

**Alimentation des nourrissons
chez les femmes à faible revenu :
le contexte social qui conditionne leur façon
de voir les choses et leurs expériences**

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Cet article analyse les points de vue des femmes à faible revenu afin de mieux comprendre le contexte social qui conditionne leur façon de voir les choses et leurs expériences en matière d'alimentation des nourrissons. À partir d'un échantillonnage dirigé, les auteures ont organisé trois groupes de discussion avec 19 femmes qui utilisaient des préparations pour nourrissons pour nourrir leur bébé dans une communauté urbaine et deux communautés rurales dans la région de l'Est de l'île de Terre-Neuve au Canada. Les éléments du contexte social pour l'alimentation comprenaient la prévalence de mythes et de renseignements erronés sur l'allaitement; les attentes culturelles concernant le comportement des nourrissons; l'expérience postnatale, y compris la médicalisation de la naissance et de l'allaitement; le soutien du partenaire et la charge de travail en matière de soins aux enfants; les préjugés culturels sur l'allaitement; et une idéologie moralisante qui associe l'allaitement à un « bon maternage ». Les auteures discutent des implications des constatations dans l'optique des soins infirmiers et de la santé publique en formulant sept recommandations sur la façon dont les infirmières et les professionnels de la santé peuvent mieux soutenir les femmes et leur famille.

Mots clés : allaitement, famille, promotion de la santé, mères, populations vulnérables

Infant-Feeding Among Low-Income Women: The Social Context That Shapes Their Perspectives and Experiences

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This article explores the perspectives of low-income women in order to better understand the social context that shapes their infant-feeding perspectives and experiences. The authors used purposive sampling to conduct 3 focus groups with 19 women who were formula-feeding their infants in 1 urban and 2 rural communities in the eastern region of the island of Newfoundland in Canada. Elements of the social context for infant-feeding included the prevalence of myths and misinformation about breastfeeding; cultural expectations about infant behaviour; the postnatal experience, including the medicalization of birth and breastfeeding; partner support and child-care workload; cultural stigma of breastfeeding; and a moralizing ideology that equates breastfeeding with “good mothering.” The authors discuss the implications of the findings from a nursing and public health perspective, offering 7 recommendations for how nurses and health professionals might better support women and their families.

Keywords: breastfeeding, family, health promotion, mothers, vulnerable populations

This article discusses the findings of a feminist sociological analysis of a qualitative study with low-income women in the Canadian province of Newfoundland and Labrador who were formula-feeding their infants. We explore the perspectives of these women in order to better understand the social factors that shaped their infant-feeding experiences. We also discuss the implications of the findings from a nursing and public health perspective, offering recommendations for how nurses and other health professionals might better support all new parents as they face the challenges of nurturing and feeding their babies.

Literature Review

Infant-feeding practices vary greatly across the world (Marshall, Godfrey, & Renfrew, 2007; Van Esterik, 2002). Breastfeeding has been the norm throughout history (Small, 1999; Stuart-Macadam & Dettwyler, 1995), but in the 19th and 20th centuries, with the development of an industry

that manufactures and heavily markets infant formula, formula-feeding largely replaced breastfeeding in many parts of the world (Cattaneo, 2012; Van Esterik, 2002). While breastfeeding rates have now generally started to rebound, they remain low in many regions of the world, including Newfoundland and Labrador (Public Health Agency of Canada [PHAC], 2008). The World Health Organization (WHO) recommends that all infants be breastfed for 2 years and beyond, with no additional fluids or solids for the first 6 months (Kramer & Kakuma, 2009; WHO, 2012). In Canada, 90% of new mothers initiate breastfeeding but only a quarter continue to breastfeed their infants to 6 months of age (PHAC, 2008). Newfoundland and Labrador has the lowest breastfeeding rates in Canada (PHAC, 2008). In some of its rural areas breastfeeding initiation rates are as low as 46% (Newfoundland and Labrador Provincial Perinatal Program, 2011). Infant-feeding differences are tied to socio-economic status, with lower incomes and lower educational levels associated with higher levels of formula-feeding (Association of Registered Nurses of Newfoundland and Labrador, 2006; Lee, 2007; MacGregor & Hughes, 2010; Millar & Maclean, 2005).

From a public health perspective, infant-feeding has important consequences for population health. Breastfeeding has been shown to have many health benefits for both mother and child (Alexander, Dowling, & Furman, 2010; Steube, 2009; Wojcicki et al., 2010). Formula-fed infants have higher rates of diarrhea, respiratory tract infection, otitis media, and sudden infant death syndrome (Hanson, 1999; Plagemann & Harder, 2005). There is also evidence to suggest that children who were breastfed are less likely to develop chronic conditions such as types 1 and 2 diabetes (Gerstein, 1994; Rosenbauer, Herzig, & Giani, 2008).

Yet to reduce infant-feeding to a public health concern would be an oversimplification. Infant-feeding is a complex issue — a personal, social, and deeply cultural experience (Callaghan & Lazard, 2011; Choudry & Wallace, 2012; Dykes, 2005; MacGregor & Hughes, 2010; Stuart-Macadam & Dettwyler, 1995). According to Dykes (2005),

breastfeeding practices within a given culture represent the ways in which women negotiate and incorporate dominant ideologies and institutional and cultural norms with the realities of their embodied experiences, personal circumstances and social support systems. (p. 2283)

Infant-feeding is often framed as a “choice” to breastfeed or formula-feed, but there is increasing criticism of this language, particularly by feminist researchers (Callaghan & Lazard, 2011; Hausman, 2008). The notion of choice brings with it individualist assumptions that mask the social inequities that are key to understanding differences in infant-feeding practices. As Hausman (2008) points out, “it is our responsibility, as

feminists, to identify the constraints that reveal the ‘choice’ itself to be not so much a choice but a class privilege, and then to figure out how to challenge the status quo that makes it so” (p. 12).

The notion of choice also takes the focus away from breastfeeding as a women’s rights issue. It opens the door to criticizing women for “choosing” the “wrong” method of feeding. Many have argued that our ideas about infant-feeding have become inextricably linked with morality and that public health promotion of breastfeeding, with its discourse of “breast is best” and use of language such as “successful breastfeeding,” equates breastfeeding with “good mothering” and formula-feeding with “failure” (Burns, Schmied, Sheehan, & Fenwick, 2010; Knaak, 2010; Lee, 2007, 2008; Murphy, 1999; Ryan, Bissell, & Alexander, 2010; Sheehan, Schmied, & Barclay, 2009). Feminist researchers have also argued that messages promoting breastfeeding have contributed to the medicalization of breastfeeding practices, dwelling on fear and on individual mothers’ responsibility for the “risk” associated with formula-feeding (Knaak, 2010; Lee, 2007, 2008; Murphy, 1999, 2000; Sheehan et al., 2009) and undermining women’s trust in and knowledge about their own bodies (Bartlett, 2002; Burns et al., 2010).

As multidisciplinary public health researchers who are concerned with the health and well-being of women, their babies, and their families, we are committed to promoting breastfeeding for its health benefits, but also to profoundly respecting and supporting all new parents and their children. In this article we explore the social factors that shape the infant-feeding perceptions and experiences of low-income women in Newfoundland and Labrador. In the long term, our purpose is to use the knowledge gained to improve supports for these women and their families and to strive towards a society where breastfeeding is a right, not a privilege.

The Study

Method

This study was carried out as part of a developing body of research on infant-feeding conducted by the Breastfeeding Research Working Group under the Breastfeeding Coalition of Newfoundland and Labrador. This multidisciplinary team includes clinicians, nurses, lactation consultants, faculty, and researchers committed to improving population health in the province. The body of research is focused on understanding the reasons for the province’s low rates of breastfeeding, with the long-term goal of developing interventions to raise the rates.

The initial inquiry for the study was based on the research question *What attitudes, beliefs, and values influence mothers’ decision not to breastfeed?* As explained above, a feminist analysis of the findings made it clear that

there is much more complexity to the issue of infant-feeding. Widening our perspective from a simple decision-making focus to encompass a more complex understanding of women's perspectives and experiences allowed us to examine the subtleties of the social context of infant-feeding.

Participants

In summer 2010, a purposive sampling of low-income women who were formula-feeding their infants was initiated in the eastern region of the island of Newfoundland. Contact was made with staff of one urban and two rural prenatal nutrition programs. The women were offered a package of material and information about the time and place for the focus group sessions; if they were interested, they could contact the principal interviewer and/or attend the gathering. (The rate of participation is unknown, as staff did not record the number of women approached.) A \$20 gift card was offered to each participant as an honorarium.

A total of 19 women participated, with an average age of 26 years and an infant between 1 month and 2 years of age. Nine were single mothers. Eighty-four percent had a high-school education or less and the median annual household income was \$10,000 to \$20,000, with most participants receiving some form of government support. There were six participants in the urban focus group, 12 in the first rural group, and only 1 in the final rural group. The sessions took place in a room in the local community and lasted between 30 and 50 minutes.

Procedure

The research question used to guide discussion was *Why did you choose to formula-feed your baby?* An experienced qualitative researcher collected demographic information on a pre-approved form, introduced the study, and requested permission to audiorecord the sessions. She also assured the participants that their identifying information would be removed. Once completed, the interviews were transcribed verbatim. Ethical approval for the study was obtained from the Human Investigation Committee of Memorial University of Newfoundland.

The data were originally analyzed by two researchers (KB and VL) together, and the results of the analysis are published elsewhere (Ludlow et al., 2012). In order to explore the research results in terms of the social context of infant-feeding, a secondary analysis was conducted by a third researcher (JTN), who had not taken part in the focus groups. This secondary analysis, from a feminist sociological perspective, was the basis for this article. Manual coding and qualitative content analysis were conducted from the transcripts. Social factors were identified and categorized using continuous comparison of items within and between the groups.

The validity and reliability of the findings were enhanced by using the participants' own words.

Results

The participants described their own experiences and perspectives regarding the feeding of their baby but in doing so highlighted a number of social and cultural factors that shape the context of infant-feeding in Newfoundland and Labrador. These include the prevalence of breastfeeding myths and misinformation, the postnatal experience and the medicalization of birth and breastfeeding, cultural expectations regarding infant behaviour, partner support and child-care workload, the cultural stigma of breastfeeding, and a moralizing ideology that equates breastfeeding with "good mothering."

Breastfeeding Myths and Misinformation

The results make it clear that in Newfoundland and Labrador there is a great deal of conflicting and inaccurate information and many myths about breastfeeding. Many of the myths circulate among the public, but research has also documented inconsistency in the messages of health professionals about infant-feeding and has indicated that this may be an important factor in breastfeeding cessation (MacGregor & Hughes, 2010).

Participants confirmed several myths about infant-feeding, including the belief that formula is better for the baby if (1) the mother smokes — "[formula-feeding] is a lot more expensive, but I know she's getting every vitamin . . . and besides, I'm a smoker. It [isn't] fair to feed her from me"; (2) the mother does not have a nutritious diet — "Your diet affects it . . . if you don't eat a lot of what I'll call 'the healthy food.' . . . They're getting more nutrients on the formula"; and, curiously, (3) the infant is lactose intolerant — "My daughter is lactose intolerant anyway, so she wouldn't have been able to be breastfed."

Perhaps the most important aspect of this misinformation is the belief that breastfeeding is an innate and rather rare ability and that many women are simply not physically capable of producing enough breastmilk to meet the needs of their child: "[Breastfeeding] is just not made for some people." Dykes (2005) found that women conceptualized their breasts as "potentially faulty machines" (p. 2285) and expressed a profound distrust of their bodies being able to produce milk for their babies. This distrust has been termed "insufficient milk syndrome" (Dykes, 2002, 2005; Dykes & Williams, 1999; Hillervik-Lindquist, 1991; MacGregor & Hughes, 2010). One of our participants was discouraged from breastfeeding by the experience of her older sister:

She tried to breastfeed. It never worked out for her. The child was just constantly screaming, screaming, screaming, I guess hungry all the time or not getting enough.

Another spoke of her early attempts at breastfeeding:

I was frightened to death. . . . is your child going to get enough to eat? Because, a newborn baby, [you]’re [breast]feeding them and they could drink a little bit and go to sleep and 5 minutes later they want more. . . . At least [with formula-feeding] you can tell [how much] they’re getting.

One woman was concerned about being able to measure the amount her baby was consuming:

If you make a two-ounce or a four-ounce or an eight-ounce bottle, you know. If they drink it, they got it. But with breastfeeding you don’t know — you don’t know what they’re getting.

This concern with insufficient milk, strongly encouraged by the infant-formula industry, is common in Western cultures, where breastmilk is seen as a product (Dykes, 2005; Van Esterik, 2002). The emphasis on particular nutrients in breastmilk also reflects our society’s concentration on the benefits of breastfeeding only in terms of the known physical constituents of breastmilk, as opposed to the mother–infant nursing relationship, skin-to-skin contact, intimacy, and emotional benefits for the infant. Most other cultures throughout the world do not make a distinction between the nutritional and emotional needs of the baby (Dykes, 2005; Van Esterik, 2002) or, for that matter, between the mother’s needs and those of the infant.

Finally, fear of not producing enough breastmilk may be exacerbated by the medicalization of breastfeeding. Researchers have found that health professionals’ focus on the frequency of feeding rather than on the infant’s behavioural cues tends to undermine women’s confidence in their ability to breastfeed (Burns et al., 2010).

Postnatal Experience and the Medicalization of Birth and Breastfeeding

Learning to breastfeed is part of the postnatal experience, an experience that is difficult for many women (Kelleher, 2006). Many have argued that, like women’s health in general, birth, breastfeeding, and the postpartum period have become overly medicalized in our society (Burns et al., 2010; Gustafson, 2005; Jones & Ste. Croix Rothney, 2001; Mauthner, 1999; Morgan, 1998). In the past, generations of women passed down breastfeeding knowledge within families and communities, but today “there has been a ‘cultural shift in authority’ away from women’s own shared embodied knowledge towards a ‘biomedical narrative’” (Burns

et al., 2010, citing Bartlett, 2002, p. 376). One participant contrasted the nurses' biomedical approach to feeding and infant care with her own trust in her personal, lived experience. She took offence at nurses' attempts to scientifically monitor her breastfeeding:

[The nurse said], "Oh, have a nap," and by the time you get to sleep they're coming in with the baby again or they're coming in to say, "Oh, did you wake the baby? Did you feed the baby?" No offence, but I've . . . had enough kids to know [that] if the baby is sleeping, let the baby sleep. I'm not going to wake the baby. If I was bottle-feeding in the hospital I'd be left alone. "When was the last time the baby fed? Did it have a pee? Did it have a poo?" Breastfeeding, every hour on the hour.

Researchers have found that the biomedical discourse of health professionals, with its focus on correct latch position, feeding frequency, weighing the baby, and language of "demand" and "success," can undermine women's confidence in their mothering skills and lead to disillusionment and a sense of failure (Burns et al., 2010; Redshaw & Henderson, 2012).

Some of the women in our study specifically stated that they wanted to formula-feed because they were tired after a long and exhausting labour or a Caesarean section. Caesarean section is associated with low breastfeeding rates (Lin, Lee, Yang, & Gau, 2011). This highlights the need for professional labour support, which has been shown to reduce the length of labour and the rates of Caesarean section (McGrath & Kennell, 2008), as well as to increase breastfeeding rates (Mottl-Santiago et al., 2008; Nommsen-Rivers, Mastergeorge, Hansen, Cullum, & Dewey, 2009).

Many participants spoke about the difficulty of learning to breastfeed in the hospital. Research has documented the negative effect of routine interruptions on maternity wards on breastfeeding (Morrison & Ludington-Hoe, 2012). Some of the women, particularly those who had given birth in an urban centre, described nurses' attempts to help women learn to breastfeed as "intrusive" and "aggressive." One participant claimed that she was not permitted to have visitors while she was learning to breastfeed. She said that she decided to formula-feed because she wanted to leave the hospital and was not permitted to do so until breastfeeding was well established:

They will not let you leave the hospital until they know that child is getting something to eat. That was one of the main reasons why I [formula-fed]. [When I was breastfeeding], it was just me and him and there was nobody allowed to come visit me. They said, "Well, we're going to keep you here now another couple of days." I said, "No, you're not. I'm going home now. I'm giving him a bottle."

Such findings have led many researchers to question whether the “chaotic nature of hospital-based post-natal care in many countries may not be conducive to women taking on their roles as new mothers and learning to breastfeed” (Sheehan et al., 2009, p. 378).

In contrast, women who had given birth in a rural centre described an assumption of formula-feeding on the part of health professionals:

I don't think there [are] enough people encouraging [women] to breastfeed. I went to the doctor and he never once asked me if I was going to breast-feed. When I had the baby that morning, you're usually asked if you're going to breastfeed or are you formula-feeding. They just brought in formula: “Here, this is what your baby is getting.”

Clearly, in regions where the majority of women formula-feed their baby from birth, there may be a particular need to educate health professionals on the importance of supporting breastfeeding.

Once women return home from hospital with their infant, there is an immediate reduction in professional support. Many participants described feeling overwhelmed with breastfeeding once they were discharged:

You get home from the hospital and that baby is not latching on. Well, everybody is getting frustrated. The baby is screeching because it's starving to death and you don't know what to do. So, here's the bottle, you know. Obviously you got to feed him.

Several participants said that they had to formula-feed because they found engorgement too painful and did not realize that this was temporary or know how to alleviate their discomfort. These experiences, and particularly the decision to discontinue breastfeeding in response to difficulties encountered early on, illustrate the lack of information and support for women once they are discharged from hospital. They also point very clearly to the need for high-quality postnatal care and breastfeeding support in the first days and weeks after delivery.

Cultural Expectations Regarding Infant Behaviour

Cultural expectations about infant-feeding are inseparable from cultural beliefs about infant behaviour and parenting. Researchers have noted that when women believe that their baby is “unsettled” they are less confident about breastfeeding and come under more pressure from family members to formula-feed (Marshall et al., 2007). This idea of a “settled” baby is part of Western society’s focus on “civilizing” babies, a concept that is rare in other societies (Dykes, 2005; Marshall et al., 2007; Small, 1999; Van Esterik, 2002; Vincent, 1999). Women in our study spoke of the importance of getting their baby onto a schedule of feeding and napping and

felt that formula-feeding was much more suited than breastfeeding to establishing a routine:

Feeding off of me, it was non-stop. She was constantly attached to a boob. Now . . . she drinks her four bottles a day, sometimes five. . . . She's set to her times, set to her schedules.

The infant behaviour described may represent normal behaviour for a breastfeeding baby, yet there clearly is considerable pressure for women to produce a “good” baby who fits into a particular schedule and does not make too many demands (Dykes, 2005; Van Esterik, 2002). For health professionals working with new parents, it may be important to acknowledge this pressure and to contextualize infant-feeding as part of a holistic approach to infant care, including an emphasis on the normal range of infant behaviour, and supports to draw on for the challenges of infant care.

We need more research on how differences in parenting behaviour, such as that around sleeping arrangements and infant-carrying, might shape infant-feeding in various cultural settings such as Newfoundland and Labrador.

Partner Support and Child-Care Workload

Research has shown that partner support is a key factor in whether or not a woman initiates and continues with breastfeeding (Rempel & Rempel, 2004, 2011). However, research in the United States has found that expectant parents emphasize the father's support for the new infant but rarely his support for the mother (Avery & Magnus, 2011). The partner of one of our participants was quite willing to give his infant daughter a bottle of formula but was not inclined to help out with less pleasant tasks:

He doesn't like diapers. I can count on two hands how many times he's changed the diapers in 4 and a half months.

Many of the participants reported that their partner preferred that they formula-feed, sometimes simply because they purportedly did not want to be “left out of the nighttime feedings.” Although some of the women tried to pump breastmilk, they all agreed that this was too time-consuming to be feasible on a regular basis. Unfortunately, we have no more details on the women's pumping experiences, such as whether they had access to hospital-grade pumps.

A strongly gendered imbalance in parenting expectations and child-care workload was a key social element of the participants' infant-feeding experiences. This is an important finding, since research has shown that domestic workload can have consequences for mental and physical health

(Messing, 1998; Temple, 2009). Several women who had initially attempted breastfeeding felt that it had created an enormous imbalance in child-care responsibilities between themselves and their partner and that formula-feeding was a way to force their partner to take on some of the workload:

I breastfed my other children but . . . after 3 months of lying on my couch and being the only one that bathed and changed her . . . [I said to my partner], “You know what? I grew [the baby], I gave birth to [her], for 3 months I had [her] attached to my boobs 24/7. Guess what. It’s your turn.”

Many participants described feeling overwhelmed by their child-care and domestic responsibilities after the birth of a new baby. Even though some of these women began breastfeeding and would have liked to continue, formula-feeding allowed them to better manage their heavy workload:

With the formula-fed baby . . . I could feed her her bottle at nighttime and lie down and sleep through the night. Breastfeeding, I couldn’t do it. I’ve got other kids in the house. It’s too much.

With three kids at home, I can say, “Guys, can somebody give me a hand feeding the baby?” Because supper could be half-cooked and that’s when she decides she wants to be fed. . . . When you got two other kids at home and a little baby and you’re trying to do homework, do the pick-ups from school and the drop-offs to school . . . it’s not easy.

Participants described being exhausted, finding themselves getting angry with their partners and children, and being unable to cope with day-to-day infant care. They struggled to balance their own needs with those of their baby, sometimes challenging the ideology of “intensive mothering” (Hays, 1996), whereby the mother’s needs are always subordinated to those of the infant (Marshall et al., 2007). For these women, the decision to discontinue breastfeeding was a matter of coming to terms with their own limits for the sake of the whole family and their own mental and physical health: “You’re no good to your child if you’re not fit yourself.” The words of these women echo those in a serial-interview study in the United Kingdom, which found that women and their families experienced pivotal moments when it seemed that the only way to improve the well-being of the immediate family was to discontinue breastfeeding (Hoddinott, Craig, Britten, & McInnes, 2012).

Like most women in Canada (Duxbury & Higgins, 2003), the majority of women in this study had primary responsibility for child care

within their household. If lack of child-care support is an important factor in women's decision to formula-feed, then it is crucial that those promoting breastfeeding acknowledge that increased child-care assistance is an essential part of supporting women who want to breastfeed.

The Cultural Stigma of Breastfeeding

In Newfoundland and Labrador, as in most Western cultures, there is a powerful stigma around the public exposure of breasts and discomfort with reconciling the sexual and nurturing aspects of women's bodies. Consequently, there is a strong tendency to see breastfeeding in public as embarrassing (MacGregor & Hughes, 2010; Matthews, Webber, McKim, Banoub-Baddour, & Laryea, 1998) and as risking predatory male attention (Henderson, McMillan, Green, & Renfrew, 2011). For example, Henderson and colleagues (2011) found that men tend to see formula-feeding as convenient and safe and breastfeeding as "natural" but problematic because they believe it involves excessive public exposure.

The participants were very concerned about exposing their breasts while feeding their baby. They talked about their own discomfort with breasts and breastfeeding and the social pressure not to breastfeed openly in public areas:

Lots of people . . . give the look as if to say, "How dare you do that in public!" . . . If I breastfed I don't think I'd leave the house, because I'm really private. The public health nurse had to come to my house to see what problems I was having . . . I was really happy that she had called and offered that. I was lucky because I needed her and I wasn't going to go up [to the clinic] and say, "Gee, can you take a look?"

Many participants indicated that they were pressured not to breastfeed by partners or family members because of the public exposure of breasts. One woman admitted that she would not feel comfortable breastfeeding even in her own home. Others reported that family members were embarrassed or even "horrified" that they intended to try breastfeeding. One participant recalled being discouraged from even discussing breastfeeding as soon as she announced her pregnancy: "My mom said, 'Now, we're not even going to talk about that. You're not going at it!'"

Ironically, lack of exposure to breastfeeding has also been identified as an important factor in the low breastfeeding rates among low-income women, and increased public exposure to breastfeeding has been recommended in order to develop a supportive breastfeeding culture (MacGregor & Hughes, 2010).

Breastfeeding Equated With “Good Mothering”

The association of breastfeeding with “good mothering” (Marshall et al., 2007) was painfully clear in the words of our participants. Almost every participant admitted feeling guilty about not breastfeeding. One woman said that health professionals “make you feel guilty and improper as a mother if you’re not doing it.” Another admitted that she felt so guilty about deciding to use formula that when the public health nurse asked if she was still breastfeeding she said yes even though she had discontinued several months before. Also, many women clearly had internalized the “risk” discourse surrounding formula (Knaak, 2010; Lee, 2007, 2008), worrying that they were harming their children by feeding them formula. One participant put it in terms of feeling she had betrayed herself and her daughter by switching to formula:

There’s so much pressure put on you about the breastfeeding that, even though that’s what I wanted to do, when I knew that . . . I couldn’t do it any more I felt guilty . . . I knew I gave her what I could give her and it was better than nothing at all, but I still felt that guilt because of the pressure that was put on me about breastfeeding. I didn’t want to admit to caregivers or doctors or the health nurses that I wasn’t doing it any more, because that made me feel inadequate — that made me feel like I was a failure.

Perhaps the most telling comment to come out of the study emerged in a discussion of how the women would feed any future children they might have. Although every woman in the group was currently using formula, some were determined to try breastfeeding again should they have another child:

If I were to find out I was pregnant tomorrow, you know what the sad thing is? I’d breastfeed again. I’d do it. I’d put myself through it, knowing full well . . . within 3 months I’d be right back to the formula-feeding for my own sanity. I know that.

For nurses and other health professionals, these words are a reminder of how committed many women are to breastfeeding, how difficult breastfeeding can be in many circumstances, and, most importantly, how pressing is the need for formal and informal supports for women and their families.

Discussion

In Newfoundland and Labrador, as in Canada generally and much of the Western world, society is structured in a way that makes breastfeeding challenging, particularly for women with low levels of resources, educa-

tion, and life experience (Hausman, 2008). Under such conditions, breastfeeding becomes not a right or a choice but a privilege of class. From our perspective, this is very much an issue of health equity, since it means that breastfeeding disproportionately benefits more affluent mothers and children. The insights of the women in this study have helped us to develop seven recommendations for raising breastfeeding rates as well as for supporting new families, no matter how they feed their babies. These recommendations concern *research, resources, maternity care, child care, partner support, public education, and empowerment and respect.*

Research

From a research perspective, we need more detailed information on infant-feeding, particularly on breastfeeding initiation and duration rates in areas such as Newfoundland and Labrador. To this end, in order to design evidence-based interventions, we need quantitative and qualitative research specifically with women who intend to and attempt to breastfeed but later switch to formula. In terms of public health, we also need research on how best to deliver positive breastfeeding messages to different target groups. Hoddinott and colleagues (2012) suggest that a family-centred, narrative approach to breastfeeding support would be more effective than our current feeding education programs. They also indicate that the current recommendation of 6 months exclusive breastfeeding may be unrealistic and overwhelming for many families and that it might be more helpful to set achievable incremental goals. More research is needed on this issue and on the effectiveness of these approaches.

Resources

There is a pressing need for increased resources to improve breastfeeding support. All nurses working with mothers and infants should have core knowledge of breastfeeding (Centers for Disease Control and Prevention [CDC], 2012). We recommend that frontline hospital and community health nurses avail themselves of comprehensive breastfeeding-education programs such as the World Health Organization/United Nations Children's Fund 24-hour course, including 3 hours of supervised clinical work (WHO & UNICEF, 2009). This would help to ensure that new mothers have access to high-quality breastfeeding advice. We need more lactation consultants, so that all women experiencing difficulty with breastfeeding have access to professional advice. Physicians, particularly family doctors, obstetricians, and pediatricians, also need high-quality breastfeeding education. In addition, we need to increase the number of Canadian hospitals certified by the WHO/UNICEF Baby-Friendly Hospital Initiative, which recommends specific ways to improve breastfeeding support in the hospital setting (WHO & UNICEF, 2009). In

addition to hospital support, women need more prenatal and postnatal support, “pro-actively offered to women who want to breastfeed” (Renfrew et al., 2005, p. 63; see also Health Canada, 2011; WHO & UNICEF, 2009), including peer-support groups, high-quality breastfeeding programs as part of prenatal classes, and 24/7 support via telephone, text, and Internet, and, where possible, face-to-face. With a publicly funded health-care system, this inevitably would mean an increase in public funding for breastfeeding. However, we believe that such funding would more than pay for itself, considering the long-term health benefits associated with breastfeeding.

Maternity Care

Infant-feeding decisions need to be understood within the context of women’s other postnatal experiences and needs. We recommend a holistic, evidence-based approach to maternal and postnatal care (Baker, Choi, Henshaw, & Tree, 2005) that integrates breastfeeding as a core part of the postnatal experience and builds women’s trust and confidence in their own bodies and mothering abilities. We echo the call of Burns et al. (2010) for a more holistic language around infant-feeding and infant care that better articulates the “embodied reality of breastfeeding” (p. 212). Considering the high rate of Caesarean section in Canada, which is steadily rising and is at its highest in Newfoundland and Labrador (Canadian Institute for Health Information, 2012), we must also increase women’s options for care during labour and delivery. This means regulating the midwifery profession and incorporating it into the provincial medicare system in jurisdictions (such as Newfoundland and Labrador) where midwifery legislation has yet to be enacted. It also means encouraging labour professionals, such as doulas, since a growing body of research (including a randomized controlled trial) shows that labour support improves women’s birth and breastfeeding experiences (McGrath & Kennell, 2008; Mottl-Santiago et al., 2008; Nommsen-Rivers et al., 2009).

Child Care

If we are serious about supporting women who are learning to breastfeed, we will challenge current gender dynamics and child-care expectations that place primary responsibility for care on the mother and will press for political change that includes high-quality affordable child care. In terms of the immediate postpartum period, we also need to support and promote a cultural shift towards respecting a new mother’s need for a period of rest and recuperation following the birth of her child, freed from other domestic responsibilities.

Partner Support

Research has shown that the support of a woman's partner is vitally important in breastfeeding (Rempel & Rempel, 2011). We recommend that a new mother's partner (whether or not he or she is a co-parent) become involved by developing a nurturing relationship with the infant, "by becoming breastfeeding savvy, by using their knowledge to encourage and assist mothers in breastfeeding, by valuing the breastfeeding mothers, and by sharing housework and child care" (Rempel & Rempel, 2011, p. 115). We also recommend a sharper focus on the role of the entire family, educating fathers, partners, grandmothers, and other family members about breastfeeding (CDC, 2012).

Public Education

We recommend public education campaigns that promote breastfeeding based on knowledge and empowerment rather than risk and fear (Lee, 2007). We also recommend a realistic approach that addresses the lived experiences and physical and emotional challenges associated with early breastfeeding (Kelleher, 2006; Sheehan et al., 2009).

Empowerment and Respect

We need a change in focus, from a scientific-bureaucratic, medicalized approach to breastfeeding (Sheehan et al., 2009) that is centred on "measuring" an infant's breastmilk intake to an empowering approach (Kang, Choi, & Ryu, 2008) that respects individual needs and diversity while bolstering a woman's trust and confidence in herself, her body's ability to produce milk for her baby, and her baby's nursing and satiation cues (Dykes, 2005). In their metasynthesis of research on women's experiences of breastfeeding support, Schmied, Beake, Sheehan, McCourt, and Dykes (2011) found that continuity of caregiver facilitated "an authentic presence, involving supportive care and a trusting relationship with professionals" (p. 58). In addition, for nurses and other health-care providers, as well as for researchers and for society, it is important to show respect for all families and to avoid language that frames infant-feeding in moral terms such as "right" or "wrong." For nurses working with parents and newborns, it also means providing high-quality support and information to all families, no matter how they feed their babies (Lee, 2007).

Limitations

One limitation of this study was its small number of participants. One group became an individual interview since there was only one participant, though the information was mirrored by the stories of the other rural group, comprising 12 individuals. The findings cannot be statistically

generalized to larger populations; however, the purpose of qualitative research is not to make statistical generalizations but to provide rich detail about participants' perceptions and experiences (Denzin & Lincoln, 2005).

A second limitation is that the study was restricted to mothers. This focus was chosen because, in our society, it is most often women who make the infant-feeding decision. In many families there are two parents who both contribute (equally or not) to this decision, and it would be valuable to do a study that focuses on both parents. (There are also cases where grandparents or other individuals take part in the decision. We are currently conducting a study of grandmothers' contribution to the infant-feeding decision.) Our focus on mothers excludes families in which infants are raised by single fathers, gay male couples, or grandparents or other caregivers and also omits the experiences of transgendered fathers who may be breastfeeding. It would be worthwhile to conduct research that specifically addresses infant-feeding experiences and support needs in diverse family settings.

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