Mala Leche: Interpretation of Risk and Medical Challenges to Exclusive Breastfeeding in urban Chiapas

This paper explores mestiza women’s narratives and beliefs concerning mother’s milk as a source of contamination for their baby. My chosen narrative and subsequent discussion draws from doctoral fieldwork on transition to motherhood carried out in a barrio of the small city of San Cristóbal de Las Casas, Chiapas in the South East of Mexico. My aim in this paper to build upon tropes of women’s bodies as a potential risk to foetuses and newly born infants inherent in medical and lay models of reproduction. The notion of what makes a ‘good mother’ in the eyes of the state, its place in neoliberal political economic agenda and local use within a rhetoric of risk and uncertainty have been prominent throughout my research into maternal transition amongst mestiza women in Chiapas. The female reproduction process, particularly pregnancy, has long been of interest to those interested in the problematics of biopolitics and bodies as sites of power relations and conflict. In Mexico (as with most other parts if the world) the clinical management of pregnancy and birth give rise to treating women’s bodies as potential danger to new human life. Though these gendered bodies are charged with protecting and growing life, through the pathologizing of pregnancy they are also deemed at risk of damaging or ending it. The relationship between women (as patients), communities, physicians and larger institutions therefore becomes a complex web (or meshwork) of negotiation and gendered power struggles. Though ideas about negotiation and agency are prevalent during the gestation and birth stages of maternal transition this does not cease once the infant had been born. Throughout the postpartum and subsequent semi-exclusive breastfeeding period women’s bodies and the fluids contained there within continued to be evoked as a source of danger to infants and efforts made to intervene/prevent risk of permanent damage. During my fieldwork in the barrio and wider city I came across repeated incidences where mother’s milk or the mother’s body itself was blamed for illness in a newborn. Despite public health messages promoting the benefits of exclusive breastfeeding women were repeatedly told by individual doctors that existing medical problems or
complications in birth meant that their milk was causing harm to their baby. Physical and emotional conditions could literally turn a woman’s milk bad (mala leche). This reinforced a notion perpetuated throughout the clinical management of pregnancy and birth that without intervention a woman was at risk of harming her child.

In this shorter version of my paper I will explore how mestiza women in San Cristóbal interpret and measure medical models of risk at home in the postpartum period. I will also highlight how doctors exploit local beliefs about purity and contamination of postpartum bodies within medical and bio-political discourse and established power relations. My research sits within a woman-centred approach to maternal embodiment and my discussion here is limited to women’s own interpretations of events and experience. My use of the term postpartum encompasses three distinct phases. These are identified by Romano et al (2010) as the acute period, the first six to twelve hours after birth; the subacute period lasting two to six weeks and the delayed postpartum period lasting up to six months. The continuous postpartum phases centre on the physiological recovery of the maternal body and dovetail nicely with universal lactation advice that promotes exclusive breastfeeding for four to six months (WHO 2001). In my experience the duration of breastfeeding amongst mestiza mothers in San Cristóbal varies depending upon though not restricted to class, economic activity, health, birth outcome, community and family practice, and can be anything form four months to five years. It is very rarely exclusive feeding due to local beliefs about milk quality, hydration and non-serious illness in infants, hence my previous use of the term semi-exclusive – adhering to the use of other liquids for medicinal or minor supplementary purposes. For the purpose of my discussion in this short paper I limit the postpartum period even more specifically to the forty day confinement practised by a large majority of mestiza families. It is during this confinement that new mothers have the opportunity to establish feeding and milk supply, and also when they are most likely to remain in contact with medical professionals in regards to either maternal or infant health.

Cross-cultural critique of breastfeeding practices and gender politics

The phenomena of multiple bodies within one has meant that reproduction has long remained an important case study within biopolitics (Martin 1989; Lock 2007; Fordyce and Maraesa 2012). Particularly as pregnancy care today includes increasing prescriptions for risk management via the rapid advancement and access to reproductive technologies (Davis-Floyd and Dumit 1998; Edwards et al 1999; Rapp 2000; Mitchell 2001). The representation of
maternal subjects within various disciplines as ‘bodies who give birth to Others’ has faces the accusation of appropriating motherhood without taking into account women’s actual experience (LaChance Adams 2014; Mol 2015). Because of this much remains misunderstood about cross-cultural maternal embodiment, socio-cultural ethics of maternal practices and the impact on individuals’ transition through the lifecycle. Whilst much cross-cultural attention has been placed upon managing conception, gestation and birth stages of reproduction, less attention has been given to practices in the postpartum period as part of a whole process of ongoing transition to motherhood. There is a healthy tradition of anthropological work on breastfeeding practices across cultures and some of this establishes lactation within a wider political economy of reproduction and biopolitics (Maher 1995; Scheper-Hughes 1993; Cassidy and Abdullahi 2015). Despite a wealth of material focusing mainly on non-industrial societies and pre-industrial Europe there remains a disparity of ethnographic analysis that joins conceiving, gestating, baring and suckling as an interconnected process. This is particularly the case in analysis of biopolitical models of risk that first appear in conception and pregnancy and continue throughout the postpartum period to shape women’s lives as citizens and ‘good mothers’.

Newly industrialised countries in the twentieth century, such as Mexico, provide important sites of analysis. They provide a locus of activity and relationships where established socio-cultural beliefs about purity and contamination intersect with globalised and universalised knowledge practices. Mexico in particular exists in a meshwork within which it is tied to overlapping discourses of neoliberalism, indigeneity, traditionalism, modernity and development. Amongst these discourses that remain about but not of the people, daily lives are put through a tug of war over the way they should behave as modern nation state citizens. Economic and social policies appear to force rapid change upon individuals and communities. In contrast to this daily life happens through much more complex and integrated practices of embodied and gendered power relations which complicates the pace of actual change in practices and thinking. It is within these embodied and gendered power relations that more established or traditional ways of thinking become interpreted through modernity and, in this case, reproductive biopolitical discourse. When this happens, rather than it becoming a conscious way of manipulating local knowledge and practices, it creates a space for women to demonstrate the ways in which their knowledge remains authoritative.

Carlita
One new mother who best illustrates the conflict between medical and lay attitudes to mothers’ milk was my neighbour’s daughter Carlita. Her forty day confinement was typical of new mothers in the barrio and demonstrates the concern for a woman and newborn to be mothered as a unit whilst they transition into this new life phase. This was a multi-generational home typical within this barrio and all women gave birth at home with the local partera empirica (empirical midwife). I visited Carlita around one week after her baby had been born. She had given birth at home with the support of the family partera, (also Carlita’s mother-in-law), her mother Doña Carla, and Paternal Grandmother Doña Reina. Carlita and Alison had left the house just once since the birth in order to register the birth and obtain a first round of vaccinations at the local maternity hospital. This had been the family’s first contact with medical professionals since prenatal care.

Within two weeks Carlita’s forty day confinement was interrupted by the sudden illness and hospitalisation of baby Alison. The baby’s illness went undiagnosed and after four days internment and administering of antibiotics she was allowed home. There was a second, shorter admission to hospital and subsequent release home. During this time the family were given various non-specific explanations from emergency doctors and paediatricians. Shortly after the second hospital admission I saw Doña Carla in the street and enquired about the Carlita and Alison’s wellbeing. She explained in her own words that Alison had caught a stomach infection that had then moved to her brain. The illness had started with a fever and then progressed to the baby coughing up blood when they decided to call an ambulance and have her transferred to a private clinic. The first doctors to assess her claimed the infection was a result of the baby not having received all its vaccines at birth, therefore placing blame on the women for a high risk out-of-hospital birth. This explanation was later contradicted on a follow up visit to the clinic after Alison and Carlita had returned home. On this occasion a paediatrician had suggested that the infection had been passed through Carlita’s milk as she had a history of colitis. This time blame was proportioned further from maternal practices to the baby’s mother with the suggestion that her milk was contaminated. On each occasion medication was given to Alison without any official diagnosis as to the problem. The second

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1 The reference to colitis is understood as an ethno-diagnosis given by medics to many women I spoke to though not necessarily referring to the strict medical definition of inflamed colon or diarrhoea. Over the last five years or so it seems to have replaced a disproportionate diagnosis of gastritis in Mexico. I also noticed during fieldwork in 2013 changes in television and radio adverts that were once dominated with over the counter cures for gastritis had now moved on to cures for colitis though they listed the same symptoms and dietary causes for both illnesses. In either case there is no medical evidence to suggest that breast milk can become ‘contaminated’ by the mother’s stomach complaint.
paediatrician advised that Carlita stop breastfeeding and begin using formula as he believed that her milk was the root of the problem. Once home Doña Carla sought advice from the family partera and then made a decision to continue with the medications for the stomach infection diagnosed by the clinic. The partera however advised to continue breastfeeding with the addition of fennel tea given to both baby and mother to help settle the stomach. Carlita and Alison eventually completed their cuarenta días without further complications and continued to breastfeed throughout the postpartum period without having to substitute with formula.

**Discussion**

This is not the first instance I have been told about mother’s milk or the mother’s body itself making a baby ill. Such explanations generally come from the women themselves based upon family knowledge or interpretations of medical advice. Local medicalised postpartum advice often included how a woman should wash her breasts and nipples as an unclean body could cause stomach infections. On occasions when babies were taken ill with stomach upsets I noticed how women who came from families with generations of hospital births would comment on how the mother mustn’t have sterilised her breasts properly. The practice of washing breasts resembles the public health advice given to women around bottle feeding and home hygiene. This message is validated often by doctors and nurses in the pre-natal platicas (talks) at public clinics and reinforces the moral notion of the mother’s body as a source of contamination for the baby. Women also often spoke of personality traits in mothers and emotional outbursts that could cause a mother’s milk to go bad making the baby ill or interrupting milk flow and feeding.

The beliefs and concerns about the risks and consequences of mothers’ milk ‘gone bad’ were manifest in both lay and local bio-medical knowledge practices, though the approaches to remedying the issue and retaining the corporeal and emotional connection between mother and infant were in stark contrast. Much of this has to do with how mothers’ milk and breastfeeding serve a purpose that goes beyond nutrition. Different herbs, either consumed as infusions or inhaled through steam baths, are used to increase the flow of milk such as fennel, spearmint, pine and eucalyptus. The use of herbs and foods to help milk supply continues throughout the breastfeeding lifecycle but is most intense during the initial postpartum period. The forty day confinement, though often interrupted for various reasons, provides the opportunity for mother and baby to remain relatively protected from external (outside family) influences. To retain or recoup the bond that began in utero. It is practiced no matter whether
birth takes place at home or in a clinic and regardless of birth outcome. The confinement and intense support is evidenced to have a positive effect of breastfeeding retention and mental and physical wellbeing of the mother. The comments from women about quantity and quality of milk – that it is not enough to fill the baby or it is too watery – do mirror the types of things told to women who are encouraged to supplement with formula milk by medical professionals. It is a case of bolstering pre-existing beliefs as opposed to creating new ones. The environmental protection afforded to a new mother and her infant demonstrates the importance of emotional connection and mutual reliance in the process of recuperation. In this way breastfeeding and the flow of milk are part of a comprehensive system of beliefs that is deeply entrenched in sensory awareness. Thermal dynamics – notions of hot and cold – vulnerability and risk play an intrinsic role in how the senses shape and inform action in local postpartum practices. A closer awareness of thermal dynamics and sensory apparatus reveals how local biologies contrast and converge with medical ideas about postpartum healing. Overall in the context of this discussion postpartum practices show that though susceptible to contamination, mothers’ milk can be made pure again. The emphasis is on the bodily and sensual connection between mother and infant via breast, mouth and milk being paramount for the wellbeing of both.

Clinical and state attitudes to breastmilk and maternal bodies appear contradictory and disjointed at best. The strength of the Mexican state’s efforts to project modernity through maternal bodies meets with techno-scientific models of risk so that responsibility and blame lay squarely at the feet of mothers. My research in San Cristóbal shows how local ways of knowing are not simply dismissed, but manipulated to legitimize physicians’ interventions in postpartum and feeding practices. This is however challenged by women’s authoritative knowledge which lies within more comprehensive and holistic maternal belief systems. The decision to interrupt semi-exclusive feeding or cease and replace with formula depends upon the wider social network of the mother.

Whilst local knowledge about purifying mother’s milk and sustaining semi-exclusive feeding in the postpartum period goes undervalued and ignored women will be in conflict with medical professionals. Indeed medical authority is asserted more readily if a woman is seen to flout best practice does not leave space for considering why she may be doing so (Smith-Oka 2012a). In Mexico women who are seen to go against advice are perceived to be increasing their risk of complications and in doing so they are considered bad mothers and citizens. Adhering to medical advice defines women as good mothers because they are
demonstrating risk averse behaviour. The advice given to women to replace breastfeeding with formula does not take into account the logics of intercultural norms that breastmilk can be made good again by treating the mother with non-medical interventions. This leads to decision making in the home that goes against medical opinion. New mothers find themselves in an in-between space where interpretation of risk is dependent upon the importance of being a good mother in the eyes of the state or adhering to intercultural norms that a mother’s milk is best.

References


