The Right to Express Milk

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ABSTRACT: Breastfeeding in public has become more accepted, but milk expression—defined as removing milk from the breasts manually or using a breast pump—continues to be seen as a distasteful bodily function analogous to urination or sex, which should be confined to the private sphere. Few states explicitly exempt milk expression from their indecent exposure and obscenity laws. Yet, far from being a marginal activity, milk expression is often a necessary component of successful lactation. It allows parents with disabilities that challenge feeding at the breast to produce milk. It is instrumental in feeding babies who are unable to suckle at the breast or those who are temporarily separated from their parents, whether because the parents are ill, must report to work, have shared custody, or need to participate in political, social, and other aspects of life. In other words, milk expression is vital for human milk feeding in numerous circumstances and necessary for lactating parents to enjoy equal citizenship on par with non-lactating people.

Legal scholarship is growing in the field of lactation law, but work that specifically focuses on milk expression and its legal implications beyond the workplace—from the regulation of breast pumps as medical devices to the question of whether public milk expression should be protected—is missing. This Article contributes to the literature by arguing that milk expression should be recognized as part of a reproductive justice-based right to breastfeed through a combination of civil rights, FDA law, insurance law, health law, tax law, and work law. Parents need paid parental leave, paid lactation breaks, and access to affordable, high-quality, and culturally competent healthcare and lactation counseling and technology. In addition, they should have the right to express milk in every space where they have the right to be present.

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Milk expression has become an integral part of lactation in the United States. The term refers to the removal of milk from the mammary gland by means other than a baby suckling, whether by using a breast pump or one’s own hands. Once expressed, milk is typically offered to children from a bottle. While milk expression has long been part of infant feeding regimens across time and places, today lactating parents in the Global North and East Asia increasingly express milk, be it occasionally or on a daily basis. Some people feed their children human milk suckled directly at the breast, others feed them expressed milk, and still others use a combination of both. Even people who generally feed their children at the breast may occasionally need to resort to milk expression when they are separated from their children for longer than the usual interval between feeds. This need is due to the basic physiology of lactation: if milk is not continuously removed from the breast, lactation will eventually stop.

Despite federal and state measures, comprehensive legal protections for lactation and milk expression are still lacking. Discrimination based on lactation is now prohibited under Title VII of the 1964 Civil Rights Act, the federal employment discrimination statute. In 2010, the Affordable Care Act (ACA) gave millions of workers the right to a break time (which can be unpaid) and a

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1. I understand the terms breastfeeding and lactation broadly as referring to all human milk feeding practices, be it feeding at the breast or chest or feeding a baby expressed human milk in a cup or bottle. When relevant, I use the phrase “feeding at the breast” or variations, to distinguish at-the-breast feeding from human milk expressed by hand or pump before it is fed to an infant—in doing so I do not mean to exclude people who feed at the breast. See generally Kathleen M. Rasmussen et al., The Meaning of “Breastfeeding” Is Changing and So Must Our Language About It, 13 BREASTFEEDING MED. 510 (2017) (proposing the adoption of new sets of terms to describe breastfeeding related behaviors).


4. See Clemons & Amir, supra note 2, at 260 (describing an online survey of 903 Australian breastfeeding or formerly breastfeeding women finding that 98% had expressed milk—including 60% by hand and 66% by electric pump. These results should not be generalized, however, given that the respondents were members of the Australian Breastfeeding Association); Wei Wei Pang et al., Determinants of Breastfeeding Practices and Success in a Multi-Ethnic Asian Population, 43 BIRTH ISSUES IN PERINATAL CARE 68, 74 (2016) (finding that 70% of surveyed Chinese mothers in Singapore expressed milk when their babies were 6 months, suggesting that the practice of expressing milk is spreading).


private and clean space to express milk. In 2019, Congress passed the Federal Employee Paid Leave Act, which offers twelve weeks of paid parental leave to approximately 2.1 million federal workers, facilitating lactation initiation. Some states have similar or more protective measures for lactation; such as the state of New York, that also offers twelve weeks of paid parental leave, and the state of Illinois that requires employers to provide paid lactation breaks. Yet, according to a 2018 report, “27.6 million women workers of childbearing age nationwide are left without the basic protections needed by all breastfeeding workers.” Lactating workers are refused lactation breaks, ridiculed for lactating, denied privacy to express milk or, conversely, precluded from expressing milk publicly in shared work spaces, provided inadequate or inaccessible lactation facilities, and prevented from leaving the workplace to feed their babies at the breast (or from bringing their babies to work for the same purpose). These inequities have devastating consequences, including negative health outcomes for parents and children, diminished milk supply, early weaning, and economic and job loss.

There is now a robust literature on lactation laws and policies. This literature focuses on several key questions including whether there is or should

7. 29 U.S.C. § 207(r) (amending the Fair Labor Standard Act to require that employers provide “reasonable break time for an employee to express breast milk for her nursing child . . . each time such employee has need to express the milk.” Employers are also required to provide “a place, other than a bathroom, that is shielded from view and free from intrusion from coworkers and the public, which may be used by an employee to express breast milk.”).
13. See id. at 4.
be a right to breastfeed, what type of right it should be, and if breastfeeding is a right, whose right is it? Previous authors have asked: What are the remedies for a violation of that right? And who is empowered to bring a claim?15 This Article makes the argument that lactation—understood broadly to encompass feeding at the breast and milk expression—should be seen as a component of equality law16 and reproductive justice17 known as lactation justice.18 Because lactation is typically the result of pregnancy and birth, it is closely related to reproductive health and the choice whether to reproduce.19 Deciding whether and how to feed one’s baby human milk (i.e., at the breast, with expressed milk, or through a combination of both) should therefore be protected by the law not only as a matter of equality, but also on par with other reproductive choices, such as accessing reproductive health services, deciding the conditions of one’s birth, and parenting children with support, safety, and dignity.20

Why adopt this equality and reproductive justice lens instead of the more prevalent view of lactation as a lifestyle choice? This constitutional lens

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15. See, for example, the literature on the right to breastfeed as an international human right: Olivia Ball, Breastmilk is a Human Right, 18 BREASTFEEDING REV 9 (2010); Naomi Bromberg Bar-Yam, Breastfeeding and Human Rights: Is There a Right to Breastfeed? Is There a Right to be Breastfed?, 19 J. HUM. LACTATION 357 (2003); George Kent, Breastfeeding: A Human Rights Issue?, 44 DEVELOPMENT 94 (2001); Benjamin Mason Meier & Miriam Labbok, From the Bottle to the Grave: Realizing a Human Right to Breastfeeding Through Global Health Policy, 60 CASE W. RES. L. REV. 1073 (2010).

16. See generally Naomi Schoenbaum, Unsexing Breastfeeding (2021) (unpublished manuscript) (draft on file with author) (critiquing the sexism of breastfeeding and arguing for its unsexing through the application of heightened scrutiny under the U.S. Supreme Court’s equal protection jurisprudence).

17. See generally LORETTA J. ROSS & RICKIE SOLINGER, REPRODUCTIVE JUSTICE: AN INTRODUCTION 9-10 (2017) (listing the three primary principles of reproductive justice as “(1) the right not to have a child, (2) the right to have a child, and (3) the right to parent children in safe and healthy environments.”).


20. See ROSS & SOLINGER, supra note 17, at 14-16 (describing how feminist activists of color launched the reproductive justice movement in the 1990s to broaden the focus on White women’s access to birth control and abortion to a larger set of social justice issues affecting women who hold marginalized social identities).
recognizes that at times, parents’ and children’s interests may conflict in relation to human milk feeding, but that the parent’s right to choose should prevail. Without it, some parents’ ability to participate as full citizens in work and civil life is seriously curtailed. People’s infant feeding decision should not threaten their economic security or any rights or entitlements they may otherwise have. Despite the intense pressure to breastfeed conveyed by the dominant public health and parenting discourses, too many parents lack the support they need to achieve their lactation goals. They are expected to breastfeed and yet must do it with little support and privately. Typically, activities deemed to have a positive impact for individuals and communities are welcome in public, sometimes even flaunted, such as physical exercise. Yet, as this Article shows, lactation by and large continues to be cast as a “private” activity not appropriate for the “public” sphere. This equality and reproductive justice paradigm recognizes the systemic barriers that stand in the way of parents’ self-determination and the corresponding need to ensure the economic, social, and legal conditions necessary for them to have a realistic choice in how to care for and feed their children. The capacity of people to make decisions whether to breastfeed and to do so in ways that are consistent with their own values, is compromised in a country that lacks universal healthcare, paid parental leave for all new parents, paid lactation breaks, and other protections. The most vulnerable parents are also the most likely to receive discriminatory and subpar prenatal and postnatal care and the least likely to have access to leaves and flexible work conditions.21

Against this backdrop, the notion of a right to express milk should be viewed as one dimension of a broad set of lactation rights, not a substitution. Too often, governments and employers are tempted to protect milk expression rather than lactation more broadly conceived in order to save on costs.22 At the same time, milk expression is indispensable for lactating people to fully participate in society not only as reproductive and productive beings, but also as beings with wants and desires of their own. Milk expression’s regulation should therefore not

21. See Ann P. Bartel et al., Racial and Ethnic Disparities in Access to and Use of Paid Family and Medical Leave: Evidence from Four Nationally Representative Datasets, U.S. BUREAU LAB. STAT. (Jan. 2019), https://www.bls.gov/opub/mlr/2019/article/racial-and-ethnic-disparities-in-access-to-and-use-of-paid-family-and-medical-leave.htm [https://perma.cc/2WZP-BNH3] (commenting that mothers of color are less likely to take unpaid leaves such as those provided by the Family and Medical Leave Act (FMLA) because they cannot afford to and that “Hispanic and, to a lesser extent, Black non-Hispanic workers are less likely than their White non-Hispanic counterparts to have access to paid leave’’); Gianna Melillo, Racial Disparities Persist in Maternal Morbidity, Mortality and Infant Health, AM. J. MANAGED CARE (June 13, 2020), https://www.ajmc.com/view/racial-disparities-persist-in-maternal-morbidity-mortality-and-infant-health [https://perma.cc/5XJ2-74W6] (reporting that American women die in childbirth at a higher rate than in any other developed country, while non-Hispanic Black women are more than three times more likely to have a maternal death than White women in the United States).

22. See Jill Lepore, Baby Food: If Breast Is Best, Why Are Women Bottling Their Milk?, NEW YORKER (Jan. 12, 2009), https://www.newyorker.com/magazine/2009/01/19/baby-food [https://perma.cc/P9ML-J9MX] (arguing that accommodating pumping is a cheap way for private and public organizations to claim that they are supportive of breastfeeding without actually providing maternity or breastfeeding leaves, on-site childcare, and other forms of tangible support).
be confined to the work context. As ACLU attorney Galen Sherwin has written, “[t]he ability to breastfeed (and pump milk) . . . implicates one of our most fundamental freedoms — the liberty to exist in the public world.”23 Lactating parents should have the ability to move around the world with and without their children. This means that laws and policies should not only support the presence of babies at work, in educational institutions, medical centers, public accommodations, transportation hubs, and other facilities lactating people frequent, but also support their parents’ need to express milk in those very same locations.

This Article offers three main contributions. First, it provides an in-depth examination of milk expression practices and their regulation beyond merely pumping. Pumping refers to the expression of milk using manual or electric breast pumps, which are classified as medical devices by the Food and Drug Administration (FDA). No attention has been paid in the legal literature to date to the regulation of pumps as medical devices or to their alternative, hand expression, whereby a person releases milk by pressing and compressing their breasts with their hands.24

Second, this Article seeks to reorient the legal and policy debates around lactation, which too often focus upon the compatibility of pumping with work instead of addressing the systemic reasons preventing parents from being able to breastfeed. In part due to the legal system’s inadequacy, the expanding possibilities of milk expression are simultaneously emancipating and alienating in four main ways: (1) by allowing for the separation between parents and children; (2) by inducing reliance on consumer goods such as pumps; (3) by relegating milk expression to hidden, private spaces; and (4) by not recognizing lactation as a form of labor deserving of recognition and compensation. Building stronger institutional support for families would enable them to have more positive experiences with human milk feeding without compromising their social, economic, and personal well-being.

Third, the Article advocates for a broad, equality and reproductive justice-based right to express milk including a negative as well as a positive component.25 Under a negative rights framework, people should be protected from state interference in their lactation, especially when they do not correspond

24. See infra Parts I.A & B.
25. The negative right/positive rights dichotomy is arguably flawed, but given that it continues to shape much constitutional jurisprudence and case law, this Article does not enter into its critique. See Susan Bandes, The Negative Constitution: A Critique, 88 MICH. L. REV. 2271, 2272 (1990) (critiquing the idea that the U.S. Constitution is a charter of negative liberties and proposing discarding the rhetoric of negative rights altogether).
to the idealized, class-based, and racialized vision of good motherhood.\textsuperscript{26} Under a positive rights framework, the federal and state governments should require—and sometimes directly offer—concrete lactation support. The right to express milk should comprise a bundle of entitlements, such as the freedom to express milk in every location (public and private) in which a person is lawfully present; to access appropriate spaces for milk expression; to receive paid parental and lactation leaves as well as paid lactation breaks; and to obtain free or sliding-scale, knowledgeable healthcare and lactation support, as well as high-quality lactation equipment. Moreover, lactation law and policy must shift from a perspective focused on the needs and interests of White middle-class cishet women, of which I am an example, to those of parents of color, low-income parents, LGBTQIA+ parents, disabled parents, immigrant parents, and other parents whose circumstances and needs are insufficiently centered in mainstream legal and policy discourse. The normative proposals in this Article should thus be read as preliminary recommendations, as legal and policy change should be driven by the voices and needs of those parents who have been most marginalized.

The Article proceeds as follows. Part I provides a background understanding of milk expression, its motivations, and risks and benefits. Part II canvases the recent growth of lactation law. Part III highlights some of the shortcomings of the current regulatory framework, in particular the ambivalent status of milk expression as an emancipatory yet also alienating practice and the exclusion from existing protections of groups who do not fit into idealized conceptions of motherhood. Part IV proposes legal and policy changes to increase parents’ choices as to how to feed and care for their children with an eye to recognizing and enhancing lactation justice.

I. WHAT IS MILK EXPRESSION?

This Part provides an overview of the wide variety of reasons why people resort to milk expression and the techniques available to support the practice.

A. History of Milk Expression

Milk expression is not a new practice. In Europe,\textsuperscript{27} for example, archeological evidence indicates that breast pumps existed around the


\textsuperscript{27} No evidence suggests that milk expression was less common on other continents and my goal is not to center Europe in this section but to trace the genealogy of milk expression from Ancient European precedents to the contemporary American mainstream. \textit{See, e.g.}, Lawrence M. Gartner & Charles Stone, \textit{Two Thousand Years of Medical Advice on Breastfeeding: Comparison of Chinese and Western Texts}, 18
Mediterranean in Antiquity and that milk expression may have been practiced in the Bronze Age.28 Pumps were used for a variety of reasons,29 such as to allow people with inverted nipples to produce milk without a baby suckling, to reduce breast engorgement, to increase yield, to get rid of colostrum,30 or to obtain milk for medical indications in adults and children.31 Hand milking must have been common for similar purposes, but because it does not require an external device, the practice did not leave physical traces.32 Little is known about milk expression in the Middle Ages, but starting in the Renaissance, European White male physicians and inventors devised a steady series of breast pumps.33 By the nineteenth century, pumps were so well-established that they were sold to the general public in pharmacies34 and graced with their own entry in the dictionary of the French language.35 Doctors embraced pumps, in particular to feed premature and sick babies.36 Around the same time, a few American inventors filed patents for breast pumps.37 Historically, breast pump design has been led primarily by men with formal expertise in the fields of science and engineering, even though different kinds of voices and knowledge are increasingly expressed and heard.38 Today, engineering remains one of the most male-dominated

28. See Julie Dunne et al., Milk of Ruminants in Ceramic Baby Bottles from Prehistoric Child Graves, 574 NATURE 246, 248 (2019) (reporting archeological finding in Germany of clay spouted infant-feeding vessels dated between 800-450 BC, which may have been used for animal milk possibly mixed with some human milk).


30. See M. Papastavrou et al., Breastfeeding in the Course of History, 2 J. PEDIATRICS & NEONATAL CARE 1, 1 (2015) (explaining that the fluid secreted after giving birth was often considered noxious); see also John Ruhrah, Bartholomaeus Meltinger, in PEDIATRICS OF THE PAST: AN ANTHOLOGY 71, 79 (1925) (counseling that “the mother should have her breasts sucked by a young wolf or the milk should be sucked off” for the first fourteen days postpartum before she could nurse her child).


33. See generally Obladen, supra note 31.


35. See F. RAYMON, 2 DICTIONNAIRE GENERAL DE LA LANGUE FRANCAISE ET VOCABULAIRE UNIVERSEL DES SCIENCES, DES ARTS ET DES METIERS 270, 622 (1832) (containing not one, but two entries for breast pumps, which were known as either “pompe à sein” or “téétor”).

36. See Obladen, supra note 31, at 672.


professions in the United States, with women making up only about 13% of the engineering workforce.  

It was not until the 1920 that the first electric pump was developed. For the next seventy years, the electric pump remained confined to the medical setting, typically reserved for mothers of hospitalized babies too weak to suckle at the breast. In 1991, the Swiss company Medela launched the first commercial electric pump, making the appliance available to the general public. Since then, electric and battery-powered pumps have increased their presence in American households. In 2010, the passage of the ACA and its requirement that insurance plans cover the cost of a pump began contributed to their mainstreaming. The global breast pump market size was valued at USD 1.9 billion in 2019. In 2005-2007 in the United States, an estimated 85% of breastfeeding mothers expressed milk when their infant was between 1.5 and 4.5 months old. This share has likely grown since then, leading some researchers to estimate “the number of pumping [U.S.] women [to be] around 1.8 million.” Among those are White, middle-class women who not only have the economic ability to breastfeed and access lactation support, but also are culturally expected to do so as part of performing good mothering. Parents of color and/or low-income parents


40. See Calvina MacDonald, ABT’s Electric Breast Pump, 25 AM. J. NURSING 277 (1925) (presenting the new invention).


42. See Garber, supra note 37.


47. See Elizabeth J. O’Sullivan et al., Human Milk Expression as a Sole or Ancillary Strategy for Infant Feeding: A Qualitative Study, 13 MATERNAL & CHILD NUTRITION 1, 4 (2017) (reporting findings from study of 41 mothers experienced with hand or pump expression, finding 85% were married, 78%
express milk, too, but they may have reduced support to do so, largely because they tend to have less access to both family and medical leaves as well as to high quality and culturally relevant pre- and post-natal care.\textsuperscript{48}

Despite pumps’ wide dissemination, journalist Siobhan Adcock writes that their “basic design . . . hasn’t changed much since the first breast pump was patented, before the Civil War: It’s a pump, attached to a tube, that you stick on your breast. And hope for the best.”\textsuperscript{49} In response to this lack of technological innovation, the first “Make the Breast Pump Not Suck” Hackathon was held at MIT in 2014.\textsuperscript{50} Organizers endeavored to “engage with user perspectives that are left out of a design regime dominated by Western universalism, including perspectives from women, communities of color, children, low-resource contexts, and the Global South.”\textsuperscript{51} In the years that followed, new, innovative pump companies founded or co-founded by (mostly White) women such as Babyation, Elvie, Freemie, and Willow began to manufacture silent, wearable, and “smart” pumps allowing “discreet” milk expression on the go.\textsuperscript{52} However, these devices come at a price. At the time of writing, double Elvie or Willow pumps cost $499, and Babyation pumps can be preordered for $450. Some accessories are more accessible: Freemie collection cups, which are compatible with most pumps, cost around $60 to $70. Freemie cups were invented by Stella Dao, an emergency room doctor and one of the few women of color in the pumping business who, as a mother of premature twins and a refugee from Vietnam, was well positioned to understand the need for a wearable, yet affordable option.\textsuperscript{53} While this new generation of products represents a significant improvement in milk expression technology, their cost and the devaluation of the needs and health of people gendered as female contribute to their limited use. Capital is needed to innovate and “technology that almost exclusively benefits women seems to struggle to get consistent funding and

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\textsuperscript{48} See Bartel, supra note 21; Bailey Houghtaling, Carmen Byker Shanks & Mica Jenkins, Likelihood of Breastfeeding within the USDA’s Food and Nutrition Service Special Supplemental Nutrition Program for Women, Infants, and Children Population, 33 J. HUM. LACTATION 83 (2017) (finding support from the WIC staff, from health care professionals, and social support increase the likelihood of breastfeeding for WIC participants); Paige P. Hornsby et al., Reasons for Early Cessation of Breastfeeding Among Women with Low Income, 14 BREASTFEEDING MED. 375, 377 tbl. 2 (2019) (finding 2% of a sample of low-income women stopped breastfeeding because their breast pump was not working, among other reasons).


\textsuperscript{51} See D’Ignazio et al., supra note 46, at 3.


\textsuperscript{53} See Dan Garbez, We Can Double the Production of Human Milk By 2025, PRWEB (Sept. 8, 2015), http://www.prweb.com/releases/2015/09/prweb12946523.htm [https://perma.cc/Y792-H49Q].
In the past few years, some of the most creative pumping companies failed to obtain necessary funding or were bought out and/or shut down.  

Despite its long existence as a milk expression technique, hand expression has received significantly less focus in the literature. Breast pump marketing and the lack of hand expression education have created the perception that pumps are the only way to express milk. By contrast, hand expression, a technique that is silent and free, only requiring hands, is often met with chuckles and discomfort, if not outright hostility. Yet some studies suggest that milk can be removed more comfortably and effectively via hand expression. Manually expressed milk also appears to have a higher fat content than electrically pumped milk. Moreover, hand expression can help people feel more empowerment and control over their body and lactation. When practiced before birth it can boost confidence, especially for first-time parents. Of course, hand expression and pumping need not be mutually exclusive, as both methods can be combined to maximize the amount and quality of milk.

This concludes my brief survey of past and present practices of milk expression. The next question is why parents turn to it.

54. See Adcock, supra note 49.
58. See, e.g., Jimi Francis & Darby Dickton, Physical Analysis of the Breast After Direct Breastfeeding Compared with Hand or Pump Expression: A Randomized Clinical Trial, 14 BREASTFEEDING MED. 75 (2019) (reporting findings from observational study of 46 women comparing hand and pump expression and concluding that pump use correled with significant pain scores and resulted in inflammatory changes the authors characterize as soft tissue injury).
59. Makiko Ohyama, Harumi Watabe, & Yumiko Hayasaka, Manual Expression and Electric Breast Pumping in the First 48 h After Delivery, 52 PEDIATRIC INT’L 39 (2010) (showing that hand expression is more effective than pumping in the first days after birth when colostrum is thick and breast swollen).
60. See Laurence Mangal et al., Higher Fat Content in Breastmilk Expressed Manually: A Randomized Trial, 10 BREASTFEEDING MED. 352 (2015) (hypothesizing that this difference is due to the presence of hindmilk in manually expressed milk, which is more likely ejected with hand milking and has a higher fat content than foremilk).
62. See Jill R. Demirci et al., “It Gave Me So Much Confidence”: First-Time U.S. Mothers’ Experiences with Antenatal Milk Expression, 15 MATERNAL & CHILD NUTRITION e12824 (2019) (reporting based on interviews with postpartum women who had been trained in hand expression before birth that it increased their confidence in their ability to breastfeed successfully postpartum).
63. See Jane Morton et al., Combining Hand Techniques with Electric Pumping Increases Milk Production in Mothers of Preterm Infants, 29 J. PERINATOLOGY 757 (2009).
B. Reasons for Milk Expression

People express milk due to its benefits, be they medical or social or a mix of both. One medical reason is premature birth, which often makes it difficult (or impossible) for very small and weak infants to suckle at the breast and for birthing parents to produce milk without expressing. Some illnesses and disabilities in children may also prevent effective latching, that is, the positioning of a baby’s lips around the nipple so that the maximum amount of milk can be removed painlessly. In such cases, milk expression is required for optimal milk production and to avoid nipple injuries. Inverted nipples and certain surgeries (such as mastectomies or breast augmentations) may have similar effects. Premature as well as older babies with certain conditions cannot digest fat in human milk; milk must thus be expressed to be made fat-free. Expressed milk is also believed by some to increase an infant’s intake and may therefore be resorted to when a child is not putting on sufficient weight at the breast. Parents’ infections, medications, drug or alcohol use, and milk under- or over-production, among other reasons, may also require milk expression either as a temporary fix or as a lasting feeding solution. Certain disabilities and long-term illnesses in parents such as fibromyalgia and rheumatic diseases make it physically difficult or painful to feed at the breast. Trauma, overwhelming sensory issues, and the dysphoric milk ejection reflex—a condition whereby lactating people experience intense negative feelings just

65. See, e.g., Iris A.C. de Vries et al., Prevalence of Feeding Disorders in Children with Cleft Palate Only: A Retrospective Study, 18 CLINICAL ORAL INVESTIGATION 1507 (2014) (finding children with cleft palate are at high risk of developing feeding difficulties).
66. See, e.g., STACEY ATKINSON ET AL., eds., INTELLECTUAL DISABILITY IN HEALTH AND SOCIAL CARE 145 (2015) (explaining that babies with Down’s syndrome and babies with a heart disease are prone to feeding problems as sucking is hard for them, requiring expression before they latch on to make it easier for them to get milk).
67. See D’Ignazio et al., supra note 46, at 6.
69. See Valerie J. Flaherman et al., Positive and Negative Experiences of Breast Pumping During the First 6 Months, 12 MATERNAL & CHILD NUTRITION 291, 296 (2016).
before their milk is released—may also prevent feeding at the breast, leaving milk expression as an alternative.72

On the social end of the spectrum, reasons for milk expression include the need for parents to be separated from their children because of shared custody arrangements, or because of needs to work, care for others, do housework, study, participate in political and civil life, exercise, shop, seek medical care, socialize, engage in leisure, and so on. Some parents also choose to express milk in order to share the feeding responsibility with a partner or another caregiver.73 Because expression allows one to visualize and quantify milk volume, others express milk due to concerns about the adequacy of their supply.74 Some “African American women may see pumping breast milk as a more culturally appropriate means to breastfeed” due to a combination of factors including the traumatic history of enslaved wet nursing and a sense of security provided by pumps.75 Non-gestational parents may use milk expression to trigger lactation in the absence of pregnancy and birth.76 Still others may express milk not because they will be separated from their baby, but because feeding at the breast would be frowned upon where they go and/or because they find it uncomfortable.77 Conversely, those surrounded by breastfeeding enthusiasts and activists (aka “lactivists”)78 who cannot or do not want to feed at the breast may feel pressured to express milk to conform with community norms.79 Finally, lactating parents may be separated from their children due to emergencies,80 such as personal or family crises, natural disasters, public health emergencies, such as pandemics, and acts of terror or armed conflicts.81 In these situations, milk expression is the only method to maintain their lactation until they can be reunited. People may express milk for still other purposes. Human milk banks rely on donors with an

72. See Alia M. Heise & Diane Wiessinger, Dysphoric Milk Ejection Reflex: A Case Report, 6 INT’L BREASTFEEDING J. 1 (2011) (presenting the intense negative feelings that can arise just before milk is released while feeding at the breast).
73. See Labiner-Wolfe et al., supra note 45 (reporting that sharing responsibility was the predominant reason given for expressing milk in the National Immunization Survey II).
74. See Flaherman et al., supra note 69 (examining breast pumping experiences of mothers with milk supply concerns).
76. See supra note 19.
81. Id.
oversupply of milk who express and donate it to be redistributed to infants in need. Some parents simply prefer expressing their milk over direct nursing. Still others express milk for erotic pleasure, art-making, or culinary experiments.

A prominent reason for milk expression is the rising prevalence of exclusive pumping. Exclusive pumping refers to the practice of feeding a baby solely expressed milk because either the baby or the parent cannot or chooses not to feed at the breast. During the 2005-2007 period, close to 6% of mothers in the United States were found to feed their babies exclusively expressed milk. As with so many things related to childrearing and female-coded bodies, exclusive pumping is controversial. The breast-versus-bottle battle has found a new iteration in the feeding-at-the-breast versus feeding-expressed-milk clash. On one side, public health discourse does not frame exclusive pumping as a standard breastfeeding practice. Some claim that “pumpmoms” are alienated by

83. Alexandria Peary, At the Pump, BRAIN CHILD MAG. (Sept. 18, 2013), https://www.brainchildmag.com/2013/09/at-the-pump/ [https://perma.cc/PXM4-5NG7] (writing, based on experiences pumping when her first child was born premature, “[y]ou’re not supposed to fall in love with your breast pump, to mourn the end of your relationship with the machine, as I did when I had to return my hospital rental. . . . No one ever says how beautiful—how maternal—the image of the woman at the breast pump is”).
85. See generally STEPHANIE CASEMORE & SHARON DEWEY HETKE, EXCLUSIVELY PUMPING BREAST MILK: A GUIDE TO PROVIDING EXRESSED BREAST MILK FOR YOU BABY (2014); see also Fiona M. Jardine, Poster: Breastfeeding Without Nursing: Reasons for Initiation and Cessation of Exclusively Pumping Human Milk, 13 BREASTFEEDING MED. A-1-A68 (2018) (identifying the reasons for exclusive pumping based on a survey of 2,007 current and former exclusive pumping and finding that the leading motivation in 69% of the respondents was latch problems, followed by infants not transferring milk well while on the breast, having a NICU infant, or just wanting to).
86. See Dorothy Li Bai et al., Practices, Predictors and Consequences of Expressed Breast-Milk Feeding in Healthy Full-Term Infants, 20 PUB. HEALTH NUTRITION 492, 492 (2016) (finding that in a sample of lactating mothers in Hong Kong, across the first six months postpartum, the rate of exclusive expressed breast-milk feeding ranged from 5.1 to 8.0 % in 2006–2007 and from 18.0 to 19.8 % in 2011–2012); Sheela R. Geraghty, Jane C. Khoury, & Heidi J. Kalkwarf, Human Milk Pumping Rates of Mothers of Singleton and Multiples, 21 J. HUM. LACTATION 413 (2005) (reporting that 5% of a sample of mothers exclusively pumped, all of whom were mothers of premature infants); Dana M. Hornbeak, et al., Emerging Trends in Breastfeeding Practices in Singaporean Chinese Women: Findings from a Population-Based Study, 39 ANN. ACAD. MED. SINGAPORE 88 (2010) (reporting an increase in exclusive expressed breastmilk feeding in Singapore from 9% in 2000-2001 to 18% in 2006-2008); Labiner-Wolfe et al., supra note 45; Katherine R. Shealy et al., Characteristics of Breastfeeding Practices Among US Mothers, 122 PEDIATRICS S50 (2008).
88. Neither the AAP nor the CDC offer official guidance on exclusive pumping. The majority of online resources on the topic is found on parenting blogs, forums, social media, personal webpages, in particular, former exclusive pumpers and certified lactation counselors. See also Fiona M. Jardine, Breastfeeding Without Nursing: ‘If only I’d Known
pumping technology, missing out on the bonding aspects of nursing such as eye locking, skin-to-skin contact, and cuddling. A related argument is that pumping is disconnected from the stimulus and positive emotional and hormonal feedback of having a baby at the breast. On the other side, scholar and activist Fiona Jardine has emerged as a champion of exclusive pumping on social media and in academic circles. She advocates for the use of the present participle “breastfeeding” as an umbrella term to designate both feeding at the breast and milk expression and therefore as encompassing exclusive pumping.

C. Risks of Milk Expression

Milk expression presents risks and benefits for parents and children, as well as for the environment. The preceding section identified some of the benefits; risks are addressed below. For many parents, the benefits outweigh the risks, justifying the idea of a protected right to express milk. On the parents’ side, the risks can be categorized as social, emotional, and physical. Social and emotional risks include embarrassment, tension, fear of failure, pain, fatigue, and anxiety that may block the neurochemical pathways required for milk ejection. Pumps, in particular, are objects everyone loves to hate. Some people report that the time spent pumping reduces the time available to nurture and care for their infant; others, that it interferes with personal time. Catherine D’Ignazio observes that it is not so much the pumps women resent, but the social norms and policies pushing them to go back to work and the lack of affordable childcare and other forms of economic and emotional support. She concludes that “women internalize the failings of public policy” and are left blaming pumps. Even the “best” pumps—perhaps especially the high-tech ones—have been seen by some as problematic. Jill Demirci notes that the “smart pumps” that track milk output


89. See, e.g., Thorley, supra note 3.


91. Id.


93. See Orit Avishai, At the Pump, 6 J. ASS’N FOR RESEARCH ON MOTHERING 139 (2004); Julia Felice et al., “Breastfeeding” Without Baby: A Longitudinal, Qualitative Investigation of How Mothers Perceive, Feel About, and Practice Human Milk Expression, 13 MATERNAL & CHILD NUTRITION e12426 (2017); Nancy M. Hurst, Joan Engebretson & Jane S. Mahoney, Providing Mother’s Own Milk in the Context of the NICU, 29 J. HUM. LACTATION 366 (2013); D’Ignazio et al., supra note 46, at 2.

94. See Flaherman, supra note 74, at 294.

and are connected to smartphone apps may “contribute to additional stress and anxiety for mothers,” as6 they may fuel obsessive behaviors over the quantity of milk produced.97 Moreover, with improvements in pumping technology, some employers and lawmakers could be tempted to assume that parents no longer need parental leaves, lactation breaks, or onsite childcare on the ground that they can express anytime and everywhere, and in some case without ceasing to work at all.98

Several trials have affirmed the overall safety and effectiveness of pumps, yet pumping can still lead to physical injuries such as sore nipples, plugged ducts, mastitis, abscesses, fissures, trauma, nipple wounds, and to provoking (or worsening) hyperlactation, that is, the overproduction of milk beyond the volume required for a healthy infant.101 The FDA maintains a medical product reporting program enabling health professionals and consumers to notify the agency of problems with marketed products.102 Dozens of reports are filed each month about pumps, in their manual, battery-operated, and electric iterations.103

99. See Donald K. Hayes, Comparison of Manual and Electric Breast Pumps Among WIC Women Returning to Work or School in Hawaii, 3 BREASTFEED MED. 3 (2008); Judy Hopkinson & William Heird, Maternal Response to Two Electric Breast Pumps, 4 BREASTFEED MED. 1 (2009); Paula P. Meier et al., A Comparison of the Efficiency, Efficacy, Comfort, and Convenience of Two Hospital-Grade Electric Breast Pumps for Mothers of Very Low Birthweight Infants, 3 BREASTFEED MED. 141 (2008); Tina Slusher et al., Electric Breast Pump Use Increases Maternal Milk Volume in African Nurseries, 53 J. TROPICAL PEDIATRICS 125 (2007) (mentioning that at the time of writing, the safety and effectiveness of the newer generation of pumps compared to standard electric pumps had not been the object of published studies).
100. See Pamela Berens et al., ABM Clinical Protocol #26: Persistent Pain with Breastfeeding, 11 BREASTFEEDING MED. 1, 2 (2016) (noting that breastfeeding or using a pump “can induce an inflammatory response in nipple skin, which may result in erythema, edema, fissures, and/or blisters”); S. Lori Brown et al., Breast Pump Adverse Events: Reports to the Food and Drug Administration, 21 J. HUM. LACTATION 169 (2005) (finding that the most commonly adverse events reported to the FDA between 1992 to 2003 for electric pumps were pain, soreness, or discomfort; the need for medical intervention; and breast tissue damage, and for manual pumps were breast tissue damage and infection); Clemons & Amir, supra note 2.
102. See MAUDE - Manufacturer and User Facility Device Experience, U.S. FOOD & DRUG ADMIN., https://www.accessdata.fda.gov/scripts/cdrh/cfdocs/cfmaude/search.cfm [https://perma.cc/T74X-TCCV] (identifying the adverse event or product problem, when it occurred, the brand name of the product, what it is, the manufacturer’s name and address, and some information about the person using the device such as if they are a health professional, client, or patient, etc.).
103. Id.
2014, Youlin Qi and his colleagues found that of a sample of 1,844 pump users, 62% reported at least one pump-related problem and close to 15% at least one pump-related injury.\footnote{104}

When parents express their milk rather than feeding it directly from nipple to mouth, a number of risks may arise for their babies. As Sheela Geraghty and Kathleen Rasmussen have written, “expressed milk may become contaminated in the process of transferring it to the infant, or the way it is stored may compromise its nutritional and anti-infective benefits.”\footnote{105} Milk containers may leach dangerous substances\footnote{106} and storage itself contributes to the loss of beneficial components such as fat content.\footnote{107} A 2019 study showed that breast pumps may harbor harmful bacteria and that pumped milk contains more pathogens than milk suckled at the breast, suggesting that it could pose a risk of respiratory infection.\footnote{108} Other risks for children pertain to the question whether milk expression is associated with shorter duration of human milk feeding, even though the evidence here is mixed,\footnote{109} and nipple confusion, that is, an infant’s difficulty in latching at the breast after being exposed to bottle-feeding or other artificial nipples.\footnote{110} Some of the risks of milk expression are more pronounced in the case of pumping than hand expression.\footnote{111}

\footnote{104. Youlin Qi et al., \textit{Maternal and Breast Pump Factors Associated with Breast Pump Problems and Injuries}, 30 J. HUM. LACTATION 62, 65 (2014) (“The top 3 most commonly reported breast pump-related problems were not being able to express enough milk, taking too long to get enough milk, and that it was uncomfortable or painful to use the breast pump . . . . The top 3 most commonly reported breast pump-related injuries were sore nipples, a pressure bruise, and nipple injury.”).}


\footnote{107. See Yu-Chuan Chang, Chao-Huei Chen & Ming-Chih Lin, \textit{The Macronutrients in Human Milk Change after Storage in Various Containers}, 53 PEDIATRICS & NEONATOLOGY 205 (2012).}

\footnote{108. See Shirin Moossavi et al., \textit{Composition and Variation of the Human Milk Microbiota Are Influenced by Maternal and Early-Life Factors}, 25 CELL HOST & MICROBE 324 (2019).}

\footnote{109. See Dorothy Li Bai et al., \textit{Practices, Predictors and Consequences of Expressed Breast-Milk Feeding in Healthy Full-Term Infants}, 20 PUB. HEALTH NUTRITION 492, 499 (2016); Beiqiu Jiang et al., \textit{Evaluation of the Impact of Breast Milk Expression in Early Postpartum Period on Breastfeeding Duration: A Prospective Cohort Study}, 15 BMC PREGNANCY & CHILDBIRTH 268 (2015).}

\footnote{110. See generally Marianne Neffert, Ruth Lawrence & Joy Seacat, \textit{Nipple Confusion: Toward a Formal Definition}, 6 J. PEDIATRICS S125, S125 (1995) (defining nipple confusion as “an infant’s difficulty in achieving the correct oral configuration, latching technique, and suckling pattern necessary for successful breast-feeding after bottle feeding or other exposure to an artificial nipple”).}

\footnote{111. See Genevieve E. Becker, Fionnuala Cooney & Hazel A. Smith, \textit{Methods of Milk Expression for Lactating Women}, 9 COCHRANE DATABASE OF SYSTEMATIC REVIEWS 1, 2, 91 (2016) (reviewing methods of milk expression and finding no difference in the contamination of milk and the level of breast pain across methods of expression, but variations in nutrient content with hand-expressed milk yielding higher sodium and lower potassium milk); see also N-Y Boo et al., \textit{Contamination of Breast Milk Obtained by Manual Expression and Breast Pumps in Mothers of Very Low Birthweight Infants}, 49 J. HOSP. INFECTION 274 (2001); Maria Marin et al., \textit{Cold Storage of Human Milk: Effect on its Bacterial
Finally, feeding children human milk is often presented as the environmentally responsible thing to do as opposed to formula-feeding, which relies on intensive dairy farming, commodity crops, packaging, storing, shipping, and baby bottles.\footnote{See Karin Cadwell et al., Powdered Baby Formula Sold in North America: Assessing the Environmental Impact, 15 BREASTFEEDING MED. 671 (2020) (estimating that in 2016 the greenhouse gas emissions attributable to sales of powdered formula in the United States were 655,956 tons of CO\textsubscript{2} eq.); Julie P. Smith, A Commentary on the Carbon Footprint of Milk Formula: Harms to Planetary Health and Policy Implications, 14 INT’L BREASTFEEDING J. 49 (2019) (arguing that infant formula results in staggering greenhouse gas emissions, warranting urgent action to protect breastfeeding).} Yet, when human milk “feeding relies on pumped mother’s milk, the environmental picture changes.”\footnote{See Genevieve E. Becker & Yvonne Ryan-Fogarty, Reliance on Pumped Mother’s Milk Has an Environmental Impact, CHILDREN (Sept. 10, 2016), https://www.mdpi.com/2227-9067/3/3/14/pdf [https://perma.cc/WJU6-34PP].} The environmental cost of milk expression includes the manufacturing and disposal of the pumping equipment, collection kits, electricity or batteries, sterilization products, and other accessories, in addition to storage bags, bottles, and nipples. Plastic has been shown to be dangerous for humans, animals, and the environment, even when it is BPA-free, yet most pumps use it as their primary material.\footnote{See Buying and Renting a Breast Pump, U.S. FOOD & DRUG ADMIN. (Jan. 15, 2018), https://www.fda.gov/medical-devices/breast-pumps/buying-and-renting-breast-pump [https://perma.cc/P5LX-LFXB] (“With the exception of multiple user pumps, the FDA considers breast pumps to be single-user devices. That means that a breast pump should only be used by one woman because there is no way to guarantee the pump can be cleaned and disinfected between uses by different women.”).} Additionally, most pumps are not designed for multiple users, which would facilitate secondhand use.\footnote{See Walker & Auerbach, supra note 92, at 448 (indicating that until the early 1980s some electric pumps used glass bottles and flanges).}

Milk expression represents an important dimension of lactation in the United States, which comes with risks and benefits. The right to milk expression should be recognized and protected not because milk expression is necessarily beneficial for all parents all the time, but because all parents have a fundamental right to make (and be supported in) decisions about how to feed their children. The next Part critically examines how current laws and policies regulate the practice of milk expression.

II. THE REGULATION OF MILK EXPRESSION

This Part describes the two main ways in which milk expression is regulated: first, as an action, which can be alternatively protected and unprotected by the law and, second, as a practice that often requires equipment in the form of regulated breast pumps and accessories. Existing legal protections can be instrumental in supporting lactation for a subset of parents who benefit from

\textit{Composition}, 49 J. PEDIATRIC GASTROENTEROLOGY & NUTRITION 343 (2009) (suggesting that hand milking produces milk that has lower bacterial counts than pumped milk).
them. But they remain a far cry from the robust equality and reproductive justice rights parents need to have a meaningful choice of whether to breastfeed and how.

A. Regulating the Act of Milk Expression

Federal courts have recognized a constitutional right to breastfeed as a component of due process,\textsuperscript{116} but they have typically not found that it includes positive obligations on the part of the government to ensure that people can actually feed their children at the breast or express milk. The right to breastfeed does not even benefit from negative obligations in all circumstances. Actions interfering with lactation such as prohibiting a parent to express milk, particularly in situations involving the carceral state, have been upheld.\textsuperscript{117} More generally, many parents are ineligible for the parental leaves and lactation breaks that would concretely allow them to breastfeed.\textsuperscript{118} In practice, it is in the context of work law and public accommodations law, rather than constitutional law, that lactation rights have proven most successful, as people’s reproductive labor is mainly considered worthy of protection when it may conflict with their productive labor. As Meghan Boone has written, “[t]he two most common types of lactation laws are those that encourage or require employers to accommodate lactating employees and those that protect public breastfeeding.”\textsuperscript{119} Both the state and federal governments have passed these types of laws, which are examined in turn below.

1. Lactation at Work

Federal and state laws mandating that employers offer lactation breaks and facilities to their employees “attempt to address the two most cited barriers to continuation of breastfeeding once back at work—a lack of privacy and adequate

\textsuperscript{116} See Dike v. Orange County Sch. Bd., 650 F.2d 783 (5th Cir. 1981) (basing its reasoning in part on the right to privacy on par with marriage as recognized in \textit{Griswold v. Conn.}, 381 U.S. 479, 486 (1965)).

\textsuperscript{117} See, e.g., Safar v. Tingle, 859 F.3d 241, 244 (4th Cir. 2017) (“As part of the incarceration process, Safar was strip searched and inspected for smuggled contraband. She was the primary caregiver for three young children at the time and was denied the opportunity to use a breast pump.”); Glatz v. Marshall Cty. Sheriff Office, No. 16-1152, 2016 WL 3747945, at *1 (C.D. Ill. July 11, 2016) (granting a motion to dismiss in case brought by Glatz who was “incarcerated in the Marshall County Sheriff’s Office in Lacon, Illinois, for a period of 48 hours. Unable to nurse her daughter, her breasts started to swell, causing sharp pain. Glatz requested a breast pump from the Sheriff’s personnel, but her request was denied and no immediate medical attention was provided. By the end of the 48 hours, Glatz was in extreme pain. Upon her release, she sought medical attention and was diagnosed with Mastitis, an infection caused by the buildup of stale breast milk.”).

\textsuperscript{118} See, e.g., MORRIS ET AL., supra note 12; Kendall Powell, Babies on Board: Why US Scientist-Mums Need Support in the Early Years of Parenthood, 569 NATURE 149 (2019) (pointing out the lack of legally mandated parental leave for students and post-docs).

\textsuperscript{119} See Boone, supra note 9, at 1836.
time to express milk while at work.  

The passage of the ACA in 2010, which amended the Fair Labor Standard Act (FLSA), was game-changing for milk expression, not only because the Act protects certain categories of workers’ “break time . . . to express breast milk,” but also because it mandates that health insurance plans cover the cost of a pump. 

A growing number of state and local jurisdictions require that certain or all employers offer paid lactation breaks and a private location to express milk. Others only encourage such “accommodations.” Relief can also come from the state executive branch. For instance, in 2019, New Hampshire governor Chris Sununu passed an executive order allowing state employees to take their infant children to work. The policy states that cooperating agencies must allow lactating mothers flexible schedules to feed at the breast and/or express milk.

Unfortunately, many workers do not benefit from these measures for several reasons. First, employers can often claim exemptions if providing these accommodations creates an undue burden or hardship. Second, the federal rules leave large portions of employees helpless as they do not cover employees otherwise exempt from the requirements of FLSA such as salaried employees and teachers; only require employers to provide break time to express breast milk for children younger than one year; and do not entitle workers to bring in their babies to feed at the breast. To address some of these issues, in 2020, the U.S. Senate proposed a bill that would expand protections for nursing mothers. The “Providing Urgent Maternal Protections (PUMP) for Nursing Mothers Act” is intended to extend the federally protected break time to express milk already in

120. See Boone, supra note 9, at 1839.
121. See supra note 7 and accompanying text.
122. See H.B. 1090, 2020 Leg., Reg. Sess. (Ga. 2020) (codifying a new lactation break law requiring employers to offer paid lactation breaks on the employer’s worksite); H.B. 1595, 100th Gen. Assemb., Reg. Sess. (Ill. 2018); IND. CODE §§ 5-10-6-2 & 22-2-14-2 (2021) (enacted 2008) (requiring state and political subdivisions to provide reasonable paid breaks for an employee to express breast milk for her infant); ME. REV. STAT. ANN. tit. 26, § 604 (2021) (enacted 2009) (requiring an employer to provide adequate unpaid or paid break time to express breast milk for up to 3 years following childbirth); S.B. 285, 2020 Leg., Reg. Sess. (Okla. 2020) (requiring state agencies to allow paid break times for lactating employees to a use lactation room for certain purposes); H.B. 3200, 2020 Leg., 123rd Sess. (S.C. 2020) (providing that employers shall provide employees with reasonable unpaid break time daily or shall permit employees to use paid break time or meal time to express breast milk).
123. The word is in quotation marks, as I subscribe to Kimberly Seals Allers’ critique that describing this right as an “accommodation” “makes women feel as if they are being done a special favor.” Kimberly Seals Allers, The Big Letdown: How Medicine, Big Business, and Feminism Undermine Breastfeeding 5 (2017).
125. Id.
126. See MORRIS ET AL., supra note 12.
place from hourly employees to salaried ones. This bipartisan bill would “provide salaried employees in traditional office environments—a group of approximately 13.5 million executive, administrative, and professional women—with reasonable break time and a private place to pump breastmilk.” But it would not grant rights to non-lactating partners (regardless of their sex or gender) who participate in their children’s human milk feeding in multiple ways and may need breaks from work for that purpose. As for state law, Boone emphasizes that there is a “near-total lack of an enforcement mechanism for vindicating lactation rights.” Boone concludes that “the rights afforded to women in current lactation laws are largely symbolic in that most state laws place the onus on women to defend these rights and provide slim avenues for women to vindicate these rights when the laws are violated.” In sum, even if the work context has focused much of the legal attention, it remains insufficiently protective of lactation rights.

2. Lactation in Public

Lactation in public, rather than the workplace, also finds regulations in state and federal law, but these regulations largely focus on feeding at the breast rather than milk expression. Since 2018, all fifty states, Puerto Rico, and the District of Columbia protect public feeding at the breast, either affirmatively by allowing it in any public location or by exempting it from their incendence laws. Prior to 2018, some states’ incendence laws prohibited or discouraged public feeding at the breast by classifying the uncovering of a female breast as indecent exposure. Despite this undeniable progress, typically, public breastfeeding laws only explicitly protect feeding at the breast, not milk expression. By contrast, work laws tend to protect milk expression only, not feeding at the breast. In other words, people are entitled to feed their children at the breast in

128. The text of the bill is available here: https://www.congress.gov/bill/116th-congress/senate-bill/3170/text?r=2&s=1 [https://perma.cc/XX8W-5MS6] (at the time of writing the bill has been introduced in both Houses of Congress).
130. See Schoenbaum, supra note 16 (arguing that breastfeeding carework can be performed by parents of either sex and that men should be included in breastfeeding legal protections).
131. See Boone, supra note 9, at 1858 (noting that only thirteen states and the District of Columbia created a private right of action for lactating women whose rights have been violated).
132. See Boone, supra note 9, at 1859.
134. Breastfeeding State Laws, supra note 133.
public spaces and to express milk at work, but rarely entitled to express milk in public and to feed their babies at the breast at work.

The assumption behind this legal regime is that different spaces come with differently appropriate forms of lactation. Feeding at the breast is reserved for the home or (non-work) public context, reflecting the traditional (classed and racialized) vision of the good mother as a non-worker. Consequently even people protected by existing federal and state lactation laws may find themselves in challenging situations: Workers may be prohibited from feeding their babies at the breast at their workplace or from leaving the premises for the same purpose, even when their children will not take bottles. Those who share office spaces with coworkers may want the option to express milk at their station rather than losing time (and money when their lactation break is unpaid) traveling to uncomfortable and distant lactation spaces.

In contrast to the widespread protections of public feeding at the breast, at the time of writing, only five states statutes explicitly protect public milk expression. That said, people who need to express milk in public may already be protected under anti-discrimination public accommodation laws. Most state public accommodation laws prohibit discrimination on the basis of sex, which is usually interpreted as including pregnancy and breastfeeding discrimination. In those jurisdictions, reprimanding or harassing someone for expressing milk in a restaurant, a public library, or a mall would be illegal as it would be construed as discrimination on the basis of a sex-related trait. Another form of public milk expression protection at the state and local levels is the growing movement to offer lactation rooms open to members of the public. For instance, in 2017, New York adopted an ordinance stating that public buildings must have lactation rooms that are available to the public. Likewise, since 2019, Illinois has required that every facility housing a circuit court designate at least one public lactation room.

135. See Frederick v. New Hampshire, Case No. 14-cv-403-SM, 2016 WL 4382692 (D.N.H. Aug. 16, 2016) (describing how a lactating employee of the Department of Health was terminated when she failed to return to work after her supervisor refused to allow her to leave her worksite to feed at the breast her baby — who would not accept milk from a bottle — at his daycare facility, which was only 0.3 miles away, or to arrange for him to be fed in the office’s lactation room).

136. See Idaho (IDAHO CODE § 18-4101 (2021)); Kentucky (KY. REV. STAT. ANN. § 211.755 (West 2021); Missouri (MO. REV. STAT. §§ 191.918(1)-(2) (2021)), Texas (TEX. HEALTH & SAFETY CODE. ANN. § 165.002 (West 2021)); and Washington (WA. REV. CODE § 9A.88.010(1) (2021)).

137. See NAT’L CONF. ST. LEGISLATURES, supra note 133 (noting that forty-five states have anti-discrimination public accommodation laws). But see Elizabeth Sepper & Deborah Dinner, Sex in Public, 129 YALE L.J. 78, 144, n.387 (2019) (emphasizing that when a statute does not list breastfeeding in particular, different courts might reach different conclusions as to whether it protects lactating women from eviction from public accommodations).


As noted above, federal lactation law is known for its regulation of milk expression in the work context, but Congress occasionally made strides toward protecting feeding at the breast and expressing more generally, if not haphazardly. For instance, a 2004 federal statute provides that “a woman may breastfeed her child at any location in a Federal building or on Federal property, if the woman and her child are otherwise authorized to be present at the location.”\(^\text{140}\) The Fairness for Breastfeeding Mothers Act of 2019 requires certain public buildings to make their lactation rooms “available for use by members of the public to express breast milk,”\(^\text{141}\) which seems to exclude feeding at the breast.\(^\text{142}\) Federal law also regulates lactation during air travel. According to the Federal Aviation Act (FAA) reauthorization signed in 2018, medium and large hub airports must provide “a lactation area in the sterile area of each passenger terminal building of the airport.”\(^\text{143}\) Under the Transportation Security Administration (TSA) policies, expressed human milk is considered a medical liquid, which is not subject to other restrictions on quantities of fluids.\(^\text{144}\) Travelers are thus permitted to carry on human milk “in reasonable quantities through the security checkpoint,” even though it is screened separately from other luggage.\(^\text{145}\)

Though it is comforting that public milk expression is often protected under these different laws, the recognition of a specific, explicit right to express milk would provide lactating people with the assurance that the law is on their side and contribute to the normalizing of the practice. The recognition of a right to express milk in public would also entitle people to sue for civil rights violations if they were prevented from or harassed for expressing in public. As the next section highlights, existing regulations also fail to address other situations, such as that of essential lactating workers and telecommuting lactating workers. This gap has become particularly visible in light of the COVID-19 pandemic.


\(^{141}\) Fairness for Breastfeeding Mothers Act of 2019, 40 U.S.C. § 3318(c) (listing exemptions for public buildings that do not contain a lactation room for employees who work in the building and lack a room that could be repurposed as a lactation room at a reasonable cost; or when new construction would be required to create a lactation room in the public building and the cost of such construction is unfeasible).

\(^{142}\) This exclusion could rest on the assumption that because feeding at the breast is allowed in public, it does not require access to a special facility. It would also be based on the inference that parents do not visit public buildings with their children, reflecting the continuing influence of the separate sphere ideology. See infra Part III.A.3.


\(^{145}\) See Traveling with Children, supra note 144.
B. Regulating Milk Expression Equipment and Support

Milk expression often relies on equipment in the form of breast pumps and their accessories, in addition to containers to collect and store the milk and other paraphernalia. Milk expression may also require specialized counseling. Milk expression equipment and counseling are regulated by several areas of the law, including FDA law, insurance law, health law, and tax law.

1. FDA Law

Breast pumps and certain lactation aids, such as breast massagers, are regulated as medical devices by the FDA. Device types are allocated into one of three regulatory classes based on their risks and the evaluation necessary to demonstrate safety and effectiveness. Manual (“nonpowered”) breast pumps and accessories, such as massagers, are Class I devices, that is, they are considered low-risk, on par with elastic bandages and manual stethoscopes. They are subject only to “general controls,” such as tests of sterility. Manufacturers must register them with the FDA but are typically exempted from premarket notification procedures. Electric or battery-powered (“powered”) pumps are Class II devices, that is, they are considered higher risk, on par with powered wheelchairs and some pregnancy tests. They must meet general controls as well as “special controls,” such as additional labeling requirements. Manufacturers must typically submit a premarket 510(k) notification to the FDA, which is an application that demonstrates the device’s safety and effectiveness by showing its equivalence to another device which has already been legally marketed. Most other milk expression aids, such as breast pads, hands-free bras, coolers, portable sinks, storage bags or bottles, and breast bowls to collect hand expressed milk, are not considered medical devices.

149. See 21 C.F.R. § 884.5150 (2020); see also Madelyn Lauer et al., FDA Device Regulation, 114 MOD. MED. 283, 285 (2017) (noting that 95% of Class I devices “are exempt from undergoing any formal clearance or approval.”).
151. See Wilson & Heyl, supra note 148, at 215.
There are pros and cons to the classification of pumps and massagers as medical devices. Given the risks of pump use reviewed above, not only consumers, but also makers benefit from regulation. It protects the first from injuries and malfunctioning devices and bestows the latter with credibility with consumers. Pump companies and their supply chain must register with the FDA, obtain certain required certifications (or work with third parties such as labs and medical device manufacturers that already are already certified), be subject to inspections, have a quality management system in place, and, in some cases, conduct tests for their devices. The regulatory process increases the likelihood that the devices employ safe materials, batteries and circuit boards, among others. Another benefit of the medical device classification is that it comes with entitlements for users. For instance, the TSA allows pumps as checked or carried-on items on airplanes because they are medical devices. Airlines have different policies on the matter, but they typically do not charge an extra fee for checking or carrying on pumps on the ground that they are medical devices. Finally, there is an economic advantage to the classification. Qwa medical devices, pumps can be purchased through pre-tax accounts for those workers eligible for them or deducted as medical expenses.

On the downside, the medical device classification creates bureaucratic hurdles that may stymie innovation, drive up costs, and hamper user access to novel technology. The FDA regulatory process is complex, time consuming, and expensive. The medical device category might also support the status quo, in which a few large, established industry players control the majority of the pump market. Such companies have the resources to comply with the regulation and little incentive to innovate. Moreover, the most common regulatory pathway to market a medical device, commonly known as “510(k)” clearance, disincentivizes innovation. The process required to certify a medical device is completely opposite from that required to obtain a patent. Patent rights are granted to the inventor of a process or article that is new, useful, and non-obvious. By contrast, the “510(k)” process requires that the manufacturer of a

153. See supra Part I.C.
156. See, e.g., Carry-on Baggage, UNITED AIRLINES, https://www.united.com/ual/en/us/fly/travel/baggage/carry-on.html (stating that passengers may board with a breast pump in addition to a carry-on bag and personal item) [https://perma.cc/8PLX-P7P9].
157. See infra note 210 and accompanying text.
158. See Covert, supra note 55.
159. See id.
160. See id.
new device demonstrate “substantial equivalence” to a device already approved or cleared by the FDA, or to a pre-amendment device that was in use prior to May 28, 1976. This is typically done by proving that the new device has a similar purpose and is at least as safe and effective as devices already approved. Thus, a truly revolutionary pump that could not be compared to any of those already available would be harder to put on the market. Finally, the medical device paradigm may present a linguistic and symbolic disadvantage. Under the Food, Drug, and Cosmetic Act, a medical device is “an instrument . . . intended for use in the diagnosis of disease or other conditions, or in the cure, mitigation, treatment, or prevention of disease, in man or other animals.” But lactation is neither a disease nor a condition which must be cured, nor is milk expression an attempt to affect the structure or function of the body. On the contrary, it is a highly functional manifestation of the body. The medical device language thus pathologizes lactation as a medical condition or disability requiring treatment rather than celebrating it as an emotional, physical, and social achievement.

Overall, the safety benefits of regulation far outweigh its disadvantages, which could be offset with government and other support for innovation in the field.

2. Insurance and Public Health Law

Milk expression is regulated through insurance law and other public health regulations. With the passage of the ACA, starting in 2012, all non-grandfathered insurance plans were required to cover the cost of a pump and lactation counseling for new mothers without cost sharing. These requirements were lauded for increasing breastfeeding rates and democratizing pump use, with low-income families now able to obtain a pump through their private insurance or Medicaid.

162. See Lauer & Heyl, supra note 149, at 285.
163. This is a relatively easy burden to meet as ultimately all pumps have the same function: extracting milk from breasts. As Samantha Rudolph put it jokingly, “if you were trying to get it [milk] out a finger it would trigger something different.” Telephone Interview with Samantha Rudolph, Co-founder & CEO, Babynation (Sept. 3, 2019) (on file with author).
165. See 29 C.F.R. § 2590.715-2713; Kandice A. Kapinos, Lindsey Bullinger & Tami Gurley-Calvez, The Affordable Care Act, Breastfeeding, and Breast Pump Health Insurance Coverage, 172 JAMA PEDIATRICS 1002, 1002 (2018); see also 42 U.S.C. § 18022(c)(3)(A)(i) (defining “cost-sharing” to include “deductibles, coinsurance, copayments, or similar charges”).
166. See Tami Gurley-Calvez, Lindsey Bullinger & Kandice A. Kapinos, Effect of the Affordable Care Act on Breastfeeding Outcomes, 108 AM. J. PUB. HEALTH 277 (2018) (finding that the ACA mandate increased breastfeeding duration by 0.57 months).
Nonetheless, significant insurance-related obstacles remain in the path of families wanting to feed their children human milk. A 2017 study found that the ACA breastfeeding provisions resulted in an eleven-fold rise in claims for breast pumps in Maine by women with private insurance, suggesting that they “will likely increase breastfeeding initiation or duration; however, without additional support for women with Medicaid, disparities in breastfeeding may increase.”

Black parents are less likely than other groups to receive support or treatment for their lactation needs due to racially biased health care and inadequate access to culturally competent lactation resources. For all families, finding an in-network lactation consultant can be an uphill battle. Some plans do not allow out-of-network services at no cost-sharing, in violation of the federal rules.

Even plans that reimburse for out-of-network service may raise insurmountable barriers for families that cannot afford to pay at the point of service and seek later reimbursement. Other companies impose administrative hurdles, such as requirements of prior authorization and time restrictions, that hamper people’s ability to secure lactation benefits. For instance, in 2018, CareFirst paid over “$3.6 million to settle allegations that it failed to cover breastfeeding support, supplies, and counseling as required by the [ACA].” Moreover, pumping supplies such as spare pump parts (which must be changed every few weeks for those who pump on a daily basis), breast pads, and milk storage bags are


169. See Angela Johnson et al., Enhancing Breastfeeding Rates Among African American Women: A Systematic Review of Current Psychosocial Interventions, 10 BREASTFEEDING MED. 45, 46 (2015) (highlighting the many barriers to breastfeeding among African American women); Katherine M. Jones, et al., Racial and Ethnic Disparities in Breastfeeding, 10 BREASTFEEDING MED. 186, 189 (2015) (finding that Native American mothers “have the second lowest rates of breastfeeding initiation (73.8%) among all races/ethnicities following African American women (59.7%)”).

170. See Anne Bucher, BCBS Seeks Dismissal of Lactation Consultant Coverage Class Action, TOP CLASS ACTIONS (Apr. 21, 2017), https://topclassactions.com/lawsuit-settlements/lawsuit-news/631050-bcbs-seeks-dismissal-lactation-consultant-coverage-class-action (describing a class action lawsuit against Blue Cross Blue Shield (BCBS) that alleged that it had few certified lactation consultants in its preferred provider network anywhere in the country) [https://perma.cc/5XXG-NXGR].


172. See id. at 7.

expensive. In theory, these supplies should be covered by insurance, but they rarely are.\footnote{174}

Another issue is that the ACA does not include a quality standard for pumps, leaving it up to individual insurance plan administrators to determine which models to cover.\footnote{175} According to a 2015 report, “[i]nurance plan noncompliance—and the lack of clear federal standards and inadequate guidance—means that women are not getting insurance coverage that meets their needs.”\footnote{176} Some plans solely cover manual pumps, even though electric pumps extract more milk on average and speed up the process.\footnote{177} Other plans only cover the rental of a pump,\footnote{178} or require a pre-authorization from a doctor to obtain a pump. Still other programs, such as some WIC clinics, will not allow clients to obtain a pump until after the birth of their child,\footnote{179} a time when they may be overwhelmed and urgently needing to express milk. Finally, even if, in principle, all new gestational parents can receive a free pump through their insurance, they may be unaware of the benefit. The process to obtain it may also require time and know-how they do not have.\footnote{180}

Generally, low-cost plans offer lower quality pumps and fewer options to choose from. Even mainstream private insurer Anthem Blue Cross Blue Shield, which has an estimated 74 million enrollees, rolled back the value of its pump benefit in 2018, reducing reimbursement from $169 to $95.\footnote{181} It is possible to find basic, portable double electric pumps for $95, but such pumps are not always of the highest quality and may not be suitable for people initiating their lactation or pumping on a daily basis.\footnote{182} High-end pumps can cost several hundreds of


\footnote{176} Nat’l Women’s Law Ctr., supra note 171, at 1.


\footnote{180} See Nat’l Women’s Law Ctr., supra note 171, at 1.

\footnote{181} See Kapinos, Bullinger & Gurley-Calvez, supra note 165, at 1002.

\footnote{182} See Paula P. Meier et al., Which Breast Pump for Which Mother: An Evidence-Based Approach to Individualizing Breast Pump Technology, 36 J. Perinatology 493 (2016) (highlighting that personal-use pumps are not designed to initiate lactation and that hospital-grade pumps should be provided in those scenarios).
dollars and insurance companies typically do not cover them at all.\textsuperscript{183} Some plans allow customers to pay the difference between a premium pump and a list of standard pumps, which can lead to significant savings, but still requires several hundreds of dollars of out-of-pocket costs.\textsuperscript{184} To address this problem of access to pumping equipment, private initiatives have arisen to help low-income parents, such as by subsidizing the cost of pumps.\textsuperscript{185}

There is also a legal and policy gap in insurance and health care law in the recognition and support for hand expression. As part of the Baby-Friendly Hospital Initiative, a global program to protect and support breastfeeding,\textsuperscript{186} all new parents should be taught how to hand express their milk right after birth.\textsuperscript{187} In practice, only about 11.5% of U.S. births take place in baby-friendly facilities\textsuperscript{188} and some participating hospitals fail to teach hand expression.\textsuperscript{189} Non-participating hospitals are even less likely to teach it.\textsuperscript{190} During the COVID-19 pandemic, lactation support was curtailed both at the hospital and at home.\textsuperscript{191} At the hospital, the personnel usually allocated to lactation to support may be overwhelmed or reassigned to other tasks, and patients may be discharged before they are able to receive lactation help. At home, in-person lactation counseling may be unavailable due to social distancing, making it unlikely that hand expression is being taught, since it is a skill best learned through hands-on

\begin{enumerate}
\item[183.] See D'Ignazio et al., supra note 46, at 2618 (emphasizing that even when pumps are covered, users must periodically purchase expensive additional parts and accessories, such as “differently-sized flanges, hands-free bras, a carrying case, additional bottles, back-up parts, and extension cords”).
\item[185.] See Barbara L. Philipp, Elizabeth Brown & Anne Merewood, \textit{Pumps for Peanuts: Leveling the Field in the Neonatal Intensive Care Unit}, 44 J. PERINATOLOGY 249 (2000) (describing a program that used to make pumps available to under-resourced families with a baby in the NICU); see also Medela Cares, MEDELA, https://www.medela.us/breastfeeding/medela-cares (mentioning that the company donated “more than 200 hospital-grade, multi-user breast pumps to Ronald McDonald Houses across the country”) [https://perma.cc/F4QA-Z8JU].
\item[187.] See Vergie Hughes, \textit{The Baby-Friendly Hospital Initiative in US Hospitals}, 7 INFANT, CHILD & ADOLESCENT NUTRITION 182, 186 (2015).
\item[189.] Ann M. Witt, Maya Bolman, & Sheila Kredit, \textit{Mothers Value and Utilize Early Outpatient Education on Breast Massage and Hand Expression in Their Self-Management of Engorgement}, 11 BREASTFEEDING MED. 433, 434 (2016) (noting that only 62% of mothers in a 2013-2013 study sample had been taught hand expression at the of Baby-Friendly Hospital where they delivered).
\item[190.] See, e.g., Demirci et al., supra note 62, at 4; see also Valerie J. Flaherman, Randomised Trial \textit{Comparing Hand Expression with Breast Pumping for Mothers of Term Newborns Feeding Poorly}, 97 ARCHIVES DISEASE CHILDHOOD (FETAL & NEONATAL ED.) F18, F22 (2012) (recommending that healthcare providers “teach[] hand expression rather than breast pumping” to mothers of newborns).
demonstration. Even in ordinary times, there is no specific requirement that insurance companies cover the cost of a hand expression tutorial, and this is assuming that people can find one, as skilled instructors can be hard to come by. There is a similarity between hand expression and unmedicated vaginal deliveries. When indicated, unmedicated vaginal deliveries are the least resource intensive methods of giving birth—they are low-tech, cheaper, potentially even free—and can be profoundly empowering for the person who is the leading actor of their own birth, rather than a patient. Similarly, hand expression is a low-tech, affordable (or free) method to express milk in which the lactating person can gain greater attunement with their body and lactation. Yet, both practices are marginalized in mainstream medical, policy, and legal culture in which incentives are built—in part through insurance law—to bill and consume expensive medical procedures and devices.

Some in the breastfeeding community believe that increased regulation of lactation counseling generally, particularly in the form of licensure laws, would improve access to skilled lactation assistance. The lactation counseling profession includes a variety of providers, from peer counselors, to certified lactation counselors (CLCs) who have completed at least 45 to 52 hours of lactation education providers credentialed by the International Board of Certified Lactation Consultant Examiners (IBCLCE) after a two-year equivalent training, and to healthcare professionals such as nutritionists, occupational therapists, doctors, midwives, and nurses, among other titles and certifications.

193. See Martinelli, supra note 57.
195. See Diana West, The Power of Hand Expression, LA LECHE LEAGUE INT’L (Jan. 15, 2020), https://www.lili.org/the-power-of-hand-expression (“Getting to know the landscape of your breasts and the way they work can help you start to think of them as your breasts.”) [https://perma.cc/2BM7-5JE8].
197. Peer counselors are typically parents in the community who have lactation experience and some training to give information and support new parents. See, e.g., Get Support from WIC, WIC BREASTFEEDING SUPPORT, https://wicbreastfeeding.fns.usda.gov/get-support-wic (describing WIC’s breastfeeding peer counselors’ program) [https://perma.cc/S9EA-VZHA].
199. See Marsha Walker & Leah S. Aldridge, The Road to Licensure of the IBCLC, 8 CLINICAL LACTATION 53, 53-54 (2017) (noting that the IBCLCE is a non-profit, independent Board set up in 1985 to oversee the credentialing process for so-called IBCLC lactation consultants. Currently an exam candidate needs 14 college-level health science and related courses, 90 hours of lactation-specific coursework and 300 to 1,000 hours of clinical training, depending on the candidate’s pathway. The education and training process takes about 2 years to complete for a full-time student with no prior college education).
There is a split between, on the one hand, IBCLCs, who tend to favor occupational licensure laws that would give them control over clinical lactation care and delimit other providers’ (particularly CLCs’) scope of practice, and, on the other hand, CLCs, who tend to support the status quo (i.e., the absence of a licensure requirement) or licensure laws that recognize them to be on par with IBCLCs. The arguments offered in favor of licensure laws are the protection of the public, the advancement of the profession, and better reimbursement as most health insurance programs require that care be provided by a licensed professional. On the other side, opponents point out the need for greater racial equity and representation in lactation, a field long dominated by middle class White cishet women and their interests. The IBCLC credential, the most demanding in terms of formal educational requirements and clinical training, has been critiqued as centering White lactation practices and perspectives and failing to enable large numbers of BIPOC candidates to get certified due to the time, cost, and difficulty of finding host organizations or mentors to complete the hundreds of required clinical hours. To address this issue, the National

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200. See Licensure, U.S. LACTATION CONSULTANT ASS’N, https://uslca.org/licensing-ibclc (advocating for the licensure of IBCLCs in all 50 states, creating a model statute, and offering support to individuals willing to push for licensure with their state legislators) [https://perma.cc/84RN-GXUF]; see also U.S. OFF. SURGEON GEN., U.S. DEP’T HEALTH & HUM. SERVS., THE SURGEON GENERAL’S CALL TO ACTION TO SUPPORT BREASTFEEDING (2011) (calling for the reimbursement of the services of IBCLCs regardless of licensure or alternatively encouraged the states to enact licensure laws for lactation professionals). The following states have enacted lactation consultant licensure laws and regulations: Rhode Island, R.I. GEN. LAWS ANN. § 23-13.6 (West 2020); Georgia, GA. CODE ANN. § 43-22A (West 2020); New Mexico, N.M. STAT. ANN. § 61-36-4 (West 2020); and Oregon, OR. REV. STAT. § 676.669 (West 2020). At the time of writing at least four states introduced new licensure and reimbursements bills: Mississippi, H.B. 587, 2021 Leg., Reg. Sens. (Miss. 2021); Texas, H.B. 1072, 87th Leg., Reg. Sens. (Tex. 2021); New York, Assem. B. 2297, 2021-2022 Leg. Sens. (N.Y. 2021); Massachusetts, SD1213, and Massachusetts SD 1162.


202. See generally Walker & Aldridge, supra note 199 (presenting arguments in favor of licensure from the perspective of IBCLC certified providers).

203. See Camie Goldhammer, The Indigenous Breastfeeding Counselor—Decolonizing Breastfeeding Education, http://www.usbreastfeeding.org/ll/redirect?redirect=p%2Fdo%2F%2Ftopics%3D858%26sd%3D1083 (“Historically all breastfeeding certifications and most breastfeeding education has been taught by and centers on white women and their families. Because of this many lactation supporters are ill equipped to serve communities of color.”).

Association of Professional and Peer Lactation Supporters of Color (NAPPLSC) launched initiatives “to help the lack of accredited lactation consultant training programs established using an equity lens,” including partnerships with “Historically Black Colleges and Universities and other academic institutions located in communities of color nationally.” The CLC certification, which is considerably shorter and more affordable, has allowed a broader share of counselors of color to become certified. Some lactation professionals have chosen yet a different route in devising independent courses attuned to the cultural needs of diverse lactating people, which do not lead to the standard IBCLC or the CLC certifications. For instance, Camie Goldhammer, a Sisseton-Wahpeton lactation consultant, founded the Indigenous Breastfeeding Counselor training to “provide . . . foundational lactation education to Native people so that they provide clinical breastfeeding support in their communities.”

In summary, while the ACA significantly improved the insurance coverage of lactation equipment and counseling, significant barriers remain in the way of many families in accessing high quality pumps and lactation education and supports.

3. Tax Law

Milk expression is also shaped by its treatment in tax law. The Internal Revenue Service (IRS) made breast pumps tax deductible in 2011 and some states have their own tax exemptions for lactation supplies. The federal tax benefit effectively lowers the price of these products for taxpayers who meet certain eligibility rules. However, it is only available to those who have a


206. See Demographic Report of current CLCs in the U.S. & Territories, ACAD. LACTATION POL’Y & PRAC. (July 1, 2020), https://alpp.org/images/pdf/CLC_Demographics.pdf (showing that as of 2020, 10.3% of CLCs identified as Black, Afro-Caribbean, or African American, 8.3% as Latinx or Hispanic-American, 1.5% as American Native or Alaskan Native, 2.6% as East Asian or Asian American, and 74.8% as White or Euro-American) [https://perma.cc/4UK9-8TU6]. But see 2019 Lactation Care Provider Demographic Survey, U.S. LACTATION CONSULTANT ASS’N (2019), https://uslca.org/wp-content/uploads/2020/06/2019-Lactation-Care-Provider-Demographic-Survey.pdf (suggesting that IBCLCs tend to be significantly Whiter than CLCs) [https://perma.cc/VYD6-JBQ5].


208. See INTERNAL REVENUE SERV., ANNOUNCEMENT 2011-14: LACTATION EXPENSES AS MEDICAL EXPENSES, https://www.irs.gov/pub/irs-drop/a-11-14.pdf (“The Internal Revenue Service has concluded that breast pumps and supplies that assist lactation are medical care under § 213(d) of the Internal Revenue Code because, like obstetric care, they are for the purpose of affecting a structure or function of the body of the lactating woman.”) [https://perma.cc/DQ7K-A4B6].


Health Savings Account (HSA), a Flexible Spending Account (FSA) account, or medical expenses above 7.5% of their adjusted gross income for the year.²¹¹ These accounts thus perpetuate economic inequalities, as they benefit mostly high-income earners who can afford to put funds aside as health savings or to pay out of pocket for the difference between an upscale and a regular device. The accounts also require time and know-how in setting them up, figuring out how much money to put in them, and using them to purchase covered items, which can be overwhelming for people pressed for time and/or inexperienced with this type of paperwork.²¹² As a result, many families cannot take advantage of the benefit, and it is burdensome to obtain for those who are eligible.

Expressed milk itself does not benefit from any favorable tax treatment. The IRS does not allow a deduction for donating “human body materials,”²¹³ including human milk, despite its relatively high market value.²¹⁴ Human milk donors can deduct the expenses incurred in producing the milk, such as transportation or the cost of their pumps and supplies, but not the milk itself.²¹⁵ The time they spend expressing milk and its economic opportunity cost are not factored in either.²¹⁶

While lawmakers and regulators have made important strides, on both the federal and state level, to protect lactation in general and milk expression in particular, the current legal and policy framework still fails to ensure that all parents who so desire have the opportunity to breastfeed. As a result, the next Part argues that lactation laws contribute to milk expression’s ambivalent role in parents’ breastfeeding experiences and to the exclusion of lactating (or potentially lactating) people who do not meet dominants norms of good motherhood.

III. PROBLEMS WITH THE CURRENT REGULATIONS AND CONCEPTIONS OF MILK EXPRESSION

Current milk expression practices and their regulation are ambivalent, simultaneously empowering and constraining. On the one hand, they represent considerable improvement from the previous dearth of equipment, support, and

²¹¹ See IRS, supra note 208.
²¹² See Elizabeth Emens, Life Admin: How I Learned to Do Less, Do Better, and Live More (2019) (making visible the various types of admin that shape our lives and their costs).
²¹⁴ See Cohen, Should Human Milk Be Regulated?, supra note 14, at 560, 578-579 (noting that one ounce of milk can be sold peer-to-peer online for an average of $1.50-2.50, non-profit milk banks charge an average processing fee of about $4.50/ounce, and commercial companies charge varying amounts for their human-milk based products).
²¹⁵ See Zelenak, supra note 213, at 66.
²¹⁶ See Julie P. Smith, Counting the Cost of Not Breastfeeding Is Now Easier, but Women’s Unpaid Health Care Work Remains Invisible, 34 HEALTH POL’Y & PLANNING 479 (2019) (discussing the economic opportunity cost of unpaid breastfeeding time).
legal protection. On the other hand, they contribute to making milk expression a fraught practice, compromising gender equality and reproductive autonomy. This Part begins by presenting the ambivalence of milk expression as alternatively chaining and freeing parents, before singling out the categories of people who are left out by the law because they do not cohere with mainstream ideas of who should reproduce and parent and how they should do so.

A. The Ambivalence of Milk Expression

The expanding possibilities of milk expression afforded by existing lactation laws and policies are simultaneously emancipating and alienating in at least four main ways: by allowing for the separation between parents and children; by inducing reliance on consumer goods; by relegating milk production to private spaces; and by not recognizing lactation as work deserving of compensation.

I. Milk Expression as a Vector for Parent-Child Separation

By enabling and encouraging separation between parent and child, milk expression regulations render it concurrently emancipating and disenfranchising. Milk expression can be liberating in allowing parents to lactate in a wide variety of situations in which, without it, they might otherwise need to wean or supplement with infant formula. And yet, the very opportunity for separation created by lactation laws and policies may set up the expectation that parents and their babies can or should be separated; in particular, to allow for wage work. Pamela Laufer-Ukeles and Arianne Renan Barzilay thus critique the two predominant “separation strategies” for working mothers:

[S]ocietal developments and legal reactions to the global health push towards breastfeeding, especially for mothers who work, have focused on separating the mother from the human milk she produces. Purchasing and pumping human milk are two ways of extracting the milk from a woman and then feeding the child that milk at a later time. While separation strategies may be essential for many women and important for supporting breastfeeding, it is troubling that they represent the main legal and societal response to the health push.

In their view, lactation breaks and recourse to donor human milk are problematic as they decouple the nurturing act of breastfeeding from the nutritional and immunological benefits associated with human milk feeding.

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217. See supra Part I.B.
218. See Laufer-Ukeles & Renan Barzilay, supra note 14, at 305. See also Kath Ryan, Victoria Team & Jo Alexander, Expressionists of the Twenty-First Century: The Commodification and Commercialization of Expressed Breast Milk, 32 MED. ANTHROPOLOGY 467 (2013) (reporting qualitative empirical research on UK women’s experience of breastfeeding and arguing that pumping fragments the mother-infant dyad and technologizes breastfeeding).
219. See Laufer-Ukeles & Renan Barzilay, supra note 14, at 268.
One positive effect of the COVID-19 crisis may be its demonstration that when parents are allowed, or forced, to be home with their babies, a lot more feeding at the breast takes place, especially in well-resourced families, reducing the need for milk expression, donor human milk, and formula feeding.\footnote{See Corinne Botz & Mathilde Cohen, Is Online Breastfeeding a New Thing? How the Pandemic is Changing Everything and Nothing, MS. MAG. (Jan. 26, 2021), https://msmagazine.com/2021/01/26/online-breastfeeding-nursing-lactation-zoom-video-call [https://perma.cc/KH6S-CSYU].} Tellingly, during the pandemic, human milk banks were flooded with milk donations from parents stuck home.\footnote{Id.} Some of these donors were now exclusively feeding at the breast when they would normally have been expressing milk at work. No longer needing their stash of frozen milk, they were eager to make room in their freezer for groceries at a time when shopping trips were limited. That said, these observations should be qualified, considering that the crisis may have had the opposite effect on already-marginalized communities. The rigors of essential work or the loss of jobs, childcare, access to health care, and breastfeeding support may have hampered people’s ability to initiate and maintain lactation.\footnote{Id.}

While laws and policies should enable all parents to stay home with their children during their first months (or years) of life through a combination of paid leave and flexible work programs, not everyone may want that arrangement. Presented with the choice between paid leave and going back to work with the option of expressing milk, some may prefer the latter, at least for a portion of the time. In addition, separation is helpful (and sometimes necessary) for parents to exist as individuals with wants and needs beyond just work or managing shared custody, such as exercising, socializing, engaging in politics, education, seeking healthcare, and other activities. Finally, expressing and donating milk can create connections with others, rather than merely leading to “a prioritization of the provision of nutrition in a manner that is alienated from nurture and care.”\footnote{See Laufer-Ukeles & Renan Barzilay, supra note 14, at 268.} There is nurture and care between donors and recipients, whether it is mediated by the materiality of bottled milk or whether it occurs in person as relationships are formed around milk sharing.\footnote{See generally TANYA M. CASSIDY & FIONA DYKES, BANKING ON MILK: AN ETHNOGRAPHY OF HUMAN MILK EXCHANGE RELATIONS (2019) (offering an ethnography of human milk banking in the United Kingdom and beyond); SUSAN FALLS, WHITE GOLD: STORIES OF BREASTMILK SHARING (2017) (offering an ethnography of human milk sharing in the United States).}

In brief, for people to enjoy a meaningful right to lactate and express milk, they should thus have the legally protected option to express milk while separated from their children, but also to bring their children with them feed them at the breast in a broader range of contexts, including at work, at school, and when seeking medical care. As Naomi Schoenbaum has argued, non-lactating
parents should also benefit from some of these rights so as to support their lactating partners, such as taking breaks from work to attend a breastfeeding class or to bring a forgotten pump to their partner’s workplace.  

2. Milk Expression as Requiring Consumer Goods

Milk expression is both facilitated and hindered by the centering of breast pumps in law and policy and the comparatively absence of hand expression from regulatory oversight. Since electric double breast pumps became commercially available in the 1990s, their trajectory has followed that of other consumer electronics. They have become slicker, smaller, quieter, and more comfortable. Despite the freeing aspects of this technology and its prioritization in lactation support through insurance coverage, it has been critiqued as a neoliberal form of consumption associated with intensive motherhood, the dominant parenting ideology among middle class White women. For this group, the maternal experience is increasingly a consumer’s experience—it is about which products, services, diagnostic tests they purchase, from strollers to postpartum doulas to breast pumps.

A number of feminist voices have condemned breast pumps on the ground that they encourage consumerism and distract from the lack of support for infant care and lactation in general. Julie Stephens writes, “[b]reast pumps may appear personal but their purpose is profoundly industrial: increasing productivity in the workplace.” Kate Boyer and Maia Boswell-Penc question whether “the breast pump can be considered a feminist technology. . . . [and whether it] can be considered liberatory and/or empowering and, if so, for whom.” They also wonder whether “the breast pump unwittingly create[s] ’more work for mother,’ as . . . so many so-called labor-saving technologies have done?” Demirci denounces the use of pumps in lieu of support for women and its association with “rise in the ‘technomedical discourse’ on breastfeeding” that “emphasizes product (breast milk) over process (breastfeeding) and certainty/quantification (duration, frequency, volume of feeds) over women’s ‘embodied’

225. See Schoenbaum, supra note 16.
226. See supra I.A.
228. See Gillian Hewitson, The Commodified Womb and Neoliberal Families, 46 REV. RADICAL POL. ECON. 489 (2014); see also MOTHERHOOD, MARKETS AND CONSUMPTION: THE MAKING OF MOTHERS IN CONTEMPORARY WESTERN CULTURES (Stephanie O’Donohoe et al. eds., 2013) (on the construction of pregnant women as specific types of consumers).
230. See Boyer & Boswell-Penc, supra note 38, at 119.
231. Id. (citations omitted).
knowledge.”

The breast pump is the target of critiques as it represents the contradictions of motherhood as an embodied labor that is simultaneously celebrated and hampered by gendered social constraints.

Interestingly, hand expression, an aspect of lactation that does not require consumer goods, has been overlooked in society and in the law. Yet, with the generalization of breast pumps parents have arguably been deskilled. They must now purchase on the market a device and its accessories instead of relying on their own bodies. Hand expression is an immemorial practice, which does not require any expensive machinery or participation in the marketplace. It can be described as a “technique of the body,” using the term coined by Marcel Mauss to refer to the ways in which humans know how to use their bodies in given cultural contexts, for example, by walking or swimming. Mauss points out that there is no “natural way” for people to engage in these actions, which are learned through education and socialization. Similarly, it could be said that there is no natural way to breastfeed. Each culture—and individuals within cultures—are socialized into breastfeeding in a certain way; be it on demand or on a schedule, on the breast or with expressed milk, using pumps or hand milking, or in other ways. In the contemporary United States, few people learn hand expression as part of standard breastfeeding education, either because providers do not prioritize it or because parents are not interested. For this reason, hand expression is a skill many end up teaching themselves with the help of how-to videos and instructions posted online when they need to express milk without having a pump available or run into difficulties with their pump. Hand expression could thus be understood as an anti-neoliberal, anti-technomedical practice through which some people feel that they reclaim autonomy over their bodies and lactation. As such, it should be considered a component on the right to lactate. In practice, however, laws and policies prioritize access to breast pumps rather than (also) encouraging the teaching and normalizing of hand expression.

3. Milk Expression as a Private Act

If milk expression can be liberatory in allowing parents to feed their children human milk in a broad range of situations, its construction as a private act, even


233. DIY pumps can represent a third way between commercial pumps and hand expression. See Walker & Auerbach, supra note 92114, at 408.


235. Id. at 74.

when performed in public, contributes to the spatial segregation (and
devaluation) of parenting.\textsuperscript{237} The focus of lactation laws and policies on lactation breaks has precipitated the growing availability of lactation facilities. This development has been applauded as providing a modicum of comfort and privacy—a welcome alternative to expressing milk in bathroom stalls. But what is the message sent by lactation rooms? Is it that “we support you and your infant feeding choice” or “we expect you to produce this highly valuable liquid concealed behind a locked door because we find the sight of nipples and female-coded bodily fluids disgusting?” Parents are urged to feed their children human milk, but public milk expression is neither socially acceptable nor legally protected. Despite being legal in all of the fifty states, feeding at the breast in public remains fraught.\textsuperscript{238} During the pandemic, as Zoom and other videoconferencing software have become our new public space, a different form of lactation in public has emerged.\textsuperscript{239} People feed at the breast or express milk while working remotely or connecting with others online. While they are technically in private places (their homes, most often), they still run the risk of being reprimanded for lactating “in public.”\textsuperscript{240} This development highlights the malleability of the private/public dichotomy where “private” typically refers to the home and “public” denotes places outside the home.\textsuperscript{241} Any space can become coded as public depending on the presence of certain others, even if only virtually.\textsuperscript{242}

Henri Lefebvre’s idea that space is a tool of social power and is “produced,”\textsuperscript{243} rather than preexisting as a neutral given, is helpful for thinking about the spatial nature of lactation law.\textsuperscript{244} Lactation law relies on a dualistic vision of space according to which some manifestations of lactation are

\textsuperscript{237} Cindy A. Stearns, \textit{Breastfeeding and the Good Maternal Body}, 13 \textit{GENDER \& SOC’Y} 308 (1999) (identifying the notion of “the good maternal body” whereby women must be constantly vigilant about how their breastfeeding is viewed by others).

\textsuperscript{238} See, e.g., Christina Zdanowicz, \textit{A Woman Was Told to Cover Up at Chick-fil-A While Nursing. To Support Her, Moms Held a Breastfeeding Sit-In}, CNN (Jan. 24, 2020), https://edition.cnn.com/2020/01/23/us/breastfeeding-mom-chick-fil-a-trnd/index.html (reporting a recent example of the type of shaming and intimidation to which lactating people are subjected to when they feed their children at the breast in public) [https://perma.cc/329D-ACKY].

\textsuperscript{239} See Botz & Cohen, supra note 220 (dubbing “lazoom,” the new phenomenon of feeding at the breast or expressing milk visibly while online).


\textsuperscript{243} See generally HENRI LEFEBVRE, \textit{THE PRODUCTION OF SPACE} (1974) (exploring the meaning of the physical and social spaces in the everyday life of home and city).

\textsuperscript{244} See NICHOLAS K. BLOMLEY, \textit{LAW, SPACE, AND THE GEOGRAPHIES OF POWER} (1994) (“Space, like law, is not an empty or objective category, but has a direct bearing on the way power is deployed, and social life structured.”).
appropriate in some spaces but not others. Yet the notion of what is “public” and what is “private” is deeply contested. Feminists have critiqued the supposedly private sphere, including “family” and “the home,” as permeated by collective norms and state power. Critical race theorists have pointed out that so-called public spaces are designated for members of the public, yet, their use and enjoyment by racial minorities, especially Black people, has been and remains restricted, closely monitored, or otherwise highly regulated. Thus, nondisabled cisgender White women feeding at the breast young babies in majority-White public places may receive praises and approving nods, while disabled parents, and parents of other genders, sexual orientations, races, ethnicities, and/or older children engaging in the same behavior in the same spaces may be met with disapproval and hostility.

Indeed, it is worth noting that lactation rooms are construed as eminently private—the statutory or regulatory language typically insists that to qualify as such, a space must be “shielded from view,” susceptible to being locked from the inside, and/or “free from intrusion.” This design leads Jennifer Porter and Robert Oliver to ask, “[w]hat is at stake in designing private, often invisible, spaces for a group that has been historically excluded from the formal workplace?” Rather than reimagining space—be it the work space or public


246. See, e.g., Nicola Lacey, Theory into Practice? Pornography and the Public/Private Dichotomy, 20 J.L. & SOC’Y 93, 97 (1993) (asserting that the public/private distinction “allows government to clean its hands of any responsibility for the state of the ‘private’ world”); Frances E. Olsen, The Family and the Market: A Study of Ideology and Legal Reform, 96 HARV. L. REV. 1497, 1506 (1983) (describing the casting of “inequality and domination” as “private matters that the state did not bring about”). The public/private distinction derives in part from the “separate-spheres” ideology according to which women, especially White middle-class women, belong to the private sphere, while the public space is for men. See Linda K. Kerber, Separate Spheres, Female Worlds, Woman’s Place: The Rhetoric of Women’s History, 75 J. AM. HIST. 9, 10 (1988).


and semi-public places—with the lactating body in mind, Porter and Oliver argue that “lactation spaces may serve to closet lactation as a female-body specific act to maintain the universal disembodied individual.”251 Lactating people are excluded from the default, common space.252

The expanding legal requirement that private and public institutions offer lactation-specific facilities can thus be understood as both normalizing and pathologizing human milk feeding. On the one hand, their growing presence makes lactation more acceptable. On the other hand, because they provide a dedicated space, they may set up the expectation that people should use them regardless of whether they are actually convenient or adapted. In some circumstances, feeding at the breast or expressing in public may be more practical, for example, when the closest lactation room is busy, locked, out of order, far away, or when support from a partner who is not allowed to use the room is needed.253 Moreover, the notion that a lactation facility should be single occupancy and as private as a bathroom stall can be helpful for people who need that seclusion (or during a pandemic to minimize contagion), but it can also be problematic if several people need access contemporaneously.254 Lactation is a time-sensitive and time-consuming activity. Any added delay in access can be a deterrent.255 Mandating private, single-user lactation facilities can also deprive users of the opportunity to meet, bond, and support one another, transforming the space into a community room of sorts. The current legal construction of a lactation room as spatially separated and often single occupancy is thus beneficial for some parents, but it also risks having the effect of making lactation only acceptable when hidden, illustrating the devaluing of activities related to the private sphere and to people gendered as female. If lactation is a fundamental right including milk expression, people should be supported to exercise it in a broad range of locations and situations, including those coded as public.

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251. Id. at 88.
252. See Boyer & Boswell-Pence, supra note 38, at 129.
255. See Jenna Sauers, Why Women Really Quit Breastfeeding, HARPERS BAZAAR, (July 17, 2018), https://www.harpersbazaar.com/culture/features/a21203672/why-women-stop-breastfeeding-pumping-at-work/ [https://perma.cc/TV3E-3MMJ] (describing how long lines to use lactation rooms at work can be a factor leading some women to stop lactating)
4. Milk Expression as Non-Work

Milk expression has an ambivalent legal status as an activity most often categorized as non-work despite involving time and effort and producing multiple forms of value (affective, economic, health). Existing lactation laws and policies encourage parents to combine breastfeeding and work outside the home via lactation breaks, but typically refrain from casting lactation itself as work. The time workers spend expressing milk is categorized as a “break” and it is generally unpaid.\(^{256}\) Yet, as a form of gendered, embodied labor at the cusp of care work and dirty work, lactation has oscillated in status depending on the context and time. Wet nursing, the breastfeeding by one woman of the child of another, is one of the oldest female professions.\(^{257}\) As wet nurses disappeared toward the beginning of the twentieth century, they were replaced by women donating or selling their milk to charitable medical organizations that dispensed it in bottles to infants in need.\(^{258}\) Milk expression was viewed as a job, with so-called milk bureaus (the predecessors of milk banks) paying a set price for the milk collected.\(^{259}\) In 1943, the American Academy of Pediatrics stipulated in their standards of operation for milk bureaus that “[r]egular milk donors should receive compensation sufficient to insure good standards of living and relief from financial worry.”\(^{260}\) In other words, milk providers were to be paid a living wage. Since then, human milk has been “giftified,” as Marisa Gerstein Pineau has shown.\(^{261}\) Although some commercial human milk companies pay their providers a fee,\(^{262}\) non-profit milk banks no longer compensate donors.\(^{263}\)

The government, employers, and insurers free ride on people’s lactation work, whose economic worth is insufficiently acknowledged, like much of female-coded reproductive and affective labor. In 2017, Kimberly Seals Allers

\(^{256}\) 29 U.S.C. § 207(r)(2) (“An employer shall not be required to compensate an employee receiving reasonable break time . . . for any work time spent for such purpose.”); see also Boone, supra note 9, at 1846, 1850 n.114.

\(^{257}\) See generally Valerie A. Fildes, Wet Nursing: A History from Antiquity to the Present (1988) (showing that wet nursing was common practice for centuries in many parts of the world and that for wet nurses it was a significant economic factor in their lives).

\(^{258}\) See Swanson, supra note 82, at 17-32 (describing how wet nursing was transformed into the job of producing bottles of human milk in the 1910s under the lead of Boston-based physicians).

\(^{259}\) See, e.g., Mary D. Blankenthorn, A Breast Milk Dairy, 11 Hygeia 411, 412 (1933) (noting that the Children’s Welfare Federation of New York City paid milk providers twelve cents an ounce and sold the milk for thirty cents an ounce “except in those cases in which the presence of destitution forbids its purchase”).


\(^{262}\) See Cohen, Should Human Milk Be Regulated?, supra note 14, at 608.

\(^{263}\) See Human Milk Banking Association of North America (HMBANA), Guidelines for Establishment and Operation of a Donor Human Milk Bank (2018) (stipulating that donors are not paid for their milk though some of the costs they incur can be reimbursed).
calculated that, on the assumption that exclusive breastfeeding can take up to six
hours per day:

Even at a proposed federal minimum wage of $15 per hour, that’s . . .
up to $32,400 for the year if you meet the American Academy of
Pediatrics’ recommended twelve months of breastfeeding. That’s a
basic compensation that nobody is willing to pay mothers yet it is much
less than what you will pay for a nanny in places like Brooklyn, New
York.264

Standard accounting practices include infant formula, but not human milk,
in Gross Domestic Product (GDP) calculations.265 People who produce this
highly valuable resource do it at great personal cost—those “who breastfeed for
six months or longer suffer more severe and more prolonged earnings losses than
do mothers who breastfeed for shorter durations or not at all.”266 The longer
people lactate to feed their children, the more likely they are to be non-employed
or to work fewer hours.

The current regulation of lactation as an individual choice that is not work
relies on a gendered, racialized, classed, and ableist construction of infant
feeding that primarily benefits middle-class White women. As Boone has shown,
lactation law is about “protecting the ‘right’ kind of lactating woman,”267 in
particular the one who adheres to traditional gender roles, as this body of law is
built upon the “expectations that women are modest, private, and above all,
maternal.”268 Laws and policies do not consider lactation as work, but rather a
domestic activity freely undertaken which needs to be accommodated to allow
parents to engage in wage work outside the home. In contrast to such a view, this
Article’s claim is that lactation is both a right and a form of work deserving of
support and compensation, whether or not lactating people are engaged in other
forms of paid work.

This section has argued that existing laws and policies around milk
expression tend to empower parent to feed their children human milk while
constricting them into a narrow range of acceptable behaviors and practices.
Achieving lactation justice will require to legally support individuals and
communities wanting to exercise their right to lactate without parent-infant
separation, reliance on pumps, segregation in private spaces, and lactation

264. See ALLERS, supra note 123, at 125.
265. See Julie Smith, Markets in Mothers’ Milk: Virtue or Vice, Promise or Problem?, in MAKING
MILK. THE PAST, PRESENT AND FUTURE OF OUR PRIMARY FOOD 117, 118–19 (Mathilde Cohen & Yoriko
Otomo eds., 2017).
Consequences of Breastfeeding for Women, 77 AM. SOC. REV. 244, 244 (2012).
267. See Boone, supra note 9, at 1861-70; see also Shannon K. Carter & James McCutcheon,
Discursive Constructions of Breastfeeding in U.S. State Laws, 53 WOMEN & HEALTH 419 (2013)
(arguing that state lactation laws reflect and reinforce dominant cultural norms around mothering and
breastfeeding).
268. See Boone, supra note 9, at 1861.
construed as non-work. The next section looks at another limitation in current lactation law — who it leaves out.

B. Who Is Left Out?

One problem with current regulatory framework is the kind of parent it imagines as rightfully lactating, implicitly casting others as deviant or not entitled to lactate, or only in a limited way. First, as Schoenbaum has shown, lactation law is one of the few sexed areas of law to withstand constitutional scrutiny despite protecting women only. This is one of the reasons why this Article proposes that lactation protections should cover parents regardless of sex and gender. Second, with a few exceptions, lactation law assumes that the main purpose for milk expression is to enable employment outside the home in traditional wage work positions. Yet many workers are not covered by the lactation provisions of the ACA and their state law counterparts. People who work in non-office environments rarely benefit from lactation support and accommodations. As for the non-employed, they are often ignored by lactation law. As of 2019, only 66.4 percent of mothers with children under age 6 participated in the labor force and only 75.8 percent of these worked full time. In the absence of laws and policies to support parents outside of the wage work context, lactation remains parents’ individual physical, emotional, and financial burden to bear. This is one factor that explains the continuing racial, ethnic, and income disparities in breastfeeding rates.

This section focuses on four specific non-work circumstances in which lactation is particularly challenging, either due to the government’s interference or to the lack of affirmative legal protections: in the carceral context, when disabled, as a student, and when serving on a jury. Parents in these situations do not fit into normative conceptions of what makes a “good” mother. To

269. See Schoenbaum, supra note 16.
270. See Morris et al., supra note 12.
273. The armed forces or psychiatric wards would have been other worthy case studies. See Emily Drake, Karin Cadwell, & Joan E. Dodgson, Calls for Improved Military Policy to Support Breastfeeding Among U.S. Armed Forces, 65 Nursing Outlook 343 (2017) (offering a review of the lactation issues in the army and providing references to the literature); April Dembosky, She Wanted to Be The Perfect Mom. Then Landed in A Psychiatric Unit (Jan. 19, 2019), https://www.npr.org/sections/health-shots/2019/01/19/681603052/she-wanted-to-be-the-perfect-mom-then-landed-in-a-psychiatric-unit?utmcontent=1613136173760 (recounting the story of a new mother committed to a psychiatric ward due to her postpartum psychosis and whose husband had to negotiate with the staff to obtain that she could pump when prohibited to visit with her baby) [https://perma.cc/Y7BP-LJA9].
different extents, the first three—prisoners, the disabled, and students—are marginalized groups that many believe should not even be parents in a culture that idealizes nondisabled White middle-class married mothers. The fourth—lactating parents wanting to serve on juries—counts the traditional image of domestic motherhood as incompatible with civic engagement and political leadership.

1. Prisoners

Social and medical norms have created an expectation that parents identified as female feed their children human milk lest they be cast as bad mothers. But when in government custody, very little is done to support them in this endeavor.274 Quite the reverse, it is often impossible or very difficult for them to maintain their lactation in jails, prisons, and detention centers.275 This could be analyzed not only as a devaluation of their parenting, but also as a form of punishment since this means that they are often deprived of the right to choose whether to breastfeed. According to a 2019 report by the Prison Policy Initiative produced in collaboration with the ACLU, 231,000 women and girls are incarcerated in the United States, the vast majority of whom are in local jails and state prisons.276 Among the women incarcerated, 80% are mothers277 and between 3 to 5% are pregnant at the time of admission.278 These figures suggest that a significant number of prisoners lactate or have the potential to lactate. As noted by Carolyn Sufrin and her colleagues, “that prison pregnancy data have previously not been systematically collected or reported signals a glaring

274. See generally Rebecca J. Shlafer et al., Intention and Initiation of Breastfeeding Among Women Who Are Incarcerated, 22 NURSING FOR WOMEN’S HEALTH 64 (2018) (analyzing barriers to breastfeeding encountered by incarcerated women).
277. Id.
278. U.S. DEP’T JUST. BUREAU JUST. STAT., MEDICAL PROBLEMS OF PRISONERS, https://www.bjs.gov/content/pub/pdf/mpp.pdf (stating that 5% of women in local jails were pregnant at the time of admission, 4% in state prisons, and 3% in federal prisons) [https://perma.cc/K6EY-8NA5]; see also Carolyn Sufrin et al., Pregnancy Outcomes in US Prisons, 2016-2017, 109 AM. J. PUB. HEALTH 799 (2019) (reporting on a national survey of pregnancy among women in state and federal prisons stating that 3.8% of newly admitted women and 0.6% of all women were pregnant in December 2016).
disregard for the health and well-being of incarcerated pregnant women.”

The same could be said about the dearth of lactation data.

Given the racialized dimensions of mass incarceration, understanding what happens to lactation in prison is a crucial part of the broader legal and public health effort to address the impact of systemic racism on disparities in maternal and infant health; including breastfeeding rates. Incarcerated women are disproportionately women of color—Black women are imprisoned at twice the rate of White women—and by definition, those in detention centers are immigrants. Typically, incarceration means separation between parents and children as few prisons or detention centers allow detainees to keep their children with them, therefore requiring milk expression to maintain lactation.

A growing body of laws and policies support lactation in the carceral context at the international, federal, and state and local levels. Internationally, the so-called Bangkok Rules—the United Nations’ set of minimum standards for the treatment of prisoners—demand that breastfeeding mothers not be punished by close confinement or disciplinary segregation and “not be discouraged from breastfeeding their children.” This provision has yet to be incorporated into U.S. legislation. At the domestic level, though federal courts have held that a woman’s decision to breastfeed her child is a fundamental right protected by the Constitution, they have not always been sympathetic to lactation rights in the prison context on security grounds. There has been litigation about whether federal prisons should provide breast pumps to inmates. The issue seems to be

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279. See Sufrit et al., supra note 278.
280. See Michelle Alexander, The New Jim Crow: Mass Incarceration in the Age of Colorblindness (2010); see also Kajstura, supra note 276 (noting that “[I]ncarcerated women are 53% White, 29% Black, 14% Hispanic, 2.5% American Indian and Alaskan Native, 0.9% Asian, and 0.4% Native Hawaiian and Pacific Islander.”).
281. See Heather Marcoux, This Separated Immigrant Mom Hasn’t Been Able to Breastfeed Her Baby for 2 Weeks, MOTHERLY (Aug. 21, 2019), https://www.motherly.com/news/separated-breastfeeding-immigrant-mother-ice-raid/moms-lawyers-say-she-was-not-able-to-nurse-or-pump-since-being-detained (reporting on the fact that, despite the Department of Homeland Security’s policy of not separating children under five from their parents, claims have emerged that lactating parents and their babies are sometimes separated) [https://perma.cc/HD4R-U3E2]; see also Naomi Schaefer Riley, On Prison Nurseries, 41 NAT’L AFF. 84 (2019) (debating the costs and benefits of existing programs on parents and children); Hendrik DeBoer, Prison Nursery Programs in Other States, CONN. GEN. ASSEM. OFF. LEGIS. RES. (Mar. 30, 2012), https://www.cga.ct.gov/2012/rpt/2012-R-0157.htm (reporting that federal prison policies and a number of states have created prison nursery programs whereby nursing inmates may have the option to serve a portion of their sentence living with and nursing their babies) [https://perma.cc/BL52-LU7T].
283. Southerland v. Thigpen, 784 F.2d 713, 717 (5th Cir. 1986) (holding that accommodating breastfeeding “would impair legitimate goals of the penal system . . . [and that] such accommodation would also interfere with the maintenance of internal security”).
284. See Villegas v. Metro. Gov’t of Nashville, 709 F.3d 563, 579-80 (6th Cir. 2014) (finding that the issue of whether a breast pump not being provided to a lactating, incarcerated mother constituted a medical need, was a genuine issue of fact not suited to summary judgment); see also Mendiola-Martinez v. Arpaio, 836 F.3d 1239, 1258-59 (9th Cir. 2016) (finding that a failure to provide a breast pump to a lactating prisoner did not constitute a violation of the Eighth Amendment).
settled by the 2016 Female Offender Manual, which provides that “[f]emales who have given birth have the option to pump breast milk with a pump provided by the institution for as long as desired. Pumping allows the mother to nurse the child during visits or to retain her milk supply until her release.”

It is not clear, however, whether these options are always made available, whether because inmates and staff are unaware of them or because the guidelines are under-enforced. The U.S. Immigration and Customs Enforcement has its own standards, stating that female detainees’ initial assessment ought to include an inquiry into breastfeeding status and that lactating detainees must have access to dedicated services. The policy fails to specify what these services encompass, in particular whether detainees can express milk and/or feed their children at the breast in person during visitation. It is also unclear whether detainees are actually able to access these services.

A growing number of state prison systems have adopted policies to allow inmates to express milk under specific conditions. Policies vary: certain states refuse to provide prisoners with breast pumps, while others supply them.


288. See, e.g., Rebecca Klar, Updated: ICE Rejects Claims It Separated Breastfeeding Mother from Her Child, Hill (Aug. 19, 2019), https://thehill.com/latino/457915-ice-defends-detaining-breastfeeding-mom (reporting on the contested case of a breastfeeding migrant woman claiming she was separated from her infant and neither able to feed at the breast nor express milk) [https://perma.cc/7LVK-C7WB].

289. See, e.g., Maggie Shepard, MDC Among First to Have Inmate Breastfeeding Policy, Albuquerque J. (May 1, 2018), https://www.abqjournal.com/1165424/mdc-among-first-to-have-inmate-breastfeeding-policy.html (reporting that New Mexico’s Metropolitan Detention Center now has a policy offering inmates access to a breast pump and support in addition to breastfeeding visitation sessions) [https://perma.cc/2E9K-TY3Q]; Beth Shelburne, Alabama Women’s Prison Opens First-Of-Its Kind Lactation Room, WABF9 (Nov. 17, 2018), https://www.wafb.com/2018/11/16/alabama-womens-prison-opens-first-of-its-kind-lactation-room/ (reporting on Alabama’s maximum security prison for women in which incarcerated women can express milk and have it shipped out to their infants, although women are separated from their baby 24 to 48 hours after giving birth) [https://perma.cc/WR5L-4K8K].

290. Lawson v. Superior Court, 180 Cal. App. 4th. 1372, 1385 (Cal. App. Ct. 2010) (finding that the deprivation of a breast pump to a lactating prisoner was not a “serious medical” condition triggering liability by prison employees).

Some states decline to store expressed milk and deliver it to children,292 while others have begun to do so routinely.293 Litigation has flared up in state courts on the topic. Most prominently, in 2017, a New Mexico court found incarcerated mother Monique Hidalgo’s choice to breastfeed her infant to be a fundamental right, the interference with which constituted gender-based discrimination violating the New Mexico Constitution’s guarantee of equal protection.294 The court enjoined the state “from implementing a broad ban on live breastfeeding or mechanical production of breast milk.”295 Hopefully, other states will follow this lead in the years to come, opening the door for a broader range of parental identities for those behind bars and safeguarding their reproductive choices.

2. Disabled Parents

Current lactation laws and policies fail to adequately account for disability in two main ways. First, they contribute to turning lactation into a social disability, while at the very same time excluding lactation from disability law for the purpose of obtaining legal redress for non-accommodation and discrimination. According to the social model of disability, disabilities are in part socially constructed by the way in which societies are constituted and construct impairments.296 Lactation illustrates how social oppression can turn a typical, biological function into a handicap that needs to be accommodated because it does not fit the expectation of its environment. At the same time, lactation fails to meet the requirements of the social model of disability in that it involves no impairment. The issue is, as Angela Lea Nemecck argues, that “the lactating body is like the disabled body, which, as Lennard Davis argues, ‘violates the understanding that people should be self-sufficient, and, in a culture based on independence rather than interdependence . . . appears to be asking for too much.’”297

292. Berrios-Berrios v. Thornburg, 716 F. Supp. 987, 990 (E.D. Ky. 1989) (finding that prison security interests outweighed prisoners’ interest in having human milk stored and delivered to prisoner’s child as handling the storage and delivery of milk “would be a costly and monumental task for prison officials” and create security risks).
295. Id. at 23.
Under the Americans with Disabilities Act (ADA), a qualified person with a disability is someone who has an impairment that substantially limits a major life activity, but uncomplicated pregnancy and lactation are not disabilities covered by the ACA. Thus, an employer would not be required to provide accommodations for lactating workers as a requirement under that statute. Before the ACA broadened federal protections of lactation in 2010, some workers attempted to use the ADA to obtain lactation accommodations or seek redress for failing to, but courts generally rejected the framing of lactation as a disability. In 1998, for example, a New York District Court held that pregnancy-related disability claims are typically only upheld in the presence of a physiological impairment. Judge Thomas McAvoy wrote, “[i]t is simply preposterous to contend a woman’s body is functioning abnormally because she is lactating.” In other words, he assumed that disability is defined against the background of what is biologically “normal.” But so long as prejudice, discrimination, and oppression hamper parents trying to feed their children human milk, lactation will be experienced by many as a form of disability.

Second, lactation laws and policies fail to acknowledge the special lactation needs of disabled parents. Similar to the prison context, this failure may be due to the perception that such individuals are unsuited for the role of motherhood. Yet according to a 2013 survey, 15.7% of women of childbearing age in the United States report having a disability, variously related to hearing, vision, cognition, mobility, self-care, and/or independent care. Though people with and without physical disabilities have comparable rates of pregnancy, a 2015 study found that the breastfeeding rate for disabled women is significantly lower than for nondisabled women.

Disabled parents face a number of obstacles to lactation: disability-related health considerations, limited expert information and support, unavailability of


299. See Jendi B. Reiter, Accommodating Pregnancy and Breastfeeding in the Workplace: Beyond the Civil Rights Paradigm, 9 TEX. J. WOMEN & L. 1, 9 (1999).


301. Id. at 311.


305. See Monika Mitra et al., Maternal Characteristics, Pregnancy Complications, and Adverse Birth Outcomes Among Women with Disabilities, 53 MED. CARE 1027 (2015); see also Maggie Redshaw, Women with Disability: The Experience of Maternity Care During Pregnancy, Labour and Birth and the Postnatal Period, 13 BMC PREGNANCY & CHILDBIRTH 174 (2013) (finding that across physical, sensory, and mental health disabilities, birthing parents with disabilities were less likely to feed at the breast right after birth).
adaptations and suitable equipment, and heightened discomfort.\footnote{306} Some people may not have the physical strength to hold their infants long enough to feed directly at the breast or to express milk manually or with a pump, such that these individuals require physical assistance.\footnote{307} Certain disabilities may require exclusive or quasi-exclusive milk expression. For example, sensory sensitivity may be a barrier to feeding at the breast for those with autism spectrum disorders.\footnote{308} Lactation, because it can be exhausting, can also exacerbate disabilities such as rheumatoid arthritis or lupus.\footnote{309} Finally, disability creates added challenges to lactation, due to the fact that “[c]ompared to women without disabilities, women with disabilities are more likely to be of low socioeconomic status and lack health insurance, both factors limiting healthcare access”\footnote{310} and thus limiting access to lactation support.

Breast pumps are typically not designed with disability in mind. For instance, older models can be quite heavy, especially for people with weight lifting limitations, and both older and newer models require assembly, switches, software, and accessories that may not be accessible, especially to parents who have a visual impairment.\footnote{311} Similarly, lactation rooms may be inaccessible to parents with mobility or vision impairments and some of the lactation pods that are increasingly popular in airports and businesses (especially the smaller models) are not ADA compliant.\footnote{312}

These multiple failures at supporting disabled parents are all the more distressing because a positive lactation experience can be lived as a transformative experience for these same parents. Heather Kuttai, who is paraplegic, was hospitalized soon after giving birth to treat her spinal cord injury. She poignantly recounts that as she lay in intense pain, feeling her body failing her, she found comfort and strength in breastfeeding. During that period, she

\footnote{307} See Powell et al., supra note 304, at 256 (physical assistance could be installing, positioning, and/or holding the pump or caring for children while expressing).
\footnote{308} See generally Dori Pelz-Sherman, Supporting Breastfeeding Among Women on the Autistic Spectrum. Disability, Difference, and Delight, 5 CLINICAL LACTATION 62 (2014) (examining the challenges and advantages of breastfeeding while being on the autistic spectrum).
\footnote{309} Rogers, supra note 306, at 270.
\footnote{311} Anna Nowogrodzki, The Time Has Come for a Better Breast Pump, NEO.LIFE (May 3, 2018), https://neo.life/2018/05/the-time-has-come-for-a-better-breast-pump/ (noting that the visually impaired parents’ team at the second MIT “Make the Breast Pump Not Suck” Hackathon won an award for developing a milk “storage bag with raised buttons on the side as Braille-like volume markings and sensors that beep to indicate the liquid level in a bottle”)[https://perma.cc/V4BL-ZHAQ].
writes, “[t]he one familiar thing is breastfeeding. My breasts still work.”³¹³ And yet all around her, medical professionals and acquaintances counseled her to wean her daughter. It is thus critical for laws and policies to not only avert lactation from being experienced as a form of disability, but also to include the perspectives and needs of disabled parents in lactation protections.

3. Students

High schools and higher education institutions too often fail to meet the needs of lactating students. The US teen pregnancy rate is higher than in other comparable countries.³¹⁴ Parent students are a sizable group. In 2017, 194,377 babies were born to teens aged fifteen to nineteen.³¹⁵ 26% of the total college population raises their own dependent children, and women make up 71% of all student parents.³¹⁶ Notwithstanding these numbers, this is another population receiving few legal protections for lactation.³¹⁷ The gap is likely to affect the vulnerable and marginalized the most, considering that youth of color and those growing up in low-income families are disproportionately likely to have children in their teens.³¹⁸ Indeed, rather than being viewed as a group in need of public support, young parents—especially young BIPOC mothers—have become identified as a stigmatized group for which pregnancy and parenting is seen as a “problem” to eradicate.³¹⁹

The laws and policies pertaining to lactating students are nebulous, in keeping with the prevalent prejudice that teenage and other young parents are

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³¹³ Heather Kuttai, Nurturing the Nurturer Reflections on an Experience of Breastfeeding, Disability, and Physical Trauma, in Disability and Mothering 160 (Cynthia Lewiecki-Wilson & Jen Cellio eds., 2011).
³¹⁴ See Gilda Sedgh et al., Adolescent Pregnancy, Birth, and Abortion Rates Across Countries: Levels and Recent Trends, 56 J. ADOLESCENT HEALTH 223 (2015).
³¹⁷ See Mary Welsh Bostick et al., Do American Colleges and Universities Support the Lactation Needs of Students?, 11 BREASTFEEDING MED. 376 (2016).
³¹⁸ See Ana Penman-Aguilar et al., Socioeconomic Disadvantage as a Social Determinant of Teen Childbearing in the U.S., 1 PUB. HEALTH REP. 5 (2013) (finding that unfavorable socioeconomic conditions experienced at the community and family levels contribute to the high teen birth rate); see also Trends in Teen Pregnancy and Childbearing Fig. 3, DEP’T OF HEALTH & HUM. SERVS., https://www.hhs.gov/ash/oah/adolescent-development/reproductive-health-and-teen-pregnancy/teen-pregnancy-and-childbearing/trends/index.html (indicating that the birth rate for Latinx teens was 28.9 births per 1,000; for Black teens, 27.6 births per 1,000, and for White teens 13.4 births per 1,000) [https://perma.cc/2BXZ-96X4].
not capable of making the best choices for themselves and their babies.\textsuperscript{320} The 
ACA requirement that workers obtain lactation breaks and rooms applies to 
educational institutions’ employees, but not to their students. However, as a 
condition related to sex, pregnancy, and parental status, student lactation is in 
principle protected under federal civil rights law. While Title IX, the federal civil 
rights law passed as part of the Education Amendments of 1972, does not 
mandate any specific lactation strategies, its protection against exclusion and 
discrimination based on sex has been interpreted to cover lactation.\textsuperscript{321} In 2013, 
the U.S. Department of Education released a pamphlet recommending that 
school administrators “[d]esignate a private room for young mothers to 
breastfeed, pump milk, or address other needs related to breastfeeding during the 
school day.”\textsuperscript{322} This guidance has yet to be widely followed in high schools.\textsuperscript{323} 
Only a few states have enacted specific lactation protections for students.\textsuperscript{324} A 
2016 study of 139 colleges and universities across the nation found that a mere 
3.6% had an official policy for lactating students or had the lactation spaces 
mentioned in their student handbook.\textsuperscript{325} In the absence of formal rules and clear 
policies, the onus is on students themselves to negotiate with school 
administrators, instructors, and educational and professional testing 
organizations\textsuperscript{326} the conditions under which they will be allowed to feed at the 
breast and/or express milk.\textsuperscript{327}

\textsuperscript{320} \textit{Id.}
\textsuperscript{321} 34 C.F.R. § 106.40(b)(1) (regulating implementation of Title IX as specifically prohibiting 
discrimination against a student based on pregnancy, childbirth, false pregnancy, termination of 
pregnancy, or recovery from any of these conditions).
\textsuperscript{322} \textit{See Off. for C.R., U.S. Dep’t of Educ., Supporting the Academic Success of Pregnant 
and Parenting Students Under Title IX of the Education Amendments of 1972} (2013), 
https://www2.ed.gov/about/offices/list/ocr/docs/pregnancy.pdf [https://perma.cc/SCT8-JDCL].
\textsuperscript{323} \textit{See generally} Sandra Davis-Hathaway & Alejandra Barragan, \textit{Breastfeeding The Teenage 
Years, 7 Infant, Child & Adolescent Nutrition 188} (2015) (discussing the various barriers in the 
path of teenage mothers wishing to breastfeed).
colleges and the State University to provide reasonable accommodations to student to express milk and feed 
schools to provide reasonable accommodations to students to express milk and feed at the breast); \textit{Neb. Rev. Stat.} § 20-170 (2021) (enacted 2017) (requiring schools to have a written policy to 
accommodate breastfeeding students); \textit{Va. Code Ann.} § 22.1-79.6 (2021) (enacted 2014) (directing 
schools to designate area in which any mother employed by the local school board or enrolled as a student 
may take lactation breaks).
\textsuperscript{325} \textit{See Bostick et al., supra note 317.}
\textsuperscript{326} \textit{See Nursing Mothers, L. SCH. ADMISSION COUNCIL,} https://www.lsac.org/about/lsac-policies/nursing-mothers (stating that “nursing mother[s]” who can “document their need for a 
modification to the standard LSAT administration . . . to address lactation issues . . . may request a nursing 
mother modification”) [https://perma.cc/TRH4-MPFK]. Note that most bar examiners allow the same for 
the bar exam. \textit{See also} Kirti Magudia et al., \textit{Carpe Diem: An Opportunity for the ABR to Support Its 
Trainees With Family-Friendly Policies, Clinical Imaging} (July 4, 2020) (calling for the American 
Board of Radiology to offer extra break time for people to pump during their test-taking and additional 
dates during which to schedule exams).
\textsuperscript{327} They can also reach out to a Title IX coordinator for help and if their needs are still not met, file 
a complaint with the Department of Education’s Office for Civil rights, or file a lawsuit, but the time, 
anxiety, and expense involved are major deterrents.
As a result, the logistics of lactation can be overwhelming for students. Unlike many employees, students, especially those in high school or college, do not typically have access to a private or shared office. Relatedly, they also often lack access to a refrigerator where to store milk as well as to a space where they can leave their pumping equipment throughout the day. Even when their campuses offer designated lactation facilities, these may be located at a significant distance from their classrooms, labs, libraries, gyms, or other stations, requiring taxing traveling and schlepping. A 2015 study conducted at a public university revealed that “the inconvenience of carrying equipment is a significant barrier to pumping while on campus.”328 In summary, educational institutions increasingly take into account the needs of lactating students, but there is still much room for expanded and formalized lactation programs, especially in secondary education.

4. Jurors

Lactating jurors are also excluded from current lactation protections—however, their status is slightly different from that of the preceding three groups discussed as it is short-lived and not stigmatized per se. In principle, nothing prevents lactating people from participating in every aspect of political and civic life such as running for election, voting, or demonstrating. However, at the same time, these activities are not typically organized with the needs of lactating people in mind, given that historically, political and civic life were reserved for White cismen. Parents wanting to get involved in politics must thus figure out how to manage their lactation by bringing their baby with them (when allowed to), scheduling activities around their lactation schedule, or by expressing milk in public or designated spaces if available.329

Jury duty, however, is one form of political engagement which is commonly incompatible with lactation due to its temporal and spatial structure. Prospective jurors must often wait at length in courtrooms and sit in during selection. Once sworn in, they may attend hours of hearings and deliberations. Instead of making lactation and jury service compatible by welcoming babies feeding at the breast and milk expression in the jury box, legal reform has centered upon exempting lactating parents from serving at all. At the time of writing, twenty states and Puerto Rico have adopted laws allowing breastfeeding women to defer jury

328. See Yeon K. Bai, Lauren M. Dinour & Gina A. Pope, Determinants of the Intention to Pump Breast Milk on a University Campus, 61 J. MIDWIFERY WOMEN’S HEALTH 563, 564 (2016).
329. See, e.g., Kyla Carlos, Black Lives Matter, KYLA CARLOS BLOG (2020), https://kylacarlos.com/blog/blacklivesmatter (discussing how Carlos decided to join a Black Lives Matter protest in Virginia with her children and how a picture of her feeding her youngest child at the breast went viral as a symbol of Black breastfeeding as a racial equity issue) [https://perma.cc/Y79U-SFZK].
service. Some excuse mothers until they no longer lactate, such as Kansas, while others grant an exemption only for the first year of their child, such as South Dakota. As Boone asks, “should states not also offer women the option of serving on a jury while nursing by providing the necessary accommodations? . . . [T]he laws were often conceived and drafted in a manner that reinforces—and sometimes demands adherence to—traditional notions of women and motherhood.” These exemptions implicitly relegate lactating parents to the “privacy” of the home, rather than welcoming and integrating them into the “public” space of the court. Going forward, the federal and the state governments should adopt programs allowing parents who want to serve to do so all the while feeding their children at the breast or expressing milk.

This Part examined the shortcomings of the current regulations and conceptions of milk expression regulations in force, highlighting that they privilege a vision of the idealized mother as a female worker who pumps at work. Other parental identities and forms of lactation are backgrounded and, in some cases, hindered by this state of affairs. The next Part offers suggestions for reform.

IV. TOWARD A RIGHT TO EXPRESS MILK

Lactation in general and milk expression in particular are gendered forms of labor, which are unrecognized and uncompensated as such by the law. Parents are expected to feed their children human milk invisibly, on their own dime and time, while facing many economic, practical, social, and legal hurdles. The most vulnerable and marginalized parents are also those who suffer most from these impediments and lack of affirmative support. As a result, many parents do not have a realistic choice between breastfeeding and not breastfeeding and between different modes of breastfeeding, such as milk expression. Yet, as discussed earlier, lactation justice is a component of equality law and reproductive justice, and should therefore be grounded on similar principles. Every person should have the right to decide whether to lactate and how in safe, healthy, and dignified environments, with access to a range of community-based resources and the necessary social supports. The fact that lactation is a form of labor does not preclude it from being also protected as a right. Reproduction itself is often described as a form of labor, which is also thought as deserving to be entrenched

330. See NAT’L CONF. ST. LEGISLATURES, supra note 133.
331. KAN. STAT. ANN. § 43-158 (West 2021) (enacted 2006) (allowing a mother breastfeeding her child to be excused from jury service and allowing postponement of jury service until the mother is no longer breastfeeding).
332. S.D. COD. LAWS ANN. § 16-13-10.4 (West 2021) (enacted 2012) (providing for an exemption from jury duty for a mother who is breastfeeding a baby younger than one year).
333. See Boone, supra note 9, at 1869, n.229.
334. See ROSS & SOLINGER supra note 17.
as a legal entitlement. Similarly, a rights-based lens to lactation labor might help ensure that lactation becomes a freely chosen labor whose conditions are fair.

An equality law and reproductive rights movement approach that would include litigation and other forms of legal mobilization could be used to promote lactation justice. At the same time, rights are not a panacea. Empirical social science literature on rights’ effectiveness shows that governments can often ignore rights even in the face of judicial review. But this literature also suggests that rights are most effective when backed by groups of citizens willing to litigate and mobilize political pressure against rights encroachments. In practice, achieving lactation justice should thus combine a rights-based approach with social and political mobilization in favor of federal and state economic interventionism and massive health, childcare, and work reform, with the goal of rebuilding a social welfare state that supports families. President Biden’s plan to send to U.S. households monthly checks based on their number of children is a promising development. But to be truly transformational, this measure should be accompanied by the requirement that all U.S. residents have access to free or sliding-scale high-quality healthcare, regardless of their citizenship status, and fully-paid parental leave whether or not they are employed. Such universal programs should be the primary focus of law and policymakers. Others have written extensively about how parental leave and healthcare reform should


339. See H.R. 1185 & S.463 Family Act—116th Congress (2019-2020) (providing federal comprehensive paid family and medical leave to all workers in the United States); see also Deborah A. Widiss, Equalizing Parental Leave, 105 MINN. L. REV. (forthcoming 2021) (suggesting that parental leave reform has begun to happen in the United States, especially at the state level and for federal employees).


be designed. This Article will not repeat their findings. However, taken on their own, neither are sufficient to guarantee that all parents have the opportunity to choose to breastfeed, as is apparent in countries that offer universal healthcare and generous leave policies but where many parents do not reach their lactation goals.\(^{342}\)

Accordingly, this Part focuses on legal and policy interventions that should accompany healthcare and parental leave reform by relying on a combination of civil rights law, FDA law, insurance law, licensing law, health law, tax law, and work law. Through these different interventions, lactation in general and milk expression in particular should be protected as a negative as well as a positive right requiring the government to not only refrain from interfering, but also to provide specific entitlements. The US Constitution is generally interpreted as guaranteeing negative rights, i.e., the right to be free from discrimination on the basis of sex or from government intrusion in reproductive decisions, rather than obtaining concrete aid from the government, for example, in the form of comprehensive sex education, healthcare, or childcare.\(^{343}\) Unless the U.S. Supreme Court decides to reject either the notion of a negative Constitution or the positive versus negative rights dichotomy itself, the judicial recognition of a broad right to lactate encompassing milk expression is unlikely come with affirmative government duties.\(^{344}\) But as the sections below argues, there may be other legal avenues to impose positive duties on the government to protect and enable lactation. The animating principle behind these various reform initiatives should be decolonizing lactation, that is, decentering the Whiteness of lactation laws and policies and promoting the needs, interests, and autonomy of BIPOC and immigrant parents and lactation providers. Concrete legal, policy, and funding decisions should not be made without the leadership and engagement of marginalized communities, in particular, parents of color, LGBTQIA+ parents, disabled parents, immigrant parents, and low-income parents. As such, the following proposals should be read as a blueprint to be adapted and expanded in light of what these communities prioritize.

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\(^{342}\) See Melissa A. Theurish et al., *Breastfeeding Rates and Programs in Europe: A Survey of 11 National Breastfeeding Committees and Representatives*, 68 J. PEDIATRIC GASTROENTEROLOGY & NUTRITION 400 (2019) (pointing out that among the world’s regions, Europe has the lowest rates of exclusive breastfeeding at the age of six months with approximately 25% of mothers breastfeeding, even though under the European Union Maternity leave directive (92/85/EEC), women have the right to a minimum of fourteen weeks of paid maternity leave, of which at least two weeks are compulsory).


\(^{344}\) But see Phillip M. Kannan, *Logic from the Supreme Court that May Recognize Positive Constitutional Rights*, 46 U. MEM. L. REV. 637 (2016) (arguing that the US Supreme Court is prepared to recognize limited positive constitutional rights).
A. Protect Milk Expression

Laws and policies should protect those who express milk (and their partners who support them in this endeavor) through a series of negative rights, including freedom from interference in milk expression wherever people have the right to be and freedom from discrimination in the language and visual culture around lactation and milk expression.

1. Normalize Milk Expression

People should have the right to express milk wherever they are allowed to be, be it on public or private property and regardless of their employment or other circumstances. This includes prisoners, disabled parents, students, and jurors, but also transit workers, domestic workers, health workers, pilots, flight attendants, armed service members, and others who perform non-office types of work. People should have an explicitly protected right to express milk in places of public accommodation, including restaurants, theater, gyms, trains, buses, medical centers, parks, and so on. This right would contribute to normalizing lactation, fighting its social exclusion. Non-lactating partners should share in those rights in as much as they support human milk feeding, for example by assisting with latch, positioning, holding the baby, or carrying supplies.

Progress toward this goal is already being made. A handful of states expressly protect public milk expression, but a national right to express milk could be entrenched judicially, legislatively, or regulatorily. State and federal courts could recognize that broad lactation rights, including the right to express milk, are protected by the state and federal Constitutions, whether as a component of due process or equal protection. The federal government and the states should also adopt legislation and regulations on the model of the public breastfeeding provision proposed by Boone: “Notwithstanding any other provision of law, an individual has the right to breastfeed or express breast milk

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345. See supra note 136 and accompanying text; see also Frequently Asked Questions. Lactation Accommodations and Model Policy N.Y.C. Administrative Code §8-107(22), NYC HUMAN RIGHTS, https://www1.nyc.gov/site/cchr/law/lactation-faqs.page (detailing several model lactation accommodation policies developed by the New York Commission on Human Rights, including a policy stating, “[a]n employee who wishes to pump at their usual workspace shall be permitted to do this so long as it does not create an undue hardship for the employer. Discomfort expressed by a coworker, client, or customer expresses generally does not rise to the level of ‘undue hardship’ for the employer”) [https://perma.cc/R5YG-LVNV].

346. Existing federal case law could expand upon the following recognition as the right to breastfeed under the due process clause. See Dike v. Orange County Sch. Bd., 650 F.2d 783 (5th Cir. 1981); Mathilde Cohen, Toward an Interspecies Right to Breastfeed, 26 Animal L. Rev. 1, 24-25 (2020) (analyzing the constitutional recognition of a right to breastfeed by federal courts and its limitation).

347. For a state court recognizing the right to breastfeed including via milk expression under a state equal protection clause, see supra note 294 and accompanying text. See also Schoenbaum, supra note 16.
in any public or private location where they are otherwise authorized to be.”

This would be easy to do at the state level because all jurisdictions now protect breastfeeding in public. They would only need to amend their existing public breastfeeding laws to explicitly include milk expression. Alternatively, they could issue interpretive guidance specifying that “breastfeeding,” “nursing,” and “lactation” should be understood to include milk expression. Another relatively easy fix would be for states to explicitly list lactation—understood broadly to include feeding at the breast and milk expression—in their public accommodation statutes banning discrimination because of “sex.”

Federal and state law and policymakers should also address the needs of lactating parents in specific situations such as prisons, educational institutions, and jury duty, in which people do not have full control over their movement and actions. The fullest protection of inmates from state interference would be prison abolition—that is, overhauling the criminal justice system so that convicts are no longer incarcerated except in rare and extreme circumstances. Though the question of whether incarceration itself is a morally acceptable or socially useful practice is beyond the scope of this Article, growing evidence indicates that it is detrimental not only for imprisoned people but also for their children and relatives, disproportionately affecting communities of color, particularly Black communities. Should incarceration continue, every effort should be made to exempt pregnant people and parents from being put behind bars. If this also fails, they should have the option of keeping their children with them full-time in high-quality, humane prison nursery programs and to breastfeed. Additionally, all incarceration and detention facilities should allow inmates to feed their children at the breast during daily visitation and to express milk and make it available for their children.

Educational institutions could take a leading role in supporting and normalizing lactation by requiring that all instructors adopt the following policy and include it in their syllabi: “If a student is lactating and needs to express milk during class, they should feel free to do so by taking a break or by expressing milk during the class at their desk or station if convenient to them. Students

348. See Boone, supra note 9, at 1876.
351. See supra note 281. But it may be that there is no such a thing as a high-quality, humane prison nursery program, as argued by Lynne Haney, Motherhood as Punishment: The Case of Parenting in Prison, 39 SIGNS 105 (2013).
should also feel free to bring their baby to class to feed at the breast or to take a break for the same purpose.” A variation of this policy should be adopted for exams and tests dispensed by educational institutions or independent professional or testing organizations.

As for prospective jurors, instead of being “excused” from service due to their lactating status, they should be allowed to express milk during voir dire, trial, and deliberations in the court’s dedicated lactation facility (if there is one) or publicly in the courtroom or the deliberation room, and/or to bring their babies with them for the same purpose. This might mean granting rights to their partners or caregivers to be present in the court to care for children while they serve and/or bring children for regular feeds.

Finally, federal and state law makers should address lactation in their emergency preparedness plans, including guidance on keeping lactating parents and children together whenever feasible and on how to support milk expression as a temporary solution in case of separation.352

2. Adopt Inclusive Language and Iconography

Milk expression can also be better protected by adopting inclusive language and iconography in laws, policies, and spaces. Lactating parents are already protected from discrimination in places of public accommodation,353 but lactation laws and policies are typically ableist, classed, gendered, and racialized, centering upon the lactation practices of nondisabled middle-class White cishet mothers.354 For instance, lactation facilities tend to be sex-differentiated, which can have the result of excluding people who do not identify as women or mothers. A growing community of transmen and nonbinary people (and others who do not identify as women or mothers) lactate and feed their children human milk, either directly at the breast or chest, or through milk expression.355 They have been pushing for gender inclusive reform of lactation laws and policies. The gendered language and iconography of lactation, with labels such as “mothers’ rooms,” “breastfeeding,” “nursing mother,” and images reinforcing the female-coding of lactation may be experienced as demeaning, deterring some from taking advantage of lactation accommodations and thus compromising

353. See Morris et al., supra note 12.
354. See Boone, supra note 9, at 1861-70.
their lactation. This phraseology can also undermine medical care, lactation support, research, and data collection as people who feel excluded may shy away from health care providers, researchers, and surveys that fail to acknowledge and include them.356

Laws and policies should thus not only be reworded, but also require that the language and iconography of lactation be as inclusive as possible. In this spirit, Fiona Jardine proposed a “universal breastfeeding symbol,” which is gender neutral and highlights through the pump visual that lactation is broader than suckling at the breast, as it can also encompass milk expression.357 Emily Wolfe-Roubatis and Diane Spatz proposed model guidelines in the context of healthcare provided to transmen in the postpartum period. Among other recommendations, they call for health professionals to educate themselves in trans-specific health care, pay special attention to the language they use in forms and oral interactions, make no assumption about patients’ gender identity, ask their patients’ consent before touching a body part during a physical exam, and inquire about the way they want their body parts to be referred to.358 Law and policymakers should broadly consult with LGBTQIA+ individuals and families to determine whether these and/or other specific protections should be backed by laws and policies. Similar efforts must be undertaken to make lactation support and facilities inclusive for BIPOC and disabled parents too, as discussed below.

Fig. 1: Fiona Jardine, Universal Breastfeeding Symbol

357. See fig. 1, infra.
B. Enable Milk Expression

In addition to these negative rights, positive entitlements in the form of robust lactation breaks and leaves, a public network of lactation rooms, and wider availability of high-tech pumping equipment and lactation support should be guaranteed by the law.

1. Establish and Expand Lactation Breaks and Leaves

Milk expression can be enabled through positive entitlements to lactations breaks and leaves for both lactating parents and non-lactating partners who support them. The COVID-19 pandemic forced the adoption of new ways of working, revealing that many tasks that were considered indispensable to carry out in person can be accomplished remotely. This lesson should be applied for the benefit of caregivers who need the flexibility to conduct professional and other tasks remotely whenever possible, particularly lactating parents feeding their children at the breast and/or expressing milk frequently.359 For some families, regular telework would actually reduce the need for milk expression as it would facilitate feeding at the breast, especially for infants who are home cared. Remote work could also prove a major time saver, since feeding at the breast and milk expression can often be done concurrently with most types of standard office tasks. However, the pandemic uncovered the lack of legal and policy guidance for lactation in the context of telework. In the future, telecommuting workers should be explicitly allowed to feed at the breast and express milk during their workday, including during online meetings, without any incidence on their pay. For workers who feel comfortable multitasking, keeping mics and cameras on while lactating should be permitted so that they can fully participate in group discussions. For those who need or prefer to unplug and take a break when lactating, sufficient time should be allocated between meetings and other forms of expected online presence.

Once their paid parental leaves are over, parents should be eligible for government- and employer-sponsored flexible work arrangements, including lactation leaves. Non-lactating parents should be eligible for those leaves too so that they can support human milk feeding, for example, by joining a lactation consultation or bringing a baby to their lactating partner’s workplace to allow for a feed on the breast.360 Both unpaid and paid lactation leaves programs should be established. Unpaid lactation leaves would entitle workers to reduced work

359. This proposal may not benefit workers whose housing conditions make remote work and lactation at home challenging, be it due to homelessness or to small, shared housing conditions in which they lack space and privacy.

360. See Schoenbaum, supra note 16 (considering the many ways in which fathers and other partners can support breastfeeding and require legal protections such as break time from work to do so).
hours or adaptable schedules for the purpose of facilitating childcare and lactation. For lactating parents who work, study, or are otherwise stationed in an environment posing a health risk to their milk (due to exposure to dangerous substances or contact with people suffering from viral infections transmissible through human milk), efforts should be made to adapt their surroundings to reduce the risk. If that is not possible, paid leave should be granted.

Last, to recognize the labor involved in lactation and to ensure that low-income parents can afford to breastfeed, lactation breaks should be paid. This idea is neither utopian nor foreign: a few states have already adopted it.\textsuperscript{361} In 2018, the Illinois Nursing Mothers in the Workplace Act was amended to require that employers provide \textit{paid} breaks to mothers who express milk at work.\textsuperscript{362} Lactation breaks may run concurrently with other breaks, thus not costing more to employers, but employers “may not reduce an employee’s compensation for the time used for the purpose of expressing milk or nursing a baby.”\textsuperscript{363} Other states and the federal government should follow suit.

More broadly, serious thought should be given to the idea of paying non-employed parents to produce human milk for their children. A few studies suggest that cash incentives are successful at increasing breastfeeding rates,\textsuperscript{364} but the notion remains controversial. More research would be helpful to determine whether people want to be paid to lactate and what would constitute a fair compensation. At minimum, however, as Phyllis Rippeyoun has argued, parents should not be penalized for taking parental and lactation leaves, but rather should be compensated for “foregone wage appreciation and/or wage depreciation.”\textsuperscript{365}

\textbf{2. Improve Public Lactation Rooms}

Lactation facilities accessible not only to workers, but also to lactating members of the public (and their partners if needed) should be systematically

\begin{itemize}
\item \textsuperscript{361} See supra note 122.
\item \textsuperscript{363} Id.
\item \textsuperscript{364} See Yukiko Washio et al., \textit{Incentive-Based Intervention to Maintain Breastfeeding Among Low-Income Puerto Rican Mothers}, 139 \textit{Pediatrics} e20163119 (2017) (describing a randomized experiment among 36 Puerto Rican WIC recipients living in Philadelphia and finding that those who received a cash incentive had higher breastfeeding rates through 6 months postpartum); Clare Relton et al., \textit{Effect of Financial Incentives on Breastfeeding A Cluster Randomised Clinical Trial}, 172 \textit{JAMA Pediatrics} e174523 (2017) (describing a randomized trial of 10,010 mother-infant dyads in areas of England with low breastfeeding prevalence and finding that mothers offered shopping vouchers conditional on their infant receiving any breast milk were 5.7% more likely to breastfeed at 6-8 weeks than those in the control group); see also Nana Anokye, et al., \textit{Cost-Effectiveness of Offering an Area-Level Financial Incentive on Breast Feeding: A Within-Cluster Randomised Controlled Trial Analysis}, 105 \textit{Archive Disease Childhood} 155 (2020) (finding that the abovementioned English experiment with financial incentive for breastfeeding is cost-effective).
\item \textsuperscript{365} Phyllis L.F. Rippeyoun, \textit{Feeding the State: Breastfeeding and Women’s Well-Being in Context}, 11 J. ASS’N. RES. ON MOTHERING 36, 45 (2009).
\end{itemize}
provided to ensure that all individuals can exercise their fundamental right to lactate in safe and dignified environments. This Article has critiqued the framing of lactation as an activity parents are pressured to perform, but only in “private.”

This is not to say, however, that people should have to express milk in public. On the contrary, some people desperately need seclusion, whether for cultural reasons, psychological and physical comfort, or because of the very real possibility that they will be disparaged or harassed out in the open. Research supports the notion that the availability of protected time and space to express milk are crucial to lactation. This finding is to be expected in a society in which lactating people are designed out and made feel “out of place” in public and work spaces. Reliable data is lacking on the availability of lactation facilities accessible to the general public nationally, but anecdotal evidence suggests that they continue to be in short supply. According to the Society for Human Resource Management, in 2019, 51% of workplaces had an onsite lactation room, up from 35% in 2015. Some industries appear particularly behind. A 2015 study of national convention centers found that only 5.5% had permanently designated lactation rooms and 32% made temporary accommodations upon request. In the medical profession, lactation rooms are few and far between—as of 2016, only 13% of radiology practices reported having dedicated lactation facilities.

The federal and state mandates that certain buildings have lactation rooms open for public use are a step in the right direction, but they should be strengthened. Public and private organizations should incorporate lactation planning into other sustainability, justice, and diversity initiatives, in addition to integrating lactation into their campus and physical plans so as to identify and create lactation spaces. All public places of accommodations meeting certain criteria of size and frequence, both public and private, should maintain

366. See supra Part III.A.3.
367. Katy B. Kozhimannil et al., Access to Workplace Accommodations to Support Breastfeeding After Passage of the Affordable Care Act, 26 WOMEN’S HEALTH ISSUES 6 (2016) (analyzing data from “Listening to Mothers III,” a national survey of working women ages 18 to 45 who gave birth in 2011 and 2012 and showing that those with adequate break time and private space were 2.3 times as likely to breastfeed exclusively at 6 months and 1.5 times as likely to continue breastfeeding with each passing month.).
368. See Boyer & Boswell-Penc, supra note 38, at 127.
371. See Elizabeth Kagan Arleo et al., Lactation Facilities in U.S. Radiology Practices, 14 J. AM. COLLEGE RADIOLOGY 733, 733 (2017). See also Kristin Kelly Porter et al., A Mother’s Room to Support Women in Radiology, 13 J. AM. COLLEGE RADIOLOGY 1438 (2016) (underlining that though female radiologists are in the minority, radiologic technicians are overwhelmingly female and hypothesizing that most women in radiology have or would like to have children).
372. See supra notes 138-143 and accompanying text.
lactation facilities, opening them up to the general public whenever feasible. An up-to-date app should centralize information on the location and conditions of access of all lactation facilities in the nation.\textsuperscript{373}

Standards for these facilities remain ambiguous. Since 2009, the American Institute of Architects’ Best Practice Guide has offered specific guidelines to complement the often cursory statutory specifications for lactation rooms.\textsuperscript{374} These are demanding guidelines, specifying that they “should provide, at a minimum, a lockable door; a work surface and chair; a small utility-type sink; storage for cleaning supplies and paper towels; adequate HVAC service, and well-placed electrical outlets” and a “minimum footprint of 7 feet by 7 feet.”\textsuperscript{375} Such standards are laudable, but they could hinder the availability of lactation rooms due to the work and expense necessary to meet them. As an alternative, different tiers of lactation facilities could be devised, with different standards set depending on the number of users and the frequency of use. Under such a system, facilities could range from basic ADA-compliant rooms with a chair, a desk, and an electric outlet catering to occasional use by members of the public to fully outfitted facilities in large organizations where people may need access on a daily basis (and sometimes multiple times per day). To maximize usage, multi-occupancy lactation rooms with the option for non-lactating parents to accompany their lactating partner for support should be the norm, with the possibility of using privacy curtains, screens, and/or a booking system for users who require isolation.

3. Provide Other Forms of Lactation Support

To secure a positive right to lactation, a wide range of lactation support should be incorporated into different bodies of law. This section presents how a combination of FDA, insurance, licensure, tax, health law, and work law reform could strengthen people’s concrete ability to feed their children human milk.

FDA Law—The medical device approval process for pumps and other lactation aids should be made more accessible to encourage a broader range of entrepreneurs to devise new equipment. The step-by-step clearance and approval process should be clearly described and made available publicly, saving start-up companies the significant entry costs by reducing anxiety and the need for hiring specialized legal counsel before embarking on a new project. To diminish the

\textsuperscript{373} In the absence of state or national databases of lactation rooms, several locator apps are in circulation—for instance, Mamava’s. Mamava, https://www.mamava.com/mobile-app [https://perma.cc/88ND-TZUR]. Though very useful, in the author’s personal experience, these apps tend to provide incomplete information as they may not reflect in real time the closure of a lactation room, if it has moved, or the procedure to access it.


\textsuperscript{375} Id.
environmental impact of pumps, the use of sustainable materials should be mandated for pump equipment and accessories (including milk storage bags) and pumps designed for multiple users (and thus able to be sanitized for reuse) should be incentivized.

Insurance Law—First, existing lactation coverage rules and regulations should be enforced. The ACA mandated that private insurers provide coverage for lactation services.\textsuperscript{376} This requirement should be extended to Medicaid, to which it does not currently apply and for which coverage decisions are managed at the state level.\textsuperscript{377} The key recommendations of the 2015 National Women’s Law Center’s report on breastfeeding insurance coverage should be implemented so that lactation support can be reimbursed with no cost-sharing, both in- or out-of-network.\textsuperscript{378} Additionally, the federal government should provide more specific guidance regarding what services and which providers ought to be covered so as to ensure the most extensive coverage possible.\textsuperscript{379} Second, a broader range of breastfeeding equipment and accessories should be fully covered by insurance for those who need them, including high-tech wearable pumps and breast bowls for hand milking.\textsuperscript{380} Third, specific insurance codes and direct billing should be set up for lactation counseling and support to facilitate billing and reimbursement.\textsuperscript{381} The reimbursement rate should be set high enough to ensure that providers are gainfully employed and rewarded for the time they spend with clients.

\textsuperscript{376} Section 2713 of the Public Health Service Act (PHS Act) as added by the Affordable Care Act requires that non-grandfathered group health plans and health insurance issuers provide coverage of certain specified preventive services without cost sharing, including breastfeeding and lactation counseling. 29 C.F.R. § 2590.715 – 2713 (2015).

\textsuperscript{377} See CTRS. FOR MEDICARE & MEDICAID SERVS., MEDICAID COVERAGE OF LACTATION SERVICES (2012), https://www.medicaid.gov/medicaid/quality-of-care/downloads/lactation_services_issuebrief_01102012.pdf (encouraging states to increase lactation services by covering them as part of already covered “pregnancy-related services”) [https://perma.cc/5ME5-2WH]. See also Improving Coverage and Care for Mothers Act, S. 3443, 116th Cong. (2020) (authorizing Medicaid to extend coverage of services provided to include lactation consultants).


\textsuperscript{380} Insurers should also be required to cover a minimum dollar amount and/or quality standard for pumps and other lactation supplies. In particular, all parents should have access to a high-quality double-electric pump free of out-of-pocket cost (if they want one).

\textsuperscript{381} See JUDITH L. GUTOWSKI, REIMBURSEMENT QUESTIONS AND ANSWERS FOR IBCLCS, U.S. LACTATION CONSULTANT ASSOC. (2012), https://uslca.org/wp-content/uploads/2013/02/Reimbursement_FAQ_Article_for_USLCA_6-2012_v2.pdf (showing that currently, in states that do not have lactation licensure laws, providers who are not otherwise licensed—for instance, as nurses, midwives, and therapists—cannot bill their lactation services directly to insurance, requiring them to partner with a licensed provider, often a pediatrician, in order to get their services covered via what is called “incident-to-billing”) [https://perma.cc/JFH3-UWEL].
Licensure Laws—Lactation implicates several types of licensure laws, including childcare licensing and occupational licensure for lactation professionals, which are addressed in turn. State childcare licensing laws and regulations should include a requirement that daycares facilitate human milk feeding. A number of statutes and regulations already include language to the extent that caregivers shall safely store and serve human milk.382 Parents should be welcome to feed their children at the breast or express milk at drop off, pick up, and throughout the day in a comfortable place. They should also be allowed to send expressed milk to the daycare for feedings for as long as they desire. Daycare personnel should not impose special handling procedures other than labelling given that occupational exposure to human milk has not been shown to lead to infection.383 Some centers have rules requiring the throwing away of leftover human milk, which can be very upsetting for parents who worked hard to produce it.384 Instead, families should have the option to recover unfinished bottles to take home. The relatively new occupation of lactation counseling should be supported and integrated into the health care system.385 Currently, few parents benefit from lactation assistance from friends and relatives, making access to skilled and allied specialists key to establish and support lactation. As Joan Dodgson has written, “the needs of breastfeeding families are many and diverse, with some needing the care of IBCLCs and others needing the care of CLCs,”386 and still others requiring peer counselors and idiosyncratic forms of community support. Different credentials should thus be recognized, ensuring that all families have access to affordable care from lactation providers matched to their needs.387


385. Aimee R. Eden, The Professionalization and Practice of Lactation Consulting: Medicalized Knowledge, Humanistic Care 9 (Mar. 1, 2013) (unpublished Ph.D. dissertation, University of South Florida) (showing that while the midwifery profession has existed for centuries, “there was never a formalized, separate social role for breastfeeding supporter, no identifiable individual that had lactation knowledge or expertise”).

386. See Dodgson, supra note 198, at 124.

387. Promising initiatives have sprung up in recent years in the form of inclusive state statutes. See N.J. REV. STAT. § 30-4D-60 (2020) (mandating Medicaid coverage of “lactation support, counseling, and consultation . . . with no cost-sharing” and specifying that “lactation consultant” means an IBCLC and “lactation counselor” someone “licensed or certified to practice lactation counseling under any law . . . or a community-based lactation supporter who has received at least 40 hours of specialty education in breastfeeding and lactation”); N.Y. SOC. SERV. LAW § 365-a (McKinney 2020) (bypassing the issue of
Health Law—There is a growing movement led by families and lactation professionals of color to decolonize breastfeeding. The movement and its recommendations should be integrated into the health care system, which has a long history of prioritizing White medical norms. As several breastfeeding advocates such as Kimberly Seals Allers, Camie Goldhammer, and Acquanda Stanford have shown, lactation education, counseling, and support is being reclaimed by BIPOC communities. Alternative narratives, traditions, forms of knowledge, embodied practices, and temporali(s)es are promoted and communicated in different languages, formats, and venues, among other differences. These initiatives should be supported at all levels of government, grounding lactation interventions. Among those, multiple aspects of pre- and post-natal care should be revamped for all parents to be able to lactate, including to express milk, if they need to, without injuring themselves. The U.S. model of pre and postpartum care, which is heavily medicalized and a site of systemic racism, should not only equitably represent providers of color and offer high-

licensure by mandating that public and private insurance plans reimburse lactation services provided by any “qualified lactation care provider” broadly defined as “a person who possesses current certication as a lactation care provider from a certication program accredited by a nationally recognized accrediting agency”).


389. See, e.g., Black Maternal Health Mommibus Act of 2021, H.R. 959 & S. 346, 117th Cong. (2021) (addressing multiple dimensions of Black maternal health, including establishing grant programs to increase lactation consultants who culturally appropriate support); Anti-Racism in Public Health Act of 2021, S. 162 & H.R. 666, 117th Cong. § 4 (2021) (declaring structural racism a public health crisis that would create a National Center on Antiracism and Health at the Centers for Disease Control and Prevention).

390. The primary determinants of lactation initiation and duration tend to be racial and socioeconomic, but the differences are partly explained by the fact that socioeconomically privileged families have access to higher quality pre and postnatal care, including midwives, doula(s), and lactation consultants, while marginalized families tend to lack such access. See Cathleen Odar Stough et al., Predictors of Exclusive Breastfeeding for 6 Months in a National Sample of US Children, 33 AM. J. HEALTH PROMOTION 48, 48 (2019) (analyzing data from 2011-12 to show that ethnicity/race, maternal education, household tobacco exposure, family composition, and family income predicted odds of both exclusive breastfeeding for 6 months and breastfeeding for a suboptimal duration or not exclusively); see also Jennifer N. Lind, Cria G. Perrine & Ruowei Li, Relationship Between Use of Labor Pain Medications and Delayed Onset of Lactation, 30 J. HUM. LACTATION 167, 167 (2014) (analyzing data suggesting that 23.4% of women in the United States who received labor pain medications experienced delayed onset of lactation).

quality, competent and respectful care to patients of color, but also be re-oriented toward a family- or parent-centered paradigm to amplify patients’ voices. As part of their reproductive rights, parents and communities should have the choice between home births, birthing centers, and hospitals, including Baby-Friendly Hospitals. They should have the option of beginning lactation education and support (including hand expression) during prenatal appointments and continue after birth with visits with lactation counselors, be it at their office, at home, or online. As lactation consultant Freda Rosenfeld has advocated, every locality that wants it should receive federal and state funding for a “lactation emergency room,” that is, a specialized lactation clinic open 24/7, staffed by skilled providers offering free or sliding scale support. Health professionals such as primary care doctors, OB/GYNs, pediatricians, and pediatric nurses, among others, should receive comprehensive lactation training as part of their standard curriculum so that they can better support families, including education on how to best support parents of color, immigrant parents, disabled parents, and parents who do not identify as women. Finally, the government should encourage and fund public and private research and development on lactation and lactation equipment. The mammary gland is an

392. See, e.g., Tyra Toston Gross et al., Long-Term Breastfeeding in African American Mothers: A Positive Deviance Inquiry of WIC Participants, 33 J. HUM. LACTATION 128 (2017) (studying the breastfeeding experiences of African American mothers and offering tailored suggestions to improve breastfeeding support for other African American women).

393. See Amanda Marie Lubold, Historical-Qualitative Analysis of Breastfeeding Trends in Three OECD Countries, 14 INT’L BREASTFEEDING J. 1, fig. 2 & tbl. 1 (2019) (indicating that Sweden consistently surpasses other countries in breastfeeding initiation rates and duration and tying it to its family-centered healthcare system).


395. See generally Jane Francis, et al., Vulnerable Mothers’ Experiences Breastfeeding with an Enhanced Community Lactation Support Program, 16 MATERNAL CHILD NUTRITION e12957 (2020) (presenting the benefits found for vulnerable mothers in Canada in a community lactation support consisting of free postnatal lactation support including access to certified lactation consultants, pumps, and in-home visits).

396. Telephone interview with Freda Rosenfeld, Board Certified Lactation Consultant (Nov. 30, 2020) (on file with author).

397. See Sharon Radzyninski & Lynn Clark Callister, Health Professionals’ Attitudes and Beliefs About Breastfeeding, 24 J. PERINATAL EDUC. 102 (2015) (interviewing 53 healthcare professionals providing care to lactating women showing inconsistencies between providers’ perceived support and behaviors, lack of knowledge, and significant lack of skill in the assessment and management of breastfeeding).

398. See Angela M. Johnson et al., Enhancing Breastfeeding Through Healthcare Support: Results from a Focus Group Study of African American Mothers, 20 MATERNAL CHILD HEALTH J. 92 (2016); Powell et al., supra note 304, at 259.
under-explored subject of medical knowledge and training for medical professionals.399

*Work Law*—Work law reform would ensure that parents can choose to combine breastfeeding and wage work, rather than being forced to, and retain agency over how to organize their work around their lactation. First, lactating parents on welfare should be exempt from work requirements such as those of the Temporary Assistance for Needy Families (TANF) which are associated with differences in breastfeeding rates.400 Second, to take into account the COVID-19 crisis and the future of work, the regulation of lactation breaks must be overhauled. For essential workers (as for other workers), lactation breaks should not only be paid, but also lengthened and afforded more flexibility in recognition of the challenges introduced by the pandemic—for instance, lactation rooms’ frequented may now be restricted to one user at a time to prevent contamination, facilities may need to be sanitized between users, occupation may be spaced out to improve air quality, and users may need to sanitize their station and equipment before and after use.401 Additionally, workers who do not normally have a private office should be offered the opportunity to use offices or other spaces left vacant due to the rise in telecommuting for their lactation needs.

*Tax Law*—Lactation supplies should be exempt from state or sales taxes of any kind (including pumps, extra pump parts, breast bowls, breast massagers, nipple ointments, breast pads, ice packs, and milk storage bags and bottles, among others). Feminist and critical tax scholars, such as Bridget Crawford, have shown that tax laws contribute to maintaining racial and gender inequality, along with other injustices.402 Just like Crawford has argued that tampons and other menstrual hygiene products should be exempt from sales taxes,403 products and activities designed to further human milk feeding should no longer be taxed by

399. See Katie Hinde, *What We Don’t Know About Mother’s Milk*, TEDWOMEN (Oct. 2016), https://www.ted.com/talks/katie_hinde_what_we_don_t_know_about_mother_s_milk#t-199612 ( remarking that significantly more research exists on coffee, wine, and tomatoes than on human milk) [https://perma.cc/445P-5527].


the federal and state governments. In 2011, the IRS made a step in this direction by declaring lactation equipment tax deductible. But federal tax deductions are too burdensome and hardly redeemable for families not subject to federal taxes or who do not spend enough on medical care. Moreover, human milk donors make a contribution not only to individual recipients’ health, but also to society at large as human milk feeding is associated with reductions in present and future illnesses and health costs. As such, they should obtain a tax deduction for their donations at a fair market value of human milk.

This Part argued the U.S. healthcare and welfare systems should be structurally reformed so that all people have equal opportunities to control their reproductive and parenting destinies, lactation included. It zeroed in on the specific types of legal and social supports necessary for individual and community lactation choices to be optimally realized. These may come across as a fairly disparate list of policy and legal recommendations, but one advantage is that they could be implemented piecemeal even in the absence of systemic reform. In the event sweeping health and welfare change did occur, they could be integrated into the new systems put in place.

CONCLUSION

This Article has shown that for many parents, milk expression is an essential component of breastfeeding and that lactation itself raises equality and reproductive justice issues. This constitutional framework considers how the ability of any parent to determine their infant feeding choice is linked to other social justice issues such as economic justice, racial justice, LGBTQIA+ justice, environmental justice, immigration justice, disability rights, and the specific conditions in their communities. While in principle the decision of whether or not to breastfeed (and whether to use milk expression) is an individual choice, in practice it is informed by the social reality of inequalities of opportunities, against the backdrop of a political and legal system that does too little to support parents and families, especially the most vulnerable and under-resourced.

404. See INTERNAL REVENUE SERV., supra note 208.
405. See Melissa Bartick & Arnold Reinhold, The Burden of Suboptimal Breastfeeding in the United States: A Pediatric Cost Analysis, 125 PEDIATRICS e1048, e1048 (2010) (showing health care cost savings of $12.4 billion in 2018 U.S. dollars ($10.5 billion in 2007 U.S. dollars) during the infant’s first year of life if 80% of infants were breastfed exclusively for 6 months); see also Stan M. Robinson, Infant Nutrition and Lifelong Health: Current Perspectives and Future Challenges, 6 J. DEV. ORIGINS HEALTH & DISEASE 384, 384 (2015) (highlighting the importance of understanding the role and importance of nutrition in early postnatal life, as an influence on lifelong vulnerability to poor health).
The COVID-19 pandemic presented communities in the United States with previously unprecedented challenges, many of which have exacerbated longstanding racial, gender, and class inequalities.\textsuperscript{407} Lactation stands in a peculiar position, as it has both been facilitated and hindered by the crisis. On the one hand, stay-at-home orders and transition to remote learning, working, and other virtual environments have allowed some parents to be home 24/7, enabling them to feed their children at the breast or to express milk in conditions sometimes more favorable than they would ordinarily experience. They could now lactate in the comfort of their homes, uninterrupted by commutes, colleagues, visitors, or other usual activities and demands. In less rosy scenarios, however, their lactation labor intensified due to their constant availability to their children and their other responsibilities, including teleworking, homeschooling, childcare, homecare, and other forms of caregiving.\textsuperscript{408}

On the other hand, those considered essential personnel continued report to work even when they were lactating. For this group, the pandemic made lactation even harder to combine with wage work. They were constrained to express milk using heightened precautions to avoid contamination while holding onto jobs that often failed to provide them with adequate lactation breaks and facilities.\textsuperscript{409} Among essential workers are health care workers, but also blue-collar workers such as grocery clerks, delivery workers, warehouse workers, who tend to be disproportionately women of color.\textsuperscript{410} At the onset of the pandemic, leading public health organizations and facilities required the temporary separation of COVID-positive or COVID-suspected parents from their babies at birth.\textsuperscript{411}


\textsuperscript{408} See Caitlyn Collins et al., \textit{COVID-19 and the Gender Gap in Work Hours}, 28 GENDER, WORK, & ORG. 101 (2021) (highlighting that school and daycare closures due to COVID-19 increased caregiving responsibilities for working parents, particularly for mothers who reduced their work hours four to five times more than fathers to meet new caregiving demands).

\textsuperscript{409} See Botz & Cohen, \textit{supra} note 220.


These practices sometimes prevented feeding at the breast even though early evidence suggested that SARS-CoV-2 was not transmitted through human milk and disproportionately harmed Black and Indigenous women. Milk expression proved a critical bridge to allow the initiation and maintenance of lactation before parents and babies could be reunited, but not all families were adequately supported in this endeavor.

The dominant public health and parenting discourses pressure parents to breastfeed, yet as the pandemic illustrates, U.S. laws and policies fail to provide an environment in which all parents can actually breastfeed. The right to express milk should be an expansion of, not a substitute for, robust lactation rights. If for most parents, feeding at the breast is their preferred version of human milk feeding, as this Article has argued, others may favor milk expression or may need to resort to it for various reasons. Parents of infants are not a homogeneous group; they have different needs and wishes and experience different life challenges. Families need more, rather than fewer, options to feed their children.

longer recommending the separation of mothers with Covid-19 and their infants except where the mother is not feeling well enough to care for her infant but still recommending that “During the birth hospitalization, the mother should maintain a reasonable distance from her infant when possible.”) [https://perma.cc/4HPW-XCNC], But see Breastfeeding Advice During the COVID-19 Outbreak, WORLD HEALTH ORG. REGIONAL OFF. FOR MEDITERRANEAN (2020), http://www.emro.who.int/nutrition/nutrition-infocus/breastfeeding-advice-during-covid-19-outbreak.html (recommending that infants and mothers with suspected or confirmed COVID-19 “should be enabled to remain together and practice skin-to-skin contact, kangaroo care and to remain together and to practice rooming in throughout the day and night.”) [https://perma.cc/2P9J-3LBQ]; Alison Stuebe, Should Infants Be Separated from Mothers with COVID-19? First, Do No Harm, 15 BREASTFEEDING MED. 451 (2020) (arguing that there are more health and psychological risks to separating infants and mothers than to keeping them together).

412. See Guido E. Moro & Enrico Bertino, Breastfeeding, Human Milk Collection and Containers, and Human Milk Banking: Hot Topics During the COVID-19 Pandemic, 36 J. HUM. LACTATION 604 (2020); see also Natalie Shenker et al., Response of UK Milk Banks to Ensure the Safety and Supply of Donor Human Milk in the COVID-19 Pandemic and Beyond, 16 INFANTS 118, 120 (2020).


414. See Diane L. Spatz, Using the Coronavirus Pandemic as an Opportunity to Address the Use of Human Milk and Breastfeeding as Lifesaving Medical Interventions, 49 J. OBSTETRIC, GYNECOLOGIC & NEONATAL NURSING 225, 225 (2020).