about refugees and their health that pervade as culturalist racism, whereby assumption that refugees are more prone to a myriad of health complications because of their history as refugees, current practices or cultural practices that clash with practices in the United States or behaviors that lead to poor health belie the fact that they are by and large living in poverty and under stress. The behaviors and practices that emerge from living under stress and in poverty interpreted as “cultural” succeeds in what Ong describes as a cultural “blackening” in order to maintain the equation of “American-ness” with “White-ness.” To employ Bridges language, she calls this poverty-based racialization the “always already Blackness of the undeserving poor.”
“To the extent undeservingness is defined as the rejection of the values necessary to the functioning of a capitalist economy, and that capitalism’s values define (and, consequently, are synonymous to) those values espoused as ‘American values,’ undeservingness describes the individual’s distance from ‘American-ness.’ When one recognizes ‘American-ness’ exists within discourse as ‘whiteness,’ the undeserving poor’s distance from ‘American-ness’ is their distance from ‘whiteness.’” (Bridges 2011:220).

The equation of refugees with poverty, poverty with undeservingness, undeservingness with distance from American-ness and distance from American-ness with distance from whiteness, support measures that look to cultural practices to explain health disparities and poor health measures and the widespread belief within health care and medicine that some groups of people necessitate more medical intervention and supervision than others. Within this racialized interpretation of health, the persistence of racial and ethnic disparities in health are less confounding. At the root of these disparities is a system that entrenches individuals in poverty and simultaneously equates poverty with deservingness, American-ness, and ultimately culture. Medical racism, including physician racism, both creates and perpetuates the health stereotypes that contribute to health disparities categorized along racial and ethnic categories.

It is widely accepted that the racial and ethnic disparities that persist, particularly in measures of maternal and infant health, and are due to socioeconomic disadvantage. This equation leads to conclusions and recommendations to reduce this disadvantage through closer care, support and surveillance through prenatal care programs and WIC. This view that class alone is the culprit has recently been challenged by the Institute of Medicine (IOM) who described and “uncomfortable reality” where “racial and ethnic minorities receive lower quality health care than white people—even when insurance status, income, age and severity of conditions are comparable” (2005). As Bridges highlights in her ethnography of prenatal care of low-income women of color in New York City, “lower quality care” in reality signifies inferior care or that people of color are more likely to not receive the most effective tests, treatments, and
therapies. Bridges points to physician racism, or individual racism practiced by health care
practitioners, as a culprit in racial and ethnic disparities in health. Understanding that health care
can be practiced differently by different people to different groups of people, and that health care
practitioners are not separated from the views, perceptions and judgment of the general
population helps to explain the different care and advice that the group of 20 refugee mothers
from different ethnic backgrounds received from their caregivers which played a role in their
overall infant feeding journey. The juxtapositioning of the promotion of breastfeeding rhetoric
as good mothering amidst pronounced racial disparities in maternal care positions women of
color as “always and already” in a position to “fail” at breastfeeding. Therefore the positioning of
mothers of color, especially immigrant mothers of color, as disempowered to reproduce, nurture,
and follow biomedical models of mothering, succeeds in defining and reinforcing norms of
mothering in attempts to control populations. These efforts are not made by encouraging all
mothers to adhere to an idealized mother-subject position, but by defining, justifying and
reproducing an underclass position.

In the stories refugee mothers tell about their own motherhood the role of personal
responsibility, to the self or to her children, appropriate neoliberal discourse in surprising ways.
Just as Ong’s (1999; 2003) model of “flexible citizenship” can be used to describe how
individuals construct their notion of belonging while traversing different fields of power, the
refugee mothers in this study appropriate a flexible and biological-based notion of citizenship in the
ways in which they present and fashion themselves as mothers. Ong describes the new model
of citizenship, which is flexible in that it is ever-changing, transformative and appropriated by
different groups, as the actively produce citizenship differently within different fields of power.
Within their new cultural homes where neoliberal technologies of governance are deployed as a
“sophisticated, population-focused, and responsive instrument” (Kanna 2010:107) through refugee resettlement programs employing what Kanna calls “idioms of citizenship,” refugee mothers produce their own citizenship through their everyday lived experiences as mothers, selectively, adaptively and at times simultaneously.

As Ong proposes, within models of neoliberal governance, power is a “social technology that derives unity not from a process of homogenization or totalization, but from transversality” where power relations “adjust citizen-subjects to key values of autonomy and self-definition” (2003:276). The degree to which idioms of citizenship were embraced by each refugee mother depended on a number of factors, including the representation of the idealized citizen-subject mother in health promotion. As Ahmed Kanna highlights “the ways neoliberal ideologies resonate with and are made persuasive within local formations of identity, conceptions of selfhood, and idioms of citizenship are essential to their appropriation by the subjects targeted by neoliberal modes of governance” (2010: 102). I argued that the degree to which the idioms of citizenship, the values of personal responsibility and autonomy particularly, resonated with each mother depended on her idealization, expectation and aspirations of development within the United States. In the cases of refugees such as Salma, Bhakti, Noor and Cecile, striving to embody the preferred attributes of the citizen-subject mother represented the culmination of a trajectory toward development. In the cases of refugees such as Mary, Jala and Aye, Isabelle, Mu and Mahnin, the equation of the development with idioms of citizenship did not resonate with their personal conception of mothering. What is interesting is that as Ong’s models predicts, despite the degree to which idioms of citizenship did or did not resonate, none of the refugee mothers internalized “technologies of the self” in regards to infant feeding or child rearing uncritically. Rather each constituted her practices based on prior experiences, relationships and
notions of mothering and breastfeeding. These prior experiences and notions mirrored their experiences in the United States to different degrees depending on each refugee’s relationship to development. Therefore idioms of citizenship resonated to varying degrees as well to produce a flexible and adaptive biological citizenship as a continuation of their pre-migration experiences. Therefore, I propose that refugee’s decisions, actions and practices represent the reality of their prior conception of “development” and continues the production of a flexible and adaptive biological citizenship.

6.1 Mothering as Belonging

The consideration of breastfeeding and mothering as a form of the production of political power, where inequalities are produced and reproduced on a broad scale, positions medical discourse about mothering and breastfeeding as a disciplinary mechanism to delineate ideal citizen/subject mothers. As I have demonstrated medicalized discourses about breastfeeding and mothering intersect with citizenship discourses about which values and practices constitute citizen-subject mothers. As Rima Apple demonstrates, medicalized discourses regarding infant feeding and mothering incorporate key American values such as the supremacy of technological progress and mechanistic quality of the body (also see Davis-Floyd 1992; Martin 1987; Stein 1990). Mothers who challenge or resist dominant trends in the United States risk categorization as deviant, pathological or “bad mothers,” positioning medical officials and associated agents in an authoritative position despite the fact that understandings of what constitutes “good mothering” can result in conflicting medical advice. As I have shown, infant feeding recommendations intended to create clarity often create uncertainty in practice which can result in the mother being at odds with medical authorities and their allies, putting mothers in a
precarious and vulnerable position. The entrenchment of biomedical models of mothering and breastfeeding has resulted in of alternative or experiential mothering knowledge as devalued, backward, naïve and potentially troublesome to established medical norms (Craven 2005).

Recognition and a critique of the power of medical discourse to exert control and establish norms has an extensive history within sociological and anthropological theory beginning with Ivan Illich (1975) (see Lupton 1997). In his examination of verbal encounters between doctors and patients, Howard Waitzkin argues that the “dominant ideologies of a society are reinforced and individuals’ acquiescence is sought” (1989:339). The incorporation of Foucault’s theory of power, where the application of power is simultaneously productive and repressive, positions medicalized paradigms—as well as citizenship discourses—as flexible and even adaptive. Rather than repressing and obliterating alternative forms of knowledge and experiences, new forms of agency, empowerment, resistance and responsibility emerge. In fact, as Deborah Lupton writes, Foucault contradicts himself within his theorization of power because the creation of docile bodies is an inherently futile task, for in order for power to be productive rather than simply repressive, it must be seductive. Thus docility would be negated by “the local techniques and strategies of power, or the micro-powers that are exercised at the everyday life, and the ways that resistance may be generated at those levels by people refusing to engage in those techniques and strategies” (Lupton 1997:103).

In order to address how the refugee mothers in this project responded differently the larger social project described by Aihwa Ong (2003) and the resistance by of low income mothers of color described by Khiara Bridges (2011), I will turn to a recent article by Marcia Inhorn and Emily Wentzell (2011) who employ the concepts of emergence and embodiment to describe social changes in masculinity among men in the Middle East and Mexico. In their
theorization of masculinity they move away from notions of hierarchy to changing conceptions and practice. They propose the term “emergent masculinities,” drawing on the work of Raymond Williams (1977) who proposed that a dominant group maintains a cultural system and describes how the system transforms over time. Williams uses the term “emergence” to describe novel meanings, values, practices and relationships that are continually being created and eventually incorporated in to the dominant culture which causes the social order itself to change over time. Inhorn and Wentzell argue that “emergence” must be understood in relation to embodiment as subjectivities are locally and historically situated, thus co-develop with changes in the ideals and possibilities of the dominant group. Inhorn and Wentzell also argue that “embodied emergent” subjectivities also incorporate new medical technologies to enable and novel forms of practice.

I will employ Inhorn and Wentzell’s concept of “embodied emergence” to theorize the mothering practices of my participants. Through my participant’s narratives I have demonstrated that both the acts of breastfeeding and formula feeding are just as tied to the construction of citizen-subject mothers as the citizen-subject mother is tied to class position. When applied to mothering, embodied emergence encapsulates the change over the life course as women become mothers, change over the period of breastfeeding practice which co-develops with physical changes, change over generations as mothers pass on their knowledge to their children and changes to the social order that involve mothers in transformative social processes. Thus, embodied emergent mothering transforms with the changing ideals and possibilities for mother’s physical practice at different times and different places and is often tied to the availability of medical technology. Numerous refugee mothers, like Mahnin and Mu stated that though they birthed their children without medical intervention in their home country of Burma, they desperately wanted pain relief and medical supervision. Many others, like Mahnin and Mu,
stated that they would have used formula to feed prior children if only they had been able to afford it. Others like, Cecile and Noor, did not see a possibility for social and economic security until migrating to the United States, thus were eager to engage in wage labor—and formula feeding—in order to make their families economically secure.

While all participating refugee mothers engaged in mixed feeding to some degree, their reasons for doing so were justified in their constructions of themselves as “good mothers.”

Previously I argued that the degree to which the idioms of citizenship resonated with each mother depended on her aspirations of development. These aspirations are expressed and embodied in each refugees mothering practices in comparison to the citizen-subject mother ideal. Refugees, like Salma, Bhakti, Noor and Cecile, who sought to embody the citizen-subject mother position through their practices also sought class mobility. Though the benefits of breastfeeding are stressed within the scientific mothering paradigm, as these refugee mothers demonstrated the scientific mothering paradigm is entrenched in a capitalist economic system where wage labor and the exercise of personal responsibility trump the potential health benefits of long term breastfeeding. While Bhakti and Noor cited low milk production as the culprit in their choice to switch to full time formula feeding they were also both anxious to reenter the job market and improve their economic standing. Likewise Salma cited health problems as the culprit but was relieved that she was free to pursue higher education. Cecile was forthright in her justification that beginning factory work was essential to the economic future of her family. In contrast, Mary, Jala and Aye, Isabelle, Mu and Mahnin, opted to eschew wage labor in order to continue breastfeeding long term while adding formula based on the perceived hunger of the baby. Just as the notion of citizenship is flexible and adaptive, the practices of these refugee mothers demonstrate that the dual empowerment and disempowerment of women to mother and nurture
is likewise flexible and adaptive. Therefore, I propose that breastfeeding is an embodied emergent practice mothers employ to empower themselves as mothers in novel ways.

The consideration of breastfeeding as a form of the production positions medical discourse about mothering and breastfeeding as a disciplinary mechanism that imposes a medical scrutiny, surveillance and regulation of infant feeding and mothering. These medical models are intended to decrease uncertainty and doubt but due the variable nature of the human experience can create uncertainty and doubt. As I demonstrated in my description of my encounter with my physician about my daughter’s growth, medical scrutiny is not applied only to disempowered women, but to women in all class positions. The power of medical discourse to produce and reproduce norms and ideals in society, particularly in the discourse between a patient and provider, has a long history within medical anthropology (see Wilce 2009). The possibilities of resisting or speaking back to medical or techno-scientific authority do exist, however the availability of these possibilities are highly dependent on class and social positioning. As Linda Blum points out, the mother who can speak back to medical authority is “a very specific and privileged woman” (1999:188). The relations of power that exist between medical authority and the public leaves little room to question, challenge or subvert accepted scientific dogma. Those who do risk being vilified, thus often come from a position of privilege that enables the possibility of engagement. These challenges often attack the science itself rather than valorizing the practices of groups of people. Recent examples can be seen in the anti-vaccination campaign among middle and upper class parents in the United States, where the science behind vaccination is called into question.

In this dissertation I reviewed the work of Rima Apple (1987-2006) and the history of infant feeding in the United States. As Apple demonstrates, infant feeding recommendations
changed several times in the United States and with each transformation a group of middle-class white mothers led the charge. When promoting artificial feeding at the turn of the twentieth century it was in the interest of “baby saving” and allied with the emergence of a strong medical authority so that by mid-century artificial feeding was the norm. The movement back to breastfeeding was also initiated by middle-class white mothers in a “back to nature” campaign but gained significant momentum with the formation of La Leche League and the alliance with medical authority. Now, while national campaigns are focused on increasing breastfeeding and decreasing artificial feeding, Joan Wolf investigated the science behind breastfeeding superiority and discovered that “the scientific evidence for breastfeeding’s benefits are not nearly as compelling as various advocates insist” (2011:16). She argues “despite overwhelming sentiment to the contrary, epidemiological research does not demonstrate persuasively that breast milk is medically superior to infant formula for most babies in the developed world. While breastfeeding does appear to reduce the risk for various GI infections, the evidence for virtually every other health measure is plagued by unexamined confounding variables, potential selection bias, and inconsistent outcomes” (2011:16). Despite widespread acknowledgement of these shortcomings by the scientific community, the results of breastfeeding research are distributed and circulated by journalists and other unschooled in epidemiological research and taken up by the public where health becomes the defining characteristic of selfhood and citizenship (2011:17). In her analysis of the National Breastfeeding Awareness Campaign (2004-2006), Wolf concludes that breastfeeding is breastfeeding is a “microcosm of total motherhood” in the United States (2011:19).

Pam Carter (1995) and Linda Blum (1999) wrote foundational texts for understanding breastfeeding in the United Kingdom and the United States respectively. Carter proposes that
pro-breastfeeding policies serve as disciplinary measures to police disadvantaged minority mothers. Breast milk, she argues, is a disembodied product that can be measured, assessed, and produced in a mechanical way using a breast pump rendering the woman invisible and disempowered. Unless there was a lack of production in which case the mother was the cause. This surveillance began in the hospital where the principles of timing, production, surveillance, and control of breast milk production were instilled in the mother before discharge to ensure she assumed “responsibility” for appropriate infant feeding. Carter (and others) argue that as the reliance of scheduled, timed-feedings became a routine part of the breastfeeding relationship through breastfeeding promotion and support, breastfeeding itself became disembodied and breast milk is seen primarily as a product (Balsamo, DeMari, Maher and Serini 1992; Dykes 2005; Millard 1990). As Linda Blum points out, and Jala experienced this first-hand when her infant son was in the neonatal intensive care unit, the breast pump makes the nutritional presence of the mother possible who need not be present. She was incensed that she could not breastfeed her son personally and blamed the mechanistic intrusion as the cause of her low milk production. Despite the efforts of La Leche League alongside white middle class mothers to resituate breastfeeding as an embodied relationship, Blum demonstrates that experiencing breastfeeding as an embodied relationship assumes the time, socioeconomic resources, and near constant availability of the maternal body for optimal child development available to a few non-white, non-middle class mothers. The entrenchment of the medical model of breastfeeding, where breasts are viewed as productive entities and breast milk as a product leads to uncertainty in production capability. This uncertainty and doubt in the bodies’ ability to product an adequate supply of milk is most evident in the period immediately following birth when the mother are waiting for their “milk to come in.”
In an examination of women’s experiences breastfeeding following birth in two hospitals in England, Fiona Dykes found that uncertainty and doubt surrounded all aspects of breastfeeding. She states, “the most striking and consistent theme was women’s lack of confidence and trust in their ability to produce enough milk or milk of the right quality” (2005:2285). This perception of insufficient milk was expressed by both the mothers and the midwives and nurses attending the mothers. Dykes found that women conceptualized their breasts as faulty machines, focusing on the inability to measure how much the baby was taking in at each feeding. This lack of measurement in the breastfeeding process led women to assess other aspects of the infant’s behavior such as whether the baby appeared to be settled or unsettled after feedings and the amount of waste the baby produced. This emphasis on measurement and scrutiny was supported by their caregivers in the hospital and encouraged to be continued at home. Dykes argues that employing the supply and demand metaphor common to breastfeeding promotion and support to characterize the breastfeeding relationship leads to a disembodied experience with a focus on measurement and self-regulation which ultimately stress uniformity in the process and create uncertainty and doubt.

The existence of uncertainty in breastfeeding was a regular theme expressed by my participants, with the period following birth being especially fraught with uncertainty. Many expressed that waiting for their milk to come in led to uncertainty in their own body’s capability to produce breast milk long term. While their reactions varied, Bhakti and Mahnin gave infant formula against the recommendations of the nursing staff while Cecile, Isabelle, and Mu unsuccessfully warded off the efforts of the nursing staff to formula feed, each was presented with formula as the only other option. This demonstrates that to refugee women (and women in general) infant feeding options are few. One can exclusively breastfeed (in person or expressed
in a bottle), exclusively formula feed, or mix-feed (feed both formula and breast milk). Other options include feeding donor milk or feeding non-milk foods such as tea or porridge though these are rarely practiced in the United States and were not mentioned by any of the refugee mothers I spoke with. It is also telling that both Isabelle and Cecile, and two of the three African mothers included in this project, were unable to ward off the nursing staff from giving formula to their infants while Bhakti and Mahnin were counseled against giving formula by the nursing staff. These experiences concur with research that shows that Black mothers are the most likely to have formula introduced in the hospital and least likely to receive breastfeeding support from hospital lactation consultants (Beal et al. 2007; Celi et al. 2014; Demota et al. 2012; Evans et al. 2011; Petrova et al. 2007; Singh et al 2007; Tender et al. 2008). The high percentage of emergency cesareans experienced by the refugee mothers (7/20 emergency cesareans, 10/20 overall) in this project also concur with a recent review article by Louise Roth and Megan Henley (2013), that concludes that Black and Asian women who are otherwise low-risk are more likely to undergo an emergency cesarean. These refugee mothers who underwent emergency cesareans were also counseled to supplement their initial breastfeeding with formula during their stay in the hospital. Cesarean delivery is widely accepted to negatively impact breastfeeding due to delaying breastfeeding initiation (Cakmak 2007; Karlstrom et al. 2007; Perez-Rios et al. 2007; Prior et al. 2012; Zanardo et al. 2010). 2007; Singh et al 2007; Tender et al. 2008). The high incidence of cesareans among this cohort of mother demonstrates a widely held belief within the medical system, that some women necessitate more medical intervention and supervision than others.

The concept of uncertainty and doubt in breastfeeding is a difficult measure to assess and may also obscure other factors present in the infant feeding relationship, namely the presence of
stress. Hunger is a common “idiom of distress” or signifier of somatized physical or emotional pain. Interestingly in this context, the context of infant feeding, the hunger is attributed to the infant rather than being expressed by the mother, indicated the closeness of the embodied experience within the mother-infant dyad. The perceptions of low milk or doubt in their ability to produce enough milk can be interpreted as another idiom of distress. However I have yet to meet a new mother who is not in distress and concerned about her milk production, her infant’s hunger, the constant crying and lack of sleep. The factor that truly belies the somatization of the multiple layers of distress embodied by these refugee mothers is the prevalence of very small infants. Though I was only able to gather data on birth weight anecdotally from the mother on fourteen babies following birth, nine would be considered low birth weight, defined as less than 2500 grams or five and a half pounds.

As refugees, a unifying factor is that all refugee mothers have been exposed to violence, the threat of violence and the threat of long term displacement. As resettled refugees they experience additional stressors of living in a new cultural home, being separated from family and loved ones and living in poverty. As women of color I suggest in the United States they are subjected to daily instances of culturalist racism and other forms of racial and ethnic discrimination. The combination of these stressors can be heard overtly, such as Aye’s concerns about meeting the parameters of good mothering relayed to her such as how many times a day to feed her children milk and getting them to school on time, and in Mary’s recounting of the death of her third child in Sudan. The accumulation of stress can also be heard in their anxieties about hunger and crying, such as Noor’s disappointment that her daughter would not latch and “did not like” her milk and Isabelle’s concern about her son’s constant crying. A small body of research literature has reported an adverse relationship between past experiences of violence and abuse,
often manifesting clinically as Post Traumatic Stress Disorder (PTSD), and adverse childbearing outcomes including difficulties with lactation, depression and low birth weight (Dailey 2009; Camacho 2008; Giscombe and Lobel 2005, Stancil et al. 2000; Rosen; Seng 2002; Wadhwa et al. 1993). Adriana Camacho (2008) examined the national birth data from Columbia during a period of random terrorist attacks during 1998-2004 and found a negative relationship between stress during early pregnancy and low birth weight. Dawn Dailey (2009) conducted a prospective study with 119 pregnant Black women who reported past exposure to trauma and daily exposure to stress from instances of discrimination, fourteen percent of whom delivered low birth weight babies.

The prevalence of babies of low birth weight and exposure to multiple stressors points to the impact that multiple layers of stress has on the embodied relationship of breastfeeding, beginning with the tangible fact of low birth weight. Though the relatively small sample of 20 refugee mothers and the data on birth weight was collected anecdotally, the fact that nine of fourteen births (64%) would be classified as low birth weight is striking and telling of the amount of cumulative or lifetime stress refugee mothers endure and the effects on maternal and child health. While birth weight and generational impacts of stress and trauma was not a focus of this research it points to avenues of future research on maternal and child health. On a positive note, within a highly the medicalized discourse of pregnancy and mothering, social support, defined as the exchange of tangible and emotional assistance, has been found to buffer or positively influence birth weight among women under stress, making them less likely to deliver low birth weight babies (Cohen an Wills 1985; Feldman et al. 2000; Morgan 1996; Tilden, Nelson and May 1990).
While breastfeeding is situated within a medicalized discourse that focuses on “supply and demand” breastfeeding and personal responsibility rather than maternal autonomy, the promotion of breastfeeding has rested on its superiority to formula feeding. As Joan Wolf points out, the “fact” of the medical superiority of breast milk remains relatively unquestioned with the American Academy of Pediatrics arguing “human milk is uniquely superior for infant feeding” (1997:1035) citing that breastfed babies tend to fare better emotionally, physically and cognitively. Wolf argues that the outcomes are linked to greater socioeconomic standing rather than breastfeeding alone indicating that the desirable outcomes on long term breastfeeding are more tied to the myriad if social factors that accompany class position. In an effort to address both breastfeeding and the financial standing of low income women in the United Kingdom, an ongoing study in the United Kingdom offers financial vouchers to low-income white mothers in order to examine whether a financial incentive could alter practices where not breastfeeding is the cultural norm (Renfrew 2013). Similar to the history of infant feeding in the United States, artificial feeding became the norm following World War II and the movement to reestablish breastfeeding as the norm is led by white middle-class mothers. The movement to increase breastfeeding among mothers in the United Kingdom is driven by the perception of savings to the health care system that would accompany a reduction in chronic disease, though the quantitative modeling employed by the researchers was difficult due to the popularity of mixed feeding, rather than a discrete differentiation between breastfeeding and artificial feeding, and the difficulty of controlling for socioeconomic status (Renfrew 2013). Despite their intentions, the authors recognize that due to these difficulties it is possible that their estimations of the health outcomes attributed to exclusively breastfeeding may be overestimated or underestimated. Many of the child development and chronic health outcomes measured were based on evidence
of association where the assumption of statistical significance was employed, demonstrating the
difficulty in untangling breastfeeding from the social context in which it exists.

Outside of being protective of gastrointestinal issues, respiratory problems, ear infections
and the life-threatening condition necrotizing enterocolitis (Renfrew UNICEF report 2013), the
extensive claims of the benefits of breastfeeding are understood to be enmeshed in
socioeconomic factors that are difficult to separate (Wolf 2011). The dominant response is that it
is better to err on the side of the advancing breastfeeding over artificial feeding as the benefits
continue to be tested and reviewed, or is it? The claims that breastfeeding protects against
chronic diseases or enhances cognitive development may be more the result of social advantage
rather than breastfeeding alone, just as the likelihood that a mother will breastfeed her infant is
due to myriad of social factors and privilege in Western society. The multiple benefits deemed
to occur from breastfeeding alone leads to widespread though very popular claims that
breastfeeding will give your baby the best or optimal start in life—both in terms of health and
social advantage, blurring the fact that those who are breastfed are already at a socially
advantageous place—otherwise it is unlikely that their mother would have time to breastfeed
them. As more researchers examine the science of breastfeeding, the more it is appearing that the
benefits associated with breastfeeding are an outcome of privilege over breastfeeding alone. I
have demonstrated with these narratives of mothering that the choice to breastfeed, formula feed,
or combine the two is neither made in a vacuum nor is it the result simply of social pressure.
Rather it is a complex decision that is made several times a day through an embodied and
emergent mothering practice.

The emphasis placed on breastfeeding practice and choice can obscure the relatively few
options available to mothers in regards to infant feeding in a broader context. The lack of viable
options are even fewer in the current policy context of the United States that doesn’t support breastfeeding mothers in the workplace through extended paid maternity leaves and the ability to express milk at work or full time mothers at home through extended welfare benefits. The absence of policies that fully support breastfeeding mothers are clear in their prescription that devotion to breastfeeding is valued within a “normal” two parent household that enables the mother to stay at home. Otherwise the option is to formula feed, disemboby the experience of breastfeeding via pumping, or stay out of the workforce. This contradiction in public policy leaves little room for negotiations of power, but within the uncertainty created by medicalized breastfeeding discourse lies the possibility of maternal autonomy. As many refugee mothers demonstrated in their stories about breastfeeding, the uncertainty they experienced in their own bodies led them to act on their own behalf in what they determined was best for their baby by adding formula, sometimes against the advice of the doctors. Repeating “I know what my baby needs,” refugee mothers like Mahnin, Bhakti, Noor and Mu demonstrate that by eschewing medical authority they have the power to transform their own subject position. Therefore I propose that that the deployment of medical knowledge about mothering and breastfeeding as a disciplinary mechanism in order to promote uniformity creates both uncertainty and possibilities for maternal autonomy.

Throughout this dissertation I have explored how refugee mothers negotiate mothering practices, infant feeding choices in particular, within the cultural landscape of the United States where race, ethnicity and class encourage agency within some groups of mothers and discourage it in others. I have also stated that my position as a breastfeeding mother was an integral component of my fieldwork. In addition to providing common ground with my participants I was aware that my position was that of an anthropologist studying breastfeeding holding the position
that breastfeeding deserves support. My own position and perspective on infant feeding changed as well based on my relationships with my participants and experiences with my own children.

Though I positioned the notion of the ideal citizen-subject mother as being based on the experiences of white middle-class mothers, being painfully aware that I embody that position, my experiences also demonstrate that as a white middle-class mother I am not immune to public and medical scrutiny and criticism. On a recent visit to my doctor for my infants nine month wellness checkup I was criticized, as I had been when my son was an infant, for my daughter being too “small.”

“Oh my gosh, she’s fallen off the charts!” my doctor exclaimed with a light giggle as I sat in the office with my nine-month old daughter. “Look here, do you see how she’s dropping?” she asked as she turned the computer screen towards me to show me my daughter’s growth curve plotted against the range for normal infant growth. She continued to explain the chart to me.

“Do you see how she started in the 10th percentile when she was born? And then she dropped to the fifth percentile, then to the 3rd, and now she’s fallen off? She’s dropping off the chart.” She then turned to her medical student who was observing the well baby check up and showed her the growth chart asking, “Do you see how she’s dropped off the chart?”

“You say she’s dropped off, but she’s not losing weight,” I countered. “She’s gaining weight.”

“Well yes, she’s gaining weight, but she’s not staying on the chart.”

“But when you say she’s dropped off it sounds like she’s losing weight and she isn’t. She is gaining weight and growing” I replied again.

“Well, yes she is gaining weight but it isn’t at the pace that we prefer.”
The discussion of growth and weight gain with my doctor inevitably led to the questions of infant feeding as I found my own mothering practices coming under scrutiny. Was I still breastfeeding? How many times a day for how long? What solid foods was she eating? Would I supplement with formula? Why not? Knowing my choice to exclusively breastfeed for the first six months, my doctor suggested adding formula to my baby’s diet now, at nine months, purely to stimulate more rapid weight gain as by every other measure my baby was developing normally. “Adding formula doesn’t really matter now, right?” she asked me. “I mean, you made it to six months only breastfeeding and she’s eating other foods. Why not give her some formula to see if she’ll grow a bit. That’s the most important thing, right?”

The question itself, rhetorical in nature, illustrates that assumptions permeate the daily lives of mothers: what is “most important” to mothers, how to address uncertainty in infant feeding and the equation of “normal” and “healthy.” The assumption being put forth was that if my baby was not growing within the range of “normal” it must be because I was not feeding her enough, and if I was breastfeeding then my breast milk was insufficient. Within the world of assumptions each mother must navigate, discord between what mothers do and what mothers are expected to do force mothers to make choices about the quotidian practices that are often invisible to outsiders. As we have seen with the stories of each refugee mother, how each mother responds to these assumptions depends upon how she sees herself and understands her own subjectivity. Like my participants, as the mother of an infant my own practices had come under scrutiny which led me to question my choices. As my baby was nine months old, I had assumed that questions about whether to breastfeed, formula feed, or both ceased after solid foods were introduced at six months. I was unprepared to reexamine my infant feeding practices. Why is breastfeeding so important to me? Do I consider formula to be harmful? If not, should I
feed my baby breast milk and formula? Was it possible that my breast milk was not sufficient to
fully nourish my baby? Was my baby hungry? What did it say about me that my baby might still
be hungry after breastfeeding? Was I being a good mom by continuing to only give breast milk
and solid foods or should I also give formula to be a good mom? Was my goal to have a baby
grow within the range of “normal” or to be healthy overall? Could my baby be considered
healthy if she was small? Was I making decisions in the best interest of my baby or of myself,
and could I differentiate between the two?

The experiences shared by the refugee mothers in this dissertation share many common
themes with mothers as a whole in the United States. Notions of race, ethnicity and class
permeate discussions and perceptions of “good mothering” in regards to all mothers. While
refugee mothers are united by some important characteristics (experiencing violence or the threat
of violence, accumulative stress from the experience of being a refugee and separation from
family), I argue what unites mothers’ experiences I the United States outweighs what separates
us. Therefore I also argue that refugee mothers contribute to transformations in mothering
practice as a whole in the United States, leading to potentially greater genuine freedom in infant
choices and mothering practices. As Linda Blum (1999), one of the leading scholars on
breastfeeding points out, questions about infant feeding are about citizenship, national and global
politics and as such should be at the center of scholarship.

6.2 Study Limitations and Future Directions

Despite the above contributions my research has limitations worth noting. First, it is
limited by the small-scale design. The benefits and limitations of a small scale design are many.
With only 20 participants the primary benefit is that I could maintain a depth in understanding
the everyday lives of my participants. The primary limitation is that a small sample may not
necessarily be representative of the entire community and can lead to unfounded and inaccurate
generalizations. To try and avoid these traps I employed a comparative framework and focused
on the specifics of everyday negotiations as they fit into the larger narrative of each refugee
mother. These limitations should not hinder further breastfeeding research, rather should provide
a framework for future comparison among lower, middle and upper-class mothers across racial
and ethnic boundaries. Second, although my research pointed to important differences within the
refugee experience (especially prior to resettlement), my design and purpose was not to examine
these differences in adequate detail. Gaining entry and trust into the community was difficult as
refugees are hesitant to divulge prior experiences. Breastfeeding and mothering provided my
entry into the lives of my participants and assurances were made that I would not ask them to
recount the details of their experiences prior to resettlement—though many participants raised
the issue on their own. Finally, though the multi-ethnic composition of my sample proved to
have limitations in the ability to fully examine and compare mothering and breastfeeding
practices, beliefs, and attitudes along ethnic lines, the multi-ethnic sample did demonstrate the
utility of considering forms of commonality outside of traditional categories of race, ethnicity
and class. Despite the differences each refugee mother experienced prior to resettlement and after
resettlement, there were more powerful commonalities that they all shared including migrating to
the United States in the framework of refugee resettlement services, experiencing pregnancy and
delivery (with one exception) in a new cultural context and entering into motherhood where the
medical authority and public services are enmeshed.

Promising avenues for future research are demonstrated by these findings. One such
avenue is the relationship between accumulated, lifetime stress, and racial and ethnic disparities
in maternal outcomes, particularly birth weight, in another avenue of future research that holds potential. Racial and ethnic disparities in the United States is described as an “elusive” problem by public health researchers (Alexander et al. 2008; Dailey 2009). Socioeconomic status, access to healthcare, and of course “culture” have all been examined as culprits in different health outcomes but this research points to general profiling of “certain groups of people necessitating more medical intervention than others” and the accumulation of all stressors leading to adverse outcomes such as low birth weight, lower rates of breastfeeding, and a higher incidence of cesarean surgery. Another such research direction I hope will be developed from this work is to broaden breastfeeding research using an ethnographic approach to include women from different socio-economic and ethnic backgrounds in an effort to discover what women actually do. The revelation that all of my refugee participants engaged in mixed feeding at some point during their infants first six months of life and that many saw little conflict in mixed feeding could broaden both the approach to breastfeeding promotion and our understanding of how women approach infant feeding. Though rates of breastfeeding have increased in the past 25 years, only about half (49%) of infants breastfeed past six months and only a small margin (18%) exclusively breastfeed. Considering exclusive breastfeeding is recommended for the first six months of the infant’s life, followed by complementary feeding and breastfeeding for two years or as long as the mother and infant wish (CDC 2014) there is a lot of room to increase breastfeeding within the entire population. One avenue to increasing breastfeeding among the population as a whole is to move the narrative away from exclusive breastfeeding, which categorizes “success” as exclusively breastfeeding and “failure” as supplementing or switching to formula, to breastfeeding by incorporating recommendations for mixed feeding. This approach may be more successful as it mirrors what the majority of breastfeeding mothers are likely doing already, can
begin to break down divisive breastfeeding and mothering discourse and can open avenues for mothers to experiment with more infant feeding options for a truer sense of maternal autonomy.

In conclusion I have argued that the study of breastfeeding and mothering practices in the United States can yield rich results for anthropological theory, provide an avenue to engage anthropological inquiry in public health advocacy, and offer new directions for breastfeeding research. Ultimately my hope is that my research has provided new paths for investigating how power relations impact breastfeeding and mothering practices.
## APPENDIX A

Refugee Pregnancy and Postnatal Support Group Curriculum 2012-2013

<table>
<thead>
<tr>
<th>Week</th>
<th>Topic(s)</th>
<th>Learning Objectives</th>
<th>Guest Speaker</th>
</tr>
</thead>
</table>
| Week 1: Oct. 9, 2012 | Introduction & Yoga Session       | > Introduce purpose and goals of support group  
> Hear updates on returning participants and meet new participants  
> Learn basic yoga exercises to promote wellness and relaxation | Refugee Health Programs          |
| Week 2: Oct 23, 2012 | Pregnancy 101                     | > Discuss physical changes accompanying each trimester                                | School of Nursing, DePaul University |
| Week 3: Nov. 6, 2012 | Preparing for baby/Baby safety    | > Introduce the importance of choosing a doctor and medical home  
> Learn how to maintain hygiene in the pre and postnatal periods  
> Provide handouts on the basics of baby proofing | Refugee Health Programs          |
| Week 4: Nov. 20, 2012 | Nutrition for Pregnancy           | > Introduce an understanding of vitamins, minerals, fats  
> Introduce how to maintain a healthy weight | Refugee Health Programs          |
| Week 5: Dec. 4 2012 | Breastfeeding                      | > Introduce an understanding of vitamins, minerals, fats  
> Introduce how to maintain a healthy weight | Private Certified Lactation Consultant |
| Week 6: Dec 18, 2012 | Field trip: Illinois Masonic      | > Introduce and tour a hospital maternity ward  
> Discuss the hospital intake, stay, and outtake process and requirements | Illinois Masonic                 |
| Week 7: Jan. 8, 2013 | Mental Health                     | > Introduce the different mental health issues of pregnant and postnatal women  
> Provide tips on how to improve mental health | RefugeeOne                       |
| Week 8: Jan. 22, 2012 | Nutrition for Children            | > Introduce nutritional tips to promote healthy growth in infants and toddlers  
> Encourage the use of breastfeeding  
> Provide handouts on the physical growth stages of children and when to transition foods | Refugee Health Programs          |
## APPENDIX A (continued)

<table>
<thead>
<tr>
<th>Week</th>
<th>Date</th>
<th>Topic</th>
<th>Description</th>
<th>Organizing Body</th>
</tr>
</thead>
</table>
| Week 9 | Feb 5, 2013 | Pelvic Health | > Introduce pelvic anatomy  
> Changes in pelvis during and after pregnancy  
> Learn techniques for simple pelvic exercises to promote pelvic health  
> Learn nutritional tips to promote pelvic health | Women’s Health Foundation |
| Week 10 | Feb 19, 2013 | Field trip: Children’s Museum | > Introduce the various physical, emotional, and educational needs of children  
> Introduce basic parenting techniques  
> Provide a fun experience where mothers and children can interact and play | Chicago Children’s Museum |
| Week 11 | March 5, 2013 | Post-pregnancy | > Introduce nutritional facts to promote health for mothers and children  
> Introduce the different nutritional needs according to stages of childhood | Refugee Health Programs |
| Week 12 | March 19, 2013 | WIC | > Introduce the purpose of WIC  
> Discuss ways to maximize | University of Illinois at Chicago, Department of Kinesiology |
| Week 13 | April 2, 2013 | Family Planning | > Introduce family planning options  
> Discuss the benefits and drawbacks of the different family planning methods | School of Nursing, DePaul University |
| Week 14 | April 16, 2013 | Infant Care | > Introduce the basics of infant care and first aid | Heartland Health Outreach |
| Week 15 | April 30, 2013 | CPR and Choking | > Introduce basic CPR  
> Introduce several choking techniques for young children and infants | American Red Cross |
| Week 16 | May 14, 2013 | Domestic Violence | > Discuss what constitutes domestic violence and the services available to victims of domestic violence | RefugeeOne |
| Week 17 | May 28, 2013 | Maternal Nutrition | > Introduce nutritional facts to promote health for mothers following childbirth  
> Introduce the different nutritional needs for mothers following childbirth | Refugee Health Programs |
| Week 18 | June 11, 2013 | Arts and Crafts and Closing Day | > Promote creativity  
> Discuss the curriculum and what we’ve learned  
> Collect participant feedback and evaluation | Refugee Health Programs |
# APPENDIX B
Refugee Pregnancy and Postnatal Support Group Curriculum 2013-2014

<table>
<thead>
<tr>
<th>Week</th>
<th>Topic(s)</th>
<th>Learning Objectives</th>
<th>Guest Speaker</th>
</tr>
</thead>
<tbody>
<tr>
<td>Week 1: Oct. 3, 2013</td>
<td>Introduction &amp; What to Expect during Pregnancy</td>
<td>Learn basic prenatal care for the home.</td>
<td>School of Nursing, DePaul University</td>
</tr>
<tr>
<td>Week 2: Oct 17, 2013</td>
<td>Pregnancy 101</td>
<td>Learn what changes happen in your body</td>
<td>School of Nursing, DePaul University</td>
</tr>
<tr>
<td>Week 4: Nov. 14, 2013</td>
<td>Nutrition for Pregnancy</td>
<td>Healthy eating during pregnancy</td>
<td>Refugee Health Programs</td>
</tr>
<tr>
<td>Week 5: Dec. 5 2013</td>
<td>Medical Conditions during pregnancy</td>
<td>When to call the doctor during pregnancy</td>
<td>School of Nursing, DePaul University</td>
</tr>
<tr>
<td>Week 6: Dec 19, 2013</td>
<td>C-sections</td>
<td>When a C-section is necessary</td>
<td>School of Nursing, DePaul University</td>
</tr>
<tr>
<td>Week 7: Jan. 9, 2014</td>
<td>Pain relief during delivery</td>
<td>Pain relief options during labor</td>
<td>School of Nursing, DePaul University</td>
</tr>
<tr>
<td>Week 8: Jan. 23, 2014</td>
<td>Breastfeeding Part 2: Extended Breastfeeding and returning to work</td>
<td>Breastfeeding an older baby and breastfeeding while working</td>
<td>School of Nursing, DePaul University</td>
</tr>
<tr>
<td>Week 9: Feb. 6, 2014</td>
<td>Physical Changes in the Post-partum</td>
<td>Learn how your body changes after delivery</td>
<td>School of Nursing, DePaul University</td>
</tr>
<tr>
<td>Week 10: Feb 20, 2014</td>
<td>Pelvic Health</td>
<td>Learn how to care for your pelvis after delivery</td>
<td>Women’s Health Foundation</td>
</tr>
<tr>
<td>Week 11: March 6, 2014</td>
<td>Mental Health and the Post-partum period</td>
<td>Talk about emotional changes after delivery</td>
<td>Kovler Center</td>
</tr>
<tr>
<td>Week 12: March 20, 2014</td>
<td>Infant Care safety</td>
<td>Talk about infant care and safety</td>
<td>Heartland Health Outreach</td>
</tr>
<tr>
<td>Week 13: April 3, 2014</td>
<td>Family Planning</td>
<td>Discuss different family planning options that are available</td>
<td>School of Nursing, DePaul University</td>
</tr>
<tr>
<td>Week 14: April 17, 2014</td>
<td>CPR and Choking</td>
<td>Learn CPR and choking techniques for infants and children</td>
<td>Affinity Institute</td>
</tr>
<tr>
<td>Week 15: May 1, 2014</td>
<td>Maternal Nutrition</td>
<td>Healthy eating after pregnancy</td>
<td>Refugee Health Programs</td>
</tr>
<tr>
<td>Week 16: May 8, 2014</td>
<td>Celebration of Participant Achievement</td>
<td>Celebrate your achievement</td>
<td>Refugee Health Programs</td>
</tr>
</tbody>
</table>
APPENDIX C

Diagram of Refugee Migration

Flight

Refugee camp: processing and recognition

Urban migration

Resettlement Naturalization Repatriation

Informal Migration

???
## APPENDIX D

Participant Demographic Information

<table>
<thead>
<tr>
<th>Name</th>
<th>Country of Origin</th>
<th>Age</th>
<th>Time in US (last int.)</th>
<th>Cesarean Section (*elective)</th>
<th>Number of Children</th>
<th>Age of child (last interview)</th>
<th>Low Birth Weight</th>
<th>Infant Feeding Method- 1 week</th>
<th>Infant Feeding Method- 1 month</th>
<th>Infant Feeding Method- 3 months</th>
<th>Infant Feeding Method- 6 months</th>
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</thead>
<tbody>
<tr>
<td>Mary</td>
<td>Sudan</td>
<td>26-30</td>
<td>2 yr</td>
<td>No</td>
<td>4</td>
<td>6 mo.</td>
<td>Yes</td>
<td>Breast milk and Formula</td>
<td>Breast milk and Formula</td>
<td>Breast milk and Formula</td>
<td>Breast milk and Formula</td>
</tr>
<tr>
<td>Cecile</td>
<td>Democratic Republic of Congo</td>
<td>20-25</td>
<td>1 yr</td>
<td>Yes</td>
<td>1</td>
<td>6 mo.</td>
<td>No</td>
<td>Breast milk and Formula</td>
<td>Breast milk</td>
<td>Breast milk and Formula</td>
<td>Breast milk and Formula</td>
</tr>
<tr>
<td>Isabelle</td>
<td>Democratic Republic of Congo</td>
<td>20-25</td>
<td>1 yr</td>
<td>No</td>
<td>1</td>
<td>6 mo.</td>
<td>No</td>
<td>Breast milk and Formula</td>
<td>Breast milk and Formula</td>
<td>Breast milk</td>
<td>Breast milk</td>
</tr>
<tr>
<td>Noor</td>
<td>Burma</td>
<td>26-30</td>
<td>2-3 yr</td>
<td>Yes*</td>
<td>2</td>
<td>6 mo.</td>
<td>Yes</td>
<td>Breast milk and Formula</td>
<td>Formula</td>
<td>Formula</td>
<td>Formula</td>
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<tr>
<td>Aye</td>
<td>Burma</td>
<td>26-30</td>
<td>1 yr</td>
<td>No</td>
<td>3</td>
<td>26 mo.</td>
<td>Unknown</td>
<td>Breast milk</td>
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<td>Aarya</td>
<td>Burma</td>
<td>26-30</td>
<td>&gt; 2yr</td>
<td>No</td>
<td>2</td>
<td>18 mo.</td>
<td>Unknown</td>
<td>Breast milk and Formula</td>
<td>Breast milk and Formula</td>
<td>Breast milk and Formula</td>
<td>Breast milk and Formula</td>
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<tr>
<td>Yamin</td>
<td>Burma</td>
<td>26-30</td>
<td>&gt; 2yr</td>
<td>No</td>
<td>3</td>
<td>14 mo.</td>
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<td>Breast milk and Formula</td>
<td>Breast milk and Formula</td>
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<tr>
<td>Mahnin</td>
<td>Burma</td>
<td>31-35</td>
<td>&gt; 2yr</td>
<td>Yes</td>
<td>4</td>
<td>6 mo.</td>
<td>Yes</td>
<td>Breast milk and Formula</td>
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<tr>
<td>Thi</td>
<td>Burma</td>
<td>26-30</td>
<td>&gt; 2yr</td>
<td>Yes</td>
<td>2</td>
<td>6 mo.</td>
<td>No</td>
<td>Breast milk and Formula</td>
<td>Breast milk and Formula</td>
<td>Breast milk</td>
<td>Breast milk</td>
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<tr>
<td>Mu</td>
<td>Burma</td>
<td>26-30</td>
<td>&gt; 2yr</td>
<td>Yes</td>
<td>3</td>
<td>6 mo.</td>
<td>Yes</td>
<td>Breast milk and Formula</td>
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<tr>
<td>Bhakti</td>
<td>Bhutan</td>
<td>26-30</td>
<td>2-3 yr</td>
<td>Yes*</td>
<td>2</td>
<td>6 mo.</td>
<td>No</td>
<td>Breast milk and Formula</td>
<td>Breast milk and Formula</td>
<td>Formula</td>
<td>Formula</td>
</tr>
<tr>
<td>Deepa</td>
<td>Bhutan</td>
<td>20-25</td>
<td>&gt; 2yr</td>
<td>No</td>
<td>1</td>
<td>18 mo.</td>
<td>Unknown</td>
<td>Breast milk and Formula</td>
<td>Breast milk and Formula</td>
<td>Breast milk</td>
<td>Breast milk</td>
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<tr>
<td>Gunjita</td>
<td>Bhutan</td>
<td>20-25</td>
<td>&gt; 2yr</td>
<td>No</td>
<td>1</td>
<td>19 mo.</td>
<td>Unknown</td>
<td>Breast milk and Formula</td>
<td>Breast milk</td>
<td>Breast milk</td>
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<tr>
<td>Name</td>
<td>Country</td>
<td>Age</td>
<td>Duration</td>
<td>Abate</td>
<td>Breastfeeding</td>
<td>Duration</td>
<td>Follow-up</td>
<td>Feeding</td>
<td></td>
<td></td>
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<tr>
<td>Hema</td>
<td>Bhutan</td>
<td>26-30</td>
<td>&gt;2yr</td>
<td>Yes</td>
<td>Yes</td>
<td>6 mo.</td>
<td>Yes</td>
<td>Breast milk and Formula</td>
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<td>Injira</td>
<td>Bhutan</td>
<td>20-25</td>
<td>&gt;1 yr</td>
<td>No</td>
<td>Yes</td>
<td>2 mo.</td>
<td>Yes</td>
<td>Breast milk and Formula</td>
<td></td>
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<tr>
<td>Jala</td>
<td>Bhutan</td>
<td>31-35</td>
<td>2 yr</td>
<td>No</td>
<td>Yes</td>
<td>2 mo.</td>
<td>Yes</td>
<td>Breast milk and Formula</td>
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<td>Kamal</td>
<td>Bhutan</td>
<td>31-35</td>
<td>&gt;1 yr</td>
<td>Yes</td>
<td>Unknown</td>
<td>14 mo.</td>
<td>Unknown</td>
<td>Breast milk and Formula</td>
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<td>Latika</td>
<td>Bhutan</td>
<td>20-25</td>
<td>&gt;1 yr</td>
<td>Yes</td>
<td>No</td>
<td>6 mo.</td>
<td>No</td>
<td>Breast milk and Formula</td>
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<td>Salma</td>
<td>Iraq</td>
<td>31-35</td>
<td>&gt;1 yr</td>
<td>Yes*</td>
<td>Yes</td>
<td>6 mo.</td>
<td>Yes</td>
<td>Formula</td>
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APPENDIX E

Semi-structured Interview Guides for Primary Participants

These interviews are semi-structured ethnographic interviews during which time topics are discussed. The questions are intended to elicit open-ended responses and encourage conversations to emerge freely from the participant. Additional questions may be prompted.

INTERVIEW GUIDE- APPROXIMATELY 1 MONTH POSTPARTUM

1. Deciding to breastfeed
   a. Previous awareness
   b. Gathering information and making the decision

2. Getting Started
   a. The first breastfeed
   b. Role of hospital staff
   c. Role of other supporters
   d. Positioning and attaching
   e. The milk coming in
   f. Sore nipples
   g. Sensation of breastfeeding
   h. Early feeding patterns
   i. Going home with a breastfed baby

3. Managing breastfeeding
   a. Daily life with baby
   b. Feeding at night
   c. Bf support
   d. Baby’s growth
   e. Difficult times
   f. Effect on mother
   g. Variations
   h. Emotional aspect of breastfeeding
   i. Cultural views

4. Introducing Food
   a. How and when
   b. Thoughts and feelings about weaning

5. Reflections
   a. Advice for new mothers
   b. Comments for health professionals
   c. Wider environment
APPENDIX E (continued)

INTERVIEW GUIDE- APPROXIMATELY 3 and 6 MONTHS POSTPARTUM

1. Managing breastfeeding
   a. Daily life with baby
   b. Feeding at night
   c. Breastfeeding support
   d. Baby’s growth
   e. Difficult times
   f. Effect on mother
   g. Variations
   h. Emotional aspect of breastfeeding
   i. Cultural views

2. Introducing Food
   a. How and when
   b. Thoughts and feelings about weaning

3. Mothering
   a. Feelings about mothering
   b. Experiences with health care practitioners
   c. Family size
   d. Memorable events

4. Reflections
   a. Advice for new mothers
   b. Comments for health professionals
   c. Wider environment
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Education

2009 M.A., Anthropology, University of Illinois at Chicago, Chicago, IL
M.P.H., Community Health Sciences, University of Illinois at Chicago, Chicago, IL
2001 B. A., English Literature, Florida State University, Tallahassee, FL

Research Interests
Medical Anthropology, Mothering, Breastfeeding, Subjectivity, Refugees

Teaching Experience and Lectures

2012 Guest Lecturer, University of Illinois at Chicago
-Introduction to Epidemiology
2012 Instructor, University of Illinois College of Medicine at Chicago
-Essentials of Clinical Medicine 1: Medical Anthropology
2012 Graduate Instructor, University of Illinois at Chicago
Department of Anthropology
-Introduction to Cultural Geography
2006-11 Graduate Teaching Assistant, University of Illinois at Chicago
Department of Anthropology
-Introduction to Anthropology: The Human Adventure
-World Cultures: Introduction to Social Anthropology
-Human Evolution
-Introduction to Cultural Geography

Awards

2013 Provost Award, Graduate College, University of Illinois at Chicago, for
“Breastfeeding and the Practice of Mothering Among Refugees,” $2000
2011 Grant-In-Aid of Research from Sigma Xi, The Scientific Research Society, for
2010 Board of Trustees Tuition Waiver, University of Illinois at Chicago
2009 Passaro Scholar Research Appointment, School of Public Health, University of
Illinois at Chicago for the National HIV Behavioral Surveillance Project
2008 Charles Reed Research Award, Department of Anthropology, University of Illinois at
Chicago, for “A Biocultural Examination of the Peripartum Period,” $700
Field Experience

2012-13  “Breastfeeding and the Practice of Mothering Among Refugees in Chicago, IL,”
Principal Investigator
  • Fieldwork will result in dissertation. Examine breastfeeding and mothering practices among refugees living in Chicago, IL. (ongoing)
  • IRB Protocol #2012-0629

  • Fieldwork resulted in Capstone Project in Public Health, UIC. Examined healthcare access among urban and refugee migrants in Dar es Salaam, Tanzania. (5 weeks)
  • IRB Protocol #2009-0357

2009  “National HIV Behavioral Surveillance Project,” Chicago Department of Public Health, Chicago, IL, Passaro Scholar
  Principal Investigator, Nik Prachand.
  • Fieldwork resulting in an ethnography of urban Injection Drug Users and HIV risk behavior in Chicago in preparation for surveillance. (16 weeks)

2008  “A Biocultural Examination of the Peripartum Period,” Research Assistant, Mbulu District, Tanzania
  Principal Investigators Dr. Crystal Patil and Dr. Elizabeth Abrams.
  • Fieldwork investigating the peripartum period in home births among rural women. (8 weeks)

2007  “Program Assessment of Refugee Resettlement Program,” Interfaith Refugee and Immigration Ministries, Chicago, IL, Principal Investigator
  • Fieldwork conducting an assessment of the refugee resettlement program as part of the Urban Ethnography Field School, Northwestern University, Chicago, IL. (8 weeks)

Conference Papers and Posters

2013  “Addressing the Needs of Pregnant and Postpartum Refugee Women,” E. Antalis, 2013 National Refugee and Immigrant Conference, Chicago, IL- poster
2013  “Romanian Wine Styles: A Study of the Romanian Wine Industry Through the Lens of Cultural Capital and Acculturation Theories,” Cheryl Nakata and Erin Antalis, 7th International Conference of the Academy of Wine Business Research, St. Catherines, Ontario
2013  “Pathways to Wine Export Innovation: A Study of Romanian Wine Makers,” Cheryl Nakata and Erin Antalis, 7th International Conference of the Academy of Wine Business Research, St.


“Unauthorized Status and a ‘Web of Barriers’: Urban Refugees in Dar es Salaam, Tanzania,” E. Antalis, American Anthropological Association 100th Annual Meeting, Montreal, QC, Canada 2010


“An Ecological Assessment of Urban Refugees in Dar es Salaam,” E. Antalis, Society for Applied Anthropology 70th Annual Meeting, Merida, Mexico 2010

Professional Memberships
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